Australian Government

Department of Health, Disability and Ageing

Medicare Benefits Schedule Book

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The latest Medicare Benefits Schedule information is available from *MBS Online* at https://www.health.gov.au/mbsonline

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GUIDE TO SUMMARY OF CHANGES INCLUDED IN THIS EDITION

Summary of Changes for 1 November 2026

From 1 November 2026, there will be changes to the Medicare Benefits Schedule (MBS) to implement a range of administrative and policy amendments, including the Australian Government's response to recommendations from the Medical Services Advisory Committee (MSAC) and new and amended MBS services agreed to in the 2026-27 Budget. The changes are in line with the following legislation:

- *Health Insurance (General Medical Services Table) Regulations 2021*;
- *Health Insurance (Diagnostic Imaging Services Table) Regulations (No. 2) 2020*;
- *Health Insurance (Pathology Services Table) Regulations 2020*;
- *Health Insurance Regulations 2018*; and
- Determinations made under section 3C of the *Health Insurance Act 1973*

Thriving Kids Initiative

From 1 November 2026, as part of the Government's *Thriving Kids initiative* a new MBS health assessment service called the Medicare Healthy Kids Check will be introduced for 3-year-old children using the time-tiered health assessment items (701-707 and 224-227). Introduction of a 3-year-old health check was recommended by the Thriving Kids Advisory Group, to improve early identification of developmental delay and/or neurodevelopmental differences in children, and facilitate connections with appropriate supports, or referrals for further assessment where needed. Further information is available at MBS Online - Medicare Healthy Kids Check.

Other changes to general medical services

From 1 November 2026, changes will be made relating to general medical services. These changes include:

- Introducing four new phone attendance items 92033, 92034, 92063 and 92064 for chronic condition management (CCM) attendances by a general practitioner or prescribed medical practitioner to prepare or review a CCM plan for a patient;
- Permanently listing six items (92478, 92479, 92480, 92481, 92482 and 92483) for inpatient telehealth psychiatry services which were first introduced as temporary items on 1 November 2024. Additionally, amendments will be made to the claiming restrictions for the six items to allow for two time-tiered services within a 7-day period where previously only one other time-tiered service was permitted in a 7-day period;
- Enabling immunomodulating treatment item 14245 to be provided by a qualified health practitioner on behalf of the prescribing medical practitioner;
- Enabling participating nurse practitioners to refer patients for bone mineral densitometry services described in items 12306 to 12322;
- Expanding ambulatory blood pressure monitoring item 11607 to include child and adolescent blood pressure measurements and thresholds;
- Amending item 18360 to provide treating clinicians access to a third pharmaceutical option (Xeomin) to treat patients with moderate and severe focal spasticity caused by a neurological disorder;
- Enabling services provided under item 45518 to be performed outside of a hospital setting;
- Administrative amendments to replace references to the term "residential aged care facility" with "residential care home" to align with terminology in the *Aged Care Act 2024*;

- Administrative amendments to align Modified Monash (MM) location classifications with the most recent 2023 MM location categories;
- Administrative amendments to reflect the new name of the committee that provides accreditation in relation to undertaking transcatheter aortic valve implantation and transcatheter mitral valve repair services, which is the Australian Transcatheter Valve Therapies Accreditation Committee;
- Expanding the definitions of the terms "eligible Aboriginal and Torres Strait Islander health worker" and "health professional" in relation to services to which item 73813 applies for detection of infection with chlamydia trachomatis, neisseria gonorrhoeae or trichomonas vaginalis;
- Administrative amendment to correct a typographical error in item 10997;
- Amending clause 1.2.11 to enable proton beam therapy item 15990 to be administered by persons other than medical practitioners and removing rhinology item 41764 to restrict its provision by only a medical practitioner or a speech pathologist on behalf of an otolaryngology head and neck surgeon;
- Amending section 52 of the *Health Insurance Regulation 2018*, (which sets out prescribed particulars of a person rendering a service and a person claiming or receiving fees) to include reference to all items currently in Group T2 (Radiation Oncology) and Group T3 (Therapeutic Nuclear Medicine).

Changes relating to diagnostic imaging services

From 1 November 2026, changes will be made relating to diagnostic imaging services. This includes:

- Enabling the maximum benefit payable for item 61438 for patients accessing this nuclear medicine imaging service;
- Amending the frequency restriction for item 61564 for prostate-specific membrane antigen positron emission tomography studies for the restaging of recurrent prostate adenocarcinoma to allow the service to apply once in a 12-month period;
- Administrative amendments to replace references to the term “residential aged care facility” with “residential care home” to align with terminology in the *Aged Care Act 2024*;
- Administrative amendments to align Modified Monash (MM) location classifications with the most recent 2023 MM location categories.

Changes relating to pathology services

From 1 November 2026, changes will be made relating to pathology services. This includes:

- Administrative amendments to replace references to the term “residential aged care facility” with “residential care home” to align with terminology in the *Aged Care Act 2024*;
- Amendments to remove the requirement for specialist paediatricians to consult a clinical geneticist before requesting genetic testing for childhood syndromes under items 73358, 73359 and 73360;
- Amending item 71099 to enable the use of the Crithidia method as a choice of testing for double-stranded DNA antibody assessment under this item;
- Amending item 73433 to expand *NTRK1-3* testing to adult patients with locally advanced or metastatic glioma, glioneuronal tumour or glioblastoma.

Relevant Legislation

- *Health Insurance Legislation Amendment (2026 Measures No. 3) Regulations 2026*
- *Health Insurance Legislation Amendment (Residential Care Home Consequential Amendments) Determination 2026*
- *Health Insurance (Section 3C General Medical Services – Telehealth Attendances) Amendment (In-hospital Psychiatry Services) Determination 2026*
- *Health Insurance (Section 3C General Medical Services – Telehealth Attendances) Amendment (Chronic Condition Management Phone Services) Determination 2026*
- *Health Insurance (Section 3C Co-Dependent Pathology Services) Amendment (Expanding NTRK1-3 Testing) Determination 2026*
- *Health Insurance Legislation Amendment (Administrative – Transcatheter Valve Therapies Accreditation) Determination 2026*
- *Health Insurance (Section 3C Pathology Services – Point-of-Care Testing Services) Amendment (Expanding Eligible Providers) Determination 2026*

SUMMARY OF CHANGES FROM 01/11/2026

The 01/11/2026 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

New Items

92033 92034 92063 92064

Description Amended

4	24	37	47	58	59	60	65	124	165	181	187	191
206	228	232	235	236	237	238	239	240	249	294	303	374
375	377	378	380	381	390	391	715	731	735	739	743	747
750	758	761	763	766	769	772	776	788	789	903	2198	2200
2485	2486	2488	2489	2491	2492	2494	2495	5003	5010	5023	5028	5043
5049	5063	5067	5076	5077	5220	5223	5227	5228	5260	5261	5262	5263
5265	5267	10931	10955	10957	10959	10997	11607	14245	16408	18360	45515	45518
51700	51703	57541	61564	71099	73358	73359	73360	73433	73932	73933	73934	73935
90001	90002	90020	90035	90043	90051	90054	90092	90093	90095	90096	90098	90183
90188	90202	90212	90215	92027	92058	92478	92479	92480	92481	92482		

GENERAL EXPLANATORY NOTES

GENERAL EXPLANATORY NOTES

GN.0.1 AskMBS Email Advice Service

AskMBS responds to enquiries from providers of services listed on the Medicare Benefits Schedule (MBS) seeking advice on interpretation of MBS items (including those for dental, pathology and diagnostic imaging), explanatory notes and associated legislation. AskMBS advice is informed by current policy settings and intended primarily to assist health professionals, practice managers and others to understand and comply with MBS billing requirements. AskMBS works closely with policy areas within the Department of Health, Disability and Ageing, and with Services Australia, to ensure enquirers receive accurate, authoritative and up-to-date information.

Enquiries can be emailed to askMBS@health.gov.au.

AskMBS has no involvement in or visibility of the administration of claims under Medicare. If you are seeking advice in relation to such a matter (including billing, rejections, refunds, adjustments, information on provider registration, provider numbers, specific provider eligibility, or system matters such as HPOS and PRODA) please contact Services Australia on the Provider Enquiry Line on 13 21 50.

AskMBS also issues advisories summarising responses to frequently asked questions on specific subject areas, and these resources may provide answers to your specific question/s.

AskMBS Email Advice Service

GN.1.1 The Medicare Benefits Schedule - Introduction

Schedules of Services

Each professional service contained in the Schedule has been allocated a unique item number. Located with the item number and description for each service is the Schedule fee and Medicare benefit, together with a reference to an explanatory note relating to the item (if applicable).

If the service attracts an anaesthetic, the word (Anaes.) appears following the description. Where an operation qualifies for the payment of benefits for an assistant, the relevant items are identified by the inclusion of the word (Assist.) in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

Higher rates of benefits are provided for consultations by a recognised consultant physician where the patient has been referred by another medical practitioner or an approved dental practitioner (oral surgeons).

Differential fees and benefits also apply to services listed in Category 5 (Diagnostic Imaging Services). The conditions relating to these services are set out in Category 5.

Explanatory Notes

Explanatory notes relating to the Medicare benefit arrangements and notes that have general application to services are located at the beginning of the schedule, while notes relating to specific items are located at the beginning of each Category. While there may be a reference following the description of an item to specific notes relating to that item, there may also be general notes relating to each Group of items.

GN.1.2 Medicare - an outline

The Medicare Program ('Medicare') provides access to medical and hospital services for all Australian residents and certain categories of visitors to Australia. Services Australia administers Medicare and the payment of Medicare benefits. The major elements of Medicare are contained in the *Health Insurance Act 1973*, as amended, and include the following:

a. Free treatment for public patients in public hospitals.
b. The payment of benefits, for professional services listed in the Medicare Benefits Schedule (MBS). The relevant benefit rates are:

i. 100% of the Schedule fee for services provided by a general practitioner to non-referred, non-admitted patients, or for general practitioner attendances specified as not being hospital treatments - see note below;
ii. 100% of the Schedule fee for services provided on behalf of a general practitioner by a practice nurse or Aboriginal and Torres Strait Islander health practitioner*;
iii. 75% of the Schedule fee for professional services rendered to a patient as part of an episode of hospital treatment (other than services provided to public patients), including services provided in hospital outpatient settings but not generally including services set out in the note below. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '*' or the letter 'H' directly after an item number where used; or a description of the professional service and an indication the service was rendered as an episode of hospital treatment (for example, 'in hospital', 'hospital outpatient service', 'admitted' or 'in patient');
iv. 75% of the Schedule fee for professional services rendered as part of a privately insured episode of hospital-substitute treatment such as ‘hospital in the home’, but generally not including certain services listed below. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service, preceded by the words 'hospital-substitute treatment';
v. 85% of the Schedule fee for all other services.

Note: while hospital treatments and hospital-substitute treatments attract a 75% benefit, most attendances, services provided to private patients in emergency departments, pathology services and diagnostic imaging services do not generally require hospital treatment and therefore do not attract a benefit of 75% of the Schedule fee unless certified as a 'Type C' treatment. A list of most MBS items in scope of this exception, and the requirements around certifying a treatment as 'Type C' can be found in the *Private Health Insurance (Benefit Requirement) Rules 2011*. Services provided to a private patient in an emergency department are exempted under the P*rivate Health Insurance (Health Insurance Business) Rules 2018*.

Medicare benefits are claimable only for 'clinically relevant' services rendered by an appropriate health practitioner. A 'clinically relevant' service is one which is generally accepted by the relevant profession as necessary for the appropriate treatment of the patient.

When a service is not clinically relevant, the fee and payment arrangements are a private matter between the practitioner and the patient.

Services listed in the MBS must be rendered according to the provisions of the relevant Commonwealth, State and Territory laws. For example, medical practitioners must ensure that the medicines and medical devices they use have been supplied to them in strict accordance with the provisions of the *Therapeutic Goods Act 1989*.

Where a Medicare benefit has been inappropriately paid, Services Australia may request its return from the practitioner concerned.

* MBS items 10988 and 10989 generally attract a 100% benefit but can be specified as 'Type C' treatments and attract a 75% benefit.

GN.1.3 Medicare benefits and billing practices

Key information on Medicare benefits and billing practices

The *Health Insurance Act 1973* stipulates that Medicare benefits are payable for professional services. A professional service is a clinically relevant service which is listed in the MBS. A medical service is clinically relevant if it is generally accepted in the medical profession as necessary for the appropriate treatment of the patient.

Medical practitioners are free to set their fees for their professional service. However, the amount specified in the patient's account must be the amount charged for the service specified. The fee may not include a cost of goods or services which are not part of the MBS service specified on the account.

Billing practices contrary to the Act

A *non-clinically relevant service* must not be included in the charge for a Medicare item. The non-clinically relevant service must be separately listed on the account and not billed to Medicare.

Goods supplied for the patient's home use (such as wheelchairs, oxygen tanks, continence pads) must not be included in the consultation charge. Medicare benefits are limited to services which the medical practitioner provides at the time of the consultation - any other services must be separately listed on the account and must not be billed to Medicare.

Charging part of all of an episode of hospital treatment or a hospital substitute treatment to a non-admitted consultation is prohibited. This would constitute a false or misleading statement on behalf of the medical practitioner and no Medicare benefits would be payable.

An account may not be re-issued to include charges and out-of-pocket expenses excluded in the original account. The account can only be reissued to correct a genuine error.

Potential consequence of improperly issuing an account

The potential consequences for improperly issuing an account are

(a) No Medicare benefits will be paid for the service;

(b) The medical practitioner who issued the account, or authorised its issue, may face charges under sections 128A or 128B of the *Health Insurance Act 1973*.

(c) Medicare benefits paid as a result of a false or misleading statement will be recoverable from the doctor under section 129AC of the *Health Insurance Act 1973*.

Providers should be aware that Services Australia is legally obliged to investigate doctors suspected of making false or misleading statements, and may refer them for prosecution if the evidence indicates fraudulent charging to Medicare. If Medicare benefits have been paid inappropriately or incorrectly, Services Australia will take recovery action.

Services Australia (SA), in consultation with the Department of Health, Disability and Ageing, has developed a Health Practitioner Guideline for responding to a request to substantiate that a patient attended a service. There is also a Health Practitioner Guideline for substantiating that a specific treatment was performed. These guidelines are located on the Department of Health, Disability and Ageing's website.

GN.2.4 Provider eligibility for Medicare

To be eligible to provide medical service which will attract Medicare benefits, or to provide services for or on behalf of another practitioner, practitioners must meet one of the following criteria:

(a) be a recognised specialist, consultant physician or general practitioner; or

(b) be in an approved placement under section 3GA of the *Health Insurance Act 1973*; or

(c) be a temporary resident doctor with an exemption under section 19AB of the *Health Insurance Act 1973*, and working in accord with that exemption.

Any practitioner who does not satisfy the requirements outlined above may still practice medicine but their services will not be eligible for Medicare benefits.

NOTE: New Zealand citizens entering Australia do so under a special temporary entry visa and are regarded as temporary resident doctors.

NOTE: It is an offence under Section 19CC of the *Health Insurance Act 1973* to provide a service without first informing a patient where a Medicare benefit is not payable for that service (i.e. the service is not listed in the MBS).

Non-medical practitioners

To be eligible to provide services which will attract Medicare benefits under MBS items 10950-10968 and MBS items 80000-82035 and 82100-82140 and 82200-82383, allied health professionals, Aboriginal and Torres Strait Islander primary health care professionals, dentists, and dental specialists, participating midwives and participating nurse practitioners must be

(a) registered according to State or Territory law or, absent such law, be members of a professional association with uniform national registration requirements; and

(b) registered with Services Australia to provide these services.

GN.2.5 Provider Numbers

Practitioners eligible to have Medicare benefits payable for their services and/or who for Medicare purposes wish to raise referrals for specialist services and requests for pathology or diagnostic imaging services, may apply ***in writing*** to Services Australia for a Medicare provider number for the locations where these services/referrals/requests will be provided. The form may be downloaded from the Services Australia website.

For Medicare purposes, an account/receipt issued by a practitioner must include the practitioner's name and ***either*** the provider number for the location where the service was provided ***or*** the address where the services were provided.

Medicare provider number information is released in accord with the secrecy provisions of the *Health Insurance Act 1973* (section 130) to authorised external organisations including private health insurers, the Department of Veterans' Affairs and the Department of Health, Disability and Ageing.

When a practitioner ceases to practice at a given location they must inform Medicare promptly. Failure to do so can lead to the misdirection of Medicare cheques and Medicare information.

GN.2.6 Locum tenens

Where a locum tenens will be in a practice for more than two weeks ***or*** in a practice for less than two weeks but on a regular basis, the locum should apply for a provider number for the relevant location. If the locum will be in a practice for less than two weeks and will not be returning there, they should contact Services Australia (provider liaison - 132 150) to discuss their options (for example, use one of the locum's other provider numbers).

A locum must use the provider number allocated to the location if

(a) they are an approved general practice or specialist trainee with a provider number issued for an approved training placement; or

(b) they are associated with an approved rural placement under Section 3GA of the *Health Insurance Act 1973*; or

(c) they have access to Medicare benefits as a result of the issue of an exemption under section 19AB of the *Health Insurance Act 1973* (i.e. they have access to Medicare benefits at specific practice locations); or

(d) they will be at a practice which is participating in the Practice Incentives Program; or

(e) they are associated with a placement on the MedicarePlus for Other Medical Practitioners (OMPs) program, the After Hours OMPs program, the Rural OMPs program or Outer Metropolitan OMPs program.

GN.2.7 Overseas trained doctor

Ten year moratorium

Section 19AB of the *Health Insurance Act 1973* states that services provided by overseas trained doctors (including New Zealand trained doctors) and former overseas medical students trained in Australia, will not attract Medicare benefits for 10 years from either

a. their date of registration as a medical practitioner for the purposes of the *Health Insurance Act 1973*; or
b. their date of permanent residency (the reference date will vary from case to case).

Exclusions - Practitioners who before 1 January 1997 had

a. registered with a State or Territory medical board and retained a continuing right to remain in Australia; or
b. lodged a valid application with the Australian Medical Council (AMC) to undertake examinations whose successful completion would normally entitle the candidate to become a medical practitioner.

The Minister of Health and Ageing may grant an overseas trained doctor (OTD) or occupational trainee (OT) an exemption to the requirements of the ten year moratorium, with or without conditions. When applying for a Medicare provider number, the OTD or OT must

a. demonstrate that they need a provider number and that their employer supports their request; and
b. provide the following documentation:
    i. Australian medical registration papers; and
    ii. a copy of their personal details in their passport and all Australian visas and entry stamps; and
    iii. a letter from the employer stating why the person requires a Medicare provider number and/or prescriber number is required; and
    iv. a copy of the employment contract.

GN.2.8 Contact details for Services Australia

The day-to-day administration and payment of benefits under the Medicare arrangements is the responsibility of Services Australia.

Changes to Provider Contact Details

It is important that you contact Services Australia promptly of any changes to your preferred contact details. Your preferred mailing address is used to contact you about Medicare provider matters. We require requests for changes to your preferred contact details to be made by the provider in writing to Services Australia at:

Medicare

GPO Box 9822

in your capital city

or

the Medicare Provider telephone line on 132 150.

You may also be able to update some provider details through HPOS http://www.servicesaustralia.gov.au/hpos

GN.3.9 Patient eligibility for Medicare services

This note sets out who can access Medicare services.

ELIGIBLE GROUPS

To be eligible for Medicare, a person must ordinarily live in Australia, be located in Australia at the time of the service, and be:

- an Australian citizen
- an Australian permanent resident
- a New Zealand citizen
- a Resident Return visa holder
- an applicant for permanent residency (conditions apply) or
- a temporary visa holder covered by a Ministerial Order.

Ministerial Orders made under Section 6(1) of the *Health Insurance Act 1973* grant eligibility to groups including Australian citizens who have been absent from Australia for up to five years and holders of particular temporary visa types.

Note: access to Medicare by visitors to Australia who are covered by a Reciprocal Health Care Agreement is subject to the specific conditions of each Agreement (see below).

ENROLLING IN MEDICARE

The patient must enrol with Medicare before receiving Medicare benefits. Once enrolled, they will receive a Medicare Card. There are three types of Medicare cards, in the following colours:

Green – this is the standard Medicare card for Australian citizens, permanent residents and New Zealand citizens living in Australia and Resident Return visa holders.

Blue – this is the card for people who have applied for permanent residence or who hold a temporary visa covered by a Ministerial Order.

Yellow – this is the card for visitors to Australia from a country with a Reciprocal Health Care Agreement.

More information about enrolling in Medicare and the different Medicare cards is available from Services Australia.

RECIPROCAL HEALTH CARE AGREEMENTS

Under Section 7 of the *Health Insurance Act 1973*, the Australian Government has agreements with 11 other governments to cover the cost of certain medical care when Australians and overseas residents visit each other's countries.

Eligible overseas visitors from these countries generally receive:

- inpatient/outpatient services as a public patient in a public hospital
- out of hospital care
- Pharmaceutical Benefits Scheme (PBS) prescription medicines

Exceptions: Visitors from New Zealand and Ireland are entitled to public hospital care and PBS drugs only (not MBS services).

Reciprocal Health Care Agreements do not cover the cost of treatment as a private patient in a public or private hospital.

People visiting Australia for the specific purpose of receiving medical treatment are not covered.

Eligible Countries:

As at 1 November 2026, Australia has Reciprocal Health Care Agreements with the following countries:

- Belgium
- Finland
- Italy (eligibility limited to six months from date of arrival)
- Malta (eligibility limited to six months from date of arrival)
- Netherlands
- New Zealand (public hospital care and PBS medicines only, not MBS services)
- Norway
- Ireland (public hospital care and PBS medicines only, not MBS services)
- Slovenia
- Sweden
- United Kingdom

Eligible patients from these countries need to enrol in Medicare to access MBS services. Once enrolled they will have a yellow Medicare card.

- Visitors from New Zealand and Ireland do not need to enrol in Medicare to access public hospital services and PBS medicines under the Reciprocal Health Care Agreements. They are not eligible for MBS services unless they hold a green Medicare card.

More information about access to medical care under each Reciprocal Health Care Agreement is available from Services Australia.

OTHER VISITORS AND TEMPORARY RESIDENTS

Other visitors and temporary residents are not eligible for Medicare and should arrange private health insurance cover.

RELEVANT LEGISLATION

Information about the legislative arrangements applying to Medicare and the Reciprocal Health Care Agreements is set out in the *Health Insurance Act 1973*, which can be found on the Federal Register of Legislation.

GN.4.13 Who can use the Medicare Benefits Schedule GP items?

SUMMARY

This general note sets out which medical practitioners can use the MBS general practitioner (GP) items.

Medical practitioners that are eligible to provide Medicare services who are not GPs but provide services in a general practice setting can use the medical practitioner and prescribed medical practitioner (explanatory note AN.7.1) MBS items.

WHO CAN USE THE MBS GP ITEMS?

The *Health Insurance Act 1973* (the Act), and legal instruments made under the Act, set out which medical practitioners can claim MBS GP items. The four categories of medical practitioner that can access MBS GP items are those that are:

1. General practitioners registered under the National Law in the specialty of General Practice
2. On an approved placement in a general practice training program
3. Listed on the Vocational Register of GPs (closed to new participants)
4. Eligible non-VR GPs (closed to new participants)

Before you can claim MBS GP items you must have a Medicare provider number for the location at which you are practising. You can apply for a Medicare provider number through Services Australia.

1. General practitioners registered under the National Law in the specialty of General Practice

Services Australia uses the Australian Health Practitioner Regulation Agency (Ahpra) Register of Medical Practitioners to determine practitioners' access to the GP items. Fellows of the RACGP and ACRRM must hold specialist registration as a GP with the Medical Board of Australia to access the GP items. The Ahpra registration for these medical practitioners will indicate that they are a specialist in the field of general practice.

2. Medical practitioners on an Approved Placement in a general practice training program

Section 1.1.3 of the *Health Insurance (General Medical Services Table) Regulations 2021* provides access to the MBS GP items to medical practitioners undertaking an approved training placement. That is, a training placement that will lead to fellowship with the RACGP or ACCRM.

- For more information on approved training placements see the General Practice Fellowship Program Placement Guidelines.

Your placement organisation must advise Services Australia of the placement before MBS GP items can be accessed.

3. Medical practitioners on the Vocational Register of GPs

The Vocational Register of GPs closed to new participants on 16 June 2021.

Section 16 of the *Health Insurance Regulation 2018* allows medical practitioners whose names are entered onto the Vocational Register of GPs to access MBS GP items provided they continue to be registered with Ahpra.

4. Eligible non-vocationally recognised medical practitioners

The programs below closed to new participants on 1 January 2019.

Section 1.1.2 of the *Health Insurance (General Medical Services Table) Regulations 2021* specifies which non-vocationally recognised medical practitioners can access MBS GP items:

1. Medical practitioners who have been notified by the Chief Executive of Medicare that they have completed the requirements of the MedicarePlus for Other Medical Practitioners Program before 31 December 2023.

2. Participants in the Other Medical Practitioners Extension Program who were enrolled in one of the following programs as at 30 June 2023:
    a. After Hours Other Medical Practitioner Program
    b. Outer Metropolitan Other Medical Practitioner Program
    c. Rural Other Medical Practitioner Program

RELEVANT LEGISLATION

Details of the legislative arrangements applying to the categories of medical practitioners able to use the MBS GP items can be found on the Federal Register of Legislation, and are set out in three regulatory instruments:

- *Health Insurance Act 1973*
- *Health Insurance (General Medical Services Table) Regulations 2021*
- *Health Insurance Regulations 2018*

GN.5.14 Recognition as a Specialist or Consultant Physician

A medical practitioner who:

· is registered as a specialist under State or Territory law; or

· holds a fellowship of a specified specialist College and has obtained, after successfully completing an appropriate course of study, a relevant qualification from a relevant College; and

· has formally applied and paid the prescribed fee, may be recognised by the Minister as a specialist or consultant physician for the purposes of the *Health Insurance Act 1973*.

A relevant specialist College may also give Services Australia's Chief Executive Officer a written notice stating that a medical practitioner meets the criteria for recognition.

A medical practitioner who is training for a fellowship of a specified specialist College and is undertaking training placements in a private hospital or in general practice, may provide services which attract Medicare benefits. Specialist trainees should consult the information available at Services Australia's Medicare website.

Once the practitioner is recognised as a specialist or consultant physician for the purposes of the *Health Insurance Act 1973*, Medicare benefits will be payable at the appropriate higher rate for services rendered in the relevant speciality, provided the patient has been appropriately referred to them.

Further information about applying for recognition is available at Services Australia Medicare website.

Services Australia (SA), in consultation with the Department of Health, Disability and Ageing, has developed a Health Practitioner Guideline to substantiate that a valid referral existed (specialist or consultant physician) which is located on the Department of Health, Disability and Ageing website.

GN.5.15 Emergency Medicine

A practitioner will be acting as an emergency medicine specialist when treating a patient within 30 minutes of the patient's presentation, and that patient is

(a) at risk of serious morbidity or mortality requiring urgent assessment and resuscitation; or

(b) suffering from suspected acute organ or system failure; or

(c) suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or

(d) suffering from a drug overdose, toxic substance or toxin effect; or

(e) experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or

(f) suffering acute severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or

(g) suffering acute significant haemorrhage requiring urgent assessment and treatment; and

(h) treated in, or via, a bona fide emergency department in a hospital.

Benefits are not payable where such services are rendered in the accident and emergency departments or outpatient departments of public hospitals.

GN.6.16 Referral Of Patients To Specialists Or Consultant Physicians

For certain services provided by specialists and consultant physicians, the Medicare benefit payable is dependent on acceptable evidence that the service has been provided following referral from another practitioner.

A reference to a referral in this Section does not refer to written requests made for pathology services or diagnostic imaging services. Information about the form of a diagnostic imaging request can be found in **Note IN.0.6** of the Diagnostic Imaging Services Table (Category 5) and information about the form of a pathology request can be found in **Note PN.2.1** of the Pathology Services Table (Category 6).

What is a Referral?

A "referral" is a request to a specialist or a consultant physician for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s).

Subject to the exceptions in the paragraph below, for a valid "referral" to take place

(i) the referring practitioner must have undertaken a professional attendance with the patient and turned their mind to the patient's need for referral and have communicated relevant information about the patient to the specialist or consultant physician (this need not mean an attendance on the occasion of the referral);

(ii) the instrument of referral must be in writing as a letter or note to a specialist or to a consultant physician and must be signed and dated by the referring practitioner; and

(iii) the specialist or consultant physician to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

The exceptions to the requirements in paragraph above are that

(a) sub-paragraphs (i), (ii) and (iii) do not apply to

- a pre-anaesthesia consultation by a specialist anaesthetist (items 16710-17625);

(b) sub-paragraphs (ii) and (iii) do not apply to

- a referral generated during an episode of hospital treatment, for a service provided or arranged by that hospital, where the hospital records provide evidence of a referral (including the referring practitioner's signature); or

- an emergency where the referring practitioner or the specialist or the consultant physician was of the opinion that the service be rendered as quickly as possible; and

(c) sub-paragraph (iii) does not apply to instances where a written referral was completed by a referring practitioner but was lost, stolen or destroyed.

Examination by Specialist Anaesthetists

A referral is not required in the case of pre-anaesthesia consultation items 17610-17625. However, for benefits to be payable at the specialist rate for consultations, other than pre-anaesthesia consultations by specialist anaesthetists (items 17640 -17655) a referral is required.

Who can Refer?

The general practitioner is regarded as the primary source of referrals. Cross-referrals between specialists and/or consultant physicians should usually occur in consultation with the patient's general practitioner.

Referrals by Dentists or Optometrists or Participating Midwives or Participating Nurse Practitioners

For Medicare benefit purposes, a referral may be made to

(i) a recognised specialist:

(a) by a registered dental practitioner, where the referral arises from a dental service; or

(b) by a registered optometrist where the specialist is an ophthalmologist; or

(c) by a participating midwife where the specialist is an obstetrician or a paediatrician, as clinical needs dictate. A referral given by a participating midwife is valid until 12 months after the first service given in accordance with the referral and for I pregnancy only or

(d) by a participating nurse practitioner to specialists and consultant physicians. A referral given by a participating nurse practitioner is valid until 12 months after the first service given in accordance with the referral.

(ii) a consultant physician, by an approved dental practitioner (oral surgeon), where the referral arises out of a dental service.

In any other circumstances (i.e. a referral to a consultant physician by a dentist, other than an approved oral surgeon, or an optometrist, or a referral by an optometrist to a specialist other than a specialist ophthalmologist), it is <u>not</u> a valid referral. Any resulting consultant physician or specialist attendances will attract Medicare benefits at unreferred rates.

Registered dentists and registered optometrists may refer themselves to specialists in accordance with the criteria above, and Medicare benefits are payable at the levels which apply to their referred patients.

Billing

Routine Referrals

In addition to providing the usual information required to be shown on accounts, receipts or assignment agreement, specialists and consultant physicians must provide the following details (unless there are special circumstances as indicated in paragraph below):-

- name and either practice address or provider number of the referring practitioner;

- date of referral; and

- period of referral (when other than for 12 months) expressed in months, eg "3", "6" or "18" months, or "indefinitely" should be shown.

Special Circumstances

(i) Lost, stolen or destroyed referrals.

If a referral has been made but the letter or note of referral has been lost, stolen or destroyed, benefits will be payable at the referred rate if the account, receipt or the assignment form shows the name of the referring medical practitioner, the practice address or provider number of the referring practitioner (if either of these are known to the consultant physician or specialist) and the words 'Lost referral'. This provision only applies to the initial attendance. For subsequent attendances to attract Medicare benefits at the referred rate a duplicate or replacement letter of referral must be obtained by the specialist or the consultant physician.

(ii) Emergencies

If the referral occurred in an emergency, benefit will be payable at the referred rate if the account, receipt or assignment agreement is endorsed 'Emergency referral'. This provision only applies to the initial attendance. For subsequent attendances to attract Medicare benefits at the referred rate the specialist/consultant physician must obtain a letter of referral.

(iii) Hospital referrals.

Private Patients - Where a referral is generated during an episode of hospital treatment for a service provided or arranged by that hospital, benefits will be payable at the referred rate if the account, receipt or assignment form is endorsed 'Referral within (name of hospital)' and the patient's hospital records show evidence of the referral (including the referring practitioner's signature). However, in other instances where a medical practitioner within a hospital is involved in referring a patient (e.g. to a specialist or a consultant physician in private rooms) the normal referral arrangements apply, including the requirement for a referral letter or note and its retention by the specialist or the consultant physician billing for the service.

Public Hospital Patients

State and Territory Governments are responsible for the provision of public hospital services to eligible persons in accordance with the National Healthcare Agreement.

Bulk-Billing

Bulk-billing assignment forms should also include the same information as detailed above.

However, faster processing of the claim will be facilitated where the provider number (rather than the practice address) of the referring practitioner is shown.

Additionally, the bulk billing assignment form must include:

(i) the full name of the individual for whom the service was provided;

(ii) the date on which the assignment agreement was made;

(iii) indication the assignment of benefit agreement was completed prior to (pre-assignment) the provision of the professional service;

(iv) confirmation if the assignor is the patient (yes or no);

(v) the date on which the specimen was obtained;

(vi) a statement confirming the assignor’s consent;

(vii) a description of the service delivered.

(viii) be signed by the patient (or their assignor)

Specifications for bulk billed assignment of benefit agreements are outlined in Part 65C of the *Health Insurance Regulation 2018*.

Period for which Referral is Valid

The referral is valid for the period specified in the referral which is taken to commence on the date of the specialist's or consultant physician's first service covered by that referral.

Specialist Referrals

Where a referral originates from a specialist or a consultant physician, the referral is valid for 3 months, except where the referred patient is an admitted patient. For admitted patients, the referral is valid for 3 months or the duration of the admission and ceases when the patient is discharged.

A referral for a specialist professional service to a patient in a hospital who is not a public patient is valid until the patient ceases to be a patient in the hospital.

As it is expected that the patient's general practitioner will be kept informed of the patient's progress, a referral from a specialist or a consultant physician must include the name of the patient's general practitioners and/or practice. Where a patient is unable or unwilling to nominate a general practitioner or practice this must be stated in the referral.

Referrals by other Practitioners

Where the referral originates from a practitioner other than those listed in *Specialist Referrals*, the referral is valid for a period of 12 months, unless the referring practitioner indicates that the referral is for a period more or less than 12 months (eg. 3, 6 or 18 months or valid indefinitely). Referrals for longer than 12 months should only be used where the patient's clinical condition requires continuing care and management of a specialist or a consultant physician for a specific condition or specific conditions.

Definition of a Single Course of Treatment

A single course of treatment involves an initial attendance by a specialist or consultant physician and the continuing management/treatment up to the stage where the patient is referred back to the care of the referring practitioner. It also includes any subsequent review of the patient's condition by the specialist or the consultant physician that may be necessary. Such a review may be initiated by either the referring practitioner or the specialist/consultant physician.

The presentation of an unrelated illness, requiring the referral of the patient to the specialist's or the consultant physician's care would initiate a new course of treatment in which case a new referral would be required.

The receipt by a specialist or consultant physician of a new referral following the expiration of a previous referral for the same condition(s) does not necessarily indicate the commencement of a new course of treatment involving the itemisation of an initial consultation. In the continuing management/treatment situation the new referral is to facilitate the payment of benefits at the specialist or the consultant physician referred rates rather than the unreferred rates.

However, where the referring practitioner:-

(a) deems it necessary for the patient's condition to be reviewed; and

(b) the patient is seen by the specialist or the consultant physician outside the currency of the last referral; and

(c) the patient was last seen by the specialist or the consultant physician more than 9 months earlier

the attendance following the new referral initiates a new course of treatment for which Medicare benefit would be payable at the initial consultation rates.

Retention of Referral Letters

The prima facie evidence that a valid referral exists is the provision of the referral particulars on the specialist's or the consultant physician's account.

A specialist or a consultant physician is required to retain the instrument of referral (and a hospital is required to retain the patient's hospital records which show evidence of a referral) for 2 years from the date the service was rendered.

A specialist or a consultant physician is required, if requested by the Services Australia CEO, to produce to a medical practitioner who is an employee of Services Australia, the instrument of referral within seven days after the request is received. Where the referral originates in an emergency situation or in a hospital, the specialist or consultant physician is required to produce such information as is in his or her possession or control relating to whether the patient was so treated.

Attendance for Issuing of a Referral

Medicare benefit is attracted for an attendance on a patient even where the attendance is solely for the purpose of issuing a referral letter or note. However, if a medical practitioner issues a referral without an attendance on the patient, no benefit is payable for any charge raised for issuing the referral.

Locum-tenens Arrangements

It should be noted that where a non-specialist medical practitioner acts as a locum-tenens for a specialist or consultant physician, or where a specialist acts as a locum-tenens for a consultant physician, Medicare benefit is only payable at the level appropriate for the particular locum-tenens, eg, general practitioner level for a general practitioner locum-tenens and specialist level for a referred service rendered by a specialist locum tenens.

Medicare benefits are not payable where a practitioner is not eligible to provide services attracting Medicare benefits acts as a locum-tenens for any practitioner who is eligible to provide services attracting Medicare benefits.

Fresh referrals are not required for locum-tenens acting according to accepted medical practice for the principal of a practice ie referrals to the latter are accepted as applying to the former and benefit is not payable at the initial attendance rate for an attendance by a locum-tenens if the principal has already performed an initial attendance in respect of the particular instrument of referral.

Self Referral

Medical practitioners may refer themselves to consultant physicians and specialists and Medicare benefits are payable at referred rates.

GN.7.17 Billing procedures

The Services Australia website contains information on Medicare billing and claiming options. Please visit the Services Australia website for further information.

Bulk billing

Under the *Health Insurance Act 1973*, a bulk billing facility for professional services is available to all persons in Australia who are eligible for a benefit under the Medicare program. If a practitioner bulk bills for a service the practitioner undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service cannot be raised. This includes but is not limited to:

- any consumables that would be reasonably necessary to perform the service, including bandages and/or dressings;
- record keeping fees;
- a booking fee to be paid before each service, or;
- an annual administration or registration fee.

Where the patient is bulk billed, an additional charge can **only** be raised against the patient by the practitioner where the patient is provided with a vaccine or vaccines from the practitioner's own supply held on the practitioner's premises. This exemption only applies to general practitioners and other non-specialist practitioners in association with attendance items **3 to 96**, **179 to 212**, **733 to 789** and **5000 to 5267** (inclusive) and only relates to vaccines that are not available to the patient free of charge through Commonwealth or State funding arrangements or available through the Pharmaceutical Benefits Scheme. The additional charge must only be to cover the supply of the vaccine.

Where a practitioner provides a number of services (excluding operations) on the one occasion, they can choose to bulk bill some or all of those services and privately charge a fee for the other service (or services), in excess of the Medicare benefit. The privately charged fee can only be charged in relation to said service (or services). Where two or more operations are provided on the one occasion, all services must be either bulk billed or privately charged.

It should be noted that, where a service is not bulk billed, a practitioner may privately raise an additional charge against a patient, such as for a consumable. An additional charge can also be raised where a practitioner does not bulk bill a patient but instead charges a fee that is equal to the benefit for the Medicare service. For example, where a general practitioner provides a professional service to which item 23 relates the practitioner could, in place of bulk billing the patient, charge the benefit for the service and then also raise an additional charge (such as for a consumable).

Simplified billing for privately insured patients

Under the *Health Insurance Act 1973* privately insured patients receiving hospital and hospital-substitute treatment may choose to assign their Medicare benefit to an approved billing agent or their private health insurer. This enables the patient to allow a private health insurer or billing agent to receive and manage Medicare benefits on their behalf along with their private health insurance benefits. This is known as simplified billing, a process that aims to reduce the number of accounts a patient receives.

Simplified billing does not relate to claims for benefits paid by the private health insurer to the hospital for theatre and accommodation.

For simplified billing to occur, the patient is required to assign their Medicare benefit to either their insurer or an approved billing agent. In the majority of cases, this assignment will occur prior to treatment or prior to admission, at the same time as Informed Financial Consent. However, in instances where a patient is incapacitated or unable to assign benefits for treatment, the law allows assignment to be made by the eligible person (assignor) or by a person lawfully authorised to act for the patient.

For patients covered by a private health insurance policy who are receiving hospital (in-patient) or hospital-substitute treatment, there are 2 pathways for a simplified billing assignment of benefits to occur:

Implied assignment: If a healthcare provider has an arrangement with a private health insurer (such as a medical gap cover agreement) and that arrangement applies to the service, then the assignment is automatic. This means no patient signature is required.
Requested assignment: If the healthcare provider does not have an arrangement with the private health insurer or the arrangement does not apply to the service, the healthcare provider will need to facilitate an assignment request for the patient to assign their benefit.

For each claim for Medicare benefits, the person making the claim must select either implied or requested assignment and provide an Assignment of Benefits (AoB) declaration, stating that the AoB process has been completed in accordance with legislation. It is the responsibility of the person making the claim for Medicare benefits (either the hospital, medical provider, organisation, or approved billing agent) to state that they have met the requirements.

The AoB declaration is part of the claim for Medicare benefits and is required for both implied and requested simplified billing assignment requests, whether the claim is submitted electronically or manually. The format of the

declaration is not mandated. It may be electronic as part of an online claims process or a statement as part of a manual claim.

The wording below (or similar) can be included in the manual claim:

- For claims for benefits assigned through implied assignment: “This claim for Medicare benefits has been assigned under implied assignment.”
- For claims for benefits assigned through requested assignment: “This claim for Medicare benefits has been assigned under requested assignment.”

Hospitals, healthcare providers and billing agents must keep records that evidence simplified billing benefit assignments. Details of what must be kept and for how long depend on the type of assignment.

Practitioners are advised to review detailed information on simplified billing requirements at Section 65D of the *Health Insurance Regulations 2018* and by searching for **Assignment of Medicare Benefits for Simplified Billing – Frequently Asked Questions**.

GN.8.18 Provision for review of individual health professionals

The Professional Services Review (PSR) reviews and investigates service provision by health practitioners to determine if they have engaged in inappropriate practice when rendering or initiating Medicare services, or when prescribing or dispensing under the PBS.

Section 82 of the *Health Insurance Act 1973* defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude that it would be unacceptable to the general body of the members of the profession in which the practitioner was practicing when they rendered or initiated the services under review. It is also an offence under Section 82 for a person or officer of a body corporate to knowingly, recklessly or negligently cause or permit a practitioner employed by the person to engage in such conduct.

Services Australia monitors health practitioners' claiming patterns. Where Services Australia detects an anomaly, it may request the Director of PSR to review the practitioner's service provision. On receiving the request, the Director must decide whether to a conduct a review and in which manner the review will be conducted. The Director is authorized to require that documents and information be provided.

Following a review, the Director must:

decide to take no further action; or

enter into an agreement with the person under review (which must then be ratified by an independent Determining Authority); or

refer the matter to a PSR Committee.

A PSR Committee normally comprises three medically qualified members, two of whom must be members of the same profession as the practitioner under review. However, up to two additional Committee members may be appointed to provide wider range of clinical expertise.

The Committee is authorized to:

investigate any aspect of the provision of the referred services, and without being limited by the reasons given in the review request or by a Director's report following the review;

hold hearings and require the person under review to attend and give evidence;

require the production of documents (including clinical notes).

The methods available to a PSR Committee to investigate and quantify inappropriate practice are specified in legislation:

(a) Patterns of Services - The *Health Insurance (Professional Services Review) Regulations 1999* specify that when a general practitioner or other medical practitioner reaches or exceeds 80 or more attendances on each of 20 or more days in a 12-month period, they are deemed to have practiced inappropriately.

A professional attendance means a service of a kind mentioned in group A1, A2, A5, A6, A7, A9, A11, A13, A14, A15, A16, A17, A18, A19, A20, A21, A22 or A23 of Part 3 of the General Medical Services Table.

If the practitioner can satisfy the PSR Committee that their pattern of service was as a result of exceptional circumstances, the quantum of inappropriate practice is reduce accordingly. Exceptional circumstances include, but are not limited to, those set out in the *Regulations*. These include:

an unusual occurrence;

the absence of other medical services for the practitioner's patients (having regard to the practice location); and

the characteristics of the patients.

(b) Sampling - A PSR Committee may use statistically valid methods to sample the clinical or practice records.

(c) Generic findings - If a PSR Committee cannot use patterns of service or sampling (for example, there are insufficient medical records), it can make a 'generic' finding of inappropriate practice.

Additional Information

A PSR Committee may not make a finding of inappropriate practice unless it has given the person under review notice of its intention to review them, the reasons for its findings, and an opportunity to respond. In reaching their decision, a PSR Committee is required to consider whether or not the practitioner has kept adequate and contemporaneous patient records (See general explanatory note G15.1 for more information on adequate and contemporaneous patient records).

The practitioner under review is permitted to make submissions to the PSR Committee before key decisions or a final report is made.

If a PSR Committee finds that the person under review has engaged in inappropriate practice, the findings will be reported to the Determining Authority to decide what action should be taken:

(i) a reprimand;

(ii) counselling;

(iii) repayment of Medicare benefits; and/or

(iv) complete or partial disqualification from Medicare benefit arrangements for up to three years.

Further information is available from the PSR website - www.psr.gov.au

GN.8.19 Medicare Participation Review Committee

The Medicare Participation Review Committee determines what administrative action should be taken against a practitioner who:

(a) has been successfully prosecuted for relevant criminal offences;

(b) has breached an Approved Pathology Practitioner undertaking;

(c) has engaged in prohibited diagnostic imaging practices; or

(d) has been found to have engaged in inappropriate practice under the Professional Services Review scheme and has received Final Determinations on two (or more) occasions.

The Committee can take no further action, counsel or reprimand the practitioner, or determine that the practitioner be disqualified from Medicare for a particular period or in relation to particular services for up to five years.

Medicare benefits are not payable in respect of services rendered by a practitioner who has been fully disqualified, or partly disqualified in relation to relevant services under the *Health Insurance Act 1973* (Section 19B applies).

GN.8.20 Referral of professional issues to regulatory and other bodies

The *Health Insurance Act 1973* provides for the following referral, to an appropriate regulatory body:

i. a significant threat to a person's life or health, when caused or is being caused or is likely to be caused by the conduct of the practitioner under review; or
ii. a statement of concerns of non-compliance by a practitioner with 'professional standards'.

GN.8.21 Comprehensive Management Framework for the MBS

The Government announced the Comprehensive Management Framework for the MBS in the 2011-12 Budget to improve MBS management and governance into the future. As part of this framework, the Medical Services Advisory Committee (MSAC) Terms of Reference and membership have been expanded to provide the Government with independent expert advice on all new proposed services to be funded through the MBS, as well as on all proposed amendments to existing MBS items. Processes developed under the previously funded MBS Quality Framework are now being integrated with MSAC processes under the Comprehensive Management Framework for the MBS.

GN.8.22 Medical Services Advisory Committee

The Medical Services Advisory Committee (MSAC) advises the Minister on the strength of evidence relating to the safety, effectiveness and cost effectiveness of new and emerging medical services and technologies and under what circumstances public funding, including listing on the MBS, should be supported.

MSAC members are appointed by the Minister and include specialist practitioners, general practitioners, health economists, a health consumer representative, health planning and administration experts and epidemiologists.

For more information on the MSAC refer to their website - www.msac.gov.au or email on msac.secretariat@health.gov.au or by phoning the MSAC secretariat on (02) 6289 7550.

GN.8.23 Pathology Services Table Committee

This Pathology Services Table Committee comprises six representatives from the interested professions and six from the Australian Government. Its primary role is to advise the Minister on the need for changes to the structure and content of the Pathology Services Table (except new medical services and technologies) including the level of fees.

GN.9.25 Penalties and Liabilities

Penalties of up to $10,000 or imprisonment for up to five years, or both, may be imposed on any person who makes a statement (oral or written) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used with a claim for benefits. In addition, any practitioner who is found guilty of such offences by a court shall be subject to examination by a Medicare Participation Review Committee and may be counselled or reprimanded or may have services wholly or partially disqualified from the Medicare benefit arrangements.

A penalty of up to $1,000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on a direct-billing form without the obligatory details having been entered on the form before the person signs, or who fails to cause a patient to be given a copy of the completed form.

GN.10.26 Schedule fees and Medicare benefits

Medicare benefits are based on fees determined for each service listed in the Medicare Benefit Schedule (MBS). The fee is referred to in these notes as the "Schedule fee". The fee for any item listed in the MBS is that which is regarded as being reasonable on average for that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered.

The Schedule fee and Medicare benefit levels for the medical services contained in the MBS are located with the item descriptions. Where appropriate, the calculated benefit has been rounded to the nearest higher 5 cents. However, in no circumstances will the Medicare benefit payable exceed the fee actually charged.

There are presently three levels of Medicare benefit payable:

a. 75% of the Schedule fee:
    i. for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients). Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '*' or the letter 'H' directly after an item number where used; or a description of the professional service and an indication the service was rendered as an episode of hospital treatment (for example, 'in hospital', 'hospital outpatient service', 'admitted' or 'in patient'). Certain services are not generally considered hospital treatments – see GN1.2;
    ii. for professional services rendered as part of an episode of hospital-substitute treatment, and the patient who receives the treatment chooses to receive a benefit from a private health insurer, medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service, preceded by the words 'hospital-substitute treatment'. Certain services are not generally considered hospital treatments – see GN1.2.
b. 100% of the Schedule fee for non-referred attendances by general practitioners to non-admitted patients and services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a general practitioner – see GN1.2 for exceptions.
c. 85% of the Schedule fee, or the Schedule fee less $108.50 inline with Greatest Permissible Gap (GPG) indexation which is applied on 1 November.

Public hospital services are to be provided free of charge to eligible persons who choose to be treated as public patients in accordance with the 2020-2025 Addendum to the National Health Reform Agreement.

Where a Medicare item with multiple components is provided, and some components are provided in the hospital and the remainder outside of the hospital (e.g. aftercare), the 75% benefit level applies. With regard to obstetric items, benefits would be attracted at the 75% level where the confinement takes place in hospital.

Pathology tests performed after discharge from hospital on bodily specimens taken during hospitalisation also attract the 75% level of benefits if not a type of item specified in GN1.2 as not generally being a hospital treatment.

It should be noted that the *Health Insurance Act 1973* makes provision for private medical insurers to cover the "patient gap" (that is, the difference between the Medicare benefit and the Schedule fee) for services attracting benefits at the 75% level. Patients may insure with private health insurance organisations for the gap between the 75% Medicare benefits and the Schedule fee or for amounts in excess of the Schedule fee where the patient has an arrangement with their health fund.

GN.10.27 Medicare Safety Nets

The Medicare Safety Nets provide families and individuals with an additional benefit for out-of-hospital Medicare services, once annual thresholds are reached. There are two safety nets: the Original Medicare Safety Net (OMSN) and the Extended Medicare Safety Net (EMSN).

Original Medicare Safety Net:

Under the OMSN, the Medicare benefit for out-of-hospital services is increased to 100% of the Schedule Fee (up from 85%) once an annual threshold in gap costs is reached. Gap costs refer to the difference between the Medicare benefit (85%) and the Schedule Fee. The threshold from 1 January 2026 is $594.40. This threshold applies to all Medicare-eligible individuals and families.

Extended Medicare Safety Net:

Under the EMSN, once an annual threshold in out-of-pocket costs for out-of-hospital Medicare services is reached, Medicare will pay for up to 80% of any future out-of-pocket costs for out-of-hospital Medicare services for the remainder of the calendar year. However, where the item has an EMSN benefit cap, there is a maximum limit on the EMSN benefit that will be paid for that item. Further explanation about EMSN benefit caps is provided below. Out-of-pocket costs refer to the difference between the Medicare benefit and the fee charged by the practitioner.

In 2026, the threshold for concessional individuals and families, including families that received Family Tax Benefit Part (A), is $861.20. The threshold for all other (non-concessional) individuals and families in 2026 is $2699.10.

The thresholds for both safety nets are indexed on 1 January each year in line with the Consumer Price Index (CPI).

Individuals are automatically registered with Services Australia for the safety nets. Families (including couples) are required to register in order to be recognised as a family for the purposes of the safety nets. In most cases, registered families have their expenses combined to reach the safety net thresholds. This may help to qualify for safety net benefits more quickly. Registration forms can be completed online at https://www.servicesaustralia.gov.au/individuals/services/medicare/medicare-safety-nets.

EMSN Benefit Caps:

The EMSN benefit cap is the maximum EMSN benefit payable for that item and is paid in addition to the standard Medicare benefit. Where there is an EMSN benefit cap in place for the item, the amount of the EMSN cap is displayed in the item descriptor. Once the EMSN threshold is reached, each time the item is claimed the patient is eligible to receive up to the EMSN benefit cap. In other words, once the patient reaches the EMSN threshold, they will receive either 80% of their out-of-pocket costs back or the EMSN cap amount, whichever is the lower amount.

For example: Item A has a Schedule fee of $100, the out-of-hospital benefit is $85 (85% of the Schedule fee). The EMSN benefit cap is $30. Assuming that the patient has reached the EMSN threshold:

o If the fee charged by the doctor for Item A is $125, the standard Medicare benefit is $85, with an out-of-pocket cost of $40. The EMSN benefit is calculated as $40 x 80% = $32. However, as the EMSN benefit cap is $30, only $30 will be paid.

o If the fee charged by the doctor for Item A is $110, the standard Medicare benefit is $85, with an out-of-pocket cost of $25. The EMSN benefit is calculated as $25 x 80% = $20. As this is less than the EMSN benefit cap, the full $20 is paid.

GN.11.28 Services not listed in the MBS

Benefits are not generally payable for services not listed in the MBS. However, there are some procedural services which are not specifically listed because they are regarded as forming part of a consultation or else attract benefits on an attendance basis. For example, intramuscular injections, aspiration needle biopsy, treatment of sebhorreic keratoses and less than 10 solar keratoses by ablative techniques and closed reduction of the toe (other than the great toe).

If you are seeking advice in relation to Medicare billing, claiming, payments or obtaining a provider number, please contact Services Australia on the Provider Enquiry Line - 13 21 50.

If you have a query relating exclusively to interpretation of the Schedule, you should email mailto:askmbs@health.gov.au

GN.11.29 Ministerial Determinations

Section 3C of the *Health Insurance Act 1973* empowers the Minister to determine an item and Schedule fee (for the purposes of the Medicare benefits arrangements) for a service not included in the health insurance legislation. This provision may be used to facilitate payment of benefits for new developed procedures or techniques where close monitoring is desirable. Services which have received section 3C approval are located in their relevant Groups in the MBS with the notation "**(Ministerial Determination)**".

GN.12.30 Professional services

Professional services which attract Medicare benefits include medical services rendered by or "on behalf of" a medical practitioner. The latter include services where a part of the service is performed by a technician employed by or, in accordance with accepted medical practice, acting under the supervision of the medical practitioner.

The following medical services will attract benefits only if they have been personally performed by a medical practitioner on not more than one patient on the one occasion (i.e. two or more patients cannot be attended simultaneously, although patients may be seen consecutively), unless a group session is involved (i.e. Items 170-172). The requirement of "personal performance" is met whether or not essential assistance is provided, according to accepted medical practice:-

(a) Category 1 (Professional Attendances) items except 170-172, 342-346, 820-880, 6029–6042, 6064-6075;

(b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11304, 11600, 11627, 11705, 11724, 11728, 11729, 11730, 11731, 11921, 12000, 12003;

(c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13750-13760, 13950, 14050, 14217, 14220, 14221 and 14245);

(d) Item 15600 in Group T2 (Radiation Oncology);

(e) All Group T3 (Therapeutic Nuclear Medicine) items;

(f) All Group T4 (Obstetrics) items (except 16400 and 16514);

(g) All Group T6 (Anaesthetics) items;

(h) All Group T7 (Regional or Field Nerve Block) items;

(i) All Group T8 (Operations) items;

(j) All Group T9 (Assistance at Operations) items;

(k) All Group T10 (Relative Value Guide for Anaesthetics) items.

For the group psychotherapy and family group therapy services covered by Items 170, 171, 172, 342, 344 and 346, benefits are payable only if the services have been conducted personally by the medical practitioner.

Medicare benefits are not payable for these group items or any of the items listed in (a) - (k) above when the service is rendered by a medical practitioner employed by the proprietor of a hospital (not being a private hospital), except where the practitioner is exercising their right of private practice, or is performing a medical service outside the hospital. For example, benefits are not paid when a hospital intern or registrar performs a service at the request of a staff specialist or visiting medical officer.

Medicare benefits are only payable for items 12306 - 12322 (Bone Densitometry) when the service is performed by a specialist or consultant physician in the practice of the specialist's or consultant physician's specialty where the patient is referred by another medical practitioner.

GN.12.31 Services rendered on behalf of medical practitioners

Medical services in Categories 2 and 3 not included in GN.12.30 and Category 5 (Diagnostic Imaging) services continue to attract Medicare benefits if the service is rendered by:-

(a) the medical practitioner in whose name the service is being claimed;

(b) a person, other than a medical practitioner, who is employed by a medical practitioner or, in accordance with accepted medical practice, acts under the supervision of a medical practitioner.

See Category 6 Notes for Guidance for arrangements relating to Pathology services.

So that a service rendered by an employee or under the supervision of a medical practitioner may attract a Medicare benefit, the service must be billed in the name of the practitioner who must accept full responsibility for the service. All practitioners should ensure they maintain adequate and contemporaneous records. All elements of the service must be performed in accordance with accepted medical practice.

Supervision from outside of Australia is not acceptable.

While the supervising medical practitioner need not be present for the entire service, they must have a direct involvement in at least part of the service. Although the supervision requirements will vary according to the service in question, they will, as a general rule, be satisfied where the medical practitioner has:-

(a) established consistent quality assurance procedures for the data acquisition; and

(b) personally analysed the data and written the report.

Benefits are not payable for these services when a medical practitioner refers patients to self-employed medical or paramedical personnel, such as radiographers and audiologists, who either bill the patient or the practitioner requesting the service.

GN.12.32 Medicare benefits and vaccinations

Where a medical practitioner administers an injection for immunisation purposes on the medical practitioner's own patient, Medicare benefits for that service would be payable on a consultation basis, that is, for the attendance at which the injection is given. However, the cost of the vaccine itself does not attract a Medicare benefit. The Medicare benefits arrangements cover only the professional component of the medical practitioner's service. There are some circumstances where a Medicare benefit is not payable when a medical practitioner administers an injection for immunisation purposes – please refer to example 3 below for further details.

Example 1

A patient presents to a GP to receive the influenza vaccination. The patient is not in the cohort of patients which is covered for the influenza vaccine under the NIP.

After taking a short patient history, the GP administers the vaccine to the patient. The GP has met the requirements of a level A consultation and claims item 3. The GP can bulk bill the patient for the cost of the MBS service and can charge a separate amount for the cost of the vaccine, which is not covered under the NIP.

If a patient presented to a GP to receive a vaccine and to enquire about a medical condition, the GP may claim the appropriate item (such as item 23).

Example 2

A patient presents to a GP to receive the influenza vaccination. The patient is in the cohort of patients which is covered for the influenza vaccine under the NIP.

After taking a short patient history, the GP administers the vaccine to the patient. The GP has met the requirements of a level A consultation and claims item 3. The GP can bulk bill the patient but does not need to charge a separate amount for the cost of the vaccine, which is covered under the NIP.

If a patient presented to a GP to receive a vaccine and to enquire about a medical condition, the GP may claim the appropriate item (such as item 23).

Example 3

A GP is employed by a State or Territory community health centre to administer vaccines and provides no additional medical services.

A Medicare benefit is not payable as the GP is providing the service under an arrangement with the State or Territory, which is prohibited under subsection 19(2) of the *Health Insurance Act 1973*. The service is also prohibited on the basis that it is a mass immunisation which is prohibited under subsection 19(4).

A mass immunisation is a program to inoculate people that is funded by the Commonwealth or State Government, or through an international or private organisation.

GN.13.33 Services which do not attract Medicare benefits

Medical services that do not attract Medicare benefits

(a) issue of repeat prescriptions when the patient does not attend the surgery in person;

(b) group attendances (unless otherwise specified in the item, such as items 170, 171, 172, 342, 344 and 346);

(c) non-therapeutic cosmetic surgery;

(d) euthanasia and any service directly related to the procedure. However, services rendered for counselling/assessment about euthanasia will attract benefits.

Medicare benefits are not payable where the medical expenses for the service

(a) are paid/payable to a public hospital;

(b) are for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability. (Please note that if the medical expenses relate to a compensable injury/illness for which the insurer/compensation agency is disputing liability, then Medicare benefits are payable until the liability is accepted.);

(c) are for a medical examination for the purposes of life insurance, superannuation, a provident account scheme, or admission to membership of a friendly society;

(d) are incurred in mass immunisation (see General Explanatory Note 12.3 for further explanation).

Unless the Minister otherwise directs

Medicare benefits are not payable where:

(a) the service is rendered by or on behalf of, or under an arrangement with the Australian Government, a State or Territory, a local government body or an authority established under Commonwealth, State or Territory law;

(b) the medical expenses are incurred by the employer of the person to whom the service is rendered;

(c) the person to whom the service is rendered is employed in an industrial undertaking and that service is rendered for the purposes related to the operation of the undertaking; or

(d) the service is a health screening service.

(e) the service is a pre-employment screening service

Current regulations preclude the payment of Medicare benefits for professional services rendered in relation to or in association with:

(a) chelation therapy (that is, the intravenous administration of ethylenediamine tetra-acetic acid or any of its salts) other than for the treatment of heavy-metal poisoning;

(b) the injection of human chorionic gonadotrophin in the management of obesity;

(c) the use of hyperbaric oxygen therapy in the treatment of multiple sclerosis;

(d) the removal of tattoos;

(e) the transplantation of a thoracic or abdominal organ, other than a kidney, or of a part of an organ of that kind; or the transplantation of a kidney in conjunction with the transplantation of a thoracic or other abdominal organ, or part of an organ of that kind;

(f) the removal from a cadaver of kidneys for transplantation;

(g) the administration of microwave (UHF radio wave) cancer therapy, including the intravenous injection of drugs used in the therapy.

Pain pumps for post-operative pain management

The cannulation and/or catheterisation of surgical sites associated with pain pumps for post-operative pain management cannot be billed under any MBS item.

The filling or re-filling of drug reservoirs of ambulatory pain pumps for post-operative pain management cannot be billed under any MBS items.

Non Medicare Services

No MBS item applies to a service mentioned in the item if the service is provided to a patient at the same time as, or in connection with, an injection of blood or a blood product that is autologous.

No MBS item applies to a service mentioned in the item if the service is provided to a patient at the same time as, or in connection with, the harvesting, storage, in vitro processing or injection of non-haematopoietic stem cells.

An item in the range 1 to 10943 does not apply to the service described in that item if the service is provided at the same time as, or in connection with, any of the services specified below:

(a) endoluminal gastroplication, for the treatment of gastro-oesophageal reflux disease;

(b) gamma knife surgery;

(c) intradiscal electro thermal arthroplasty;

(d) intravascular ultrasound (except where used in conjunction with intravascular brachytherapy);

(e) intro-articular viscosupplementation, for the treatment of osteoarthritis of the knee;

(f) low intensity ultrasound treatment, for the acceleration of bone fracture healing, using a bone growth stimulator;

(g) lung volume reduction surgery, for advanced emphysema;

(h) photodynamic therapy, for skin and mucosal cancer;

(i) placement of artificial bowel sphincters, in the management of faecal incontinence;

(j) selective internal radiation therapy for any condition other than hepatic metastases that are secondary to colorectal cancer;

(k) specific mass measurement of bone alkaline phosphatase;

(l) transmyocardial laser revascularisation;

(m) vertebral axial decompression therapy, for chronic back pain;

(n) autologous chondrocyte implantation and matrix-induced autologous chondrocyte implantation;

(o) extracorporeal magnetic innervation.

Health Screening Services

Unless the Minister otherwise directs Medicare benefits are not payable for health screening services. A health screening service is defined as a medical examination or test that is not reasonably required for the management of the medical condition of the patient. Services covered by this proscription include such items as:

(a) multiphasic health screening;

(b) mammography screening (except as provided for in Items 59300/59303);

(c) testing of fitness to undergo physical training program, vocational activities or weight reduction programs;

(d) compulsory examinations and tests to obtain a flying, commercial driving or other licence;

(e) entrance to schools and other educational facilities;

(f) for the purposes of legal proceedings;

(g) compulsory examinations for admission to aged persons' accommodation and pathology services associated with clinical ecology.

The Minister has directed that Medicare benefits be paid for the following categories of health screening:

(a) a medical examination or test on a symptomless patient by that patient's own medical practitioner in the course of normal medical practice, to ensure the patient receives any medical advice or treatment necessary to maintain their state of health. Benefits would be payable for the attendance and tests which are considered reasonably necessary according to patients individual circumstances (such as age, physical condition, past personal and family history). For example, a cervical screening test in a person (see General Explanatory note 12.3 for more information), blood lipid estimation where a person has a family history of lipid disorder. However, such routine check-up should not necessarily be accompanied by an extensive battery of diagnostic investigations;

(b) a pathology service requested by the National Heart Foundation of Australia, Risk Evaluation Service;

(c) age or health related medical examinations to obtain or renew a licence to drive a private motor vehicle;

(d) a medical examination of, and/or blood collection from persons occupationally exposed to sexual transmission of disease, in line with conditions determined by the relevant State or Territory health authority, (one examination or collection per person per week). Benefits are not paid for pathology tests resulting from the examination or collection;

(e) a medical examination for a person as a prerequisite of that person becoming eligible to foster a child or children;

(f) a medical or optometrical examination provided to a person who is an unemployed person (as defined by the Social Security Act 1991), as the request of a prospective employer.

The National Policy for the National Cervical Screening Program (NCSP) is as follows:

(a) Cervical screening should be undertaken every five years in asymptomatic persons, using a primary human papillomavirus (HPV) test with partial genotyping and reflex liquid based cytology (LBC) triage;

(b) Persons who have ever been sexually active should commence cervical screening at 25 years of age;

(c) Persons aged 25 years or older and less than 70 years will receive invitations and reminders to participate in the program;

(d) Persons will be invited to exit the program by having a HPV test between 70 years or older and less than 75 years of age and may cease cervical screening if their test result is low risk;

(e) Persons 75 years of age or older who have either never had a cervical screening test or have not had one in the previous five years, may request a cervical screening test and can be screened;

(f) All persons, both HPV vaccinated and unvaccinated, are included in the program;

(g) Self collection of a sample for testing is available for persons who are aged 30 years and over and has never participated in the NCSP; or is overdue for cervical screening by two years or longer.

· Self collection must be facilitated and requested by a healthcare professional who also routinely offers cervical screening services;

· The self collection device and the HPV test, when used together, must meet the requirements of the National Pathology Accreditation Advisory Council (NPAAC) Requirements for Laboratories Reporting Tests for the NCSP; and

(h) Persons with intermediate and higher risk screening test results should be followed up in accordance with the cervical screening pathway and the NCSP: Guidelines for the management of screen detected abnormalities, screening women in specific populations and investigation of women with abnormal vaginal bleeding (2016 Guidelines) – endorsed by the Royal Australian College of General Practitioners, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Royal College of Pathologists of Australasia, the Australian Society of Gynaecologic Oncologists and the Australian Society for Colposcopy and Cervical Pathology.

Note 1: As separate items exist for routine screening, screening in specific population and investigation of persons with abnormal vaginal bleeding, treating practitioners are asked to clearly identify on the request form, if the sample is collected as part of routine screening or for another purpose (see paragraph PP.16.11 of Pathology Services Explanatory Notes in Category 6).

Note 2: Where reflex cytology is performed following the detection of HPV in routine screening, the HPV test and the LBC test results must be issued as a combined report with the overall risk rating.

Note 3: See items 2501 to 2509, and 2600 to 2616 in Group A18 and A19 of Category 1 - Professional Attendances and the associated explanatory notes for these items in Category 1 - Professional Attendances.

Services rendered to a doctor's dependants, practice partner, or practice partner's dependants

Medicare benefits are not paid for professional services rendered by a medical practitioner to dependants or partners or a partner's dependants.

A 'dependant' person is a spouse or a child. The following provides definitions of these dependant persons:

(a) a spouse, in relation to a dependant person means:

a. a person who is legally married to, and is not living, on a permanent basis, separately and apart from, that person; and

b. a de facto spouse of that person.

(b) a child, in relation to a dependant person means:

a. a child under the age of 16 years who is in the custody, care and control of the person or the spouse of the person; and

b. a person who:

(i) has attained the age of 16 years who is in the custody, care and control of the person of the spouse of the person; or

(ii) is receiving full time education at a school, college or university; and

(iii) is not being paid a disability support pension under the Social Security Act 1991; and

(iv) is wholly or substantially dependent on the person or on the spouse of the person.

GN.14.34 Principles of interpretation of the MBS

Each professional service listed in the MBS is a complete medical service. Where a listed service is also a component of a more comprehensive service covered by another item, the benefit for the latter service will cover the former.

Where a service is rendered partly by one medical practitioner and partly by another, only the one amount of benefit is payable. For example, where a radiographic examination is started by one medical practitioner and finalised by another.

GN.14.35 Services attracting benefits on an attendance basis

Some services are not listed in the MBS because they are regarded as forming part of a consultation or they attract benefits on an attendance basis.

GN.14.36 Consultation and procedures rendered at the one attendance

Where, during a single attendance, a consultation (under Category 1 of the MBS) and another medical service (under any other Category of the Schedule) occur, benefits are payable subject to certain exceptions, for both the consultation and the other service. Benefits are not payable for the consultation in addition to an item rendered on the same occasion where the item is qualified by words such as "each attendance", "attendance at which", "including associated attendances/consultations", and all items in Group T6 and T9. In the case of radiotherapy treatment (Group T2 of Category 3) benefits are payable for both the radiotherapy and an initial referred consultation.

Where the level of benefit for an attendance depends upon the consultation time (for example, in psychiatry), the time spent in carrying out a procedure which is covered by another item in the MBS, may not be included in the consultation time.

A consultation fee may only be charged if a consultation occurs; that is, it is not expected that consultation fee will be charged on every occasion a procedure is performed.

GN.14.37 Aggregate items

The MBS includes a number of items which apply only in conjunction with another specified service listed in the MBS. These items provide for the application of a fixed loading or factor to the fee and benefit for the service with which they are rendered.

When these particular procedures are rendered in conjunction, the legislation provides for the procedures to be regarded as one service and for a single patient gap to apply. The Schedule fee for the service will be ascertained in accordance with the particular rules shown in the relevant items.

GN.14.38 Residential care home

A residential care home is defined in the *Aged Care Act 2024*; the definition includes facilities formerly known as residential aged care facilities, nursing homes and hostels.

GN.15.39 Practitioners should maintain adequate and contemporaneous records

All practitioners who provide, or initiate, a service for which a Medicare benefit is payable, should ensure they maintain **adequate** and **contemporaneous** records.

Note: 'Practitioner' is defined in Section 81 of the *Health Insurance Act 1973* and includes: medical practitioners, dentists, optometrists, chiropractors, physiotherapists, podiatrists and osteopaths.

Since 1 November 1999, PSR Committees determining issues of inappropriate practice have been obliged to consider if the practitioner kept adequate and contemporaneous records. It will be up to the peer judgement of the PSR Committee to decide if a practitioner's records meet the prescribed standards.

The standards which determine if a record is adequate and contemporaneous are prescribed in the *Health Insurance (Professional Services Review Scheme) Regulations 2019*.

To be ***adequate***, the patient or clinical record needs to:

- clearly identify the name of the patient; and
- contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated; and
- each entry needs to provide clinical information adequate to explain the type of service rendered or initiated; and
- each entry needs to be sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the patient's ongoing care.

To be ***contemporaneous***, the patient or clinical record should be completed at the time that the service was rendered or initiated or as soon as practicable afterwards. Records for hospital patients are usually kept by the hospital and the practitioner could rely on these records to document in-patient care.

Services Australia (SA), in consultation with the Department of Health, Disability and Ageing, has developed a Health Practitioner Guideline to substantiate that a specific treatment was performed which is located on the Department of Health, Disability and Ageing's website.

CATEGORY 1: PROFESSIONAL ATTENDANCES

SUMMARY OF CHANGES FROM 01/11/2026

The 01/11/2026 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

New Items

92033 92034 92063 92064

Description Amended

4	24	37	47	58	59	60	65	124	165	181	187	191
206	228	232	235	236	237	238	239	240	249	294	303	374
375	377	378	380	381	390	391	715	731	735	739	743	747
750	758	761	763	766	769	772	776	788	789	903	2198	2200
2485	2486	2488	2489	2491	2492	2494	2495	5003	5010	5023	5028	5043
5049	5063	5067	5076	5077	5220	5223	5227	5228	5260	5261	5262	5263
5265	5267	10931	90001	90002	90020	90035	90043	90051	90054	90092	90093	90095
90096	90098	90183	90188	90202	90212	90215	92027	92058	92478	92479	92480	92481
92482												

Thriving Kids Initiative

From 1 November 2026, as part of the Government's *Thriving Kids initiative* a new MBS health assessment service called the Medicare Healthy Kids Check will be introduced for 3-year-old children using the time-tiered health assessment items (701-707 and 224-227). Introduction of a 3-year-old health check was recommended by the Thriving Kids Advisory Group, to improve early identification of developmental delay and/or neurodevelopmental differences in children, and facilitate connections with appropriate supports, or referrals for further assessment where needed. Further information is available at MBS Online - Medicare Healthy Kids Check.

Other changes to general medical services

From 1 November 2026, changes will be made relating to general medical services. These changes include:

- Introducing four new phone attendance items 92033, 92034, 92063 and 92064 for chronic condition management (CCM) attendances by a general practitioner or prescribed medical practitioner to prepare or review a CCM plan for a patient;
- Permanently listing six items (92478, 92479, 92480, 92481, 92482 and 92483) for inpatient telehealth psychiatry services which were first introduced as temporary items on 1 November 2024. Additionally, amendments will be made to the claiming restrictions for the six items to allow for two time-tiered services within a 7-day period where previously only one other time-tiered service was permitted in a 7-day period;
- Administrative amendments to replace references to the term "residential aged care facility" with "residential care home" to align with terminology in the *Aged Care Act 2024*; and
- Administrative amendments to align Modified Monash (MM) location classifications with the most recent 2023 MM location categories.

PROFESSIONAL ATTENDANCES NOTES

AN.0.1 Personal Attendance by Practitioner

The personal attendance of the medical practitioner upon the patient is necessary, before a "consultation" may be regarded as a professional attendance. In itemising a consultation covered by an item which refers to a period of time, only that time during which a patient is receiving active attention should be counted. Periods such as when a patient is resting between blood pressure readings, waiting for pupils to dilate after the instillation of a mydriatic, or receiving short wave therapy etc., should not be included in the time of the consultation. Similarly, the time taken by a doctor to travel to a patient's home should not be taken into consideration in the determination of the length of the consultation. While the doctor is free to charge a fee for "travel time" when patients are seen away from the surgery, benefits are payable only in respect of the time a patient is receiving active attention.

AN.0.2 Benefits For Services

All Australian residents and certain categories of visitors to Australia can claim Medicare benefits for services by optometrists. The *Health Insurance Act 1973* contains legislation covering the major elements of the Medicare program.

Responsibility for regulating the Medicare program lies with the Australian Government through the Department of Health, Disability and Ageing. Services Australia is responsible for consideration of applications and for the day-to-day operation of Medicare and the payment of benefits. Contact details of the Department of Health, Disability and Ageing and Services Australia are located at the end of these Notes.

AN.0.3 Professional Attendances

Professional attendances by medical practitioners cover consultations during which the practitioner: evaluates the patient's health-related issue or issues, using certain health screening services if applicable; formulates a management plan in relation to one or more health-related issues for the patient; provides advice to the patient and/or relatives (if authorised by the patient); provides appropriate preventive health care; and records the clinical detail of the service(s) provided to the patient. (See the General Explanatory Notes for more information on health screening services.)

AN.0.4 Provider Numbers

To ensure that benefits are paid only for services provided by optometrists registered with the Optometry Board of Australia, each optometrist providing services for which a Medicare benefit is payable requires an individual provider number.

Provider numbers will be issued only to registered optometrists. Corporations, other business entities and individuals who are not registered optometrists will not be issued with provider numbers.

Provider numbers are allocated to enable claims for Medicare benefits to be processed. The number may be up to eight characters. The second last character identifies the practice location, the last being a check character.

Optometrists can obtain a provider number from Services Australia. A separate provider number is issued for each location at which an optometrist practises and has current registration. Provider numbers for additional practice locations may also be obtained from Services Australia following confirmation of registration. Optometrists cannot use another optometrist's provider number.

Locum Tenens

An optometrist who has signed an Undertaking and is to provide services at a practice location as a locum for more than two weeks or will return to the practice on a regular basis for short periods should apply for a provider number for that location.

If the locum is to provide services at a practice for less than two weeks, the locum can use their own provider number or can obtain an additional provider number for that location.

Normally, Medicare benefits are payable for services rendered by an optometrist only when the optometrist has completed an Undertaking. However, benefits may be claimed for services provided by an optometrist who has not signed the Undertaking if the optometrist has provided them on behalf of an optometrist who has signed the Undertaking.

To ensure benefits are payable when a locum practises in these circumstances, the locum optometrist should:

· Check that they will be providing optometry services on behalf of a participating optometrist i.e. their employer has a current Undertaking.

· Complete the Schedule which is available on Services Australia's website https://www.servicesaustralia.gov.au/, before commencing the locum arrangement of the name and address of the participating optometrist on whose behalf they will be providing services.

Locums can direct Medicare payments to a third party, for example the principal of the practice, by either arranging a pay group link and/or by nominating the principal as the payee provider in the assignment agreement.

AN.0.5 Services not Attracting Medicare Benefits

Letters of advice by medical practitioners, the issue of repeat prescriptions when the patient is not in attendance, post mortem examinations, the issue of death certificates, cremation certificates, counselling of relatives (Note - items 348, 350 and 352 are not counselling services), group attendances (other than group attendances covered by items 170, 171, 172, 342, 344 and 346) such as group counselling, health education, weight reduction or fitness classes do not qualify for benefit.

Although Medicare benefits are not payable for the issue of a death certificate, an attendance on a patient at which it is determined that life is extinct can be claimed under the appropriate attendance item. The outcome of the attendance may be that a death certificate is issued, however, Medicare benefits are only payable for the attendance component of the service.

AN.0.7 Multiple Attendances on the Same Day

Payment of benefit may be made for each of several attendances on a patient on the same day by the same medical practitioner provided the subsequent attendances are not a continuation of the initial or earlier attendances. However, there should be a reasonable lapse of time between such attendances before they can be regarded as separate attendances.

Where two or more attendances are made on the one day by the same medical practitioner the time of each attendance should be stated on the account (eg 10.30 am and 3.15 pm) in order to assist in the assessment of benefits.

In some circumstances a subsequent attendance on the same day constitutes a continuation of an earlier attendance. For example, a preliminary eye examination may be concluded with the instillation of a mydriatic and then some time later an eye refraction is undertaken. These sessions are regarded as being one attendance for benefit purposes. Further examples of single attendances are skin sensitivity testing, and when a patient is issued a prescription for a vaccine and subsequently returns to the surgery for the injection.

AN.0.8 Benefits For Optometrists

What services are covered?

The *Health Insurance Act 1973* stipulates that Medicare benefits are payable for professional services. The professional services coming within the scope of the optometric benefit arrangements are those clinically relevant services ordinarily rendered by the optometrist in relation to a consultation on ocular or vision problems or related procedures. *The Health Insurance Act 1973* defines a 'clinically relevant service' as a service rendered by an optometrist that is generally accepted in the optometrical profession as being necessary for the appropriate treatment of the patient to whom it is rendered.

From 1 January 2015, optometrists will be free to set their own fees for their professional service. However, the amount specified in the patient's account must be the amount charged for the service specified. The fee may not include a cost of goods or services which are not part of the MBS service specified on the account. A non-clinically relevant service must not be included in the charge for a Medicare item. The non-clinically relevant service must be separately listed on the account and not billed to Medicare. Where it is necessary for the optometrist to seek patient information from Services Australia in order to determine appropriate itemisation of accounts, receipts or bulk-billed claims, the optometrist must ensure that:

(a) the patient is advised of the need to seek the information and the reason the information is required;

(b) the patient's informed consent to the release of information has been obtained; and

(c) the patient's records verify the patient's consent to the release of information.

Benefits may only be claimed when:

(a) a service has been performed and a clinical record of the service has been made;

(b) a significant consultation or examination procedure has been carried out;

(c) the service has been performed at premises to which the Undertaking relates;

(d) the service has involved the personal attendance of both the patient and the optometrist; and

(e) the service is "clinically relevant" (as defined in the *Health Insurance Act 1973*).

Where Medicare benefits are not payable

Medicare benefits may not be claimed for attendances for:

(a) delivery, dispensing, adjustment or repairs of visual aids;

(b) filling of prescriptions written by other practitioners.

Benefits are not payable for optometric services associated with:

(a) cosmetic surgery;

(b) refractive surgery;

(c) tests for fitness to undertake sporting, leisure or vocational activities;

(d) compulsory examinations or tests to obtain any commercial licence (e.g. flying or driving);

(e) entrance to schools or other educational facilities;

(f) compulsory examinations for admissions to residential care homes;

(g) vision screening.

Medicare benefits are not payable for services in the following circumstances:

(a) where the expenses for the service are paid or payable to a recognised (public) hospital;

(b) an attendance on behalf of teaching institutions on patients of supervised students of optometry;

(c) where the service is not "clinically relevant" (as defined in the *Health Insurance Act 1973).*

Unless the Minister otherwise directs, a benefit is not payable in respect of an optometric service where:

(a) the service has been rendered by or on behalf of, or under an arrangement with, the Commonwealth, a State or a local governing body or an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory; or

(b) the service was rendered in one or more of the following circumstances -

(i) the employer arranges or requests the consultation

(ii) the results are provided to the employer by the optometrist

(iii) the employer requires that the employee have their eyes examined

(iv) the account for the consultation is sent to the employer

(v) the consultation takes place at the patient's workplace or in a mobile consulting room at the patient's

workplace.

Services rendered to an optometrist's dependants, employer or practice partner or dependants

A condition of the participating arrangement is that the optometrist agrees not to submit an account or a claim for services rendered to any dependants of the optometrist, to the optometrist's employer or practice partner or any dependants of that employer or partner.

A 'dependant' person is a spouse or a child. The following provides definitions of these dependant persons:

a ***spouse***, in relation to a dependant person means:

(a) a person who is legally married to, and is not living, on a permanent basis, separately and apart from, that person; and

(b) a de facto spouse of that person.

a ***child***, in relation to a dependant person means:

(a) a child under the age of 16 years who is in the custody, care and control of the person or the spouse of the person; and

(b) a person who:

(i) has attained the age of 16 years who is in the custody, care and control of the person of the spouse of the person; or

(ii) is receiving full time education at a school, college or university; and

(iii) is not being paid a disability support pension under the *Social Security Act 1991*; and

(iv) is wholly or substantially dependent on the person or on the spouse of the person.

AN.0.9 Using time-tiered professional (general) attendance items

SUMMARY

This note sets out the key common principles that apply when using the time-tiered professional attendance (also referred to as general attendance, time-tiered attendance, and Level A-E attendance) MBS items for general practitioners (GPs), medical practitioners (who are not GPs) and prescribed medical practitioners (i.e. medical practitioners who are not GPs, specialists or consultant physicians). These items are usually claimed in a general practice setting.

Unless otherwise stated these principles apply to all general attendance items, regardless of location (in consulting rooms, out of consulting rooms or residential care homes), time (business or after-hours), or mode (face to face or video or phone). For some categories of attendances e.g. telehealth (video or phone) additional requirements may apply.

Note: that within the general practice context, prescribed medical practitioners and medical practitioners who are not GPs are sometimes referred to as Other Medical Practitioners (OMPs) or non-vocationally registered (non-VR) GPs. References to OMPs in this Explanatory Note include both prescribed medical practitioners and medical practitioners who are not GPs.

Information on the definition of a GP for Medicare purposes is available in GN.4.13 and prescribed medical practitioners in AN.7.1.

Tables setting out the item numbers for the various time-tiers and locations, times of day and modes are available in Note AN.0.74 for GPs, and AN.7.2 for OMPs.

USE OF THE ITEMS

General attendance items are claimed for a professional attendance when no other MBS item applies. It is a general principle of the MBS that the item that best describes the service is the item that should be claimed. This means that where a more specific MBS items exists (for example a skin biopsy under MBS item 30071), the more specific item should be claimed. If no other MBS item accurately reflects the service provided, and the requirements of a general attendance item are met, the general attendance item is claimed.

General attendance items generally require that the medical practitioner attends the patient and does *at least* one of the following:

- taking a patient history
- performing a clinical examination
- arranging any necessary investigation
- implementing a management plan
- providing appropriate preventive health care.

Appropriate and contemporaneous records must be kept.

The time-tiers range from Level A short consultation for straightforward tasks to 60+ minute Level E consultations.

General attendance items are both professional and personal attendances.

What is a professional attendance?

The Regulations state that a professional attendance includes the "*provision, for a patient, of any of the following services:*

- *evaluating the patient's condition or conditions including, if applicable, evaluation using a health screening service mentioned in subsection 19(5) of the [Health Insurance] Act*
- *formulating a plan for the management and, if applicable, for the treatment of the patient's condition or conditions*
- *giving advice to the patient about the patient's condition or conditions and, if applicable, about treatment*

- *if authorised by the patient—giving advice to another person, or other persons, about the patient's condition or conditions and, if applicable, about treatment*
- *providing appropriate preventive health care*
- *recording the clinical details of the service or services provided to the patient."*

Further information on professional attendances is at AN.0.3.

What is a personal attendance?

The Regulations specify that personal attendance items *"apply to a service provided in the course of a personal attendance by a single medical practitioner on a single patient on a single occasion."* This means that:

- the patient must be present and only time spent with the patient counts towards the attendance
- another health practitioner (e.g. a practice nurse) cannot provide the service on behalf of a medical practitioner
- benefits are not payable if more than one medical practitioner provides an attendance on the same patient at the same time.

In the case of telehealth (video and phone) attendances this requirement is modified to be "a service that is an attendance by a single health professional on a single person".

A guide on substantiating a patient's attendance is available on the Department of Health, Disability and Ageing's website.

Further information on personal attendances is at AN.0.1.

How do I choose which general attendance item to use?

The correct general attendance item will depend on:

- practitioner type – GP, medical practitioner (excluding GPs) or prescribed medical practitioner
- length of time spent with the patient (i.e. the personal attendance time)
- location of the consultation – in consulting rooms, out of consulting rooms or residential care home
- time of the consulting – business or after-hours
- mode of the consultation – face to face, phone or video, and
- for prescribed medical practitioners only – the location (by Modified Monash area) of the practice.

Reference tables setting out the relevant general attendance items are available at AN.0.74 for GPs and AN.7.2 for OMPs.

Can I address more than one issue in a general attendance?

Yes. All general attendance items can be claimed to address multiple issues with a patient.

When multiple issues are addressed in a single consultation, and more specific MBS items do not apply for any of these issues, medical practitioners should use the appropriate MBS general attendance item for the total time of the consultation. In these circumstances, medical practitioners should not claim each issue as a separate attendance.

What activities count towards the consultation time?

Only time spent with the patient (or on the telephone/video conference with the patient in the case of telehealth) performing clinically relevant tasks can be included in the consultation time. Clinically relevant tasks include, but are not limited to:

- undertaking any of the activities described in the item descriptor
- communicating with the patient (and where relevant their carer)
- writing clinical notes, prescriptions or referrals, completing forms, reports or other paperwork relating to the patient while the patient is present
- reviewing, creating or updating entries in the patient's My Health Record while the patient is present.

Time taken to write clinical notes, complete forms, reports or other paperwork, upload records in My Health Record (or other systems), or talk to carers or relatives when the patient is not present cannot be included in the consultation time.

If the patient has particular needs that mean good communication takes longer than average can this time be included?

Yes, communicating effectively with patients is crucial to achieving clinical outcomes and a key part of a clinical service. A wide range of factors may affect the time needed to communicate effectively with a patient during a consultation. These include, but are not limited to, situations where a language barrier exists between the medical practitioner and patient (including when an interpreter is required), or when a patient has hearing problems, difficulty with speech, an intellectual disability, and/or dementia.

When claiming for time-tiered MBS items, the total consultation time includes the time required to communicate effectively with the patient. Where more time than usual is required to communicate effectively with a particular patient, it is considered reasonable to claim a longer attendance item than might otherwise be expected for the service. This applies to both face to face and telehealth services.

In such situations, medical practitioners and other providers should make a brief record in the patient's notes including details about why the additional time was required. For example, stating 'consultation extended due to use of interpreter' and, if relevant, citing the Translating and Interpreting Service (TIS) job number.

Can I provide another medical service that is not a general attendance (e.g. a procedure or diagnostic test) and a general attendance to the same patient on the same day?

In general, yes. However, there are some limitations including:

- both services must be clinically relevant and distinct services
- the other item must not have restrictions on same day claiming as a general attendance item, and
- the other item is not listed in MBS Group T6 (Anaesthetics) or T9 (Assistance at Operation).

Where more than one service is provided to a patient on the same day, the time taken for the second service (e.g. a procedure) must not be included in the consultation time for the general attendance.

Procedural items include all necessary components required to provide the service. This would include obtaining informed procedural and financial consent, the procedure itself, a discussion of the results of the procedure and (unless stated otherwise) the provision of routine aftercare.

Where the results of a procedure inform a further consultation on management, the consultation may be eligible for a Medicare benefit.

Can I provide more than one general attendance service to the same patient on the same day?

Yes, provided that the subsequent attendance is not a continuation of the first attendance, both services are clinically relevant and distinct, and the item requirements are met for both attendances. Further information is available in AN.0.7.

Are there specific requirements for any of the general attendance items?

Yes, several general attendance items have additional, specific requirements:

- Telehealth (video and phone) – patients can only access these services through their "eligible telehealth practitioner" with limited exemptions, or through MyMedicare with the patient's registered practice. See AN.1.1 for further information. Some longer telephone items require the patient to be registered with MyMedicare and can only be claimed at their registered practice.

- After-hours attendance items – can only be claimed in specific time periods. See AN.0.19 (GPs) and AN.7.24 (OMPs) for further information.

- Out of consulting rooms attendance items – have derived fee structures that vary with the number of patients attended or, in the case of some residential care home items, may be co-claimed with a flag fall item. See AN.0.11 (derived fees) and AN.35.1 and AN.35.2 (flag falls) for further information.

- Residential care home items – See AN.0.15, AN.35.1 and AN.35.2 for further information.

- Items 179, 185, 189, 203, 301, 91906, 91916, 19794, 91806, 91807, 91808, 91926 – can only be claimed when the service is provided at a practice located in a Modified Monash 2-7 area. Practice locations can be checked on the Health Workforce Locator.

Can I claim a general attendance for providing aftercare?

No, you cannot claim a general attendance item if you performed the procedure that resulted in the need for aftercare.

However, the *Health Insurance (Subsection 3(5) General Practitioner Post-Operative Treatment) Direction 2017* allows a medical practitioner working in general practice to use a general attendance item to provide aftercare provided that they did not perform the initial service that caused the need for aftercare. See AN.0.71 for further information.

ELIGIBLE PATIENTS

Any patient who is eligible to receive Medicare benefits is eligible for face to face (in consulting rooms and out of consulting rooms) general attendance items (business hours or after-hours).

Residential care home-specific items are only available to Medicare-eligible patients who are care recipients in a residential care home.

Patients must meet the "eligible telehealth practitioner" requirement to access video and phone items, unless an exemption applies (see AN.1.1 for more information). In the case of telephone items 91900, 91903, 91906, 91910, 91913, 91916, the patient must also be registered with the practice providing the service through MyMedicare.

ELIGIBLE PRACTITIONERS

General attendance items are available for different practitioner types:

- general practitioner items can be claimed by general practitioners only (see GN.4.13).

- medical practitioner items can be claimed by any medical practitioner that is not explicitly excluded in the relevant item descriptor.

- prescribed medical practitioner items can be claimed by prescribed medical practitioners only (see AN.7.1).

CO-CLAIMING RESTRICTIONS

To co-claim a general attendance item and another item both services must be clinically relevant and distinct services.

General attendance items and chronic condition management items 392, 393, 965, 967, 92029, 92030, 92033, 92034, 92060, 92061 , 92063 and 92064 cannot be claimed on the same day for the same patient. This restriction is set out in clause 2.16.11 of the *Health Insurance (General Medical Services Table) Regulations 2021*.

RECORD KEEPING AND REPORTING REQUIREMENTS

The department undertakes regular post payment auditing to ensure that MBS items are claimed appropriately. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item(s) can be found on the Federal Register of Legislation at www.legislation.gov.au. Attendance items are set out in three regulatory instruments:

- *Health Insurance (Section 3C General Medical Service – Other Medical Practitioner) Determination 2018* – items 733, 737, 741, 745, 761, 763, 766, 769, 772, 776, 788, 789, 2197, 2198, 2200

- *Health Insurance (Section 3C General Medical Services – Telehealth Attendances) Determination 2021*– video and phone attendance items.

- *Health Insurance (General Medical Services Table) Regulations 2021* – all other attendance items.

AN.0.11 Derived fee items for general practice

Derived fees apply to a range of attendance items that are used when services are provided outside of consulting rooms, including some MBS items used in residential care homes.

An item is a derived fee item if the MBS benefit payable depends on the number of patients that are seen at the location. Not all out of consulting rooms items are derived fee items. Some out of consulting rooms items attract a flag fall, instead of using a derived fee. See AN.35.1 and AN.35.2 for further information on flag falls.

To facilitate assessment of the correct Medicare benefit in respect of a number of patients attended on the one occasion at one location, it is important that the total number of patients seen be recorded on each individual account, receipt or assignment agreement. For example, where ten patients were visited (for a brief consultation) in the one facility/location on the one occasion, each account, receipt or assignment agreement would show "Item 4 - 1 of 10 patients" for a general practitioner.

The number of patients seen should not include attendances which do not attract a Medicare benefit (e.g. public in-patients, attendances for normal after-care), or where a Medicare benefit is payable under an item other than these derived fee items (e.g. health assessments, care planning, emergency after-hours attendance - first patient).

AN.0.12 Billing Procedures

There are three ways benefits may be paid for professional services:

(a) the claimant may pay the practitioner's account in full and then claim benefits from Services Australia by submitting the account and the receipt;

(b) the claimant may submit the unpaid account to Services Australia who will then send a cheque in favour of the practitioner, to the claimant; or

(c) the practitioner may direct-bill Medicare instead of the patient for the consultation. This is known as bulk billing. If a practitioner direct-bills, they undertake to accept the relevant Medicare benefit as full payment for the consultation. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient.

Claiming of benefits

The patient, upon receipt of an practitioner's account, has two options open for paying the account and receiving benefits.

Paid accounts

If the account has been paid in full a claimant can claim Medicare benefits in a number of ways:

- Electronically if the claimant's doctor offers this service and the claimant has completed and lodged bank account details with Medicare.
- Online through Medicare Online Services.
- At the claimant's local Services Australia Service Centre.
- By mail by sending a completed Medicare claim form (MS014) with the original accounts and/or receipts to:

Services Australia

Medicare

GPO Box 9822

In the claimant's capital city

- Over the phone by calling 132 011 and giving the claim details and then sending the accounts and/or receipts to:

Services Australia

Medicare

GPO Box 9822

In the claimant's capital city

Practitioners seeking information regarding registration to allow EFT payments and other E-Business transactions, can do so by viewing the Health Professionals section at Services Australia's website.

Unpaid and partially paid accounts

Where the patient has not paid the account in full, the unpaid account may be presented to Medicare with a completed Medicare Claim form (MS014). In this case Medicare will forward to the claimant a benefit cheque made payable to the practitioner.

It is the patient's responsibility to forward the cheque to the practitioner and make arrangements for payment of the balance of the account, if any. "Pay doctor" cheques involving Medicare benefits not be sent direct to practitioner, or

to the claimant at an practitioner's address (even if requested by the claimant to do so). "Pay doctor" cheques are required to be forwarded to the claimant's last known address.

When issuing a receipt to a patient for an account that is being paid wholly or in part by a Medicare "pay doctor" cheque the practitioner should indicate on the receipt that a "Medicare cheque for $..... was involved in the payment of the account". The receipt should also include any money paid by the claimant or patient.

Itemised accounts

When a practitioner bills a patient for a service, the patient should be issued with a correctly itemised account and receipt to enable the patient to claim Medicare benefits. Where both a consultation and another service occur these may be itemised on the same account.

Medicare benefits are only payable in respect of professional services where it is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of each service to each patient, the following information:

(a) patient's name;

(b) date on which the service(s) was rendered;

(c) a description of the service(s) (e.g. "initial consultation," "subsequent consultation" or "contact lens consultation" and/or "computerised perimetry" in those cases where it is performed);

(d) Medicare Benefits Schedule item number(s);

(e) the name and practice address or name and provider number of the practitioner who actually rendered the service(s). Where the practitioner has more than one practice location, the provider number used should be that which is applicable to the practice location where the service(s) was given;

(f) the fee charged for the service(s); and

(g) the time each service began if the practitioner attended the patient on more than one occasion on the same day and on each occasion rendered a professional service relating to an MBS item, except where a perimetry item is performed in association with a consultation item, where times do not need to be specified.

The practitioner billing for the service bears responsibility for the accuracy and completeness of the information included on accounts, receipts and assignment of benefits forms even where such information has been recorded by an employee of the practitioner.

Payment of benefits could be delayed or disallowed if the account does not clearly identify the service as one which qualifies for Medicare benefits or that the practitioner is a registered practitioner practising at the address where the service was rendered. It is important to ensure that an appropriate description of the service, the item number and the practitioner's provider number are included on accounts, receipts and assignment of benefit forms.

Details of any charges made other than for services, e.g. a dispensing charge, a charge for a domiciliary visit, should be shown separately either on the same account or on a separate account.

Patients must be eligible to receive Medicare benefits and must also meet the clinical requirements outlined in the relevant item descriptors.

Duplicate accounts

Only one original itemised account per service should be issued, except in circumstances where both a consultation and computerised perimetry occur, in which case these may be itemised on the same original account. Duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

Assignment of benefit (bulk billed) arrangements

Under the *Health Insurance Act 1973* an Assignment of Benefit (bulk-billing) for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This is not confined to pensioners or people in special need.

If a practitioner bulk-bills, they undertake to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:

- a patient's assignment of benefit can be obtained before or after a service is rendered; it must be obtained by a provider before a claim is made;
- the assignment agreement must include the 'data set' as outlined in the *Health Insurance Regulation 2018*;
- the practitioner must cause the particulars relating to the professional service to be set out in the agreement before the patient signs the agreement, and if requested provide the patient with a copy of the completed agreement form as soon as practicable; and,
- the practitioner must retain a copy of the competed assignment agreement for up to 2 years following the making of a related claim.

Where a patient is unable to sign the form through either a wet or electronic signature:

- an assignor (for example a parent, partner, carer, relative, individual with power of attorney, or friend) may be requested to sign the agreement.
- should neither the patient nor an assignor provides a signature, the assignment of benefit agreement remains incomplete, and a bulk billed claim must not be submitted.

The administration of bulk billing arrangements under Medicare as well as the payment of Medicare benefits on patient claims is the responsibility of Services Australia and any enquiries in regard to these matters should therefore be directed to Services Australia.

For pathology, the patient 'pre-assigns' their benefits at the time of consultation/request is made, but the date of service for pathology is reported as the date of the specimen collection or, where multiple samples are taken for a single Medicare-billed test, the date of the first specimen collection.

Use of Medicare cards in bulk-billing

An eligible person who applies to enrol for Medicare benefits will be issued with a uniquely numbered Medicare card which shows the Medicare card number, the patient identification number (reference number), the applicant's first given name, initial of second given name, surname and an effective "valid to" date. These cards may be issued on an individual or family basis. Up to 5 persons may be listed on the one Medicare card, and up to 9 persons may be listed under the one Medicare card number.

The Medicare card number must be quoted on bulk bill agreements. If the number is not available, then assignment of benefit arrangements should not be used. To do so would incur a risk that the patient is not eligible and Medicare benefits not payable.

Where a patient presents without a Medicare card and indicates they have been issued with a card but do not know the details, the patients may present a digital copy of their Medicare card from their Medicare app, providing they have a myGov account and have linked to Medicare from this account. The practitioner may also contact Services Australia to obtain the number.

Assignment of benefit forms

From 1 July 2026, the assignment of benefit approved form (for example DB4e or DB020) will no longer be required.

Instead, assignment agreements must include the required 'data set' as specified in the *Health Insurance Regulations 2018*, ensuring patients are adequately informed when making decisions.

Services Australia has downloadable assignment agreement templates available on its website for pre and post assignment agreements for different medical specialities. These are available for use where practitioners do not wish to create their own agreement based on the Regulations or use agreements generated by medical software.

Time limits applicable to lodgement of bulk bill claims for assigned benefits

Claims for bulk billed services rendered may be paid if the claim is made up to 1 year from the date of service. For services rendered prior to 5 September 2025, this timeframe is up to 2 years from the date of service.

Provision exists whereby in certain circumstances (e.g. hardship cases), the Minister may waive the time limits. More information is available on the Services Australia website.

AN.0.13 Attendances at a Hospital (Items 4, 24, 37, 47, 124, 58, 59, 60, 65, 165)

These items refer to attendances on patients admitted to a hospital. Where medical practitioners have made arrangements with a local hospital to routinely use out-patient facilities to see their private patients, items for services provided in consulting rooms would apply.

AN.0.14 Referrals (Read in Connection with the Relevant Paragraphs at O.6)

General

Optometrists are required to refer a patient for medical attention when it becomes apparent to them that the patient's condition is such that it would be more appropriate for treatment to be undertaken by a medical practitioner.

Optometrists may refer patients directly to specialist ophthalmologists with the patient being able to claim benefits for the ophthalmologist's services at the referred specialist rate.

Optometrists may refer patients directly to another optometrist, based on the clinical needs of the patient.

A referral letter or note must have been issued by the optometrist for all such services provided by specialist ophthalmologists or optometrists in order for patients to be eligible for Medicare benefits at the referred rate. Unless such a letter or note has been provided, benefits will be paid at the non-referred attendance rate, which has a lower benefit.

Medicare benefits at the referred rate are not paid for patients referred by optometrists to consultant physicians or to specialists other than ophthalmologists. See relevant paragraph regarding emergency situations.

What is a referral?

For the purposes of the optometric arrangements, a "referral" is a request to a specialist ophthalmologist or another optometrist for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s).

Subject to the exceptions in the paragraph below, for a valid "referral" to take place:

(a) the referring optometrist must have turned their mind to the patient's need for referral and communicate relevant information about the patient to the specialist ophthalmologist or optometrist to whom the patient is referred (but this does not necessarily mean an attendance on the occasion of the referral);

(b) the instrument of referral must be in writing by way of a letter or note and must be signed and dated by the referring optometrist; and

(c) the practitioner to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

The exceptions to the requirements in the above paragraph are that:

(a) sub-paragraphs (b) and (c) do not apply to an emergency situation where the specialist ophthalmologist was of the opinion that the service be rendered as quickly as possible (see paragraph below on emergency situations); and

(b) sub-paragraph (c) does not apply to instances where a written referral was completed by a referring optometrist but was lost, stolen or destroyed.

Period for which referral is valid

A referral from an optometrist to an ophthalmologist is valid for twelve months unless the optometrist specifies on the referral that the referral is for a different period (e.g. three, six or eighteen months or valid indefinitely).

The referral applies for the period specified in the referral from the date that the ophthalmologist provides the first service to the patient. If there is no period specified in the referral then the referral is valid for twelve months from the date of the first service provided by the ophthalmologist.

Referrals for longer than twelve months should be made only when the patient's clinical condition requires continuing care and management.

An optometrist may write a new referral when a patient presents with a condition unrelated to the condition for which the previous referral to an ophthalmologist was written. In these circumstances Medicare benefits for the consultation with the ophthalmologist would be payable at initial consultation rates.

A new course of treatment for which Medicare benefits would be payable at the initial consultation rates will also be paid where the referring optometrist:

(a) deems it necessary for the patient's condition to be reviewed; and

(b) the patient is seen by the ophthalmologist outside the currency of the previous referral; and

(c) the patient was last seen by the specialist ophthalmologist more than nine months earlier than the attendance following a new referral.

Self referral

Optometrists may refer themselves to specialist ophthalmologists or other optometrists and Medicare benefits are payable at referred rates.

Lost, stolen or destroyed referrals

If a referral has been made but the letter or note of referral has been lost, stolen or destroyed, benefits will be payable at the referred rate if the account, receipt or the assignment agreement shows the name of the referring practitioner, the practice address or provider number of the referring practitioner (if either of these are known to the consultant physician or specialist) and the words 'Lost referral'. This provision only applies to the initial attendance. For subsequent attendances to attract Medicare benefits at the referred rate, a duplicate or replacement letter of referral must be obtained by the specialist or the consultant physician.

Emergency situations

Medicare benefits are payable even though there is no written referral in an emergency situation (as defined in the *Health Insurance Regulations 2018*). The specialist or the consultant physician should be of the opinion that the service must be rendered as quickly as possible and endorses the account, receipt or assignment agreement as an "Emergency referral".

A referral must be obtained from a medical practitioner or, in the case of a specialist ophthalmologist, a medical practitioner or an optometrist if attendances subsequent to the emergency attendance are to attract Medicare benefits at the referred rate.

AN.0.15 After-Hours Residential Care Home Attendances (Items 772, 776, 788, 789, 2200, 5010, 5028, 5049, 5067, 5077, 5260, 5262, 5263, 5265, 5267)

These items refer to attendances on patients in residential care homes.

Where a medical practitioner attends a patient in a self-contained unit, within a residential care home complex, the attendance attracts benefits under the appropriate home visit item.

Where a patient living in a self-contained unit attends a medical practitioner at consulting rooms situated within the precincts of the residential care home, or at free standing consulting rooms within the residential care home complex, the appropriate surgery consultation item applies.

If a patient who is accommodated in the residential care home visits a medical practitioner at consulting rooms situated within the residential care home complex, whether free standing or situated within the residential care home precincts, benefits would be attracted under the appropriate residential care home attendance item.

To facilitate assessment of the correct Medicare benefit in respect of a number of patients attended on the one occasion at one of the above locations, it is important that the total number of patients seen be recorded on each individual account, receipt or assignment agreement. For example, where two patients were visited (for a brief consultation) in the one residential care home on the one occasion, each account, receipt or assignment agreement would show "Item 5010 - 1 of 2 patients" for a general practitioner.

The number of patients seen should not include attendances which do not attract a Medicare benefit (e.g. public in-patients, attendances for normal after-care), or where a Medicare benefit is payable under an item other than these derived fee items (e.g. items that attract a flag fall, health assessments, care planning, emergency after-hours attendance - first patient).

AN.0.18 Provision for Review of Practitioner Behaviour

Professional Services Review (PSR) Scheme

The Professional Services Review (PSR) Scheme is a scheme for reviewing and investigating the provision of services by a health practitioner to determine whether the practitioner has engaged in inappropriate practice in the rendering or initiating of Medicare services or in prescribing under the Pharmaceutical Benefits Scheme (PBS). 'Practitioner' is defined in Section 81 of the *Health Insurance Act 1973* and includes: medical practitioners, dentists, optometrists, chiropractors, midwives, nurse practitioners, physiotherapists, podiatrists and osteopaths.

Section 82 of the *Health Insurance Act 1973* defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude that it would be unacceptable to the general body of the members of the profession in which the practitioner was practising when they rendered or initiated the services. It is also an offence under Section 82 for a person who is an officer of a body corporate to knowingly, recklessly or negligently cause or permit a practitioner employed by the person to engage in such conduct.

Services Australia monitors health practitioners' claiming patterns. Where an anomaly is detected, for which a satisfactory explanation cannot be provided, Services Australia can request that the Director of PSR review the provision of services by the practitioner. On receiving the request, the Director must decide whether to conduct a review and in which manner the review will be conducted. The Director is authorised to require that documents and information be provided.

Following a review, the Director must:

(a) decide to take no further action; or

(b) enter into an agreement with the person under review (which must then be ratified by an independent Determining Authority); or

(c) refer the matter to a PSR Committee.

A PSR Committee consists of the Chairperson and two other panel members who must be members of the same profession as the practitioner under review. However, up to two additional Committee members may be appointed to provide a wider range of clinical expertise.

The Committee is authorised to:

(a) investigate any aspect of the provision of the referred services, and without being limited by the reasons given in the review request or by a Director's report following the review;

(b) hold hearings and require the person under review to attend and give evidence; and

(c) require the production of documents (including clinical notes).

A PSR Committee may not make a finding of inappropriate practice unless it has given the person under review notice of its intention to review them, the reasons for its findings, and an opportunity to respond. In reaching their decision, a PSR Committee is required to consider whether or not the practitioner has kept adequate and contemporaneous patient records. It will be up to the peer judgement of the PSR Committee to decide if a practitioner's records meet the prescribed standards.

The standards which determine if a record is adequate and contemporaneous are prescribed in the *Health Insurance (Professional Services Review) Regulations 1999*.

To be ***adequate***, the patient or clinical record needs to:

clearly identify the name of the patient; and

contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated; and

each entry needs to provide clinical information adequate to explain the type of service rendered or initiated; and

each entry needs to be sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the patient's ongoing care.

To be ***contemporaneous***, the patient or clinical record should be completed at the time that the service was rendered or initiated or as soon as practicable afterwards. Records for hospital patients are usually kept by the hospital and the practitioner could rely on these records to document in-patient care.

The practitioner under review is permitted to make submissions to the PSR Committee before key decisions or a final report is made.

If a PSR Committee finds that the person under review has engaged in inappropriate practice, the findings will be reported to the Determining Authority to decide what action should be taken:

(i) a reprimand;

(ii) counselling;

(iii) repayment of Medicare benefits; and/or

(iv) complete or partial disqualification from Medicare benefit arrangements for up to three years.

Further information on the Professional Services Review is available at www.psr.gov.au and information on Medicare compliance is available at https://www.health.gov.au/topics/medicare/compliance/our-approach.

Penalties

Penalties of up to $10,000 or imprisonment for up to five years, or both may be imposed on any person who makes a statement (either orally or in writing) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used with a claim for benefits. In addition, any practitioner who is found guilty of such offences shall be subject to examination by a Medicare Participation Review Committee (MPRC) and may be counselled or reprimanded or may have services wholly or partially disqualified from the Medicare benefit arrangements.

A penalty of up to $1,000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on an assignment of benefit form without necessary details having been entered on the form before the patient signs or who fails to cause a patient to be given a copy of the completed form.

Medicare Participation Review Committee (MPRC)

The Medicare Participation Review Committee determines what administrative action should be taken against a practitioner who:

(a) has been successfully prosecuted for relevant criminal offences; or

(b) has been found to have engaged in inappropriate practice under the Professional Services Review scheme.

The Committee can take no further action, counsel or reprimand the practitioner, or determine that the practitioner be disqualified from Medicare for a particular period or in relation to particular services for up to five years.

Medicare benefits are not payable in respect of services rendered by a practitioner who has been fully disqualified, or partly disqualified in relation to relevant services under the *Health Insurance Act 1973* (Section 19B applies).

AN.0.19 After-Hours Attendances (Items 585, 588, 591, 594, 599, 600, 5000, 5003, 5010, 5020, 5023, 5028, 5040, 5043, 5049, 5060, 5063, 5067, 5071, 5076, 5077, 5200, 5203, 5207, 5208, 5209, 5220, 5223, 5227, 5228, 5260, 5261, 5262, 5263, 5265 and 5267)

After-hours attendance items may be claimed as follows:

Items 585, 588, 591, 594, 599, 600 apply only to a professional attendance that is provided:

- on a public holiday;
- on a Sunday;
- before 8am, or after 12 noon on a Saturday;
- before 8am, or after 6pm on any day other than a Saturday, Sunday or public holiday.

Items 5000, 5020, 5040, 5060, 5071, 5200, 5203, 5207, 5208 and 5209 apply only to a professional attendance that is provided:

- on a public holiday;
- on a Sunday;
- before 8am, or after 1 pm on a Saturday;
- before 8am, or after 8pm on any day other than a Saturday, Sunday or public holiday.

Items 5003, 5010, 5023, 5028, 5043, 5049, 5063, 5067, 5076, 5077, 5220, 5223, 5227, 5228, 5260, 5261, 5262, 5263, 5265 and 5267 apply to a professional attendance that is provided:

- on a public holiday;

- on a Sunday;

- before 8am, or after 12 noon on a Saturday;

- before 8am, or after 6pm on any day other than a Saturday, Sunday or public holiday.

Urgent After-Hours Attendances (Items 585 - 600)

Items 585, 588, 591, 594, 599 and 600 can be used for urgent after-hours services.

Urgent After-Hours Attendances (Items 585, 588, 591, and 594) allow for urgent attendances (other than an attendance between 11pm and 7am) in an after-hours period.

Urgent After-Hours Attendances during Unsociable Hours (Items 599 and 600) allow for urgent attendances between 11pm and 7am in an after-hours period.

The attendance for all these items must be requested by the patient or a responsible person during the same unbroken urgent after-hours period in which the medical service is provided. The medical practitioner must first determine that the patient requires urgent medical assessment.

In considering the need for an urgent assessment of a patient's condition, the practitioner may rely on information conveyed by the patient or patient's carer, other health professionals or emergency services personnel. A record of the assessment must be completed and included in the patient's medical record.

The MBS urgent after-hours items may be used when, on the information available to the medical practitioner, the patient's condition requires urgent medical assessment during the after-hours period to prevent deterioration or potential deterioration in their health. Specifically, the patient's assessment:

· cannot be delayed until the next in-hours period; and

· the medical practitioner must attend the patient at the patient's location or reopen the practice rooms.

Appendix B of the Approved Medical Deputising Service (AMDS) Program Guidelines offers a useful protocol to determine whether prospective after-hours patients should be seen by a deputising medical practitioner or see their regular medical practitioner. The Guidelines are available on the Department of Health, Disability and Ageing website at AMDS Program Guidelines.

If the attendance is undertaken at consulting rooms, it is necessary for the practitioner to return to and specially open the consulting rooms for the attendance.

MBS Item 585 is available to medical practitioners who are:

- listed on the Vocational Register of General Practitioners maintained by Services Australia; or

- holders of the Fellowship of the Royal Australian College of General Practitioners (FRACGP) who participate in, and meet the requirements of the RACGP for continuing medical education and quality assurance as defined in the RACGP Continuing Professional Development Program; or

- holders of the Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) who participate in, and meet the requirements of the Australian College of Rural and Remote Medicine (ACRRM) for continuing medical education and quality assurance as defined in ACRRM's Professional Development Program; or

- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FRACGP or training recognised by the RACGP as being of an equivalent standard; or

- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FACRRM or training recognised by ACRRM as being of an equivalent standard.

MBS Item 588 is available to non-vocationally recognised medical practitioners who are providing services (as a contractor, employee, member or otherwise) for a general practice or clinic or as part of medical deputising arrangements in Modified Monash Model Areas 2 to 7.

A locator map to identify a medical practice's Modified Monash Model Area location is on the Health Workforce Locator.

MBS item 591 is available to non-vocationally recognised medical practitioners who perform attendances for after-hours clinics or as part of deputising arrangements in Modified Monash Model Area 1.

If more than one patient is seen on the same occasion (that is, the second and any further services are consequential to the first service) using either MBS items 585, 588 or 591.

MBS item 594 must be used in respect of the second and subsequent services to patients attended on the same occasion.

Medical practitioners who routinely provide services to patients in the after-hours periods at consulting rooms, or who provide the services (as a contractor, employee, member or otherwise) for a general practice or clinic that routinely provides services to patients in after-hours periods at consulting rooms, will not be able to bill urgent after-hours items 585, 588, 591, 594, 599 and 600.

A *routine service* means a regular or habitual provision of services to patients. This does not include *ad hoc* services provided after-hours in consulting rooms by a medical practitioner (excluding consultant physicians and specialists) working in a general practice or a clinic while participating in an on-call roster.

There is no change to the types of providers who can render services under the *Urgent After-Hours Attendances during Unsociable Hours items* (MBS items 599 and 600). Attendances using these items must be booked during the same unbroken urgent after-hours period.

MBS item 599 continues to be available to medical practitioners who are:

- listed on the Vocational Register of General Practitioners maintained by Services Australia; or

- holders of the Fellowship of the Royal Australian College of General Practitioners (FRACGP) who participate in, and meet the requirements of the RACGP for continuing medical education and quality assurance as defined in the RACGP Continuing Professional Development Program; or

- holders of the Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) who participate in, and meet the requirements of the Australian College of Rural and Remote Medicine (ACRRM) for continuing medical education and quality assurance as defined in ACRRM's Professional Development Program; or

- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FRACGP or training recognised by the RACGP as being of an equivalent standard.

MBS item 600 continues to be available to non-vocationally recognised medical practitioners.

Non-Urgent After-Hours Attendances (5000 - 5077 and 5200 - 5267)

Non-Urgent After-Hours Attendances in Consulting Rooms (Items 5000, 5020, 5040, 5060, 5071, 5200, 5203, 5207, 5208 and 5209) are to be used for non-urgent consultations at consulting rooms initiated either on a public holiday, on a Sunday, or before 8am and after 1pm on a Saturday, or before 8am and after 8pm on any other day.

Non-Urgent After-Hours Attendances at a Place Other than Consulting Rooms (Other than a Hospital or Residential Care Home) (items 5003, 5023, 5043, 5063, 5076, 5220, 5223, 5227, 5228 and 5261) and *Non-Urgent After-Hours Attendances in a Residential Care Home* (Items 5010, 5028, 5049, 5067, 5077, 5260, 5262, 5263, 5265 and 5267) are to be used for non-urgent attendances on 1 or more patients on 1 occasion on a public holiday, on a Sunday, or before 8am and after 12 noon on a Saturday, or before 8am and after 6pm on any other day.

Attendance Period	**Applicable Time**			**Items**
	Monday to Friday	**Saturday***	**Sunday and/or public holiday**	
Urgent after-hours attendance	Between 7am - 8am and 6pm - 11pm	Between 7am - 8am and 12 noon - 11pm	Between 7am - 11pm	585, 588, 591, 594
Urgent after-hours in unsociable hours	Between 11pm - 7am	Between 11pm - 7am	Between 11pm - 7am	599, 600
Non-urgent after-hours in consulting rooms	Before 8am or after 8pm	Before 8am or after 1pm	24 hours	5000, 5020, 5040, 5060, 5071 5200, 5203, 5207, 5208, 5209
Non-urgent after-hours at a place other than consulting rooms (other than a hospital or residential care home)	Before 8am or after 6pm	Before 8am or after 12 noon	24 hours	5003, 5023, 5043, 5063, 5076 5220, 5223, 5227, 5228, 5261
Non-urgent after-hours in a residential care home	Before 8am or after 6pm	Before 8am or after 12 noon	24 hours	5010, 5028, 5049, 5067, 5077 5260, 5262, 5263, 5265, 5267

*with the exception of public holidays which fall on a Saturday

AN.0.20 Visiting Optometrists Scheme (VOS)

Special arrangements exist under the provisions of Section 129A of the *Health Insurance Act 1973* to ensure that people in rural and remote locations have access to optometry services. Optometrists are encouraged to provide outreach services to national priority locations, particularly remote and very remote locations, Aboriginal and Torres Strait Islander communities and rural locations with an identified need for optometry services.

Under these arrangements, financial assistance may be provided to cover costs associated with delivering outreach services, including travel, accommodation and meals and facility fees.

AN.0.21 Minor Attendance by a Consultant Physician (Items 119, 120, 131)

A minor consultation is regarded as being a consultation in which the assessment of the patient does not require the physical examination of the patient and does not involve a substantial alteration to the patient's treatment. Examples of consultations which could be regarded as being 'minor consultations' are listed below (this is by no means an exhaustive list) :-

- hospital visits where a physical examination does not result, or where only a limited examination is performed;

- hospital visits where a significant alteration to the therapy or overall management plan does not ensue;

- brief consultations or hospital visits not involving subsequent discussions regarding patient's progress with a specialist colleague or the referring practitioner.

AN.0.22 Video Patient-end Support Services by Optometrists

Video Patient-end Support Services by Optometrists

These notes provide information on the video MBS attendance items for optometrists to provide clinical support to their patients, when clinically relevant, during video consultations with ophthalmologists under items 10945 and 10946 in Group A10.

Video patient-end support services can only be claimed where:

- a Medicare eligible specialist service is claimed;
- the service is rendered in Australia; and
- this is necessary for the provision of the specialist service.

A video consultation will involve a single optometrist attending to the patient, with the possible participation of another medical practitioner, a participating nurse practitioner, a participating midwife, practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal and Torres Strait Islander health worker at the patient end. The above time-tiered items provide for patient-end support services in various settings, including consulting rooms, other than consulting rooms, eligible residential care homes and Aboriginal Medical Services.

Clinical indications

The ophthalmologist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the ophthalmologist.

Video specialist services can be provided to patients when there is no patient-end support service provided.

Collaborative Consultation

The optometrist who provides assistance to the patient where this is necessary for the provision of the specialist service, may seek assistance from a health professional (e.g. a medical practitioner, practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal and Torres Strait Islander health worker) but only one item is billable for the patient-end support service. The optometrist must be present during part or all of the consultation in order to bill an appropriate time-tiered MBS item. Any time spent by another health professional called to assist with the consultation may not be counted against the overall time taken to complete the video consultation.

Restrictions

The MBS video attendance items are not payable for services to an admitted hospital patient (this includes Hospital in the Home patients). Benefits are not payable for telephone or email consultations. In order to fulfil the item descriptor there must be a visual and audio link between the patient and the ophthalmologist. If the ophthalmologist is unable to establish both a video and audio link with the patient, a MBS benefit for a video attendance is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

Record Keeping

Optometrists must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Multiple attendances on the same day

In some situations a patient may receive a video consultation and a face-to-face consultation by the same or different practitioner on the same day, provided that subsequent attendances are not a continuation of the initial or earlier attendances.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Also, if a patient has an initial consultation via video, they cannot also claim an initial face-to-face consultation as part of the same course of treatment.

Aftercare Rule

Video consultations are subject to the same aftercare rules as face-to-face consultations.

Referrals

The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Duration of attendance

The optometrist attending at the patient end of the video consultation does not need to be present for the entire consultation, only as long as is clinically relevant - this can be established in consultation with the ophthalmologist. The MBS fee payable for the supporting optometrist will be determined by the total time spent assisting the patient. This time does not need to be continuous.

AN.0.23 Referred Patient Consultant Physician Treatment and Management Plan (Items 132 and 133)

Patients with at least two morbidities which can include complex congenital, development and behavioural disorders are eligible for these services when referred by their referring practitioner.

Item 132 should include the development of options for discussion with the patient, and family members, if present, including the exploration of treatment modalities and the development of a comprehensive consultant physician treatment and management plan, with discussion of recommendations for services by other health providers as appropriate.

Item 133 is available in instances where a review of the consultant physician treatment and management plan provided under item 132 is required, up to a maximum of two claims for this item in a 12 month period. Should further reviews of the consultant physician treatment and management plan be required, the appropriate item for such service/s is 116.

Where a patient with a GP health assessment or GP Chronic Condition Management Plan (CCMP) (or a GP Management Plan or Team Care Arrangement put in place prior to 1 July 2025) is referred to a consultant physician for further assessment, it is intended that the consultant physician treatment and management plan should augment the CCMP for that patient.

Preparation of the consultant physician treatment and management plan should be in consultation with the patient. If appropriate, a written copy of the consultant physician treatment and management plan should be provided to the patient. A written copy of the consultant physician treatment and management plan should be provided to the referring medical practitioner, usually within two weeks of the consultant physician consultation. In more serious cases, more prompt provision of the plan and verbal communication with the referring medical practitioner may be appropriate. A guide to the content of such consultant physician treatment and management plans which are to be provided under this item is included within this Schedule.

(Note: This information is provided as a guide only and each case should be addressed according to a patient's individual needs.)

REFERRED PATIENT CONSULTANT PHYSICIAN TREATMENT AND MANAGEMENT PLAN

- The following content outline is indicative of what would normally be sent back to the referring practitioner.

- The consultant physician treatment and management plan should address the specific questions and issues raised by the referring practitioner.

History

The consultant physician treatment and management plan should encompass a comprehensive patient history which addresses all aspects of the patient's health, including psychosocial history, past clinically relevant medical history, any relevant pathology results if performed and a review of medication and interactions. There should be a particular focus on the presenting symptoms and current difficulties, including precipitating and ongoing conditions. The results of relevant assessments by other health professionals, including GPs and/or specialists, including relevant care plans or health assessments performed by GPs under the Enhanced Primary Care and Chronic Condition Management should also be noted.

Examination

A comprehensive medical examination means a full multi-system or detailed single organ system assessment. The clinically relevant findings of the examination should be recorded in the management plan.

Diagnosis

This should be based on information obtained from the history and medical examination of the patient. The list of diagnoses and/or problems should form the basis of any actions to be taken as a result of the comprehensive assessment. In some cases, the diagnosis may differ from that stated by the referring practitioner, and an explanation of why the diagnosis differs should be included. The report should also provide a risk assessment, management options and decisions.

Management plan

Treatment options/Treatment plan

The consultant physician treatment and management plan should include a planned follow-up of issues and/or conditions, including an outline of the recommended intervention activities and treatment options. Consideration should also be given to recommendations for allied health professional services, where appropriate.

Medication recommendations

Provide recommendations for immediate management, including the alternatives or options. This should include doses, expected response times, adverse effects and interactions, and a warning of any contra-indicated therapies.

Social measures

Identify issues which may have triggered or are contributing to the problem in the family, workplace or other social environment which need to be addressed, including suggestions for addressing them.

Other non medication measures

This may include other options such as life style changes including exercise and diet, any rehabilitation recommendations and discussion of any relevant referrals to other health providers.

Indications for review

It is anticipated that the majority of patients will be able to be managed effectively by the referring practitioner using the consultant physician treatment and management plan. If there are particular concerns about the indications or possible need for further review, these should be noted in the consultant physician treatment and management plan.

Longer term management

Provide a longer term consultant physician treatment and management plan, listing alternative measures that might be taken in the future if the clinical situation changes. This might be articulated as anticipated response times, adverse effects and interactions with the consultant physician treatment and management plan options recommended under the consultant physician treatment and management plan.

Services Australia (SA), in consultation with the Department of Health, Disability and Ageing, has developed an Health Practitioner Guideline to substantiate that a valid referral existed (specialist or consultant physician) which is located on the Department of Health, Disability and Ageing's website.

AN.0.24 Attendance services for complex neurodevelopmental disorders (such as autism)

Intention of this service under item 135 and video equivalent item 92140

Items 135 or video equivalent item 92140 are intended for complex conditions, characterised by multi-domain cognitive and functional impairment. Patient eligibility is for neurodevelopmental disorders (NDD), which are assessed to be complex and mean that individuals require support across multiple domains.

The intention of this service is to provide access to treatment, through the development of a treatment and management plan by a paediatrician, for individuals diagnosed with a complex NDD. The development of the treatment and management plan follows a comprehensive medical assessment, and provides the opportunity to refer to eligible allied health practitioners for up to a total of 20 MBS treatment services per patient's lifetime (items 82015, 82020, 82025, 82035, 93035, 93036, 93043 or 93044). This item is claimable once in a patient's lifetime.

Eligibility:

In the context of item 135 (or 92140), the diagnosis of a complex NDD requires evidence of requiring support and showing impairment across two or more neurodevelopmental domains. **Complexity** is characterised by multi-domain cognitive and functional disabilities, delay or clinically significant impairment.

Neurodevelopmental domains include:

- Cognition
- Language
- Social-emotional development
- Motor skills
- Adaptive behaviour: conceptual skills, practical skills, social skills or social communication skills

Age eligibility:

Whilst it is not expected that a paediatrician would routinely assess adult individuals (item 289 provides for assessments undertaken by a psychiatrist for patients aged over 18 years to under 25 years), item 135 provides an age ceiling which is consistent across all MBS items related to complex NDD and related allied health services. Where a paediatrician has been referred a patient (under 18 years of age) and the diagnostic formulation is not completed until after their 18th birthday, the higher age limit will allow the completion of the assessment by the paediatrician (as clinically appropriate).

Referral pathways:

Early identification of, and intervention for, individuals with complex NDD is important in promoting positive longer-term outcomes. Symptoms can cause clinically significant impairment in social, occupational or other important areas of functioning.

Where neurodevelopmental concerns have been identified and brought to the attention of the patient's GP to initially assess these concerns and the GP considers there are persisting indications that require more specialised assessment, they are encouraged to refer to either a consultant paediatrician or psychiatrist for a comprehensive assessment.

Diagnostic Assessment:

The assessment and diagnosis of a complex NDD should be evaluated in the context of both a physical and developmental assessment. The paediatrician may require a number of separate attendances (through usual time-tiered or subsequent attendance items 110, 116, 119, 122, 128, 131 or video items 91824 to 91826) to complete a comprehensive accurate assessment and formulate a diagnosis, exclude other disorders or assess for co-occurring conditions.

Multi-disciplinary assistance with assessment and/or contribution to the treatment and management plan:

Depending on a range of factors, not limited to the patient's age and nature of suspected complex NDD, the consultant physician may require a multi-disciplinary approach to complete a comprehensive accurate assessment and formulate a diagnosis.

Where the paediatrician determines the patient requires additional assessments to formulate a diagnosis, through the assistance of an allied health practitioner, they are able to refer the patient to an eligible allied health provider from standard attendance items (110 to 131 or telehealth (video or phone) items equivalent items).

Whilst Medicare benefits provide for a total of 8 allied health assessment services per patient per lifetime, an eligible allied health practitioner can only provide **up to 4 services** before the need for a review (the type of review can be specified in the referral to the eligible allied health professional) by the referring paediatrician, who must agree to the need for any additional allied health services prior to the delivery of the remaining 4 allied health assessment services.

Eligible allied health assessment practitioners include:

- Psychologist (MBS item 82000, 93032, 93040)
- Speech pathologist (MBS item 82005, 93033, 93041)
- Occupational therapist (MBS item 82010, 93033, 93041)
- Audiologist, dietitian, exercise physiologist, optometrist, orthoptist, physiotherapist (MBS item 82030, 93033, 93041)

Requirements of the referral to allied health practitioners

The paediatrician can refer to multiple eligible allied health practitioners concurrently, but a separate referral letter must be provided to each allied health practitioner. The referral should specify the intent of the assessment and if appropriate, specify the number of services to be provided. Where the number of sessions is not specified, each allied health practitioner can provide up to 4 assessment services without the need for review or agreement to provide further assessment services.

Review requirements following delivery of four (4) allied health assessment services

Where an eligible allied health practitioner has provided 4 assessment services (through items 82000, 82005, 82010, 82030, 93032, 93033, 93040 or 93041) and considers additional assessment services are required, they must ensure the referring paediatrician undertakes a review. If the type of review is not specified by the referring paediatrician an acceptable means of review includes: a case conference, phone call, written correspondence, secure online messaging exchange or attendance of the patient with the referring paediatrician.

Inter-disciplinary allied health referral

Eligible allied health practitioners are also able to make inter-disciplinary referrals to other eligible allied health practitioners as clinically necessary to assist with the formulation of the diagnosis or contribute to the treatment and management plan. Inter-disciplinary referrals must be undertaken in consultation and agreement with the referring paediatrician. Whilst they do not require the need for an attendance with the patient (face-to-face/video/phone) by the referring paediatrician, they do require an agreement from the referring paediatrician. This can be undertaken (but is not limited to) an exchange by phone, written communication or secure online messaging.

Contribution to the Treatment and Management Plan through allied health referral

In addition to referring to allied health practitioners for assistance with formulating a diagnosis, once a paediatrician makes a complex NDD diagnosis, the paediatrician may require the contribution of an eligible allied health practitioner to assist with the development of the Treatment and Management plan (before billing item 135 or 92140).

MBS items 82000, 82005, 82010, 82030, 93032, 93033, 93040 or 93041 provide a dual function for this purpose. It is important to note that the service limit of a total of 8 services per patient per lifetime apply regardless of whether the items are used for assistance with diagnosis or contribution to the treatment and management plan, and the referring paediatrician should be mindful of this when referring to eligible allied health practitioners.

Development of the Treatment and Management Plan

Once the paediatrician has made a diagnosis of a complex NDD, to complete the item requirements of item 135 or 92140 they must develop a treatment and management plan which includes:

Written documentation of the patient's confirmed diagnosis of a complex NDD, including any findings of assessments performed (which assisted with the formulation of the diagnosis or contributed to the treatment and management plan)

- A risk assessment which means assessment of:
    - the risk to the patient of a contributing co-morbidity and
    - environmental, physical, social and emotional risk factors that may apply to the patient or to another individual.
- Treatment options which include:
    - Recommendations using a biopsychosocial model
    - Identifying major treatment goals and important milestones and objectives
    - Recommendation/s and referral for treatment services provided by eligible allied health practitioners (where relevant) and who should provide this, specifying number of treatments recommended (to a maximum of 20 treatment services)
    - Indications for review or episodes requiring escalation of treatment strategies
- Documenting the Treatment and Management plan and providing a copy to the referring medical practitioner and relevant allied health practitioner/s.

Referral for allied health treatment services

Once a treatment and management plan is in place (under item 135 or 92140) the paediatrician can refer the individual to eligible allied health practitioners for the provision of treatment services. Treatment services address the functional impairments identified through the comprehensive medical assessment which are outlined in the treatment and management plan. Treatment services focus on interventions to address developmental delays/disabilities or impairments.

Eligible allied health treatment practitioners include:

- Psychologist (MBS items 82015, 93035, 93043)
- Speech pathologist (MBS items 82020, 93036, 93044)
- Occupational therapist (MBS items 82025, 93036, 93044)

- Audiologist, dietitian, exercise physiologist, optometrist, orthoptist, physiotherapist (MBS items 82035, 93036, 93044)

A total of 20 allied health treatment services per patient per lifetime are available through the MBS, which may consist of any combination of items 82015, 82020, 82025 or 82035 or equivalent video or phone items. Whilst the paediatrician can refer to multiple eligible allied health practitioners concurrently, a separate referral letter must be provided to each allied health practitioner.

The referral should specify the goals of the treatment and if appropriate, specify the number of services to be provided. It is the responsibility of the referring paediatrician to allocate the number of treatment services (up to a maximum of 10 services per course of treatment) in keeping with the individual's treatment and management plan.

It is important to note, that a benefit will not be paid for the MBS allied health treatment services unless the pre-requisite items (135 or 92140) have been processed through the Medicare claiming system.

On the completion of a "course of treatment" (specified by the referring paediatrician, up to maximum of 10 services), the eligible allied health practitioner must provide a written report to the referring paediatrician, which should include information on the treatment provided, recommendations on future management of the individual's disorder and any advice to caregivers (such as parents, carers, school teachers). This written report will inform the referring paediatrician's decision to refer for further treatment services. Where subsequent courses of treatment are required after the initial 10 services (up to a maximum of 20 services per patient per lifetime) a new referral is required.

Inconclusive assessment:

Where a patient does not meet the diagnostic threshold of a complex NDD and where ongoing medical management is required, patients can be managed through subsequent attendance items (such as 116 or 91825) or where at least two separate diagnoses are made through item 132 or 92422.

Examples include where:

- Neurodevelopmental assessment is incomplete or inconclusive
- Neurodevelopmental impairment is present in fewer than two domains
- Neurodevelopmental impairment is present in two or more domains, but individuals do not require sufficient support to meet criteria
- Comprehensive, age-appropriate neurodevelopmental assessment is impossible or unavailable (e.g. in infants or young children- particularly those under 6 years of age)

These individuals may be considered "at risk of a complex NDD" and require follow-up and reassessment in the future.

AN.0.25 Attendance services for eligible disabilities

Intention and eligibility of this service under item 137 and video equivalent item 92141

Items 137 or video equivalent item 92141 are intended for diagnosis and treatment for patients under 25 years of age with an eligible disability by a specialist or consultant physician.

Definition of eligible disabilities is found at AR.29.1.

Referral pathways:

Early identification of, and intervention for, individuals with eligible disabilities is important in promoting positive longer-term outcomes. Symptoms can cause clinically significant impairment in social, occupational or other important areas of functioning.

Where indications of eligible disability concerns have been identified and brought to the attention of the patient's GP to initially assess these concerns and the GP considers there are persisting indications that require more

specialised assessment, they are encouraged to refer to a specialist or consultant physician for a comprehensive assessment.

Diagnostic Assessment:

The assessment and diagnosis of an eligible disability should be evaluated in the context of both a physical and developmental assessment. The specialist or consultant physician may require a number of separate attendances (through usual time-tiered or subsequent attendance items 104, 105, 107, 108, 110, 116, 119, 122, 128, 131, 296, 297, 299, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 320, 324, 326, 328, 330, 332, 334, 336, 338, 341, 342, 343, 344, 345, 346, 347 or 349 or telehealth (video and phone) items 91822 to 91831, 91833, 91836 to 91839, 91868 to 91878 to 91882 to 91884, 92437 or 92455 to 92457) to complete a comprehensive accurate assessment and formulate a diagnosis, exclude other disorders or assess for co-occurring conditions.

Multi-disciplinary assistance with assessment and/or contribution to the treatment and management plan:

Depending on a range of factors, not limited to the patient's age and nature of suspected disabilities, the specialist or consultant physician may require a multi-disciplinary approach to complete a comprehensive accurate assessment and formulate a diagnosis.

Where the specialist or consultant physician determines the patient requires additional assessments to formulate a diagnosis, through the assistance of an allied health practitioner, they are able to refer the patient to an eligible allied health practitioner from standard attendance items 104, 105, 107, 108, 110, 116, 119, 122, 128, 131, 296, 297, 299, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 320, 324, 326, 328, 330, 332, 334, 336, 338, 341, 342, 343, 344, 345, 346, 347 or 349 or telehealth items (video and phone) 91822 to 91831, 91833, 91836 to 91839, 91868 to 91878 to 91882 to 91884, 92437 or 92455 to 92457.

Whilst MBS items provide for a total of 8 allied health assessment services per patient per lifetime, an eligible allied health practitioner can only provide up to 4 services before the need for a review (the type of review can be specified in the referral to the eligible allied health practitioner) by the referring specialist or consultant physician, who must agree to the need for any additional allied health services prior to the delivery of the remaining 4 allied health assessment services.

Eligible allied health assessment practitioners include:

- Psychologist (MBS item 82000, 93032, 93040)
- Speech pathologist (MBS item 82005, 93033, 93041)
- Occupational therapist (MBS item 82010, 93033, 93041)
- Audiologist, dietitian, exercise physiologist, optometrist, orthoptist, physiotherapist (MBS item 82030, 93033, 93041)

Requirements of the referral to allied health practitioners

The specialist or consultant physician can refer to multiple eligible allied health practitioners concurrently, but a separate referral letter must be provided to each allied health practitioner. The referral should specify the intent of the assessment and if appropriate, specify the number of services to be provided. Where the number of sessions is not specified, each allied health practitioner can provide up to 4 assessment services without the need for review or agreement to provide further assessment services.

Review requirements following delivery of 4 allied health assessment services

Where an eligible allied health practitioner has provided 4 assessment services (through items 82000, 82005, 82010, 82030, 93032, 93033, 93040 or 93041) and considers additional assessment services are required, they must ensure the referring specialist or consultant physician undertakes a review. If the type of review is not specified by the referring specialist or consultant physician an acceptable means of review includes: a case conference, phone call, written correspondence, secure online messaging exchange or attendance of the patient with the referring psychiatrist.

Inter-disciplinary allied health referral

Eligible allied health practitioners are also able to make inter-disciplinary referrals to other eligible allied health practitioners as clinically necessary to assist with the formulation of the diagnosis or contribute to the treatment and management plan. Inter-disciplinary referrals must be undertaken in consultation and agreement with the referring specialist or consultant physician. Whilst they do not require the need for an attendance with the patient (face-to-face/video/phone) by the referring specialist or consultant physician, they do require an agreement from the referring specialist or consultant physician. This can be undertaken (but is not limited to) an exchange by phone, written communication or secure online messaging.

Contribution to the treatment and management plan through allied health referral

In addition to referring to allied health practitioners for assistance with formulating a diagnosis, once the specialist or consultant physician makes a diagnosis, the specialist or consultant physician may require the contribution of an eligible allied health practitioner to assist with the development of the treatment and management plan (before billing item 137 or 92141).

MBS items 82000, 82005, 82010, 82030, 93032, 93033, 93040 or 93041 provide a dual function for this purpose. It is important to note that the service limit of a total of 8 services per patient per lifetime apply regardless of whether the items are used for assistance with diagnosis or contribution to the treatment and management plan, and the referring specialist or consultant physician should be mindful of this when referring to eligible allied health practitioners.

Development of the treatment and management plan

Once the specialist or consultant physician has made a diagnosis of an eligible disability, to complete the item requirements of item 137 or 92141 they must develop a treatment and management plan which includes:

- Written documentation of the patient's confirmed diagnosis of an eligible disability, including any findings of assessments performed (which assisted with the formulation of the diagnosis or contributed to the treatment and management plan)
- A risk assessment which means assessment of:

    o the risk to the patient of a contributing co-morbidity and

    o environmental, physical, social and emotional risk factors that may apply to the patient or to another individual.

- Treatment options which include:

    o Recommendations using a biopsychosocial model

    o Identifying major treatment goals and important milestones and objectives

    o Recommendation/s and referral for treatment services provided by eligible allied health practitioners (where relevant) and who should provide this, specifying number of treatments recommended (to a maximum of 20 treatment services)

    o Indications for review or episodes requiring escalation of treatment strategies

- Documenting the treatment and management plan and providing a copy to the referring medical practitioner and relevant allied health practitioner/s.

Referral for allied health treatment services

Once a treatment and management plan is in place (after item 137 or 92141 has been claimed) the specialist or consultant physician can refer the individual to eligible allied health practitioners for the provision of treatment services. Treatment services address the functional impairments identified through the comprehensive medical

assessment which are outlined in the treatment and management plan. Treatment services focus on interventions to address developmental delays/disabilities or impairments.

Eligible allied health treatment practitioners include:

- Psychologist (MBS items 82015, 93035, 93043)
- Speech pathologist (MBS items 82020, 93036, 93044)
- Occupational therapist (MBS items 82025, 93036, 93044)
- Audiologist, dietitian, exercise physiologist, optometrist, orthoptist, physiotherapist (MBS items 82035, 93036, 93044)

A total of 20 allied health treatment services per patient per lifetime are available through the MBS, which may consist of any combination of items 82015, 82020, 82025 or 82035 or equivalent video items. Whilst the specialist or consultant physician can refer to multiple eligible allied health practitioners concurrently, a separate referral letter must be provided to each allied health practitioner.

The referral must specify the goals of the treatment and if appropriate, specify the number of services to be provided. It is the responsibility of the referring psychiatrist to allocate the number of treatment services (up to a maximum of 10 services per course of treatment) in keeping with the individual's treatment and management plan.

It is important to note, that a benefit will not be paid for the MBS allied health treatment services unless the pre-requisite items (137 or 92141) have been processed through the Medicare claiming system.

On the completion of a "course of treatment" (specified by the referring specialist or consultant physician, up to maximum of 10 services), the eligible allied health practitioner must provide a written report to the referring specialist or consultant physician, which must include information on the treatment provided, recommendations for future management of the individual's disorder and any advice to caregivers (such as parents, carers, schoolteachers). This written report will inform the referring specialist or consultant physician's decision to refer for further treatment services. Where subsequent courses of treatment after the initial 10 services are required (up to a maximum of 20 services per patient per lifetime) a new referral is required.

AN.0.26 Geriatrician Referred Patient Assessment and Management Plan (Items 141-147)

Items 141 -147 apply only to services provided by a consultant physician or specialist in the specialty of Geriatric Medicine who has completed the additional requirements of the Royal Australasian College of Physicians for recognition in the subspecialty of geriatric medicine.

Referral for Items 141-147 should be through the general practitioner for the comprehensive assessment and management of frail older patients, older than 65, with complex, often interacting medical, physical and psychosocial problems who are at significant risk of poor health outcomes. In the event that a specialist of another discipline wishes to refer a patient for this item, the referral should take place through the GP.

A comprehensive assessment of an older person should as a minimum cover:

· current active medical problems

· past medical history;

· medication review;

· immunisation status;

· advance care planning arrangements;

· current and previous physical function including personal, domestic and community activities of daily living;

· psychological function including cognition and mood; and

· social function including living arrangements, financial arrangements, community services, social support and carer issues.

Note: Guidance on all aspects of conducting a comprehensive assessment on an older person is available on the Australian and New Zealand Society for Geriatric Medicine website at www.anzsgm.org.

Some of the information collection component of the assessment may be rendered by a nurse or other assistant in accordance with accepted medical practice, acting under the supervision of the geriatrician. The remaining components of the assessment and development of the management plan must include a personal attendance by the geriatrician.

A prioritised list of diagnoses/problems should be developed based on information provided by the history and examination, and any additional information provided by other means, including an interview of a person other than the patient.

The management plan should be explained and if necessary provided in written form to the patient or where appropriate, their family or carer(s).

A written report of the assessment including the management plan should be provided to the general practitioner within a maximum of 2 weeks of the assessment. More prompt verbal communication may be appropriate.

The Patient Assessment and Management plans must be kept for 2 years after the date of service.

Items 143 and 147 are available in instances where the GP initiates a review of the management plan provided under items 141 and 145, usually where the current plan is not achieving the anticipated outcome. It is expected that when a management plan is reviewed, any modification necessary will be made.

Items 143 and 147 can be claimed once in a 12 month period. However, if there has been a significant change in the patient's clinical condition or care circumstances necessitating another review, an additional item 143 or 147 can be claimed. In these circumstances, the patient's invoice or Medicare voucher should be annotated to briefly indicate the reason why the additional review was required (e.g. annotated as clinically indicated, exceptional circumstances, significant change etc).

AN.0.27 Prolonged Attendance in Treatment of a Critical Condition (Items 160 164)

The conditions to be met before services covered by items 160-164 attract benefits are:-

(i) the patient must be in imminent danger of death;

(ii) if the personal attendance is not continuous, the occasion on which the service is provided is taken to be the total time of the attendance; and

(iii) if personal attendance on a single patient is provided by 1 or more general practitioners, specialists or consultant physicians concurrently, each general practitioner, specialist or consultant physician may claim an attendance fee.

AN.0.28 Family Group Therapy (Items 170, 171, 172)

These items refer to family group therapy supervised by general practitioner, specialist or consultant physician (other than consultant psychiatrists). To be used, these items require that a formal intervention with a specific therapeutic outcome, such as improved family function and/or communication, is undertaken. Other types of group attendances do not attract benefits. It should be noted that only one fee applies in respect of each group of patients.

AN.0.29 Acupuncture (Item 193, 195, 197 and 199)

Items 193, 195, 197 and 199 cover not only the performance of the acupuncture but include any consultation on the same occasion and any other attendance on the same day for the condition for which acupuncture was given.

For the purpose of payment of Medicare benefits "acupuncture" is interpreted as including treatment by means other than the use of acupuncture needles where the same effect is achieved without puncture, eg by application of ultrasound, laser beams, pressure or moxibustion, etc.

For more information on the content-based item structure used in this Group, see para AN.0.9 of explanatory notes to this Category.

AN.0.30 Consultant Psychiatrist - Referred Patient Assessment and Management Plan - Items 291 or 92435 and 293 or 92436

Intention of Item 291 and 92435:

It is expected that item 291 or 92435 will be a single attendance. The intention of this item is to provide access to psychiatry expertise and the provision of a detailed written report to the referrer, so that the medical practitioner in general practice (including a general practitioner, but not a specialist or consultant physician) or participating nurse practitioner can provide the ongoing management of the patient. The detailed report is a fundamental component of this item and must address not only a comprehensive diagnostic assessment but also the recommended management of the patient in both the immediate and longer term.

Where a patient's clinical needs are complex and the psychiatrist assesses it is not appropriate for the referrer to provide the ongoing management of the patient, the psychiatrist should use item 296, 297 or 299 (for a new patient) or 300, 302, 304, 306 or 308 (for subsequent attendance) or telehealth equivalent items 92437, 91827 to 91831, 91837 to 91839 (refer to Note AN.0.75).

The referrer can seek a revision of this management plan once in a 12 month period, through item 293 or 92436.

Referral:

Referral for items 291 or 92435 and 293 or 92436 are required from a medical practitioner in general practice or participating nurse practitioner for the assessment and development of a management plan of a patient with mental health condition.

Note: If a specialist of a discipline outside of psychiatry, wishes to refer a patient for this item the referral should take place through the medical practitioner in general practice or participating nurse practitioner.

Claiming other psychiatry items in association with 291 or 92435:

Whilst it is not expected that additional attendance items would be routinely used prior to item 291 or 92435, there may be circumstances where a patient has been referred (by a medical practitioner in general practice or participating nurse practitioner) for an assessment or management plan, but it is not possible for the psychiatrist to determine in the initial consultation whether the patient is suitable for management under such a plan.

In those circumstances, where the psychiatrist undertakes a consultation prior to the 291 or 92435 consultation, time based consultation items can be claimed, according to the item requirements. In these cases, where clinically appropriate, items 296, 297 or 299 (for a new patient) or 300, 302, 304, 306 or 308 (for subsequent attendance) or telehealth equivalent items (92437, 91827 to 91831, 91837 to 91839) may be used. Non-patient interview items 341, 343, 345, 347 or 349 or telehealth equivalent items 91874 to 91878, 91882 to 91884 may be used, where clinically appropriate, to assist with diagnosis assessment and preparation of treatment plans.

Claiming other psychiatry items following item 291 or 92435:

Whilst it is not expected that psychiatry time-based attendance items, such as items 300 to 308, would be used following the billing of item 291 or 92435, there may be clinical circumstances where limited follow up is required to provide short term assistance to enable the medical practitioner in general practice or participating nurse practitioner to provide the ongoing management of the patient. For example, one or two consultations monitoring the titration of a Schedule 8 medication prior to transfer of care back to a medical practitioner in general practice. As the intention of this item is to provide detailed recommendations to the referrer to manage the patient's

ongoing care, only short-term non-ongoing management which enables this intent would be considered appropriate.

Item 293 or 92436 provides opportunity for a comprehensive review of the management plan initiated by the referrer and can be claimed once in a 12 month period following use of item 291 or 92435.

Requirements of item 291 or 92435 - Use of outcome tools:

In order to contribute to the diagnostic assessment and monitor response to therapy, where clinically appropriate, an assessment and/or outcome tool should be utilised during the assessment and review stage of treatment. The choice of the evidence-based tool/s to be used is at the clinical discretion of the practitioner, however the following outcome tools are recommended:

- Kessler Psychological Distress Scale (K10)
- Short Form Health Survey (SF12)
- Health of the Nation Outcome Scales (HoNOS)
- DASS 21 (Depression, Anxiety and Stress)
- BDI (Depression)
- BAI (Anxiety)
- BDRS (Bipolar Disorder)
- YBOCS (OCD)
- GRS (Older adults)
- EPDS (Postnatal Depression)

Requirements of item 291 or 92435 - Management Plan Report:

A written copy of the detailed management plan in consultation with the patient, must be provided to the referring GP or participating nurse practitioner within a maximum of two weeks of the assessment.

It should be noted that two weeks is the outer limit and in more serious cases more prompt provision of the plan and verbal communication with the referring GP or participating nurse practitioner may be appropriate.

The detailed Management Plan **should** contain:

- The findings of the comprehensive diagnostic assessment and the formulation that contributed to this assessment (including the finding of the outcome tools where clinically appropriate)
- Relevant history and Mental Status Examination
- Identification of any risks to the patient or others
- Detailed management plan which includes, as clinically appropriate, not limited to one or more of the following recommendations:

    - Biopsychosocial management

    - Non-medication recommendations including (where relevant): psychoeducation; recommendations for psychological treatment (and who should provide this); social prescribing

    - Indications for review or episode and escalation of treatment strategies

    - Longer term management goals

Review of Management Plan - Item 293 or 92436:

Item 293 or 92436 is available in instances where the referring medical practitioner in general practice or participating nurse practitioner initiates a review of the plan provided under item 291 or 92435, usually where the current plan is not achieving the anticipated outcome or there has been a change in the clinical circumstances. It is expected that when a plan is reviewed, any modifications necessary will be made. Item 293 or 92436 can only be claimed once in a 12 month period, following the provision of a service under 291 or 92435.

AN.0.31 Psychiatric Attendances (Items 319 and 91873)

Item 319 or 91873 provides for an attendance, by a psychiatrist, to provide intensive psychotherapy where the patient's clinical condition requires intensive treatment. Clinical appropriateness and indications for intensive psychotherapy are determined following a comprehensive assessment and formulation of a diagnosis and should be documented in the patient's notes. It is also expected that other appropriate psychiatric treatment has been used for a suitable period and the patient has shown little or no response to such treatment. Such treatment would include, but not be limited to: shorter term psychotherapy; less frequent but long-term psychotherapy; pharmacological therapy; and cognitive behaviour therapy.

Once a patient is identified as meeting the criteria of item 319 or 91873, eligibility continues under that item for the duration of that course of treatment (provided that attendances under items 296, 297, 299, 300, 302, 304, 306, 308, 319, 91827 to 91831, 91837 to 91839, 91873 and 92437 do not exceed 160 in a calendar year). If the patient requires more than 160 services in a calendar year for intensive psychotherapy, then such attendances would be covered by items 310, 312, 314, 316, 318, 91868 to 91872 or 91879 to 91881.

AN.0.32 Interview of Person other than a Patient by Consultant Psychiatrist (Items 341, 343, 345, 347, 349, 91874 to 91878 and 91882 to 91884)

Intention of these items:

Items 341, 343, 345, 347 and 349 and video equivalent items 91874 to 91878 and 91882 to 91884 are for the purpose of interviews with patient relatives or close associates to investigate the particular problem with which the patient presented or the interaction between the patient and the person interviewed. The items also provide for interviews concerned with the continuing management of the patient, focusing on clinically relevant problems rising in the management of the patient.

These items do not cover counselling of family or friends of the patient.

Referral requirements:

The patient who is the subject of the interview needs a referral to attend the psychiatrist in the first place, however the non-patient contacts who are interviewed do not require their own referral.

Claiming of Medicare benefits:

The payment of Medicare benefits under these items is limited to a total of 15 services in a calendar year.

For Medicare benefit purposes, claims relating to services covered by items 341, 343, 345, 347, 349 and telehealth (video and phone) equivalent items 91874 to 91878 and 91882 to 91884 should be raised against the patient rather than against the person interviewed.

Same day attendance items:

Medicare benefits are payable on the same day for an interview under any of items 341, 343, 345, 347 and 349 or telehealth (video and phone) equivalent items 91874 to 91878 and 91882 to 91884 and for a consultation with a patient (under item 291, 293, 296, 297, 299, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 320, 322, 324, 326 or 328) provided that separate attendances are involved. This item can only be claimed if the interviewee attends without the patient.

AN.0.33 Consultant Occupational Physician Attendances (Items 385 to 388 and 92748 to 92750))

Attendances by consultant occupational physicians will attract Medicare benefits only where the attendance relates to one or more of the following:

(i) evaluation and assessment of a patient's rehabilitation requirements where the patient presents with an accepted medical condition(s) which may be affected by the consultant occupational physician's working environment or employability; or

(ii) management of accepted medical condition(s) which may affect a patient's capacity for continued employment or return to employment following a non-compensable accident, injury or ill-health; or

(iii) evaluation and opinion and/or management of a patient's medical condition(s) where causation may be related to acute or chronic exposures from scientifically accepted environmental hazards or toxins.

AN.0.34 Contact Lenses (Items 10801-10809)

Benefits are paid for consultations concerned with the prescription and fitting of contact lenses only if patients fall into specified categories (ie patients with certain conditions). The classes of patients eligible for benefits for contact lens consultations are described in items 10801 to 10809.

Benefits are not payable for item 10809 in circumstances where patients want contact lenses only for:

(a) reasons of appearance (because they do not want to wear spectacles);

(b) sporting purposes;

(c) work purposes; or

(d) psychological reasons (because they cannot cope with spectacles).

Benefits are payable for an initial referred consultation rendered in association with the fitting and prescribing of the lenses. Subsequent follow-up attendances attract benefits on a consultation basis.

AN.0.35 Refitting of Contact Lenses (Item 10816)

This item covers the refitting of contact lenses where this becomes necessary within the thirty-six month time limit where the patient requires a change in contact lens material or basic lens parameters, other than simple power change, because of a structure or functional change in the eye or an allergic response.

AN.0.36 Time-Tiered Health Assessments (Items 701, 703, 705, 707, 224, 225, 226, 227)

SUMMARY

This note sets out common principles that apply when using MBS time-tiered health assessment items for general practitioners (GPs see GN.4.13) and prescribed medical practitioners (PMPs see AN.7.1).

Time-tiered health assessment items are only available to specific patient cohorts. Details of the requirements for a health assessment for each patient cohort are at:

- Type 2 diabetes risk evaluation (40-49 years) – see AN.0.37.
- Health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease – see AN.0.38.
- Health assessment provided for people aged 75 years and older – see AN.0.39.
- Health assessment provided as a comprehensive medical assessment for care recipients in residential care homes – see AN.0.40.
- Health assessment provided for people with an intellectual disability – see AN.0.41.
- Health assessment provided for refugees and other humanitarian entrants – see AN.0.42.
- One-off health assessment for veterans – see AN.0.69.
- Medicare Healthy Kids Check provided for children aged 3 years old – see AN.14.4.

USE OF THE ITEMS

Health assessment items are used to assess eligible patients' health and physical, psychological and social function. This includes the medical practitioner's consideration of whether preventive health care and education should be offered to the patient to improve their health or function.

The items apply only to a service provided in the course of a personal attendance by a single GP or PMP on a single patient.

While the requirements for health assessments vary according to patient cohort, in general they all require the GP or PMPs to undertake a range of activities, including:

- information collection, including taking a patient history and undertaking or arranging examinations and investigations as required
- making an overall assessment of the patient
- recommending appropriate interventions, and
- providing advice and information to the patient.

Additional item requirements apply to all health assessments conducted, tailored to meet the needs of each patient group being targeted under the items (see 'Eligible Patients'). Information on additional item requirements is available in Notes: AN.0.37, AN.0.38, AN.0.39, AN.0.40, AN.0.41, AN.0.42, AN.0.69, AN.14.4.

How do I choose which health assessment item to use?

The correct health assessment item will depend on:

- practitioner type – GP or PMP, and
- length of time spent with the patient (i.e. the personal attendance time).

Health Assessment service	GP	PMP
Brief health assessment lasting no more than 30 minutes	701	224
Standard health assessment lasting at least 30 minutes and less than 45 minutes	703	225
Long health assessment lasting at least 45 minutes and less than 60 minutes	705	226
Prolonged health assessment lasting more than 60 minutes	707	227

Are there specific requirements for any of the health assessment items?

Yes, additional item requirements apply to all health assessments conducted, tailored to meet the needs of each patient group being targeted under the items (see 'Eligible Patients'). Information on additional item requirements is available in Notes: AN.0.37, AN.0.38, AN.0.39, AN.0.40, AN.0.41, AN.0.42, AN.0.69, AN.14.4.

Is a health assessment a health screening service?

No. Clause 2.15.14 of the *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations) specifies that a time-tiered health assessment must not include a screening service.

The *Health Insurance Act 1973* (the Act) defines a health screening service as a medical examination or test that is not reasonably required for the management of the medical condition of the patient. A health screening service does not include a medical examination or a test on a symptomless patient by the that patient's own medical practitioner in the course of normal medical practice, to ensure the patient receives any medical advice or treatment necessary to maintain their state of health.

Further information is available in Note GN.13.33.

Can another person assist the medical practitioner to undertake the health assessment?

Yes. Clause 2.15.14 of the Regulations states that practice nurses, Aboriginal and Torres Strait Islander health workers and Aboriginal and Torres Strait Islander health practitioners may assist in accordance with accepted medical practice under the supervision of the medical practitioner.

Assistance provided must be in accordance with accepted medical practice and under the supervision of the GP or prescribed medical practitioner. This may include activities associated with:

- information collection, and
- providing patients with information about recommended interventions, at the direction of the medical practitioner.

The GP or prescribed medical practitioner should be satisfied that the assisting health professional has the necessary skills, expertise and training to collect the information required for the health assessment.

MBS items for time-tiered health assessments are for a complete service. Items for services provided on behalf of a medical practitioner by a practice nurse or Aboriginal and Torres Strait Islander health practitioner (e.g. items 10987 and 10997) may not be claimed when providing assistance for a health assessment service.

Additional advice on the use of other health professionals' time when undertaking health assessments can be found in the AskMBS Advisory – General Practice 1 (health.gov.au).

A *Practice nurse* means a registered or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice or by a health service to which a direction made under subsection 19(2) of the Act applies.

An *Aboriginal and Torres Strait Islander health practitioner* means a person who:

- is registered under the National Law in the Aboriginal and Torres Strait Islander health practice profession, and
- who is employed by, or whose services are otherwise retained by, a medical practitioner in a general practice or a health service to which a direction made under subsection 19(2) of the Act applies.

An *Aboriginal and Torres Strait Islander health worker* means a person who:

- holds a qualification of Certificate III or higher in Aboriginal and/or Torres Strait Islander Primary Health Care from the Health (HLT) training package, and
- is engaged by a medical practitioner in a general practice or a health service to which a direction made under subsection 19(2) of the Act applies.

Can I include additional time required for communications (e.g. with an interpreter) in the time taken for the health assessment?

Yes, a wide range of factors may affect the time needed to communicate effectively with a patient during a consultation. These include, but are not limited to, situations where a language barrier exists between the medical practitioner and patient (including when an interpreter is required), or when a patient has hearing problems, difficulty with speech, an intellectual disability, and/or dementia.

When claiming for time-tiered MBS items, the total consultation time includes the time required to communicate effectively with the patient. Where more time than usual is required to communicate effectively with a particular patient, it is considered reasonable to claim a longer attendance item than might otherwise be expected for the service.

In such situations, medical practitioners should make a brief record in the patient's notes including details about why the additional time was required. For example, stating 'consultation extended due to use of interpreter' and, if relevant, citing the Translating and Interpreting Service (TIS) job number.

My patient is eligible for more than one category of health assessment. Which health assessment should I do?

Patients can receive each health assessment they are eligible for. For example, a 42-year-old patient with an intellectual disability who is also found to be at high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool can receive:

- a health assessment for a person with an intellectual disability annually, and
- a type 2 diabetes risk evaluation every 3 years until they are 49 (inclusive).

Children may also be eligible for more than one health assessment. For example, a 3-year-old child with an intellectual disability can receive:

- a Medicare Healthy Kids Check once only, and
- a health assessment for a person with an intellectual disability annually.

Aboriginal and Torres Strait Islander children are also eligible for both:

- a Medicare Healthy Kids Check when they are 3 years old, and
- a health assessment for a person of Aboriginal and Torres Strait Islander descent every 9 months (see AN.0.43).

Practitioners should consider which health assessment is most clinically relevant to determine the appropriate item to claim. If a patient receives more than one health assessment, each service must be independently clinically relevant and meet all MBS requirements for MBS benefits to be payable.

Where the patient is eligible for more than one health assessment there is no minimum interval of time between the provision of the different health assessments. Where patients are eligible for more than one health assessment the practitioner should ensure they identify which target group the health assessment relates to when submitting claims to Services Australia. Additional information on claiming limits is available on the Services Australia - Health assessments and your record keeping responsibilities webpage.

ELIGIBLE PATIENTS

Any patient who is eligible to receive Medicare benefits and meets the criteria for one or more of the following target groups may receive a health assessment service, at the stated frequencies:

Target Group	Frequency of Service	Associated Note
A type 2 diabetes risk evaluation for people aged 40-49 years (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool	Once every three years to an eligible patient	AN.0.37
A health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease	Once only to an eligible patient	AN.0.38
A health assessment for people aged 75 years and older	Provided annually to an eligible patient	AN.0.39
A comprehensive medical assessment for care recipients in a residential care home	Provided annually to an eligible patient	AN.0.40
A health assessment for people with an intellectual disability	Provided annually to an eligible patient	AN.0.41
A health assessment for refugees and other humanitarian entrants	Once only to an eligible patient	AN.0.42
A health assessment for former serving members of the Australian Defence Force	Once only to an eligible patient	AN.0.69

A Medicare Healthy Kids Check for children aged 3 years old	Once only to an eligible patient	AN.14.4

Residential care home-specific items are only available to Medicare-eligible patients who are care recipients in a residential care home and who are currently not in-patients of a hospital.

All other health assessment items are not available to people who are in-patients of a hospital or care recipients in a residential care home.

ELIGIBLE PRACTITIONERS

Health assessment items are available for different practitioner types:

- general practitioner items can be claimed by GPs only (see GN.4.13).
- prescribed medical practitioner items can be claimed by prescribed medical practitioners only (see AN.7.1).

Note: Clause 2.15.14 of the Regulations specifies patients must access health assessment services through their usual GP or prescribed medical practitioner, if reasonably practicable.

The patient's usual GP or prescribed medical practitioner means the practitioner:

- who has provided the majority of services to the patient in the past 12 months, or
- who is likely to provide the majority of services to the patient in the following 12 months, or
- is located at a medical practice that:
    - has provided the majority of services to the patient in the past 12 months, or
    - is likely to provide the majority of services to the patient in the next 12 months.

CO-CLAIMING RESTRICTIONS

Clause 2.15.14 of the Regulations specifies a separate consultation must not be performed in conjunction with a health assessment, unless clinically necessary.

RECORD KEEPING AND REPORTING REQUIREMENTS

The department undertakes regular post payment auditing to ensure that MBS items are claimed appropriately. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document it created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS items can be found on the Federal Register of Legislation at www.legislation.gov.au. Health assessment items are set out in the following regulatory instrument:

- *Health Insurance (General Medical Services Table) Regulations 2021*.

AN.0.37 Time-tiered Health Assessment - Type 2 Diabetes Risk Evaluation

SUMMARY

Time-tiered health assessment items may be used to undertake a Type 2 Diabetes Risk Evaluation for Medicare eligible patients aged 40-49 years (inclusive) with a high risk of developing type 2 diabetes.

Note: The requirements below must be met in addition to common principles for time-tiered health assessment items, contained in AN.0.36.

USE OF THE ITEMS

The specific requirements of the Type 2 Diabetes Risk Evaluation are set out in clause 2.15.4 of the *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations).

The Regulations require that a Type 2 Diabetes Risk Evaluation must include:

- a review of the risk factors underlying a patient's high-risk score as identified by the Australian Type 2 Diabetes Risk Assessment Tool, and
- initiating interventions, if appropriate, to address risk factors or to exclude diabetes.

The Regulations also state that the evaluation must include:

- assessing the patient's high-risk score as determined by the Australian Type 2 Diabetes Risk Assessment Tool
- updating the patient's history and performing physical examinations and clinical investigations
- making an overall assessment of the patient's risk factors and the results of examinations and investigations
- initiating interventions, if appropriate, including referrals and follow-up services relating to the management of any risk factors identified, and
- giving the patient advice and information, including strategies to achieve lifestyle and behaviour changes if appropriate.

For the purposes of a Type 2 Diabetes Risk Evaluation, risk factors include:

- lifestyle risk factors (e.g. smoking, physical inactivity or poor nutrition)
- biomedical risk factors (e.g. high blood pressure, impaired glucose metabolism or excess weight), and
- a family history of a chronic disease.

ELIGIBLE PATIENTS

Patients eligible for a Type 2 Diabetes Risk Evaluation are:

- aged between 40-49 years (inclusive), and
- have a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool.

The Australian Type 2 Diabetes Risk Assessment Tool must have been completed by the patient no more than 3 months prior to the Type 2 Diabetes Risk Evaluation.

A Type 2 Diabetes Risk Evaluation cannot be claimed more than once every 3 years by an eligible patient.

ELIGIBLE PRACTITIONERS

Type 2 Diabetes Risk Evaluations can be undertaken by a general practitioner (see GN.4.13) or a prescribed medical practitioner (see AN.7.1).

CO-CLAIMING RESTRICTIONS

A separate consultation must not be performed in conjunction with a Type 2 Diabetes Risk Evaluation, unless clinically necessary.

To co-claim a Type 2 Diabetes Risk Evaluation item and another item, both items must be clinically necessary and distinct services.

RECORD KEEPING AND REPORTING REQUIREMENTS

The department undertakes regular post payment auditing to ensure that MBS items are claimed appropriately. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and where a document is created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS items can be found on the Federal Register of Legislation at www.legislation.gov.au. Health assessment items are set out in the following regulatory instrument:

- *Health Insurance (General Medical Services Table) Regulations 2021*.

AN.0.38 Time-Tiered Health Assessment - People aged 45-49 years who are at risk of developing chronic disease

SUMMARY

Time-tiered health assessment items may be used to undertake a health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease.

Note: The requirements below must be met in addition to common principles for time tiered health assessment items, contained in AN.0.36.

USE OF ITEMS

The specific requirements of the Type 2 Diabetes Risk Evaluation are set out in clause 2.15.5 of the *Health Insurance (General Medical Service Table) Regulations 2021* (the Regulations).

The Regulations specify GPs (see GN.4.13) and prescribed medical practitioners (PMP, see AN.7.1) can provide this health assessment to patients, where in the clinical judgement of the attending medical practitioner, a specific risk factor for chronic disease has been identified.

Specific risk factors the medical practitioner can consider when providing this health assessment include, but are not limited to:

- lifestyle risk factors (such as smoking, physical inactivity, poor nutrition or alcohol misuse)
- biomedical risk factors (such as high cholesterol, high blood pressure, impaired glucose metabolism or excess weight)
- a family history of a chronic disease.

The regulation states the health assessment must include:

- information collection, including taking a patient's history and performing examinations and investigations, as required
- making an overall assessment of the patient
  initiating interventions or referrals, as appropriate, and
  giving health advice and information to the patient.

The Regulations state that a chronic disease is one that "has been, or is likely to be, present for at least 6 months, including, but not limited to: asthma, cancer, cardiovascular illness, diabetes mellitus, a mental health condition, arthritis or a musculoskeletal condition." It is important to note that this definition of a chronic disease is specific to this health assessment cohort. It does not apply more broadly across the MBS.

ELIGIBLE PATIENTS

Eligible patients for a health assessment for people who are at risk of developing a chronic disease are:

- aged between 45-49 years (inclusive), and
- are at risk of developing a chronic disease, in the clinical judgement of the attending medical practitioner based on the identification of a specific risk factor.

A health assessment for a patient at risk of developing a chronic disease cannot be claimed more than once per eligible patient.

ELIGIBLE PRACTITIONERS

A health assessment for patients at risk of developing a chronic disease can be undertaken by a general practitioner (see GN.4.13) or a prescribed medical practitioner (see AN.7.1).

CO-CLAIMING RESTRICTIONS

Clause 2.15.14 of the Regulations specifies a separate consultation must not be performed in conjunction with a health assessment for patients at risk of developing a chronic disease, unless clinically necessary.

To co-claim the health assessment item for patients at risk of developing a chronic disease and another item, both items must be clinically necessary and distinct services.

RECORD KEEPING AND REPORTING REQUIREMENTS

The department undertakes regular post payment auditing to ensure that MBS items are claimed appropriately. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document is created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS items can be found on the Federal Register of Legislation at www.legislation.gov.au. Health assessment items are set out in the following regulatory instrument:

- *Health Insurance (General Medical Services Table) Regulations 2021*.

AN.0.39 Time-Tiered Health Assessment - Older Person's Health Assessment provided for people aged 75 years and older

SUMMARY

Time-tiered health assessment items may be used to undertake an Older Person's health assessment for Medicare-eligible patients aged 75 years and older every 12 months.

Note: The requirements below must be met in addition to common principles for time-tiered health assessment items, contained in AN.0.36.

USE OF THE ITEMS

The specific requirements of the Older Person's health assessment are set out in clause 2.15.6 of the *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations).

The Regulations state that an Older Person's health assessment is the assessment of:

- a patient's health and physical, psychological and social function, and

- whether preventive health care and education should be offered to the patient, to improve the patient's health and physical, psychological and social function.

The Regulations also state that the health assessment must include:

- personal attendance by a general practitioner or prescribed medical practitioner
- measurement of the patient's blood pressure, pulse rate and rhythm
- an assessment of the patient's medication
- an assessment of the patient's continence
- an assessment of the patient's immunisation status
- an assessment of the patient's physical function, including the patient's activities of daily living, and whether or not the patient has had a fall in the last 3 months
- an assessment of the patient's psychological function, including the patient's cognition and mood, and
- an assessment of the patient's social function, including:
    - the availability and adequacy of paid and unpaid help, and
    - whether the patient is responsible for caring for another person.

Practitioners may also wish to utilise publicly available guidelines such as the Royal Australian College of General Practitioner's *Aged Care Clinical Guidance (Silver Book)*, the National Immunisation Program Schedule and advice of bodies such as the Australian Technical Advisory Group on Immunisation (ATAGI) as guides when conducting patient assessments to current clinical standards.

ELIGIBLE PATIENTS

Patients eligible for an Older Person's health assessment are:

- aged 75 years and older and not an in-patient of a hospital or a care recipient in a residential care home.

For comprehensive medical assessments for care recipients of residential care homes see AN.0.40.

An Older Person's health assessment cannot be claimed more than once every 12 months by an eligible patient.

ELIGIBLE PRACTITIONERS

An Older Person's health assessment can be undertaken by a general practitioner (see GN.4.13) or a prescribed medical practitioner (see AN.7.1).

CO-CLAIMING RESTRICTIONS

A separate consultation must not be performed in conjunction with an Older Person's health assessment service, unless clinically necessary.

To co-claim a health assessment item and another item, both items must be clinically necessary and distinct services. Each co-claimed service must independently meet all relevant requirements listed in the item descriptor.

RECORD KEEPING AND REPORTING REQUIREMENTS

The Regulations state that an Older Person's health assessment must include:

- keeping a record of the health assessment
- offering the patient a written report on the health assessment, with recommendations about matters covered by the health assessment, and
- offering the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements and they may be required to submit evidence for compliance checks related to Medicare

claims. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document it created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item(s) can be found on the Federal Register of Legislation at www.legislation.gov.au. Health assessment items are set out in the following regulatory instruments:

- *Health Insurance (General Medical Services Table) Regulations 2021*.

AN.0.40 Time-Tiered Health Assessment - Comprehensive Medical Assessment for a care recipient in a residential care home

SUMMARY

Time-tiered health assessment items may be used to undertake a Comprehensive Medical Assessment for a care recipient of a residential care home.

Note: The requirements below must be met in addition to common principles for time-tiered health assessment items, contained in AN.0.36.

USE OF THE ITEMS

The specific requirements of the Comprehensive Medical Assessment for care recipients in a residential care home are set out in clause 2.15.7 of the *Health Insurance (General Medical Service Table) Regulations 2021* (the Regulations).

The Regulations require that a Comprehensive Medical Assessment for a care recipient in a residential care home must include an assessment of the resident's health, physical and psychological function.

It must also include:

- a personal attendance by a general practitioner or prescribed medical practitioner
- taking a detailed patient history of the resident
- conducting a comprehensive medical examination of the resident
- developing a list of diagnoses and medical problems based on the medical history and examination, and
- making a written summary of the Comprehensive Medical Assessment.

ELIGIBLE PATIENTS

Patients eligible for a Comprehensive Medical Assessment are care recipients in a residential care home. The Regulations define a care recipient as a person to whom residential care (as defined in the *Aged Care Act 2024*) is provided.

A Comprehensive Medical Assessment may be claimed by eligible patients:

- on admission to a residential care home, if a Comprehensive Medical Assessment has not already been provided to the patient in another residential care home in the last 12 months, and
- at 12 month intervals after that assessment.

ELIGIBLE PRACTITIONERS

A Comprehensive Medical Assessment can be undertaken by a general practitioner (see GN.4.13) or a prescribed medical practitioner (see AN.7.1).

CO-CLAIMING RESTRICTIONS

A Comprehensive Medical Assessment may be performed in conjunction with a consultation for another purpose, but must be claimed separately.

To co-claim a Comprehensive Medical Assessment item and another item, both items must be clinically necessary and distinct services.

RECORD KEEPING AND REPORTING REQUIREMENTS

The Regulations state that a Comprehensive Medical Assessment must include:

- making a written summary of the Comprehensive Medical Assessment
- giving a copy of the summary to the residential care home, and
- offering the resident a copy of the summary.

The department undertakes regular post payment auditing to ensure that MBS items are claimed appropriately. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document it created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS items can be found on the Federal Register of Legislation at www.legislation.gov.au. Health assessment items are set out in the following regulatory instrument:

- *Health Insurance (General Medical Services Table) Regulations 2021*.

AN.0.41 Time-Tiered Health Assessment - Heath assessment for a person with an intellectual disability

SUMMARY

Time-tiered health assessment items may be used to undertake a health assessment for a person with an intellectual disability.

Note: The requirements below must be met in addition to common principles for time-tiered health assessment items, contained in AN.0.36.

USE OF THE ITEMS

The specific requirements of a health assessment for a person with an intellectual disability are set out in clause 2.15.8 of the *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations).

The Regulations specify that a Health assessment for a person with an intellectual disability is an assessment of:

- the patient's physical, psychological and social function, and
- whether any medical intervention and preventive health care is required.

They also state that the health assessment must include the following matters, to the extent that they are relevant to the patient:

- checking dental health (including dentition)
- conducting an aural examination (including arranging a formal audiometry if an audiometry has not been conducted within the last 5 years)

- assessing ocular health (arrange review by an ophthalmologist or optometrist if a comprehensive eye examination has not been conducted within the last 5 years)
- assessing nutritional status (including weight and height measurements) and a review of growth and development
- assessing bowel and bladder function (particularly for incontinence or chronic constipation)
- assessing medications including:
    - non-prescription medicines taken by the patient, prescriptions from other doctors, medications prescribed but not taken, interactions, side effects and review of indications
    - advice to carers on the common side effects and interactions, and
    - consideration of the need for a formal medication review
- assessing the patient's immunisation status
- checking exercise opportunities (with the aim of moderate exercise for at least 30 minutes each day)
- checking whether the support provided for activities of daily living adequately and appropriately meets the patient's needs, and considering formal review if required
- considering the need for breast examination, mammography, testicular examination, lipid measurement and prostate assessment as for the general population
- checking the patient's participation in the National Bowel Cancer Screening Program, National BreastScreen Australia Program, National Cervical Screening Program, and National Lung Cancer Screening Program
- checking for dysphagia and gastroesophageal disease (especially for patients with cerebral palsy) and arranging for investigation or treatment as required
- assessing risk factors for osteoporosis (including diet, exercise, Vitamin D deficiency, hormonal status, family history, medication and fracture history) and arranging for investigation or treatment as required
- for a patient diagnosed with epilepsy—reviewing seizure control (including anticonvulsant drugs) and considering referral to a neurologist at appropriate intervals
- screening for thyroid disease at least every 2 years (or yearly for patients with Down syndrome)
- for a patient without a definitive aetiological diagnosis—considering referral to a genetic clinic every 5 years
- assessing or reviewing treatment for comorbid mental health issues
- considering timing of puberty and management of sexual development, sexual activity and reproductive health, and
- considering whether there are any signs of physical, psychological or sexual abuse.

Practitioners may also wish to utilise publicly available guidelines such as the Royal Australian College of General Practitioner's *Guidelines for preventative activities in general practice*, the National Immunisation Program Schedule and advice of bodies such as the Australian Technical Advisory Group on Immunisation (ATAGI) as guides when conducting patient assessments to current clinical standards.

Eligible health practitioners may wish to consider the use of relevant assessment tools in the delivery of this service, such as the Adult Comprehensive Health Assessment Program (CHAP). However, it remains the responsibility of the treating practitioner to ensure all requirements of the items are met.

ELIGIBLE PATIENTS

Patients are eligible for this assessment if they are a person living with an intellectual disability.

A health assessment for a person with an intellectual disability cannot be claimed more than once every 12 months by an eligible patient.

ELIGIBLE PRACTITIONERS

Health assessment for a person with an intellectual disability can be undertaken by a general practitioner (see GN.4.13) or a prescribed medical practitioner (see AN.7.1).

CO-CLAIMING RESTRICTIONS

To co-claim a health assessment for a person with an intellectual disability item and another item, both items must be clinically necessary and distinct services. Each co-claimed service must independently meet all relevant requirements listed in the item descriptor.

RECORD KEEPING AND REPORTING REQUIREMENTS

A health assessment for a person with an intellectual disability must include:

- keeping a record of the health assessment;
- offering the patient a written report on the health assessment;
- offering the patient's carer (if any, and if the general practitioner or the prescribed medical practitioner considers it appropriate, and the patient agrees) a copy of the report or extracts of the report; and
- offering relevant disability professionals (if the general practitioner or the prescribed medical practitioner considers it appropriate and the patient or, if appropriate, the patient's carer, agrees) a copy of the report or extracts of the report.

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements and they may be required to submit evidence for compliance checks related to Medicare claims. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document it created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item(s) can be found on the Federal Register of Legislation at www.legislation.gov.au. Health assessment items are set out in the following regulatory instruments:

- *Health Insurance (General Medical Services Table) Regulations 2021*.

AN.0.42 Time-Tiered Health Assessment - Health Assessment provided for a refugee and other humanitarian entrant

SUMMARY

Time-tiered health assessment items may be used to undertake a health assessment provided for a refugee or other humanitarian entrant.

Note: The requirements below must be met in addition to common principles for time-tiered health assessment items, contained in AN.0.36.

USE OF THE ITEMS

The specific requirements of the health assessment for a refugee or other humanitarian entrant are set out in clause 2.15.9 of the *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations).

The Regulations require that a health assessment provided for a refugee or other humanitarian entrant is an assessment of:

- the patient's health and physical, psychological and social function, and
- whether preventive health care and education should be offered to the patient to improve their health and physical, psychological or social function.

The Regulations also state that the health assessment must include:

- a personal attendance by a GP or prescribed medical practitioner
- taking the patient's history
- examining the patient
- performing or arranging any required investigations
- assessing the patient, using the information gained from the above points
- developing a management plan addressing the patient's health care needs, health problems and relevant conditions, and
- making or arranging any necessary interventions and referrals.

A wide range of factors may affect the time needed to communicate effectively with a patient during a consultation. These include, but are not limited to, situations where a language barrier exists between the medical practitioner and patient (including when an interpreter is required), or when a patient has hearing problems, difficulty with speech, an intellectual disability, and/or dementia.

When claiming for time-tiered MBS items, the total consultation time includes the time required to communicate effectively with the patient. Where more time than usual is required to communicate effectively with a particular patient, it is considered reasonable to claim a longer attendance item than might otherwise be expected for the service.

In such situations, medical practitioners and other providers should make a brief record in the patient's notes including details about why the additional time was required. For example, stating 'consultation extended due to use of interpreter' and, if relevant, citing the Translating and Interpreting Service (TIS) job number.

ELIGIBLE PATIENTS

Patients are eligible for this assessment if they are:

- a refugee or humanitarian entrant, with eligibility for Medicare, and
- either:
    - hold a relevant visa that the person has held for less than 12 months at the time of the assessment, or
    - first entered Australia less than 12 months before the assessment is performed.

A relevant visa means any of the following visas granted under the Migration Act 1958:

- Subclass 070 Bridging (Removal Pending) visa
- Subclass 200 (Refugee) visa
- Subclass 201 (In-country Special Humanitarian) visa
- Subclass 202 (Global Special Humanitarian) visa
- Subclass 203 (Emergency Rescue) visa
- Subclass 204 (Woman at Risk) visa
- Subclass 786 (Temporary (Humanitarian Concern)) visa
- Subclass 790 (Safe Haven Enterprise) visa
- Subclass 866 (Protection) visa

A health assessment provided for a refugee or other humanitarian entrant may only be claimed once by an eligible patient.

ELIGIBLE PRACTITIONERS

A health assessment provided for a refugee or other humanitarian entrant can be undertaken by a general practitioner (see GN.4.13) or a prescribed medical practitioner (see AN.7.1).

CO-CLAIMING RESTRICTIONS

To co-claim a health assessment provided for a refugee or other humanitarian entrant item and another item, both items must be clinically necessary and distinct services.

RECORD KEEPING AND REPORTING REQUIREMENTS

A health assessment provided for a refugee or other humanitarian entrant must include:

- keeping a record of the health assessment; and
- offering the patient a written report on the health assessment.

The department undertakes regular post payment auditing to ensure that MBS items are claimed appropriately. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document it created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS items can be found on the Federal Register of Legislation at www.legislation.gov.au. Health assessment items are set out in the following regulatory instrument:

- *Health Insurance (General Medical Services Table) Regulations 2021*

AN.0.43 Health assessments for persons of Aboriginal and Torres Strait Islander descent (MBS Items 715, 228, 92004, 92011)

SUMMARY

This note sets out requirements that apply to conducting a health assessment for persons of Aboriginal and Torres Strait Islander descent. This assessment is undertaken by GPs (see GN.4.13) and prescribed medical practitioners (see AN.7.1) to support the delivery of holistic care to patients throughout their life.

USE OF THE ITEMS

The *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations) and the *Health Insurance (Section 3C General Medical Services – Telehealth Attendances) Determination 2021* (the Telehealth Determination) define a health assessment for persons of Aboriginal and Torres Strait Islander descent as:

- an assessment of a patient's health and physical, psychological and social function, and
- based on this assessment, whether preventive health care, education and other assistance should be offered to the patient, or the patient's parent or carer, to improve the patient's health and physical, psychological or social function.

Under MBS items 715, 228, 92004 and 92011, a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent must include:

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*

As part of good medical practice, GPs and prescribed medical practitioners should apply the principles of informed patient consent when considering a health assessment service. The Medical Board of Australia's *Good Medical Practice, a Code of Conduct for Doctors in Australia* describes what is expected of all doctors registered to practise medicine in Australia, including informed consent.

Are there guidelines to support delivery of health assessments for persons of Aboriginal and Torres Strait Islander descent?

When delivering a health assessment for persons of Aboriginal and Torres Strait Islander descent, health practitioners should refer to current Australian preventive health guidelines which are culturally and clinically suitable to Aboriginal and Torres Strait Islander patient needs, are evidence-based and are generally accepted in primary care practice. Where appropriate, approaches should be tailored to community priorities and local epidemiology. For example, patients living in communities with a high prevalence of rheumatic heart disease.

Examples include (but are not limited to) current editions of the *National Guide to preventive healthcare for Aboriginal and Torres Strait Islander people* and its associated templates, developed by the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Royal Australian College of General Practitioners (RACGP), the Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual and the RACGP *Guidelines for preventive activities in general practice (Red Book)*.

It is the responsibility of the medical practitioner to ensure all item requirements are met to bill the health assessment item.

Can another person assist the medical practitioner to undertake the health assessment?

Yes. The Regulations state that practice nurses, Aboriginal and Torres Strait Islander health workers and Aboriginal Torres and Strait Islander health practitioners may assist in conducting a health assessment, in accordance with accepted medical practice and under the supervision of the medical practitioner. This can include activities associated with:

- information collection, and
- providing patients with information about recommended interventions, at the direction of the medical practitioner.

It is a requirement that the GP or prescribed medical practitioner sees the patient as part of the service and are responsible for the service.

The GP or prescribed medical practitioner should be satisfied that the assisting health professional has the necessary skills, expertise and training to collect the information required for the health assessment.

The terms practice nurse, Aboriginal and Torres Strait Islander health practitioner and Aboriginal and Torres Strait Islander health worker are defined in the Regulations.

A practice nurse means a *'registered or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice or by a health service to which a direction made under subsection 19(2) of the [Health Insurance] Act applies.'*

An Aboriginal and Torres Strait Islander health practitioner means a person:

a. *who is registered under the National Law in the Aboriginal and Torres Strait Islander health practice profession; and*

b. *who is employed by, or whose services are otherwise retained by, a medical practitioner in a general practice or a health service to which a direction made under subsection 19(2) of the [Health Insurance] Act applies.*

Aboriginal and Torres Strait Islander health worker means a person:

a. *who holds a qualification of Certificate III or higher in Aboriginal and/or Torres Strait Islander Primary Health Care from the Health (HLT) training package; and*
b. *who is engaged by a medical practitioner in a general practice or a health service to which a direction made under subsection 19(2) of the [Health Insurance] Act applies.*

MBS items for a health assessment for persons of Aboriginal and Torres Strait Islander descent are for a complete service. Items 10987 and 10997 (see MN.12.4) cannot be claimed when a practice nurse or Aboriginal and Torres Strait Islander Primary Health Care Professional assist with the provision of a health assessment.

Can I refer patients for allied health services following a health assessment for persons of Aboriginal and Torres Strait Islander descent?

Where a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health or Aboriginal and Torres Strait Islander health and wellbeing services, the medical practitioner may refer Aboriginal and Torres Strait Islander patients for up to 10 MBS-supported individual allied health or Aboriginal and Torres Strait Islander health and wellbeing services per calendar year (January to December).

The annual total limit of 10 individual health services per patient can include a combination of the following items, up to a maximum of 10 services:

- up to 5 services under a GP chronic condition management plan or, for care recipients in a residential care home, under a multidisciplinary care plan (10950, 10951, 10952, 10953, 10954, 10956, 10958, 10960, 10962, 10964, 10966, 10968, 10970, 93000 and 93013 - MBS Group M3 and equivalent telehealth services) (see MN.3.1).
- up to 10 services under MBS Group M11 and equivalent telehealth services (81300 to 81360, 93048 and 93061) (see MN.11.1).

The 10 services can be made up of one type of service (e.g. 10 physiotherapy services) or a combination of different types of services (e.g. 2 dietetic and 8 podiatry services).

In addition, up to 10 follow up services may be provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner (MBS item 10987) for an Aboriginal and Torres Strait Islander person who has received a health assessment.

Referral requirements for Aboriginal and Torres Strait Islander health and wellbeing services (81300 to 81360, 93048 and 93061) are set out in the *Health Insurance (Section 3C – Allied Health and Other Primary Health Care Services) Determination 2024* (the Allied Health Determination) and mirror those for referrals to medical specialists and other MBS-supported services. The Allied Health Determination requires the following "prescribed particulars" to be included in the referral:

- the name of the referring practitioner
- the address of the practice, or the practitioner's provider number at that practice, of the referring practitioner, and
- the date on which the referring practitioner made the referral

The Allied Health Determination also requires that referrals:

- be in writing
- signed by the referring practitioner (noting this can be an electronic signature)
- dated, and

- explain the reasons for referring the patient, including any information about the patient's condition that the referring practitioner considers necessary to give the health professional.

Further information on available allied health services is available in Note MN.11.1.

Is a health assessment a health screening service?

Clause 2.15.14 of the Regulations specifies that a health assessment must not include a screening service. The *Health Insurance Act 1973* defines a health screening service as a medical examination or test that is not reasonably required for the management of the medical condition of the patient.

However, for the purposes of the MBS, Medicare benefits are payable for a medical examination or a test on a symptomless patient by the that patient's own medical practitioner in the course of normal medical practice, to ensure the patient receives any medical advice or treatment necessary to maintain their state of health.

ELIGIBLE PATIENTS

Any patient who identifies as being of Aboriginal and/or Torres Strait Islander descent and would benefit from an assessment of this type may receive this service.

A health assessment for persons of Aboriginal and Torres Strait Islander descent cannot be claimed more than once every 9 months per eligible patient.

MBS items 715 and 228 cannot be billed for a patient who is an in-patient of a hospital or a care recipient in a residential care home. MBS telehealth items 92004 and 92011 may be billed for patients in all community settings but may not be billed for an admitted patient of a hospital.

ELIGIBLE PRACTITIONERS

Health assessment items are available for different practitioner types:

- general practitioner items can be claimed by GPs only (see GN.4.13).
- prescribed medical practitioner items can be claimed by prescribed medical practitioners only (see AN.7.1).

Note: Clause 2.15.14 of the Regulations specifies patients must access health assessment services through their usual GP or prescribed medical practitioner, if reasonably practicable. The patient's usual GP or prescribed medical practitioner means the practitioner:

- who has provided the majority of services to the patient in the past 12 months, or
- who is likely to provide the majority of services to the patient in the following 12 months, or
- is located at a medical practice that:
    - has provided the majority of services to the patient in the past 12 months, or
    - is likely to provide the majority of services to the patient in the next 12 months.

Telehealth items – 92004 and 92011

Telehealth items are subject to the established clinical relationship rule (see AN.1.1) which applies to most general practice telehealth items.

CO-CLAIMING RESTRICTIONS

Clause 2.15.14 of the Regulations specifies a separate consultation must not be performed in conjunction with a health assessment, unless clinically necessary.

To co-claim a health assessment item and another item, both items must be clinically necessary and distinct services and each independently meeting all relevant requirements set out in the item descriptors.

RECORD KEEPING AND REPORTING REQUIREMENTS

The Regulations state that health assessments for persons of Aboriginal and Torres Strait Islander descent must include:

- 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, and
- adding a record of the health assessment to the patient's medical records.

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements and they may be required to submit evidence for compliance checks related to Medicare claims. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document is created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item(s) can be found on the Federal Register of Legislation at www.legislation.gov.au. MBS items for health assessments for persons of Aboriginal and Torres Strait Islander descent are set out in the following regulatory instruments:

- *Health Insurance (General Medical Services Table) Regulations 2021* – items 715, 228
- *Health Insurance (Section 3C General Medical Services – Telehealth Attendances) Determination 2021* – items 92004, 92011

AN.0.47 GP chronic condition management plans (MBS items 392, 393, 965, 967, 92029, 92030, 92033, 92034, 92060, 92061, 92063 and 92064)

SUMMARY

This note sets out the requirements for developing and reviewing GP chronic condition management plans. GP chronic condition management plans are used by GPs (see GN.4.13) and prescribed medical practitioners (see AN.7.1) to plan the management of patients with one or more chronic conditions.

GP chronic condition management plan items replaced GP Management Plans and Team Care Arrangements on 1 July 2025. For information on the transition arrangements for patients with an existing GP Management Plan and/or Team Care Arrangement see AN.15.5.

GP chronic condition management plans are not available to people in residential care homes. Care recipients of a residential care home may be eligible for a multidisciplinary care plan (see AN.15.8).

USE OF THE ITEMS

GP chronic condition management plans are intended for patients that would benefit from a structured approach to managing their chronic condition(s). The MBS items allow GPs and prescribed medical practitioners to work with their patients to set the goals for the patient's treatment/management of their condition, roles and responsibilities, and a structured plan for their care.

Items 392, 965, 92029, 92033 and, 92060 and 92063 are for the preparation of a GP chronic condition management plan. The *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations) defines preparing a GP chronic condition management plan as the process whereby the GP or prescribed medical practitioner:

"(a) prepares a written plan for the patient that describes

(i) the patient's chronic condition and associated health care needs; and

(ii) health and lifestyle goals developed by the patient and medical practitioner using a shared decision making approach; and

(iii) actions to be taken by the patient; and

(iv) treatment and services the patient is likely to need; and

(v) if the patient would benefit from multidisciplinary care to manage the chronic condition, the treatments or services to which the practitioner will refer the patient (including the purposes of those treatments or services); and

(vi) arrangements to review the plan (including the proposed timeframe for review); and

(b) if the patient is to be referred to a member or members of a multidisciplinary team for management of the patient's chronic condition:

(i) obtains the patient's consent to sharing relevant information (including relevant parts of the plan) with the members of the multidisciplinary team; and

(ii) if the patient so consents—provides relevant parts of the plan to the members of the multidisciplinary team; and

(c) records the patient's consent and agreement to the preparation of the plan; and

(d) offers a copy of the plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and

(e) adds a copy of the plan to the patient's medical records."

Items 393, 967, 92030, 92034, 92061 and 92064 are for reviewing a patient's GP chronic condition management plan. The Regulations define reviewing a plan as the process by which a GP or prescribed medical practitioner:

"(a) discusses and documents:

(i) the patient's progress in relation to the goals mentioned in paragraph (a) of the definition of preparing a GP chronic condition management plan; and

(ii) whether any updates should be made to the GP chronic condition management plan; taking into account:

(iii) whether the goals remain appropriate and the degree of progress towards meeting the goals; and

(iv) information provided by members of the multidisciplinary team (if any) referred to in paragraph (b) of the definition of preparing a GP chronic condition management plan in relation to the members' treatment of the patient and the extent to which the services provided by the members are supporting the patient to meet the patient's goals; and

(b) updates the arrangements to review the plan (including the proposed timeframe for review); and

(c) makes any other updates to the plan required as a result of the discussions referred to in paragraph (a); and

(d) if the patient is to be referred to a member or members of a multidisciplinary team for management of the patient's chronic condition

(i) obtains the patient's consent to sharing relevant information (including relevant parts of the plan) with the members of the multidisciplinary team; and

(ii) if the patient so consents—provides relevant updated parts of the plan to the members of the multidisciplinary team; and

(e) records the patient's consent and agreement to the updates; and

(f) offers a copy of the updated plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and

(g) adds a copy of the updated plan to the patient's medical records."

Who are considered members of a multidisciplinary care team?

The Regulations define a member of the multidisciplinary team as a person who:

"(a) provides treatment or a service to the patient; and

(b) provides a different kind of treatment or service to the patient than each other member of the multidisciplinary team; and

(c) is not an unpaid carer of the patient."

This can include both health care professionals who provide MBS-supported services, such as medical specialists, allied health providers or Aboriginal and Torres Strait Islander primary health care professionals, as well as providers who do not provide services through the MBS, such as disability support workers.

When should a GP chronic condition management plan be considered?

Patients are eligible for a GP chronic condition management plan if they have at least one medical condition that has been (or is likely to be) present for at least 6 months, or is terminal.

There is no list of eligible conditions. It is up to the GP or prescribed medical practitioner's clinical judgment to determine whether an individual patient with a chronic condition would benefit from a GP chronic condition management plan.

In considering the need for a structured plan, GPs and prescribed medical practitioners need to ensure the service is clinically relevant, which is a requirement of the *Health Insurance Act 1973*. The Act defines a clinically relevant service as *"a service rendered by a medical or dental practitioner or an optometrist that is generally accepted in the medical, dental or optometric profession (as the case may be) as being necessary for the appropriate treatment of the patient to whom it is rendered."*

Patients with a GP chronic condition management plan may be eligible for a range of MBS-supported allied health and Aboriginal and Torres Strait Islander health and wellbeing services (see AN.15.4) and services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner (see MN.12.4).

Does my patient need to be diagnosed with a specific disease or pathological entity to access GP chronic condition management plans?

No. Patients are eligible for a GP chronic condition management plan if they have at least one medical condition that has been (or is likely to be) present for at least 6 months, or is terminal.

For example, if your patient has had chronic pain for more than 6 months, and the specific underlying cause of the pain has not been diagnosed, it may be appropriate to put in place a GP chronic condition management plan to set out management goals and agreed patient actions. It may also be appropriate to consider referring them to allied health services such as exercise physiology services or psychological services to support the management of their condition.

What are the collaboration requirements? Do the members of the multidisciplinary care team need to agree before I can bill the item?

No. The plan should set out the multidisciplinary services that the patient will be referred to. There is no requirement for a provider to agree to accept the referral prior to the plan/review being finalised. For detailed information on referrals to allied health and Aboriginal and Torres Strait Islander health and wellbeing services see AN.15.6.

How frequently can GP chronic condition management plans be provided?

The Regulations provide for a plan to be:

- prepared no more than once every 12 months, and that any new plan must be at least 3 months after the last review
- reviewed no more than once every 3 months

unless exceptional circumstances apply (see below).

My patient has a GP chronic condition management plan for their asthma, which was reviewed 1 month ago. They have just been diagnosed with type 1 diabetes. Can I review their plan (or develop a new plan) and refer them to a diabetes educator and other appropriate services as a priority?

Yes, the Regulations provide for GP chronic condition management plan services to be provided to a patient sooner if exceptional circumstances apply. The Regulations define exceptional circumstances as *"there has been a significant change in the patient's clinical condition or care circumstances that necessitates the performance of the service for the patient"*. The particulars of the exceptional circumstances should be documented in the patient's record to substantiate the claim.

Services Australia needs to be advised that exceptional circumstances apply to pay a benefit sooner than is generally allowable. To facilitate this the patient's invoice, Medicare voucher or the digital claim should indicate that exceptional circumstances apply, no further explanation is required to support payment.

My patient has had their plan for 12 months. Should I review the plan or prepare a new one?

This is a matter for clinical judgement. However, for most patients, unless there is a major change in their clinical condition (or other circumstances) that warrants a completely new plan it is likely that periodic reviews are appropriate. The review items allow the plan to be adjusted as required. While a new plan can be prepared every 12 months, this is not required.

Can anyone assist with preparing or reviewing the plan?

Yes, the Regulations allow for a practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal and Torres Strait Islander health worker to assist with the preparation or review of the plan as appropriate. However, the GP chronic condition management plan is a plan between the GP/prescribed medical practitioner and their patient. It is a requirement that the GP/prescribed medical practitioner sees the patient as part of the service, and they are responsible for the service.

The items for preparing and reviewing a GP chronic condition management plan are complete medical services. Item 10997 (and its telehealth equivalents) cannot be used when a practice nurse or Aboriginal and Torres Strait Islander health practitioner assists with the preparation or review of a GP chronic condition management plan.

A practice nurse assisted with reviewing my patient's plan. Can I claim item 10997 (or its telehealth equivalents)?

No, item 10997 cannot be co-claimed when a practice nurse assists with preparing or reviewing a GP chronic condition management plan. The items for preparing and reviewing a GP chronic condition management plan are complete medical services.

See MN.12.4 for further information on item 10997, including circumstances where co-claiming of 10997 and preparation or a review of a GP chronic condition management plan may be appropriate.

Is there a minimum amount of time I need to spend with the patient?

No. However, all MBS requirements must be met including that the GP or prescribed medical practitioner must attend the patient, have a discussion with them about the plan, and be satisfied that the patient understands and agrees with the plan (including actions they are to take), even if a practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal and Torres Strait Islander health worker has assisted in preparing or reviewing the plan.

There will be several factors that determine how long this will take, including the complexity of their condition(s) whether this is the patient's first plan, whether their condition is stable or has changed significantly, and whether their treatment goals remain the same.

Do GP chronic condition management plans expire?

No, GP chronic condition management plans do not expire. However, to promote continuous care for patients with a chronic condition, patients must have had their plan prepared or reviewed within the last 18 months to continue to access allied health and Aboriginal and Torres Strait Islander health and wellbeing services, and other services.

How many allied health and Aboriginal and Torres Strait Islander health and wellbeing services can patients access?

Patients with a GP chronic condition management plan may be eligible for the following MBS-supported services per calendar year:

- up to 5 individual health services (10 for patients of Aboriginal or Torres Strait Islander descent). Individual health services include allied health and Aboriginal and Torres Strait Islander health and wellbeing services (see AN.15.4)
- up to 5 services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner (see MN.12.4)
- if the patient has type 2 diabetes, one assessment of their suitability for group allied health services and, if they are suitable, up to 8 group allied health sessions (see MN.9.1 and MN.9.2).

Do patients need a referral for allied health and Aboriginal and Torres Strait Islander health and wellbeing services?

Yes, a referral is required for MBS benefits to be payable. For detailed information on referrals to individual and group health services see AN.15.6.

It is November and I would like to put a GP chronic condition management plan in place for my patient. Will it need to be reviewed before they can access their allocation of services next year?

No, patient's eligibility is reset on 1 January every year automatically. You are not required to review their plan to enable services or otherwise reset the count provided patients continue to meet the eligibility requirements for the service.

To be eligible for services the patient must have had their plan prepared or reviewed within the previous 18 months.

It is December. If I issue new referrals for allied health and Aboriginal and Torres Strait Islander health and wellbeing services to my patient now, will they have to be reissued next year before they can access services?

No. Allied health and Aboriginal and Torres Strait Islander health and wellbeing referrals remain valid until all services under the referral have been provided, or they expire (see AN.15.6).

The MBS only provides for 5 individual health services per year or up to 10 for patients of Aboriginal or Torres Strait Islander descent. My patient would benefit from more allied health or Aboriginal and Torres Strait Islander health and wellbeing services. How do I determine what services I should refer them to?

This is a matter that should be discussed as part of the development of the plan. While the number of MBS-supported allied health and Aboriginal and Torres Strait Islander health and wellbeing services is limited at 5 per calendar year, some patients can access additional services using private health insurance extras cover, non-MBS services (e.g. through state or PHN programs), or self-funding.

For patients who don't have access to non-MBS services, services should be prioritised, in discussion with the patient. Factors to consider when prioritising services include clinical need and the patient's management goals for their condition.

My patient is willing and able to fund additional allied health and Aboriginal and Torres Strait Islander health and wellbeing services this year. Which services will the MBS support?

MBS benefits are patient benefits. Ultimately it is up to the patient to decide how they use their MBS benefits, noting that the number of services available under the MBS is limited. When considering which services they should use their MBS benefits for patients may wish to consider factors such as the total cost of the service (and therefore any likely out of pocket costs) and the availability of any other support (e.g. private health insurance cover).

My patient only used 3 allied health services this year. Do the unused services carry over into next year?

No, unused services do not rollover. Patients are eligible for up to 5 services per calendar year regardless of any prior claiming patterns.

My patient needs physiotherapy services but I am not sure how many services they need. Can I still refer them?

Yes. You are not required to specify the number of services in the referral.

My patient has a GP chronic condition management plan. I know that allied health services are to be provided consistent with the plan. Is it ever appropriate to refer my patient to an allied health service under their plan for an acute condition?

It may be appropriate if the acute condition is likely to exacerbate the patient's chronic condition or the chronic condition led to the acute condition. For example:

- Mrs Jones has chronic obstructive pulmonary disease and diabetes. She has a GP chronic condition management plan which includes goals relating to maximising exercise tolerance and keeping her feet healthy. She has existing allied health referrals to an exercise physiologist and podiatrist. However, she contracts acute pneumonia and in conjunction with her GP it is determined she would benefit from chest physiotherapy to assist with her recovery. A referral is provided to a physiotherapist consistent with her goal to maximise exercise tolerance.

- Jim, 42, has type 2 diabetes. It's generally been well controlled, and he has a GP chronic condition management plan. His goals include maintaining a tight HbA1c as he is relatively young, and to assist with this he has been referred to an exercise physiologist and a diabetes educator. However, whilst exercising he has an accident, and a nail ends up embedded in the plantar surface of his foot. The GP removes it under local anaesthetic but is concerned that the wound may be slow to heal due to previous wound healing issues. Therefore, the following day Jim's GP chronic condition management plan is reviewed and goals updated to incorporate maintenance of foot health and prevention of ulceration. He is also referred to a podiatrist for assistance with wound care, pressure off-loading at the wound site and appropriate footwear for optimal healing.

Can I include social prescribing in my patient's GP chronic condition management plan?

The GP chronic condition management plan is intended to set out the agreed actions and services that would be beneficial to the patient in managing their chronic condition. There is nothing that precludes the inclusion of activities or services that are not covered by MBS funding arrangements, such as social prescribing. However, it is important that patients are aware when services that are not supported by the MBS are included in their plan.

Can I use a GP chronic condition management plan to support a patient with managing obesity?

It may be appropriate if obesity requires management alongside the patient's chronic condition. For example:

- A patient, during attendance with their GP, is assessed as needing a GP chronic condition management plan to manage all their risk factors that contributed to their recent heart attack. The GP and the patient have agreed to establishing a GP chronic condition management plan and it is being completed in this appointment.

  As part of the GP chronic condition management plan, the GP identifies that the patient's hypertension and obesity puts them at a higher risk of another cardiovascular event. The GP and patient recognise weight reduction would assist in reducing the cardiovascular risk. The GP and patient agree that addressing these risk factors should be included in their plan.

  The patient gives consent for a referral to a psychologist to address their underlying relationship with food, an exercise physiologist to assist with increased physical activity and a dietician to support nutritional changes. The patient identifies that a family member already attends ParkRun and commits to attending with them. This is documented in the plan.

- A patient, during previous attendances with their GP, is assessed as having multiple cardiovascular risk factors including hypertension, and pre-clinical obesity. They are a current smoker with daily alcohol use. They have a family history of diabetes but are not diabetic themselves.

  The GP and the patient both recognise that things need to change to prevent developing diabetes, a heart attack or stroke. There is a recognised evidence-based role for a multi-disciplinary care team in this situation. The GP and patient have agreed to establishing a GP chronic condition management plan to enable multi-disciplinary support and the plan is being completed in this appointment.

  The patient gives consent for a referral to an exercise physiologist to assist with increased physical activity and a dietician to support nutritional changes. The patient identifies the Quitline is available to support their smoking cessation attempt alongside nicotine replacement therapy. They also commit to attending the local heart health walking group. This is documented in the plan.

  During the consultation it becomes clear that anxiety has prevented the patient engaging with services in the past. It also becomes clear that alcohol use is a form of self-managing the anxiety. The patient requests referral to the local mental health services to address their anxiety and for support with broader lifestyle changes including a reduction in alcohol. As the patient has a clear indication for at least moderate intensity mental health support requirements, a GP mental health treatment plan is also completed to support this referral.

Do I need to upload the plan to My Health Record?

GPs and prescribed medical practitioners are strongly encouraged to upload GP chronic condition management plans to the patient's My Health Record. However, as upload is not a requirement of the item it is not essential that the plan be uploaded prior to submitting an MBS claim.

ELIGIBLE PATIENTS

To be eligible for a GP chronic condition management plan patients must:

- have at least one medical condition that has been (or is likely to be) present for at least 6 months, or is terminal, and

- either:
    - Be living in the community (i.e. they are not a care recipient in a residential care home), or
    - For face-to-face items only, be an in-patient of a private hospital. Patients that are public in-patients of a hospital are not eligible for these services.

Patients registered under MyMedicare must access GP chronic condition management services through the practice where they are registered. Patients that are not registered through MyMedicare can access the services through their usual medical practitioner. The Regulations define "usual medical practitioner" as:

"a general practitioner or prescribed medical practitioner:

(a) who has provided the majority of services to the person in the past 12 months; or

(b) who is likely to provide the majority of services to the person in the following 12 months; or

(c) located at a medical practice that:

(i) has provided the majority of services to the person in the past 12 months; or

(ii) is likely to provide the majority of services to the person in the next 12 months."

Telehealth items – 92029, 92030, 92033, 92034, 92060, 92061, 92063 and 92064

These items are not subject to the established clinical relationship rule (see AN.1.1) that applies to most general practice telehealth items. Instead, these items are subject to the same MyMedicare and usual medical practitioner requirements of the GP chronic condition management plan face-to-face items.

Consistent with the general rules applying to telehealth services, items 92029, 92030, 92033, 92034, 92060, 92061, 92063 and 92064 cannot be used when the patient is an admitted patient of a hospital.

ELIGIBLE PRACTITIONERS

GP chronic condition management plan items are available for different medical practitioner types:

- General practitioner items can be claimed by GPs only (see GN.4.13)
- Prescribed medical practitioner items can be claimed by prescribed medical practitioners only (see AN.7.1)

Name of Item	GP item number	Prescribed medical practitioner item number
Prepare a GP chronic condition management plan – face to face	965	392
Prepare a GP chronic condition management plan – video	92029	92060
Prepare a GP chronic condition management plan – phone	92033	92063
Review a GP chronic condition management plan – face to face	967	393
Review a GP chronic condition management plan – video	92030	92061
Review a GP chronic condition management plan – phone	92034	92064

Noting that, under certain circumstances GP chronic condition management plan services can be provided to a patient in a hospital, the Regulations state that the care items can only be used by medical practitioners that:

- are not employed by the proprietor of a hospital that is not a private hospital, or
- is employed by the proprietor of a hospital that is not a private hospital and provides the service otherwise that in the course of employment by that proprietor.

CO-CLAIMING RESTRICTIONS

Planning and review items for GP chronic condition management plans cannot be co-claimed by the same practitioner on the same day for the same patient as general attendance items (note the date of service should be recorded as the date the attendance occurred):

- items 3, 4, 23, 24, 36, 37, 44, 47, 52, 53, 54, 57, 58, 59, 60, 65, 123, 124, 151 and 165
- items 179, 181, 185, 187, 189, 191, 203, 206, 301, 303, 733, 737, 741, 745, 761, 763, 766, 769, 2197 and 2198
- items 585, 588, 591, 594, 599 and 600
- items 5000, 5003, 5020, 5023, 5040, 5043, 5060, 5063, 5071 and 5076
- items 5200, 5203, 5207, 5208, 5209, 5220, 5223, 5227, 5228 and 5261
- items 91790, 91792, 91794, 91800, 91801, 91802, 91803, 91804, 91805, 91806, 91807, 91808, 91890, 91891, 91892, 91893, 91900, 91903, 91906, 91910, 91913, 91916, 91920, 91923, 91926, 92210 and 92211.

RECORD KEEPING AND REPORTING REQUIREMENTS

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements and they may be required to submit evidence for compliance checks related to Medicare claims. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document is created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item(s) can be found on the Federal Register of Legislation at www.legislation.gov.au. GP chronic condition management plan items are set out in two regulatory instruments:

- *Health Insurance (General Medical Services Table) Regulations 2021* – items 392, 393, 965, 967
- *Health Insurance (Section 3C General Medical Services – Telehealth Attendances) Determination 2021* – items 92029, 92030, 92033, 92034, 92060, 92061, 92063, 92064

AN.0.49 Multidisciplinary Case Conferences by Primary Care Medical Practitioners (MBS items 235, 236, 237, 238, 239, 240, 735, 739, 743, 747, 750 and 758)

SUMMARY

This note covers services for general practitioners (GPs see GN.4.13), and prescribed medical practitioners (PMPs see AN.7.1) to organise and coordinate, or participate in, time-tiered multidisciplinary case conferences for:

- patients in the community, or
- patients being discharged into the community from hospital, or
- care recipients in residential care homes.

For information on allied health practitioner, Aboriginal and Torres Strait Islander primary health care professional, and nurse practitioner participation in multidisciplinary case conferences see MN.3.2. For information on case conferencing items for consultant physicians see AN.0.51.

For information on GPs and PMPs organising and coordinating, or participating in a mental health case conference see AN.15.1. For information on cancer case conferences see AN.0.65.

USE OF THE ITEMS

Multidisciplinary case conference items for GPs and PMPs are time-tiered. There are separate items for organising and coordinating a multidisciplinary case conference and participating in a multidisciplinary case conference that has been organised by another person. The multidisciplinary case conference items can be used when:

- the patient is living in the community, or
- the patient is a care recipient in a residential care home, or
- the case conference is for an admitted patient of a hospital prior to their discharge.

The requirements of multidisciplinary case conferences are set out in the *Health Insurance (General Medical Service Table) Regulations 2021* (the Regulations).

What is a multidisciplinary case conference?

Clause 1.1.4 of the Regulations defines a multidisciplinary case conference as *"a process by which a multidisciplinary case conference team carries out all of the following activities:*

- *discussing a patient's history;*
- *identifying a patient's multidisciplinary care needs;*
- *identifying outcomes to be achieved by members of the multidisciplinary case conference team giving care and service to the patient;*
- *identifying tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the multidisciplinary case conference team;*
- *assessing whether previously identified outcomes (if any) have been achieved."*

What is a multidisciplinary discharge case conference?

Clause 2.16.14 of the Regulations defines a multidisciplinary discharge case conference as *"a multidisciplinary case conference carried out for a patient before the patient is discharged from a hospital."*

In accordance with the overarching MBS rule, where the patient is an admitted patient of a hospital the 75% benefit must be claimed.

What is a multidisciplinary case conference team?

A multidisciplinary case conference team must include, at a minimum, a medical practitioner and at least two (2) other members, one of whom may be another medical practitioner. Each member must provide a different kind of care or service to the patient.

Unpaid carers of the patient do not count towards the minimum participation requirements.

Is there a minimum number of participants for a multidisciplinary case conference?

Yes, there must be at least three (3) participants, none of whom can be an unpaid carer of the patient, and no more than two (2) can be a medical practitioner.

Is there a maximum number of participants?

No. Each member must provide a different kind of care or service to the patient. None can be an unpaid carer of the patient; and only two may be medical practitioners.

It would benefit my patient for more than two medical practitioners to participate as they are part of the team. Is this allowed?

Yes. However, while there is no limit on the number of medical practitioners who may participate as these items are for multidisciplinary case conferences, a maximum of two medical practitioners count towards the minimum participation requirements. That is, at least one member of the multidisciplinary team must be someone who is not a medical practitioner (and meets the requirements set out above).

Do all members of the multidisciplinary case conference team need to be health professionals?

No, not all members are required to be health professionals. It may be appropriate to include others involved in the patient's care, including but not limited to education providers, "meals on wheels" providers, personal care workers and probation officers.

Do all members of a multidisciplinary case conference team have to provide services under the MBS?

No, for example members of the team who are not health professionals would not provide services under the MBS.

Do all members of a multidisciplinary case conference team have to meet the MBS item requirements?

Any team member who bills an MBS multidisciplinary case conference item must meet the requirements of the item.

Members of the team who do not bill these MBS items are not required to meet all item requirements.

Does the patient need to attend the multidisciplinary case conference?

No, the patient does not need to attend but may do so. However, the patient must consent to the case conference.

What does "organising and coordinating" a multidisciplinary case conference involve?

To organise and coordinate a conference the medical practitioner must meet the requirements of clause 2.16.15 of the Regulations which states that organising and coordinating a case conference *"means undertaking all of the following activities:*

(a) explaining to the patient the nature of the conference;

(b) asking the patient whether the patient agrees to the conference taking place;

(c) recording the patient's agreement to the conference;

(d) recording the day the conference was held and the times the conference started and ended;

(e) recording the names of the participants;

(f) recording the activities mentioned in the definition of ***multidisciplinary case conference*** *in clause 1.1.4 and putting a copy of that record in the patient's medical records;*

(g) offering the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees), and giving each other member of the team, a summary of the conference;

(h) discussing the outcomes of the conference with the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees)."

What does "participating" in a multidisciplinary case conference involve?

To participate in a case conference the medical practitioner must meet the requirements of clause 2.16.16 of the Regulations which states that to participate:

"(a) does not include organising and coordinating the conference; and

(b) involves undertaking all of the following activities in relation to the conference:

(i) explaining to the patient the nature of the conference;

(ii) asking the patient whether the patient agrees to the practitioner's participation in the conference;

(iii) recording the patient's agreement to the practitioner's participation in the conference;

(iv) recording the day the conference was held and the times the conference started and ended;

(v) recording the names of the participants;

(vi) recording the matters mentioned in the definition of ***multidisciplinary case conference*** *in clause 1.1.4 and putting a copy of that record in the patient's medical records."*

I organised and coordinated the multidisciplinary case conference and participated in it. Can I claim both items for the same multidisciplinary case conference?

No. The item for organising and coordinating the multidisciplinary case conference includes participation in the conference.

I organised and coordinated a multidisciplinary case conference with two other members of the multidisciplinary care team but only one of them attended as the other was called to an emergency. Can I still claim the item?

No. To meet the requirements of the items at least three (3) participants who are not unpaid carers of the patient are required to attend. No more than two of the three can be medical practitioners.

Does a GP or PMP have to organise the multidisciplinary case conference? Can I still use the participation items if the multidisciplinary case conference is organised by a specialist, residential care home or someone else?

No. A GP or PMP does not have to organise the case conference. The participation items can be used regardless of who organises the case conferences, provided all the requirements of the items are met.

Can I claim the organise and coordinate items if administrative or other staff assist, for example with diary coordination, room or IT set up?

Yes. Provided that the claiming GP or PMP meets all the requirements of the organising and coordinating items, they can claim those items regardless of whether someone else assists with establishing the case conference.

If the patient doesn't have to attend the multidisciplinary case conference when do I explain the purpose and get their consent?

Generally, the need for a multidisciplinary case conference is established in a standard attendance. This would typically be the appropriate time to discuss the need for a multidisciplinary case conference and get patient consent. Alternatively, a practitioner could contact the patient to explain the nature and purpose of the case conference and obtain informed patient consent.

Do all members of the multidisciplinary care team have to meet in person for a multidisciplinary case conference?

No, team members can participate in a case conference in person, by video conference, by phone, or any combination of these. However, attendance of all participants must be synchronous.

Can I claim a multidisciplinary case conference item for a review of a GP chronic condition management plan or multidisciplinary care plan?

No, a multidisciplinary case conference item cannot be used as part of the development or review of a GP chronic condition management plan or multidisciplinary care plan.

However, if a multidisciplinary case conference is clinically relevant for a patient who has a plan, and is separate to developing or reviewing the plan, multidisciplinary case conference items may be used.

ELIGIBLE PATIENTS

All Medicare eligible patients are eligible for this service.

ELIGIBLE PRACTITIONERS

There are multidisciplinary case conference items for general practitioners (see GN.4.13) or prescribed medical practitioners (see AN.7.1).

Item	GP item number	Prescribed medical practitioner item number
Organise and coordinate		
At least 15 minutes but less than 20 minutes	735	235
At least 20 minutes but less than 40 minutes	739	236
At least 40 minutes	743	237
Participate		
At least 15 minutes but less than 20 minutes	747	238
At least 20 minutes but less than 40 minutes	750	239
At least 40 minutes	758	240

Noting that a multidisciplinary case conference may be a for a patient being discharged from hospital, the Regulations state that multidisciplinary care items can only be used by medical practitioners who:

- are not employed by the proprietor of a hospital that is not a private hospital, or
- are employed by the proprietor of a hospital that is not a private hospital and provides the service other than in the course of employment by that proprietor.

RECORD KEEPING AND REPORTING REQUIREMENTS

All Medicare claiming is subject to compliance checks and providers may be required to submit evidence about the services they bill. More information about the department's compliance program can be found on its website at Medicare compliance. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item(s) can be found on the Federal Register of Legislation at www.legislation.gov.au. Multidisciplinary case conference items for GPs and PMPs are set out in the *Health Insurance (General Medical Service Table) Regulations 2021*.

AN.0.50 Public Health Medicine - (Items 410 to 417)

Attendances by public health physicians will attract Medicare benefits under the new items only where the attendance relates to one or more of the following: -

(i) management of a patient's vaccination requirements for accepted immunisation programs; or

(ii) prevention or management of sexually transmitted disease; or

(iii) prevention or management of disease due to environmental hazards or poisons; or

(iv) prevention or management of exotic diseases; or

(v) prevention or management of infection during outbreaks of infectious disease.

For more information on the content-based item structure used in this Group, see A.5 in the explanatory notes.

AN.0.51 Case Conferences by Consultant Physician - (Items 820 to 838, 6029 to 6034 and 6064 to 6075)

Items 820, 822, 823, 825, 826, 828, 6029, 6031, 6032, 6034, 6064, 6065, 6067, 6068, 6035, 6037, 6038, 6042, 6071, 6072, 6074 and 6075 apply to a community case conference (including a case conference conducted in a residential care home) organised to discuss one patient in detail and applies only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and has complex needs requiring care from a multidisciplinary team. Community case conference items i.e. 820, 822, 823, 825, 826 and 828 do not apply to an in-patient of a hospital.

For items 830, 832, 834, 835, 837 and 838, a discharge case conference is a case conference carried out in relation to a patient before the patient is discharged from a hospital. Items 830, 832, 834, 835, 837 and 838 are payable not more than once for each hospital admission.

The purpose of a case conference is to establish and coordinate the management of the care needs of the patient.

A case conference is a process by which a multidisciplinary team carries out the following activities:

- discusses a patient's history;
- identifies the patient's multidisciplinary care needs;
- identifies outcomes to be achieved by members of the case conference team giving care and service to the patient;
- identifies tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and
- assesses whether previously identified outcomes (if any) have been achieved.

For the purposes of items 820, 822, 823, 830, 832, 834, 6029, 6031, 6032, 6034, 6064, 6065, 6067 and 6068 (that is, where a consultant physician organises a case conference) a multidisciplinary team requires the involvement of a minimum of four formal care providers from different disciplines. The consultant physician is counted toward the minimum of four. Although they may attend the case conference, neither the patient nor their informal carer can be counted toward the minimum of four. One member may be another medical practitioner.

For the purposes of items 825, 826, 828, 835, 837, 838, 6035, 6037, 6038, 6042, 6071, 6072, 6074 and 6075 (that is, where a consultant physician participates in a case conference) a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines. The consultant physician is counted toward the minimum of three. Although they may attend the case conference, neither the patient nor their informal carer can be counted toward the minimum of three. One member may be another medical practitioner.

In addition to the consultant physician and one other medical practitioner, "formal care providers" include:

- allied health professionals, being: registered nurse, physiotherapist, occupational therapist, podiatrist, speech pathologist, pharmacist, dietician, psychologist, orthoptist, orthotist and prosthetist, optometrist,

audiologist, social worker, mental health worker, asthma educator, diabetes educator, dental therapist and dentist;

- Aboriginal and Torres Strait Islander primary health care professionals, being: Aboriginal and Torres Strait Islander health practitioner and Aboriginal and Torres Strait Islander health worker; and
- community service providers being: personal care worker, home and community care service provider, meals on wheels provider, education provider and probation officer.

Organisation of a case conference

For items 820, 822, 823, 830, 832, 834, 6029, 6031, 6032, 6034, 6064, 6065, 6067 and 6068, organise and coordinate a community case conference means undertaking the following activities in relation to a case conference:

(a) explaining to the patient or the patient's agent the nature of a case conference, and asking the patient or the patient's agent whether they agree to the case conference taking place; and

(b) recording the patient's or agent's agreement to the case conference; and

(c) recording the day on which the conference was held, and the times at which the conference started and ended; and

(d) recording the names of the participants; and

(e) putting a copy of that record in the patient's medical records; and

(f) giving the patient or the patient's agent, and each other member of the team a summary of the conference; and

(h) giving a copy of the summary of the conference to the patient's usual general practitioner; and

(i) discussing the outcomes of the patient or the patient's agent.

Organisation of a discharge case conference (items 830, 832 and 834) may be provided for private in-patients only, and must be organised by the medical practitioner who is providing in-patient care.

Participation in a case conference

For items 825, 826, 828, 835, 837, 838, 6035, 6037, 6038, 6042, 6071, 6072, 6074, 6075. participation in a case conference must be at the request of the person who organises and coordinates the case conference and includes undertaking the following activities when participating in a case conference:

(a) recording the day on which the conference was held, and the times at which the conference started and ended; and

(b) recording the matters mentioned in **Organisation of a case conference** in so far as they relate to the medical practitioner's participation in the case conference and putting a copy of that record in the patient's medical records.

General requirements

The case conference must be arranged in advance, within a time frame that allows for all the participants to attend. The minimum of three care providers for participating in a case conference or four care providers for organising a case conference must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

A record of the case conference which contains: a list of the participants; the times the conference commenced and concluded; a description of the problems, goals and strategies; and a summary of the outcomes must be kept in the

patient's record. The notes and summary of outcomes must be provided to all participants and to the patient's usual general practitioner.

Prior informed consent must be obtained from the patient, or the patient's agent. In obtaining informed consent the consultant physician should:

- Inform the patient that their medical history, diagnosis and care preferences will be discussed with other case conference participants;
- Provide an opportunity for the patient to specify what medical and personal information they want to be conveyed to, or withheld from, the other care providers;
- Inform the patient that they will incur a charge for the service for which a Medicare benefit will be payable.

Medicare benefits are only payable in respect of the service provided by the coordinating consultant physician or the participating consultant physician. Benefits are not payable for another medical practitioner organising a case conference or for participation by other medical practitioners at a case conference, except where a medical practitioner organises or participates in a case conference in accordance with items 735 to 758 (GPs), and items 235 to 244 (non-specialist practitioners).

The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided. See General Explanatory Notes for further details on billing procedures.

It is expected that a patient would not normally require more than 5 case conferences in a 12-month period.

This item does not preclude the claiming of a consultation on the same day if other clinically relevant services are provided.

AN.0.52 Domiciliary Medication Management Reviews (MBS items 245 and 900)

SUMMARY

This note sets out the requirements for domiciliary medication management reviews (DMMRs), also known as home medication management reviews. DMMRs allow GPs (see GN.4.13) and prescribed medical practitioners (see AN.7.1) to refer to, and work with, a pharmacist to maximise a patient's benefit from their medication and prevent or reduce the risk of medication-related problems.

DMMRs are for patients living in the community. Patients who are care recipients in a residential care home may be eligible for a Residential Medication Management Review (see AN.7.18).

While the GP's or prescribed medical practitioner's work in the DMMR is supported through the MBS, the pharmacist's participation is funded through other programs.

From 1 July 2027 DMMRs patients will require a GP chronic condition management plan to access DMMRs.

USE OF THE ITEMS

The requirements for DMMRs are set out in the *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations). The Regulations specify that a DMMR consists of the following activities, that must be undertaken by the GP or 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 their therapeutic goals met; and

b) following that assessment:

i. refers the patient to a community pharmacy or an accredited pharmacist for the DMMR; and

ii. provides relevant clinical information required for the DMMR; and

c) discusses with the reviewing pharmacist the results of the DMMR including suggested medication management strategies; and

d) develops a written medication management plan following discussion with the patient; and

e) provides the written medication management plan to a community pharmacy chosen by the patient"

Do I need to see the patient as part of the DMMR?

Yes. The Regulations state that DMMRs are a *"service provided in the course of personal attendance by a single [general practitioner/prescribed medical practitioner] on a single patient"*. This means that the medical practitioner must physically see the patient as part of the DMMR service**.**

However, the medical practitioner's interactions with the pharmacist can be done in writing, or by video or phone.

How often can a DMMR be provided to a patient?

Patients can have a DMMR (either item 245 or item 900) every 12 months if it is clinically appropriate. Exceptional circumstances apply if there is a significant change in the patient's medical condition or medication management plan requiring a new DMMR, in which case a service can be provided sooner than 12 months. It is a matter for the GP or prescribed medical practitioner's professional judgement to determine whether exceptional circumstances warrant an early DMMR.

Services Australia needs to be advised that exceptional circumstances apply to pay a benefit sooner than is generally allowable. To facilitate this the patient's invoice, Medicare voucher or the digital claim should indicate that exceptional circumstances are in play, no further explanation is required to support payment. However, the GP or prescribed medical practitioner must also ensure that their records are adequate, contemporaneous and include the nature of the exceptional circumstances.

This is a complex service. When can I bill the MBS?

An MBS claim can only be submitted once all the requirements of the DMMR have been completed (i.e. at the end of the DMMR).

Can I claim another service for the same patient on the same day as the DMMR?

In general, yes. However, there are some limitations including:

- both services must be clinically relevant and distinct services
- the other item must not have restrictions on same day claiming with an DMMR. For items requiring the attendance of the provider and the patient the date recorded as the date of service as being the date of the attendance.

If the consultation with the patient relates solely to the DMMR only the DMMR items can be claimed.

ELIGIBLE PATIENTS

Patients assessed as having a chronic medical condition and not having their therapeutic goals met are eligible for a DMMR. Patients must be living in the community. The Regulations define living in the community as meaning *"the patient is not an in-patient of a hospital or a care recipient in a residential care home."*

From 1 July 2027 patients will only be eligible for DMMRs if they have a GP chronic condition management plan and that plan was put in place or reviewed in the last 18 months.

ELIGIBLE PRACTITIONERS

DMMR items are available for different practitioner types:

- general practitioner items can be claimed by GPs only (see GN.4.13) – item 900
- prescribed medical practitioner items can be claimed by prescribed medical practitioners only (see AN.7.1) – item 245

RECORD KEEPING AND REPORTING REQUIREMENTS

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements and they may be required to submit evidence for compliance checks related to Medicare claims. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document is created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item(s) can be found on the Federal Register of Legislation at www.legislation.gov.au. items 245 and 900 are set out in the *Health Insurance (General Medical Services Table) Regulations 2021*.

AN.0.56 GP Mental Health Treatment Plans and Consultation

Mental Health Treatment Plans and Consultation Items

Associated items: 272, 276, 281, 282, 2700, 2701, 2715, 2717, 92112, 92113, 92114, 92117, 92118, 92119, 92122 and 92123.

This note provides information on the preparation and review of Mental Health Treatment Plans under the Better Access initiative by a general practitioner (GP) or prescribed medical practitioner (PMP) at the patient's MyMedicare registered practice or by their usual medical practitioner (refer to explanatory note AN.0.78 – Better Access Initiative).

Who can provide

The Mental Health Treatment Plan Medicare Benefits Schedule (MBS) items are available for use by a GP or PMP at the patient's MyMedicare registered practice or by their usual medical practitioner

Under MyMedicare and usual medical practitioner requirements, GPs and PMPs will be able to access time-tiered professional (general) attendance items to review a Mental Health Treatment Plan and refer and/or provide ongoing management of a patient's mental health condition, recognising the time spent with patients to provide quality care. There will be no limitation on the number of health-related issues that can be addressed as part of a general attendance consultation, if the requirements of the service are met, and adequate and contemporaneous records are maintained. Key principles for using time-tiered professional (general) attendance items and any specific requirements is available at AN.0.9 | Using time-tiered professional (general) attendance items.

Patient eligibility

These services are available to patients who meet the relevant eligibility requirements (refer to explanatory note AN.0.78 – Better Access Initiative) undertaken by either a GP or PMP at the general practice in which the patient is enrolled in MyMedicare, or regardless of whether the patient in enrolled in MyMedicare, by the patient's usual medical practitioner. This also includes a GP or PMP who is located at a medical practice that has provided the majority of their care over the previous 12 months or will be providing the majority of their care over the next 12 months. These services can also be provided to private inpatients (including private inpatients who are care

recipients of residential care homes) being discharged from hospital. Where the service is provided as part of an episode of hospital treatment, the service must be claimed at the 75% MBS benefit.

Services attracting Medicare benefits

The Mental Health Treatment Plan items define services for which Medicare benefits are payable where a patient's GP or PMP at the patient's MyMedicare registered practice or by their usual medical practitioner to undertake early intervention, assessment, and management of patients with diagnoseable mental disorders. For information on the service requirements of these items, please see the relevant headings below.

There are 16 MBS items for the preparation of a Mental Health Treatment Plan. These are:

For GPs providing Mental Health Treatment Plans who have undertaken mental health skills training recognised through the General Practice Mental Health Standards Collaboration:

- Face-to-face items: 2715 and 2717
- Video items 92116 and 92117

For GPs who have not undertaken mental health skills training:

- Face-to-face items 2700 and 2701
- Video items 92112 and 92113

For PMPs providing Mental Health Treatment Plans who have undertaken mental health skills training recognised through the General Practice Mental Health Standards Collaboration:

- Face-to-face items 281 and 282
- Video items 92122 and 92123

For PMPs who have not undertaken mental health skills training:

- Face-to-face items 272 and 276
- Video items 92118 and 92119

It is strongly recommended that GPs and PMPs providing mental health treatment have appropriate mental health training. GP organisations support the value of appropriate mental health training for practitioners using these items.

There are items that exist for the review of Psychiatrist Assessment and Management Plans. For further information, refer to explanatory note AN.0.30 – Consultant Psychiatrist – Referred Patient Assessment and Management Plan.

Preparation of a Mental Health Treatment Plan

A Mental Health Treatment Plan is intended to identify and document the care needs of patients with a clinically diagnosed mental disorder to allow for a structured approach to the management of their treatment. For the purposes of Better Access services, a mental disorder is defined as a significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder. This definition is informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version. For the purposes of Better Access services, dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders.

Before proceeding with a Mental Health Treatment Plan service, the GP or PMP at the patient's MyMedicare registered practice or their usual medical practitioner must ensure that:

- the Mental Health Treatment Plan preparation service and the steps involved in preparing a Mental Health Treatment Plan are explained to the patient and (if appropriate and with the patient's permission) to the patient's carer; and

- the patient's agreement to proceed is recorded.

The preparation of a Mental Health Treatment Plan involves the assessment of a patient's mental disorder and preparation of a plan to assist the patient in managing their mental disorder. The preparation of a Mental Health Treatment Plan must be documented in writing, and include an assessment process consisting of:

- the administration of an outcome measurement tool (except if considered clinically inappropriate); and
- the formulation of the mental disorder, including a provisional or formal diagnosis.

An outcome measurement tool refers to a tool used to monitor changes in a patient's health that occur in response to treatment received by the patient.

The choice of the evidence-based outcome measurement tool/s to be used is at the clinical discretion of the practitioner, however examples of appropriate outcome tools include:

- Kessler Psychological Distress Scale (K10)
- DASS 21 (Depression, Anxiety and Stress)

GPs using such tools should be familiar with their appropriate clinical use, and if not, should seek appropriate education and training.

Once a GP or PMP at the patient's MyMedicare registered practice or by their usual medical practitioner has completed an assessment of a patient's mental disorder, the following must be undertaken:

- identify and discuss referral and treatment options with the patient, including appropriate support services;
- agree upon treatment goals with the patient and any actions the patient will take;
- provide relevant and suitable education about the patient's mental disorder;
- create a plan for crisis intervention and/or for relapse prevention; and
- make arrangements for required referrals, treatment, appropriate support services, review and follow-up.

This information must be recorded in writing in the patient's Mental Health Treatment Plan. The Initial Assessment and Referral Decision Support Tool (IAR-DST) can be used by the GP or PMP at the patient's MyMedicare registered practice or their usual medical practitioner. It helps to determine the most appropriate level of mental health care needed and informs a suitable referral decision. The IAR-DST aligns with the assessment components required in a patient's Mental Health Treatment Plan and can be incorporated during its preparation. This enables streamlined referrals to mental health services, many of which require a completed IAR at the point of entry. Referrals for treatment services under the Better Access initiative should be utilised for patients who require at least a moderate level of support.

Upon completion of the preparation of a Mental Health Treatment Plan, a copy must be offered to the patient, and where relevant and if the practitioner considers it appropriate, the patient's carer, before a Mental Health Treatment Plan item may be claimed. A copy of the Mental Health Treatment Plan must be added to the patient's medical records.

A patient's Mental Health Treatment Plan should be treated as a living document for updating as required. In particular, the plan can be updated at any time to incorporate relevant information, such as feedback or advice from other health professionals on the diagnosis or treatment of the patient. A new plan should not be prepared unless clinically required, and generally not within 12 months of a previous plan, unless exceptional circumstances exist, e.g. if the patient has had a significant change to their mental health. Ongoing mental health consultations and reviews of progress can be provided by the GP or PMP through the time-tiered professional (general) attendance MBS items, as required.

MBS Telehealth (video) services for Mental Health Treatment Plans

MyMedicare and usual medical practitioner requirements apply to GP and PMP telehealth (video) items for Mental Health Treatment Plans, with these services not exempt from the MBS telehealth eligibility criteria. For further information on the MBS telehealth eligibility criteria, refer to explanatory note AN.1.1.

Referral and treatment options

Eligible patients must be referred to eligible treatment services by either a GP or PMP at the general practice in which the patient is enrolled in MyMedicare, or regardless of whether the patient is enrolled in MyMedicare, by the patient's usual medical practitioner who is managing the patient under a Mental Health Treatment Plan. This also includes a GP or PMP who is located at a medical practice that has provided the majority of their care over the previous 12 months or will be providing the majority of their care over the next 12 months. Eligible patients may also be referred for Better Access treatment services under a Psychiatrist Assessment and Management Plan, or on direct referral from a psychiatrist or paediatrician.

Once a Mental Health Treatment Plan has been completed and claimed on an appropriate Medicare service, a patient is eligible to access relevant treatment and referral options. Medicare benefits are available for up to 10 individual and 10 group therapy mental health treatment services in a calendar year. The services may consist of:

- psychological therapy services delivered by eligible clinical psychologists (refer explanatory note MN.6.2 - Provision of Psychological Therapy); and/or
- focussed psychological strategies services delivered by eligible GPs, eligible PMPs, eligible psychologists (registered), eligible social workers and eligible occupational therapists (refer to explanatory note MN.7.4 – Provision of Focussed Psychological Strategies).

The referring practitioner can decide how many individual treatment services the patient will receive in a course of treatment, within the maximum service limit for the course of treatment. The maximum service limit for each course of treatment is set out below:

- Initial course of treatment - a maximum of 6 individual services.
- Subsequent course of treatment - remaining individual services up to the patient's cap of 10 services per calendar year (for example, if the patient received 6 services in their initial course of treatment, they could only receive 4 services in a subsequent course of treatment provided within the same calendar year).
- Up to a maximum of 10 group therapy mental health treatment services per calendar year

The referring practitioner must specify on the referral the number of services to be provided as part of the course of treatment. Once a course of treatment is undertaken, a review of the patient's Mental Health Treatment Plan is required for the patient to access an additional course of treatment.

For additional information on Better Access referral requirements, please see explanatory note MN.6.3 - Referral requirements for Better Access Treatment Services.

Reviewing a Mental Health Treatment Plan

A review of a patient's Mental Health Treatment Plan, including referral of treatment services and ongoing management of a patient's mental healthcare, is a key component for assessing and managing the patient's progress. A Mental Health Treatment Plan should be reviewed at least once a year by a GP or PMP at the patient's MyMedicare registered practice or by their usual medical practitioner using time-tiered professional (general) attendance MBS items. Key principles for using time-tiered professional (general) attendance items and any specific requirements is available at explanatory Note AN.0.9 | Using time-tiered professional (general) attendance items.

Once a systematic review of the patient's progress against the Mental Health Treatment Plan review requirements has been completed, a Medicare benefit can be claimed using the time-tiered professional (general) attendance items. Where a psychiatrist has prepared a referred Psychiatrist Assessment and Management Plan (item 291 or 92435), as if that patient had a Mental Health Treatment Plan, the dedicated MBS items for a review of a Psychiatrist Assessment and Management Plan (items 293, 296, 297, 299 or 92436 or 92437) can be used.

Before proceeding with any Mental Health Treatment review service, the GP or PMP at the patient's MyMedicare registered practice or by their usual medical practitioner must ensure:

- the Mental Health Treatment Plan review service and the steps involved are explained to the patient and (if appropriate and with the patient's permission) to the patient's carer; and

- the patient's agreement to proceed is recorded.

The review, undertaken using time-tiered professional (general) attendance MBS items, must include:

- a review of the patient's progress against the goals outlined in the Mental Health Treatment Plan;
- checking, reinforcing and expanding education;
- a plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided;
- re-administration of the outcome measurement tool used in the assessment stage, except where considered clinically inappropriate; and
- modification of the documented Mental Health Treatment Plan if required.

A medical practitioner may administer an appropriate triage tool, such as the IAR-DST, to determine the most appropriate level of mental health care required. This tool can also support and inform a practitioners referral decision.

If amendments are made to the patient's Mental Health Treatment Plan, a copy of the amended plan must be offered to the patient, and where relevant and appropriate, the patient's carer, before a Mental Health Treatment Plan review service (undertaken using time-tiered professional [general] attendance MBS items), may be claimed. A copy of the amended plan must also be added to the patient's medical records. GPs and PMPs are able to address a number of health-related issues, in addition to reviewing a Mental Health Treatment Plan, as part of using time-tiered professional (general) attendance MBS items, as long as the requirements of the service are met, and adequate and contemporaneous records are maintained.

In general, most patients should not require more than 2 time-tiered professional (general) attendance items, for the specific purpose of reviewing a Mental Health Treatment Plan in a calendar year. A review of a Mental Health Treatment Plan should not be undertaken more than once in a 3-month period, or within 4 weeks following a claim for a Mental Health Treatment Plan item. When reviewing a Mental Health Treatment Plan, any referrals for additional treatment services under the Better Access initiative should be utilised for patients who require at least a moderate level of support. Consideration should be given to other treatment interventions and pathways (e.g. digital mental health services, Medicare Mental Health Centres, etc) should the patient's level of support no longer require psychological intervention under the Better Access initiative.

Patients will be required to obtain a new referral from their referring practitioner after they have received the number of services stated on the referral, or the maximum number of services (10 group therapy mental health treatment services) allowed in a calendar year.

Mental health treatment consultation

For an extended consultation with a patient where the primary treating problem is related to a mental disorder, including for a patient being managed under a Mental Health Treatment Plan, time-tiered professional (general) attendance items can be used. These items should not be used for the initial development of a Mental Health Treatment Plan. Time-tiered professional (general) attendance items should only be used for Mental Health Treatment Plan review services and to deliver mental health care and support to patients.

A Mental Health Treatment Consultation must include:

- taking relevant history and identifying the patient's presenting problem(s) (if not previously documented);
- providing treatment, advice and/or referral for other services or treatment;
- documenting the outcomes of the consultation in the patient's medical records and other relevant mental health plan (where applicable); and
- any other requirement set out in the item descriptor for the time-tiered professional (general attendance) items.

A patient may be referred from this consultation for other treatment and services. This does not include referral for Better Access services, unless the patient is being managed by a GP or PMP at the patient's MyMedicare registered practice or by their usual medical practitioner under a Mental Health Treatment Plan or under a Psychiatrist

Assessment and Management Plan (item 291 or 92435). A direct referral may also be made by a psychiatrist or paediatrician.

Additional claiming information

The time-tiered professional (general) attendance items should be used to review a Mental Health Treatment Plan and deliver mental health care and support to patients. There will be no limitation on the number of health-related issues that can be addressed in the time-tiered professional (general) attendance items, as long as the requirements of the service are met (as part of a review of a Mental Health Treatment Plan or a Mental Health Treatment Consultation) and adequate and contemporaneous records are maintained. For information on what constitutes adequate and contemporaneous records, refer to explanatory note GN.15.39 - Practitioners should maintain adequate and contemporaneous records. To co-claim a Mental Health Treatment Plan MBS item and another attendance item, both services must be clinically relevant and distinct services.

Where an additional consultation is undertaken, both services must be clinically relevant, and all item requirements must be met which are set out in the item descriptor for the time-tiered professional (general attendance) items. For example, for item 2700, the duration of the service must have been at least 20 minutes. The time of the preceding consultation must not be counted towards the time of the mental health service.

All consultations conducted as part of the Mental Health Treatment Plan must be rendered by a GP or PMP at the patient's MyMedicare registered practice or by their usual medical practitioner. A specialist mental health nurse, other allied health professionals, Aboriginal and Torres Strait Islander health practitioner or Aboriginal and Torres Strait Islander health worker with appropriate mental health qualifications and training may provide assistance to GPs in provision of mental health care, however, for a Medicare benefit to be payable all requirements of the item must be met.

Further information

For further information on the Better Access Initiative, refer to explanatory note AN.0.78 – Better Access Initiative.

For further information about Medicare Benefits Schedule items, please visit the MBS online website at www.health.gov.au/mbsonline.

Further information is available for providers from the Services Australia provider enquiry line on 132 150.

If you are a patient seeking advice about Medicare services, patient benefits, or your Medicare claims, please contact Services Australia on the Medicare General enquiry line on 132 011.

AN.0.58 Pain and Palliative Medicine (Items 2801 to 3093 and 92751 to 92758)

Attendance by a recognised specialist or consultant physician in the specialty of pain medicine (2801, 2806, 2814, 2824, 2832, 2840, 92751, 92752, 92753, 92754) and Case conference by a recognised specialist or consultant physician in the specialty of pain medicine (2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000).

Items 2801, 2806, 2814, 2824, 2832, 2840, 2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000, 92751, 92752, 92753, 92754, apply only to a service provided by a recognised specialist or consultant physician in the specialty of pain medicine, in relation to a pain patient referred from another practitioner (see Paragraph 6 of the General Explanatory notes).

The conditions that apply to the Case Conferences items (2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000) are the same as those for the Case Conferences by consultant physicians (Items 820 to 838). See explanatory note AN.0.51 for details of these conditions.

Where the service provided to a referred patient is by a medical practitioner who is a recognised specialist or consultant physician in the specialty of pain medicine and that service is pain medicine, then the relevant items from the pain specialist group (2801, 2806, 2814, 2824, 2832, 2840, 2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984,

2988, 2992, 2996, 3000, 92751, 92752, 92753, 92754) must be claimed. Services to patients who are not receiving pain medicine services should be claimed using the relevant attendance or case conferencing items.

Attendance by a recognised specialist or consultant physician in the specialty of palliative medicine (3005, 3010, 3014, 3018, 3023, 3028, 92755, 92756, 92757, 92758) and Case conference by a recognised specialist or consultant physician in the specialty of palliative medicine (3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093).

Items 3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093, 92755, 92756, 92757, 92758, apply only to a service provided by a recognised specialist or consultant physician in the specialty of palliative medicine, in relation to a palliative patient referred from another practitioner (see Paragraph 6 of the General Explanatory notes).

General Practitioners who are recognised specialists in the specialty of palliative medicine and are treating a referred palliative patient and claiming items 3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093 cannot access the GP Chronic Condition Management Plan items (765 767, 92029 and 92030) for that patient. The referring practitioner is able to provide these services.

The conditions that apply to the Case Conferences items (3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093) are the same as those for the Case Conferences by consultant physicians (Items 820 to 838). See explanatory note AN.0.51 for details of these conditions.

Where the service provided to a referred patient is by a medical practitioner who is a recognised specialist or consultant physician in the specialty of palliative medicine and that service is a palliative medicine service, then the relevant items from the palliative specialist group 3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093, 92755, 92756, 92757, 9275, must be claimed. Services to patients who are not receiving palliative care services should be claimed using the relevant attendance or case conferencing items.

AN.0.60 Attendances by Medical Practitioners who are Emergency Physicians - (Items 5001 to 5036)

Items 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 and 5019 under Group A21 relate specifically to attendances rendered by medical practitioners who are holders of the Fellowship of the Australasian College for Emergency Medicine (FACEM) and who participate in, and meet the requirements for, quality assurance and maintenance of professional standards by the Australasian College for Emergency Medicine (ACEM).

Other than for point-of-care ultrasound (see below), only modifying add-on therapeutic and procedural items under Subgroup 14 in Group T1 may be claimed in conjunction with attendance items 5001 to 5019.

Items relating to point-of-care ultrasound services are not separately payable from emergency attendance items 5001 to 5019 where performed for a reason that represents routine use as standard of care in an Emergency Department attendance. For example, the following four (non-exhaustive) reasons:

a. To identify nerves for the purposes of administering nerve blocks.
b. To identify vessels, including abdominal aortic aneurysms.
c. As part of a focused assessment with sonography for trauma (FAST) scan.

Where the "standard of care" principle does not apply, items relating to point-of-care ultrasound services are payable in addition to emergency attendance items 5001 to 5019, where the following three criteria are met:

a. A formal report is provided and is stored in a manner that reasonably facilities future retrieval / access.
b. The images are stored in a manner that reasonably facilitates future retrieval / access.
c. The provider is appropriately credentialed to provide the particular service, by a recognised body for the credentialing of ultrasound services.

For the sake of clarity, hospitals do not constitute recognised bodies for the credentialing of ultrasound services. The ACEM has published policy on the appropriate credentialing for Emergency Medicine ultrasonography, such as the

"Policy on Credentialing for Emergency Medicine Ultrasonography". As noted by ACEM, examples of appropriate credentials include the Diploma in Diagnostic Ultrasound (DDU) and the Certificate in Clinician Performed Ultrasound (CCPU) offered by the Australasian Society for Ultrasound in Medicine (ASUM).

Emergency Attendance Categories

Items 5001 to 5019 cover three categories of attendance to reflect the differing categories of professional involvement required during emergency attendances undertaken in a recognised emergency medicine department of a private hospital, based on the number of differential diagnoses and comorbidities that require consideration rather than simply on the time spent with the patient. The emergency department must be part of a private hospital and this department must be licensed as a "recognised emergency department" by the appropriate State or Territory government authority.

Mirror emergency attendance items (items 5021 to 5036) are provided for medical practitioners who are not emergency physicians to ensure a consistent framework for all emergency attendances, regardless of provider type (see notes below under 'Emergency Medicine Attendances by Medical Practitioners who are not Emergency Physicians').

A new subgroup of therapeutic and procedural add-on items is provided under Subgroup 14 in Group T1 of the MBS for services most commonly performed in emergency medicine (for example, fractures and resuscitation). These items are to be claimed in conjunction with attendances on patients by emergency physicians (items 5001 to 5019) or medical practitioners (5021 to 5036). Explanatory notes for Group T1, Subgroup 14 items are provided in TN.1.24.

The following notes in respect of the three categories are provided to assist emergency physicians and medical practitioners in selecting the appropriate attendance item number for Medicare benefit purposes. The essential difference between the three attendance categories relate not to time but to complexity.

It is recognised that change of shift handovers are common occurrences within the emergency care setting. Emergency physicians and medical practitioners assuming responsibility of care for patients from the first practitioner may bill the attendance items based on the level of complexity and engagement appropriate to the patient's care.

The attendances for items 5001 to 5019 (and non-emergency physician items 5021 to 5036) are divided into three categories relating to the level of complexity involved in medical decision-making, namely:

a. Ordinary complexity
b. Complexity that is more than ordinary but not high
c. High complexity

Age modifiers have been applied to each category of attendance to reflect the level of additional complexity and professional involvement, namely:

a. Aged 4 years or over but under 75 years
b. Aged under 4 years
c. Aged 75 years or over

Ordinary Complexity

These items are for the consultation, investigation (if required) and management of a single system issue in a patient with no relevant comorbidities where the differential diagnosis is limited.

Includes targeted history and examination, interpretation of relevant investigations (if required), development and initiation of a management plan, relevant GP and specialist communication and associated documentation. These patients would typically be discharged home from the Emergency Department. A period of observation is not required for these patients.

Complexity More than Ordinary but Not High

These items are for the assessment, investigation and management of an undifferentiated presentation or a presentation with a clear diagnosis that needs risk stratification and complication exclusion. Where the diagnosis is clear from the outset, this item should be used when management is time consuming or more than one strategy is required. The attendance may include referral or consultation with alternate specialist(s). These patients may or may not be admitted.

Includes a period of observation in response to initial treatment and / or requiring results of investigations to inform an ongoing management plan, and includes any routine point-of-care procedures (such as ECGs, in-dwelling urinary catheterisation, venous and arterial blood gas sampling, ultrasound in conjunction with procedures such as vascular access or nerve block).

For patients requiring a prolonged period of observation, admission to an emergency department short stay unit may be required.

High Complexity

These items are for the assessment, investigation and management of an undifferentiated ED patient with one or more comorbidities and more than one differential diagnosis.

These items may include time consulting with alternate specialists, liaising with community services and arrangement of admission, pharmacy reconciliation, communication with family, carers and general practitioners; and any routine point-of-care procedures (such as ECGs, in-dwelling urinary catheterisation, venous and arterial blood gas sampling, ultrasound in conjunction with procedures such as vascular access or nerve block).

For patients requiring a prolonged period of observation, admission to an emergency department short stay unit may be required.

Related Items: 5001 5004 5011 5012 5013 5014 5016 5017 5019

Emergency Medicine Attendances by Medical Practitioners who are not Emergency Physicians (Items 5021 to 5036)

Mirror items (5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 and 5036) are provided for emergency medicine attendance services performed by medical practitioners who are not emergency physicians to ensure a consistent framework for all emergency attendances, regardless of provider type.

The mirror items reflect the emergency physician items and are divided into three categories relating to the level of complexity with age modifiers applied to each attendance category.

Related Items: 5021 5022 5027 5030 5031 5032 5033 5035 5036

AN.0.61 Emergency Medicine Attendances for the provision of Goals of Care (Items 5039, 5041, 5042 and 5044)

Items 5039 and 5041 are for goals of care services, performed by emergency physicians to support gravely ill patients to make informed decisions regarding treatment of their medical condition.

Mirror items (5042 and 5044) are for the provision of goals of care by medical practitioners who are not emergency physicians.

Items 5039 for emergency physicians and 5042 for medical practitioners are for goals of care services to be performed in conjunction with, or after, the new emergency medicine attendance services (items 5001 to 5036). It is expected the doctor would have performed the emergency attendance service on the patient and would be familiar with the patient's medical issues and circumstances.

Items 5041 for emergency physicians and 5044 for medical practitioners are for goals of care services that are not performed in conjunction with, or after, the new emergency medicine attendance services (items 5001 to 5036).

These items are for situations where the doctor would not be familiar with the patient's medical issues and circumstances and the attendance is for at least 60 minutes.

Notes:

The conditions to be met before services covered by items 5039, 5041, 5042 and 5044 attract benefits are provided under the following definitions of "gravely ill patient lacking goals of care" and "preparation of goals of care" in the GMST.

"gravely ill patient lacking current goals of care" means a patient to whom all of the following apply:

(a) the patient either:

(i) is suffering a life-threatening acute illness or injury; or

(ii) is suffering acute illness or injury and, apart from the illness or injury, has a high risk of dying within 12 months;

(b) one or more alternatives to management of the illness or injury are clinically appropriate for the patient;

(c) either:

(i) there is not a record of goals of care for the patient that can readily be retrieved by providers of health care for the patient and that identifies interventions that should, or should not, be made in care of the patient; or

(ii) there is such a record but it is reasonable to expect that, due to changes in the patient's condition, the goals recorded will change substantially.

"preparation of goals of care" for a patient, by a medical practitioner, means the carrying out of all of the following activities by the practitioner:

(a) comprehensively evaluating the patient's medical, physical, psychological and social issues;

(b) identifying major issues that require goals of care for the patient to be set;

(c) assessing the patient's capacity to make decisions about goals of care for the patient;

(d) discussing care of the patient with the patient, or a person (the surrogate) who can make decisions on the patient's behalf about care for the patient, and as appropriate with any of the following:

(i) members of the patient's family;

(ii) other persons who provide care for the patient;

(iii) other health practitioners;

(e) offering in that discussion reasonable options for care of the patient, including alternatives to intensive or escalated care;

(f) agreeing with the patient or the surrogate on goals of care for the patient that address all major issues identified;

(g) recording the agreed goals so that:

(i) the record can be readily retrieved by other providers of health care for the patient; and

(ii) interventions that should, or should not, be made in care of the patient are identified.

Patients could be assessed for “a life-threatening acute illness or injury” (and suspicion that alternatives to active management may be an appropriate clinical choice) through the use of tools that assist in predicting end-of-life, such as the Supportive and Palliative Care Indicators Tool (SPICTTM).

“offering reasonable options for care” means that the patient must be provided with reasonable alternatives to continued intensive/active treatment or escalation of care, including where the patient has not directly asked for such information (in recognition that patients may not ask if they are not aware of such alternatives).

“recording the agreed goals” should be undertaken using standard forms (where available) appropriate to the facility in which a patient is receiving care.

Patients with existing goals of care plans are eligible if such records cannot be readily retrieved by the medical practitioners; or if their condition has changed to the point the record does not reflect the patient’s current medical condition and it is reasonable for new goals of care to be developed.

Providers of goals of care services should be appropriately trained to provide end-of-life care options and goals of care discussions.

Items 5039, 5041, 5042 and 5044 should not be claimed where the goals of care are defined only in relation to a sub-set of the patient’s major issues.

Related Items: 5039 5041 5042 5044

AN.0.62 Case Conferences by Consultant Psychiatrists - (Items 855 to 866)

A range of items are available for case conferences by consultant psychiatrists in community settings and for discharge planning for hospital in-patients. These items are introduced to improve the effectiveness of psychiatric case conferences and make it easier for psychiatrists to work with general practitioners, allied health professionals and Aboriginal and Torres Strait Islander primary health care professionals, thereby ensuring better coordinated care for patients. Three items (855, 857 and 858) cover the organisation of a community case conference and a further three (861, 864 and 866) cover the organisation of a discharge case conference. Where a consultant psychiatrist organises a case conference a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines. The consultant psychiatrist and one other medical practitioner are counted towards the minimum of three.

Items 855, 857, and 858 apply to a community case conference (including a case conference conducted in a residential care home) organised to discuss one patient in detail and applies only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal. Items 855, 857, and 858 do not apply to an in-patient of a hospital.

For items 861, 864 and 866 a discharge case conference is a case conference carried out in relation to a patient before the patient is discharged from a hospital. Items 861, 864 or 866 are payable not more than once for each hospital admission.

The purpose of a case conference is to establish and coordinate the management of the care needs of the patient.

A case conference is a process by which a multidisciplinary team carries out the following activities:

- discusses a patient's history;
- identifies the patient's multidisciplinary care needs;
- identifies outcomes to be achieved by members of the case conference team giving care and service to the patient;

- identifies tasks that need to be undertaken to achieve these outcomes, and allocates those tasks to members of the case conference team; and assesses whether previously identified outcomes (if any) have been achieved.

For the purposes of items 855 to 866, a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines, each of whom provides a different kind of care or service to the patient, and can include the patient's usual medical practitioner. The consultant psychiatrist and the medical practitioner are counted toward the minimum of three.

The patient's carer may be included as a member of the team, in addition to the minimum of three health or care providers but do not count towards the minimum of three for Medicare purposes.

For the purposes of items 855 to 866 a consultant psychiatrist should generally be the consultant psychiatrist that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

In addition to the consultant psychiatrist and one other medical practitioner, "formal care providers" include:

- allied health professionals and Aboriginal and Torres Strait Islander primary health care professionals such as but not limited to: Aboriginal and Torres Strait Islander health practitioners; Aboriginal and Torres Strait Islander health workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dieticians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.
- home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers.

The involvement of a patient's carer, such as a friend or family member, in a multidisciplinary case conference team can provide significant benefits in terms of coordination of care for the patient. Where the patient has a carer, the consultant psychiatrist should consider inviting the carer to be an additional member of the multidisciplinary case conference team, with the patient's agreement and where the carer's input is likely to be relevant to the subject matter of the case conference. The involvement of the patient's carer is not counted towards the minimum of three members.

Where the patient's carer is not a member of the multidisciplinary team, the practitioner should involve the carer and provide information to the carer where appropriate and with the patient's agreement. However, the practitioner should take account of the impact of the tasks identified in the case conference on the capacity of the carer to provide support to the patient. Additional responsibilities should not be assigned to the patient's carer without the carer's agreement.

Organisation of a case conference

Organise and coordinate a case conference means undertaking the following activities in relation to a case conference:

- explaining to the patient the nature of a case conference, and asking the patient whether the patient agrees to the case conference taking place; and
- recording the patient's agreement to the case conference; and
- recording the day on which the conference was held, and the times at which the conference started and ended; and
- recording the names of the participants; and
- recording the matters mentioned in AN.0.51 and putting a copy of that record in the patient's medical records; and
- offering the patient (and the patient's carer, if appropriate and with the patient's agreement), and giving each other member of the team a summary of the conference; and
- discussing the outcomes of the case conference with the patient.

General requirements

It is expected that a patient would not normally require more than 5 case conferences in a 12-month period.

The case conference must be arranged in advance within a time frame that allows for all the participants to attend. The minimum three care providers must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

In explaining to the patient the nature of a case conference and asking the patient whether he or she agrees to the case conference taking place, the medical practitioner should:

- Inform the patient that their medical history, diagnosis and care preferences will be discussed with other care providers;
- Provide an opportunity for the patient to specify what medical and personal information they want to be conveyed to or withheld from the other case conference team members; and
- Inform the patient that they will incur a charge for the service provided by the practitioner for which a Medicare benefit will be payable.
- Inform the patient of any additional costs they will incur. The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided.

AN.0.63 Case Conference by Consultant Physicians in Geriatric/Rehabilitation Medicine - (Item 880)

Item 880 applies only to a service provided by a consultant physician or a specialist in the specialty of Geriatric or Rehabilitation Medicine who has completed the additional requirements of the Royal Australasian College of Physicians for recognition in the subspecialty of geriatric medicine or rehabilitation medicine. The service must be in relation to an admitted patient in a hospital (not including a patient in a residential care home) who is receiving one of the following types of specialist care:

· geriatric evaluation and management (GEM), in which the clinical intent is to maximise health status and/or optimise the living arrangements for a patient with multidimensional medical conditions with disabilities and psychosocial problems, who is usually (but not always) an older patient; or

· rehabilitation care, in which the clinical intent is to improve the functional status of a patient with an impairment or disability.

Both types of care are evidenced by multi-disciplinary management and regular assessments against a plan with negotiated goals and indicative time-frames. A case conference is usually held on each patient once a week throughout the patient's admission, usually as part of a regular scheduled team meeting, at which all the inpatients under the consultant physician's care are discussed in sequence.

The specific responsibilities of the coordinating consultant physician or specialist are defined as:

- coordinating and facilitating the multidisciplinary team meeting;
- resolving any disagreement or conflict so that management consensus can be achieved;
- clarifying responsibilities; and
- ensuring that the input of participants and the outcome of the case conference is appropriately recorded.

The multidisciplinary team participating in the case conference must include a minimum of three formal inpatient care providers from different disciplines, including at least two providers from different allied health disciplines (listed at dot point 2 of A24.7). The consultant physician or specialist is counted toward the minimum of three. Although they may attend the case conference, neither the patient nor their informal carer, or any other medical practitioner can be counted toward the minimum of three.

The case conference must be arranged in advance, within a time frame that allows for all the participants to attend. The minimum of three formal inpatient care providers must be present for the whole of the case conference.

Prior informed consent must be obtained from the patient, or the patient's agent including informing the patient that they will incur a charge for the service for which a Medicare benefit will be payable.

Item 880 is not payable more than once a week or on the same day as a claim for any of the physician discharge case conferencing items 830, 832, 834, 835, 837 and 838, in respect of a particular patient.

AN.0.64 Neurosurgery Specialist Referred Consultation - (Items 6007 to 6015)

Referred consultations provided by specialist neurosurgeons will be covered under items 6007 to 6015. These new items replace the use of specialist items 104 and 105 for referred consultations by neurosurgeons.

The neurosurgical consultation structure comprises an initial consultation (item 6007) and four categories of subsequent consultations (items 6009-6015). These categories relate to the time AND level of complexity of the attendance i.e

(i) Level 1 - 6009

(ii) Level 2 - 6011

(iii) Level 3 - 6013

(iv) Level 4 - 6015

The following provides further guidance for neurosurgeons in utilising the appropriate items in common clinical situations:

(i) Initial consultation item 6007 will replace item 104.

(ii) Subsequent consultation items 6009-6015 will replace item 105

Item 6009 (subsequent consultation on a patient for 15 mins or less) covers a minor subsequent attendance which is straightforward in nature. Some examples of a minor attendance would include consulting with the patient for the purpose of issuing a repeat script for anticonvulsant medications or the routine review of a patient with a ventriculo-peritoneal shunt.

Item 6011 (subsequent consultation on a patient for a duration of between 16 to 30 mins) would involve an detailed and comprehensive examination of the patient which is greater in complexity than would be provided under item 6009, arranging or evaluating any necessary investigations and include detailed relevant patient notes. Where a management plan is formulated it is expected that this plan is discussed in detail with the patient and a written record included in the patient notes. Some examples of a detailed neurosurgical attendance would include:

· the reviewing of neuroimaging for the monitoring of a tumour or lesion and discussion of the results with the patient (e.g. meningiomaglioma, spinal cord tumour);

· consultation on a patient to review imaging for spinal cord/cauda equina/ nerve root compression from a disc prolapse and discussion of results; or

· consultation on a patient prior to insertion of a ventriculo-peritoneal shunt)

Item 6013 (subsequent consultation on a patient with complex neurological conditions for the duration of between 31 to 45 mins) should involve a extensive and comprehensive examination of the patient greater in complexity than under item 6011, arranging or evaluating any necessary investigations and include detailed relevant patient notes. Item 6013 would be expected to cover complications, adverse outcomes, or review of chronic conditions. Where a management plan is formulated it is expected that this plan is discussed in detail with the patient and a written record be included in the patient notes. Some examples of an extensive neurosurgical attendance would include:

· an attendance on a patient prior to a craniotomy for cerebral tumour;

· surgery for spinal tumour;

· revision of spinal surgery;

· epilepsy surgery; or

· for the treatment of cerebral aneurysm.

Examination of such patients would include full cranial nerve examination or examination of upper and lower limb nervous system.

Item 6015 (subsequent consultation on a patient with complex neurological conditions for a duration of more than 45 mins) should involve an exhaustive examination of the patient that is more comprehensive than 6013 and any ordering or evaluation of investigations and include detailed relevant patient notes. It would be expected to cover complications, adverse outcomes, or review of chronic conditions. Where a management plan is formulated it is expected that this plan is thoroughly discussed with the patient and a written record be included in the patient notes. An exhaustive neurosurgical consultation includes:

· managing adverse neurological outcomes;

· detailed discussion when multiple modalities are available for treatment (e.g. clipping versus coiling for management of a cerebral aneurysm, surgical resection versus radiosurgery for cerebral tumour); or

· discussion where surgical intervention is likely to result in a neurological deficit but surgery is critical to patient's life or to stop progressive neurologic decline (e.g. cranial nerve dysfunction, motor dysfunction secondary to a cerebral or spinal cord lesion).

Examination of such patients would include exhaustive neurosurgical examination including full neurological examination (cranial nerves and limbs) or detailed 'focused examination' (e.g.: brachial plexus examination)

Complex neurosurgical problems referred to in items 6013 and 6015 include:

· deterioration in neurologic function following cranial or spinal surgery;

· presentation with new neurologic signs/symptoms; multifocal spinal and cranial disease (e.g. neurofibromatosis); or

· chronic pain states following spinal surgery (including discussion of other treatment options and referral to pain management)

NOTE: It is expected that informed financial consent be obtained from the patient where possible.

AN.0.65 Cancer Care Case Conference - (Items 243, 244, 871 and 872)

For the purposes of these items:

- private patients in public or private hospitals or the community with a malignancy of a solid organ or tissue or a systemic cancer such as a leukaemia or lymphoma are covered, with the exception of patients whose only cancer is a non-melanoma skin cancer;
- the billing general practitioner, specialist or consultant physician may be from any area of medical practice and must be a treating doctor of the patient discussed at the case conference. A treating doctor should generally have treated or provided a formal diagnosis of the patient's cancer in the past 12 months or expect to do so within the next 12 months. Attending non-treating clinicians, allied health providers, Aboriginal and Torres Strait Islander primary health care professionals or support staff are not eligible to bill the item.
- only one practitioner is eligible to claim item 871 for each patient case conference. This should be the doctor who assumes responsibility for leading and coordinating the case conference, ensures that records are kept and that the patient is informed of the outcome of the case conference. In most cases this will be the lead treating doctor.

- each billing practitioner must ensure that their patient is informed that a charge will be incurred for the case conference for which a Medicare benefit will be payable;
- participants must be in communication with each other throughout the case conference, either face-to-face, or by telephone or video link;
- suitable allied health practitioners and Aboriginal and Torres Strait Islander primary health care professionals would generally be from one of the following disciplines: Aboriginal and Torres Strait Islander health worker; Aboriginal and Torres Strait Islander health practitioner; asthma educator; audiologist; dental therapist; dentist; diabetes educator; dietician; mental health worker; occupational therapist; optometrist; orthoptist; orthotist or prosthetist; pharmacist; physiotherapist; podiatrist; psychologist; registered nurse; social worker; or, speech pathologist;
- in general, it is expected that no more than two case conferences per patient per year will be billed by a practitioner; and
- cancer care case conferences are for the purpose of developing a cancer treatment plan in a multidisciplinary team meeting and should not be billed against case conference items for other purposes e.g. community or discharge case conferences.

AN.0.66 Non-directive Pregnancy Support Counselling Service (MBS items 792, 4001, 92136, 92137, 92138 and 92139)

SUMMARY

This note relates to MBS items for non-directive pregnancy support counselling for GPs (see GN.4.13) and prescribed medical practitioners (PMPs see AN.7.1).

For MBS items for non-directive pregnancy counselling for eligible psychologists, social workers and mental health nurses see MN.8.1 to MN.8.4.

USE OF THE ITEMS

These items are for the provision of non-directive pregnancy support counselling in a general practice setting for a person who is pregnant or was pregnant in the previous 12 months.

The requirements of the items are set out in the *Health Insurance (General Medical Service Table) Regulations 2021* (the Regulations) and, for telehealth (video and phone), the *Health Insurance (Section 3C General Medical Services – Telehealth Attendances) Determination 2021* (the Telehealth Attendance Determination).

Clause 2.22.1 of the Regulations defines non-directive pregnancy support counselling as counselling *"to a patient in which:*

> *(a) information and issues relating to pregnancy are discussed; and*
>
> *(b) the medical practitioner does not impose the medical practitioner's views or values about what the patient should or should not do in relation to the pregnancy."*

The non-directive pregnancy support counselling items are professional attendances. For more information on the meaning of professional attendance see AN.0.3.

Are these time-tiered items?

Yes. The Regulations specify that the provider's attendance on each patient must be at least 20 minutes duration.

What is non-directive counselling?

Non-directive counselling is a form of counselling based on the understanding that, in many situations, people can resolve their own problems without being provided with a solution by the counsellor. The counsellor's role is to encourage the person to express their feelings but not suggest what decision the person should make. By listening

and reflecting back what the person reveals to them, the counsellor helps them to explore and understand their feelings. With this understanding, the person is able to make the decision which is best for them.

When should these items be used?

The service involves the GP or PMP undertaking a safe, confidential process that helps the patient explore concerns they have about a current pregnancy or a pregnancy that occurred in the preceding 12 months. This includes providing, on request, unbiased, evidence-based information about all options and services available to the patient.

The service may be used to address any pregnancy-related issues for which non-directive counselling is appropriate.

Is there a limit on the number of non-directive pregnancy support counselling services available?

Yes. A patient is eligible for up to three MBS non-directive pregnancy counselling services per pregnancy.

There are MBS item numbers for non-directive pregnancy counselling for eligible psychologists, social workers and mental health nurses, as well as GPs and PMPs. The cap of three services applies to the total number of services provided for the pregnancy, regardless of which provider (or combinations of providers) provide the services. A patient cannot access additional services by seeing multiple types of providers.

How do I know how many non-directive pregnancy support counselling services a patient has already used for a pregnancy?

Health professionals can check a patient's eligibility via Health Professional Online Services (HPOS). HPOS is a fast and secure way for health professionals and administrators to check if a patient is eligible for a Medicare benefit for a specific item on the date of the proposed service. However, this system will only return advice that the service/item is payable or not payable. Patients can also access their own claiming history with a My Health Record or by establishing a Medicare online account through myGov or the Express Plus Medicare mobile app. Alternatively, health professionals can call Services Australia on 132 150 to check this information, while patients can seek clarification by calling 132 011.

Can a partner attend the session?

Yes, with the patient’s consent. However, these items are not family or group counselling items, they are personal attendance items meaning that only the time spent counselling the person who is pregnant or was pregnant in the previous 12 months can contribute to the 20 minute minimum time. Only one MBS benefit is payable (for the patient) regardless of whether their partner and/or another support person(s) attends the session.

ELIGIBLE PATIENTS

These services are for people who:

- are pregnant, or
- were pregnant in the 12 months before the first of these services was provided in relation to the same pregnancy.

For telehealth services (video and phone), the existing clinical relationship criteria must be satisfied for the patient to be eligible for a telehealth service. See AN.1.1 for information on the existing clinical relationship criteria.

There is a combined limit of three services per pregnancy that applies across all provider types and modes.

ELIGIBLE PRACTITIONERS

GPs and PMPs must be registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service to claim these items.

Clause 2.22.1 of the Regulations prohibits a medical practitioner that has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination from providing a service using the non-directive pregnancy support counselling items.

	Face to face	Video	Phone
GP item number	4001	92136	92138
Prescribed medical practitioner item number	792	92137	92139

RECORD KEEPING AND REPORTING REQUIREMENTS

All Medicare claiming is subject to compliance checks and providers may be required to submit evidence about the services they bill. More information about the Department's compliance program can be found on its website at Medicare compliance. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item(s) can be found on the Federal Register of Legislation at www.legislation.gov.au. Non-directive pregnancy support counselling service items are set out in the following regulatory instruments:

- *Health Insurance (General Medical Service Table) Regulations 2021* – MBS items 792, 4001
- *Health Insurance (Section 3C General Medical Services – Telehealth Attendances) Determination 2021* – MBS items 92136, 92137, 92138, 92139

AN.0.69 Time-Tiered Health Assessment - Veterans' Health Assessment

SUMMARY

Time tiered health assessment items may be used to undertake a one-off Veterans' Health Assessment for former serving members of the Australian Defence Force (ADF), including former members of permanent and reserve forces.

Annual Veterans' Health Checks are available for certain DVA Veteran Card holders. These health checks are not provided through the MBS. More information on the Annual Veterans' health checks is available from the Department of Veterans' Affairs.

Note: The requirements below must be met in addition to common principles for time tiered health assessment items, contained in AN.0.36.

USE OF ITEMS

The specific requirements of the Veterans' Health Assessment are set out in Clause 2.15.10 of the *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations).

The Regulations require that a Veterans Health Assessment must include:

- an assessment of a patient's physical and psychological health and social function, and
- whether health care, education or other assistance should be offered to the patient to improve the patient's physical or psychological health or social function.

The Regulations also state that the health assessment must include taking a history of the patient that includes the following:

- an assessment of the patient's service with the Australian Defence Force, including service type, years of service, field of work, number of deployments and reason for discharge
- the patient's social history, including relationship status, number of children (if any) and current occupation
- the patient's current medical conditions, and
- whether the patient suffers from hearing loss or tinnitus
- the patient's use of medication, including medication prescribed by another doctor and medication obtained without a prescription
- the patient's smoking, if applicable
- the patient's alcohol use, if applicable
- the patient's substance use, if applicable
- the patient's level of physical activity
- whether the patient has bodily pain
- whether the patient has difficulty getting to sleep or staying asleep
- whether the patient has psychological distress
- whether the patient has post-traumatic stress disorder
- whether the patient is at risk of harm to self or others
- whether the patient has anger problems
- the patient's sexual health, and
- any other health concerns the patient has.

Note: The Regulations do not preclude a medical practitioner's consideration of the patient's broader immunisation status, such as for immunisations listed under the National Immunisation Program schedule or for COVID-19, or broader health factors, such as a patient's occupational exposure to biological or chemical substances that may be potentially harmful.

A Veterans Health Check must also include:

- measuring the patient's height
- weighing the patient and ascertaining, or asking the patient, whether the patient's weight has changed in the last 12 months
- measuring the patient's waist circumference
- taking the patient's blood pressure
- using information gained in the course of taking the patient's history to assess whether any further assessment of the patient's health is necessary either by:
    - making the further assessment, or
    - or referring the patient to another medical practitioner who can make the further assessment,
- documenting a strategy for improving the patient's health, and
- offering to give the patient a written report of the assessment that makes recommendations for treating the patient including preventive health measures.

The Veterans Health Assessment may be performed using the ADF *Post-discharge GP Health Assessment Tool* found on the Department of Veterans' Affairs website at: https://www.dva.gov.au/about-us/dva-forms/veteran-health-check-assessment-tool.

ELIGIBLE PATIENTS

Patients eligible for a Veterans' Health Assessments are former members of the Permanent Forces or a former member of the Reserves.

A Veterans' Health Assessment cannot be claimed more than once by an eligible patient.

ELIGIBLE PRACTITIONERS

A Veterans' Health Assessment can be undertaken by a general practitioner (see GN.4.13) or a prescribed medical practitioner (see AN.7.1).

Patients must access a Veterans' Health Assessment through their usual GP or prescribed medical practitioner. In relation to a patient, means a general practitioner, or a prescribed medical practitioner, employed by a medical practice:

- that has provided at least 50% of the primary health care required by the patient in the last 12 months, or
- that the patient anticipates will provide at least 50% of the patient's primary health care requirements in the next 12 months.

Note: the usual doctor requirements for the Veterans' Health Assessment are different to those applying to health assessments generally.

Information on the definition of usual GP or prescribed medical practitioner for health assessment items is available in AN.0.36.

CO-CLAIMING RESTRICTIONS

A separate consultation must not be performed in conjunction with a Veterans' Health Assessment service, unless clinically necessary.

To co-claim a health assessment item and another item, both items must be clinically necessary and distinct services.

RECORD KEEPING AND REPORTING REQUIREMENTS

The Regulations require that the doctor must keep a record of the assessment.

The department undertakes regular post payment auditing to ensure that MBS items are claimed appropriately. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document it created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS items can be found on the Federal Register of Legislation at www.legislation.gov.au. Health assessment items are set out in the following regulatory instrument:

- *Health Insurance (General Medical Services Table) Regulations 2021*.

AN.0.70 Limitation of items—certain attendances by specialists and consultant physicians

Medicare benefits are not payable for items 105, 116, 119, 386, 2806, 2814, 3010, 3014, 6009, 6011, 6013, 6015, 6019, 6052, 16404, 91823, 91825, 91826, 91833, 91836, 92611, 92612, 92613, 92614, 92618, 92749, 92750, 92752, 92753, 92754, 92756, 92757, 92758, 92760, 92761, 92765 and 92766 when claimed in association with an item in group T8 with a schedule fee of $349.95 or more.

The restriction applies when the procedure is performed by the same practitioner, on the same patient, on the same day.

AN.0.71 General practitioner attendances and aftercare

Medical practitioners working in general practice (excluding specialists and consultant physicians) can provide an aftercare service for which patients are eligible to receive a Medicare benefit, providing that practitioner did not complete the initial procedure for which aftercare treatment is being provided.

Routine aftercare that is provided as follow-up care for a procedure, or that is specified as routine aftercare for a procedure in an MBS item, is not eligible to be billed to the MBS when it is provided by the same practitioner who

provided the initial service requiring aftercare. Further information on aftercare treatments can be found in explanatory note TN.8.4 and on Services Australia's website.

RELEVANT LEGISLATION

Further details about the legislative requirements for practitioners to be eligible for Medicare benefits when providing aftercare can be found on the Federal Register of Legislation in the *Health Insurance (Subsection 3(5) General Practitioner Post-Operative Treatment) Direction 2017*.

AN.0.72 Attendance services for complex neurodevelopmental disorders (such as autism)

Intention of this service under item 289 and video equivalent item 92434

Items 289 or video equivalent item 92434 are intended for complex conditions, characterised by multi-domain cognitive and functional impairment. Patient eligibility is for neurodevelopmental disorders (NDD), which are assessed to be complex and mean that individuals require support across multiple domains.

The intention of this service is to provide access to treatment, through the development of a treatment and management plan by a psychiatrist, for individuals under 25 years of age, diagnosed with a complex NDD. The development of the treatment and management plan, follows a comprehensive medical assessment, and provides the opportunity to refer to eligible allied health practitioners for up to a total of 20 MBS treatment services per patient's lifetime (items 82015, 82020, 82025, 82035, 93035, 93036, 93043 or 93044). This item is claimable once in a patient's lifetime.

Eligibility:

In the context of item 289 (or 92434), the diagnosis of a complex NDD requires evidence of requiring support and showing impairment across two or more neurodevelopmental domains. **Complexity** is characterised by multi-domain cognitive and functional disabilities, delay or clinically significant impairment.

Neurodevelopmental domains include:

- Cognition
- Language
- Social-emotional development
- Motor skills
- Adaptive behaviour: conceptual skills, practical skills, social skills or social communication skills

Referral pathways:

Early identification of, and intervention for, individuals with complex NDD is important in promoting positive longer-term outcomes. Symptoms can cause clinically significant impairment in social, occupational or other important areas of functioning.

Where neurodevelopmental concerns have been identified and brought to the attention of the patient's GP to initially assess these concerns and the GP considers there are persisting indications that require more specialised assessment, they are encouraged to refer to either a consultant paediatrician or psychiatrist for a comprehensive assessment.

Diagnostic assessment:

The assessment and diagnosis of a complex NDD should be evaluated in the context of both a physical and developmental assessment. The psychiatrist may require a number of separate attendances (through usual time-tiered or subsequent attendance items 296 to 308, 310, 312, 314, 316, 318, 319 to 349, 91827 to 91831 or 91837 to 91839, 92437, 92455 to 92457) to complete a comprehensive accurate assessment and formulate a diagnosis, exclude other disorders or assess for co-occurring conditions.

Multi-disciplinary assistance with assessment and/or contribution to the treatment and management plan:

Depending on a range of factors, not limited to the patient's age and nature of suspected disabilities, the consultant physician may require a multi-disciplinary approach to complete a comprehensive accurate assessment and formulate a diagnosis.

Where the psychiatrist determines the patient requires additional assessments to formulate a diagnosis, through the assistance of an allied health practitioner, they are able to refer the patient to an eligible allied health provider from standard attendance items (296 to 308, 310, 312, 314, 316, 318, 319 to 349 or telehealth (video and phone) items 91827 to 91831, 91837 to 91839, 92437, 92455 to 92457).

Whilst Medicare benefits provide for a total of 8 allied health assessment services per patient per lifetime, an eligible allied health practitioner can only provide **up to 4 services** before the need for a review (the type of review can be specified in the referral to the eligible allied health professional) by the referring psychiatrist, who must agree to the need for any additional allied health services prior to the delivery of the remaining 4 allied health assessment services.

Eligible allied health assessment practitioners include:

- Psychologist (MBS item 82000, 93032, 93040)
- Speech pathologist (MBS item 82005, 93033, 93041)
- Occupational therapist (82010, 93033, 93041)
- Audiologist, dietitian, exercise physiologist, optometrist, orthoptist, physiotherapist (MBS item 82030, 93033, 93041)

Requirements of the referral to allied health practitioners

The psychiatrist can refer to multiple eligible allied health practitioners concurrently, but a separate referral letter must be provided to each allied health practitioner. The referral should specify the intent of the assessment and if appropriate, specify the number of services to be provided. Where the number of sessions is not specified, each allied health practitioner can provide up to 4 assessment services without the need for review or agreement to provide further assessment services.

Review requirements following delivery of four (4) allied health assessment services

Whilst an eligible allied health practitioner has provided 4 assessment services (through items 82000, 82005, 82010, 82030, 93032, 93040, 93033 or 93041) and considers additional assessment services are required, they must ensure the referring psychiatrist undertakes a review. If the type of review is not specified by the referring psychiatrist an acceptable means of review includes: a case conference, phone call, written correspondence, secure online messaging exchange or attendance of the patient with the referring psychiatrist.

Inter-disciplinary allied health referral

Eligible allied health practitioners are also able to make inter-disciplinary referrals to other eligible allied health practitioners as clinically necessary to assist with the formulation of the diagnosis or contribute to the treatment and management plan. Inter-disciplinary referrals must be undertaken in consultation and agreement with the referring psychiatrist. Whilst they do not require the need for an attendance with the patient (face-to-face/video/phone) by the referring psychiatrist, they do require an agreement from the referring psychiatrist. This can be undertaken (but is not limited to) an exchange by phone, written communication or secure online messaging.

Contribution to the Treatment and Management Plan through allied health referral

In addition to referring to allied health practitioners for assistance with formulating a diagnosis, once a psychiatrist makes a complex NDD diagnosis, the psychiatrist may require the contribution of an eligible allied health practitioner to assist with the development of the Treatment and Management plan (before billing item 289 or 92434).

MBS items 82000, 82005, 82010, 82030, 93032, 93033, 93040 or 93041 provide a dual function for this purpose. It is important to note that the service limit of a total of 8 services per patient per lifetime apply regardless of whether

the items are used for assistance with diagnosis or contribution to the treatment and management plan, and the referring psychiatrist should be mindful of this when referring to eligible allied health practitioners.

Development of the Treatment and Management Plan

Once the psychiatrist has made a diagnosis of a complex NDD, to complete the item requirements of item 289 or 92434 they must develop a treatment and management plan which includes:

- Written documentation of the patient's confirmed diagnosis of a complex NDD, including any findings of assessments performed (which assisted with the formulation of the diagnosis or contributed to the treatment and management plan)
- A risk assessment which means assessment of:
    - the risk to the patient of a contributing co-morbidity and
    - environmental, physical, social and emotional risk factors that may apply to the patient or to another individual.
- Treatment options which include:
    - Recommendations using a biopsychosocial model
    - Identifying major treatment goals and important milestones and objectives
    - Recommendation/s and referral for treatment services provided by eligible allied health practitioners (where relevant) and who should provide this, specifying number of treatments recommended (to a maximum of 20 treatment services)
    - Indications for review or episodes requiring escalation of treatment strategies
- Documenting the Treatment and Management plan and providing a copy to the referring medical practitioner and relevant allied health practitioner/s.

Referral for allied health treatment services

Once a treatment and management plan is in place (after item 289 or 92434 has been claimed) the psychiatrist can refer the individual to eligible allied health practitioners for the provision of treatment services. Treatment services address the functional impairments identified through the comprehensive medical assessment which are outlined in the treatment and management plan. Treatment services focus on interventions to address developmental delays/disabilities or impairments.

Eligible allied health treatment practitioners include:

- Psychologist (MBS items 82015, 93035, 93043)
- Speech pathologist (MBS items 82020, 93036, 93044)
- Occupational therapist (MBS items 82025, 93036, 93044)
- Audiologist, dietitian, exercise physiologist, optometrist, orthoptist, physiotherapist (MBS items 82035, 93036, 93044)

A total of 20 allied health treatment services per patient per lifetime are available through the MBS, which may consist of any combination of items 82015, 82020, 82025 or 82035 or equivalent video items. Whilst the psychiatrist can refer to multiple eligible allied health practitioners concurrently, a separate referral letter must be provided to each allied health practitioner.

The referral should specify the goals of the treatment and if appropriate, specify the number of services to be provided. It is the responsibility of the referring psychiatrist to allocate the number of treatment services (up to a maximum of 10 services per course of treatment) in keeping with the individual's treatment and management plan.

It is important to note, that a benefit will not be paid for the MBS allied health treatment services unless the pre-requisite items (289 or 92434) have been processed through the Medicare claiming system.

On the completion of a "course of treatment" (specified by the referring psychiatrist, up to maximum of 10 services), the eligible allied health practitioner must provide a written report to the referring psychiatrist, which should include information on the treatment provided, recommendations for future management of the individual's disorder and any advice to caregivers (such as parents, carers, school teachers). This written report will inform the

referring psychiatrist's decision to refer for further treatment services. Where subsequent courses of treatment after the initial 10 services are required (up to a maximum of 20 services per patient per lifetime) a new referral is required.

Inconclusive assessment:

Where a patient does not meet the diagnostic threshold of a complex NDD and where ongoing medical management is required, patients can be managed through psychiatry attendance items 300-308, 310, 312, 314, 316, 318 or telehealth equivalent items 91827-91831 (video) or 91837-91839 (phone).

Examples include where:

- Neurodevelopment assessment is incomplete or inconclusive
- Neurodevelopmental impairment is present in fewer than two domains
- Neurodevelopmental impairment is present in two or more domains, but individuals do not require sufficient support to meet criteria
- Comprehensive, age-appropriate neurodevelopmental assessment is impossible or unavailable (e.g. in infants or young children- particularly those under 6 years of age)

These individuals may be considered "at risk of a complex NDD" and require follow-up and reassessment in the future.

AN.0.73 Attendance services for eligible disabilities

Intention and eligibility of this service under item 139 and video equivalent item 92142

Items 139 or video equivalent item 92142 are intended for diagnosis and treatment for patients under 25 years of age with an eligible disability by a general practitioner.

Definition of Eligible Disabilities is found AR.29.1

The intention of this service is to provide access to treatment, through the development of a treatment and management plan by a general practitioner, for individuals under 25 years of age, diagnosed an eligible disability. The development of the treatment and management plan follows a comprehensive medical assessment, and provides the opportunity to refer to eligible allied health practitioners for up to a total of 20 MBS treatment services per patient's lifetime (items 82015, 82020, 82025, 82035, 93035, 93036, 93043 or 93044). This item is claimable once in a patient's lifetime.

Diagnostic assessment:

Early identification of, and intervention for, individuals with eligible disabilities is important in promoting positive longer-term outcomes. Symptoms can cause clinically significant impairment in social, occupational or other important areas of functioning.

The assessment and diagnosis of an eligible disability should be evaluated in the context of both a physical and developmental assessment. The GP may require a number of separate attendances (through usual time-tiered or subsequent attendance items 3 to 47 or telehealth items 91790, 91800 to 91802 (video), 91890 and 91891 (phone) to complete a comprehensive accurate assessment and formulate a diagnosis, exclude other disorders or assess for co-occurring conditions.

Multi-disciplinary assistance with assessment and/or contribution to the treatment and management plan:

Depending on a range of factors, not limited to the patient's age and nature of suspected disabilities, the GP may require a multi-disciplinary approach to complete a comprehensive accurate assessment and formulate a diagnosis.

Where the GP determines the patient requires additional assessments to formulate a diagnosis, through the assistance of an allied health practitioner, they are able to refer the patient to an eligible allied health provider from standard attendance items 3 to 47 or telehealth items 91790, 91800 to 91802 (video), 91890 and 91891(phone).

Whilst Medicare benefits provide for a total of 8 allied health assessment services per patient per lifetime, an eligible allied health practitioner can only provide **up to 4 services** before the need for a review (the type of review can be specified in the referral to the eligible allied health professional) by the referring GP, who must agree to the need for any additional allied health services prior to the delivery of the remaining 4 allied health assessment services.

Eligible allied health assessment practitioners include:

- Psychologist (MBS item 82000, 93032, 93040)
- Speech pathologist (MBS item 82005, 93033, 93041)
- Occupational therapist (MBS item 82010, 93033, 93041)
- Audiologist, dietitian, exercise physiologist, optometrist, orthoptist, physiotherapist (MBS item 82030, 93033, 93041)

Requirements of the referral to allied health practitioners

The GP can refer to multiple eligible allied health practitioners concurrently, but a separate referral letter must be provided to each allied health practitioner. The referral should specify the intent of the assessment and if appropriate, specify the number of services to be provided. Where the number of sessions is not specified, each allied health practitioner can provide up to 4 assessment services without the need for review or agreement to provide further assessment services.

Review requirements following delivery of four (4) allied health assessment services

Where an eligible allied health practitioner has provided 4 assessment services (through items 82000, 82005, 82010, 82030, 93032, 93033, 93040, or 93041) and considers additional assessment services are required, they must ensure the referring GP undertakes a review. If the type of review is not specified by the GP, an acceptable means of review includes: a case conference, phone call, written correspondence, secure online messaging exchange or attendance of the patient with the referring psychiatrist.

Inter-disciplinary allied health referral

Eligible allied health practitioners are also able to make inter-disciplinary referrals to other eligible allied health practitioners as clinically necessary to assist with the formulation of the diagnosis or contribute to the treatment and management plan. Inter-disciplinary referrals must be undertaken in consultation and agreement with the referring GP. Whilst they do not require the need for an attendance with the patient (face-to-face/video/phone) by the referring GP, they do require an agreement from the referring GP. This can be undertaken (but is not limited to) an exchange by phone, written communication or secure online messaging.

Contribution to the Treatment and Management Plan through allied health referral

In addition to referring to allied health practitioners for assistance with formulating a diagnosis, once the GP makes a diagnosis, the GP may require the contribution of an eligible allied health practitioner to assist with the development of the Treatment and Management plan (before billing item 139 or 92142).

MBS items 82000, 82005, 82010, 82030, 93032, 93033, 93040 or 93041 provide a dual function for this purpose. It is important to note that the service limit of a total of 8 services per patient per lifetime apply regardless of whether the items are used for assistance with diagnosis or contribution to the treatment and management plan, and the referring GP should be mindful of this when referring to eligible allied health practitioners.

Development of the Treatment and Management Plan

Once the GP has made a diagnosis of an eligible disability, to complete the item requirements of item 139 or 92142 they must develop a treatment and management plan which includes:

- Written documentation of the patient's confirmed diagnosis of an eligible disability, including any findings of assessments performed (which assisted with the formulation of the diagnosis or contributed to the treatment and management plan)

- A risk assessment which means assessment of:
    - the risk to the patient of a contributing co-morbidity and
    - environmental, physical, social and emotional risk factors that may apply to the patient or to another individual.
- Treatment options which include:
    - Recommendations using a biopsychosocial model
    - Identifying major treatment goals and important milestones and objectives
    - Recommendation/s and referral for treatment services provided by eligible allied health practitioners (where relevant) and who should provide this, specifying number of treatments recommended (to a maximum of 20 treatment services)
    - Indications for review or episodes requiring escalation of treatment strategies
- Documenting the Treatment and Management plan and providing a copy to relevant allied health practitioner/s.

Referral for allied health treatment services

Once a treatment and management plan is in place (after item 139 or 92142 has been claimed) the GP can refer the individual to eligible allied health practitioners for the provision of treatment services. Treatment services address the functional impairments identified through the comprehensive medical assessment which are outlined in the treatment and management plan. Treatment services focus on interventions to address developmental delays/disabilities or impairments.

Eligible allied health treatment practitioners include:

- Psychologist (MBS items 82015, 93035, 93043)
- Speech pathologist (MBS items 82020, 93036, 93044)
- Occupational therapist (MBS items 82025, 93036, 93044)
- Audiologist, dietitian, exercise physiologist, optometrist, orthoptist, physiotherapist (MBS items 82035, 93036, 93044)

A total of 20 allied health Treatment services per patient per lifetime are available through the MBS, which may consist of any combination of items 82015, 82020, 82025 or 82035 or equivalent video items. Whilst the GP can refer to multiple eligible allied health practitioners concurrently, a separate referral letter must be provided to each allied health practitioner.

The referral should specify the goals of the treatment and if appropriate, the specify the number of services to be provided. It is the responsibility of the referring psychiatrist to allocate the number of treatment services (up to a maximum of 10 services per course of treatment) in keeping with the individual's treatment and management plan.

It is important to note, that a benefit will not be paid for the MBS allied health Treatment services unless the pre-requisite items (139 or 92142) have been processed through the Medicare claiming system.

On the completion of a "course of treatment" (specified by the referring GP, up to maximum of 10 services), the eligible allied health practitioner must provide a written report to the referring GP, which should include information on the treatment provided, recommendations on future management of the individual's disorder and any advice to caregivers (such as parents, carers, schoolteachers). This written report will inform the referring GPs decision to refer for further treatment services. Where subsequent courses of treatment after the initial 10 services are required (up to a maximum of 20 services per patient per lifetime) a new referral is required.

AN.0.74 General Attendance Items - General Practitioners

GENERAL ATTENDANCE ITEMS – GENERAL PRACTITIONERS

	Level A **Straightforward**	**Level B** **6-20 minutes**	**Level C** **20+ minutes**	**Level D** **40+ minutes**	**Level E** **60+ minutes**
Business hours					

In consulting rooms	3	23	36	44	123
Out of consulting rooms	4	24	37	47	124
Residential care home	90020	90035	90043	90051	90054
After-hours					
In consulting rooms[1]	5000	5020	5040	5060	5071
Out of consulting rooms[2]	5003	5023	5043	5063	5076
Residential care home[2]	5010	5028	5049	5067	5077
Telehealth (Video and Phone)					
Video	91790	91800	91801	91802	91920
Phone	91890	91891	91900[3]	91910[3]	NA

[1]Use on: public holiday; Sunday; before 8am or after 1 pm on Saturday; before 8am or after 8pm on any other day
[2]Use on: public holiday; Sunday; before 8am or after 12 noon on Saturday; before 8am or after 6pm on any other day
[3]Patients enrolled in MyMedicare only

AN.0.75 Initial Consultation for a new patient (item 296 in rooms, item 297 at hospital, item 299 for home visits or video equivalent item 92437)

Referral for items 296, 297 and 299 or item 92437 may be from a participating nurse practitioner, medical practitioner practising in general practice, a specialist or another consultant physician.

It is intended that either item 296, 297, 299 or 92437 will be claimed once on the first occasion that the patient is seen by a consultant psychiatrist.

If the patient is referred by a medical practitioner in general practice or participating nurse practitioner for an assessment or management plan, item 291 or 92435 should be utilised (refer to note AN.0.30). It is not expected that 296, 297, 299 or 92437 items would be routinely used prior to item 291 or 92435.

Use of items 296, 297, 299 or 92437 by one consultant psychiatrist does not preclude them being used by another consultant psychiatrist for the same patient. The use of items 296, 297, 299 or 92437 are identical except for the location of where the service is rendered. That is: item 296 is only available for consultations rendered in consulting rooms, item 297 is only available for consultations rendered at a hospital, and item 299 is only available for consultations rendered at a place other than consulting rooms or a hospital (such as in a patient's home) and item 92437 is available for video consultations delivered by videoconference.

For patients who have already been seen by the consultant psychiatrist in the preceding 24 months the psychiatrist can use time-tiered attendance items 300, 302, 304, 306 and 308 or telehealth equivalent consultation items 91827 to 91831 (video) and 91837 to 91839 (phone).

AN.0.77 Group therapy by psychiatrist (Item 346)

This item refers to family group therapy supervised by consultant psychiatrists. A formal intervention is undertaken with a specific therapeutic outcome, such as security of attachment, improved family interaction and/or communication. A child less than twelve months can count as a patient for the purposes of this item if the child has been separately referred for this service and the above criteria are met.

AN.0.78 Better Access Initiative

Summary

This explanatory note provides an overview of The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative (Better Access), which commenced on 1 November 2006. Under this initiative, Medicare benefits are available to patients for selected mental health treatment services provided by eligible general practitioners (GPs), eligible prescribed medical practitioners (PMPs), psychologists (eligible clinical and eligible registered), eligible social workers and eligible occupational therapists.

Further information on the eligibility requirements of a GP can be found at 2.20.7 (Restrictions on items in Subgroup 2 of Group A20 [focussed psychological strategies]) and a PMP can be found at 2.20.7A (Restrictions on items in Subgroup 9 of Group A7 [focussed psychological strategies]). The *Health Insurance (General Medical Services Table) Regulations 2021* provides further information on the legislative requirements for eligible GPs and PMPs. For further information on the qualification requirements for Allied Health Professionals who are able to provide mental health services under Medicare, refer to Schedule 1 (Qualification requirements for allied health professionals) in the *Health Insurance (Section 3C General Medical Services – Allied Health and other Primary Health Care Services) Determination 2024*.

All Medicare Benefits Schedule (MBS) explanatory notes that are associated with the Better Access initiative are listed below:

Explanatory Note	Relevant item numbers
AN.0.56 - Mental Health Treatment Plans and Consultation	272, 276, 277, 282, 2700, 2701, 2715, 2717, 92112, 92113, 92116, 92117, 92118, 92119, 92122, and 92123.
MN.6.2 - Provision of Psychological Therapy	80000, 80005, 80010, 80015, 80020, 80021, 80022, 80023, 80024, 80025, 91166, 91167, 91181, and 91182.
MN.7.4 - Provision of Focussed Psychological Strategies	283, 285, 286, 287, 2721, 2723, 2725, 2727, 80100, 80105, 80110, 80115, 80120, 80121, 80122, 80123, 80125, 80127, 80128, 80130, 80135, 80140, 80145, 80146, 80147, 80148, 80150, 80152, 80153, 80155, 80160, 80165, 80170, 80171, 80172, 80173, 80174, 80175, 91818, 91819, 91842, 91843, 91820, 91821, 91844, 91845, 91169, 91170, 91183, 91184, 91172, 91173, 91185, 91186, 91175, 91176, 91187 and 91188.

MN.6.3 - Referral requirements for Better Access Treatment Services	272, 276, 281, 282, 283, 285, 286, 287, 2700, 2701, 2715, 2717, 2721, 2723, 2725, 2727, 80000, 80005, 80010, 80015, 80020, 80021, 80022, 80023, 80024, 80025, 80100, 80105, 80110, 80115, 80120, 80121, 80122, 80123, 80125, 80127, 80128, 80130, 80135, 80140, 80145, 80146, 80147, 80148, 80150, 80152, 80153, 80155, 80160, 80165, 80170, 80171, 80172, 80173, 80174, 80175, 91167, 91169, 91170, 91172, 91173, 91175, 91176, 91181, 91182,91183, 91184, 91185, 91186, 91187, 91188, 91818, 91819, 91820, 91821, 91842, 91843, , 91844, 91845, 92112, 92113, 92116, 92117, 92118 and 92119. *Note: for specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109 and items 91822, 91823 and 91833. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 to 308, 310, 312, 314, 316, 318 or 319 through 349; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 133.*
AN.15.1 - Mental Health Case Conferences	930, 933, 935, 937, 943, 945, 946, 948, 959, 961, 962, 964, 969, 971, 972, 973, 975, 986, 80176, 80177 and 80178.
MN.7.5 - Family and Carer Participation	309, 311, 313, 315, 2739, 2741, 2743, 2745, 80002, 80006, 80012, 80016, 80102, 80106, 80112, 80116, 80129, 80131, 80137, 80141, 80154, 80156, 80162, 80166, 91859, 91168, 91171, 91174, 91177, 91194, 91195, 91196, 91197, 91198, 91199, 91200, 91201, 91202, 91203, 91204, 91205, 91861, 91862, 91863, 91864, 91865, 91866, and 91867.

Services provided under Better Access

Through Better Access, eligible patients can claim a Medicare benefit for up to 10 individual and 10 group therapy mental health treatment services per calendar year. These services consist of:

- psychological therapy provided by eligible clinical psychologists (refer to explanatory note MN.6.2 - Provision of Psychological Therapy); and
- focussed psychological strategies provided by eligible GPs, eligible PMPs, eligible psychologists, eligible occupational therapists, and eligible social workers (refer to explanatory note MN.7.4 – Provision of Focussed Psychological Strategies).

A Medicare benefit is also available for a patient to involve another person, such as a family member or carer, in their treatment. Medicare benefits are available to a patient for up to 2 services provided to another person per calendar year. Any services delivered using these MBS items count towards the patient's course of treatment and calendar year allocations under Better Access. For further information on involving another person in a patient's treatment, refer to explanatory note MN.7.5 – Family and Carer Participation.

There are also MBS items for the provision of mental health case conferencing services to establish and coordinate the management of the care needs of a patient. For further information refer to explanatory note AN.15.1– Mental Health Case Conferences.

Patient eligibility for Better Access services

Better Access services apply to people with a clinically diagnosed mental disorder. For the purposes of Better Access services, a mental disorder is defined as a significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder. This definition is informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version. For the purposes of Better Access services, dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders.

When referring for treatment services under the Better Access initiative, services should be utilised for patients who require at least a moderate level of mental health support. Consideration should be given to other treatment interventions and pathways (e.g. digital mental health services, Medicare Mental Health Centres, etc) should the patient's level of support not require psychological intervention under the Better Access initiative.

Referral requirements

Additionally, Better Access MBS treatment items will only attract a Medicare benefit where a patient has been referred for Better Access services by a GP or PMP at the patient's MyMedicare registered practice or by their usual medical practitioner, or by a specialist or consultant physician specialising in the practice of their field of psychiatry or paediatrics. For the purposes of these services, referring practitioner means:

- *usual medical practitioner*, in relation to a patient, means a general practitioner or prescribed medical practitioner:

  (a) who has provided the majority of services to the person in the past 12 months; or
  (b) who is likely to provide the majority of services to the person in the following 12 months; or
  (c) located at a medical practice that:

    (i) has provided the majority of services to the person in the past 12 months; or

    (ii) is likely to provide the majority of services to the person in the next 12 months.

- A GP or PMP at a MyMedicare registered practice means the registration program by that name administered by the department. A MyMedicare service means a service to which an item is provided:

  (a) to a person enrolled in MyMedicare; and
  (b) at the general practice at which the person is enrolled.

- a medical practitioner who has referred the patient as part of a GP Mental Health Treatment Plan (refer to explanatory note AN.0.56 – GP Mental Health Treatment Plans and Consultation) or a Psychiatrist Assessment and Management Plan (refer to explanatory note AN.0.30 - Consultant Psychiatrist – Referred Patient Assessment and Management Plan); or

- a specialist or consultant physician specialising in the practice of their field of psychiatry directly referring for Better Access services; or

- a specialist or consultant physician specialising in the practice of their field of paediatrics directly referring for Better Access services.

- the patient referral requirements, as part of a Mental Health Treatment Plan (refer to explanatory note AN.0.56 – Mental Health Treatment Plans and Consultation Items) or a Psychiatrist Assessment and Management Plan (refer to explanatory note AN.0.30 - Consultant Psychiatrist – Referred Patient Assessment and Management Plan), have been met.

Focussed psychological strategies are available to any patient from any GP or PMP who has the appropriate training recognised by the General Practice Mental Health Standards Collaboration. GPs and PMPs who provide focussed psychological strategies do so as part of an arrangement for the treatment of an assessed mental disorder under a Mental Health Treatment Plan.

For more information on referral requirements for Better Access services, refer to explanatory note MN.6.3 - Referral requirements for Better Access Treatment Services.

If there is any doubt about a patient's eligibility, Services Australia will be able to confirm whether a Mental Health Treatment Plan and/or a Psychiatrist Assessment and Management Plan is in place and claimed; or an eligible psychiatric or paediatric service has been claimed, as well as the number of Better Access services already claimed

by the patient during the calendar year. Additionally, providers can also access the Health Professional Online Services (HPOS) to view a patient's Mental Health Treatment Plan history.

Allied health professionals can call Services Australia on 132 150 to check this information, while unsure patients can seek clarification by calling 132 011 or view their care plan history in their Medicare online account through myGov to help track services that have been claimed.

A patient will not be eligible to receive a Medicare benefit if they have not been appropriately referred or if a relevant Medicare service has not been provided to them. If the referring service has not yet been claimed, Services Australia will not be aware of the patient's eligibility. In this case the treating practitioner or allied health professional should, with the patient's permission, contact the referring practitioner to ensure a relevant referring service has been provided to the patient.

Mental Health Treatment Plan review requirements

After a patient has used the allocated number of services in the initial individual course of treatment (a maximum of 6 services on the initial referral), a review of the patient's Mental Health Treatment Plan and a new referral must be obtained from the referring practitioner for further treatment. The review will assess the patient's progress and consider further treatment options. A review is not to be undertaken more than once in a 3 month period or within 4 weeks following the preparation of a Mental Health Treatment Plan unless exceptional circumstances exist. It is recommended a Mental Health Treatment Plan be reviewed at least once during a course of treatment, with most patients generally not requiring more than 2 reviews in a calendar year.

GPs and PMPs are to use time tiered professional (general attendance) items for the specific purpose of reviewing a Mental Health Treatment Plan. A Mental Health Treatment Plan does not expire. A new Mental Health Treatment Plan should not be created unless exceptional circumstances exist. An exceptional circumstance may be where the patient has had a significant change to their mental health or the treating practitioner or treating allied health professional is unable to obtain a copy of their Mental Health Treatment Plan.

In addition to the 10 individual services, a patient can be referred up to a maximum of 10 group therapy mental health treatment services each calendar year on any one referral. Patients will be required to have a review of their Mental Health Treatment Plan and obtain a new referral from their referring practitioner after they received the number of group therapy mental health treatment services stated on the referral (if less than 10).

The referring practitioner will use their clinical discretion when undertaking a review to determine the number of allied mental health services their patient will be referred for and if the patient requires additional MBS mental health services. Medicare benefits are only available for a maximum of 10 individual and 10 group therapy mental health treatment services each calendar year. Patients can privately fund or use other funding sources they are eligible for to access further services.

Under MyMedicare and usual medical practitioner requirements, GPs and PMPs will be able to access time-tiered professional (general) attendance items to review and provide mental health care to patients recognising the time spent with patients to provide quality care. There will be no limitation on the number of health-related issues that can be addressed as part of a general attendance consultation, as long as the requirements of the service are met, and adequate and contemporaneous records are maintained. Key principles for using time-tiered professional (general) attendance items and any specific requirements is available at AN.0.9 | Using time-tiered professional (general) attendance items.

Out-of-pocket expenses and Medicare safety net

Charges in excess of the Medicare benefit for Better Access MBS items are the responsibility of the patient. However, any out-of-pocket costs will count towards the Medicare safety net for that patient. The out-of-pocket costs for mental health services which are not Medicare eligible do not count towards the Medicare safety net (refer to explanatory note GN.10.27 | Medicare Safety Nets.

Publicly funded services

Better Access MBS items do not apply for services that are provided by any other Commonwealth or state funded services or provided to an admitted patient of a hospital. Unless an exemption under subsection 19(2) of the *Health Insurance Act 1973* applies for a Medicare benefit to be payable, all requirements of the service must be met, including registration with Services Australia.

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare benefit paid for the services. If a patient has exhausted their services for which a Medicare benefit is payable for the calendar year, and if they have appropriate private health insurance which covers psychological services, they may claim from their private health fund. The benefit payable to members of private health funds will vary based on the level of their ancillary cover.

Record keeping and reporting requirements

The Department of Health, Disability and Ageing undertakes regular post payment auditing to ensure MBS items are claimed appropriately. All practitioners providing Better Access services should ensure they keep adequate and contemporaneous records, including documenting the date, time and people who attended. Only clinical details recorded at the time of attendance count towards the time of the consultation. Other notes or reports added at a later time are not included. For information on what constitutes adequate and contemporaneous records, refer to explanatory note GN.15.39 - Practitioners should maintain adequate and contemporaneous records.

Relevant Legislation

Details about the legislative requirements of the Better Access initiative MBS items can be found on the Federal Register of Legislation at www.legislation.gov.au.

Attendance items are set out in 3 regulatory instruments:

- *Health Insurance (Section 3C General Medical Services – Allied Health and other Primary Health Care Services) Determination 2024* - Eligible psychologist (clinical and registered), eligible social worker, and eligible occupational therapist items.
- *Health Insurance (General Medical Services Table) Regulations 2021* – General practitioner, prescribed medical practitioner and psychiatrist items, including items related to Focussed Psychological Strategies for eligible general practitioners and eligible prescribed medical practitioners.
- *Health Insurance (Section 3C General Medical Services – Telehealth Attendances) Determination 2021 - telehealth (video and phone) items* – General practitioner, prescribed medical practitioner, eligible psychologists (clinical and registered), eligible social worker, and eligible occupational therapist items. In addition, items related to focussed psychological strategies for eligible general practitioners and eligible prescribed medical practitioners are included in this instrument.

Further information

For further information about Medicare Benefits Schedule items, please visit the MBS Online website at www.health.gov.au/mbsonline.

For providers, further information is also available from the Services Australia provider enquiry line on 132 150.

If you are a patient seeking advice about Medicare services, patient benefits, or your Medicare claims, please contact Services Australia on the Medicare General enquiry line on 132 011.

AN.0.79 Patient end support (PES) items for GPs, Prescribed Medical Practitioners (PMP) and Nurse practitioners (NP)

These notes provide information on the MBS attendance items for health professionals to provide clinical support to their patients during video consultations with a Specialist or Consultant Physician.

The following PES services are available:

Providers	Group	Subgroup	Items
General Practitioner (GP)	Group A48—General practitioner attendances—telehealth related	Subgroup 1—General practitioner patient end support for video conferencing consultations with specialists or consultant physicians	2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495
Prescribed Medical Practitioner (PMP)	Group A7—Acupuncture and non-specialist practitioner items	Subgroup 13—Prescribed medical practitioner patient end support for video conferencing consultations with specialists or consultant physicians	373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 390, 391
Nurse Practitioner (NP)	Group M14 – Nurse practitioners	Subgroup 5—Participating nurse practitioner patient end support for video conferencing consultations with specialists or consultant physicians	82250, 82251, 82252, 82253, 82254, 82255, 82256, 82257

A PES service is a professional face to face attendance that supports a multi-disciplinary approach. They are designed for a patient's primary care provider to support them to attend and participate in a video conference consultation with a Specialist or Consultant Physician.

PES services are available nationally and can be conducted in consulting rooms, out of consulting rooms, and in residential care homes. The items are specific to these locations and providers are expected to use the appropriate items for the type of service that is being applied.

These services can only be conducted where the Specialist or Consultant Physician is working in private practice and has also billed the service to the MBS.

Clinical indications

The Specialist or Consultant Physician must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the Specialist or Consultant Physician.

Video specialist services can still be provided to patients when there is no PES service provided.

Restrictions

The MBS video attendance items are not payable for services to an admitted hospital patient (this includes 'Hospital in the Home' patients).

Benefits for PES are payable only for real-time video consultations, and not payable for telephone consultations or contributions to reports.

To fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a visual and audio link with the patient, an MBS benefit for the PES attendance is not payable.

Record Keeping

Participating practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed face-to-face simultaneously with a video conference from a Specialist or Consultant Physician, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Multiple attendances on the same day

In some situations, a patient may receive a video consultation and a face-to-face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one consultation on a patient on the same day by the same practitioner, provided the second (and any following) consultations are not a continuation of the initial or earlier consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Aftercare Rule

The video consultation portion of this service is subject to the same aftercare rules as face-to-face consultations.

Referrals

PES is available for a referred private Specialist or Consultant Physician video consultation. The referral procedure for the video consultation with the Specialist or Physician Consultant is the same as for conventional face-to-face consultations.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a video conference meets the applicable laws for security and privacy.

Duration of attendance

The practitioner attending at the patient end of the video consultation must be present for the entire consultation.

The MBS fee payable for the supporting practitioner will be determined by the total time spent assisting the patient. This time is not restricted to the time the Specialist or Consultant Physician spends on the call, but how long the patient end provider continues the consultation with the patient to complete what was discussed.

AN.1.1 Eligibility criteria for MBS telehealth (video and phone)

It is a legislative requirement that medical practitioners billing non referred services (using items from Group A40 Subgroup 1, 2, 11, 15, 16, 17 and 19) must only perform a telehealth service if:

- the patient is registered in MyMedicare and the telehealth service is from the patient’s registered practice; or
- the provider qualifies as the patient’s eligible telehealth practitioner, or an exemption applies.

The MyMedicare telehealth criteria is defined as:

- the patient is registered with MyMedicare and is receiving the telehealth service from the MyMedicare practice they are registered with.

An eligible telehealth practitioner is defined as:

- the medical practitioner who performs the service has provided a face-to-face service to the patient in the last 12 months; or
- the medical practitioner who performs the service is located at a medical or nurse practitioner practice, and the patient has a face-to-face service arranged by that practice in the last 12 months. The service must be billed to the MBS and can be performed by another medical or nurse practitioner located at the practice, or

a service performed on behalf of a medical practitioner by another health professional located at the practice (such as a practice nurse or Aboriginal and Torres Strait Islander health practitioner or Aboriginal and Torres Strait Islander health worker); or
- the medical practitioner who performs the service is a participant in the Approved Medical Deputising Service (AMDS) program, and the Approved Medical Deputising Service provider (AMDS provider) that employs the medical practitioner has a formal agreement with a medical practice that has provided at least one face-to-face service to the patient in the last 12 months.

A patient's participation in a previous video or phone consultation does not constitute a face-to-face service for the purposes of ongoing telehealth eligibility. If an exemption is applicable providers are required to document and specify the exemption in patient clinical notes at the time of service for post audit compliance.

The eligible telehealth practitioner requirement does not apply to:

- a person who is under the age of 12 months,
- a person who is experiencing homelessness,
- a person living in a natural disaster affected area,
- a person who receives the service from a medical practitioner located at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service, or
- a person isolating because of a COVID-related State or Territory public health order, or in COVID-19 quarantine because of a State or Territory public health order.

Or for the following specific Medicare Benefits Schedule services:

- An urgent after-hours service (in unsociable hours),
- Specific Mental health treatment items,
- Blood Borne Virus, Sexual or Reproductive Health telehealth items, and
- Preparing or reviewing a GP chronic condition management plan

A person who is experiencing homelessness means when a person does not have suitable accommodation alternatives, they are considered homeless if their current living arrangement:

(a) is in a dwelling that is inadequate; or

(b) has no tenure, or if their initial tenure is short and not extendable; or

(c) does not allow them to have control of, and access to space for social relations.

A person receiving mental health treatment services under the Better Access initiative through telehealth items means services must be claimed as specific eligible GP or eligible prescribed medical practitioner focussed psychological strategies items. Focussed psychological strategies services are available to any patient from any eligible GP and eligible prescribed medical practitioner as long as the patient has a Mental Health Treatment Plan, and the eligible GP and eligible prescribed medical practitioner has the appropriate training recognised by the General Practice Mental Health Standards Collaboration.

A person receiving eating disorder psychological treatment services under the Eating Disorder Treatment and Management Plan (EDTMP) through telehealth items means services must be claimed as specific eligible GP or eligible prescribed medical practitioner eating disorder psychological treatment items. Eligible allied health professionals are also able to provide telehealth psychological eating disorder treatment services under the EDTMP (see also MN.16.3).

A person receiving treatment through Blood Borne Virus, Sexual or Reproductive Health telehealth items means services must be claimed as specific GP or prescribed medical practitioner telehealth items (see also AN.40.5).

The patient eligibility criteria (including MyMedicare and usual medical practitioner requirements) for a GP chronic condition management plan to be prepared or reviewed using items 92029, 92030, 92033, 92034, 92060, 92061, 92063 or 92064 align with face-to-face items 392, 393, 965 and 967. See AN.0.47 for further information.

A person living in a natural disaster affected area is defined as a State or Territory local government area which is currently declared as a natural disaster area by a State or Territory Government until that declaration is deemed to have expired.

Providers must document in patient clinical notes any relevant exemption and the clinical reasoning.

AN.2.1 Limitation of items - certain attendances by diagnostic imaging providers

Consultations rendered by specialist radiologists

Medicare benefits are not payable for items 52, 53, 54, 57, 151, 104 and 105 when claimed by a specialist radiologist in association with any of the following diagnostic imaging items:

(a) an item in Subgroup 6 of Group I1;
(b) an item in any of Subgroups 1 to 7 of Group I3;
(c) items 58900 and 58903 in Subgroup 8 of Group I3; and
(d) item 59103 in Subgroup 9 of Group I3.

Consultations rendered in association with magnetic resonance imaging (MRI) services - Group I5

Medicare benefits are not payable for items 52, 53, 54, 57, 151, 104 and 105 in association with MRI services unless the providing practitioner determines that the consultation is necessary for the treatment or management of the patient's condition.

The restrictions above apply when these services are performed by the same practitioner, on the same patient, on the same day.

AN.3.1 Subsequent attendance items

The current regulations prohibit the payment of Medicare benefits for subsequent attendance items 105, 116, 119, 386, 2806, 2814, 3010, 3014, 6009 to 6015, 6019, 6052, 16404, 91823, 91825, 91826, 91833, 91836, 92440, 92445, 92446, 92447, 92611, 92612, 92613, 92614 and 92618 if a claim is made for any Group T8 item (30001-50952) with a schedule fee of equal to or greater than $359.05 on the same day. Non-compliance with the regulations can result in a referral to an appropriate regulatory body – such as the Professional Services Review. Subsequent attendance items (111, 117, and 120) can only be claimed on the same day as Group T8 items with schedule fees of equal to or greater than $359.05, if the procedure is urgent and not able to be predicted prior to the commencement of the attendance. It is therefore expected that these items would be claimed only in exceptional circumstances.

Subsequent attendance item 115 can only be claimed, if the nature of the attendance was not able to be predicted prior to the procedure.

Item 115 should not be claimed if the consultation relates to the booked Group T8 procedure. Any consultation component related to the booked Group T8 procedure is considered to be covered under the fee for that procedure, if the Schedule fee is $359.05 or more.

Should a component of the consultation be unrelated to the booked T8 procedure and it is considered by the medical practitioner that it would be a clinical risk to defer this consultation then item 115 could be claimable.

It would not be appropriate to claim item 115 if a patient attends for the booked operation, and prior to surgery an examination is conducted relevant to performing that procedure; together with a discussion of the outcomes and

aftercare. If the consultation extends beyond this; including the development of a management plan involving a broader diagnosis, prognosis, associated treatments and follow-up; then it could be appropriate to claim item 115.

In claiming item 115, the specialist or consultant physician must be satisfied that it would be a clinical risk to defer the consultation for the patient at this time.

Where item 115 is claimed, the records for the consultation should clearly identify why the consultation is considered necessary for the patient including the clinical risk to defer the consultation.

AN.3.2 Use of long gynaecology consultation items
Items 125, 126, 127 and 129

These items are for longer consultations relating to complex gynaecological condition/s where these longer consultations are required for the appropriate assessment and management of the patient. This may include but is not limited to presentations such as chronic pelvic pain, endometriosis, polycystic ovarian syndrome or adenomyosis.

- A referral is required to use any of these attendance items.
- A separate referral is required to initiate a separate course of treatment (e.g. obstetric attendance item 16401 for obstetric management).
- A single course of treatment is defined in GN.6.16.
- If a longer initial consultation item (125 or 127) was claimed, a patient may require a 45 minute or longer subsequent attendance (item 126 or 129) or a standard subsequent attendance (item 105).
- Subsequent longer attendance items 126 or 129 can only be claimed if initial longer attendance items 125 or 127 have previously been claimed for the patient for the same course of treatment.
    - These items should only be provided by specialists who have received a referral for the review and treatment of the patient's complex gynaecological condition.
    - Generally it is not expected that specialists providing assisted reproductive technology would bill these items unless they were also treating a patient's complex gynaecological condition.

Claiming restrictions

- No other attendance items can be claimed for the same patient on the same day for the same single course of treatment.
- Routine obstetric care cannot be claimed under items 125, 126, 127 or 129.
- A pregnant patient may be referred for treatment of gynaecological issues and item 125 may be claimed.
    - Any obstetric or maternity care that the same patient requires treatment for require a separate referral and represent a separate course of treatment.

Attendance requirements and recording of clinical notes

- Only time spent with the patient should count towards the duration of the consultation. Appropriate details of services provided should be recorded. Time taken to review information before and after the consultation, such as reports or investigations, do not count toward the duration of the consultation if the patient is not present.
- The practitioner must keep adequate and contemporaneous notes to support the service provided and justification for the mode of care used.
- Clinicians should record the date, time and duration of the consultation and retain these records for a minimum of 2 years.

Patient Examinations

- As outlined in the item descriptor, comprehensive examination is only required when clinically relevant.
- An appropriate examination may be physical (when claiming face to face items 125 or 126) or may be conducted via video or with or without assistance from another health professional when clinically appropriate (when claiming video items 127 or 129).

AN.7.1 Prescribed Medical Practitioners

A prescribed medical practitioner is a medical practitioner:

(a) who is not a general practitioner (see GN.4.13), specialist or consultant physician, and

(b) who:

a. is registered under section 3GA of the Act and is practising during the period, and in the location in respect of which the medical practitioner is registered, and insofar as the circumstances specified for paragraph 19AA(3)(b) of the Act apply; or

b. is covered by an exemption under subsection 19AB(3) of the Act; or

c. first became a medical practitioner before 1 November 1996.

AN.7.2 GENERAL ATTENDANCE ITEMS – MEDICAL PRACTITIONERS AND PRESCRIBED MEDICAL PRACTITIONERS

GENERAL ATTENDANCE ITEMS – MEDICAL PRACTITIONERS[1] (MPs) AND PRESCRIBED MEDICAL PRACTITIONERS[2] (PMPs)

	Level A Straightforward	**Level B 5-25 minutes**	**Level C 25+ minutes**	**Level D 45+ minutes**	**Level E 60+ minutes**
Business hours					
In consulting rooms (MP)[1]	52	53	54	57	151
In consulting rooms (PMP)[2] MM2-7[3]	179	185	189	203	301
Out of consulting rooms (MP)	58	59	60	65	165
Out of consulting rooms (PMP) MM2-7	181	187	191	206	303
Residential care home (MP)	90092	90093	90095	90096	90098
Residential care home (PMP) MM2-7	90183	90188	90202	90212	90215
After-hours					
In consulting rooms (MP)	5200	5203	5207	5208	5209
In consulting rooms (PMP)	733	737	741	745	2197
Out of consulting rooms (MP)	5220	5223	5227	5228	5261
Out of consulting rooms (PMP)	761	763	766	769	2198
Residential care home (MP)	5260	5263	5265	5267	5262

Residential care home (PMP)	772	776	788	789	2200
Telehealth (Video and Phone)					
Video (MP)	91792	91803	91804	91805	91923
Video (PMP) MM 2-7	91794	91806	91807	91808	91926
Phone (MP)	91892	91893	91903[4]	91913[4]	NA
Phone (PMP) MM2-7			91906[4]	91916[4]	

[1]MP items can be claimed by all MPs who are not general practitioners.

[2]PMP items can be claimed by medical practitioners that are not general practitioners, specialists or consultant physicians.

[3]MM means "Modified Monash". The Modified Monash Model is how the department defines whether a location is metropolitan, rural, remote or very remote. The model measures remoteness and population size on a scale of Modified Monash (MM) categories MM 1 to MM 7. MM 1 is a major city and MM 7 is very remote.

[4]Available to patients enrolled in MyMedicare only.

AN.7.3 Prescribed Medical Practitioner Prolonged Attendance in Treatment of a Critical Condition (Items 214 to 220)

The conditions to be met before services covered by items 214-220 attract benefits are:-

(i) the patient must be in imminent danger of death;

(ii) if the personal attendance is not continuous, the occasion on which the service is provided is taken to be the total time of the attendance; and

(iii) if personal attendance on a single patient is provided by 1 or more prescribed medical practitioners (see note AN.7.1) concurrently, each practitioner may claim an attendance fee.

Note: Medicare benefits are not payable for the issue of a death certificate, although an attendance on a patient at which it is determined that life is extinct can be claimed under the appropriate attendance item. The outcome of the attendance may be that a death certificate is issued, however, Medicare benefits are only payable for the attendance component of the service.

AN.7.4 Prescribed Medical Practitioner Family Group Therapy (Items 221, 222 and 223)

These items refer to family group therapy supervised by prescribed medical practitioners (see note AN.7.1). To be used, these items require that a formal intervention with a specific therapeutic outcome, such as improved family function and/or communication, is undertaken. Other types of group attendances do not attract benefits. It should be noted that only one fee applies in respect of each group of patients.

Telephone consultations, letters of advice by prescribed medical practitioners, the issue of repeat prescriptions when the patient is not in attendance, post mortem examinations, the issue of death certificates, cremation certificates, counselling of relatives (note - items 348, 350 and 352 are not counselling services), group attendances (other than group attendances covered by items 170, 171, 172, 221, 222, 223, 342, 344 and 346) such as group counselling, health education, weight reduction or fitness classes do not qualify for benefit.

Although Medicare benefits are not payable for the issue of a death certificate, an attendance on a patient at which it is determined that life is extinct can be claimed under the appropriate attendance item. The outcome of the attendance may be that a death certificate is issued, however, Medicare benefits are only payable for the attendance component of the service.

AN.7.18 Residential Medication Management Reviews (MBS items 249 and 903)

SUMMARY

Medication management reviews are collaborative services through which a GP (see GN.4.13) or prescribed medical practitioner (see AN.7.1) works with a pharmacist to review the patient's medications. The service is intended to support the quality use of medicines and identify patients who may be at risk of medication misadventure.

Residential medication management reviews (RMMRs) are available to care recipients in a residential care home.

Patients living in the community may be eligible for a domiciliary medication management review (see AN.0.52).

While the GP's or prescribed medical practitioner's work in the RMMR is supported through the MBS, the pharmacist's participation is funded through other programs.

USE OF THE ITEMS

The *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations) state that a RMMR is *"a collaborative service provided by a general practitioner (for item 903), or a prescribed medical practitioner (for item 249), and a pharmacist to review the medication management needs of a care recipient in a residential care home"*. A residential care home is defined with reference to the *Aged Care Act 2024* (see GN.14.38).

The Regulations state:

1. *"a medical practitioner's involvement in a RMMR includes all of the following:*

- *discussing the proposed review with the resident and seeking the resident's consent to the review;*
- *collaborating with the reviewing pharmacist about the pharmacist's involvement in the review;*
- *providing input from the resident's most recent comprehensive medical assessment or, if such an assessment has not been undertaken, providing relevant clinical information for the review and for the resident's records;*
- *[(subject to point 2 below)] participating in a post-review discussion if required (either face-to-face or by telephone) with the pharmacist to discuss the outcomes of the review including:*
    - *the findings of the review; and*
    - *medication management strategies; and*
    - *means to ensure that the strategies are implemented and reviewed, including any issues for implementation and follow-up; and*
- *developing or revising the resident's medication management plan after discussion with the reviewing pharmacist, and finalising the plan after discussion with the resident;*
- *offering a copy of the medication management plan to the resident (or the resident's carer or representative if appropriate);*
- *providing copies of the plan for the resident's records and for the nursing staff of the residential care home; and*
- *discussing the plan with nursing staff if necessary.*

2. A post-review discussion is not required if:

- *there are no recommended changes to the resident's medication management arising out of the review; or*
- *any changes are minor in nature and do not require immediate discussion; or*
- *the pharmacist and medical practitioner agree that issues arising out of the review should be considered in a case conference."*

Do I need to see the patient as part of the RMMR?

Yes. The Regulations state that RMMRs are a "*service provided in the course of personal attendance by a single* [general practitioner/prescribed medical practitioner] *on a single patient*". This means that the medical practitioner

must see the patient as part of the RMMR service. However, it is acknowledged that third parties, such a nurses or carers of people with communication difficulties, may need to communicate with the health professional at times during the consultation.

How often can an RMMR be provided to a patient?

Patients can have an RMMR (either item 249 or item 903) every 12 months if it is clinically appropriate. Exceptional circumstances apply if there is a significant change in the patient's medical condition or medication management plan requiring a new RMMR in which case a service can be provided sooner than 12 months.

Services Australia needs to be advised that exceptional circumstances apply to pay a benefit sooner than is generally allowable. To facilitate this the patient's invoice, Medicare voucher or the digital claim should indicate that exceptional circumstances are in play, no further explanation is required to support payment. However, the GP or prescribed medical practitioner should document the reasons for the exceptional circumstances in their records.

RMMRs can be provided following admission of a new resident of a residential care home if appropriate. There is no time restriction applicable between their first RMMR and any previous domiciliary medication management reviews (items 245 and 900).

This is a complex service. When can I bill the MBS?

An MBS claim can only be submitted once all the requirements of the RMMR have been completed (i.e. at the end of the RMMR).

Can I claim another service for the same patient on the same day as the RMMR?

In general, yes. However, there are some limitations including:

- both services must be clinically relevant and distinct services
- the other item must not have restrictions on same day claiming with an RMMR.

My patient had a domiciliary medication management review 6 months ago. Their condition has deteriorated significantly and they are now in a residential care home. How soon can they have a RMMR?

If it is clinically appropriate, the patient can have a RMMR once they are admitted to a residential care home. There is no time restriction between the provision of a domiciliary medication management review and a RMMR. It is recommended that the GP or prescribed medical practitioner document the reasons why the RMMR was clinically appropriate.

There is a pharmacist engaged through the Aged Care On-Site Pharmacist (ACOP) Measure at the residential care home. Is the patient still eligible for a RMMR?

Yes. Participation in the ACOP affects the source of payment for the pharmacist's time, not the patient's eligibility for a RMMR service. A key role of an ACOP is to review residents' medications regularly and resolve any issues identified promptly. This is expected to reduce (but may not eliminate) the need for RMMRs.

ELIGIBLE PATIENTS

Care recipients in a residential care home.

ELIGIBLE PRACTITIONERS

Item 903 can be claimed by General Practitioners (see GN.4.13).

Item 249 can be claimed by Prescribed Medical Practitioners (see AN.7.1).

RECORD KEEPING AND REPORTING REQUIREMENTS

The department undertakes regular post payment auditing to ensure that MBS items are claimed appropriately. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document is created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item can be found on the Federal Register of Legislation at www.legislation.gov.au. Items 249 and 903 are set out in *Health Insurance (General Medical Services Table) Regulations 2021*.

AN.7.24 Prescribed Medical Practitioner After-Hours Attendances To Which No Other Item Applies (Items 733 to 789 and 2917 to 2200)

After-hours attendance items may be claimed as follows:

Items **733, 737, 741, 745 and 2197** apply only to a professional attendance on 1 patient on 1 occasion that is provided:

- on a public holiday;
- on a Sunday;
- before 8am, or after 1 pm on a Saturday;
- before 8am, or after 8pm on any day other than a Saturday, Sunday or public holiday.

Items **761, 763, 766, 769, 772, 776, 788, 789, 2198 and 2200** apply to a professional attendance on 1 or more patients on 1 occasion that is provided:

- on a public holiday;
- on a Sunday;
- before 8am, or after 12 noon on a Saturday;
- before 8am, or after 6pm on any day other than a Saturday, Sunday or public holiday.

AN.8.1 Inpatient Video Psychiatry Items

6 items are available on the Medicare Benefits Schedule (MBS) for inpatient video psychiatry. The items are:

- Item 92483 - available for new patient video consultations in hospital of more than 45 minutes.
- Item 92478 - available for a subsequent video consultation in hospital of not more than 15 minutes.
- Item 92479 - available for a subsequent video consultation in hospital of at least 15 minutes and not more than 30 minutes.
- Item 92480 - available for a subsequent video consultation in hospital of at least 30 minutes and not more than 45 minutes.
- Item 92481 - available for a subsequent video consultation in hospital of at least 45 minutes and not more than 75 minutes.
- Item 92482 - available for a subsequent video consultation in hospital of more than 75 minutes.

The intention of this suite of items is to provide for one video consultation on admission with a maximum of two video consultations supported per week if subsequent attendances are required. Additional consultations are to be provided in person using in-hospital face-to-face subsequent consultation items. Psychiatrists are able to use items 92478 to 92482 for initial video consultations (which may be admission consultations) for patients who are not new to the psychiatrist.

MBS video items provide Medicare benefits for services provided by video conferencing. Video MBS items cannot be used for phone or email consultations.

Considerations for appropriate care

In claiming the items, the practitioner must ensure that the video appointment is safe, clinically appropriate and suitable for the patient. Psychiatric practice using this suite of items should be guided by the RANZCP Professional Practice Guideline 19 Telehealth in Psychiatry, the AHPRA guidance in relation to telehealth consultations with patients and the National Safety and Quality Digital Mental Health Standards.

Particularly, psychiatrists should consider:

- the suitability of using video in the inpatient setting for a consultation in partnership with hospital staff, the referrer, patient and, where appropriate, their carer(s) or guardians. Further, the psychiatrist using the items must provide continuity of care and keep other practitioners informed of the treatment they are providing when sharing the care of the patient;
- that any practitioner using video services is expected to continuously assess the appropriateness and safety of using video for the consultation and make arrangements for the patient to be seen in-person, if necessary;
- that the use of digital services in the mental health setting must be safe. To ensure this, there must be a model of care that includes clear roles and responsibilities and determines how the private psychiatrist works with the staff on the unit to provide safe care for the person. There is also a need to have clear mechanisms for assessing and responding to risk, and communicating for safety;
- that it is expected that the psychiatrist would consult with the patient face to face within 48 hours of a video admission. 48 hours is considered a maximum and the clinician should consult with the patient face to face sooner, if necessary; and
- that the items are expected to be used for emergency and acute admissions and are not intended for elective admissions.

Compliance Requirements

The inpatient video psychiatry items will be subject to MBS compliance processes and activities, including audits, which may require a provider to submit evidence about the services claimed.

Further Information

Further information about the MBS items and provision of inpatient video psychiatry services is available on MBS Online under ‘Fact Sheets’. The information on the website may be updated from time to time in response to questions or feedback from providers, patients and other stakeholders.

AN.10.1 Optometry - Schedule Fees and Medicare Benefits

Medicare benefits are based on fees determined for each optometrical service. The services provided by optometrists which attract benefits are set out in the *Health Insurance (General Medical Services Table) Regulations* (as amended).
If the fee is greater than the Medicare benefit, optometrists are to inform the patient of the Medicare benefit payable for the item, at the time of the consultation and that the additional fee will not attract benefits.
Medicare benefits are payable at 85% of the Schedule fee for services rendered.

Medicare Safety Nets

The Medicare safety net provides families and singles with an additional benefit for out-of-hospital Medicare services, once annual thresholds are reached. There are two safety nets: the original Medicare safety net and the extended Medicare safety net (EMSN).

Under the original Medicare safety net, the Medicare benefit for out-of-hospital services is increased to 100% of the Schedule Fee (up from 85%) once an annual threshold in gap costs is reached. Gap costs refer to the difference between the Medicare benefit (85%) and the Schedule Fee.

Under the EMSN, once an annual threshold in out-of-pocket costs for out-of-hospital Medicare services is reached, Medicare will pay for 80% of any future out-of-pocket costs for out-of-hospital Medicare services for the remainder

of the calendar year. However, where the item has an EMSN benefit cap, there is a maximum limit on the EMSN benefit that will be paid for that item. Further explanation about EMSN benefit caps is provided at www.mbsonline.gov.au.

The thresholds for the Medicare safety nets are indexed on 1 January each year.

Individuals are automatically registered with Services Australia for the safety nets, however couples and families are required to register in order to be recognised as a family for the purposes of the safety nets. In most cases, registered families have their expenses combined to reach the safety net thresholds. This may help to qualify for safety net benefits more quickly. Registration forms can be obtained from the Services Australia offices, or completed at www.servicesaustralia.gov.au If you have already registered it is important to ensure your details are up to date.

Further information on the Medicare safety nets is available at https://www.servicesaustralia.gov.au/medicare-safety-nets

Limiting rule for patient claims

Where a fee charged for a service is less than the Medicare benefit, the benefit will be reduced to the amount of the fee actually charged. In no case will the benefit payable exceed the fee charged.

Multiple attendances

Payment of benefit may be made for several attendances on a patient on the same day by the same optometrist provided that the subsequent attendances are not a continuation of the initial or earlier attendances. However, there should be a reasonable lapse of time between the services before they can be regarded as separate attendances.

Where two or more attendances are made on the one day by the same optometrist the time of each attendance should be stated on the account (e.g. 10.30 am and 3.15 pm) in order to assist in the payment of benefits. Times do not need to be specified where a perimetry item is performed in association with a consultation item.

In some circumstances a subsequent consultation on the same day may be judged to be a continuation of an earlier attendance and a second benefit is not payable. For example, a preliminary eye examination may be concluded with the instillation of mydriatic or cycloplegic drops and sometime later additional examination procedures are undertaken. These sessions are regarded as being one attendance for benefit purposes.

Release of prescription

Where a spectacle or contact lens prescription is prepared for the patient, it becomes the property of the patient, and should be available to the patient at the completion of the prescription and fitting process, who is free to have the spectacles or contact lenses dispensed by any person of the patient's choice. The optometrist will ensure that the patient is made aware that they are entitled to a copy of the spectacle or contact lens prescription at the completion of the prescription and fitting process.

Reminder notices

The optometrist will ensure that any notice sent to a patient suggesting re-examination is sent solely on the basis of the clinical needs of the patient.

Aftercare period following surgery

Medicare schedule items that apply to surgery include all professional attendances necessary for the post-operative treatment of the patient, other than attendances provided by vocationally or non-vocationally trained general practitioners. The aftercare period includes all post-operative treatment, when provided by a medical specialist, consultant physician or optometrist. The amount and duration of the aftercare may vary but includes all attendances until recovery from the operation. Attendances unrelated to the operation provided by a vocationally or non-vocationally registered general practitioner in the aftercare period can also attract Medicare benefits. Attendances provided by an optometrist in the aftercare period do not attract a Medicare benefit.

The benefit for cataract surgery includes payment for aftercare attendances so payment for aftercare services provided by an optometrist on behalf of a surgeon should be arranged with the surgeon. The optometrist should not charge the patient. In the case of cataract surgery, the first visit following surgery for which the optometrist can charge a fee which can attract a benefit is generally the attendance at which a prescription for spectacles or contact lenses is written.

Medicare benefits are not available for refractive surgery, consultations in preparation for the surgery or consultations in the aftercare period. Charges for attendances by optometrists may be made directly to the patient or to the surgeon depending on the arrangements made prior to surgery. Accounts and the receipt issued to the patient should clearly indicate the fee cannot attract a benefit.

Single Course of Attention

A reference to a single course of attention means:

a) the case of items 10905 to 10918 - a course of attention by one or more optometrists in relation to a specific episode of optometric care.

b) relation to items 10921 to 10930 - a course of attention, including all associated attendances, by one or more optometrists for the purpose of prescribing and fitting of contact lenses. This includes those after-care visits necessary to ensure the satisfactory performance of the lenses.

Referred comprehensive initial consultations (item 10905) - Read in conjunction with Associated Note AN.0.8 Benefits for Optometrists

For the purposes of item 10905, the referring optometrist, having considered the patient's need for the referred consultation, is required to provide a written or electronic referral, dated and signed, and setting out the patient's condition and the reason for the referral.

Benefits will be paid at the level of item 10905 providing the referral is received before the provision of the service, and providing the account, receipt or bulk-billing form contains the name and provider number of the referring optometrist. Referrals from medical practitioners do not attract benefits under item 10905.

The optometrist claiming the item 10905 service is obliged to retain the written referral for a period of twenty-four months.
Referrals must be at "arms length". That is to say, no commercial arrangements or connections should exist between the optometrists.

Second comprehensive initial consultation, within 36 months for a patient who is less than 65 years of age and once every 12 months for a patient who is at least 65 years of age, of a previous comprehensive consultation (item 10907)

A patient can receive a comprehensive initial consultation by another optometrist within 36 months if the patient is less than 65 years of age, and once every 12 months if the patient is at least 65 years of age, if the patient has attended another optometrist for an attendance to which item 10905, 10907, 10910, 10911, 10913, 10914 or 10915 applies.

Comprehensive initial consultations (items 10910 and 10911)

Item 10910 may be claimed for a professional attendance of more than 15 minutes for a patient who is less than 65 years of age. This item is payable once only within a 36 month period, and if the patient has not received a service in this timeframe to which item 10905, 10907, 10910, 10913, 10914 or 10915 applies.

Item 10911 may be claimed for a professional attendance of more than 15 minutes for a patient who is at least 65 years of age. This item is payable once only within a 12 month period, and if the patient has not received a service in this timeframe to which item 10905, 10907, 10910, 10911, 10913, 10914 or 10915 applies.

However, a benefit is payable under item, 10913, 10914 or 10915 where the patient has an ocular condition which

necessitates a further course of attention being started within 36 months for a patient who is less than 65 years of age (item 10910) and within 12 months for a patient who is at least 65 years of age (item 10911) of the previous initial consultation. The conditions which qualify for a further course of attention are contained in the descriptions of these items.

Where an attendance would have been covered by item 10905, 10907, 10910, 10911, 10913, 10914, or 10915 but is of 15 minutes duration or less, item 10916 (brief initial consultation) applies.

Significant change in visual function, new signs or symptoms requiring comprehensive re-evaluation (item 10913)

Significant changes in visual function which justify the charging of item 10913 could include documented changes of:

- · vision or visual acuity of 2 lines (0.2 logMAR) or more (corrected or uncorrected)
- · visual fields or previously undetected field loss
- · binocular vision
- · contrast sensitivity or previously undetected contrast sensitivity loss.

When charging item 10913 the optometrist should document the new signs or symptoms in the patient's record.

Progressive disorder requiring comprehensive re-evaluation (item 10914)

When charging item 10914, the optometrist should document the nature of the progressive disorder suffered by the patient on the patient's record card. Progressive disorders may include conditions such as maculopathy (including age related maculopathy) cataract, corneal dystrophies, glaucoma etc.

Examination of the eyes of a patient with diabetes mellitus (item 10915)

Where an examination of the eyes, with the instillation of a mydriatic, of a patient with diabetes mellitus is being conducted, where possible this item should be billed rather than item 10914 to assist in identifying whether such patients are receiving appropriate eye care.

Second or subsequent consultations (item 10918)

Each consultation, apart from the initial consultation, in a single course of attention, other than a course of attention involving the fitting and prescription of contact lenses, is covered by item 10918.

Contact lens consultations (items 10921 to 10930)

In the case of contact lens consultations, benefit is payable only where the patient is one of the prescribed classes of patient entitled to benefit for contact lens consultations as described in items 10921 to 10929.

For claims under items 10921 and 10930, eligibility is based on the patient's distance spectacle prescription, determining the spherical equivalent by adding to the spherical prescription, half the cylindrical correction.

Medicare benefits are not payable for item 10929 in circumstances where a patient wants contact lenses for:

a) reasons of appearance (because they do not want to wear spectacles);
b) sporting purposes;
c) work purposes; or
d) psychological reasons (because they cannot cope with spectacles).

All attendances subsequent to the initial consultation in a course of attention involving the prescription and fitting of contact lenses are collectively regarded as a single service under items 10921 to 10930, as appropriate. The service includes those aftercare visits necessary to ensure the satisfactory performance of the lenses. This interpretation is unaltered by the frequency of aftercare visits associated with various lens types including extended wear lenses.

Consultations during the aftercare period that are unrelated to the prescription and fitting of contact lenses or that are

not part of normal aftercare may be billed under other appropriate items (not items 10921 to 10930).

For patients not eligible for Medicare benefits for contact lens care, fees charged for contact lens consultations are a matter between the practitioner and the patient. Any account for consultations involving the fitting and prescription of contact lenses issued to a patient who does not fall into the specified categories should be prepared in such a way that it cannot be used to obtain benefits. No Medicare item should be attached to any service that does not attract benefits and the optometrist should annotate the account with wording such as "Medicare benefits not payable".

Where an optometrist wishes to apportion the total fee to show the appropriate optometric consultation benefit and the balance of the fee, he or she should ensure that the balance is described in such a way (e.g. balance of account) that it cannot be mistaken as being a separate consultation. In particular no Medicare item number should be shown against the balance.

When a patient receives a course of attention involving the prescription and fitting of contact lenses an account should not be issued (or an assignment agreement completed) until the date on which the fitting of the lens is finalised.
Benefit under items 10921 to 10929 is payable once only in any period of 36 consecutive months except where circumstances are met under item 10930 within a 36-month period.

Domiciliary visits (10931)

Where patients are unable to travel to an optometrist's practice for treatment, and where the request for treatment is initiated by the patient, a domiciliary visit may be conducted, which involves the optometrist travelling to the patient's place of residence and transporting the necessary equipment. Where possible, it is preferable that the patient travel to the practice so that the full range of equipment is available for the examination of the patient.

Benefits are payable under item 10931 to provide some financial assistance in the form of a flag fall to the optometrist, in recompense for travel costs and packing and unpacking of equipment. The flag fall fee applies once per visit to a domiciliary location and is billable only for the first patient seen on a visit, irrespective of the number of patients seen during the visit. Once the flag fall item has been billed for the first patient seen, optometrists may then bill applicable attendance items for each of the patient they see.

For the purposes of the flag fall service, acceptable places of residence for domiciliary visits are:
- the patient's home;
- a residential care home as defined by the *Aged Care Act 2024*; or
- an institution which means a place (other than a residential care home or hospital) at which residential accommodation and/or day care is made available to any of the following categories: disadvantaged children, juvenile offenders, aged persons, chronically ill psychiatric patients, homeless persons, unemployed persons, persons suffering from alcoholism, persons addicted to drugs, or physically or intellectually disabled persons.

Visits to a hospital at the patient's request are not covered by the loading and instead, an extra fee in addition to the Schedule fee can be charged, providing the service is not bulk-billed. Medicare benefits are not payable in respect of the private charge.

Item 10931 may be used whether or not the optometrist chooses to bulk-bill but it is important that if the consultation is bulk-billed the flag fall fee is also, and no private charge can then be levied. If the consultation is not bulk-billed, the flag fall fee should also not be bulk-billed and a private charge may be levied. The usual requirement that the patient must have requested the domiciliary visit applies.

Benefits are payable under item 10931 where the optometrist travels to see one patient at a single location. The appropriate consultation item can also be billed for each patient seen during the domiciliary visit.

If the optometrist goes on to see one or more patients during a different domiciliary visit, item 10931 can be billed for the first patient seen, plus the appropriate consultation item for each patient seen.

Where a private charge is levied for a domiciliary visit, bulk-billing is precluded. Medicare benefits are not payable

in respect of the private charge and the patient should be informed of this. Private charges should be shown separately on accounts issued by optometrists and must not be included in the fees for the service.

Computerised Perimetry Services (items 10938, 10939, 10940 and 10941)

Benefit under items 10940 and 10941 is payable where full quantitative computerised perimetry (automated absolute static threshold but not including multifocal multichannel objective perimetry) has been performed by an optometrist on both eyes (item 10940) or one eye (item 10941) where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report. The provider must clearly document the rationale underlying the need to perform a computerised perimetry test. Benefit under items 10938 and 10939 is payable where full quantitative computerised perimetry (automated absolute static threshold but not including multifocal multichannel objective perimetry) has been performed by an optometrist on both eyes (10938) or one eye (10939) where indicated by the presence of glaucoma with a high risk of clinically significant progression. Items 10940, 10941, 10938 and 10939 are not intended to be claimed for screening services or for Optical Coherence Tomography. Item 10940 for bilateral procedures cannot be claimed for patients who are totally blind in one eye. In this instance, item 10941 for unilateral procedures should be claimed, where appropriate.

These items can be billed either in association with comprehensive consultation items 10905, 10907, 10910, 10911, 10938, 10914, or 10915, or independently, but they cannot be billed with items 10916, 10918, or 10931. An assessment and report is required and, where referral to an ophthalmologist for further treatment is required, the printed and/or electronic results of the perimetry should be provided to the ophthalmologist to discourage repetition of perimetry unless clinically necessary. If Medicare benefits are to be claimed, a maximum of two perimetry services for item 10940 or 10941, and a maximum of one perimetry service for item 10938 or item 10939 may be provided in any twelve month period.

Use of assistants in computerised perimetry (items 10938, 10939, 10940 and 10941)

For the purposes of computerised perimetry items 10938, 10939, 10940 and 10941, the optometrist is required to take full professional responsibility for the service.

Certain aspects of computerised perimetry can be performed by a suitably trained assistant under the supervision of an optometrist. It is not necessary for the optometrist to physically operate the computerised perimeter, or to personally observe the entire visual field examination. It is acceptable for the optometrist to utilise an assistant to operate the perimeter, to ensure the patient is positioned appropriately and the test is completed correctly.

The optometrist must personally perform the following essential elements of the service:

- Explain the clinical rationale for the procedure and benefits to the patient.
- Select the appropriate computer program for the perimeter.
- Be present where the test is being undertaken throughout the procedure.
- Initiate any modifications to the test procedure.
- Review the results and determine the appropriate course of action required to manage the patient's condition.
- Clearly document the rationale underlying the need to perform the test.
- Advise the patient of the outcome of the test and in cases where the patient is being referred for further treatment, provide the printed and/or electronic results of the perimetry.

Low Vision Assessment (item 10942)

A benefit is payable under item 10942 where one or more of the tests outlined in the item description are carried out on a patient who has already been established during a comprehensive consultation as having low vision, as specifically defined in the item. This item is not intended for patients expected to undergo cataract surgery in the near future who may temporarily meet the criteria for having low vision.

Item 10942 may be claimed on the same day as either a comprehensive initial consultation (items 10905 to 10915) or a subsequent consultation (item 10918), but only where the additional low vision testing has been carried out on an eligible patient. Item 10942 is not intended to be claimed with a brief initial consultation (item 10916), or with any of the contact lens items (items 10921 to 10930).

Children's vision assessment (item 10943)

Children aged 0 to 2 years, and 15 years and over, are not eligible for item 10943 and may be treated under appropriate attendance items.

A benefit is payable under item 10943 where one or more of the assessment and testing procedures outlined in the item description are carried out on a patient aged 3 - 14 years inclusive, and where a finding of significant binocular or accommodative dysfunction is the outcome of the consultation and assessment/testing. The conditions to be assessed under this item are primarily amblyopia and strabismus, but dysfunctions relating to vergences are also covered, providing well established and evidence-based optometry practice is observed. Item 10943 is not intended to be claimed for screening services.

A benefit is not payable under item 10943 for the assessment of learning difficulties or learning disabilities.

Item 10943 may be claimed on the same day as either a comprehensive consultation (items 10905 to 10915) or a subsequent consultation (item 10918), but only where the additional assessment/testing has been carried out on an eligible child patient. Item 10943 is not intended to be claimed with a brief initial consultation (item 10916), or with any of the contact lens items (items 10921 to 10930).

Removal of an embedded corneal foreign body (item 10944)

Item 10944 has been introduced the complete removal of an embedded corneal foreign body that is sub-epithelial or intra-epithelial and the removal of rust rings from the cornea.

The removal of an embedded foreign body should be performed using a hypodermic needle, foreign body gouge or similar surgical instrument, with magnification provided by a slit lamp biomicroscope, loupe or similar device.

The optometrist should document the nature of the embedded foreign body (sub-epithelial or intra-epithelial) and method of removal. Similarly, with rust ring removal, the optometrist should document the method of removal.

Where complexity of the procedure is beyond the skill of the optometrist, or if other complications are present (e.g. globe perforation, penetration >25%, or patient unable to hold still due to pathological anxiety, nystagmus, or tremor etc, without some form of systemic medication), the patient should be referred to an ophthalmologist.

Item 10944 can be claimed once per intervention, if:

- the foreign body (including rust ring, if present) are removed on the first attendance; or
- the foreign body (including rust ring, if present) is partially removed on the first attendance, and completely removed after a second attendance on a subsequent occasion; or
- the foreign body (including rust ring, if present) is partially removed on the first attendance, remains partially removed after the second attendance, and patient is referred to an ophthalmologist or other appropriately qualified practitioner for further assessment and management.

If an optometrist does not attempt to remove the rust ring beyond the first attendance, the appropriate consultation item can be claimed for the service.

This item cannot be billed on the same occasion as items 10905, 10907, 10910, 10911, 10913, 10914, 10915, 10916 or 10918.

AN.14.2 Heart health assessment provided by general practitioners and prescribed medical practitioners

Item 699 and 177 may be used to undertake a heart health assessment, lasting at least 20 minutes, by a general practitioner (GPs see GN.4.13) or prescribed medical practitioner (PMPs see AN.7.1) to support patients with cardiovascular disease, or patients at risk of developing cardiovascular disease (CVD). Unless indicated otherwise, the term medical practitioner in this note includes both a general practitioner providing a service under item 699 or a prescribed medical practitioner providing a service under item 177.

The items provide patients with a comprehensive assessment of their cardiovascular health, identification of any physical or lifestyle-related risks to their cardiovascular health, and a comprehensive preventive health care plan to improve their cardiovascular health. The assessment may include auscultation of the patient's heart, where clinically relevant.

The heart health assessment item can be claimed once per patient in a 12-month period. The heart health assessment items cannot be claimed if a patient has had a health assessment service, excluding an Aboriginal and Torres Strait Islander Peoples Health Assessment (item 715, 228, 92004, 92011), in the previous 12 months.

This item is available to all Medicare eligible patients aged 30 years and over who would benefit from an assessment of this type. The intention of this item is to identify CVD in people not known to have CVD.

The absolute cardiovascular disease risk is calculated as per the Australian Absolute Cardiovascular Disease Risk Calculator which can viewed at 'http://www.cvdcheck.org.au/calculator/'.

The Australian guidelines for the management of absolute cardiovascular disease risk can be found at CVD Risk Guideline. Medical practitioners can also refer to the RACGP and NACCHO's *National Guide to preventive healthcare for Aboriginal and Torres Strait Islander people* to complete this assessment.

Heart health assessments are not available to people who are in-patients of a hospital or care recipients in a residential care home.

Before a health assessment is commenced, the patient (and/or the patient's parent(s), carer or representative, as appropriate) must be given an explanation of the health assessment process and its likely benefits. The patient must be asked whether they consent to the health assessment being performed. In cases where the patient is not capable of giving consent, consent must be given by the patient's parent(s), carer or representative. Consent to the health assessment must be noted in the patient's records.

The heart health assessment may only be provided by a general practitioner (699) or prescribed medical practitioner (177).

A health assessment should generally be undertaken by the patient's 'usual doctor'. For the purpose of the heart health assessment items, 'usual doctor' means the general practitioner, or a prescribed medical practitioner working in the medical practice, which has provided the majority of primary health care to the patient over the previous 12 months and/or will be providing the majority of care to the patient over the next 12 months.

A health assessment should not take the form of a health screening service.

A copy of the heart health assessment must be retained for a period of two years after the date of service.

MBS heart health assessment items must be provided by a medical practitioner personally attending upon a patient. Suitably qualified health professionals, such as practice nurses or Aboriginal and Torres Strait Islander health practitioners, employed and/or otherwise engaged by a general practice or health service, may assist medical practitioners in performing health assessments. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the medical practitioner. This may include activities associated with:

- information collection; and
- providing patients with information about recommended interventions at the direction of the medical practitioner.

The medical practitioner should be satisfied that the assisting health professional has the necessary skills, expertise and training to collect the information required for the heart health assessment.

Medical practitioners should not conduct a separate consultation for another health-related issue in conjunction with a health assessment unless it is clinically necessary (ie. the patient has an acute problem that needs to be managed separately from the assessment).

Heart health assessment items do not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, heart health assessment items can be claimed for services provided by medical practitioners salaried by or contracted to, the Service or health clinic. All other requirements of the items must be met.

Medicare bulk billing incentive items can be claimed in conjunction with any heart health assessment for eligible patients, provided the conditions of item are met.

AN.14.3 Menopause and Perimenopause Health Assessments (MBS items 695 and 19000)

SUMMARY

This note sets out the requirements for health assessment services for eligible patients experiencing signs or symptoms relating to menopause or perimenopause.

USE OF THE ITEMS

Health assessment items are used to assess eligible patients' health and physical, psychological and social function. This includes the medical practitioner's consideration of whether relevant health care and education should be offered to the patient to improve their health or function.

The specific requirements of the menopause and perimenopause health assessment are set out in the *Health Insurance (Section 3C General Medical Services – Menopause and Perimenopause Health Assessment Services) Determination 2025* (the Determination) and the *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations).

The Determination requires that a menopause and perimenopause health assessment must include, but is not limited to:

- collection of relevant information, including taking a patient history to determine pre-, peri- or post-menopausal status, patient wellbeing and contraindications for management; and
- a basic physical examination, including recording blood pressure, and review of height and weight; and
- initiating investigations and referrals as clinically indicated, with consideration given to the need for cervical screening, mammography and bone densitometry; and
- discussion of management options including non-pharmacological and pharmacological strategies including risks and benefits; and
- implementing a management plan which includes patient centred symptoms management; and
- providing the patient with preventative health care advice and information as clinically indicated, including advice on physical activity, smoking cessation, alcohol consumption, nutritional intake and weight management.

The items apply only to a service provided in the course of a personal attendance by a single general practitioner (GP) or prescribed medical practitioner (PMP) on a single patient.

Information on practitioner types is available in Note GN.4.13 for GPs and AN.7.1 for PMPs.

Medical practitioners may refer to *A Practitioner's Toolkit for Managing Menopause* for guidance with this assessment.

Is a health assessment a health screening service?

No. Clause 2.15.14 of the Regulations specifies that a health assessment must not include a screening service.

The *Health Insurance Act 1973* (the Act) defines a health screening service as a medical examination or test that is not reasonably required for the management of the medical condition of the patient.

A health screening service does not include a medical examination or a test on a symptomless patient by the that patient's own medical practitioner in the course of normal medical practice, to ensure the patient receives any medical advice or treatment necessary to maintain their state of health.

Further information is available in Note GN.13.33.

Can another person assist the medical practitioner to undertake the health assessment?

Yes. Clause 2.15.14 of the Regulations states that practice nurses, Aboriginal and Torres Strait Islander health workers and Aboriginal and Torres Strait Islander health practitioners may assist in accordance with accepted medical practice under the supervision of the medical practitioner.

Assistance provided must be in accordance with accepted medical practice and under the supervision of the GP or PMP. This may include activities associated with:

- information collection, and
- providing patients with information about recommended interventions, at the direction of the medical practitioner.

The GP or PMP should be satisfied that the assisting health professional has the necessary skills, expertise and training to collect the information required for the health assessment.

MBS items for Health Assessments are for a complete service. On behalf of items, such as item 10997 and 10987, may not be claimed when assisting with the provision of a health assessment service.

Additional advice on the use of other health professionals' time when undertaking health assessments can be found in the *AskMBS Advisory – General Practice Services 1*.

A *Practice nurse* means a registered or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice or by a health service to which a direction made under subsection 19(2) of the Act applies.

For the purpose of items 695 and 19000, an *Aboriginal and Torres Strait Islander health practitioner* means a person who:

- is registered as an Aboriginal and Torres Strait Islander health practitioner with the Aboriginal and Torres Strait Islander Health Practice Board of Australia, and
- is employed by, or whose services are otherwise retained by, a medical practitioner in a general practice, or a health service to which a direction made under subsection 19(2) of the Act applies.

For the purpose of items 695 and 19000, an *Aboriginal and Torres Strait Islander health worker* means a person who:

- has a Certificate III or above in Aboriginal and/or Torres Strait Islander Primary Health Care from the Health (HLT) training package, and
- is engaged by a medical practitioner in a general practice or a health service to which a direction made under subsection 19(2) of the Act applies.

Can a patient be eligible for more than one category of health assessment?

Where eligible, a patient may receive both a menopause and perimenopause health assessment service and a separate time tiered or Aboriginal and Torres Strait Islander health assessment service (for example, a Type 2 diabetes risk evaluation). There is no minimum interval of time between the provision of the different health assessments.

Attendance time for the completion of a health assessment service cannot be billed under multiple items. Practitioners are required to satisfy themselves that they have met the requirements of each individual MBS item descriptor prior to billing.

Information on MBS time-tiered health assessment services is available at AN.0.36.

Can I include additional time required for communications (e.g. with an interpreter) in the time taken for the health assessment?

Yes, a wide range of factors may affect the time needed to communicate effectively with a patient during a consultation. These include, but are not limited to, situations where a language barrier exists between the medical practitioner and patient (including when an interpreter is required), or when a patient has hearing problems, difficulty with speech, an intellectual disability, and/or dementia.

When claiming MBS items with time requirements, the total consultation time includes the time required to communicate effectively with the patient. Where more time than usual is required to communicate effectively with a particular patient, it is considered reasonable to claim a longer attendance item than might otherwise be expected for the service.

In such situations, medical practitioners should make a brief record in the patient's notes including details about why the additional time was required. For example, stating 'consultation extended due to use of interpreter' and, if relevant, citing the Translating and Interpreting Service (TIS) job number.

ELIGIBLE PATIENTS

Any patient who is eligible to receive Medicare benefits, has not received this service in the previous 12-month period, and is experiencing premature ovarian insufficiency, early menopause, perimenopause or menopause symptoms, or undergoing treatment for their symptoms.

ELIGIBLE PRACTITIONERS

Health assessment items are available for different practitioner types:

- the GP item 695 can be claimed by GPs only (see GN.4.13).
- the PMP item 19000 can be claimed by PMPs only (see AN.7.1).

Note: Clause 2.15.14 of the Regulations specifies patients must access health assessment services through their usual GP or PMP, if reasonably practicable.

The patient's usual GP or PMP means the practitioner:

- who has provided the majority of services to the patient in the past 12 months, or
- who is likely to provide the majority of services to the patient in the following 12 months, or
- is located at a medical practice that:
    - has provided the majority of services to the patient in the past 12 months, or
    - is likely to provide the majority of services to the patient in the next 12 months.

CO-CLAIMING RESTRICTIONS

Clause 2.15.14 of the Regulations specifies a separate consultation must not be performed in conjunction with a health assessment, unless clinically necessary.

RECORD KEEPING AND REPORTING REQUIREMENTS

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements and they may be required to submit evidence for compliance checks related to Medicare claims. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the Act specifies that, where an item specifies the creation of a document (however described) and a document is created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS items can be found on the Federal Register of Legislation at www.legislation.gov.au. Menopause and perimenopause health assessment items are set out in the following regulatory instruments:

- *Health Insurance (Section 3C General Medical Services – Menopause and Perimenopause Health Assessment Services) Determination 2025*
- *Health Insurance (General Medical Services Table) Regulations 2021*

AN.14.4 Time-Tiered Health Assessment – Medicare Healthy Kids Check

SUMMARY

Time-tiered health assessment items may be used to undertake a Medicare Healthy Kids Check.

Note: The requirements below must be met in addition to common principles for time-tiered health assessment items, contained in AN.0.36.

USE OF THE ITEMS

The specific requirements of the Medicare Healthy Kids Check are set out in clause 2.15.11 of the *Health Insurance (General Medical Service Table) Regulations 2021* (the Regulations).

The Regulations specify that a Medicare Healthy Kids Check is the assessment of:

- the patient's physical, social and emotional development, health and wellbeing; and
- whether health care (including preventive health care), education, referrals or other assistance should be offered to the patient, or the patient's parent or carer, to improve the patient's physical, social and emotional development, health and wellbeing.

The Regulations also state that the Medicare Healthy Kids Check must include:

- taking a relevant history, including the following:
    - the patient's medical history, including previous presentations, hospital admissions, medication, immunisation status and allergies;
    - the patient's behaviours and wellbeing;
    - an assessment of the patient against age-appropriate developmental milestones;
    - the patient's family relationships, social circumstances, care arrangements and engagement in early childhood education and care;

    - the patient's family environment and exposures, including nutrition, physical activity, screen use, sleep hygiene and sleep patterns;
    - the patient's toileting, including bowel habits and urinary continence;
- undertaking a basic physical examination of the patient, including by:
    - examining the patient's eyesight, hearing and oral health (teeth and gums); and
    - undertaking measurements of the patient's height and weight to assess the patient's growth against published centile charts, including body mass index;
- assessing the patient using the information gained in the health assessment;
- providing advice to the patient's parent or carer to support:
    - the patient's physical, social and emotional development, health and wellbeing; and
    - the patient's family to engage in activities that support the best potential outcomes for the patient's physical, social and emotional development, health and wellbeing;
- making or arranging any necessary interventions and referrals for the patient;
- adding a record of the health assessment to the patient's medical record;
- offering a written report on the health assessment to the patient's parent or carer, with recommendations on matters covered by the health assessment.

There are a range of publicly available, evidence-based guidelines that practitioners may wish to use when conducting a Medicare Healthy Kids Check, as relevant to the child. These include but are not limited to the:

- Royal Australian College of General Practitioners (RACGP)'s *Guidelines for preventive activities in general practice (Red Book)*
- National Mental Health Commission's *National guidelines for including mental health and wellbeing in early childhood checks*
- Relevant state or territory child health guides (e.g. NSW/SA/ACT Blue Book, Queensland Red Book, Victorian Green Book, WA Purple Book)
- National Aboriginal Community Controlled Health Organisation (NACCHO) and RACGP's *National guide to preventive healthcare for Aboriginal and Torres Strait Islander people* (NACCHO/RACGP guidelines), and,
- Central Australian Rural Practitioners Association (CARPA) *Standard Treatment Manual*.

Practitioners may also wish to refer to the National Immunisation Program Schedule and advice of bodies such as the Australian Technical Advisory Group on Immunisation as guides when conducting patient assessments to current clinical standards.

It remains the responsibility of the treating practitioner to ensure all requirements of the Medicare Healthy Kids Check are met.

What is a "basic" physical examination of eyesight, hearing and oral health?

Practitioners should undertake basic, age-appropriate examinations, paying particular attention to any concerns raised by the child's parent or carer. Specific recommendations for examination vary between guidelines, but typically include items such as:

- Checking visual acuity, for example using Lea (NACCHO/RACGP guidelines) or paediatric Snellen charts
- Screening for amblyopia or its risk factors (Red Book)
- Examining the appearance of the ear canal and ear drum using otoscopy (NACCHO/RACGP guidelines and CARPA)
- Tuning fork test (CARPA)
- Lift the lip check.

What measure of body mass index (BMI) should I use to assess the child's growth?

Practitioners should track a child's BMI using age and gender appropriate BMI centile charts. Adult BMI charts and calculators should not be used.

How should the child's family and care arrangements be considered as part of this assessment?

When assessing child development, practitioners should consider the child within their family and social context which may include factors such as parental mental health concerns, housing and food security, and changes or stresses that have occurred in the family. However, the focus of the assessment must be on the child, rather than a broader "family consultation".

If appropriate, practitioners can recommend follow up consultation with other family members for any matters identified or raised during the child's Medicare Healthy Kids Check.

I am worried about a child and would like to assess their development across all domains. They turn 3 years old in 4 weeks' time. Can I use the Medicare Healthy Kids Check items now?

No. Patients are eligible for a Medicare Healthy Kids Check using an MBS health assessment item number when they are 3 years old i.e. from their third birthday to the end of the day before their fourth birthday.

However, a GP can undertake any assessment of a child at any time using standard consultation items (see AN.0.9). These items can be used for clinically relevant services when there is not a more specific MBS item that applies, provided all requirements of the item are met.

I'm in New South Wales. I'm performing a health check on a 3-year-old in accordance with the child's My Personal Health Record ('blue book'). Which MBS item should I bill?

If all requirements of the Medicare Healthy Kids Check are met, and the child has not already had a Medicare Healthy Kids Check, medical practitioners should bill the Medicare Healthy Kids Check using the appropriate time-tiered MBS health assessment item.

If not all requirements of the Medicare Healthy Kids Check are met, the practitioner may bill the appropriate time-tiered professional attendance item (see AN.0.9), provided they meet the requirements of the item.

Practitioners are required to satisfy themselves that each service they provide meets the legislative requirements of that service.

I have identified a potential developmental concern during a Medicare Healthy Kids Check. What should I do next?

Where a developmental concern is identified, it may be appropriate for GPs to provide advice to the child's parent or carer and monitor the child for a period of time to determine whether the child requires further assessment or support.

Where further assessment or support is required, GPs should consider relevant referral pathways that are available. This may include:

- Referral to another health practitioner for assessment and management of conditions, including dentists, optometrists and audiometrists, if indicated
- Referral to a non-GP specialist (e.g. a paediatrician)
- For children with eligible disabilities (including some speech and language disorders), referral to allied health services following development of a treatment and management plan (see MBS item 139)
- Referral to Thriving Kids support services delivered by state and territory programs
- Referral to a local child and family hub or maternal, child and family health service
- For some children, supports may include referral to other community services, such as playgroups.

Practitioners can use their local Health Pathways to identify referral pathways and services.

Practitioners should also provide advice and resources to the parent or carer to assist them to support the child's developmental needs in everyday settings and complement any professional services.

Are there resources I can provide to parents and carers to support the child?

Practitioners are encouraged to refer parents and carers to high quality, reputable resources, such as the Raising Children Network and other relevant services, to assist the family to engage in activities that support the child's physical, social and emotional development, health and wellbeing.

I completed a Medicare Healthy Kids Check for a child today. I identified a developmental concern and have provided the parents with some strategies to implement at home. I would like to reassess the child's progress after a period of time to consider whether additional referrals are required. What should I bill for the follow-up?

The Medicare Healthy Kids Check is available once only for an eligible child. Any further assessment or follow-up may be conducted using time-tiered professional attendance items (see AN.0.9) or other relevant items, provided all requirements of the item are met.

I completed a Medicare Healthy Kids Check for a child today. I identified some potential developmental delays, however, the child had a cold at the time, which may have contributed to their presentation on the day. I would like to reassess some things on another day. What should I bill for the follow-up?

The Medicare Healthy Kids Check is available once only for an eligible child. Any further assessment or follow-up may be conducted using time-tiered professional attendance items (see AN.0.9) or other relevant items, provided all requirements of the item are met.

My patient is eligible for more than one category of health assessment. Which health assessment should I do?

Having a Medicare Healthy Kids Check does not affect a child's eligibility for other types of health assessment.

In addition to the Medicare Healthy Kids Check, Medicare-eligible 3-year-olds might be eligible for:

- an Aboriginal and Torres Strait Islander health assessment, every 9 months (see AN.0.43)
- a health assessment for a person with an intellectual disability, annually (see AN.0.41)
- a health assessment provided for a refugee or other humanitarian entrant, once only to an eligible patient (see AN.0.42).

Practitioners should consider which health assessment is most clinically relevant to determine the appropriate item to claim, noting that the specific requirements of each health assessment type are different.

If a child receives more than one health assessment each service must be clinically relevant for MBS benefits to be payable.

My patient missed their Medicare Healthy Kids Check appointment. They have now turned 4 years old and the family still needs a child health check to be performed to meet the Healthy Start for School requirements for Family Tax Benefit Part A purposes. What do I do?

You cannot use the MBS health assessment items to undertake the assessment once a child has turned 4. However, standard consultation items (see AN.0.9) may be used for any service where there is not a specific MBS item. When using a consultation MBS item you are required to meet the requirements of the consultation item, not the Medicare Healthy Kids Check item.

To meet the Healthy Start for School requirements, the child will need to receive an age-appropriate health check that meets the relevant state and territory requirements. Further information about the various state and territory requirements is available on the Services Australia website at Healthy Start for School health check - Family Tax Benefit - Services Australia.

My 3-year-old patient received a health check at their kindergarten. Are they eligible for a Medicare Healthy Kids Check?

Yes, if the patient has not yet received a Medicare Healthy Kids Check under the MBS. In considering the need for a Medicare Healthy Kids Check, GPs and prescribed medical practitioners need to ensure the service is clinically relevant.

Do I need to add a copy of the Medicare Healthy Kids Check to the child's My Health Record?

GPs and prescribed medical practitioners are strongly encouraged to upload the Medicare Healthy Kids Check to the child's My Health Record. However, as upload is not a requirement of the item it is not essential that the plan be uploaded prior to submitting an MBS claim.

ELIGIBLE PATIENTS

Medicare-eligible children who are 3 years old.

A Medicare Healthy Kids Check can only be claimed once for an eligible patient.

ELIGIBLE PRACTITIONERS

A Medicare Healthy Kids Check can be undertaken by a general practitioner (see GN.4.13) or a prescribed medical practitioner (see AN.7.1).

CO-CLAIMING RESTRICTIONS

A separate consultation must not be performed in conjunction with a Medicare Healthy Kids Check, unless clinically necessary.

To co-claim a health assessment item and another item, both items must be clinically necessary and distinct services.

RECORD KEEPING AND REPORTING REQUIREMENTS

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements and they may be required to submit evidence for compliance checks related to Medicare claims. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document is created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item(s) can be found on the Federal Register of Legislation at www.legislation.gov.au. Health assessment items are set out in the *Health Insurance (General Medical Services Table) Regulations 2021*.

AN.15.1 Mental Health Case Conferences

Associated Items: 930, 933, 935, 937, 943, 945, 946, 948, 959, 961, 962, 964, 969, 971, 972, 973, 975, 986, 80176, 80177, 80178

Mental Health Case Conference service requirements

The purpose of a case conference is to establish and coordinate the management of the care needs of a patient.

A case conference is a process by which a multidisciplinary team carries out the following activities:

- discusses a patient's history;
- identifies the patient's multidisciplinary care needs;
- identifies outcomes to be achieved by members of the case conference team giving care and service to the patient;
- identifies tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and
- assesses whether previously identified outcomes (if any) have been achieved.

A Medicare benefit may not be claimed until all of these activities have been completed.

Services attracting Medicare benefits

There are 21 Medicare Benefits Schedule (MBS) items for the provision of mental health case conferencing services. These services consist of:

Organisation and coordination of a mental health case conference:

- General Practitioner (GP items): 930, 933 and 935
- Psychiatrist and paediatrician items: 946, 948 and 959
- Prescribed medical practitioner (PMP) items: 969, 971 and 972.

Participation in a mental health case conference:

- GP items: 937, 943 and 945
- Psychiatrist and paediatrician items: 961, 962 and 964
- PMP items: 973, 975 and 986
- Eligible allied health professionals: 80176, 80177 and 80178.

The requirements of case conference organisation, coordination and participation are set out below. It is expected that a patient would not normally require more than 4 case conferences in a 12-month period unless there has been a significant change in the patient's clinical condition or care circumstances that necessitates the performance of additional services.

Patient eligibility

Mental Health Case conferences using these MBS items can be held for patients who have been referred for treatment under the Better Access Initiative by either a GP or PMP at the general practice in which the patient is enrolled in MyMedicare, or regardless of whether the patient is enrolled in MyMedicare, by the patient's usual medical practitioner. GPs or PMPs, and eligible allied health professionals or other members of the multidisciplinary team (psychiatrists/paediatricians) do not need to have an existing relationship with the patient, however, they must have agreed to and must be able to provide advice on the treatment and care they can or will provide the patient for the management of their condition. For further information on the Better Access Initiative, refer to explanatory note AN.0.78 - Better Access Initiative.

In addition, Mental Health Case Conferences using these MBS items can be held for patients who have an active Eating Disorder Treatment and Management Plan. For further information on Eating Disorder Treatment and Management Plans, refer to explanatory note MN.16.1 - Eating Disorders General Explanatory Notes.

Organising and Coordinating a Mental Health Case Conference

To organise and coordinate a mental health case conference, a provider must:

- explain to the patient the nature of a mental health case conference and ask for their agreement to the conference taking place;
- record the patient's agreement to the conference;
- record the day on which the conference was held, and the times at which the conference started and ended;
- record the names of the participants;
- offer the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a summary of the conference;
- provide this summary to other team members;
- discuss the outcomes of the conference with the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
- record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

The organising of a mental health case conference should generally be undertaken by the patient's usual medical practitioner. A patient's usual medical practitioner is a prescribed medical practitioner, or a medical practitioner working in the same medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

Participating in a Mental Health Case Conference

To participate in a mental health case conference, a provider must:

- explain to the patient the nature of a mental health case conference, and ask for their agreement to the prescribed medical practitioner's participation in the conference;
- record the patient's agreement to the prescribed medical practitioner's participation;
- record the day on which the conference was held, and the times at which the conference started and ended;
- record the names of the participants; and
- record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

Mental Health Case Conference members

A mental health case conference must be organised by a GP, PMP or consultant physician specialising in the practice of their field of psychiatry or paediatrics and involve at least 2 other members of the multidisciplinary case conference team providing different kinds of treatment to the patient. In some instances, 2 providers from the same profession may both participate in the case conference if they each provide different aspects of care to the patient – for example, if the providers have different specialisations which are both clinically relevant to the patient.

Other members of the case conference team may include allied health professionals, home and community service providers, and care organisers. Participating providers must be invited to attend by the organising practitioner.

During the provision of a mental health case conference service, at least 3 members of the multidisciplinary case conference team (including a medical practitioner, and at least 2 other members) must be present at the same time for the case conference to take place. Two providers from the same profession may both participate in the case conference if they each provide different aspects of care to the patient. For example, if the providers have different specialisations which are both clinically relevant to the patient.

The case conference must be arranged in advance, within a time frame that allows for all the participants to attend. The minimum of 3 case conference members as outlined above must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

Patient, Family and Carer participation

The patient should be given the option to attend the case conference, however, may choose not to do so. A family member or unpaid carer, as well as other individuals providing support to the patient (such as a close friend, counsellor, teacher, or peer worker) may also be invited to attend the case conference with the patient's consent. However, these individuals do not count towards the minimum number of providers required to meet the regulatory requirements of these items (refer to section on mental health case conference members).

Allied Health Professional Eligibility

Only eligible allied health professionals can claim participation in mental health conference services under these MBS items.

For the purpose of a mental health case conference, an eligible allied health professional means an allied health professional who meets the qualification requirements for providing the following types of treatment:

- psychological therapy services (refer to explanatory note MN.6.2 - Provision of Psychological Therapy); or

- focussed psychological strategies services (refer to explanatory note MN.7.4 - Provision of Focussed Psychological Strategies).
- dietetics health services.

Further information

For further information on the Better Access Initiative, refer to explanatory note AN.0.78 - Better Access Initiative.

For further information on Eating Disorder Treatment and Management, refer to explanatory note MN.16.1 - Eating Disorders General Explanatory Notes.

For further information about Medicare Benefits Schedule items, please visit the MBS online website at www.health.gov.au/mbsonline.

Further information is available for providers from the Services Australia provider enquiry line on 132 150.

If you are a patient seeking advice about Medicare services, patient benefits, or your Medicare claims, please contact Services Australia on the Medicare General enquiry line on 132 011.

AN.15.3 Overview of MBS items to support the management of chronic conditions in general practice

Summary

This note provides an overview of MBS items to support the management of patients with chronic conditions in general practice by general practitioners (see GN.4.13) and prescribed medical practitioners (see AN.7.1). For detailed information on the individual items, including item requirements and patient eligibility, see item-specific notes listed below.

MBS and management of patients with chronic conditions

There are a range of MBS items for clinically relevant services provided in general practice for patients with chronic conditions. These include:

- time-tiered attendance items (see AN.0.9), which can be used when a more specific MBS item does not apply
- health assessment items for early detection and prevention of chronic conditions in specific patient cohorts (see AN.0.36, AN.0.43, AN.14.2 and AN.14.3)
- items to support general practitioners and prescribed medical practitioners to develop and review plans for the care of patients with a chronic condition and, where relevant, refer patients to MBS-supported allied health and Aboriginal and Torres Strait Islander health and wellbeing services (see AN.0.47 for GP chronic condition management plans and AN.15.7 and AN.15.8 for multidisciplinary care plans)
- medication management reviews to support quality use of medicines and minimise the risk of medication misadventure (see AN.0.52 and AN.7.18)
- case conferencing items to support multidisciplinary team care (see AN.0.49).

Patients with a mental health condition or eating disorder may be eligible for treatment through the Better Access mental health items (see AN.0.78) or eating disorder items (see MN.16.1).

It is important to note that:

- some of these items have specific eligibility criteria that are detailed in the item-specific explanatory notes, and

- all MBS services must be clinically relevant, meaning they are generally accepted in the medical profession as necessary for the appropriate treatment of the patient

General practitioners and prescribed medical practitioners in primary care can also refer patients to specialists where appropriate as part of the management of their chronic condition.

GP chronic condition management plans and multidisciplinary care plans

GP chronic condition management plans and multidisciplinary care plan items allow GPs/prescribed medical practitioners to develop and periodically review structured plans for patients with a chronic condition.

Patient Eligibility

These items are available to patients that have at least one medical condition that has been (or is likely to be) present for **at least 6 months, or is terminal**. There is no list of eligible conditions. It is up to the GP or prescribed medical practitioner's clinical judgment to determine whether an individual patient with a chronic condition would benefit from a structured plan for the management of their condition.

In considering the need for a structured plan, GPs and prescribed medical practitioners need to ensure the service is clinically relevant, which is a requirement of the *Health Insurance Act 1973*. The Act defines a clinically relevant services as "*a service rendered by a medical or dental practitioner or an optometrist that is generally accepted in the medical, dental or optometric profession (as the case may be) as being necessary for the appropriate treatment of the patient to whom it is rendered*."

GP chronic condition management plans

A GP chronic condition management plan is a plan that is developed collaboratively between the general practitioner/prescribed medical practitioner and the patient for the management of the patient's chronic condition(s). Patients registered with a practice through MyMedicare must access these services through the practice at which they are registered. Patients that are not registered can access these services from their usual medical practitioner See AN.0.47 for detailed information on GP chronic condition management plans.

Multidisciplinary care plans

Multidisciplinary care plans allow for the general practitioner/prescribed medical practitioner to contribute to a plan which may be coordinated by another person. MBS items 232, 731, 92027 and 92058 are available for patients living in a residential care home; MBS items 231, 729, 92026 and 92057 are available for patients not in a residential care home.

Patients living in a residential care home who have a multidisciplinary care plan have the same access to allied health, Aboriginal and Torres Strait Islander health and wellbeing, and other services as patients with a GP chronic condition management plan.

See AN.15.7 and AN.15.8 for detailed information.

Services available under GP chronic condition management plans and multidisciplinary care plans

A range of MBS-supported multidisciplinary services may be available to patients with a GP chronic condition management plan or a multidisciplinary care plan, where those services are consistent with the plan.

Patients who had a GP management plan and/or team care arrangement prior to 1 July 2025 can continue to access the services outlined below until 30 June 2027 under those plans. For more information about the transition arrangements for GP chronic condition management plans see AN.15.5.

Services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner

Patients with a GP chronic condition management plan or a multidisciplinary care plan can access up to 5 services per calendar year provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner to support management of their chronic condition (MBS items 93201, 93203 and 10997). The services provided must be consistent with the patient's plan. See MN.12.4 for detailed information about the use of these items.

For follow up services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner, on behalf of a medical practitioner, for a person of Aboriginal or Torres Strait Islander descent who has received a health assessment see MN.12.3.

Individual allied health and Aboriginal and Torres Strait Islander health and wellbeing services

Patients with a GP chronic condition management plan or care recipients of a residential care home who have a multidisciplinary care plan can access up to 5 (10 for a person of Aboriginal or Torres Strait Islander descent) individual MBS-supported allied health and Aboriginal and Torres Strait Islander health and wellbeing services per calendar year. The services provided must be consistent with the patient's plan and a referral is required.

For more information on the types of allied health and Aboriginal and Torres Strait Islander health and wellbeing services available see AN.15.4.

For detailed information about the allied health and Aboriginal and Torres Strait Islander health and wellbeing items see MN.3.1.

For information on referral requirements for allied health and other primary health care services see AN.15.6.

Group allied health service for patients with type 2 diabetes

Patients with type 2 diabetes who have a GP chronic condition management plan, or are a care recipient of a residential care home and have a multidisciplinary care plan, can be assessed for their suitability for group diabetes education, exercise physiology or dietetics services. Patients are eligible for one assessment per calendar year and, if they are found suitable, up to 8 group services per calendar year.

For detailed information on suitability assessments and group allied health services see MN.9.1 and MN.9.2.

AN.15.4 Allied health and Aboriginal and Torres Strait Islander health and wellbeing services for chronic condition management – an overview for general practice

SUMMARY

This note sets out the range of allied health and Aboriginal and Torres Strait Islander health and wellbeing services (health services), and the professionals who can provide those services, for patients with a GP chronic condition management plan (see AN.0.47) and care recipients of a residential care home who have a multidisciplinary care plan (see AN.15.7 and AN.15.8).

Patients who had a GP management plan and a team care arrangement in place prior to 1 July 2025 can also access these services under those plans until 1 July 2027 (see AN.15.5 for further information on transition arrangements).

HEALTH SERVICES AVAILABLE

Individual allied health and Aboriginal and Torres Strait Islander health and wellbeing services

Patients with a GP chronic condition management plan or care recipients of a residential care home with a multidisciplinary care plan can access up to 5 MBS-supported individual health services in a calendar year (10 for patients of Aboriginal or Torres Strait Islander descent). The requirements for MBS individual health services are set out in the *Health Insurance (Section 3C General Medical Services – Allied Health and other Primary Health Care Services) Determination 2024* (the Determination).

The Determination sets out the following services that can be provided to individual patients under the MBS chronic condition management framework:

Service Type	**Eligible Providers**
Aboriginal and Torres Strait Islander health and wellbeing service	Aboriginal and Torres Strait Islander health worker Aboriginal and Torres Strait Islander health practitioner
Audiology health service	Audiologist
Chiropractic health service	Chiropractor
Diabetes education health service	Credentialled diabetes educator
Dietetics health service	Accredited practising dietitian
Exercise physiology health service	Accredited exercise physiologist
Mental health service	Aboriginal and Torres Strait Islander health worker Aboriginal and Torres Strait Islander health practitioner Credentialled mental health nurse Occupational therapist Psychologist (general registration) Social worker
Occupational therapy health service	Occupational therapist
Osteopathy health service	Osteopath
Physiotherapy health service	Physiotherapist
Podiatry health service	Podiatrist
Psychology health service	Psychologist (general registration)
Speech pathology health service	Certified practising speech pathologist

Group allied health services – patients with Type 2 diabetes

Patients with type 2 diabetes who have a GP chronic condition management plan or are a care recipient of a residential care home with a multidisciplinary care plan can have 1 assessment of their suitability for group allied health services per calendar year, and if suitable up to 8 allied health group sessions. The allied health services available are:

Service Type	Eligible Providers
Diabetes education health service	Credentialled diabetes educator
Exercise physiology health service	Accredited exercise physiologist
Dietetics health service	Accredited practising Dietitian

Are all members of an allied health or Aboriginal and Torres Strait Islander primary health care profession eligible to provide services through the MBS?

This depends on the profession. Some professional groups require specific qualifications, accreditation or credentialing to provide services under the MBS.

How do I check an allied health or Aboriginal and Torres Strait Islander primary health care professional is eligible to provide MBS-supported services to my patient?

To provide services under the MBS individual health professionals must have a Medicare Provider Number. Allied health and Aboriginal and Torres Strait Islander primary health care providers listed on the registers identified below are eligible to provide MBS-supported services and may have Medicare Provider Numbers.

The following health professions can be found through the Ahpra register at Australian Health Practitioner Regulation Agency - Home (ahpra.gov.au). The register can be searched by health practitioner type, state/territory, suburb and postcode. All practitioners in the following professions that appear on the Ahpra register are eligible to provide MBS-supported services if they have a Medicare Provider Number:

- Aboriginal and Torres Strait Islander health practitioners
- Chiropractors
- Occupational therapists
- Osteopaths
- Physiotherapists
- Podiatrists
- Psychologists

Other professions are registered through their member organisations, which have registers on their websites. It is important to note that some health professionals may choose not to appear on the public register.

- Aboriginal and Torres Strait Islander health workers providing these services must have a Certificate III or above in Aboriginal and/or Torres Strait Islander Primary Health Care from the Health (HLT) training package
- Accredited Exercise physiologists are accredited by Exercise & Sports Science Australia. See Find an Accredited Exercise Professional
- Accredited Practising Dietitians are accredited by Dietitians Australia. See Find a Dietitian (dietitiansaustralia.org.au)
- Audiologists are either:
    - Full members of Audiology Australia and certified as an Audiology Australia Accredited Audiologist. See Find an Audiologist - Audiology Australia, or
    - Full/Ordinary members or a Fellow of the Australian College of Audiology, with Hearing Rehabilitation Specialist and Diagnostic Rehabilitation Specialist Competencies. See Member Directory – The Australian College of Audiology (acaud.com.au)
- Certified Practising Speech pathologists are certified by Speech Pathology Australia. See Find a Speech Pathologist (speechpathologyaustralia.org.au)
- Credentialled diabetes educators are registered with the Australian Diabetes Educators Association. See ADEA | Find a CDE - ADEA
- Credentialled mental health nurses are certified by the Australian College of Mental Health Nurses. See Find a Credentialed Mental Health Nurse (acmhn.org)

- Social workers are Members of the Australian Association of Social Workers (AASW) and accredited by AASW as meeting the criteria set out in the "AASW Accredited Mental Health Social Worker Application Criteria" (July 2022) or as an accredited social worker. See Find a Social Worker (aasw.asn.au).

ELIGIBLE PATIENTS

Patients with a GP chronic condition management plan and care recipients of a residential care home with a multidisciplinary care plan can access up to 5 MBS-supported (10 for patients of Aboriginal and Torres Strait Islander descent) individual allied health services and Aboriginal and Torres Strait Islander health and wellbeing services per calendar year (see MN.3.1) for further details).

Patients with type 2 diabetes and either a GP chronic condition management plan or a multidisciplinary care plan (for care recipients of a residential care home) may also be eligible for group services (see MN.9.1 and MN.9.2 for further details).

Patients who had a GP management plan and/or team care arrangement in place prior to 1 July 2025 can continue to access individual and group services (as applicable) under those plans until 1 July 2027 under transition arrangements (see AN.15.5).

In all cases, the patient's general practitioner or prescribed medical practitioner must refer the patient to the service and the service must be consistent with the patient's GP chronic condition management plan or multidisciplinary care plan (or team care arrangement) (see AN.15.6).

RECORD KEEPING AND REPORTING REQUIREMENTS

The Determination requires the allied health professional or Aboriginal and Torres Strait Islander primary health care professional to provide a written report to the referring medical practitioner in relation to a service if that service is:

- the only service under the referral
- the first or last service under the referral, or
- any other service if the service involves matters that the referring medical practitioner would reasonably expect to be informed of.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item(s) can be found on the Federal Register of Legislation. Allied health and Aboriginal and Torres Strait Islander health and wellbeing items are set out in the *Health Insurance (Section 3C General Medical Services – Allied Health and other Primary Health Care Services) Determination 2024*.

AN.15.5 GP chronic condition management plans – transition arrangements for existing patients with a GP Management Plan and/or Team Care Arrangement

SUMMARY

On 1 July 2025, GP Management Plans (MBS items 229, 721, 92024 and 92055) and Team Care Arrangements (MBS items 230, 723, 92025 and 92056) were replaced with the new GP chronic condition management plan framework (MBS items 392, 965, 92029, 92033, 92060 and 92063). MBS items for reviewing a GP Management Plan or Team Care Arrangement (MBS items 233, 732, 92028 and 92059) also ceased. This note sets out the transition arrangements for patients that have a GP Management Plan and/or Team Care Arrangement that was put in place prior to 1 July 2025.

These transition arrangements are intended to allow for a smooth transition to the new framework, minimising the risk of service disruption for new and existing patients.

Patients with a multidisciplinary care plan (see AN.15.7 and AN.15.8) are only affected by the changes to referral requirements.

TRANSITION ARRANGEMENTS – PLANS

Patients with an existing GP Management Plan and/or Team Care Arrangements (i.e. the plans were put in place prior to 1 July 2025) can continue to access services under those plans for two years.

Patients that had a GP Management Plan and/or Team Care Arrangement in place prior to 1 July 2025 can continue to access allied health and other services that are consistent with those plans until 1 July 2027. From 1 July 2027 a GP chronic condition plan or multidisciplinary care plan will be required for ongoing access to services.

The items for reviewing GP Management Plans and Team Care Arrangements (MBS items 233, 732, 92028 and 92059) are also ceasing. GP Management Plans and Team Care Arrangements should not be reviewed under the new GP chronic condition management review items (393, 967, 92030, 92034, 92061 and 92064). If a patient requires a review of their GP Management Plan or Team Care Arrangement, it is an appropriate time to transition them to the new GP chronic condition management plan.

The services that can continue to be accessed by eligible patients with a GP Management Plan and/or Team Care Arrangement until 1 July 2027 are:

- MBS item 10997 (see MN.12.4) – patients with a GP Management Plan and/or Team Care Arrangement
- Group M3 individual allied health and Aboriginal and Torres Strait Islander health and wellbeing services for chronic condition management (see MN.3.1) – patients with a GP Management Plan and Team Care Arrangement
- Group M9 allied health group services (see MN.9.1 and MN.9.2) – patients with a GP Management Plan and type 2 diabetes
- Group M11 allied health and Aboriginal and Torres Strait Islander health and wellbeing services for Aboriginal and Torres Strait Islander people (see MN.11.1) – when accessed through a GP Management Plan and Team Care Arrangement
- Telehealth equivalent items (as applicable) for the above categories

My patient has a GP Management Plan and Team Care Arrangement. When do I need to move them to a GP chronic condition management plan?

They will need to have a GP chronic condition management plan in place by 1 July 2027 if they need to continue to access the services listed above on or after that date.

The number of allied health and Aboriginal and Torres Strait Islander health and wellbeing services (5 individual services) available is counted from 1 January each year. Will my patient need a GP chronic condition management plan before they can access these services in the new year?

No. If the health services required are still consistent with the patient's team care arrangement they do not need to transition to a GP chronic condition management plan to continue to access these services in the new year.

Patients will need to have transitioned to a GP chronic condition management plan to continue to access allied health and Aboriginal and Torres Strait Islander health and wellbeing services after 1 July 2027.

My patient's condition has changed and as a result their team care arrangement needs to be reviewed to change the types of allied health services they receive. Item 732 has been removed. What should I do?

This is an appropriate time to put in place a new GP chronic condition management plan for the patient.

Can I review my patient's GP Management Plan and Team Care Arrangement using the new items to review a GP chronic condition management plan?

No. The new items are for reviewing a GP chronic condition management plan only. Instead of reviewing the old plans a new GP chronic condition management plan should be prepared.

What happens if my patient doesn't have a GP chronic condition management plan in place on 1 July 2027?

Your patient won't be able to access MBS-supported allied health and Aboriginal and Torres Strait Islander health and wellbeing services (or item 10997 services) from 1 July 2027 until a GP chronic condition management plan is in place.

I am an allied health professional. I agreed to be part of my patient's team care arrangement before 1 July 2025. Can I continue to provide services consistent with the team care arrangement?

Yes. The patient can continue to access services that are consistent with their Team Care Arrangement until 1 July 2027. From 1 July 2027 they will need to have a GP chronic condition management plan to continue to access services. In all cases a valid referral is also required.

I am a diabetes educator. I assessed my patient as suitable for group diabetes education services for patients with type 2 diabetes before 1 July 2025 but they hadn't attended any group sessions by that date. Are they still eligible to access the group services under their GP Management Plan?

Yes, if the service is consistent with their GP Management Plan patients can continue to access services under that plan until 1 July 2027.

TRANSITION ARRANGEMENTS – REFERRALS

From 1 July 2025 all new referrals for allied health and Aboriginal and Torres Strait Islander health and wellbeing services for patients with a chronic condition should be in line with the new referral requirements (see AN.15.6). Referrals that were issued prior to this date can continue to be used until they expire.

I gave my patient a referral for physiotherapy under their GP Management Plan and Team Care Arrangement in February 2025. They still have two services remaining on that referral. Do I need to write another referral so they can continue to access the services?

No. Referrals issued before 1 July 2025 continue to be valid until all services covered by the referral have been provided.

My patient hasn't transitioned to the new GP chronic condition management plan yet, but they need a new referral for their mental health service. Should I use the old form or issue a referral letter?

The new referral should be a letter. All referrals issued from 1 July 2025 should meet the new requirements (see AN.15.6), regardless of which plan type they are made under.

I am a speech therapist. I have a new patient and their referral was issued on the old form prior to 1 July 2025. Can I accept it?

Yes. Referrals issued prior to 1 July 2025 remain valid until all services covered by the referral have been delivered.

I am a podiatrist. My patient in a residential care home has a multidisciplinary care plan that includes podiatry. What form should their new referral take?

If the referral is issued on or after 1 July 2025 the referral should be a letter and should meet the new referral requirements (see AN.15.6).

I am an occupational therapist. My patient's referral provided for 3 occupational therapy sessions in 2025. They had used two services before 1 July 2025. Is a new referral required before I can provide the third service?

No. Referrals issued before 1 July 2025 continue to be valid until all services covered by the referral have been provided.

RECORD KEEPING AND REPORTING REQUIREMENTS

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements and they may be required to submit evidence for compliance checks related to Medicare claims. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item(s) can be found on the Federal Register of Legislation at www.legislation.gov.au.

- *Health Insurance (General Medical Services Table) Regulations 2021*
- *Health Insurance (Section 3C General Medical Services – Telehealth Attendances) Determination 2021*
- *Health Insurance (Section 3C – Allied Health and Other Primary Health Care Services) Determination 2024*

AN.15.6 Referral requirements for allied health and other primary health care services

SUMMARY

This note sets out the requirements for referring patients to MBS-supported allied health and other primary health care services.

For Subgroup 1 of Group M3, Group M8, Group M9, Subgroup 1 of Group M10 or Group M11 (and telehealth equivalents) these requirements apply to referrals written on or after 1 July 2025.

For Group M6, Subgroup 1 of Group M7 and Subgroup 1, 2, 3, 4, 6, 7, 8 and 9 of Group M18, these requirements apply to referrals written on or after 1 November 2025.

APPLICATION OF REFERRAL REQUIREMENTS

The requirements outlined in this note apply to referrals written on or after 1 July 2025 for the following groups of allied health and Aboriginal and Torres Strait Islander health and wellbeing services and, where applicable, their telehealth (video and phone) equivalents:

- M3 (subgroup 1) – individual allied health and Aboriginal and Torres Strait Islander health and wellbeing services for patients with a chronic condition (referred under the chronic conditions management arrangements (see MN.3.1)
- M8 – pregnancy support counselling allied health services (see MN.8.1)
- M9 – allied health group services for patients with type 2 diabetes (referred under the chronic conditions management arrangements (see MN.9.1 and MN.9.2)
- M10 (subgroup 1) – complex neurodevelopmental disorders and eligible disabilities allied health services (see MN.10.1)

- M11 – allied health and Aboriginal and Torres Strait Islander health and wellbeing services for Aboriginal and Torres Strait Islander people (referred under the chronic conditions management arrangements or following an Aboriginal and Torres Strait Islander health assessment (see MN.11.1))

The requirements outlined in this note apply to referrals written on or after 1 November 2025 for the following groups of allied health services and, where applicable, their telehealth (video and phone) equivalents:

- M6 and M18 (subgroup 1 and 6) – Provision of psychological therapy services (see MN.6.2 and MN.7.5)
- M7 (subgroup 1) and M18 (subgroup 2, 3, 4, 7, 8, 9 – Provision of focussed psychological strategies (see MN.7.4 and MN.7.5)

As of 1 November 2025, these requirements do not apply to other MBS-supported allied health services, including eating disorder allied health services, or diagnostic audiology services.

REFERRAL REQUIREMENTS

The requirements for referrals are set out in the *Health Insurance (Section 3C – Allied Health and Other Primary Health Care Services) Determination 2024* (the Determination) and mirror those for referrals to medical specialists and other MBS-supported services. The Determination requires the following "prescribed particulars" to be included in the referral:

- The name of the referring practitioner
- The address of the practice, or the practitioner's provider number at that practice, of the referring practitioner
- The date on which the referring practitioner made the referral

The Determination also requires that referrals:

- Be in writing
- Signed by the referring practitioner (noting this can be an electronic signature)
- Dated, and
- Explain the reasons for referring the patient, including any information about the patient's condition that the referring practitioner considers necessary to give the health professional.

For psychological therapy services and focussed psychological strategies services under the Better Access initiative (Group M6, Subgroup 1 of Group M7 and Subgroup 1, 2, 3, 4, 6, 7, 8 and 9 of Group M18), additional referral requirements are required for a patient to access mental health treatment services. Further information on referral requirements for Better Access treatment services can be found at MN.6.3.

How long is a referral valid?

Referrals for patients with chronic conditions (M3, M10 and M11 and telehealth equivalents) are valid for:

- The period of time stated in the referral, or
- If no timeframe is stated, 18 months.

These timeframes are measured from the date the first service is provided under the referral, not the date of the referral.

Referrals for a focussed psychological strategy service or psychological therapy service (Group M6, Subgroup 1 of Group M7 and Subgroup 1, 2, 3, 4, 6, 7, 8 and 9 of Group M18) are valid until the end of the number of sessions in the course of treatment the referring practitioner recommends up to the maximum session limit for each course of treatment.

Does the referral need to specify the number of services to be provided?

No for referrals for patients with the management of chronic conditions. From 1 July 2025 referrals do not need to specify the number of services to be provided. However, nothing prevents the referring medical practitioner from specifying the number of services to be provided under the referral if they choose to do so.

This recognises that some patients accessing allied health and Aboriginal and Torres Strait Islander health and wellbeing services may wish to access a higher number of services than are supported by the MBS. As the MBS benefits are the patient's benefit, ultimately it is up to them to determine which services they would like to use their MBS benefit for.

For information on which allied health and Aboriginal and Torres Strait Islander primary health care professionals are eligible to provide MBS services see AN.15.4.

Yes, for psychological therapy services and focussed psychological strategies services under the Better Access initiative (Group M6, Subgroup 1 of Group M7 and Subgroup 1, 2, 3, 4, 6, 7, 8 and 9 of Group M18 services), the referral should include the number of services the patient is being referred to in the course of treatment. Further information on referral requirements for Better Access treatment services can be found at MN.6.3.

Does the referral need to include the name of the health professional who is to provide the referred service?

No. The patient can take the referral to any eligible health professional of the same profession/type specified in the referral of their choosing. For example, a referral to physiotherapy services can be taken to any physiotherapist, but it cannot be used to access chiropractic services.

I am an allied health professional. Can I accept a referral with another allied health professional's name on it?

Yes. The patient can choose to take their referral to any eligible allied health professional of the same profession/type specified in the referral.

I am an allied health professional. Am I required to accept a referral?

No. Acceptance of a referral is at the discretion of the individual practitioner, subject to anti-discrimination legislation. However, if the referral is not accepted after being presented to the practice it is important to inform the referring practitioner that the request cannot be accommodated.

I am an occupational therapist and I will be away when my patient is due for their next appointment. Can another practitioner in my practice provide the service or does the patient have to delay their appointment until I return?

Yes, your patient can see another practitioner in the practice under the same referral, provided the other practitioner is an eligible allied health professional of the same profession/type specified in the referral. In this circumstance the allied health professional that provides the service would need to report to the referring medical practitioner, if required.

The referral has to be signed and in writing. Does this mean it needs to be in hard copy?

No. The *Electronic Transactions Act 1999* allows for documents required under Commonwealth Law, such as referrals under the Determination, to be signed and transmitted electronically.

Are there any differences in the requirements for referrals to allied health and Aboriginal and Torres Strait Islander primary health care professionals and medical specialists?

Yes, there are some differences in the requirements:

- For allied health and Aboriginal and Torres Strait Islander health and wellbeing services for patients with a chronic condition (M3, M10 and M11 and telehealth equivalents), the default length of a referral is 18 months from the date of the first service provided under the referral. This aligns with the requirement for patients with a GP chronic condition management plan to have had their plan put in place or reviewed within the last 18 months to continue to access services (see AN.0.47). For specialist services the default referral length is 12 months from the date of the first service provided under the referral

- For psychological therapy services and focussed psychological strategies services under the Better Access initiative (Group M6, Subgroup 1 of Group M7 and Subgroup 1, 2, 3, 4, 6, 7, 8 and 9 of Group M18 services), additional referral requirements are required for a patient to access mental health treatment services. Further information on referral requirements for Better Access treatment services can be found at MN.6.3.

- Referrals to allied health and Aboriginal and Torres Strait Islander primary health care professionals cannot be indefinite referrals. This is in recognition of the requirement of many allied health and Aboriginal and Torres Strait Islander health and wellbeing items to provide a report back to the referring medical practitioner after the last service on the referral

- There is no emergency exception to the requirement for a written referral to exist before allied health and Aboriginal and Torres Strait Islander health and wellbeing services are rendered unlike for specialist or consultant physician referred attendances.

What happens if the referral gets lost or destroyed?

A service can be provided on the basis of a lost, stolen or destroyed referral. However, this is not expected to be a common occurrence. In these circumstances the phrase 'lost referral' replaces the prescribed particulars.

Where the intended allied health or Aboriginal and Torres Strait Islander primary health care provider is known, referring practitioners are encouraged to send referrals electronically whenever possible to minimise the risk of lost referrals.

RECORD KEEPING AND REPORTING REQUIREMENTS

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements and they may be required to submit evidence for compliance checks related to Medicare claims. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document is created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item(s) can be found on the Federal Register of Legislation at www.legislation.gov.au. Referral requirements for allied health and Aboriginal and Torres Strait Islander health and wellbeing services are set out in the *Health Insurance (Section 3C – Allied Health and other Primary Health Care Services) Determination 2024*.

AN.15.7 Multidisciplinary care plans for patients who are not a care recipient in a residential care home (MBS items 231, 729, 92026, 92057)

SUMMARY

Multidisciplinary care plans are part of the MBS framework for managing patients with chronic conditions (see AN.15.3 for an overview of MBS items that support the management of chronic conditions).

The multidisciplinary care plan items covered in this note are for patients who are not care recipients in a residential care home. The items can be used to contribute to the preparation or review of a multidisciplinary care plan prepared by another provider. For multidisciplinary care plans for patients who are care recipients in a residential care home see AN.15.8.

Multidisciplinary care plans allow GPs (see GN.4.13) and prescribed medical practitioners (see AN.7.1) to contribute to or review the patient's plan that is developed by other providers.

Patients with a multidisciplinary care plan and living in the community are not eligible for MBS-supported allied health and Aboriginal and Torres Strait Islander health and wellbeing, and other services.

USE OF THE ITEMS

Multidisciplinary care plans are intended to support multidisciplinary care for patients with a chronic condition.

The *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations) define a multidisciplinary care plan as a written plan that:

> *"(a) is prepared for the patient by:*
>
> > *(i) a general practitioner (for items 729 [and 92026]) or a prescribed medical practitioner (for items 231 [and 92057], in consultation with 2 other collaborating providers, each of whom provides a different kind of treatment or service to the patient, and one of whom may be another medical practitioner; or*
> >
> > *(ii) a collaborating provider (other than a general practitioner or a prescribed medical practitioner, as the case may be), in consultation with at least 2 other collaborating providers, each of whom provides a different kind of treatment or service to the patient; and*
>
> *(b) describes, at least, treatment and services to be provided to the patient by the collaborating providers."*

For the purpose of the multidisciplinary care plans, the Regulations specify that a collaborating provider is *"a person, including a medical practitioner, who:*

> *(a) provides treatment or a service to a patient; and*
>
> *(b) is not an unpaid carer of the patient."*

Multidisciplinary care plan items 231, 729, 92026 and 92057 allow the GP or prescribed medical practitioner to contribute to the plan, or a review a plan prepared by another provider.

The Regulations state that contributing to a multidisciplinary care plan includes the following:

> *"(a) preparing part of a multidisciplinary care plan and adding a copy of that part of the plan to the patient's medical records;*
>
> *(b) preparing amendments to part of a multidisciplinary care plan and adding a copy of the amendments to the patient's medical records;*
>
> *(c) giving advice to a person who prepares part of a multidisciplinary care plan and recording in writing, on the patient's medical records, any advice provided to the person;*
>
> *(d) giving advice to a person who reviews part of a multidisciplinary care plan and recording in writing, on the patient's medical records, any advice provided to the person."*

What is a chronic condition?

For the purpose of multidisciplinary care plans, the Regulations define a chronic condition to be a medical condition that has been (or is likely to be) present for at least 6 months, or is terminal.

There is no list of eligible conditions. It is up to the GP or prescribed medical practitioner's clinical judgment to determine whether an individual patient with a chronic condition requires multidisciplinary care to manage the condition.

The items are for contributing to a plan or review. Who prepares the multidisciplinary care plan?

The multidisciplinary care plan is prepared by another provider (i.e. not the GP or prescribed medical practitioner using MBS items 231, 729, 92026 or 92057).

Is there a maximum number of collaborating providers for a multidisciplinary care plan?

No, there is no maximum number of collaborating providers. However, a multidisciplinary care plan requires a minimum of three collaborating providers (including the GP or prescribed medical practitioner) supplying different types of services to the patient.

At least one of the collaborating providers must be a medical practitioner. A maximum of two medical practitioners can be counted in the minimum requirement of three collaborating providers. This means that if there are more than two medical practitioners collaborating on the plan (e.g. a GP, an orthopaedic surgeon and a neurologist) there must also be at least one collaborating provider that is not a medical practitioner.

Do all collaborating providers have to be health care professionals?

No. Any person providing a treatment or service to the patient is a collaborating provider unless they are an unpaid carer of the patient. However, MBS benefits are only available for the GP or prescribed medical practitioner's contribution to the multidisciplinary care plan.

Do all collaborating providers have to provide services under the MBS?

No. At least one of the collaborating providers must be the GP or prescribed medical practitioner who bills the multidisciplinary care item. That a GP or prescribed medical practitioner has contributed to or reviewed a multidisciplinary care plan under these items does not give a patient who is not a care recipient of a residential care home access to MBS subsidised allied health and Aboriginal and Torres Strait Islander health and wellbeing services. Other collaborating providers may provide MBS services (e.g. a specialist), but could also include providers that do not provide services under the MBS e.g. a social worker.

Do all collaborating providers have to meet the MBS item requirements?

The GP or prescribed medical practitioner who bills the multidisciplinary care plan item must meet the requirements of the item.

Other collaborating providers are not able to bill these MBS items and are therefore not required to comply with the item requirements.

How often can the patient have a multidisciplinary care plan?

Multidisciplinary care plan items 231, 729, 92026 and 92057 can be provided once in a 3 month period. However, it cannot be provided if the patient has:

- In the preceding 3 months had a multidisciplinary care plan for a care recipient of a residential care home (see AN.15.8) or a review of their GP chronic condition management plan, or
- In the preceding 12 months had a service:

- by the general practitioner who performs the service to which item 729 would, but for this item, apply; and
- for which a payment has been made for a GP chronic condition management plan.

My patient's clinical condition has changed unexpectedly and their plan should be updated. Can an update ever be done sooner than 3 months?

Yes, the Regulations provide for multidisciplinary care services to be provided to a patient sooner if exceptional circumstances apply. The Regulations define exceptional circumstances as *"there has been a significant change in the patient's clinical condition or care circumstances that necessitates the performance of the service for the patient"*. The reasons for exceptional circumstances should be documented in the patient's notes.

Services Australia needs to be advised that exceptional circumstances apply to pay a benefit sooner than is generally allowable. To facilitate this the patient's invoice, Medicare voucher or the digital claim should indicate that exceptional circumstances apply, no further explanation is required to support payment.

Can patients with a multidisciplinary care plan access allied health and Aboriginal and Torres Strait Islander health and wellbeing services?

Patients with a multidisciplinary care plan who are not care recipients in a residential care home are not eligible to access MBS-supported allied health and Aboriginal and Torres Strait Islander health and wellbeing services. This will apply to all patients at the time a GP or prescribed medical practitioner provides the services described in this note.

ELIGIBLE PATIENTS

Patients are eligible for multidisciplinary care plan items 231, 729, 92026 and 92057 if they:

- have at least one medical condition that has been (or is likely to be) present for at least 6 months, or is terminal, and
- the patient must not be a care recipient in a residential care home, and
- requires ongoing care from at least three collaborating providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner. One of the collaborating providers must also be a provider other than a medical practitioner.

To be eligible for a multidisciplinary care plan provided by telehealth (video) the patient must have an established clinical relationship with the medical practitioner providing the service (see AN.1.1).

ELIGIBLE PRACTITIONERS

Multidisciplinary care plan items are available for different practitioner types:

- general practitioner items can be claimed by GPs only (see GN.4.13).
- prescribed medical practitioner items can be claimed by prescribed medical practitioners only (see AN.7.1).

	GP item number	Prescribed medical practitioner item number
Face to Face	729	231
Video	92026	92057

Noting that, under certain circumstances a multidisciplinary care plan can be provided to a patient in a hospital, the Regulations state that multidisciplinary care items can only be used by medical practitioners that:

- are not employed by the proprietor of a hospital that is not a private hospital, or

- is employed by the proprietor of a hospital that is not a private hospital and provides the service otherwise that in the course of employment by that proprietor.

RECORD KEEPING AND REPORTING REQUIREMENTS

As outlined above, the Regulations require that contributions to a patient's multidisciplinary care plan, including any advice, be added to the patient's medical records.

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements and they may be required to submit evidence for compliance checks related to Medicare claims. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document is created, the document must be retained for the period of 2 years.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item(s) can be found on the Federal Register of Legislation at www.legislation.gov.au. Multidisciplinary care plan items are set out in two regulatory instruments:

- *Health Insurance (General Medical Services Table) Regulations 2021* – 231, 729
- *Health Insurance (Section 3C General Medical Services – Telehealth Attendances) Determination 2021* - 92026, 92057

AN.15.8 Multidisciplinary care plans for a care recipient in a residential care home (items 232, 731, 92027, 92058)

SUMMARY

Multidisciplinary care plans are part of the MBS framework for managing patients with chronic conditions (see AN.15.3 for an overview of MBS items that support the management of chronic conditions). Multidisciplinary care plans allow GPs (see GN.4.13) and prescribed medical practitioners (see AN.7.1) to contribute to a patient's plan that is developed by another provider.

The multidisciplinary care plan items described in this note are available to patients who are a care recipient in a residential care home. The items can be used to contribute to the preparation or review of a multidisciplinary care plan prepared by the residential care home, or another provider before the patient is discharged from a hospital. See AN.15.7 for multidisciplinary care plans for patients who are not care recipients of a residential care home.

Care recipients of a residential care home who have a multidisciplinary care plan may be eligible for MBS-supported allied health and Aboriginal and Torres Strait Islander health and wellbeing, and other services (see AN.15.3).

USE OF THE ITEMS

Multidisciplinary care plans are intended to support multidisciplinary care for patients with a chronic condition.

The *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations) define a multidisciplinary care plan as a written plan that:

> *"(a) is prepared for the patient by:*
>
> > *(i) a general practitioner (for item 731 [and 92027]) or a prescribed medical practitioner (for item 232 [and 92058], in consultation with 2 other collaborating providers, each of whom provides a different kind of treatment or service to the patient, and one of whom may be another medical practitioner; or*

(ii) a collaborating provider (other than a general practitioner or a prescribed medical practitioner, as the case may be), in consultation with at least 2 other collaborating providers, each of whom provides a different kind of treatment or service to the patient; and

(b) describes, at least, treatment and services to be provided to the patient by the collaborating providers."

For the purpose of the multidisciplinary care plans, the Regulations specify that a collaborating provider is *"a person, including a medical practitioner, who:*

(a) provides treatment or a service to a patient; and

(b) is not an unpaid carer of the patient."

Multidisciplinary care plan items 232, 731, 92027, 92058 allow the GP or prescribed medical practitioner to contribute to the plan, or review a plan prepared by:

- The residential care home, or
- Before the patient is discharged from hospital, another provider.

The Regulations state that contributing to a multidisciplinary care plan includes the following:

"(a) preparing part of a multidisciplinary care plan and adding a copy of that part of the plan to the patient's medical records;

(b) preparing amendments to part of a multidisciplinary care plan and adding a copy of the amendments to the patient's medical records;

(c) giving advice to a person who prepares part of a multidisciplinary care plan and recording in writing, on the patient's medical records, any advice provided to the person;

(d) giving advice to a person who reviews part of a multidisciplinary care plan and recording in writing, on the patient's medical records, any advice provided to the person."

What is a chronic condition?

For the purpose of multidisciplinary care plans, the Regulations define a chronic condition to be a medical condition that has been (or is likely to be) present for at least 6 months, or is terminal.

There is no list of eligible conditions. It is up to the GP or prescribed medical practitioner's clinical judgment to determine whether an individual patient with a chronic condition requires multidisciplinary care to manage the condition.

The items are for collaborating to prepare a plan or its review. Who prepares the multidisciplinary care plan?

For care recipients of a residential care home the multidisciplinary care plan is prepared by:

- The residential care home, or
- If the service occurs before the patient is discharged from hospital, another provider.

Is there a maximum number of collaborating providers for a multidisciplinary care plan?

No, there is no maximum number of collaborating providers. However, a multidisciplinary care plan requires a minimum of three collaborating providers (including the GP or prescribed medical practitioner) supplying different types of services to the patient.

At least one of the collaborating providers must be a medical practitioner. A maximum of two medical practitioners can be counted in the minimum requirement of three collaborating providers. This means that if there are more than two medical practitioners collaborating on the plan (e.g. a GP, a geriatrician and a neurologist) there must also be at least one collaborating provider that is not a medical practitioner.

Do all collaborating providers have to be health care professionals?

No. Any person providing a treatment or service to the patient is a collaborating provider unless they are an unpaid carer of the patient. However, MBS benefits are only available for the GP or prescribed medical practitioner's contribution to the multidisciplinary care plan.

Do all collaborating providers have to provide services under the MBS (e.g. allied health professionals)?

No. At least one of the collaborating providers must be the GP or prescribed medical practitioner that bills the multidisciplinary care item. Other collaborating providers may provide MBS services (e.g. a specialist or allied health providers), but it could also include providers that do not provide services under the MBS e.g. a registered nurse at the residential care home that is preparing the plan.

Do all collaborating providers have to meet the MBS item requirements?

The GP or prescribed medical practitioner who bills the multidisciplinary care plan item must meet the requirements of the item.

Other collaborating providers are not able to bill these MBS items and are therefore not required to comply with the item requirements.

How often can the patient have a multidisciplinary care plan?

Multidisciplinary care plan items 232, 731, 92027 and 92058 can be provided once in a 3 month period. However, they cannot be provided if the patient has had a GP chronic condition management plan or review (see AN.0.47) within the last 3 months.

My patient's clinical condition has changed unexpectedly and their plan should be updated. Can an update ever be done sooner than 3 months?

Yes, the Regulations provide for multidisciplinary care services to be provided to a patient sooner if exceptional circumstances apply. The Regulations define exceptional circumstances as "there has been a significant change in the patient's clinical condition or care circumstances that necessitates the performance of the service for the patient". The reasons for exceptional circumstances should be documented in the patient's notes.

Services Australia needs to be advised that exceptional circumstances apply to pay a benefit sooner than is generally allowable. To facilitate this the patient's invoice, Medicare voucher or the digital claim should indicate that exceptional circumstances are in play, no further explanation is required to support payment.

Can patients with a multidisciplinary care plan access allied health and Aboriginal and Torres Strait Islander health and wellbeing services?

Care recipients of a residential care home with a multidisciplinary care plan may be eligible to access a range of services, including up to 5 (10 for patients of Aboriginal or Torres Strait Islander descent) MBS-supported individual allied health and Aboriginal and Torres Strait Islander health and wellbeing services per calendar year (see AN.15.4 for further details).

Does the patient need a referral to access allied health and Aboriginal and Torres Strait Islander health and wellbeing services?

Yes, a referral is required for the patient to access MBS-supported allied health and Aboriginal and Torres Strait Islander health and wellbeing services. See AN.15.6 for information on referrals for these services.

ELIGIBLE PATIENTS

Patients are eligible for multidisciplinary care plan items 232, 731, 92027 and 92058 if they:

- have at least one medical condition that has been (or is likely to be) present for at least 6 months, or is terminal
- are care recipients in a residential care home
- require ongoing care from at least three collaborating providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner. At least one collaborating provider must be a provider who is not a medical practitioner, and
- for items 92027 and 92058 only, the patient must have an established clinical relationship with the medical practitioner providing the service (see AN.1.1). While the face to face items can be used prior to the patient being discharged from a hospital, consistent with the general rules applying to telehealth services items 92027 and 92058 cannot be used when the patient is an admitted patient of a hospital

ELIGIBLE PRACTITIONERS

Multidisciplinary care plan items are available for different practitioner types:

- general practitioner items can be claimed by GPs only (see GN.4.13).
- prescribed medical practitioner items can be claimed by prescribed medical practitioners only (see AN.7.1).

	GP item number	**Prescribed medical practitioner item number**
Face to face	**731**	**232**
Video	92027	92058

Noting that, under certain circumstances a multidisciplinary care plan can be provided to a patient in a hospital, multidisciplinary care plan items can only be used by medical practitioners that:

- are not employed by the proprietor of a public hospital, or
- is employed by the proprietor of a public hospital but the service is provided otherwise than in the course of employment by that proprietor.

RECORD KEEPING AND REPORTING REQUIREMENTS

As outlined above, the Regulations require that contributions to a patient's multidisciplinary care plan, including any advice, be added to the patient's medical records.

Clause 4.3 of the *Health Insurance Act 1973* specifies that, where an item specifies the creation of a document (however described) and a document is created, the document must be retained for the period of 2 years.

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements and they may be required to submit evidence for compliance checks related to Medicare claims. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item(s) can be found on the Federal Register of Legislation at www.legislation.gov.au. Multidisciplinary care plan items are set out in two regulatory instruments:

- *Health Insurance (General Medical Services Table) Regulations 2021* – 232, 731

- *Health Insurance (Section 3C General Medical Services – Telehealth Attendances) Determination 2021* - 92027, 92058

AN.33.1 TAVI CASE CONFERENCE - (ITEMS 6080 AND 6081)

Items 6080 and 6081 apply to a TAVI Case Conference organised to discuss a patient's suitability to receive the service described in items 38495 or 38514 for Transcatheter Aortic Valve Implantation (TAVI).

For items 6080 and 6081 a TAVI Case Conference is a process by which:

(a) there is a team of 3 or more participants, where:

(i) the first participant is a cardiothoracic surgeon; and

(ii) the second participant is an interventional cardiologist; and

(iii) the third participant is a specialist or consultant physician who does not perform a service described in items 38495 or 38514 for the patient being assessed; and

(iv) either the first or the second participant is also a TAVI Practitioner; and

(b) the team assesses a patient's risk and technical suitability to receive the service described in items 38495 or 38514, taking into account matters such as:

(i) the patient's risk and technical suitability for a surgical aortic valve replacement; and

(ii) the patient's cognitive function and frailty; and

(c) the result of the assessment is that the team makes a recommendation about whether or not the patient is suitable to receive the service described in item 38495 or item 38514; and

(d) the particulars of the assessment and recommendation are recorded in writing.

TAVI Practitioner

For items 6080 and 6081 a TAVI Practitioner is either a cardiothoracic surgeon or interventional cardiologist who is accredited by Cardiac Accreditation Services Limited.

Accreditation by Cardiac Accreditation Services Limited must be valid prior to the service being undertaken in order for benefits to be payable under items 38495 or 38514.

The process for accreditation and re-accreditation is outlined in the *Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners*, issued by Cardiac Accreditation Services Limited, and is available on the Cardiac Accreditation Services Limited website, www.tavi.org.au.

Cardiac Accreditation Services Limited is a national body comprising representatives from the Australian & New Zealand Society of Cardiac & Thoracic Surgeons (ANZSCTS) and the Cardiac Society of Australia and New Zealand (CSANZ).

Coordination of a TAVI Case Conference

For item 6080, coordination means undertaking all of the following activities in relation to a TAVI Case Conference:

a. ensuring that the patient is aware of the purpose and nature of the patient's TAVI Case Conference and has consented to their TAVI Case Conference;
b. recording the day the conference was held, and the times the conference started and ended;
c. recording the names of the participants of the conference;

d. provision of expertise to inform the recommendation resulting from the case conference;
e. recording minutes of the TAVI Case Conference including the recommendation resulting from the conference;
f. ensuring that the patient is aware of the recommendation.

Attendance at a TAVI Case Conference

For item 6081, attendance means undertaking all of the following activities in relation to a TAVI Case Conference:

a. retaining a record of the day the conference was held, and the times the conference started and ended;
b. retaining a record of the names of the participants;
c. provision of expertise to inform the recommendation resulting from the case conference;
d. retaining a record of the recommendation resulting from the conference.

General requirements

The TAVI Case Conference must be arranged in advance, within a time frame that allows for all the participants to attend. A TAVI Case Conference is to last at least 10 minutes and a minimum of three suitable participants (as defined under the item requirements), must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

A record of the TAVI Case Conference which contains: a list of the participants; the times the conference commenced and concluded; a description of the assessment of suitability; and a summary of the outcomes must be kept in the patient's record. The notes and summary of outcomes must be provided to all participants.

Prior informed consent must be obtained from the patient, or the patient's agent. In obtaining informed consent the TAVI Practitioner coordinating the TAVI Case Conference should ensure the patient has been:

- Informed that their medical history, diagnosis and care preferences will be discussed with other case conference participants;
- Informed that they may incur a charge for the service for which a Medicare benefit will be payable.

Medicare benefits are only payable in respect of the service provided by the coordinating TAVI Practitioner or the attending interventional cardiologist, cardiothoracic surgeon or independent specialist or consultant physician. Benefits are not payable for another medical practitioner organising a case conference or for attendance by other medical practitioners at a TAVI Case Conference.

It is expected that a patient would not normally require more than one TAVI Case Conference in determining suitability for the services described in items 38495 or 38514. As such, item 6080 is only payable once per patient in a five year period. Item 6081 is payable only twice per patient in a five year period.

Items 6080 and 6081 do not preclude the claiming of a consultation on the same day if other clinically relevant services are provided.

AN.35.1 Flag fall amount for residential care home attendance by a general practitioner

Medicare item 90001 provides a flag fall fee for the initial attendance by a general practitioner at one residential care home, on one occasion, applicable only to the first patient seen on the residential care home visit.

The Medicare benefit for the single flag fall fee and the associated general consultation (Levels A to E) applies only for patients within a residential care home who have a general consultation with a doctor in person.

If doctors do not bill the single flag fall fee, the benefit will not be paid.

If a doctor has to return to the residential care home twice or more on the same day and the attendances are not a continuation of an earlier episode of treatment, another flag fall fee would apply per subsequent residential care

home visit.

When claiming the new attendance items there is no longer a requirement to transmit the number of patients seen. A doctor would claim each attendance item like any other consultation service.

MBS item 90001 is not to be used with existing derived fee services such as for after-hours, urgent after-hours, or telehealth (video and phone) services. The bulk billing incentive only applies to the attendance item, not to the single flag fall fee.

AN.35.2 Flag fall amount for residential care home attendance by a medical practitioner or prescribed medical practitioner

Medicare item 90002 provides a flag fall fee for the initial attendance by a medical practitioner or prescribed medical practitioner at one residential care home, on one occasion, applicable only to the first patient seen on the residential care home visit.

The Medicare benefit for the single flag fall fee and the associated general consultation (Levels A to E) applies only for patients within a residential care home who have a general consultation with a doctor in person.

If doctors do not bill the single flag fall fee, the benefit will not be paid.

If a doctor has to return to the residential care home twice or more on the same day and the attendances are not a continuation of an earlier episode of treatment, another flag fall fee would apply per subsequent residential care home visit.

When claiming the new attendance items there is no longer a requirement to transmit the number of patients seen. A doctor would claim each attendance item like any other consultation service.

MBS item 90002 is not to be used with existing derived fee services such as for after-hours, urgent after-hours, or telehealth (video and phone) services. The bulk billing incentive only applies to the attendance item, not to the single flag fall fee.

AN.36.3 Preparation and Review of Eating Disorder Treatment and Management Plans

Associated items: 90250, 90251, 90252, 90253, 90254, 90255, 90256, 90257, 90260, 90261, 90264, 90265, 90266, 90267, 92146, 92147, 92148, 92149, 92150, 92151, 92152, 92153, 92162, 92163, 92170, 92171, 92172, 92173, 92176, 92177, 92441, 92442

This explanatory note provides information on the preparation and review of Eating Disorder Treatment and Management Plans.

Services attracting Medicare benefits

The Eating Disorder Treatment and Management Plan items define services for which Medicare benefits are payable where a General Practitioner (GP), Medical Practitioner, Consultant Psychiatrist or Consultant Paediatrician undertakes assessment and management of a patient with an eligible eating disorder.

There are 20 MBS items for the preparation of an Eating Disorder Treatment and Management Plan. These are:

For GPs preparing an Eating Disorder Treatment and Management Plan who have undertaken mental health skills training recognised through the General Practice Mental Health Standards Collaboration:

- Face-to-face items 90252 and 90253
- Video items 92148 and 92149

For GPs who have not undertaken mental health skills training:

- Face-to-face items 90250 and 90251
- Video items 92146 and 92147

For Medical Practitioners preparing an Eating Disorder Treatment and Management Plan who have undertaken mental health skills training recognised through the General Practice Mental Health Standards Collaboration:

- Face-to-face items 90256 and 90257
- Video items 92152 and 92153

For Medical Practitioners who have not undertaken mental health skills training:

- Face-to-face items 90254 and 90255
- Video items 92150 and 92151

For Consultant Psychiatrists preparing an Eating Disorder Treatment and Management Plan:

- Face-to-face item 90260
- Video item 92162

For Consultant Paediatricians preparing an Eating Disorder Treatment and Management Plan:

- Face-to-face item 90261
- Video item 92163

There are additional service requirements for consultant psychiatrists and consultant paediatricians to prepare an Eating Disorder Treatment and Management Plan. These additional requirements are outlined under the *Preparation of an Eating Disorder Treatment and Management Plan* section below.

Additionally, there are 12 MBS items for the review of an Eating Disorder Treatment and Management Plan. These are:

For GPs reviewing an Eating Disorder Treatment and Management Plan:

- Face-to-face item 90264
- Video item 92170
- Phone item 92176

For Medical Practitioners reviewing an Eating Disorder Treatment and Management Plan:

- Face-to-face item 90265
- Video item 92171
- Phone item 92177

For Consultant Psychiatrists providing a specialist review of an Eating Disorder Treatment and Management Plan:

- Face-to-face item 90266
- Video item 92172
- Phone item 92441

For Consultant Paediatricians providing a specialist review of an Eating Disorder Treatment and Management Plan:

- Face-to-face item 90267
- Video item 92173
- Phone item 92442

Patient eligibility

These services are available to patients who meet the relevant eligibility requirements outlined in explanatory note MN.16.1 – Overview of Eating Disorder Treatment and Management. These services cannot be provided to patients admitted to hospital.

Provider Eligibility

The Eating Disorder Treatment and Management Plan MBS items are available to use by GPs, medical practitioners, consultant psychiatrists and consultant paediatricians. It is expected that all practitioners providing services under these items should have the appropriate skills, knowledge and experience to provide eating disorder treatment.

Preparation of an Eating Disorder Treatment and Management Plan

An Eating Disorder Treatment and Management Plan is intended to identify and document the care needs of eligible patients with a clinically diagnosed eating disorder, providing a structured and coordinated approach to treatment, monitoring, and ongoing management. An Eating Disorder Treatment and Management Plan must be in place for an individual to access eating disorder treatment services under the MBS (refer explanatory note MN.16.1 – Overview of Eating Disorder Treatment and Management). While there is no requirement for a specific template to be used, all Eating Disorder Treatment and Management Plans must be documented in writing and include the following:

- an opinion on the diagnosis of the patient's eating disorder; and
- treatment options and recommendations to manage the patient's condition for 12 months commencing on the day the plan is prepared; and
- an outline of the options for the referral of the patient to allied health professionals for mental health and dietetic health services, and to specialists, as appropriate.

In addition to the requirements outlined above, Eating Disorder Treatment and Management Plans prepared by consultant psychiatrists and consultant paediatricians must comply with the additional requirements outlined below for a Medicare benefit to be payable.

For an Eating Disorder Treatment and Management Plan to be prepared by a consultant psychiatrist, during the attendance, the consultant psychiatrist must use an outcome tool (if clinically appropriate) and carry out a mental state examination. An outcome tool refers to a tool used to monitor changes in a patient's health that occur in response to treatment received by the patient. The choice of outcome tool/s to be used is at the clinical discretion of the practitioner, however any outcome tool used should be evidence-based. An example of an appropriate outcome tool for eating disorders is the Eating Disorder Examination Questionnaire (EDE-Q).

An Eating Disorder Treatment and Management Plan prepared by a consultant psychiatrist must also include:

- a comprehensive evaluation of the patient's biological, psychological and social issues; and
- management recommendations addressing those issues.

For an Eating Disorder Treatment and Management Plan to be prepared by a consultant paediatrician, during the attendance, the consultant paediatrician must:

- undertake an assessment of the patient that includes a comprehensive history (including a psychosocial history and medication review); and
- undertake a comprehensive multi-organ system assessment or a detailed single-organ system assessment; and
- Include the results of these assessments in the patient's Eating Disorder Treatment and Management Plan.

Consultant psychiatrists and consultant paediatricians must provide a copy of an Eating Disorder Treatment and Management Plan to the patient's referring practitioner within 2 weeks of an Eating Disorder Treatment and Management Plan preparation service being provided. Where clinically appropriate, the consultant psychiatrist or consultant paediatrician must also provide a copy of the plan to the patient and, where authorised by the patient, to the patient's carer, within 2 weeks of the attendance.

GPs and medical practitioners preparing an Eating Disorder Treatment and Management Plan must provide a copy of the plan and suitable education about the patient's eating disorder to the patient, and where relevant and if authorised by the patient, the patient's carer, during the attendance for an Eating Disorder Treatment and Management Plan item to be claimed.

All practitioners preparing an Eating Disorder Treatment and Management Plan should ensure a copy of the Eating Disorder Treatment and Management Plan is added to the patient's medical records where appropriate.

Referral and treatment options

Patients with an Eating Disorder Treatment and Management Plan in place are eligible to access comprehensive treatment and management services over a 12-month period commencing from when the plan is prepared. These services may consist of:

- Up to 20 eating disorder dietetic treatment services (refer explanatory note MN.16.2 - Provision of Eating Disorder Dietetic Treatment Services)
- Up to 40 eating disorder psychological treatment services, noting a patient may only be referred for a maximum 10 services at a time. A review of the patient's Eating Disorder Treatment and Management Plan is required to access additional services (refer explanatory note MN.16.3 – Provision of Eating Disorder Psychological Treatment Services)
- Case conferencing services (refer explanatory note AN.15.1 – Mental Health Case Conferencing)
- Review and ongoing management services to ensure that the patient accesses the appropriate level of intervention

A patient may be referred for a maximum of 10 eating disorder psychological treatment services within a course of treatment. To access additional services, a review of the patient's Eating Disorder and Treatment Management Plan must be undertaken to assess the patient's progress and need for further treatment. The requirements for a review of a patient's Eating Disorder and Treatment Management Plan are set out below.

Review of an Eating Disorder Treatment and Management Plan

A review of a patient's an Eating Disorder Treatment and Management Plan, including referral of treatment services and ongoing management of a patient's eating disorder, is a key component for assessing and managing the patient's progress. A review of the patient's Eating Disorder Treatment and Management Plan must be undertaken after each course of 10 eating disorder psychological treatment services. This review is required before the patient may access further services and applies at each review point (after the provision of 10, 20 and 30 services), up to the annual cap of 40 eating disorder psychological treatment services within a 12-month period. A review of a patient's Eating Disorder Treatment and Management Plan must include:

- a review of the treatment efficacy of treatments provided under the plan, including by discussing with the patient whether the treatments are meeting the patient's needs; and
- if the treatment options in the plan are to be continued - modify the plan, in writing, to include the recommendation that the treatment options are to be continued; or
- if the treatment options in the plan are to be revised - modify the plan, in writing, to include the recommendation that the treatment options are to be revised and the revised treatment options

A copy of the modified plan and suitable education about the patient's eating disorder must be given to the patient and where relevant and if authorised by the patient, the patient's carer, during the attendance for a Medicare benefit to be payable.

During a review of a patient's Eating Disorder Treatment and Management Plan, a patient may be referred for additional treatment services if clinically indicated, noting that a patient may only be referred for a maximum of 10 eating disorder psychological treatment services at a time.

To access more than 20 eating disorder psychological treatment services, a patient's Eating Disorder Treatment and Management Plan must undergo a specialist review conducted by a consultant psychiatrist or consultant

paediatrician in addition to a review conducted by GP or medical practitioner. The service requirements for a Specialist Review of an Eating Disorder Treatment and Management Plan are set out below.

Specialist Review of an Eating Disorder Treatment and Management Plan

To access more than 20 eating disorder psychological treatment services, a patient must be referred by the GP or medical practitioner managing their eating disorder to a consultant psychiatrist or consultant paediatrician for a specialist review of their Eating Disorder Treatment and Management Plan. The specialist review is required to provide an expert clinical assessment of treatment response and to confirm that the provision of additional services is clinically appropriate. A specialist review service may take place at any time during a patient's treatment but must be conducted, and the relevant MBS item claimed, before a patient is able to access more than 20 eating disorder psychological treatment services.

In addition to the requirements set out above, Eating Disorder Treatment and Management Plans reviewed by consultant psychiatrists and consultant paediatricians must comply with the additional requirements outlined below for a Medicare benefit to be payable.

For an Eating Disorder Treatment and Management Plan to be reviewed by a consultant psychiatrist, during the attendance, the consultant psychiatrist must:

- use an outcome tool (if clinically appropriate); and
- carry out a mental state examination.

An outcome tool refers to a tool used to monitor changes in a patient's health that occur in response to treatment received by the patient. The choice of outcome tool/s to be used is at the clinical discretion of the practitioner, however any outcome tool used should be evidence-based. An example of an appropriate outcome tool for eating disorders is the Eating Disorder Examination Questionnaire (EDE-Q).

For an Eating Disorder Treatment and Management Plan to be reviewed by a consultant paediatrician, during the attendance, the consultant paediatrician must:

- undertake an assessment of the patient that includes a comprehensive history (including a psychosocial history and medication review); and
- undertake a comprehensive multi-organ system assessment or a detailed single-organ system assessment

A copy of the modified plan must be given to the referring practitioner, the patient and, where relevant and if authorised by the patient, the patient's carer, within 2 weeks of the attendance for a Medicare benefit to be payable. The consultant psychiatrist or consultant paediatrician must provide their recommendation for the management of the patient's ongoing treatment to the referring GP or medical practitioner who will conduct their own review of the patient's Eating Disorder Treatment and Management Plan and can provide a referral for additional psychological eating disorder treatment services if clinically indicated.

MBS Telehealth (video) services for Eating Disorder Treatment and Management Plans

An Eating Disorder Treatment and Management Plan may be prepared and reviewed using the relevant Telehealth (Video) MBS items where clinically appropriate. Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated. For information on what constitutes adequate and contemporaneous records, refer to explanatory note GN.15.39 - Practitioners should maintain adequate and contemporaneous records. Only clinical details recorded at the time of the attendance count towards the time of the consultation.

Referral requirements

Referring practitioners are not required to use a specific Medicare form to refer patients for these services. An Eating Disorder Treatment and Management Plan is not considered a referral. A referral for eating disorder treatment services must be in writing (signed and dated by the referring practitioner [which can be by an electronic signature]) and should include:

- the patient's name, date of birth and address;
- the patient's symptoms or diagnosis;
- a list of any current medications; and
- the number of services the patient is being referred for

Eligible GPs and eligible medical practitioners who provide eating disorder psychological treatment services do so as part of an arrangement for the treatment of a clinically diagnosed eating disorder under an Eating Disorder Treatment and Management Plan. Where appropriate, and with the patient's agreement, a copy of the Eating Disorder Treatment and Management Plan can be attached to the referral.

Links to other Medicare Services

Mental health support is also available under the Better Access initiative, which provides eligible patients with Medicare benefits for up to 10 individual and 10 group mental health treatment services per calendar year when accessed under a Mental Health Treatment Plan.

There is nothing that precludes eligible patients from accessing services concurrently under an Eating Disorder Treatment and Management Plan and a Mental Health Treatment Plan. However, the creation of multiple plans would only occur where the patient has significant co-occurring mental health conditions that require psychological treatment which extends beyond eating disorder specific care.

It is important to note that service cap limits continue to apply for patients accessing care under both an Eating Disorder Treatment and Management Plan and a Mental Health Treatment Plan. Better Access mental health treatment services do not count toward the Eating Disorder Treatment and Management Plan psychological treatment service caps if they are delivered before the plan is prepared. However, they do count toward the service caps if delivered whilst an Eating Disorder Treatment and Management Plan is active.

For example, if a patient has an active Eating Disorder Treatment and Management Plan and a Mental Health Treatment Plan concurrently, they may access a combined maximum of 40 individual psychological treatment services. This total comprises eating disorder psychological treatment services and up to 10 individual services combined across focussed psychological strategy services and psychological therapy services where the relevant eligibility requirements are met. Conversely, if a patient has accessed Better Access mental health treatment services prior to the preparation of an Eating Disorder Treatment and Management Plan, they remain eligible to access up to 40 individual eating disorder psychological treatment services. In these circumstances, the previously claimed Better Access services do not count towards the eating disorder psychological treatment service cap.

For further information on the Better Access initiative, refer to explanatory note AN.0.78 – Better Access Initiative.

Additional claiming information

Practitioners providing Eating Disorder Treatment and Management services must ensure adequate and contemporaneous records are maintained. For information on what constitutes adequate and contemporaneous records, refer to explanatory note GN.15.39 - Practitioners should maintain adequate and contemporaneous records.

To co-claim an Eating Disorder Treatment and Management Plan MBS item and another attendance item, both services must be clinically relevant and distinct services. A Medicare benefit is not payable, and an account should not be rendered, until all components of the relevant items have been provided.

All consultations conducted as part of the Eating Disorder Treatment and Management Plan items must be rendered by a GP, medical practitioner, consultant psychiatrist or consultant paediatrician. A specialist mental health nurse, other allied health practitioner, Aboriginal and Torres Strait Islander health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance in provision of mental health care.

Further information

For further information about Eating Disorder Treatment and Management, refer to explanatory note MN.16.1 - Overview of Eating Disorder Treatment and Management.

For further information about Medicare Benefits Schedule items, please visit the MBS online website at www.health.gov.au/mbsonline.

Further information is available for providers from the Services Australia provider enquiry line on 132 150.

If you are a patient seeking advice about Medicare services, patient benefits, or your Medicare claims, please contact Services Australia on the Medicare General enquiry line on 132 011.

AN.40.1 Specialist and Consultant Physician MBS Telehealth (video and phone) attendance items

A number of telehealth (video and phone) items are permanently available.

The intent of these ongoing telehealth items is to allow practitioners to provide MBS attendances remotely (by videoconference or telephone) where it is safe and clinically appropriate to do so in accordance with relevant professional standards.

Providing telehealth by video/videoconference is the preferred substitute for a face-to-face consultation. However, providers can provide a phone consultation via telephone where it is clinically relevant (and the service is covered by a relevant phone item).

A list of the ongoing telehealth items and the equivalent face-to-face items can be found at Table 1.

Table 1 – Ongoing telehealth items and equivalent face-to-face services (out of hospital patients)

Service	Face-to-face items	Video items	Phone items
Specialist Services			
Specialist. Initial attendance	104	91822	-
Specialist. Subsequent attendance	105	91823	91833
Gynaecologist Specialist Services			
Specialist gynaecologist long consult initial attendance	125	127	-
Specialist gynaecologist long consult subsequent attendance	126	129	-
Consultant Physician Services			-
Consultant physician. Initial attendance	110	91824	-
Consultant physician. Subsequent attendance	116	91825	92440

Consultant physician. Subsequent minor attendance	119	91826	91836
Consultant physician. Initial assessment, patient with at least 2 morbidities, prepare a treatment and management plan, at least 45 minutes	132	92422	-
Consultant physician, Subsequent assessment, patient with at least 2 morbidities, review a treatment and management plan, at least 20 minutes	133	92423	92443
Specialist and Consultant Physician Services			
Specialist or consultant physician, develop a treatment and management plan, patient aged under 25, with an eligible disability	137	92141	-
Geriatrician Services			
Geriatrician, prepare an assessment and management plan, patient at least 65 years, more than 60 minutes	141	92623	-
Geriatrician, review a management plan, more than 30 minutes	143	92624	92448
Consultant Psychiatrist services			
Consultant psychiatrist, develop a treatment and management plan, patient aged under 25, with a complex neurodevelopmental disorder (such as autism spectrum disorder), at least 45 minutes	289	92434	-

Consultant psychiatrist, prepare a management plan, more than 45 minutes	291	92435	-
Consultant psychiatrist, review management plan, 30 to 45 minutes	293	92436	92444
Consultant psychiatrist, attendance, new patient (or has not received attendance in preceding 24 mths), more than 45 minutes	296	92437	-
Consultant psychiatrist. Consultation, not more than 15 minutes	300	91827	91837
Consultant psychiatrist. Consultation, 15 to 30 minutes	302	91828	91838
Consultant psychiatrist. Consultation, 30 to 45 minutes	304	91829	91839
Consultant psychiatrist. Consultation, 45 to 75 minutes	306	91830	-
Consultant psychiatrist. Consultation, more than 75 minutes	308	91831	-
Consultant psychiatrist, group psychotherapy, at least 1 hour, involving group of 2 to 9 unrelated patients or a family group of more than 3 patients, each referred to consultant psychiatrist	342	92455	-
Consultant psychiatrist, group psychotherapy, at least 1 hour, involving family group of 3 patients, each referred	344	92456	-

to consultant psychiatrist			
Consultant psychiatrist, group psychotherapy, at least 1 hour, involving family group of 2 patients, each referred to consultant psychiatrist	346	92457	
Consultant psychiatrist, interview of a person other than patient, in the course of initial diagnostic evaluation of patient, 20 to 45 minutes	348	92458	-
Consultant psychiatrist, interview of a person other than patient, in the course of initial diagnostic evaluation of patient, 45 minutes or more	350	92459	-
Consultant psychiatrist, interview of a person other than patient, in the course of continuing management of patient, not less than 20 minutes, not exceeding 4 attendances per calendar year	352	92460	-
Consultant psychiatrist, prepare an eating disorder treatment and management plan, more than 45 minutes	90260	92162	
Consultant psychiatrist, to review an eating disorder plan, more than 30 minutes	90266	92172	92441
Paediatrician Services (also refer to consultant physician services)			

Paediatrician, develop a treatment and management plan, patient aged under 25, with a complex neurodevelopmental disorder (such as autism spectrum disorder), at least 45 minutes	135	92140	
Paediatrician, prepare an eating disorder treatment and management plan, more than 45 minutes	90261	92163	
Paediatrician, to review an eating disorder plan, more than 20 minutes	90267	92173	92442
Public Health Physician Services			
Public health physician, level A attendance	410	92513	92521
Public health physician, level B attendance, less than 20 minutes	411	92514	92522
Public health physician, level C attendance, at least 20 minutes	412	92515	-
Public health physician, level D attendance, at least 40 minutes	413	92516	-
Neurosurgery attendances			
Neurosurgeon, initial attendance	6007	92610	-
Neurosurgeon, minor attendance	6009	92611	92618
Neurosurgeon, subsequent attendance, 15 to 30 minutes	6011	92612	92445
Neurosurgeon, subsequent attendance, 30 to 45 minutes	6013	92613	92446
Neurosurgeon, subsequent	6015	92614	92447

attendance, more than 45 minutes			
Anaesthetist attendance			
Anaesthetist, professional attendance, advanced or complex	17615	92701	-
Consultant occupational physician			
Consultant occupational physician, initial attendance	385	92748	-
Consultant occupational physician, subsequent attendance	386	92749	92750
Pain medicine services			
Pain medicine specialist or consultant, initial attendance	2801	92751	-
Pain medicine specialist or consultant, subsequent attendance	2806	92752	-
Pain medicine specialist or consultant, subsequent minor attendance	2814	92753	92754
Palliative medicine			
Palliative medicine specialist or consultant physician, initial attendance	3005	92755	-
Palliative medicine specialist or consultant physician, subsequent attendance	3010	92756	-
Palliative medicine specialist or consultant physician, subsequent minor attendance	3014	92757	92758
Addiction medicine services			

Addiction medicine specialist, initial attendance	6018	92759	-
Addiction medicine specialist, subsequent attendance	6019	92760	-
Addiction medicine specialist, subsequent minor attendance	119	-	92761
Addiction medicine specialist, initial attendance, patient with at least 2 morbidities not less than 45 minutes	6023	92762	-
Addiction medicine specialist, subsequent attendance with review of patient with at least 2 morbidities, not less than 20 minutes	6024	92763	-
Sexual health medicine services			
Sexual health medicine specialist, initial attendance	6051	92764	-
Sexual health medicine specialist, subsequent attendance	6052	92765	-
Sexual health medicine specialist, subsequent minor attendance	119	-	92766
Sexual health medicine specialist, initial attendance, patient with at least 2 morbidities not less than 45 minutes	6057	92767	-
Sexual health medicine specialist, subsequent attendance with review of patient with at least 2 morbidities, not less than 20 minutes	6058	92768	-

Further information can be found on the MBS Telehealth Services factsheet page on MBS Online.

Eligible providers

All MBS items for referred attendances require a valid referral. However, if the specialist, consultant physician, consultant psychiatrist, paediatrician or geriatrician has previously seen the patient under a referral that is still valid, there is no need to obtain a specific referral for the purposes of claiming the video and phone items.

Restrictions

All MBS telehealth (video and phone) attendance items are stand-alone items and are to be billed instead of a face-to-face MBS item.

Billing Requirements

Bulk billing of specialist (and Allied Health) telehealth services is at the discretion of the provider, so long as informed financial consent is obtained prior to the provision of the service.

Further information on the assignment of benefit for bulk billed MBS telehealth services can be found in the 'Provider Frequently Asked Questions' at www.mbsonline.gov.au.

Relevant definitions and requirements

Specialist telehealth services (91822, 91823 and 91833) can be billed by all specialities that can currently bill items 104 and 105 or equivalent MBS items. This also includes occupational and environmental health medicine specialists.

Consultant physician video services (91824, 91825 and 91826) and phone services (92440 and 91836) can be billed by all specialities that can currently bill items 110, 116 and 119 or equivalent MBS items.

Consultant physician video services to prepare and review a management plan (92422 and 92423) and phone services (92443) can be billed by all physicians that can currently bill items 132 and 133 or equivalent MBS items.

The specialist and consultant physician service for diagnosis and treatment for patients with an eligible disability (92141) can be billed by specialists and consultant physicians that are able to item 137.

Single course of treatment

The same conditions for a single course of treatment apply across all modalities (i.e. face-to-face, video or phone). Once an initial consultation is billed, all subsequent services related to the same condition are considered to be part of a single course of treatment. For example, if a patient has seen a specialist in a face-to-face consultation (where item 104 has been billed), item 91823 (video) or 91833 (phone) should be billed if the patient sees the specialist remotely for the same condition.

Anaesthetist services

The Anaesthetist video service (92701) can be billed by practitioners that can currently bill item 17615.

Service limits

At present, the service limits that apply to standard psychiatry services do not currently apply to the video and phone attendance items for psychiatry (except for item 92460). Patients who have received more than 50 attendances under existing items are eligible to receive services under the video and phone psychiatry items as long as they meet the item descriptor requirements.

In addition, patients who have received more than 50 attendances under item 319 are eligible to receive services under the video and phone psychiatry items as long as they meet the item descriptor requirements.

The Department of Health, Disability and Ageing will work with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Medicare Review Advisory Committee (MRAC) to review the current service limits, and ensure a consistent approach across all of the psychiatry attendance items, including services provided by face-to-face, video and phone.

Interview item (92460)

Item 92460 provides for an interview with a person other than the patient. A maximum of 4 services in a calendar year can be billed under item 92460, or the equivalent face-to-face item (item 352), in the continuing management of a patient. That is, a consultant psychiatrist can bill for a service under item 92460 once more in the calendar year if a patient has received three MBS services under items 352 or 92460 in the same calendar year.

Management Plan items (92435 and 92436)

The MBS remote attendance preparation and review of GP management plan items have the same diagnosis, assessment and record-keeping requirements as the existing face-to-face items (291 and 293). Refer to MBS Explanatory Note AN.0.30 for further information.

Group psychotherapy items (92455, 92456 and 92457)

The MBS remote attendance group psychotherapy items have the same requirements as the existing face-to-face items (342, 344 and 346). It is the responsibility of the practitioner rendering the service to maintain privacy and confidentiality for all participants throughout the service. Practitioners should refer to the relevant professional practice standards and guidelines for technology-based consultations.

Technical Requirements

The services can be provided by telehealth (video and phone). It is the responsibility of the practitioner rendering the service to maintain privacy and confidentiality for all participants throughout the service.

Video attendance means a professional attendance by video conference where the medical practitioner:

a. has the capacity to provide the full service through this means safely and in accordance with relevant professional standards; and
b. is satisfied that it is clinically appropriate to provide the service to the patient; and
c. maintains a visual and audio link with the patient; and
d. is satisfied that the software and hardware used to deliver the service meets the applicable laws for security and privacy.

Note – only the time where a visual and audio link is maintained between the patient and the provider can be counted in meeting the relevant item descriptor.

No specific equipment is required to provide Medicare-compliant telehealth services. Practitioners must ensure that their chosen telecommunications solution meets their clinical requirements and satisfies privacy laws. Information on how to select a web conferencing solution is available at: www.cyber.gov.au

Phone attendance means a professional attendance by telephone where the health practitioner:

a. has the capacity to provide the full service through this means safely and in accordance with professional standards; and
b. is satisfied that it is clinically appropriate to provide the service to the patient; and
c. maintains an audio link with the patient.

Recording Clinical Notes (for specialist, consultant physician, consultant psychiatrist, neurosurgery, public health medicine, geriatrician, paediatrician and anaesthetist)

In relation to the time taken in recording appropriate details of the service, only clinical details recorded at the time of the attendance count towards the time of consultation. It does not include information added later, such as reports of investigations, or when either the visual or audio link between the patient and the practitioner is lost.

Clinicians should record the date, time and duration of the consultation, and retain these records.

AN.40.5 MBS Items for Blood Borne Virus, Sexual and Reproductive Health Services

The video and phone items for the provision of services related to blood borne viruses, sexual or reproductive health provides for Medicare benefits to be paid for these health care services without the requirement for the patient to have an established clinical relationship with the physician. This does not exclude practitioners who have an established clinical relationship with the patient from using these items.

These items are intended to support patient access to medical services where there may be barriers due to privacy or limited service provision, and are not intended to replace routine services that a patient's usual practitioner might provide.

The practitioner must keep adequate and contemporary notes to support the service provided.

There are 24 MBS items for the provision of video or phone services related to blood borne viruses, sexual or reproductive health.

Video consultation

Item 92715 – services provided by a General Practitioner (level A)

Item 92716 – services provided by an Other Medical Practitioner - urban

Item 92717 – services provided by an Other Medical Practitioner – rural

Item 92718 – services provided by a General Practitioner (level B)

Item 92719 – services provided by an Other Medical Practitioner - urban

Item 92720 – services provided by an Other Medical Practitioner – rural

Item 92721 – services provided by a General Practitioner (level C)

Item 92722 – services provided by an Other Medical Practitioner - urban

Item 92723 – services provided by an Other Medical Practitioner – rural

Item 92724 – services provided by a General Practitioner (level D)

Item 92725 – services provided by an Other Medical Practitioner – urban

Item 92726 – services provided by an Other Medical Practitioner – rural

Phone consultation

Item 92731 – services provided by a General Practitioner (level A)

Item 92732 – services provided by an Other Medical Practitioner - urban

Item 92733 – services provided by an Other Medical Practitioner – rural

Item 92734 – services provided by a General Practitioner (level B)

Item 92735 – services provided by an Other Medical Practitioner - urban

Item 92736 – services provided by an Other Medical Practitioner – rural

Item 92737 – services provided by a General Practitioner (level C)

Item 92738 – services provided by an Other Medical Practitioner - urban

Item 92739 – services provided by an Other Medical Practitioner – rural

Item 92740– services provided by a General Practitioner (level D)

Item 92741– services provided by an Other Medical Practitioner – urban

Item 92742 – services provided by an Other Medical Practitioner - rural

To be eligible for use of this item, practitioners must be located at a medical practice or have a formal agreement with a medical practice that provides onsite face to face services to patients.

Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items.

AR.8.1 Attendance Services provided under Item 294 are to be provided by video conference rather than at consulting rooms

When a service provided to a patient under item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318 or 319 is provided under item 294, it may be provided by video conference rather than at consulting rooms.

AR.29.1 Attendance services for eligible disabilities

Eligibility of this service under 137 or 92141 (specialists and consultant physicians), 139 or 92142 (general practitioners)

'Eligible disabilities' for the purpose of these services means any of the following conditions:

(a) sight impairment that results in vision of less than or equal to 6/18 vision or equivalent field loss in the better eye, with correction;

(b) hearing impairment that results in:
- a hearing loss of 40 decibels or greater in the better ear, across 4 frequencies; or
- permanent conductive hearing loss and auditory neuropathy.

(c) deafblindness;

(d) cerebral palsy;

(e) Down syndrome;

(f) fragile X syndrome;

(g) Prader-Willi syndrome;

(h) Williams syndrome;

(i) Angelman syndrome;

(j) Kabuki syndrome;

(k) Smith-Magenis syndrome;

(l) CHARGE syndrome;

(m) Cri du Chat syndrome;

(n) Cornelia de Lange syndrome;

(o) microcephaly if a child has:
• a head circumference less than the third percentile for age and sex; and
• a functional level at or below 2 standard deviations below the mean for age on a standard developmental test, or an IQ score of less than 70 on a standardised test of intelligence;*

(p) Rett syndrome;

(q) fetal alcohol spectrum disorder (FASD);

(r) Lesch-Nyhan syndrome;

(s) 22q deletion syndrome;

(t) stuttering;

(u) speech sound disorders, including articulation and phonological disorders, childhood apraxia of speech (also known as dyspraxia, developmental verbal dyspraxia, or speech apraxia), and dysarthria;

(v) cleft lip, cleft palate, or cleft lip and palate.

*"standard developmental test" refers to tests such as the Bayley Scales of Infant Development or the Griffiths Mental Development Scales; "standardised test of intelligence" means the Wechsler Intelligence Scale for Children (WISC) or the Wechsler Preschool and Primary Scale of Intelligence (WPPSI). It is up to the clinical judgement of the diagnosing practitioner to determine which tests are appropriate to be used.

Information on the Ready Reckoners can be found on the MBS Online downloads page at https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Downloads-20260701

PROFESSIONAL ATTENDANCES ITEMS

A1. GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A1. General Practitioner Attendances To Which No Other Item Applies
123	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 (See para MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, MN.10.1, AN.0.9, AN.0.24, AN.0.74 of explanatory notes to this Category) **Fee:** $207.90 **Benefit:** 100% = $207.90 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
Amend 124	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential care home 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 (See para AN.0.13, AN.0.11, AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6, AN.0.24, MN.10.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 123, plus $31.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 123 plus $2.50 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
	LEVEL A
3	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 (See para MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, MN.10.1, AN.0.9, AN.0.73, AN.0.74 of explanatory notes to this Category) **Fee:** $20.55 **Benefit:** 100% = $20.55 **Extended Medicare Safety Net Cap:** $61.65 **Future End Date:**
Amend 4	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential care home 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 at one place on one occasion—each patient (See para MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, MN.10.1, AN.0.13, AN.0.9, AN.0.11, AN.0.73, AN.0.74 of explanatory notes to this Category)

A1. GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Derived Fee: The fee for item 3, plus $31.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $2.50 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
	LEVEL B
23	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 (See para MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, MN.10.1, AN.0.9, AN.0.73, AN.0.74 of explanatory notes to this Category) **Fee:** $45.05 **Benefit:** 100% = $45.05 **Extended Medicare Safety Net Cap:** $135.15 **Future End Date:**
Amend 24	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential care home 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 (See para MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, MN.10.1, AN.0.13, AN.0.9, AN.0.11, AN.0.73, AN.0.74 of explanatory notes to this Category) **Derived Fee:** The fee for item 23, plus $31.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus $2.50 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
	LEVEL C
36	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;

A1. GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	for one or more health-related issues, with appropriate documentation-each attendance (See para MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, MN.10.1, AN.0.9, AN.0.73, AN.0.74 of explanatory notes to this Category) **Fee:** $87.10 **Benefit:** 100% = $87.10 **Extended Medicare Safety Net Cap:** $261.30 **Future End Date:**
Amend 37	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential care home or 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 place on one occasion—each patient (See para AN.0.11, AN.0.73, AN.0.74, MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, MN.10.1, AN.0.13, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 36, plus $31.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus $2.50 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
	LEVEL D
44	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 (See para MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, MN.10.1, AN.0.9, AN.0.73, AN.0.74 of explanatory notes to this Category) **Fee:** $128.35 **Benefit:** 100% = $128.35 **Extended Medicare Safety Net Cap:** $385.05 **Future End Date:**

A1. GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
Amend 47	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential care home or 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 place on one occasion—each patient (See para MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, MN.10.1, AN.0.13, AN.0.9, AN.0.11, AN.0.73, AN.0.74 of explanatory notes to this Category) **Derived Fee:** The fee for item 44, plus $31.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $2.50 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**

A2. OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	1. OTHER MEDICAL PRACTITIONER ATTENDANCES
	Group A2. Other Non-Referred Attendances To Which No Other Item Applies
	Subgroup 1. Other Medical Practitioner Attendances
151	Professional attendance at consulting rooms lasting more than 60 minutes (other than a service to which any other item applies) by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner (See para AN.2.1, AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $98.40 **Benefit:** 100% = $98.40 **Extended Medicare Safety Net Cap:** $295.20 **Future End Date:**
Amend 165	Professional attendance (other than an attendance at consulting rooms or a residential care home or a service to which any other item in this Schedule applies) lasting more than 60 minutes—an attendance on one or more patients at one place on one occasion—each patient, by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner (See para AN.7.2, MN.1.6, MN.1.7, AN.0.13, MN.1.8, AN.0.9, AN.0.11, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** An amount equal to $88.20, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $88.20 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**

A2. OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	1. OTHER MEDICAL PRACTITIONER ATTENDANCES
	CONSULTATION AT CONSULTING ROOMS
52	Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which any other item applies)-each attendance, by: (a) a medical practitioner (who is not a general practitioner); or (b) a Group A1 disqualified general practitioner, as defined in the dictionary of the General Medical Services Table (GMST). (See para AN.2.1, AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $11.00 **Benefit:** 100% = $11.00 **Extended Medicare Safety Net Cap:** $33.00 **Future End Date:**
53	Professional attendance at consulting rooms of more than 5 minutes in duration but not more than 25 minutes (other than a service to which any other item applies)-each attendance, by: (a) a medical practitioner (who is not a general practitioner); or (b) a Group A1 disqualified general practitioner, as defined in the dictionary of the General Medical Services Table (GMST). (See para AN.2.1, AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00 **Future End Date:**
54	Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45 minutes (other than a service to which any other item applies)-each attendance, by: (a) a medical practitioner (who is not a general practitioner); or (b) a Group A1 disqualified general practitioner, as defined in the dictionary of the General Medical Services Table (GMST). (See para AN.2.1, AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00 **Future End Date:**
57	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) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner (See para AN.2.1, AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00 **Future End Date:**
	CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS OR A RESIDENTIAL AGED CARE FACILITY

A2. OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	1. OTHER MEDICAL PRACTITIONER ATTENDANCES
Amend 58	Professional attendance (other than an attendance at consulting rooms or a residential care home or a service to which any other item in the table applies), not more than 5 minutes in duration-an attendance on one or more patients at one place on one occasion-each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a Group A1 disqualified general practitioner, as defined in the dictionary of the General Medical Services Table (GMST). (See para AN.7.2, MN.1.6, MN.1.7, AN.0.13, MN.1.8, AN.0.9, AN.0.11, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** An amount equal to $8.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $8.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 59	Professional attendance (other than an attendance at consulting rooms or a residential care home or a service to which any other item in the table applies) of more than 5 minutes in duration but not more than 25 minutes-an attendance on one or more patients at one place on one occasion-each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a Group A1 disqualified general practitioner, as defined in the dictionary of the General Medical Services Table (GMST). (See para AN.7.2, MN.1.6, MN.1.7, AN.0.13, MN.1.8, AN.0.9, AN.0.11, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 60	Professional attendance (other than an attendance at consulting rooms or a residential care home or a service to which any other item in the table applies) of more than 25 minutes in duration but not more than 45 minutes-an attendance on one or more patients at one place on one occasion-each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a Group A1 disqualified general practitioner, as defined in the dictionary of the General Medical Services Table (GMST). (See para AN.7.2, MN.1.6, MN.1.7, AN.0.13, MN.1.8, AN.0.9, AN.0.11, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 65	Professional attendance (other than an attendance at consulting rooms or a residential care home or a service to which any other item in this Schedule 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—each patient, by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner

A2. OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	1. OTHER MEDICAL PRACTITIONER ATTENDANCES
	(See para AN.7.2, MN.1.6, MN.1.7, AN.0.13, MN.1.8, AN.0.9, AN.0.11, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**

A3. SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A3. Specialist Attendances To Which No Other Item Applies
104	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—initial attendance in a single course of treatment, other than a service to which item 106, 109, 125 or 16401 applies (See para AN.40.1, AN.2.1, TN.1.4, MN.10.1, AN.0.7, AN.0.25 of explanatory notes to this Category) **Fee:** $103.95 **Benefit:** 75% = $78.00 85% = $88.40 **Extended Medicare Safety Net Cap:** $311.85 **Future End Date:**
105	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 (See para AN.40.1, AN.2.1, AN.3.1, TN.1.4, MN.10.1, AN.0.7, AN.0.25, AN.0.70 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 75% = $39.20 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
106	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) (See para MN.10.1 of explanatory notes to this Category) **Fee:** $86.25 **Benefit:** 75% = $64.70 85% = $73.35 **Extended Medicare Safety Net Cap:** $258.75 **Future End Date:**
107	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 (See para MN.10.1, AN.0.25 of explanatory notes to this Category) **Fee:** $152.50 **Benefit:** 75% = $114.40 85% = $129.65 **Extended Medicare Safety Net Cap:** $457.50 **Future End Date:**
108	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 (See para MN.10.1, AN.0.25 of explanatory notes to this Category)

A3. SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Fee: $96.55 **Benefit:** 75% = $72.45 85% = $82.10 **Extended Medicare Safety Net Cap:** $289.65 **Future End Date:**
109	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) (See para MN.10.1 of explanatory notes to this Category) **Fee:** $234.25 **Benefit:** 75% = $175.70 85% = $199.15 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
111	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 $359.05 or more For any particular patient, once only on the same day (See para MN.10.1, AN.0.24 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 75% = $39.20 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
115	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 $359.05 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

A3. SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	For any particular patient, once only on the same day (See para AN.3.1, MN.10.1, AN.0.24 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 75% = $39.20 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
125	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 (See para GN.15.39, AN.40.1, AN.3.2, MN.10.1, AN.0.7, AN.0.1 of explanatory notes to this Category) **Fee:** $183.35 **Benefit:** 75% = $137.55 85% = $155.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
126	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;

A3. SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(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 (See para GN.15.39, AN.40.1, AN.3.1, AN.3.2, MN.10.1, AN.0.7, AN.0.1 of explanatory notes to this Category) **Fee:** $91.70 **Benefit:** 75% = $68.80 85% = $77.95 **Extended Medicare Safety Net Cap:** $275.10 **Future End Date:**
127	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. (See para AN.40.1, AN.3.2, MN.10.1 of explanatory notes to this Category) **Fee:** $183.35 **Benefit:** 85% = $155.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
129	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

A3. SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(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. (See para AN.40.1, AN.3.2, MN.10.1 of explanatory notes to this Category) **Fee:** $91.70 **Benefit:** 85% = $77.95 **Extended Medicare Safety Net Cap:** $275.10 **Future End Date:**

A4. CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A4. Consultant Physician Attendances To Which No Other Item Applies
110	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 (See para AN.36.2, AN.40.1, MN.10.1, AN.0.7, AN.0.25, AN.0.24 of explanatory notes to this Category) **Fee:** $183.35 **Benefit:** 75% = $137.55 85% = $155.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
116	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 (See para AN.36.2, AN.40.1, AN.3.1, MN.10.1, AN.0.7, AN.0.25, AN.0.24, AN.0.70 of explanatory notes to this Category) **Fee:** $91.70 **Benefit:** 75% = $68.80 85% = $77.95 **Extended Medicare Safety Net Cap:** $275.10 **Future End Date:**
117	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

A4. CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(e) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $359.05 or more For any particular patient, once only on the same day (See para MN.10.1, AN.0.24 of explanatory notes to this Category) **Fee:** $91.70 **Benefit:** 75% = $68.80 85% = $77.95 **Extended Medicare Safety Net Cap:** $275.10 **Future End Date:**
119	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 (See para AN.36.2, AN.40.1, AN.3.1, MN.10.1, AN.0.21, AN.0.7, AN.0.25, AN.0.24, AN.0.70 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 75% = $39.20 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
120	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 $359.05 or more For any particular patient, once only on the same day (See para MN.10.1, AN.0.21, AN.0.24 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 75% = $39.20 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
122	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 (See para MN.10.1, AN.0.25, AN.0.24 of explanatory notes to this Category) **Fee:** $222.40 **Benefit:** 75% = $166.80 85% = $189.05 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
128	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 (See para MN.10.1, AN.0.25, AN.0.24 of explanatory notes to this Category) **Fee:** $134.50 **Benefit:** 75% = $100.90 85% = $114.35

A4. CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Extended Medicare Safety Net Cap: $403.50 **Future End Date:**
131	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 (See para MN.10.1, AN.0.21, AN.0.25, AN.0.24 of explanatory notes to this Category) **Fee:** $96.90 **Benefit:** 75% = $72.70 85% = $82.40 **Extended Medicare Safety Net Cap:** $290.70 **Future End Date:**
132	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) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) a consultant physician treatment and management plan of significant complexity is prepared and provided to the referring practitioner, which involves: (i) an opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) medication recommendations; and (c) an attendance on the patient to which item 110, 116, 119, 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 (See para AN.36.2, AN.40.1, AN.0.23, AN.0.24 of explanatory notes to this Category) **Fee:** $320.55 **Benefit:** 75% = $240.45 85% = $272.50 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
133	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: (i) review of initial presenting problems and results of diagnostic investigations; and

A4. CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified consultant physician treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on the diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient to which item 110, 116, 119, 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 (See para AN.36.2, AN.40.1, AN.0.23 of explanatory notes to this Category) **Fee:** $160.50 **Benefit:** 75% = $120.40 85% = $136.45 **Extended Medicare Safety Net Cap:** $481.50 **Future End Date:**

A5. PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A5. Prolonged Attendances To Which No Other Item Applies
	PROLONGED PROFESSIONAL ATTENDANCE
160	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 (See para AN.0.27 of explanatory notes to this Category) **Fee:** $265.15 **Benefit:** 75% = $198.90 100% = $265.15 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
161	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 (See para AN.0.27 of explanatory notes to this Category) **Fee:** $441.85 **Benefit:** 75% = $331.40 100% = $441.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A5. PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
162	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 (See para AN.0.27 of explanatory notes to this Category) **Fee:** $618.35 **Benefit:** 75% = $463.80 100% = $618.35 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
163	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 (See para AN.0.27 of explanatory notes to this Category) **Fee:** $795.40 **Benefit:** 75% = $596.55 100% = $795.40 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
164	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 (See para AN.0.27 of explanatory notes to this Category) **Fee:** $883.80 **Benefit:** 75% = $662.85 100% = $883.80 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A6. GROUP THERAPY	
	Group A6. Group Therapy
170	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 (See para AN.0.28, AN.0.5 of explanatory notes to this Category) **Fee:** $140.70 **Benefit:** 75% = $105.55 100% = $140.70 **Extended Medicare Safety Net Cap:** $422.10 **Future End Date:**
171	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 (See para AN.0.28, AN.0.5 of explanatory notes to this Category) **Fee:** $148.25 **Benefit:** 75% = $111.20 100% = $148.25 **Extended Medicare Safety Net Cap:** $444.75 **Future End Date:**
172	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

A6. GROUP THERAPY	
	members of a family and persons with close personal relationships with that family-each group of 4 or more patients (See para AN.0.28, AN.0.5 of explanatory notes to this Category) **Fee:** $180.35 **Benefit:** 75% = $135.30 100% = $180.35 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	1. ACUPUNCTURE
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 1. Acupuncture
193	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 (See para AN.0.29 of explanatory notes to this Category) **Fee:** $44.30 **Benefit:** 100% = $44.30 **Extended Medicare Safety Net Cap:** $132.90 **Future End Date:**
195	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 (See para AN.0.29 of explanatory notes to this Category) **Derived Fee:** The fee for item 193, plus $31.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 193 plus $2.45 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
197	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 (See para AN.0.29 of explanatory notes to this Category) **Fee:** $85.80 **Benefit:** 100% = $85.80 **Extended Medicare Safety Net Cap:** $257.40 **Future End Date:**
199	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

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	1. ACUPUNCTURE
	(See para AN.0.29 of explanatory notes to this Category) **Fee:** $126.35 **Benefit:** 100% = $126.35 **Extended Medicare Safety Net Cap:** $379.05 **Future End Date:**

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	2. PRESCRIBED MEDICAL PRACTITIONER ATTENDANCE TO WHICH NO OTHER ITEM APPLIES
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 2. Prescribed medical practitioner attendance to which no other item applies
179	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 (See para GN.7.17, AN.7.1, AN.7.2, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $16.50 **Benefit:** 100% = $16.50 **Extended Medicare Safety Net Cap:** $49.50 **Future End Date:**
Amend 181	Professional attendance (other than an attendance at consulting rooms or a residential care home 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 (See para GN.7.17, AN.7.1, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.11, MN.1.4, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 179, plus $25.25 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 179 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
185	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 (See para GN.7.17, AN.7.1, AN.7.2, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $35.95 **Benefit:** 100% = $35.95 **Extended Medicare Safety Net Cap:** $107.85 **Future End Date:**
Amend 187	Professional attendance (other than an attendance at consulting rooms or a residential care home 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 (See para GN.7.17, AN.7.1, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.11, MN.1.4, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 185, plus $25.25 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 185 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	2. PRESCRIBED MEDICAL PRACTITIONER ATTENDANCE TO WHICH NO OTHER ITEM APPLIES
189	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 (See para GN.7.17, AN.7.1, AN.7.2, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $69.70 **Benefit:** 100% = $69.70 **Extended Medicare Safety Net Cap:** $209.10 **Future End Date:**
Amend 191	Professional attendance (other than an attendance at consulting rooms or a residential care home 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 (See para GN.7.17, AN.7.1, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.11, MN.1.4, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 189, plus $25.25 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 189 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
203	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 (See para GN.7.17, AN.7.1, AN.7.2, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $102.65 **Benefit:** 100% = $102.65 **Extended Medicare Safety Net Cap:** $307.95 **Future End Date:**
Amend 206	Professional attendance (other than an attendance at consulting rooms or a residential care home 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 (See para GN.7.17, AN.7.1, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.11, MN.1.4, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 203, plus $25.25 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 203 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
301	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 (See para GN.7.17, AN.7.1, AN.7.2, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, MN.10.1, AN.0.9, AN.0.72 of explanatory notes to this Category) **Fee:** $166.30 **Benefit:** 100% = $166.30 **Extended Medicare Safety Net Cap:** $498.90 **Future End Date:**
Amend 303	Professional attendance (other than an attendance at consulting rooms or a residential care home or a service to which any other item applies) lasting more than 60 minutes—an attendance on one or more

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	2. PRESCRIBED MEDICAL PRACTITIONER ATTENDANCE TO WHICH NO OTHER ITEM APPLIES
	patients at one place on one occasion by a prescribed medical practitioner in an eligible area—each patient (See para MN.1.4, AN.0.72, MN.10.1, GN.7.17, MN.1.5, AN.7.1, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.11 of explanatory notes to this Category) **Derived Fee:** The fee for item 301, plus $25.25 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 301 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	3. PRESCRIBED MEDICAL PRACTITIONER PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 3. Prescribed medical practitioner prolonged attendances to which no other item applies
214	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 (See para AN.7.1, AN.7.3 of explanatory notes to this Category) **Fee:** $212.20 **Benefit:** 75% = $159.15 100% = $212.20 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
215	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 (See para AN.7.1, AN.7.3 of explanatory notes to this Category) **Fee:** $353.55 **Benefit:** 75% = $265.20 100% = $353.55 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
218	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 (See para AN.7.1, AN.7.3 of explanatory notes to this Category) **Fee:** $494.65 **Benefit:** 75% = $371.00 100% = $494.65 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
219	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 (See para AN.7.1, AN.7.3 of explanatory notes to this Category) **Fee:** $636.40 **Benefit:** 75% = $477.30 100% = $636.40 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	3. PRESCRIBED MEDICAL PRACTITIONER PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
220	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 (See para AN.7.1, AN.7.3 of explanatory notes to this Category) **Fee:** $707.00 **Benefit:** 75% = $530.25 100% = $707.00 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	4. PRESCRIBED MEDICAL PRACTITIONER GROUP THERAPY
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 4. Prescribed medical practitioner group therapy
221	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 (See para AN.7.1, AN.7.4 of explanatory notes to this Category) **Fee:** $112.50 **Benefit:** 75% = $84.40 100% = $112.50 **Extended Medicare Safety Net Cap:** $337.50 **Future End Date:**
222	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 (See para AN.7.1, AN.7.4 of explanatory notes to this Category) **Fee:** $118.60 **Benefit:** 75% = $88.95 100% = $118.60 **Extended Medicare Safety Net Cap:** $355.80 **Future End Date:**
223	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 (See para AN.7.1, AN.7.4 of explanatory notes to this Category) **Fee:** $144.30 **Benefit:** 75% = $108.25 100% = $144.30 **Extended Medicare Safety Net Cap:** $432.90 **Future End Date:**

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	5. PRESCRIBED MEDICAL PRACTITIONER HEALTH ASSESSMENTS
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 5. Prescribed medical practitioner health assessments
177	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. (See para AN.14.2 of explanatory notes to this Category) **Fee:** $69.70 **Benefit:** 100% = $69.70 **Extended Medicare Safety Net Cap:** $209.10 **Future End Date:**
224	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 (See para AN.0.40, AN.0.37, AN.0.38, AN.0.39, AN.0.41, AN.0.42, AN.0.69, AN.0.36 of explanatory notes to this Category) **Fee:** $56.85 **Benefit:** 100% = $56.85 **Extended Medicare Safety Net Cap:** $170.55 **Future End Date:**
225	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 (See para AN.0.40, AN.0.37, AN.0.38, AN.0.39, AN.0.41, AN.0.42, AN.0.69, AN.0.36 of explanatory notes to this Category) **Fee:** $132.05 **Benefit:** 100% = $132.05 **Extended Medicare Safety Net Cap:** $396.15 **Future End Date:**
226	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 (See para AN.0.40, AN.0.37, AN.0.38, AN.0.39, AN.0.41, AN.0.42, AN.0.69, AN.0.36 of explanatory notes to this Category) **Fee:** $182.15 **Benefit:** 100% = $182.15 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
227	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

	(See para AN.0.40, AN.0.37, AN.0.38, AN.0.39, AN.0.41, AN.0.42, AN.0.69, AN.0.36 of explanatory notes to this Category) **Fee:** $257.40 **Benefit:** 100% = $257.40 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
Amend 228	Professional attendance by a prescribed medical practitioner at consulting rooms or in a place other than a hospital or a residential care home: (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. (See para AN.0.43 of explanatory notes to this Category) **Fee:** $203.25 **Benefit:** 100% = $203.25 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
19000	Menopause and Perimenopause Health Assessment Professional attendance on a patient for the assessment and management of menopause or perimenopause by a prescribed medical practitioner lasting at least 20 minutes and including, but not limited to: a) collecting relevant information, including taking a patient history to determine pre-, peri- or post-menopausal status, patient wellbeing and contraindications for management; and

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	5. PRESCRIBED MEDICAL PRACTITIONER HEALTH ASSESSMENTS
	b) undertaking a basic physical examination, including recording blood pressure, and review of height and weight; and c) initiating investigations and referrals as clinically indicated, with consideration given to the need for cervical screening, mammography and bone densitometry; and d) discussing management options including non-pharmacological and pharmacological strategies including risks and benefits; e) implementing a management plan which includes patient centred symptoms management; and f) providing the patient with preventative health care advice and information as clinically indicated, including advice on physical activity, smoking cessation, alcohol consumption, nutritional intake and weight management. (See para AN.14.3 of explanatory notes to this Category) **Fee:** $83.60 **Benefit:** 100% = $83.60 **Extended Medicare Safety Net Cap:** $250.80 **Future End Date:**

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	6. PRESCRIBED MEDICAL PRACTITIONER CHRONIC CONDITION MANAGEMENT PLANS, MULTIDISCIPLINARY CARE PLANS AND CASE CONFERENCES
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 6. Prescribed medical practitioner chronic condition management plans, multidisciplinary care plans and case conferences
231	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 (See para AN.36.2, AN.15.7, AN.15.3, AN.7.1 of explanatory notes to this Category) **Fee:** $67.40 **Benefit:** 75% = $50.55 100% = $67.40 **Extended Medicare Safety Net Cap:** $202.20 **Future End Date:**
Amend 232	Either: (a) contribution to a multidisciplinary care plan, for a patient in a residential care home, prepared by that residential care home, or contribution to a review of a multidisciplinary care plan, for a patient, prepared by such a residential care home; 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 (See para AN.36.2, AN.15.4, AN.15.8, AN.15.6, AN.15.3, AN.7.1 of explanatory notes to this Category) **Fee:** $67.40 **Benefit:** 75% = $50.55 100% = $67.40 **Extended Medicare Safety Net Cap:** $202.20 **Future End Date:**

Amend 235	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential care home; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes but less than 20 minutes, other than a service associated with a service to which any of items 231, 232, 392, 393, 729, 731, 965, 967, 92029, 92030, 92033, 92034, 92060, 92061, 92063 or 92064 apply (See para AN.7.1, AN.36.2 of explanatory notes to this Category) **Fee:** $67.75 **Benefit:** 75% = $50.85 100% = $67.75 **Extended Medicare Safety Net Cap:** $203.25 **Future End Date:**
Amend 236	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential care home; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes but less than 40 minutes, other than a service associated with a service to which any of items 231, 232, 392, 393, 729, 731, 965, 967, 92029, 92030, 92033, 92034, 92060, 92061, 92063 or 92064 apply (See para AN.7.1 of explanatory notes to this Category) **Fee:** $115.85 **Benefit:** 75% = $86.90 100% = $115.85 **Extended Medicare Safety Net Cap:** $347.55 **Future End Date:**
Amend 237	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential care home; or (c) a multidisciplinary discharge case conference; if the conference lasts at least 40 minutes, other than a service associated with a service to which any of items 231, 232, 392, 393, 729, 731, 965, 967, 92029, 92030, 92033, 92034, 92060, 92061, 92063 or 92064 apply (See para AN.7.1 of explanatory notes to this Category) **Fee:** $193.00 **Benefit:** 75% = $144.75 100% = $193.00 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
Amend 238	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential care home; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes but less than 20 minutes, other than a service associated with a service to which any of items 231, 232, 392, 393, 729, 731, 965, 967, 92029, 92030, 92033, 92034, 92060, 92061, 92063 or 92064 apply (See para AN.7.1 of explanatory notes to this Category) **Fee:** $49.75 **Benefit:** 75% = $37.35 100% = $49.75 **Extended Medicare Safety Net Cap:** $149.25

	Future End Date:
Amend 239	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential care home; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes but less than 40 minutes, other than a service associated with a service to any of items 231, 232, 392, 393, 729, 731, 965, 967, 92029, 92030, 92033, 92034, 92060, 92061, 92063 or 92064 apply (See para AN.7.1 of explanatory notes to this Category) **Fee:** $85.25 **Benefit:** 75% = $63.95 100% = $85.25 **Extended Medicare Safety Net Cap:** $255.75 **Future End Date:**
Amend 240	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential care home; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 40 minutes, other than a service associated with a service to which any of items 231, 232, 392, 393, 729, 731, 965, 967, 92029, 92030, 92033, 92034, 92060, 92061, 92063 or 92064 apply (See para AN.7.1 of explanatory notes to this Category) **Fee:** $141.90 **Benefit:** 75% = $106.45 100% = $141.90 **Extended Medicare Safety Net Cap:** $425.70 **Future End Date:**
243	Attendance by a prescribed medical practitioner, as a member of a case conference team, to lead and coordinate a multidisciplinary case conference on a patient with cancer, to develop a multidisciplinary treatment plan, if the case conference lasts at least 10 minutes, with a multidisciplinary team of at least 3 other medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health or other relevant health professionals (See para AN.7.1, AN.0.65 of explanatory notes to this Category) **Fee:** $66.35 **Benefit:** 75% = $49.80 100% = $66.35 **Extended Medicare Safety Net Cap:** $199.05 **Future End Date:**
244	Attendance by a prescribed medical practitioner, as a member of a case conference team, to participate in a multidisciplinary case conference on a patient with cancer, to develop a multidisciplinary treatment plan, if the case conference lasts at least 10 minutes, with a multidisciplinary team of at least 4 medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health or other relevant health professionals (See para AN.36.2, AN.7.1, AN.0.65 of explanatory notes to this Category) **Fee:** $30.95 **Benefit:** 75% = $23.25 100% = $30.95 **Extended Medicare Safety Net Cap:** $92.85 **Future End Date:**
392	Professional attendance by a prescribed medical practitioner to prepare a GP chronic condition management plan for a patient (See para AN.36.2, AN.15.4, AN.15.5, AN.15.6, AN.15.3, AN.0.47 of explanatory notes to this Category)

	Fee: $128.55 **Benefit:** 75% = $96.45 100% = $128.55 **Extended Medicare Safety Net Cap:** $385.65 **Future End Date:**
393	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 (See para AN.36.2, AN.15.4, AN.15.5, AN.15.6, AN.15.3, AN.0.47 of explanatory notes to this Category) **Fee:** $128.55 **Benefit:** 75% = $96.45 100% = $128.55 **Extended Medicare Safety Net Cap:** $385.65 **Future End Date:**
969	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference if the conference lasts for at least 15 minutes, but for less than 20 minutes (See para AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $67.75 **Benefit:** 75% = $50.85 100% = $67.75 **Extended Medicare Safety Net Cap:** $203.25 **Future End Date:**
971	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference if the conference lasts for at least 20 minutes, but for less than 40 minutes (See para AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $115.85 **Benefit:** 75% = $86.90 100% = $115.85 **Extended Medicare Safety Net Cap:** $347.55 **Future End Date:**
972	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference if the conference lasts for at least 40 minutes (See para AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $193.05 **Benefit:** 75% = $144.80 100% = $193.05 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
973	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference if the conference lasts for at least 15 minutes, but for less than 20 minutes (See para AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $49.75 **Benefit:** 75% = $37.35 100% = $49.75 **Extended Medicare Safety Net Cap:** $149.25 **Future End Date:**
975	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference if the conference lasts for at least 20 minutes, but for less than 40 minutes (See para AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $85.25 **Benefit:** 75% = $63.95 100% = $85.25 **Extended Medicare Safety Net Cap:** $255.75 **Future End Date:**

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	6. PRESCRIBED MEDICAL PRACTITIONER CHRONIC CONDITION MANAGEMENT PLANS, MULTIDISCIPLINARY CARE PLANS AND CASE CONFERENCES
986	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference if the conference lasts for at least 40 minutes (See para AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $141.90 **Benefit:** 75% = $106.45 100% = $141.90 **Extended Medicare Safety Net Cap:** $425.70 **Future End Date:**

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	7. PRESCRIBED MEDICAL PRACTITIONER DOMICILIARY AND RESIDENTIAL MEDICATION MANAGEMENT REVIEW
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 7. Prescribed medical practitioner domiciliary and residential medication management review
245	Participation by a prescribed medical practitioner in a Domiciliary Medication Management Review (DMMR) for a patient living in a community setting, in which the prescribed medical practitioner, with the patient's consent: (a) assesses the patient as: (i) having a chronic medical condition or a complex medication regimen; and (ii) not having the patient's therapeutic goals met; and (b) following that assessment: (i) refers the patient to a community pharmacy or an accredited pharmacist for the DMMR; and (ii) provides relevant clinical information required for the DMMR; and (c) discusses with the reviewing pharmacist the results of the DMMR including suggested medication management strategies; and (d) develops a written medication management plan following discussion with the patient; and (e) provides the written medication management plan to a community pharmacy chosen by the patient For any particular patient—applicable not more than once in each 12 month period, and only if item 900 does not apply in the same 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (See para AN.15.3, AN.7.1, AN.0.52 of explanatory notes to this Category) **Fee:** $148.25 **Benefit:** 100% = $148.25 **Extended Medicare Safety Net Cap:** $444.75 **Future End Date:**
Amend 249	Participation by a prescribed medical practitioner in a residential medication management review (RMMR) for a patient who is a care recipient in a residential care home—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 (See para AN.7.1, AN.7.18, AN.15.3 of explanatory notes to this Category) **Fee:** $101.45 **Benefit:** 100% = $101.45 **Extended Medicare Safety Net Cap:** $304.35 **Future End Date:**

	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 9. Prescribed medical practitioner mental health care
272	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 (See para AN.36.2, AN.7.1, AN.0.56, AN.0.78 of explanatory notes to this Category) **Fee:** $68.65 **Benefit:** 75% = $51.50 100% = $68.65 **Extended Medicare Safety Net Cap:** $205.95 **Future End Date:**
276	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 (See para AN.36.2, AN.7.1, AN.0.56, AN.0.78 of explanatory notes to this Category) **Fee:** $101.05 **Benefit:** 75% = $75.80 100% = $101.05 **Extended Medicare Safety Net Cap:** $303.15 **Future End Date:**
281	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 (See para AN.36.2, AN.7.1, AN.0.56, AN.0.78 of explanatory notes to this Category) **Fee:** $87.15 **Benefit:** 75% = $65.40 100% = $87.15 **Extended Medicare Safety Net Cap:** $261.45 **Future End Date:**
282	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 (See para AN.36.2, AN.7.1, AN.0.56, AN.0.78 of explanatory notes to this Category) **Fee:** $128.45 **Benefit:** 75% = $96.35 100% = $128.45 **Extended Medicare Safety Net Cap:** $385.35 **Future End Date:**
283	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 (See para AN.36.2, AN.7.1, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $88.85 **Benefit:** 100% = $88.85 **Extended Medicare Safety Net Cap:** $266.55 **Future End Date:**
285	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

	(See para AN.36.2, AN.7.1, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Derived Fee:** The fee for item 283, plus $24.90 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 283 plus $1.95 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
286	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 (See para AN.36.2, AN.7.1, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $127.10 **Benefit:** 100% = $127.10 **Extended Medicare Safety Net Cap:** $381.30 **Future End Date:**
287	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 (See para AN.36.2, AN.7.1, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Derived Fee:** The fee for item 286, plus $24.90 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 286 plus $1.95 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
309	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 (See para MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $88.85 **Benefit:** 100% = $88.85 **Extended Medicare Safety Net Cap:** $266.55 **Future End Date:**
311	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 (See para MN.7.5, AN.0.78 of explanatory notes to this Category) **Derived Fee:** The fee for item 309, plus $24.90 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 309 plus $1.95 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
313	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:

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	9. PRESCRIBED MEDICAL PRACTITIONER MENTAL HEALTH CARE
	(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 (See para MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $127.10 **Benefit:** 100% = $127.10 **Extended Medicare Safety Net Cap:** $381.30 **Future End Date:**
315	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 (See para MN.7.5, AN.0.78 of explanatory notes to this Category) **Derived Fee:** The fee for item 313, plus $24.90 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 313 plus $1.95 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	10. PRESCRIBED MEDICAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 10. Prescribed Medical Practitioner after-hours attendances to which no other item applies
733	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 (See para GN.7.17, AN.7.24, AN.7.1, AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.5, MN.1.6, MN.1.7, MN.1.7, MN.1.8, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $27.75 **Benefit:** 100% = $27.75 **Extended Medicare Safety Net Cap:** $83.25 **Future End Date:**
737	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 (See para GN.7.17, AN.7.24, AN.7.1, AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.5, MN.1.6, MN.1.7, MN.1.7, MN.1.8, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $46.85 **Benefit:** 100% = $46.85 **Extended Medicare Safety Net Cap:** $140.55 **Future End Date:**
741	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 (See para GN.7.17, AN.7.24, AN.7.1, AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.5, MN.1.6, MN.1.7, MN.1.7, MN.1.8, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $80.45 **Benefit:** 100% = $80.45 **Extended Medicare Safety Net Cap:** $241.35

	Future End Date:
745	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 (See para GN.7.17, AN.7.24, AN.7.1, AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.5, MN.1.6, MN.1.7, MN.1.7, MN.1.8, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $112.80 **Benefit:** 100% = $112.80 **Extended Medicare Safety Net Cap:** $338.40 **Future End Date:**
Amend 761	Professional attendance by a prescribed medical practitioner (other than attendance at consulting rooms, a hospital or a residential care home 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 (See para AN.7.24, GN.7.17, AN.7.1, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.11, AN.7.2, MN.1.4, MN.1.3, MN.1.5, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 733, plus $24.90 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 733 plus $1.95 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 763	Professional attendance by a prescribed medical practitioner (other than attendance at consulting rooms, a hospital or a residential care home 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 (See para AN.7.24, GN.7.17, AN.7.1, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.11, AN.7.2, MN.1.4, MN.1.3, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 737, plus $24.90 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 737 plus $1.95 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 766	Professional attendance by a prescribed medical practitioner (other than attendance at consulting rooms, a hospital or a residential care home 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 (See para AN.7.24, GN.7.17, AN.7.1, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.11, AN.7.2, MN.1.4, MN.1.3, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 741, plus $24.90 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 741 plus $1.95 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 769	Professional attendance by a prescribed medical practitioner (other than attendance at consulting rooms, a hospital or a residential care home or a service to which another item in the table applies), lasting more than 45 minutes, but not more than 60 minutes—an attendance on one or more patients on one occasion—each patient. (See para AN.7.24, GN.7.17, AN.7.1, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.11, AN.7.2, MN.1.4, MN.1.3, MN.1.3, MN.1.5 of explanatory notes to this Category)

	Derived Fee: The fee for item 745, plus $24.90 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 745 plus $1.95 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 772	Professional attendance (other than a service to which another item applies) at a residential care home (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 care home (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 care home on one occasion—each patient (See para AN.7.24, GN.7.17, AN.7.1, MN.1.6, AN.0.15, MN.1.7, MN.1.8, AN.0.9, AN.0.11, AN.7.2, MN.1.4, MN.1.3, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 733, plus $44.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 733 plus $3.15 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 776	Professional attendance (other than a service to which another item applies) at a residential care home (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 care home (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 care home on one occasion—each patient (See para AN.7.24, GN.7.17, AN.7.1, MN.1.6, AN.0.15, MN.1.7, MN.1.8, AN.0.9, AN.0.11, AN.7.2, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 737, plus $44.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 737 plus $3.15 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 788	Professional attendance (other than a service to which another item applies) at a residential care home (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 care home (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 care home on one occasion—each patient (See para MN.1.3, MN.1.5, GN.7.17, AN.0.11, AN.7.24, AN.7.1, MN.1.6, AN.0.15, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4 of explanatory notes to this Category) **Derived Fee:** The fee for item 741, plus $44.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 741 plus $3.15 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 789	Professional attendance (other than a service to which another item applies) at a residential care home (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 care home (other than accommodation in a self-contained unit) of more than 45 minutes but not more than 60 minutes in

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	10. PRESCRIBED MEDICAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	duration by a prescribed medical practitioner—an attendance on one or more patients at one residential care home on one occasion—each patient (See para MN.1.7, MN.1.8, AN.0.9, AN.0.11, AN.7.2, MN.1.4, MN.1.3, MN.1.5, AN.7.24, GN.7.17, AN.7.1, MN.1.6, AN.0.15 of explanatory notes to this Category) **Derived Fee:** The fee for item 745, plus $44.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 745 plus $3.15 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
2197	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. (See para GN.7.17, AN.7.24, AN.7.1, AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.5, MN.1.6, MN.1.7, MN.1.7, MN.1.8, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $191.60 **Benefit:** 100% = $191.60 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
Amend 2198	Professional attendance by a prescribed medical practitioner (other than attendance at consulting rooms, a hospital or a residential care home or a service to which another item in the table applies), lasting more than 60 minutes—an attendance on one or more patients on one occasion—each patient. (See para AN.7.1, GN.7.17, AN.7.24, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.11, AN.7.2, MN.1.4, MN.1.3, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 2197, plus $24.90 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2197 plus $1.95 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 2200	Professional attendance (other than a service to which another item applies) at a residential care home (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 care home (other than accommodation in a self-contained unit) of more than 60 minutes in duration by a prescribed medical practitioner—an attendance on one or more patients at one residential care home on one occasion—each patient. (See para AN.7.24, GN.7.17, AN.7.1, MN.1.6, AN.0.15, MN.1.7, MN.1.8, AN.0.9, AN.0.11, AN.7.2, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** The fee for item 2197, plus $44.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2197 plus $3.15 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	11. PRESCRIBED MEDICAL PRACTITIONER PREGNANCY SUPPORT COUNSELLING
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 11. Prescribed medical practitioner pregnancy support counselling
792	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

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	11. PRESCRIBED MEDICAL PRACTITIONER PREGNANCY SUPPORT COUNSELLING
	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 (See para AN.7.1, MN.8.2, AN.0.66 of explanatory notes to this Category) **Fee:** $73.35 **Benefit:** 100% = $73.35 **Extended Medicare Safety Net Cap:** $220.05 **Future End Date:**

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	13. PRESCRIBED MEDICAL PRACTITIONER PATIENT END SUPPORT FOR VIDEO CONFERENCING CONSULTATIONS WITH SPECIALISTS OR CONSULTANT PHYSICIANS
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 13. Prescribed medical practitioner patient end support for video conferencing consultations with specialists or consultant physicians
373	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 **Fee:** $56.50 **Benefit:** 100% = $56.50 **Extended Medicare Safety Net Cap:** $169.50 **Future End Date:**
Amend 374	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 care home; and (d) the prescribed medical practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $81.70 **Benefit:** 100% = $81.70 **Extended Medicare Safety Net Cap:** $245.10 **Future End Date:**
Amend 375	Professional attendance by a prescribed medical practitioner, at a residential care home, 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 care home; and (d) the prescribed medical practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $56.50 **Benefit:** 100% = $56.50

	Extended Medicare Safety Net Cap: $169.50 **Future End Date:**
376	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 **Fee:** $90.25 **Benefit:** 100% = $90.25 **Extended Medicare Safety Net Cap:** $270.75 **Future End Date:**
Amend 377	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 care home; and (d) the prescribed medical practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $102.85 **Benefit:** 100% = $102.85 **Extended Medicare Safety Net Cap:** $308.55 **Future End Date:**
Amend 378	Professional attendance by a prescribed medical practitioner, at a residential care home, 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 care home; and (d) the prescribed medical practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $90.25 **Benefit:** 100% = $90.25 **Extended Medicare Safety Net Cap:** $270.75 **Future End Date:**
379	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 **Fee:** $123.15 **Benefit:** 100% = $123.15 **Extended Medicare Safety Net Cap:** $369.45 **Future End Date:**
Amend 380	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 care home; and (d) the prescribed medical practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $148.40 **Benefit:** 100% = $148.40 **Extended Medicare Safety Net Cap:** $445.20 **Future End Date:**
Amend 381	Professional attendance by a prescribed medical practitioner, at a residential care home, 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 care home; and (d) the prescribed medical practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $123.15 **Benefit:** 100% = $123.15 **Extended Medicare Safety Net Cap:** $369.45 **Future End Date:**
382	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 **Fee:** $186.85 **Benefit:** 100% = $186.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
Amend 390	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 care home; and (d) the prescribed medical practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $212.05 **Benefit:** 100% = $212.05 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
Amend 391	Professional attendance by a prescribed medical practitioner, at a residential care home, 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 care home; and

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	13. PRESCRIBED MEDICAL PRACTITIONER PATIENT END SUPPORT FOR VIDEO CONFERENCING CONSULTATIONS WITH SPECIALISTS OR CONSULTANT PHYSICIANS
	(d) the prescribed medical practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $186.85 **Benefit:** 100% = $186.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A8. Consultant Psychiatrist Attendances To Which No Other Item Applies
289	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 (See para AN.40.1, AN.0.72 of explanatory notes to this Category) **Fee:** $320.55 **Benefit:** 75% = $240.45 85% = $272.50 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
291	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:

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	(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 (See para AN.40.1, AR.8.1, AN.0.30, AN.0.32, AN.0.75 of explanatory notes to this Category) **Fee:** $549.90 **Benefit:** 85% = $467.45 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
293	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

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(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 (See para AN.40.1, AR.8.1, AN.0.30, AN.0.32 of explanatory notes to this Category) **Fee:** $343.75 **Benefit:** 85% = $292.20 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
Amend 294	Professional attendance on a patient by a consultant physician practising in the consultant physician's specialty of psychiatry if: (a) the attendance is by video conference; and (b) except for the requirement for the attendance to be at consulting rooms—item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318 or 319 would otherwise apply to the attendance; and (c) the patient is not an admitted patient; and (d) the patient is bulk-billed; and (e) the patient: (i) is located: (A) within a Modified Monash 2, 3, 4, 5, 6 or 7 area; and (B) at the time of the attendance—at least 15 km by road from the physician; or (ii) is a care recipient in a residential care home; or

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(iii) is a patient of: (A) an Aboriginal medical service; or (B) an Aboriginal community controlled health service; for which a direction made under subsection 19(2) of the Act applies (See para AR.8.1 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318 or 319. **Future End Date:**
296	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 (See para AN.40.1, AR.8.1, MN.10.1, AN.0.30, AN.0.32, AN.0.25, AN.0.31, AN.0.72, AN.0.75 of explanatory notes to this Category) **Fee:** $316.30 **Benefit:** 85% = $268.90 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
297	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) (See para MN.10.1, AN.0.30, AN.0.32, AN.0.25, AN.0.31, AN.0.72, AN.0.75 of explanatory notes to this Category) **Fee:** $316.30 **Benefit:** 75% = $237.25 **Future End Date:**
299	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:

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(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 (See para MN.10.1, AN.0.30, AN.0.32, AN.0.25, AN.0.31, AN.0.72, AN.0.75 of explanatory notes to this Category) **Fee:** $378.15 **Benefit:** 85% = $321.45 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
300	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 (See para AN.40.1, AR.8.1, MN.10.1, AN.0.30, AN.0.32, AN.0.25, AN.0.31, AN.0.72, AN.0.75 of explanatory notes to this Category) **Fee:** $52.65 **Benefit:** 85% = $44.80 **Extended Medicare Safety Net Cap:** $157.95 **Future End Date:**
302	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 (See para AN.40.1, AR.8.1, MN.10.1, AN.0.30, AN.0.32, AN.0.25, AN.0.31, AN.0.72, AN.0.75 of explanatory notes to this Category) **Fee:** $105.05 **Benefit:** 85% = $89.30 **Extended Medicare Safety Net Cap:** $315.15 **Future End Date:**
304	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 (See para AN.40.1, AR.8.1, MN.10.1, AN.0.30, AN.0.32, AN.0.25, AN.0.31, AN.0.72, AN.0.75 of explanatory notes to this Category) **Fee:** $161.70 **Benefit:** 85% = $137.45 **Extended Medicare Safety Net Cap:** $485.10 **Future End Date:**
306	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

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	to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient (See para AN.40.1, AR.8.1, MN.10.1, AN.0.30, AN.0.32, AN.0.25, AN.0.31, AN.0.72, AN.0.75 of explanatory notes to this Category) **Fee:** $223.15 **Benefit:** 85% = $189.70 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
308	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 (See para AN.40.1, AR.8.1, MN.10.1, AN.0.30, AN.0.32, AN.0.25, AN.0.31, AN.0.72, AN.0.75 of explanatory notes to this Category) **Fee:** $258.95 **Benefit:** 85% = $220.15 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
310	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 (See para AR.8.1, MN.10.1, AN.0.32, AN.0.25, AN.0.31, AN.0.72 of explanatory notes to this Category) **Fee:** $26.20 **Benefit:** 85% = $22.30 **Extended Medicare Safety Net Cap:** $78.60 **Future End Date:**
312	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 (See para AR.8.1, MN.10.1, AN.0.32, AN.0.25, AN.0.31, AN.0.72 of explanatory notes to this Category) **Fee:** $52.65 **Benefit:** 85% = $44.80 **Extended Medicare Safety Net Cap:** $157.95 **Future End Date:**
314	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 (See para AR.8.1, MN.10.1, AN.0.32, AN.0.25, AN.0.31, AN.0.72 of explanatory notes to this Category) **Fee:** $81.05 **Benefit:** 85% = $68.90 **Extended Medicare Safety Net Cap:** $243.15 **Future End Date:**
316	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

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	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 (See para AR.8.1, MN.10.1, AN.0.32, AN.0.25, AN.0.31, AN.0.72 of explanatory notes to this Category) **Fee:** $111.70 **Benefit:** 85% = $94.95 **Extended Medicare Safety Net Cap:** $335.10 **Future End Date:**
318	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 (See para AR.8.1, MN.10.1, AN.0.32, AN.0.25, AN.0.31, AN.0.72 of explanatory notes to this Category) **Fee:** $129.50 **Benefit:** 85% = $110.10 **Extended Medicare Safety Net Cap:** $388.50 **Future End Date:**
319	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 (See para AR.8.1, MN.10.1, AN.0.32, AN.0.25, AN.0.31, AN.0.72 of explanatory notes to this Category) **Fee:** $223.15 **Benefit:** 85% = $189.70 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
320	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) (See para MN.10.1, AN.0.32, AN.0.25, AN.0.72 of explanatory notes to this Category) **Fee:** $52.65 **Benefit:** 75% = $39.50 **Extended Medicare Safety Net Cap:** $157.95 **Future End Date:**
322	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)

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(See para MN.10.1, AN.0.32, AN.0.72 of explanatory notes to this Category) **Fee:** $105.05 **Benefit:** 75% = $78.80 **Extended Medicare Safety Net Cap:** $315.15 **Future End Date:**
324	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) (See para MN.10.1, AN.0.32, AN.0.25, AN.0.72 of explanatory notes to this Category) **Fee:** $161.70 **Benefit:** 75% = $121.30 **Extended Medicare Safety Net Cap:** $485.10 **Future End Date:**
326	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) (See para MN.10.1, AN.0.32, AN.0.25, AN.0.72 of explanatory notes to this Category) **Fee:** $223.15 **Benefit:** 75% = $167.40 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
328	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) (See para MN.10.1, AN.0.32, AN.0.25, AN.0.72 of explanatory notes to this Category) **Fee:** $258.95 **Benefit:** 75% = $194.25 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
330	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 (See para MN.10.1, AN.0.25, AN.0.72 of explanatory notes to this Category) **Fee:** $96.65 **Benefit:** 85% = $82.20 **Extended Medicare Safety Net Cap:** $289.95 **Future End Date:**
332	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 (See para MN.10.1, AN.0.25, AN.0.72 of explanatory notes to this Category)

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Fee: $151.35 **Benefit:** 85% = $128.65 **Extended Medicare Safety Net Cap:** $454.05 **Future End Date:**
334	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 (See para MN.10.1, AN.0.25, AN.0.72 of explanatory notes to this Category) **Fee:** $220.60 **Benefit:** 85% = $187.55 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
336	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 (See para MN.10.1, AN.0.25, AN.0.72 of explanatory notes to this Category) **Fee:** $266.90 **Benefit:** 85% = $226.90 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
338	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 (See para MN.10.1, AN.0.25, AN.0.72 of explanatory notes to this Category) **Fee:** $303.20 **Benefit:** 85% = $257.75 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
341	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 (See para MN.10.1, AN.0.32, AN.0.25, AN.0.72 of explanatory notes to this Category) **Fee:** $52.65 **Benefit:** 75% = $39.50 85% = $44.80 **Extended Medicare Safety Net Cap:** $157.95 **Future End Date:**

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
342	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 (See para AN.40.1, MN.10.1, AN.0.25, AN.0.5, AN.0.72 of explanatory notes to this Category) **Fee:** $59.85 **Benefit:** 75% = $44.90 85% = $50.90 **Extended Medicare Safety Net Cap:** $179.55 **Future End Date:**
343	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 (See para MN.10.1, AN.0.32, AN.0.25, AN.0.72 of explanatory notes to this Category) **Fee:** $105.05 **Benefit:** 75% = $78.80 85% = $89.30 **Extended Medicare Safety Net Cap:** $315.15 **Future End Date:**
344	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 (See para AN.40.1, MN.10.1, AN.0.25, AN.0.5, AN.0.72 of explanatory notes to this Category) **Fee:** $79.45 **Benefit:** 75% = $59.60 85% = $67.55 **Extended Medicare Safety Net Cap:** $238.35 **Future End Date:**
345	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 (See para MN.10.1, AN.0.32, AN.0.25, AN.0.72 of explanatory notes to this Category) **Fee:** $161.70 **Benefit:** 75% = $121.30 85% = $137.45 **Extended Medicare Safety Net Cap:** $485.10 **Future End Date:**

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
346	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 (See para AN.40.1, MN.10.1, AN.0.25, AN.0.5, AN.0.72, AN.0.77 of explanatory notes to this Category) **Fee:** $117.65 **Benefit:** 75% = $88.25 85% = $100.05 **Extended Medicare Safety Net Cap:** $352.95 **Future End Date:**
347	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 (See para MN.10.1, AN.0.32, AN.0.25, AN.0.72 of explanatory notes to this Category) **Fee:** $223.15 **Benefit:** 75% = $167.40 85% = $189.70 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
349	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 (See para MN.10.1, AN.0.32, AN.0.25, AN.0.72 of explanatory notes to this Category) **Fee:** $258.95 **Benefit:** 75% = $194.25 85% = $220.15 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A9. CONTACT LENSES - ATTENDANCES	
	Group A9. Contact Lenses - Attendances

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 (See para AN.0.34 of explanatory notes to this Category) **Fee:** $147.85 **Benefit:** 75% = $110.90 85% = $125.70 **Extended Medicare Safety Net Cap:** $443.55 **Future End Date:**
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 (See para AN.0.34 of explanatory notes to this Category) **Fee:** $147.85 **Benefit:** 75% = $110.90 85% = $125.70 **Extended Medicare Safety Net Cap:** $443.55 **Future End Date:**
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 (See para AN.0.34 of explanatory notes to this Category) **Fee:** $147.85 **Benefit:** 75% = $110.90 85% = $125.70 **Extended Medicare Safety Net Cap:** $443.55 **Future End Date:**
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 (See para AN.0.34 of explanatory notes to this Category) **Fee:** $147.85 **Benefit:** 75% = $110.90 85% = $125.70 **Extended Medicare Safety Net Cap:** $443.55 **Future End Date:**
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) (See para AN.0.34 of explanatory notes to this Category) **Fee:** $147.85 **Benefit:** 75% = $110.90 85% = $125.70 **Extended Medicare Safety Net Cap:** $443.55 **Future End Date:**
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 (See para AN.0.34 of explanatory notes to this Category) **Fee:** $147.85 **Benefit:** 75% = $110.90 85% = $125.70 **Extended Medicare Safety Net Cap:** $443.55 **Future End Date:**
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

A9. CONTACT LENSES - ATTENDANCES	
	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 (See para AN.0.34 of explanatory notes to this Category) **Fee:** $147.85 **Benefit:** 75% = $110.90 85% = $125.70 **Extended Medicare Safety Net Cap:** $443.55 **Future End Date:**
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 (See para AN.0.34 of explanatory notes to this Category) **Fee:** $147.85 **Benefit:** 75% = $110.90 85% = $125.70 **Extended Medicare Safety Net Cap:** $443.55 **Future End Date:**
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 (See para AN.0.34 of explanatory notes to this Category) **Fee:** $147.85 **Benefit:** 75% = $110.90 85% = $125.70 **Extended Medicare Safety Net Cap:** $443.55 **Future End Date:**
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 (See para AN.0.35 of explanatory notes to this Category) **Fee:** $147.85 **Benefit:** 75% = $110.90 85% = $125.70 **Extended Medicare Safety Net Cap:** $443.55 **Future End Date:**

A10. OPTOMETRICAL SERVICES	1. GENERAL
	Group A10. Optometrical Services
	Subgroup 1. General
10905	REFERRED COMPREHENSIVE INITIAL CONSULTATION Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has been referred by another optometrist who is not associated with the optometrist to whom the patient is referred (See para AN.10.1 of explanatory notes to this Category) **Fee:** $79.80 **Benefit:** 85% = $67.85 **Extended Medicare Safety Net Cap:** $239.40 **Future End Date:**

10907	Professional attendance of more than 15 minutes in duration, being the first in a course of attention if the patient has attended another optometrist for an attendance to which this item or item 10905, 10910, 10911, 10913, 10914 or 10915 applies: (a) for a patient who is less than 65 years of age-within the previous 36 months; or (b) for a patient who is at least 65 years or age-within the previous 12 months (See para AN.10.1 of explanatory notes to this Category) **Fee:** $40.00 **Benefit:** 85% = $34.00 **Extended Medicare Safety Net Cap:** $120.00 **Future End Date:**
10910	Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if: (a) the patient is less than 65 years of age; and (b) the patient has not, within the previous 36 months, received a service to which this item or item 10905, 10907, 10913, 10914 or 10915 applies (See para AN.10.1 of explanatory notes to this Category) **Fee:** $79.80 **Benefit:** 85% = $67.85 **Extended Medicare Safety Net Cap:** $239.40 **Future End Date:**
10911	Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if: (a) the patient is at least 65 years of age; and (b) the patient has not, within the previous 12 months, received a service to which this item, or item 10905, 10907, 10910, 10913, 10914 or 10915 applies (See para AN.10.1 of explanatory notes to this Category) **Fee:** $79.80 **Benefit:** 85% = $67.85 **Extended Medicare Safety Net Cap:** $239.40 **Future End Date:**
10913	Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if the patient has suffered a significant change of visual function or has new signs or symptoms, unrelated to the earlier course of attention, requiring comprehensive reassessment: (a) for a patient who is less than 65 years of age—within 36 months of an initial consultation to which this item, or item 10905, 10907, 10910, 10914 or 10915 applies; or (b) for a patient who is at least 65 years of age—within 12 months of an initial consultation to which this item, or item 10905, 10907, 10910, 10911, 10914 or 10915 applies **Fee:** $79.80 **Benefit:** 85% = $67.85 **Extended Medicare Safety Net Cap:** $239.40 **Future End Date:**
10914	Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if the patient has a progressive disorder (excluding presbyopia) requiring comprehensive reassessment: (a) for a patient who is less than 65 years of age—within 36 months of an initial consultation to which this item or item 10905, 10907, 10910, 10913 or 10915 applies; or (b) for a patient who is at least 65 years of age—within 12 months of an initial consultation to which this item or item 10905, 10907, 10910, 10911, 10913 or 10915 applies (See para AN.10.1 of explanatory notes to this Category) **Fee:** $79.80 **Benefit:** 85% = $67.85 **Extended Medicare Safety Net Cap:** $239.40

	Future End Date:
10915	Professional attendance of more than 15 minutes duration, being the first in a course of attention involving the examination of the eyes, with the instillation of a mydriatic, of a patient with diabetes mellitus requiring comprehensive reassessment. (See para AN.10.1 of explanatory notes to this Category) **Fee:** $79.80 **Benefit:** 85% = $67.85 **Extended Medicare Safety Net Cap:** $239.40 **Future End Date:**
10916	Professional attendance, being the first in a course of attention, of not more than 15 minutes in duration (other than a service associated with a service to which item 10938, 10939, 10940, 10941, 10942 or 10943 applies) (See para AN.10.1 of explanatory notes to this Category) **Fee:** $40.00 **Benefit:** 85% = $34.00 **Extended Medicare Safety Net Cap:** $120.00 **Future End Date:**
10918	Professional attendance, being the second or subsequent in a course of attention and being unrelated to the prescription and fitting of contact lenses (other than a service associated with a service to which item 10938, 10939, 10940 or 10941 applies) (See para AN.10.1 of explanatory notes to this Category) **Fee:** $40.00 **Benefit:** 85% = $34.00 **Extended Medicare Safety Net Cap:** $120.00 **Future End Date:**
10921	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses for optical correction, being a course of attention for which the first attendance is a service to which item 10905, 10907, 10910, 10911, 10913, 10914, 10915 or 10916 applies For patients with any of the following: (a) myopia of 5.0 dioptres or greater (spherical equivalent) in at least one eye; (b) manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in at least one eye; (c) astigmatism of 3.0 dioptres or greater in at least one eye; (d) anisometropia of 3.0 dioptres or greater (difference between spherical equivalents) Applicable once for each condition in a period of 36 months (See para AN.10.1, AN.0.2 of explanatory notes to this Category) **Fee:** $198.50 **Benefit:** 85% = $168.75 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
10924	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, for patients with irregular astigmatism in either eye, being a condition the existence of which has been confirmed by keratometric observation, topographic or quantitative corneal morphology if: (a) the maximum visual acuity obtainable with spectacle correction is worse than 0.3 logMAR (6/12); and (b) if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens; being a course of attention for which the first attendance is a service to which item 10905, 10907, 10910, 10911, 10913, 10914, 10915 or 10916 applies Applicable once in a period of 36 months (See para AN.10.1, AN.0.2 of explanatory notes to this Category) **Fee:** $250.40 **Benefit:** 85% = $212.85

	Extended Medicare Safety Net Cap: $500.00 **Future End Date:**
10926	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, for patients with corrected visual acuity of 0.7 logMAR (6/30) or worse in both eyes, being patients for whom a contact lens is prescribed as part of a telescopic system, being a course of attention for which the first attendance is a service to which item 10905, 10907, 10910, 10911, 10913, 10914, 10915 or 10916 applies Applicable once in a period of 36 months (See para AN.10.1, AN.0.2 of explanatory notes to this Category) **Fee:** $198.50 **Benefit:** 85% = $168.75 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
10927	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, for patients for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by any of the following: (a) pathological mydriasis; (b) aniridia; (c) coloboma of the iris; (d) pupillary malformation or distortion; (e) significant ocular deformity; or (f) corneal opacity; whether congenital, traumatic or surgical in origin being a course of attention for which the first attendance is a service to which item 10905, 10907, 10910, 10911, 10913, 10914, 10915 or 10916 applies Applicable once in a period of 36 months (See para AN.10.1, AN.0.2 of explanatory notes to this Category) **Fee:** $250.40 **Benefit:** 85% = $212.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
10928	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, for patients who, because of physical deformity, are unable to wear spectacles, being a course of attention for which the first attendance is a service to which item 10905, 10907, 10910, 10911, 10913, 10914, 10915 or 10916 applies Applicable once in a period of 36 months (See para AN.10.1, AN.0.2 of explanatory notes to this Category) **Fee:** $198.50 **Benefit:** 85% = $168.75 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
10929	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, for patients who have a medical or optical condition (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10926, 10927 or 10928 applies) requiring the use of a contact lens for correction, if the condition is specified on the patient's account, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10913, 10914, 10915 or 10916 applies; and (b) the contact lenses are not required for appearance, sporting, work or psychological reasons. Applicable once in a period of 36 months

	(See para AN.10.1, AN.0.2 of explanatory notes to this Category) **Fee:** $250.40 **Benefit:** 85% = $212.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
10930	All professional attendances regarded as a single service in a single course of attention involving the prescription and fitting of contact lenses where the patient meets the requirements of an item in the range 10921-10929 and requires a change in contact lens material or basic lens parameters, other than a simple power change, because of a structural or functional change in the eye or an allergic response within 36 months of the fitting of a contact lens covered by item 10921 to 10929 (See para AN.10.1 of explanatory notes to this Category) **Fee:** $198.50 **Benefit:** 85% = $168.75 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
Amend 10931	A flag fall service to which an item in Subgroup 1 of Group A10 applies (other than this item), if the service: (a) is provided: (i) during a home visit to a person; or (ii) in a residential care home; or (iii) in an institution; and (b) is provided to one or more patients at a single location on a single occasion; and (c) is: (i) bulk-billed for the fees for this item and another item applying to the service; or (ii) not bulk-billed for the fees for this item and another item applying to the service Applicable once per occasion a service is provided under paragraph (a) for each distinct location (See para AN.10.1 of explanatory notes to this Category) **Fee:** $45.95 **Benefit:** 85% = $39.10 **Extended Medicare Safety Net Cap:** $137.85 **Future End Date:**
10938	Full quantitative computerised perimetry (automated absolute static threshold), with bilateral assessment and report, where indicated by the presence of glaucoma with a high risk of clinically significant progression that: (a) is not a service involving multifocal multichannel objective perimetry; (b) is performed by an optometrist; and (c) is performed on a patient who has received two perimetry services to which item 10940 or 10941 applies in the previous 12 months other than a service associated with a service to which item 10916 or 10918 applies Applicable once per patient (including any service to which item 10939 applies) in a 12-month period (See para AN.10.1, DN.1.6 of explanatory notes to this Category) **Fee:** $76.25 **Benefit:** 85% = $64.85 **Extended Medicare Safety Net Cap:** $228.75 **Future End Date:**
10939	Full quantitative computerised perimetry (automated absolute static threshold) with unilateral assessment and report, where indicated by the presence of glaucoma with a high risk of clinically significant progression that: (a) is not a service involving multifocal multichannel objective perimetry; and (b) is performed by an optometrist (c) is performed on a patient who has received two perimetry services to which item 10940 or 10941 applies in the previous 12 months other than a service associated with a service to which item 10916 or 10918 applies Applicable once per patient (including any service to which item 10938 applies) in a 12-month period

	(See para AN.10.1, DN.1.6 of explanatory notes to this Category) **Fee:** $46.00 **Benefit:** 85% = $39.10 **Extended Medicare Safety Net Cap:** $138.00 **Future End Date:**
10940	Full quantitative computerised perimetry (automated absolute static threshold), with bilateral assessment and report, if indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain that: (a) is not a service involving multifocal multichannel objective perimetry; and (b) is performed by an optometrist; (c) the patient has received fewer than two perimetry services to which this item or item 10941 applies in a 12-month period other than a service associated with a service to which item 10916 or 10918 applies (See para AN.10.1, DN.1.6 of explanatory notes to this Category) **Fee:** $76.25 **Benefit:** 85% = $64.85 **Extended Medicare Safety Net Cap:** $228.75 **Future End Date:**
10941	Full quantitative computerised perimetry (automated absolute static threshold) with unilateral assessment and report, if indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain that: (a) is not a service involving multifocal multichannel objective perimetry; and (b) is performed by an optometrist; (c) the patient has received fewer than two perimetry services to which this item or item 10940 applies in a 12-month period other than a service associated with a service to which item 10916 or 10918 applies (See para AN.10.1, DN.1.6 of explanatory notes to this Category) **Fee:** $46.00 **Benefit:** 85% = $39.10 **Extended Medicare Safety Net Cap:** $138.00 **Future End Date:**
10942	Testing of residual vision to provide optimum visual performance for a patient who has best corrected visual acuity of 6/15 or N12 or worse at 40cm in the better eye or a horizontal visual field of less than 110 degrees and within 10 degrees above and below the horizontal midline, involving one or more of the following: (a) spectacle correction; (b) determination of contrast sensitivity; (c) determination of glare sensitivity; (d) prescription of magnification aids; other than a service associated with a service to which item 10916, 10921, 10924, 10926, 10927, 10928, 10929 or 10930 applies Applicable twice per patient in a 12-month period (See para AN.10.1 of explanatory notes to this Category) **Fee:** $40.00 **Benefit:** 85% = $34.00 **Extended Medicare Safety Net Cap:** $120.00 **Future End Date:**
10943	Additional testing to confirm diagnosis of, or establish a treatment regime for, a significant binocular or accommodative dysfunction, in a patient aged 3 to 14 years, where the service: (a) includes assessment of one or more of the following: (i) accommodation; (ii) ocular motility; (iii) vergences; (iv) fusional reserves; (v) cycloplegic refraction; and

	(b) is not performed for the assessment of learning difficulties or learning disabilities; other than a service to which item 10916, 10921, 10924, 10926, 10927, 10928, 10929 or 10930 applies Applicable once per patient in a 12-month period (See para AN.10.1 of explanatory notes to this Category) **Fee:** $40.00 **Benefit:** 85% = $34.00 **Extended Medicare Safety Net Cap:** $120.00 **Future End Date:**
10944	Complete removal of embedded foreign body (including a rust ring, if present) from the cornea—not more than once on the same day by the same optometrist (excluding after care). Only claimable when either fully removed, or if the patient is referred to an Ophthalmologist or other appropriately qualified practitioner for further assessment and management after second attendance results in partial removal Other than a service associated with a service to which items 10905, 10907, 10910, 10911, 10913, 10914, 10915, 10916 or 10918 applies (See para AN.10.1 of explanatory notes to this Category) **Fee:** $86.35 **Benefit:** 85% = $73.40 **Extended Medicare Safety Net Cap:** $259.05 **Future End Date:**

	Group A10. Optometrical Services
	Subgroup 2. Telehealth Attendance
	TELEHEALTH ATTENDANCE AT CONSULTING ROOMS, HOME VISITS OR OTHER INSTITUTIONS
10945	A professional attendance of less than 15 minutes (whether or not continuous) by an attending optometrist that requires the provision of clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and (b) is not an admitted patient (See para MN.12.5, AN.0.22 of explanatory notes to this Category) **Fee:** $40.00 **Benefit:** 85% = $34.00 **Extended Medicare Safety Net Cap:** $120.00 **Future End Date:**
10946	A professional attendance of at least 15 minutes (whether or not continuous) by an optometrist providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist practising in the speciality of ophthalmology; and (b) is not an admitted patient (See para MN.12.5, AN.0.22 of explanatory notes to this Category) **Fee:** $79.80 **Benefit:** 85% = $67.85

A10. OPTOMETRICAL SERVICES	2. TELEHEALTH ATTENDANCE
	Extended Medicare Safety Net Cap: $239.40 **Future End Date:**

A11. URGENT ATTENDANCE AFTER HOURS	1. URGENT ATTENDANCE - AFTER HOURS
	Group A11. Urgent Attendance After Hours
	Subgroup 1. Urgent Attendance - After Hours
585	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 (See para AN.0.19 of explanatory notes to this Category) **Fee:** $155.40 **Benefit:** 75% = $116.55 100% = $155.40 **Extended Medicare Safety Net Cap:** $466.20 **Future End Date:**
588	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 (See para AN.0.19 of explanatory notes to this Category) **Fee:** $155.40 **Benefit:** 75% = $116.55 100% = $155.40 **Extended Medicare Safety Net Cap:** $466.20 **Future End Date:**
591	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

A11. URGENT ATTENDANCE AFTER HOURS	1. URGENT ATTENDANCE - AFTER HOURS
	(See para AN.0.19 of explanatory notes to this Category) **Fee:** $107.75 **Benefit:** 75% = $80.85 100% = $107.75 **Extended Medicare Safety Net Cap:** $323.25 **Future End Date:**
594	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 (See para AN.0.19 of explanatory notes to this Category) **Fee:** $50.20 **Benefit:** 75% = $37.65 100% = $50.20 **Extended Medicare Safety Net Cap:** $150.60 **Future End Date:**

A11. URGENT ATTENDANCE AFTER HOURS	2. URGENT ATTENDANCE UNSOCIABLE AFTER HOURS
	Group A11. Urgent Attendance After Hours
	Subgroup 2. Urgent Attendance Unsociable After Hours
599	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 (See para AN.0.19 of explanatory notes to this Category) **Fee:** $183.15 **Benefit:** 75% = $137.40 100% = $183.15 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
600	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 (See para AN.0.19 of explanatory notes to this Category) **Fee:** $146.35 **Benefit:** 75% = $109.80 100% = $146.35 **Extended Medicare Safety Net Cap:** $439.05 **Future End Date:**

A12. CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
Group A12. Consultant Occupational Physician Attendances To Which No Other Item Applies

A12. CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
385	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 (See para AN.40.1, AN.0.33 of explanatory notes to this Category) **Fee:** $103.95 **Benefit:** 75% = $78.00 85% = $88.40 **Extended Medicare Safety Net Cap:** $311.85 **Future End Date:**
386	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 (See para AN.40.1, AN.3.1, AN.0.33, AN.0.70 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 75% = $39.20 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
387	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 (See para AN.0.33 of explanatory notes to this Category) **Fee:** $152.50 **Benefit:** 75% = $114.40 85% = $129.65 **Extended Medicare Safety Net Cap:** $457.50 **Future End Date:**
388	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 (See para AN.0.33 of explanatory notes to this Category) **Fee:** $96.55 **Benefit:** 75% = $72.45 85% = $82.10 **Extended Medicare Safety Net Cap:** $289.65 **Future End Date:**

A13. PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A13. Public Health Physician Attendances To Which No Other Item Applies
	PUBLIC HEALTH PHYSICIAN ATTENDANCES - AT CONSULTING ROOMS
410	LEVEL A Professional attendance at consulting rooms by a public health physician in the practice of his or her specialty of public health medicine for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management. (See para AN.40.1, AN.0.50 of explanatory notes to this Category) **Fee:** $23.75 **Benefit:** 75% = $17.85 85% = $20.20

A13. PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Extended Medicare Safety Net Cap: $71.25 **Future End Date:**
411	LEVEL B Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation. (See para AN.40.1, AN.0.50 of explanatory notes to this Category) **Fee:** $51.90 **Benefit:** 75% = $38.95 85% = $44.15 **Extended Medicare Safety Net Cap:** $155.70 **Future End Date:**
412	LEVEL C Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation. (See para AN.40.1, AN.0.50 of explanatory notes to this Category) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45 **Extended Medicare Safety Net Cap:** $301.50 **Future End Date:**
413	LEVEL D Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history;

A13. PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	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. (See para AN.40.1, AN.0.50 of explanatory notes to this Category) **Fee:** $147.95 **Benefit:** 75% = $111.00 85% = $125.80 **Extended Medicare Safety Net Cap:** $443.85 **Future End Date:**
	PUBLIC HEALTH PHYSICIAN ATTENDANCES - OTHER THAN AT CONSULTING ROOMS
414	Professional attendance at other than consulting rooms 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 examination and management (See para AN.0.50 of explanatory notes to this Category) **Derived Fee:** The fee for item 410, plus $31.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 410 plus $2.45 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
415	Professional attendance by a public health physician in the practice of the public health physician's specialty of public health medicine at other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation (See para AN.0.50 of explanatory notes to this Category) **Derived Fee:** The fee for item 411, plus $31.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 411 plus $2.45 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
416	Professional attendance by a public health physician in the practice of the public health physician's specialty of public health medicine at other than consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history;

A13. PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(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 (See para AN.0.50 of explanatory notes to this Category) **Derived Fee:** The fee for item 412, plus $31.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 412 plus $2.45 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
417	Professional attendance by a public health physician in the practice of the public health physician's specialty of public health medicine at other than consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation (See para AN.0.50 of explanatory notes to this Category) **Derived Fee:** The fee for item 413, plus $31.00 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 413 plus $2.45 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**

A14. HEALTH ASSESSMENTS	
	Group A14. Health Assessments
	HEALTH ASSESSMENTS
695	Menopause and Perimenopause Health Assessment Professional attendance on a patient for the assessment and management of menopause or perimenopause by a general practitioner lasting at least 20 minutes and including, but not limited to: a) collecting relevant information, including taking a patient history to determine pre-, peri- or post-menopausal status, patient wellbeing and contraindications for management; and

A14. HEALTH ASSESSMENTS	
	b) undertaking a basic physical examination, including recording blood pressure, and review of height and weight; and c) initiating investigations and referrals as clinically indicated, with consideration given to the need for cervical screening, mammography and bone densitometry; and d) discussing management options including non-pharmacological and pharmacological strategies including risks and benefits; e) implementing a management plan which includes patient centred symptoms management; and f) providing the patient with preventative health care advice and information as clinically indicated, including advice on physical activity, smoking cessation, alcohol consumption, nutritional intake and weight management. (See para AN.14.3 of explanatory notes to this Category) **Fee:** $104.55 **Benefit:** 100% = $104.55 **Extended Medicare Safety Net Cap:** $313.65 **Future End Date:**
699	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: 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. (See para AN.14.2 of explanatory notes to this Category) **Fee:** $87.10 **Benefit:** 100% = $87.10 **Extended Medicare Safety Net Cap:** $261.30 **Future End Date:**
701	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 (See para AN.0.40, AN.0.37, AN.0.38, AN.0.39, AN.0.41, AN.0.42, AN.0.69, AN.0.36 of explanatory notes to this Category) **Fee:** $71.00 **Benefit:** 100% = $71.00

A14. HEALTH ASSESSMENTS	
	Extended Medicare Safety Net Cap: $213.00 **Future End Date:**
703	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 (See para AN.0.40, AN.0.37, AN.0.38, AN.0.39, AN.0.41, AN.0.42, AN.0.69, AN.0.36 of explanatory notes to this Category) **Fee:** $165.05 **Benefit:** 100% = $165.05 **Extended Medicare Safety Net Cap:** $495.15 **Future End Date:**
705	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 (See para AN.0.40, AN.0.37, AN.0.38, AN.0.39, AN.0.41, AN.0.42, AN.0.69, AN.0.36 of explanatory notes to this Category) **Fee:** $227.75 **Benefit:** 100% = $227.75 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
707	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 (See para AN.0.40, AN.0.37, AN.0.38, AN.0.39, AN.0.41, AN.0.42, AN.0.69, AN.0.36 of explanatory notes to this Category) **Fee:** $321.75 **Benefit:** 100% = $321.75 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
	ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES HEALTH ASSESSMENT
Amend 715	Professional attendance by a general practitioner, at consulting rooms or in a place other than a hospital or a residential care home:

A14. HEALTH ASSESSMENTS	
	(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. (See para AN.0.43 of explanatory notes to this Category) **Fee:** $254.10 **Benefit:** 100% = $254.10 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A15. GP CHRONIC CONDITION MANAGEMENT PLANS, MULTIDISCIPLINARY CARE PLANS AND CASE CONFERENCES	1. GP CHRONIC CONDITION MANAGEMENT PLANS AND MULTIDISCIPLINARY CARE PLANS
	Group A15. GP chronic condition management plans, multidisciplinary care plans and case conferences
	Subgroup 1. GP chronic condition management plans and multidisciplinary care plans
729	Contribution by a general practitioner (not including a specialist or consultant physician) 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 item 735, 739, 743, 747, 750 or 758 applies) (See para AN.36.2, AN.15.7, AN.15.3 of explanatory notes to this Category) **Fee:** $84.25 **Benefit:** 100% = $84.25 **Extended Medicare Safety Net Cap:** $252.75 **Future End Date:**

A15. GP CHRONIC CONDITION MANAGEMENT PLANS, MULTIDISCIPLINARY CARE PLANS AND CASE CONFERENCES	1. GP CHRONIC CONDITION MANAGEMENT PLANS AND MULTIDISCIPLINARY CARE PLANS
Amend 731	Contribution by a general practitioner (not including a specialist or consultant physician) to: (a) a multidisciplinary care plan for a patient in a residential care home, prepared by that residential care home, or to a review of such a plan prepared by such a residential care home; 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 item 735, 739, 743, 747, 750 or 758 applies) (See para AN.36.2, AN.15.4, AN.15.8, AN.15.6, AN.15.3 of explanatory notes to this Category) **Fee:** $84.25 **Benefit:** 100% = $84.25 **Extended Medicare Safety Net Cap:** $252.75 **Future End Date:**
965	Professional attendance by a general practitioner to prepare a GP chronic condition management plan for a patient (See para AN.36.2, AN.15.4, AN.15.5, AN.15.6, AN.15.3, AN.0.47 of explanatory notes to this Category) **Fee:** $160.60 **Benefit:** 75% = $120.45 100% = $160.60 **Extended Medicare Safety Net Cap:** $481.80 **Future End Date:**
967	Professional attendance by a general practitioner to review a GP chronic condition management plan prepared by the general practitioner or an associated medical practitioner (See para AN.36.2, AN.15.4, AN.15.5, AN.15.6, AN.15.3, AN.0.47 of explanatory notes to this Category) **Fee:** $160.60 **Benefit:** 75% = $120.45 100% = $160.60 **Extended Medicare Safety Net Cap:** $481.80 **Future End Date:**

A15. GP CHRONIC CONDITION MANAGEMENT PLANS, MULTIDISCIPLINARY CARE PLANS AND CASE CONFERENCES	2. CASE CONFERENCES
	Group A15. GP chronic condition management plans, multidisciplinary care plans and case conferences
	Subgroup 2. Case Conferences
Amend 735	Attendance by a general practitioner (not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference carried out for a care recipient in a residential care home; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which item 729, 731, 965, 967, 231, 232, 392, 393, 92026, 92027, 92029, 92030, 92033, 92034, 92057, 92058, 92060, 92061, 92063 or 92064 applies) (See para AN.0.49, AN.36.2 of explanatory notes to this Category) **Fee:** $84.65 **Benefit:** 75% = $63.50 100% = $84.65 **Extended Medicare Safety Net Cap:** $253.95

	Future End Date:
Amend 739	Attendance by a general practitioner (not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference carried out for a care recipient in a residential care home; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which item 729, 731, 965, 967, 231, 232, 392, 393, 92026, 92027, 92029, 92030, 92033, 92034, 92057, 92058, 92060, 92061, 92063 or 92064 applies) (See para AN.0.49 of explanatory notes to this Category) **Fee:** $144.70 **Benefit:** 75% = $108.55 100% = $144.70 **Extended Medicare Safety Net Cap:** $434.10 **Future End Date:**
Amend 743	Attendance by a general practitioner (not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference carried out for a care recipient in a residential care home; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 40 minutes (other than a service associated with a service to which item 729, 731, 965, 967, 231, 232, 392, 393, 92026, 92027, 92029, 92030, 92033, 92034, 92057, 92058, 92060, 92061, 92063 or 92064 applies) (See para AN.0.49 of explanatory notes to this Category) **Fee:** $241.25 **Benefit:** 75% = $180.95 100% = $241.25 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
Amend 747	Attendance by a general practitioner (not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference carried out for a care recipient in a residential care home; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which item 729, 731, 965, 967, 231, 232, 392, 393, 92026, 92027, 92029, 92030, 92033, 92034, 92057, 92058, 92060, 92061, 92063 or 92064 applies) (See para AN.0.49 of explanatory notes to this Category) **Fee:** $62.20 **Benefit:** 75% = $46.65 100% = $62.20 **Extended Medicare Safety Net Cap:** $186.60 **Future End Date:**

Amend 750	Attendance by a general practitioner (not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference carried out for a care recipient in a residential care home; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which item 729, 731, 965, 967, 231, 232, 392, 393, 92026, 92027, 92029, 92030, 92033, 92034, 92057, 92058, 92060, 92061, 92063 or 92064 applies) (See para AN.0.49 of explanatory notes to this Category) **Fee:** $106.60 **Benefit:** 75% = $79.95 100% = $106.60 **Extended Medicare Safety Net Cap:** $319.80 **Future End Date:**
Amend 758	Attendance by a general practitioner (not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference carried out for a care recipient in a residential care home; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 40 minutes (other than a service associated with a service to which item 729, 731, 965, 967, 231, 232, 392, 393, 92026, 92027, 92029, 92030, 92033, 92034, 92057, 92058, 92060, 92061, 92063 or 92064 applies) (See para AN.36.2 of explanatory notes to this Category) **Fee:** $177.35 **Benefit:** 75% = $133.05 100% = $177.35 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
820	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $168.95 **Benefit:** 75% = $126.75 85% = $143.65 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
822	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $253.60 **Benefit:** 75% = $190.20 85% = $215.60 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

823	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $337.80 **Benefit:** 75% = $253.35 85% = $287.15 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
825	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $121.30 **Benefit:** 75% = $91.00 85% = $103.15 **Extended Medicare Safety Net Cap:** $363.90 **Future End Date:**
826	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $193.55 **Benefit:** 75% = $145.20 85% = $164.55 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
828	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $265.75 **Benefit:** 75% = $199.35 85% = $225.90 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
830	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (H) (See para AN.0.51 of explanatory notes to this Category) **Fee:** $168.95 **Benefit:** 75% = $126.75 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
832	Attendance by a consultant physician in the practice of the consultant physician's specialty, 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, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (H) (See para AN.0.51 of explanatory notes to this Category) **Fee:** $253.60 **Benefit:** 75% = $190.20 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
834	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (H) (See para AN.0.51 of explanatory notes to this Category) **Fee:** $337.80 **Benefit:** 75% = $253.35 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
835	Attendance by a consultant physician in the practice of the consultant physician's specialty, 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, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (H) (See para AN.0.51 of explanatory notes to this Category) **Fee:** $121.30 **Benefit:** 75% = $91.00 **Extended Medicare Safety Net Cap:** $363.90 **Future End Date:**
837	Attendance by a consultant physician in the practice of the consultant physician's specialty, 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 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (H) (See para AN.0.51 of explanatory notes to this Category) **Fee:** $193.55 **Benefit:** 75% = $145.20 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
838	Attendance by a consultant physician in the practice of the consultant physician's specialty, 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 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (H) (See para AN.0.51 of explanatory notes to this Category) **Fee:** $265.75 **Benefit:** 75% = $199.35 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
855	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.62 of explanatory notes to this Category) **Fee:** $168.95 **Benefit:** 75% = $126.75 85% = $143.65 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

857	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.62 of explanatory notes to this Category) **Fee:** $253.60 **Benefit:** 75% = $190.20 85% = $215.60 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
858	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.62 of explanatory notes to this Category) **Fee:** $337.80 **Benefit:** 75% = $253.35 85% = $287.15 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
861	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (H) (See para AN.0.62 of explanatory notes to this Category) **Fee:** $168.95 **Benefit:** 75% = $126.75 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
864	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, 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, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (H) (See para AN.0.62 of explanatory notes to this Category) **Fee:** $253.60 **Benefit:** 75% = $190.20 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
866	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (H) (See para AN.0.62 of explanatory notes to this Category) **Fee:** $337.80 **Benefit:** 75% = $253.35 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
871	Attendance by a general practitioner, specialist or consultant physician as a member of a case conference team, to lead and coordinate a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 3 other medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health or other relevant health professionals

	(See para AN.0.65 of explanatory notes to this Category) **Fee:** $97.55 **Benefit:** 75% = $73.20 85% = $82.95 **Extended Medicare Safety Net Cap:** $292.65 **Future End Date:**
872	Attendance by a general practitioner, specialist or consultant physician as a member of a case conference team, to participate in a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 4 medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health or other relevant health professionals (See para AN.0.65 of explanatory notes to this Category) **Fee:** $45.45 **Benefit:** 75% = $34.10 85% = $38.65 **Extended Medicare Safety Net Cap:** $136.35 **Future End Date:**
880	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of geriatric or rehabilitation medicine, as a member of a case conference team, to coordinate a case conference of at least 10 minutes but less than 30 minutes—for any particular patient, one attendance only in a 7 day period (other than attendance on the same day as an attendance for which item 832, 834, 835, 837 or 838 was applicable in relation to the patient) (H) (See para AN.0.63 of explanatory notes to this Category) **Fee:** $59.10 **Benefit:** 75% = $44.35 **Future End Date:**
930	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference, if the conference lasts for at least 15 minutes, but for less than 20 minutes (See para AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $84.65 **Benefit:** 75% = $63.50 100% = $84.65 **Extended Medicare Safety Net Cap:** $253.95 **Future End Date:**
933	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference, if the conference lasts for at least 20 minutes, but for less than 40 minutes (See para AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $144.70 **Benefit:** 75% = $108.55 100% = $144.70 **Extended Medicare Safety Net Cap:** $434.10 **Future End Date:**
935	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference, if the conference lasts for at least 40 minutes (See para AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $241.25 **Benefit:** 75% = $180.95 100% = $241.25 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
937	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference, if the conference lasts for at least 15 minutes, but for less than 20 minutes (See para AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $62.20 **Benefit:** 75% = $46.65 100% = $62.20

	Extended Medicare Safety Net Cap: $186.60 **Future End Date:**
943	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference, if the conference lasts for at least 20 minutes, but for less than 40 minutes (See para AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $106.60 **Benefit:** 75% = $79.95 100% = $106.60 **Extended Medicare Safety Net Cap:** $319.80 **Future End Date:**
945	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference, if the conference lasts for at least 40 minutes (See para AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $177.35 **Benefit:** 75% = $133.05 100% = $177.35 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
946	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $168.95 **Benefit:** 75% = $126.75 85% = $143.65 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
948	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $253.60 **Benefit:** 75% = $190.20 85% = $215.60 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
959	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference of at least 45 minutes, with the multidisciplinary case conference team (See para AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $337.80 **Benefit:** 75% = $253.35 85% = $287.15 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
961	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to participate in a mental health case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $121.30 **Benefit:** 75% = $91.00 85% = $103.15 **Extended Medicare Safety Net Cap:** $363.90

A15. GP CHRONIC CONDITION MANAGEMENT PLANS, MULTIDISCIPLINARY CARE PLANS AND CASE CONFERENCES — 2. CASE CONFERENCES	
	Future End Date:
962	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to participate in a mental health case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $193.55 **Benefit:** 75% = $145.20 85% = $164.55 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
964	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to participate in a mental health case conference of at least 45 minutes, with the multidisciplinary case conference team (See para AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $265.75 **Benefit:** 75% = $199.35 85% = $225.90 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A17. DOMICILIARY AND RESIDENTIAL MANAGEMENT REVIEWS	
	Group A17. Domiciliary And Residential Management Reviews
900	Participation by a general practitioner (not including a specialist or consultant physician) in a Domiciliary Medication Management Review (***DMMR***) for a patient living in a community setting, in which the general practitioner, with the patient's consent: (a) assesses the patient as: (i) having a chronic medical condition or a complex medication regimen; and (ii) not having their therapeutic goals met; and (b) following that assessment: (i) refers the patient to a community pharmacy or an accredited pharmacist for the DMMR; and (ii) provides relevant clinical information required for the DMMR; and (c) discusses with the reviewing pharmacist the results of the DMMR including suggested medication management strategies; and (d) develops a written medication management plan following discussion with the patient; and (e) provides the written medication management plan to a community pharmacy chosen by the patient For any particular patient—applicable not more than once in each 12 month period, and only if item 245 does not apply in the same 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (See para AN.15.3, AN.0.52 of explanatory notes to this Category) **Fee:** $185.35 **Benefit:** 100% = $185.35 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
Amend 903	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 care home—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. (See para AN.7.18, AN.15.3 of explanatory notes to this Category) **Fee:** $126.90 **Benefit:** 100% = $126.90

A17. DOMICILIARY AND RESIDENTIAL MANAGEMENT REVIEWS	
	Extended Medicare Safety Net Cap: $380.70 **Future End Date:**

A20. GP MENTAL HEALTH TREATMENT	1. GP MENTAL HEALTH TREATMENT PLANS
	Group A20. GP Mental Health Treatment
	Subgroup 1. GP Mental Health Treatment Plans
2700	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 (See para AN.36.2, AN.0.56, AN.0.78 of explanatory notes to this Category) **Fee:** $85.80 **Benefit:** 75% = $64.35 100% = $85.80 **Extended Medicare Safety Net Cap:** $257.40 **Future End Date:**
2701	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 (See para AN.36.2, AN.0.56, AN.0.78 of explanatory notes to this Category) **Fee:** $126.35 **Benefit:** 75% = $94.80 100% = $126.35 **Extended Medicare Safety Net Cap:** $379.05 **Future End Date:**
2715	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 (See para AN.36.2, AN.0.56, AN.0.78 of explanatory notes to this Category) **Fee:** $108.95 **Benefit:** 75% = $81.75 100% = $108.95 **Extended Medicare Safety Net Cap:** $326.85 **Future End Date:**
2717	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 (See para AN.36.2, AN.0.56, AN.0.78 of explanatory notes to this Category) **Fee:** $160.50 **Benefit:** 75% = $120.40 100% = $160.50 **Extended Medicare Safety Net Cap:** $481.50 **Future End Date:**

A20. GP MENTAL HEALTH TREATMENT	2. FOCUSSED PSYCHOLOGICAL STRATEGIES
	Group A20. GP Mental Health Treatment
	Subgroup 2. Focussed Psychological Strategies
2721	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 (See para AN.36.2, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $111.00 **Benefit:** 100% = $111.00

	Extended Medicare Safety Net Cap: $333.00 **Future End Date:**
2723	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 (See para AN.36.2, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Derived Fee:** The fee for item 2721, plus $31.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2721 plus $2.45 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
2725	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 (See para AN.36.2, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $158.90 **Benefit:** 100% = $158.90 **Extended Medicare Safety Net Cap:** $476.70 **Future End Date:**
2727	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 (See para AN.36.2, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Derived Fee:** The fee for item 2725, plus $31.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2725 plus $2.45 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
2739	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 (See para MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $111.00 **Benefit:** 100% = $111.00 **Extended Medicare Safety Net Cap:** $333.00 **Future End Date:**
2741	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

A20. GP MENTAL HEALTH TREATMENT	2. FOCUSSED PSYCHOLOGICAL STRATEGIES
	(b) lasting at least 30 minutes, but less than 40 minutes (See para MN.7.5, AN.0.78 of explanatory notes to this Category) **Derived Fee:** The fee for item 2739, plus $31.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2739 plus $2.45 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
2743	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 (See para MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $158.90 **Benefit:** 100% = $158.90 **Extended Medicare Safety Net Cap:** $476.70 **Future End Date:**
2745	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 (See para MN.7.5, AN.0.78 of explanatory notes to this Category) **Derived Fee:** The fee for item 2743, plus $31.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2743 plus $2.45 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**

A21. PROFESSIONAL ATTENDANCES AT RECOGNISED EMERGENCY DEPARTMENTS OF PRIVATE HOSPITALS	1. CONSULTATIONS
	Group A21. Professional Attendances at Recognised Emergency Departments of Private Hospitals
	Subgroup 1. Consultations
5001	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 (See para AN.0.60 of explanatory notes to this Category) **Fee:** $70.25 **Benefit:** 75% = $52.70 85% = $59.75 **Extended Medicare Safety Net Cap:** $210.75 **Future End Date:**

A21. PROFESSIONAL ATTENDANCES AT RECOGNISED EMERGENCY DEPARTMENTS OF PRIVATE HOSPITALS	1. CONSULTATIONS
5004	Professional attendance, on a patient aged under 4 years, 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 (See para AN.0.60 of explanatory notes to this Category) **Fee:** $117.95 **Benefit:** 75% = $88.50 85% = $100.30 **Extended Medicare Safety Net Cap:** $353.85 **Future End Date:**
5011	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 (See para AN.0.60 of explanatory notes to this Category) **Fee:** $117.95 **Benefit:** 75% = $88.50 85% = $100.30 **Extended Medicare Safety Net Cap:** $353.85 **Future End Date:**
5012	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 (See para AN.0.60 of explanatory notes to this Category) **Fee:** $184.85 **Benefit:** 75% = $138.65 85% = $157.15 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
5013	Professional attendance, on a patient aged under 4 years, 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 (See para AN.0.60 of explanatory notes to this Category) **Fee:** $232.55 **Benefit:** 75% = $174.45 85% = $197.70 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
5014	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 (See para AN.0.60 of explanatory notes to this Category) **Fee:** $232.55 **Benefit:** 75% = $174.45 85% = $197.70 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
5016	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 (See para AN.0.60 of explanatory notes to this Category) **Fee:** $312.05 **Benefit:** 75% = $234.05 85% = $265.25 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A21. PROFESSIONAL ATTENDANCES AT RECOGNISED EMERGENCY DEPARTMENTS OF PRIVATE HOSPITALS	1. CONSULTATIONS
5017	Professional attendance, on a patient aged under 4 years, 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 (See para AN.0.60 of explanatory notes to this Category) **Fee:** $359.80 **Benefit:** 75% = $269.85 85% = $305.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
5019	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 (See para AN.0.60 of explanatory notes to this Category) **Fee:** $359.80 **Benefit:** 75% = $269.85 85% = $305.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
5021	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 (See para AN.0.60 of explanatory notes to this Category) **Fee:** $52.65 **Benefit:** 75% = $39.50 85% = $44.80 **Extended Medicare Safety Net Cap:** $157.95 **Future End Date:**
5022	Professional attendance, on a patient aged under 4 years, 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 (See para AN.0.60 of explanatory notes to this Category) **Fee:** $88.45 **Benefit:** 75% = $66.35 85% = $75.20 **Extended Medicare Safety Net Cap:** $265.35 **Future End Date:**
5027	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 (See para AN.0.60 of explanatory notes to this Category) **Fee:** $88.45 **Benefit:** 75% = $66.35 85% = $75.20 **Extended Medicare Safety Net Cap:** $265.35 **Future End Date:**
5030	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 (See para AN.0.60 of explanatory notes to this Category) **Fee:** $138.55 **Benefit:** 75% = $103.95 85% = $117.80 **Extended Medicare Safety Net Cap:** $415.65 **Future End Date:**

A21. PROFESSIONAL ATTENDANCES AT RECOGNISED EMERGENCY DEPARTMENTS OF PRIVATE HOSPITALS	1. CONSULTATIONS
5031	Professional attendance, on a patient aged under 4 years, 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 (See para AN.0.60 of explanatory notes to this Category) **Fee:** $174.40 **Benefit:** 75% = $130.80 85% = $148.25 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
5032	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 (See para AN.0.60 of explanatory notes to this Category) **Fee:** $174.40 **Benefit:** 75% = $130.80 85% = $148.25 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
5033	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 (See para AN.0.60 of explanatory notes to this Category) **Fee:** $234.05 **Benefit:** 75% = $175.55 85% = $198.95 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
5035	Professional attendance, on a patient aged under 4 years, 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 (See para AN.0.60 of explanatory notes to this Category) **Fee:** $269.90 **Benefit:** 75% = $202.45 85% = $229.45 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
5036	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 (See para AN.0.60 of explanatory notes to this Category) **Fee:** $269.90 **Benefit:** 75% = $202.45 85% = $229.45 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A21. PROFESSIONAL ATTENDANCES AT RECOGNISED EMERGENCY DEPARTMENTS OF PRIVATE HOSPITALS	2. PROLONGED PROFESSIONAL ATTENDANCES TO WHICH NO OTHER GROUP APPLIES
	Group A21. Professional Attendances at Recognised Emergency Departments of Private Hospitals
	Subgroup 2. Prolonged Professional Attendances To Which No Other Group Applies

A21. PROFESSIONAL ATTENDANCES AT RECOGNISED EMERGENCY DEPARTMENTS OF PRIVATE HOSPITALS	2. PROLONGED PROFESSIONAL ATTENDANCES TO WHICH NO OTHER GROUP APPLIES
5039	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 (See para AN.0.61 of explanatory notes to this Category) **Fee:** $170.50 **Benefit:** 75% = $127.90 85% = $144.95 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
5041	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 (See para AN.0.61 of explanatory notes to this Category) **Fee:** $320.55 **Benefit:** 75% = $240.45 85% = $272.50 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
5042	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 (See para AN.0.61 of explanatory notes to this Category) **Fee:** $127.95 **Benefit:** 75% = $96.00 85% = $108.80 **Extended Medicare Safety Net Cap:** $383.85 **Future End Date:**
5044	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

A21. PROFESSIONAL ATTENDANCES AT RECOGNISED EMERGENCY DEPARTMENTS OF PRIVATE HOSPITALS	2. PROLONGED PROFESSIONAL ATTENDANCES TO WHICH NO OTHER GROUP APPLIES
	(See para AN.0.61 of explanatory notes to this Category) **Fee:** $240.45 **Benefit:** 75% = $180.35 85% = $204.40 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A22. General Practitioner After-Hours Attendances To Which No Other Item Applies
5071	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 (See para MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.19, AN.0.74 of explanatory notes to this Category) **Fee:** $239.45 **Benefit:** 100% = $239.45 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
Amend 5076	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential care home 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 on one occasion—each patient (See para AN.0.11, AN.0.9, AN.0.19, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 5071, plus $31.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5071 plus $2.45 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 5077	Professional attendance by a general practitioner, on care recipients in a residential care home, 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:

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(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 care home on one occasion—each patient (See para AN.0.19, AN.0.9, AN.0.15, MN.1.7, AN.0.74, MN.1.8, AN.0.11, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 5071, plus $55.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5071 plus $4.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
	LEVEL A
5000	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 (See para MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.19, AN.0.74 of explanatory notes to this Category) **Fee:** $34.70 **Benefit:** 100% = $34.70 **Extended Medicare Safety Net Cap:** $104.10 **Future End Date:**
Amend 5003	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential care home 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 (See para AN.0.19, AN.0.11, AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 5000, plus $31.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5000 plus $2.45 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 5010	Professional attendance (other than a service to which another item applies) at a residential care home (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 residential care home 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 care home on one occasion—each patient (See para AN.0.19, AN.0.15, AN.0.9, MN.1.7, AN.0.74, MN.1.8, AN.0.11, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category)

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Derived Fee: The fee for item 5000, plus $55.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5000 plus $4.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
	LEVEL B
5020	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 (See para MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.19, AN.0.74 of explanatory notes to this Category) **Fee:** $58.65 **Benefit:** 100% = $58.65 **Extended Medicare Safety Net Cap:** $175.95 **Future End Date:**
Amend 5023	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential care home 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 (See para AN.0.19, MN.1.6, AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, AN.0.11 of explanatory notes to this Category) **Derived Fee:** The fee for item 5020, plus $31.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5020 plus $2.45 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 5028	Professional attendance by a general practitioner (other than a service to which another item in this Schedule applies), on care recipients in a residential care home, 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;

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(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 care home on one occasion—each patient (See para AN.0.19, AN.0.15, AN.0.9, MN.1.7, AN.0.74, MN.1.8, AN.0.11, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 5020, plus $55.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5020 plus $4.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
	LEVEL C
5040	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 (See para MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.19, AN.0.74 of explanatory notes to this Category) **Fee:** $100.55 **Benefit:** 100% = $100.55 **Extended Medicare Safety Net Cap:** $301.65 **Future End Date:**
Amend 5043	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential care home or 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;

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	for one or more health-related issues, with appropriate documentation—an attendance on one or more patients on one occasion—each patient (See para AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6, AN.0.19, AN.0.11 of explanatory notes to this Category) **Derived Fee:** The fee for item 5040, plus $31.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5040 plus $2.45 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 5049	Professional attendance by a general practitioner, on care recipients in a residential care home, 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 care home on one occasion—each patient (See para AN.0.19, AN.0.15, AN.0.9, MN.1.7, AN.0.74, MN.1.8, AN.0.11, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 5040, plus $55.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5040 plus $4.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
	LEVEL D
5060	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 (See para MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.19, AN.0.74 of explanatory notes to this Category) **Fee:** $140.95 **Benefit:** 100% = $140.95

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Extended Medicare Safety Net Cap: $422.85 **Future End Date:**
Amend 5063	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential care home or 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 on one occasion—each patient (See para AN.0.19, AN.0.11, AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 5060, plus $31.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5060 plus $2.45 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 5067	Professional attendance by a general practitioner, on care recipients in a residential care home, 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 care home on one occasion—each patient (See para AN.0.19, AN.0.15, AN.0.9, MN.1.7, AN.0.74, MN.1.8, AN.0.11, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Derived Fee:** The fee for item 5060, plus $55.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5060 plus $4.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**

A23. OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A23. Other Non-Referred After-Hours Attendances To Which No Other Item Applies
5209	Professional attendance at consulting rooms lasting more than 60 minutes (other than a service to which another item applies) by a medical practitioner (other than a general practitioner) (See para AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.5, MN.1.6, MN.1.7, MN.1.7, MN.1.8, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $122.40 **Benefit:** 100% = $122.40 **Extended Medicare Safety Net Cap:** $367.20 **Future End Date:**
Amend 5261	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential care home or a service to which another item in this Schedule applies), lasting more than 60 minutes—an attendance on one or more patients on one occasion—each patient (See para AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.3, MN.1.5, MN.1.8, AN.0.11, MN.1.6, MN.1.7 of explanatory notes to this Category) **Derived Fee:** An amount equal to $112.20, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $112.20 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 5262	Professional attendance (other than a service to which another item applies) at a residential care home (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 residential care home who is not a resident of a self-contained unit, lasting more than 60 minutes by a medical practitioner (other than a general practitioner)—an attendance on one or more patients at one residential care home on one occasion—each patient (See para AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.15 of explanatory notes to this Category) **Derived Fee:** An amount equal to $112.20, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $112.20 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
	CONSULTATION AT CONSULTING ROOMS
5200	Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)-each attendance (See para AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00 **Future End Date:**
5203	Professional attendance at consulting rooms of more than 5 minutes in duration but not more than 25 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)-each attendance

A23. OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(See para AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.5, MN.1.6, MN.1.7, MN.1.7, MN.1.8, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $31.00 **Benefit:** 100% = $31.00 **Extended Medicare Safety Net Cap:** $93.00 **Future End Date:**
5207	Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)-each attendance (See para AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.5, MN.1.6, MN.1.7, MN.1.7, MN.1.8, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $48.00 **Benefit:** 100% = $48.00 **Extended Medicare Safety Net Cap:** $144.00 **Future End Date:**
5208	Professional attendance at consulting rooms lasting more than 45 minutes, but not more than 60 minutes, (other than a service to which another item applies) by a medical practitioner (other than a general practitioner) (See para AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.5, MN.1.6, MN.1.7, MN.1.7, MN.1.8, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $71.00 **Benefit:** 100% = $71.00 **Extended Medicare Safety Net Cap:** $213.00 **Future End Date:**
	CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS, HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY
Amend 5220	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential care home 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 (See para MN.1.8, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5, MN.1.5, AN.0.11, MN.1.6, MN.1.7, MN.1.7 of explanatory notes to this Category) **Derived Fee:** An amount equal to $18.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $18.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 5223	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential care home 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 (See para AN.0.11, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** An amount equal to $26.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $26.00 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 5227	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential care home or a service to which another item

A23. OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	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 (See para AN.0.11, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** An amount equal to $45.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $45.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 5228	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential care home or a service to which another item in this Schedule applies), lasting more than 45 minutes, but not more than 60 minutes—an attendance on one or more patients on one occasion—each patient (See para MN.1.4, AN.0.11, MN.1.6, MN.1.7, MN.1.8, MN.1.8, AN.0.9, AN.7.2, MN.1.3, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** An amount equal to $67.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $67.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
	CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY
Amend 5260	Professional attendance (other than a service to which another item applies) at a residential care home (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 care home (other than accommodation in a self-contained unit) of not more than 5 minutes in duration by a medical practitioner (other than a general practitioner)-an attendance on one or more patients at one residential care home on one occasion-each patient (See para AN.0.15, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** An amount equal to $18.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $18.50 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 5263	Professional attendance (other than a service to which another item applies) at a residential care home (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 care home (other than accommodation in a self-contained unit) of more than 5 minutes in duration but not more than 25 minutes in duration by a medical practitioner (other than a general practitioner)-an attendance on one or more patients at one residential care home on one occasion-each patient (See para AN.0.15, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** An amount equal to $26.00, plus $31.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $26.00 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 5265	Professional attendance (other than a service to which another item applies) at a residential care home (other than a professional attendance at a self-contained unit) or professional attendance at consulting

A23. OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	rooms situated within such a complex if the patient is accommodated in the residential care home (other than accommodation in a self-contained unit) of more than 25 minutes in duration but not more than 45 minutes by a medical practitioner (other than a general practitioner)-an attendance on one or more patients at one residential care home on one occasion-each patient (See para AN.0.15, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** An amount equal to $45.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $45.50 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
Amend 5267	Professional attendance (other than a service to which another item applies) at a residential care home (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 residential care home who is not a resident of a self-contained unit, lasting more than 45 minutes, but not more than 60 minutes, by a medical practitioner (other than a general practitioner)—an attendance on one or more patients at one residential care home on one occasion—each patient (See para AN.0.15, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.7.2, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Derived Fee:** An amount equal to $67.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $67.50 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**

A24. PAIN AND PALLIATIVE MEDICINE	1. PAIN MEDICINE ATTENDANCES
	Group A24. Pain And Palliative Medicine
	Subgroup 1. Pain Medicine Attendances
2801	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 (See para AN.40.1, AN.0.58 of explanatory notes to this Category) **Fee:** $183.35 **Benefit:** 75% = $137.55 85% = $155.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
2806	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 (See para AN.40.1, AN.3.1, AN.0.58, AN.0.70 of explanatory notes to this Category) **Fee:** $91.70 **Benefit:** 75% = $68.80 85% = $77.95 **Extended Medicare Safety Net Cap:** $275.10 **Future End Date:**
2814	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

A24. PAIN AND PALLIATIVE MEDICINE	1. PAIN MEDICINE ATTENDANCES
	patient to the specialist or consultant physician by a referring practitioner-each minor attendance after the first attendance in a single course of treatment (See para AN.40.1, AN.3.1, AN.0.58, AN.0.70 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 75% = $39.20 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
2824	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 (See para AN.0.58 of explanatory notes to this Category) **Fee:** $222.40 **Benefit:** 85% = $189.05 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
2832	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 (See para AN.0.58 of explanatory notes to this Category) **Fee:** $134.50 **Benefit:** 85% = $114.35 **Extended Medicare Safety Net Cap:** $403.50 **Future End Date:**
2840	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 (See para AN.0.58 of explanatory notes to this Category) **Fee:** $96.90 **Benefit:** 85% = $82.40 **Extended Medicare Safety Net Cap:** $290.70 **Future End Date:**

A24. PAIN AND PALLIATIVE MEDICINE	2. PAIN MEDICINE CASE CONFERENCES
	Group A24. Pain And Palliative Medicine
	Subgroup 2. Pain Medicine Case Conferences
2946	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $168.95 **Benefit:** 75% = $126.75 85% = $143.65 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
2949	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes (See para AN.0.58 of explanatory notes to this Category)

	Fee: $253.60 **Benefit:** 75% = $190.20 85% = $215.60 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
2954	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $337.80 **Benefit:** 75% = $253.35 85% = $287.15 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
2958	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $121.30 **Benefit:** 75% = $91.00 85% = $103.15 **Extended Medicare Safety Net Cap:** $363.90 **Future End Date:**
2972	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $193.55 **Benefit:** 75% = $145.20 85% = $164.55 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
2974	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $265.75 **Benefit:** 75% = $199.35 85% = $225.90 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
2978	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) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $168.95 **Benefit:** 75% = $126.75 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
2984	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) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $253.60 **Benefit:** 75% = $190.20 85% = $215.60

A24. PAIN AND PALLIATIVE MEDICINE	2. PAIN MEDICINE CASE CONFERENCES
	Extended Medicare Safety Net Cap: $500.00 **Future End Date:**
2988	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) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $337.80 **Benefit:** 75% = $253.35 85% = $287.15 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
2992	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) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $121.30 **Benefit:** 75% = $91.00 85% = $103.15 **Extended Medicare Safety Net Cap:** $363.90 **Future End Date:**
2996	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) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $193.55 **Benefit:** 75% = $145.20 85% = $164.55 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
3000	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) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $265.75 **Benefit:** 75% = $199.35 85% = $225.90 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A24. PAIN AND PALLIATIVE MEDICINE	3. PALLIATIVE MEDICINE ATTENDANCES
	Group A24. Pain And Palliative Medicine
	Subgroup 3. Palliative Medicine Attendances
3005	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 (See para AN.40.1, AN.0.58 of explanatory notes to this Category) **Fee:** $183.35 **Benefit:** 75% = $137.55 85% = $155.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A24. PAIN AND PALLIATIVE MEDICINE	3. PALLIATIVE MEDICINE ATTENDANCES
3010	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 (See para AN.40.1, AN.3.1, AN.0.58, AN.0.70 of explanatory notes to this Category) **Fee:** $91.70 **Benefit:** 75% = $68.80 85% = $77.95 **Extended Medicare Safety Net Cap:** $275.10 **Future End Date:**
3014	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 (See para AN.40.1, AN.3.1, AN.0.58, AN.0.70 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 75% = $39.20 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
3018	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 (See para AN.0.58 of explanatory notes to this Category) **Fee:** $222.40 **Benefit:** 85% = $189.05 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
3023	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 (See para AN.0.58 of explanatory notes to this Category) **Fee:** $134.50 **Benefit:** 85% = $114.35 **Extended Medicare Safety Net Cap:** $403.50 **Future End Date:**
3028	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 (See para AN.0.58 of explanatory notes to this Category) **Fee:** $96.90 **Benefit:** 85% = $82.40 **Extended Medicare Safety Net Cap:** $290.70 **Future End Date:**

A24. PAIN AND PALLIATIVE MEDICINE	4. PALLIATIVE MEDICINE CASE CONFERENCES
	Group A24. Pain And Palliative Medicine
	Subgroup 4. Palliative Medicine Case Conferences

A24. PAIN AND PALLIATIVE MEDICINE	4. PALLIATIVE MEDICINE CASE CONFERENCES
3032	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 (See para AN.0.58 of explanatory notes to this Category) **Fee:** $168.95 **Benefit:** 75% = $126.75 85% = $143.65 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
3040	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $253.60 **Benefit:** 75% = $190.20 85% = $215.60 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
3044	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $337.80 **Benefit:** 75% = $253.35 85% = $287.15 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
3051	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $121.30 **Benefit:** 75% = $91.00 85% = $103.15 **Extended Medicare Safety Net Cap:** $363.90 **Future End Date:**
3055	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.58 of explanatory notes to this Category) **Fee:** $193.55 **Benefit:** 75% = $145.20 85% = $164.55 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
3062	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $265.75 **Benefit:** 75% = $199.35 85% = $225.90 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
3069	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) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $168.95 **Benefit:** 75% = $126.75 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
3074	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) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $253.60 **Benefit:** 75% = $190.20 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
3078	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) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $337.80 **Benefit:** 75% = $253.35 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
3083	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) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $121.30 **Benefit:** 75% = $91.00 **Extended Medicare Safety Net Cap:** $363.90 **Future End Date:**
3088	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) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $193.55 **Benefit:** 75% = $145.20 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
3093	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) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $265.75 **Benefit:** 75% = $199.35 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A26. NEUROSURGERY ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A26. Neurosurgery Attendances To Which No Other Item Applies
6007	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 (See para AN.40.1, AN.0.64 of explanatory notes to this Category) **Fee:** $157.40 **Benefit:** 75% = $118.05 85% = $133.80 **Extended Medicare Safety Net Cap:** $472.20 **Future End Date:**
6009	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 (See para AN.40.1, AN.3.1, AN.0.64, AN.0.70 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 75% = $39.20 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
6011	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 (See para AN.40.1, AN.3.1, AN.0.64, AN.0.70 of explanatory notes to this Category) **Fee:** $103.95 **Benefit:** 75% = $78.00 85% = $88.40 **Extended Medicare Safety Net Cap:** $311.85 **Future End Date:**
6013	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 (See para AN.40.1, AN.3.1, AN.0.64, AN.0.70 of explanatory notes to this Category) **Fee:** $144.00 **Benefit:** 75% = $108.00 85% = $122.40 **Extended Medicare Safety Net Cap:** $432.00 **Future End Date:**
6015	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 (See para AN.40.1, AN.3.1, AN.0.64, AN.0.70 of explanatory notes to this Category) **Fee:** $183.35 **Benefit:** 75% = $137.55 85% = $155.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A27. PREGNANCY SUPPORT COUNSELLING	
	Group A27. Pregnancy Support Counselling
4001	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

A27. PREGNANCY SUPPORT COUNSELLING	
	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 (See para MN.8.2, AN.0.66 of explanatory notes to this Category) **Fee:** $91.65 **Benefit:** 100% = $91.65 **Extended Medicare Safety Net Cap:** $274.95 **Future End Date:**

A28. GERIATRIC MEDICINE	
	Group A28. Geriatric Medicine
141	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

A28. GERIATRIC MEDICINE	
	(See para AN.40.1, AN.0.26 of explanatory notes to this Category) **Fee:** $549.90 **Benefit:** 75% = $412.45 85% = $467.45 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
143	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 (See para AN.40.1, AN.0.26 of explanatory notes to this Category) **Fee:** $343.75 **Benefit:** 75% = $257.85 85% = $292.20 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
145	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:

A28. GERIATRIC MEDICINE	
	(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 (See para AN.0.26 of explanatory notes to this Category) **Fee:** $666.75 **Benefit:** 85% = $566.75 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
147	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 (See para AN.0.26 of explanatory notes to this Category) **Fee:** $416.75 **Benefit:** 85% = $354.25 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A29. ATTENDANCE SERVICES FOR COMPLEX NEURODEVELOPMENTAL DISORDER OR DISABILITY	
	Group A29. Attendance services for complex neurodevelopmental disorder or disability
135	Professional attendance lasting at least 45 minutes by a consultant physician in the practice of the consultant physician's specialty of paediatrics, following referral of the patient to the consultant paediatrician by a referring practitioner, for a patient aged under 25, if the consultant paediatrician: (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 137, 139, 289, 92140, 92141, 92142 or 92434) Applicable only once per lifetime (See para AN.40.1, AN.0.24 of explanatory notes to this Category) **Fee:** $320.55 **Benefit:** 75% = $240.45 85% = $272.50 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
137	Professional attendance lasting at least 45 minutes by a specialist or consultant physician (not including a general practitioner), following referral of the patient to the specialist or consultant physician by a referring practitioner, for a patient aged under 25, if the specialist or consultant physician: (a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of an eligible disability 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

A29. ATTENDANCE SERVICES FOR COMPLEX NEURODEVELOPMENTAL DISORDER OR DISABILITY	
	(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, 139, 289, 92140, 92141, 92142 or 92434) Applicable only once per lifetime (See para AN.40.1, AR.29.1, AN.0.25 of explanatory notes to this Category) **Fee:** $320.55 **Benefit:** 75% = $240.45 85% = $272.50 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
139	Professional attendance lasting at least 45 minutes, at a place other than a hospital, by a general practitioner (not including a specialist or consultant physician), for a patient aged under 25, if the general practitioner: (a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of an eligible disability 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 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, 289, 92140, 92141, 92142 or 92434) Applicable only once per lifetime (See para AR.29.1, AN.0.73 of explanatory notes to this Category) **Fee:** $161.05 **Benefit:** 100% = $161.05 **Extended Medicare Safety Net Cap:** $483.15 **Future End Date:**

A31. ADDICTION MEDICINE	1. ADDICTION MEDICINE ATTENDANCES
	Group A31. Addiction Medicine
	Subgroup 1. Addiction Medicine Attendances

A31. ADDICTION MEDICINE	1. ADDICTION MEDICINE ATTENDANCES
6018	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 (See para AN.40.1 of explanatory notes to this Category) **Fee:** $183.35 **Benefit:** 75% = $137.55 85% = $155.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
6019	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 (See para AN.40.1, AN.3.1, AN.0.70 of explanatory notes to this Category) **Fee:** $91.70 **Benefit:** 75% = $68.80 85% = $77.95 **Extended Medicare Safety Net Cap:** $275.10 **Future End Date:**
6023	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 (See para AN.40.1 of explanatory notes to this Category)

A31. ADDICTION MEDICINE	1. ADDICTION MEDICINE ATTENDANCES
	Fee: $320.55 **Benefit:** 75% = $240.45 85% = $272.50 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
6024	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 (See para AN.40.1 of explanatory notes to this Category) **Fee:** $160.50 **Benefit:** 75% = $120.40 85% = $136.45 **Extended Medicare Safety Net Cap:** $481.50 **Future End Date:**

A31. ADDICTION MEDICINE	2. GROUP THERAPY
	Group A31. Addiction Medicine
	Subgroup 2. Group Therapy
6028	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 **Fee:** $59.85 **Benefit:** 75% = $44.90 85% = $50.90 **Extended Medicare Safety Net Cap:** $179.55

A31. ADDICTION MEDICINE	2. GROUP THERAPY
	Future End Date:

A31. ADDICTION MEDICINE	3. ADDICTION MEDICINE CASE CONFERENCES
	Group A31. Addiction Medicine
	Subgroup 3. Addiction Medicine Case Conferences
6029	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of less than 15 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $51.85 **Benefit:** 75% = $38.90 85% = $44.10 **Extended Medicare Safety Net Cap:** $155.55 **Future End Date:**
6031	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $91.70 **Benefit:** 75% = $68.80 85% = $77.95 **Extended Medicare Safety Net Cap:** $275.10 **Future End Date:**
6032	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $137.70 **Benefit:** 75% = $103.30 85% = $117.05 **Extended Medicare Safety Net Cap:** $413.10 **Future End Date:**
6034	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate the multidisciplinary case conference of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $183.35 **Benefit:** 75% = $137.55 85% = $155.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
6035	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of less than 15 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $41.50 **Benefit:** 75% = $31.15 85% = $35.30 **Extended Medicare Safety Net Cap:** $124.50 **Future End Date:**
6037	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care

A31. ADDICTION MEDICINE	3. ADDICTION MEDICINE CASE CONFERENCES
	providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $73.40 **Benefit:** 75% = $55.05 85% = $62.40 **Extended Medicare Safety Net Cap:** $220.20 **Future End Date:**
6038	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $110.10 **Benefit:** 75% = $82.60 85% = $93.60 **Extended Medicare Safety Net Cap:** $330.30 **Future End Date:**
6042	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $146.60 **Benefit:** 75% = $109.95 85% = $124.65 **Extended Medicare Safety Net Cap:** $439.80 **Future End Date:**

A32. SEXUAL HEALTH MEDICINE	1. SEXUAL HEALTH MEDICINE ATTENDANCES
	Group A32. Sexual Health Medicine
	Subgroup 1. Sexual Health Medicine Attendances
6051	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 (See para AN.40.1 of explanatory notes to this Category) **Fee:** $183.35 **Benefit:** 75% = $137.55 85% = $155.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
6052	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

A32. SEXUAL HEALTH MEDICINE	1. SEXUAL HEALTH MEDICINE ATTENDANCES
	(See para AN.40.1, AN.3.1, AN.0.70 of explanatory notes to this Category) **Fee:** $91.70 **Benefit:** 75% = $68.80 85% = $77.95 **Extended Medicare Safety Net Cap:** $275.10 **Future End Date:**
6057	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 (See para AN.40.1 of explanatory notes to this Category) **Fee:** $320.55 **Benefit:** 75% = $240.45 85% = $272.50 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
6058	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:

A32. SEXUAL HEALTH MEDICINE	1. SEXUAL HEALTH MEDICINE ATTENDANCES
	(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 (See para AN.40.1 of explanatory notes to this Category) **Fee:** $160.50 **Benefit:** 75% = $120.40 85% = $136.45 **Extended Medicare Safety Net Cap:** $481.50 **Future End Date:**

A32. SEXUAL HEALTH MEDICINE	2. HOME VISITS
	Group A32. Sexual Health Medicine
	Subgroup 2. Home Visits
6062	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 **Fee:** $222.40 **Benefit:** 85% = $189.05 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
6063	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 **Fee:** $134.50 **Benefit:** 85% = $114.35 **Extended Medicare Safety Net Cap:** $403.50 **Future End Date:**

A32. SEXUAL HEALTH MEDICINE	3. SEXUAL HEALTH MEDICINE CASE CONFERENCES
	Group A32. Sexual Health Medicine
	Subgroup 3. Sexual Health Medicine Case Conferences
6064	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal

	care providers of different disciplines, to organise and coordinate a community case conference of less than 15 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $51.85 **Benefit:** 75% = $38.90 85% = $44.10 **Extended Medicare Safety Net Cap:** $155.55 **Future End Date:**
6065	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $91.70 **Benefit:** 75% = $68.80 85% = $77.95 **Extended Medicare Safety Net Cap:** $275.10 **Future End Date:**
6067	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $137.70 **Benefit:** 75% = $103.30 85% = $117.05 **Extended Medicare Safety Net Cap:** $413.10 **Future End Date:**
6068	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $183.35 **Benefit:** 75% = $137.55 85% = $155.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
6071	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of less than 15 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $41.50 **Benefit:** 75% = $31.15 85% = $35.30 **Extended Medicare Safety Net Cap:** $124.50 **Future End Date:**
6072	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $73.40 **Benefit:** 75% = $55.05 85% = $62.40 **Extended Medicare Safety Net Cap:** $220.20

A32. SEXUAL HEALTH MEDICINE	3. SEXUAL HEALTH MEDICINE CASE CONFERENCES
	Future End Date:
6074	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $110.10 **Benefit:** 75% = $82.60 85% = $93.60 **Extended Medicare Safety Net Cap:** $330.30 **Future End Date:**
6075	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $146.60 **Benefit:** 75% = $109.95 85% = $124.65 **Extended Medicare Safety Net Cap:** $439.80 **Future End Date:**

A33. TRANSCATHETER AORTIC VALVE IMPLANTATION AND TRANSCATHETER MITRAL VALVE REPLACEMENT CASE CONFERENCE.	
	Group A33. Transcatheter Aortic Valve Implantation and Transcatheter Mitral Valve Replacement Case Conference.
6080	Coordination of a TAVI Case Conference by a TAVI Practitioner where the TAVI Case Conference has a duration of 10 minutes or more. (Not payable more than once per patient in a five year period.) (See para AN.33.1, TN.8.135 of explanatory notes to this Category) **Fee:** $60.95 **Benefit:** 75% = $45.75 85% = $51.85 **Extended Medicare Safety Net Cap:** $182.85 **Future End Date:**
6081	Attendance at a TAVI Case Conference by a specialist or consultant physician who does not also perform the service described in item 6080 for the same case conference where the TAVI Case Conference has a duration of 10 minutes or more. (Not payable more than twice per patient in a five year period.) (See para AN.33.1, TN.8.135 of explanatory notes to this Category) **Fee:** $45.45 **Benefit:** 75% = $34.10 85% = $38.65 **Extended Medicare Safety Net Cap:** $136.35 **Future End Date:**
6082	Attendance at a TMVr suitability case conference, by a cardiothoracic surgeon or an interventional cardiologist, to coordinate the conference, if: (a) the attendance lasts at least 10 minutes; and

A33. TRANSCATHETER AORTIC VALVE IMPLANTATION AND TRANSCATHETER MITRAL VALVE REPLACEMENT CASE CONFERENCE.	
	(b) the surgeon or cardiologist is accredited by the TMVr accreditation committee to perform the service Applicable once each 5 years **Fee:** $60.95 **Benefit:** 75% = $45.75 85% = $51.85 **Extended Medicare Safety Net Cap:** $182.85 **Future End Date:**
6084	Attendance at a TMVr suitability case conference, by a specialist or consultant physician, other than to coordinate the conference, if the attendance lasts at least 10 minutes Applicable once each 5 years **Fee:** $45.45 **Benefit:** 75% = $34.10 85% = $38.65 **Extended Medicare Safety Net Cap:** $136.35 **Future End Date:**

A35. SERVICES FOR PATIENTS IN RESIDENTIAL CARE HOME	1. FLAG FALL AMOUNT FOR RESIDENTIAL AGED CARE FACILITIES
	Group A35. Services For Patients in Residential Care Home
	Subgroup 1. Flag Fall Amount For Residential Aged Care Facilities
Amend 90001	For the first patient attended during one attendance by a general practitioner at one residential care home 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 $65.80. (See para AN.35.1 of explanatory notes to this Category) **Fee:** $65.80 **Benefit:** 100% = $65.80 **Extended Medicare Safety Net Cap:** $197.40 **Future End Date:**
Amend 90002	For the first patient attended during one attendance by a medical practitioner at one residential care home 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 $47.80. (See para AN.35.2 of explanatory notes to this Category) **Fee:** $47.80 **Benefit:** 100% = $47.80 **Extended Medicare Safety Net Cap:** $143.40 **Future End Date:**

A35. SERVICES FOR PATIENTS IN RESIDENTIAL CARE HOME	2. GENERAL PRACTITIONER NON-REFERRED ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
	Group A35. Services For Patients in Residential Care Home
	Subgroup 2. General Practitioner Non-Referred Attendance At A Residential Aged Care Facility
Amend 90020	Professional attendance (other than a service to which another item applies) at a residential care home (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 care home (other than accommodation in a self-contained unit) by a general practitioner for an obvious problem

A35. SERVICES FOR PATIENTS IN RESIDENTIAL CARE HOME	2. GENERAL PRACTITIONER NON-REFERRED ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
	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 care home on one occasion - each patient. (See para AN.0.9, AN.35.1, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $20.55 **Benefit:** 100% = $20.55 **Extended Medicare Safety Net Cap:** $61.65 **Future End Date:**
Amend 90035	Professional attendance by a general practitioner, on care recipients in a residential care home, 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 care home on one occasion—each patient (subject to clause 2.30.1) (See para AN.0.9, AN.35.1, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $45.05 **Benefit:** 100% = $45.05 **Extended Medicare Safety Net Cap:** $135.15 **Future End Date:**
Amend 90043	Professional attendance by a general practitioner at a residential care home to residents of the residential care home (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 care home on one occasion—each patient (See para AN.0.9, AN.35.1, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $87.10 **Benefit:** 100% = $87.10 **Extended Medicare Safety Net Cap:** $261.30 **Future End Date:**
Amend 90051	Professional attendance by a general practitioner at a residential care home to residents of the residential care home (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;

A35. SERVICES FOR PATIENTS IN RESIDENTIAL CARE HOME	2. GENERAL PRACTITIONER NON-REFERRED ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
	(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 care home on one occasion—each patient (See para AN.0.9, AN.35.1, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $128.35 **Benefit:** 100% = $128.35 **Extended Medicare Safety Net Cap:** $385.05 **Future End Date:**
Amend 90054	Professional attendance by a general practitioner, on care recipients in a residential care home, 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 care home on one occasion—each patient (subject to clause 2.30.1) (See para AN.35.1, AN.0.9, MN.1.7, AN.0.74, MN.1.8, MN.1.4, MN.1.3, MN.1.5, MN.1.6 of explanatory notes to this Category) **Fee:** $207.90 **Benefit:** 100% = $207.90 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A35. SERVICES FOR PATIENTS IN RESIDENTIAL CARE HOME	3. OTHER MEDICAL PRACTITIONER NON-REFERRED ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
	Group A35. Services For Patients in Residential Care Home
	Subgroup 3. Other Medical Practitioner Non-Referred Attendance At A Residential Aged Care Facility
Amend 90092	Professional attendance (other than a service to which any other item applies) at a residential care home (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 care home (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 care home on one occasion—each patient, by a medical practitioner who is not a general practitioner. (See para AN.0.9, MN.1.4, MN.1.3, MN.1.5, AN.7.1, AN.35.2, AN.7.2, MN.1.6, MN.1.7, MN.1.8 of explanatory notes to this Category) **Fee:** $8.50 **Benefit:** 100% = $8.50 **Extended Medicare Safety Net Cap:** $25.50 **Future End Date:**

A35. SERVICES FOR PATIENTS IN RESIDENTIAL CARE HOME	3. OTHER MEDICAL PRACTITIONER NON-REFERRED ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
Amend 90093	Professional attendance (other than a service to which any other item applies) at a residential care home (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 care home (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 care home on one occasion—each patient, by a medical practitioner who is not a general practitioner. (See para AN.7.1, AN.35.2, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Fee:** $16.00 **Benefit:** 100% = $16.00 **Extended Medicare Safety Net Cap:** $48.00 **Future End Date:**
Amend 90095	Professional attendance (other than a service to which any other item applies) at a residential care home (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 care home (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 care home on one occasion—each patient, by a medical practitioner who is not a general practitioner. (See para AN.7.1, AN.35.2, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Fee:** $35.50 **Benefit:** 100% = $35.50 **Extended Medicare Safety Net Cap:** $106.50 **Future End Date:**
Amend 90096	Professional attendance (other than a service to which any other item applies) at a residential care home (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 residential care home 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 care home on one occasion—each patient (subject to clause 2.30.1), by a medical practitioner who is not a general practitioner (See para AN.7.1, AN.35.2, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Fee:** $57.50 **Benefit:** 100% = $57.50 **Extended Medicare Safety Net Cap:** $172.50 **Future End Date:**
Amend 90098	Professional attendance (other than a service to which another item applies) at a residential care home (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 residential care home 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 care home on one occasion by a medical practitioner who is not a general practitioner—each patient (subject to subclause 2.30.1(2)) (See para AN.7.2, AN.7.1, AN.35.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.3, MN.1.5 of explanatory notes to this Category) **Fee:** $88.20 **Benefit:** 100% = $88.20 **Extended Medicare Safety Net Cap:** $264.60 **Future End Date:**

A35. SERVICES FOR PATIENTS IN RESIDENTIAL CARE HOME	4. NON-SPECIALIST PRACTITIONER NON-REFERRED ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
	Group A35. Services For Patients in Residential Care Home
	Subgroup 4. Non-Specialist Practitioner Non-Referred Attendance At A Residential Aged Care Facility
Amend 90183	Professional attendance (other than a service to which another item applies) at a residential care home (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 residential care home 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 care home on one occasion by a prescribed medical practitioner in an eligible area—each patient (subject to subclause 2.30.1(2)) (See para AN.0.9, MN.1.4, MN.1.5, AN.7.1, AN.35.2, AN.7.2, MN.1.6, MN.1.7, MN.1.8 of explanatory notes to this Category) **Fee:** $16.50 **Benefit:** 100% = $16.50 **Extended Medicare Safety Net Cap:** $49.50 **Future End Date:**
Amend 90188	Professional attendance (other than a service to which another item applies) at a residential care home (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 residential care home 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 care home on one occasion by a prescribed medical practitioner in an eligible area—each patient (subject to subclause 2.30.1(2)) (See para AN.7.1, AN.35.2, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.5 of explanatory notes to this Category) **Fee:** $35.95 **Benefit:** 100% = $35.95 **Extended Medicare Safety Net Cap:** $107.85 **Future End Date:**
Amend 90202	Professional attendance (other than a service to which another item applies) at a residential care home (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 residential care home 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 care home on one occasion by a prescribed medical practitioner in an eligible area—each patient (subject to subclause 2.30.1(2)) (See para AN.7.1, AN.35.2, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.5 of explanatory notes to this Category) **Fee:** $69.70 **Benefit:** 100% = $69.70 **Extended Medicare Safety Net Cap:** $209.10 **Future End Date:**
Amend 90212	Professional attendance (other than a service to which another item applies) at a residential care home (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 residential care home 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 care home on one occasion by a prescribed medical practitioner in an eligible area—each patient (subject to subclause 2.30.1(2)) (See para AN.7.1, AN.35.2, AN.7.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.5 of explanatory notes to this Category) **Fee:** $102.65 **Benefit:** 100% = $102.65 **Extended Medicare Safety Net Cap:** $307.95 **Future End Date:**

A35. SERVICES FOR PATIENTS IN RESIDENTIAL CARE HOME	4. NON-SPECIALIST PRACTITIONER NON-REFERRED ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
Amend 90215	Professional attendance (other than a service to which another item applies) at a residential care home (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 residential care home 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 care home on one occasion by a prescribed medical practitioner in an eligible area—each patient (subject to subclause 2.30.1(2)) (See para AN.7.2, AN.7.1, AN.35.2, MN.1.6, MN.1.7, MN.1.8, AN.0.9, MN.1.4, MN.1.5 of explanatory notes to this Category) **Fee:** $166.30 **Benefit:** 100% = $166.30 **Extended Medicare Safety Net Cap:** $498.90 **Future End Date:**

A36. EATING DISORDER SERVICES	1. PREPARATION OF EATING DISORDER TREATMENT AND MANAGEMENT PLANS: GENERAL PRACTITIONERS AND NON SPECIALIST MEDICAL PRACTITIONERS
	Group A36. Eating Disorder Services
	Subgroup 1. Preparation of eating disorder treatment and management plans: general practitioners and non specialist medical practitioners
90250	Professional attendance by a general practitioner to prepare an eating disorder treatment and management plan, lasting at least 20 minutes but less than 40 minutes. (See para AN.36.2 of explanatory notes to this Category) **Fee:** $85.80 **Benefit:** 100% = $85.80 **Extended Medicare Safety Net Cap:** $257.40 **Future End Date:**
90251	Professional attendance by a general practitioner to prepare an eating disorder treatment and management plan, lasting at least 40 minutes (See para AN.36.2 of explanatory notes to this Category) **Fee:** $126.35 **Benefit:** 100% = $126.35 **Extended Medicare Safety Net Cap:** $379.05 **Future End Date:**
90252	Professional attendance by a general practitioner to prepare an eating disorder treatment and management plan, lasting at least 20 minutes but less than 40 minutes, if the practitioner has successfully completed mental health skills training. (See para AN.36.2 of explanatory notes to this Category) **Fee:** $108.95 **Benefit:** 100% = $108.95 **Extended Medicare Safety Net Cap:** $326.85 **Future End Date:**
90253	Professional attendance by a general practitioner to prepare an eating disorder treatment and management plan, lasting at least 40 minutes, if the practitioner has successfully completed mental health skills training. (See para AN.36.2 of explanatory notes to this Category) **Fee:** $160.50 **Benefit:** 100% = $160.50 **Extended Medicare Safety Net Cap:** $481.50 **Future End Date:**

A36. EATING DISORDER SERVICES	1. PREPARATION OF EATING DISORDER TREATMENT AND MANAGEMENT PLANS: GENERAL PRACTITIONERS AND NON SPECIALIST MEDICAL PRACTITIONERS
90254	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to prepare an eating disorder treatment and management plant, lasting at least 20 minutes but less than 40 minutes. (See para AN.36.2 of explanatory notes to this Category) **Fee:** $68.65 **Benefit:** 100% = $68.65 **Extended Medicare Safety Net Cap:** $205.95 **Future End Date:**
90255	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to prepare an eating disorder treatment and management plan, lasting at least 40 minutes. (See para AN.36.2 of explanatory notes to this Category) **Fee:** $101.05 **Benefit:** 100% = $101.05 **Extended Medicare Safety Net Cap:** $303.15 **Future End Date:**
90256	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to prepare an eating disorder treatment and management plan, lasting at least 20 minutes but less than 40 minutes, if the practitioner has successfully completed mental health skills training. (See para AN.36.2 of explanatory notes to this Category) **Fee:** $87.15 **Benefit:** 100% = $87.15 **Extended Medicare Safety Net Cap:** $261.45 **Future End Date:**
90257	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to prepare an eating disorder treatment and management plan, lasting at least 40 minutes, if the practitioner has successfully completed mental health skills training. (See para AN.36.2 of explanatory notes to this Category) **Fee:** $128.45 **Benefit:** 100% = $128.45 **Extended Medicare Safety Net Cap:** $385.35 **Future End Date:**

A36. EATING DISORDER SERVICES	2. PREPARATION OF EATING DISORDER TREATMENT AND MANAGEMENT PLANS: CONSULTANT PHYSICIANS
	Group A36. Eating Disorder Services
	Subgroup 2. Preparation of eating disorder treatment and management plans: consultant physicians
90260	Professional attendance at consulting rooms by a consultant physician in the practice of the physician's specialty of psychiatry to prepare an eating disorder treatment and management plan, if: (a) the patient is referred; and (b) the attendance lasts at least 45 minutes (See para AN.36.2, AN.40.1 of explanatory notes to this Category) **Fee:** $549.90 **Benefit:** 85% = $467.45 **Extended Medicare Safety Net Cap:** $500.00

A36. EATING DISORDER SERVICES	2. PREPARATION OF EATING DISORDER TREATMENT AND MANAGEMENT PLANS: CONSULTANT PHYSICIANS
	Future End Date:
90261	Professional attendance at consulting rooms by a consultant physician in the practice of the physician's specialty of paediatrics to prepare an eating disorder treatment and management plan, if: (a) the patient is referred; and (b) the attendance lasts at least 45 minutes (See para AN.36.2, AN.40.1 of explanatory notes to this Category) **Fee:** $320.55 **Benefit:** 85% = $272.50 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A36. EATING DISORDER SERVICES	3. REVIEW OF EATING DISORDER TREATMENT AND MANAGEMENT PLANS
	Group A36. Eating Disorder Services
	Subgroup 3. Review of eating disorder treatment and management plans
90264	Professional attendance by a general practitioner to review an eating disorder treatment and management plan. (See para AN.36.3 of explanatory notes to this Category) **Fee:** $85.80 **Benefit:** 100% = $85.80 **Extended Medicare Safety Net Cap:** $257.40 **Future End Date:**
90265	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to review an eating disorder treatment and management plan. (See para AN.36.3 of explanatory notes to this Category) **Fee:** $68.65 **Benefit:** 100% = $68.65 **Extended Medicare Safety Net Cap:** $205.95 **Future End Date:**
90266	Professional attendance at consulting rooms by a consultant physician in the practice of the physician's specialty of psychiatry to review an eating disorder treatment and management plan, if: (a) the patient is referred; and (b) the attendance lasts at least 30 minutes (See para AN.36.3, AN.40.1 of explanatory notes to this Category) **Fee:** $343.75 **Benefit:** 85% = $292.20 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
90267	Professional attendance at consulting rooms by a consultant physician in the practice of the physician's specialty of paediatrics to review an eating disorder treatment and management plan, if: (a) the patient is referred; and (b) the attendance lasts at least 20 minutes (See para AN.36.3, AN.40.1 of explanatory notes to this Category) **Fee:** $160.50 **Benefit:** 85% = $136.45

A36. EATING DISORDER SERVICES	3. REVIEW OF EATING DISORDER TREATMENT AND MANAGEMENT PLANS
	Extended Medicare Safety Net Cap: $481.50 **Future End Date:**

A36. EATING DISORDER SERVICES	4. PROVIDING TREATMENTS UNDER EATING DISORDER TREATMENT AND MANAGEMENT PLANS
	Group A36. Eating Disorder Services
	Subgroup 4. Providing treatments under eating disorder treatment and management plans
90271	Professional attendance at consulting rooms by a general practitioner to provide treatment under an eating disorder treatment and management plan, lasting at least 30 minutes but less than 40 minutes. (See para AN.36.4, AN.36.2 of explanatory notes to this Category) **Fee:** $111.00 **Benefit:** 100% = $111.00 **Extended Medicare Safety Net Cap:** $333.00 **Future End Date:**
90272	Professional attendance at a place other than consulting rooms by a general practitioner to provide treatment under an eating disorder treatment and management plan, lasting at least 30 minutes but less than 40 minutes (See para AN.36.4, AN.36.2 of explanatory notes to this Category) **Derived Fee:** The fee for item 90271, plus $31.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 90271 plus $2.45 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
90273	Professional attendance at consulting rooms by a general practitioner to provide treatment under an eating disorder treatment and management plan, lasting at least 40 minutes. (See para AN.36.4, AN.36.2 of explanatory notes to this Category) **Fee:** $158.90 **Benefit:** 100% = $158.90 **Extended Medicare Safety Net Cap:** $476.70 **Future End Date:**
90274	Professional attendance at a place other than consulting rooms by a general practitioner to provide treatment under an eating disorder treatment and management plan, lasting at least 40 minutes (See para AN.36.4, AN.36.2 of explanatory notes to this Category) **Derived Fee:** The fee for item 90273, plus $31.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 90273 plus $2.45 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
90275	Professional attendance at consulting rooms by a medical practitioner (other than a general practitioner, specialist or consultant physician) to provide treatment under an eating disorder treatment and management plan, lasting at least 30 minutes but less than 40 minutes. (See para AN.36.4, AN.36.2 of explanatory notes to this Category) **Fee:** $88.85 **Benefit:** 100% = $88.85 **Extended Medicare Safety Net Cap:** $266.55 **Future End Date:**

A36. EATING DISORDER SERVICES	4. PROVIDING TREATMENTS UNDER EATING DISORDER TREATMENT AND MANAGEMENT PLANS
90276	Professional attendance at a place other than consulting rooms by a medical practitioner (other than a general practitioner, specialist or consultant physician) to provide treatment under an eating disorder treatment and management plan, lasting at least 30 minutes but less than 40 minutes (See para AN.36.4, AN.36.2 of explanatory notes to this Category) **Derived Fee:** The fee for item 90275, plus $24.85 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 90275 plus $1.95 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
90277	Professional attendance at consulting rooms by a medical practitioner (other than a general practitioner, specialist or consultant physician) to provide treatment under an eating disorder treatment and management plan, lasting at least 40 minutes. (See para AN.36.4, AN.36.2 of explanatory notes to this Category) **Fee:** $127.10 **Benefit:** 100% = $127.10 **Extended Medicare Safety Net Cap:** $381.30 **Future End Date:**
90278	Professional attendance at a place other than consulting rooms by a medical practitioner (other than a general practitioner, specialist or consultant physician) to provide treatment under an eating disorder treatment and management plan, lasting at least 40 minutes (See para AN.36.4, AN.36.2 of explanatory notes to this Category) **Derived Fee:** The fee for item 90277, plus $24.85 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 90277 plus $1.95 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**

A37. CARDIOTHORACIC SURGEON ATTENDANCE FOR LEAD EXTRACTION	
	Group A37. Cardiothoracic Surgeon Attendance for Lead Extraction
90300	Professional attendance by a cardiothoracic surgeon in the practice of the surgeon's speciality, if: (a) the service is: i. performed in conjunction with a service (the ***lead extraction service***) to which item 38358 applies; or ii. performed in conjunction with a service (the ***leadless pacemaker extraction service***) to which item 38373 or 38374 applies; or iii. 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: i. 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 ii. 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

A37. CARDIOTHORACIC SURGEON ATTENDANCE FOR LEAD EXTRACTION	
	iii. is able to immediately scrub in and perform a thoracotomy if major complications occur (H) (See para TN.8.214 of explanatory notes to this Category) **Fee:** $1,029.75 **Benefit:** 75% = $772.35 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES 1. GENERAL PRACTICE VIDEO SERVICES	
	Group A40. Telehealth attendance services
	Subgroup 1. General practice video 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) (See para MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, MN.10.1, AN.0.9, AN.0.73, AN.0.74 of explanatory notes to this Category) **Fee:** $20.55 **Benefit:** 100% = $20.55 **Extended Medicare Safety Net Cap:** $61.65 **Future End Date:**
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) (See para AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $11.00 **Benefit:** 100% = $11.00 **Extended Medicare Safety Net Cap:** $33.00 **Future End Date:**
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) (See para AN.7.2, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $16.50 **Benefit:** 100% = $16.50 **Extended Medicare Safety Net Cap:** $49.50 **Future End Date:**
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) (See para MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, MN.10.1, AN.0.9, AN.0.73, AN.0.74 of explanatory notes to this Category) **Fee:** $45.05 **Benefit:** 100% = $45.05 **Extended Medicare Safety Net Cap:** $135.15 **Future End Date:**
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) (See para MN.1.3, MN.1.3, MN.1.4, MN.1.4, MN.1.5, MN.1.5, MN.1.6, MN.1.7, MN.1.8, MN.10.1, AN.0.9, AN.0.73, AN.0.74 of explanatory notes to this Category) **Fee:** $87.10 **Benefit:** 100% = $87.10 **Extended Medicare Safety Net Cap:** $261.30 **Future End Date:**
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) (See para MN.1.3, MN.1.3, MN.1.4, MN.1.4, MN.1.5, MN.1.5, MN.1.6, MN.1.7, MN.1.8, MN.10.1, AN.0.9, AN.0.73, AN.0.74 of explanatory notes to this Category) **Fee:** $128.35 **Benefit:** 100% = $128.35 **Extended Medicare Safety Net Cap:** $385.05 **Future End Date:**
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) (See para AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00 **Future End Date:**
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) (See para AN.7.2, MN.1.3, MN.1.3, MN.1.4, MN.1.4, MN.1.5, MN.1.5, MN.1.6, MN.1.6, MN.1.7, MN.1.8, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00 **Future End Date:**
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) (See para AN.7.2, MN.1.3, MN.1.3, MN.1.4, MN.1.4, MN.1.5, MN.1.5, MN.1.6, MN.1.6, MN.1.7, MN.1.8, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	1. GENERAL PRACTICE VIDEO SERVICES
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) (See para AN.7.2, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $35.95 **Benefit:** 100% = $35.95 **Extended Medicare Safety Net Cap:** $107.85 **Future End Date:**
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) (See para AN.7.2, MN.1.4, MN.1.4, MN.1.5, MN.1.5, MN.1.6, MN.1.6, MN.1.7, MN.1.8, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $69.70 **Benefit:** 100% = $69.70 **Extended Medicare Safety Net Cap:** $209.10 **Future End Date:**
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)

	(See para AN.7.2, MN.1.4, MN.1.4, MN.1.5, MN.1.5, MN.1.6, MN.1.6, MN.1.7, MN.1.8, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $102.65 **Benefit:** 100% = $102.65 **Extended Medicare Safety Net Cap:** $307.95 **Future End Date:**
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) (See para AN.1.1, MN.1.3, MN.1.3, MN.1.4, MN.1.4, MN.1.5, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.74 of explanatory notes to this Category) **Fee:** $207.90 **Benefit:** 100% = $207.90 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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) (See para AN.1.1, AN.7.2, MN.1.3, MN.1.3, MN.1.4, MN.1.4, MN.1.5, MN.1.5, MN.1.6, MN.1.6, MN.1.7, MN.1.8, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $98.40 **Benefit:** 100% = $98.40 **Extended Medicare Safety Net Cap:** $295.20 **Future End Date:**
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;

A40. TELEHEALTH ATTENDANCE SERVICES	1. GENERAL PRACTICE VIDEO SERVICES
	(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) (See para AN.1.1, AN.7.2, MN.1.4, MN.1.4, MN.1.5, MN.1.5, MN.1.6, MN.1.6, MN.1.7, MN.1.8, MN.1.8, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $166.30 **Benefit:** 100% = $166.30 **Extended Medicare Safety Net Cap:** $498.90 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	2. GENERAL PRACTICE PHONE SERVICES
	Group A40. Telehealth attendance services
	Subgroup 2. 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) (See para MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, MN.10.1, AN.0.9, AN.0.73, AN.0.74 of explanatory notes to this Category) **Fee:** $20.55 **Benefit:** 100% = $20.55 **Extended Medicare Safety Net Cap:** $61.65 **Future End Date:**
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) (See para MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, MN.10.1, AN.0.9, AN.0.73, AN.0.74 of explanatory notes to this Category) **Fee:** $45.05 **Benefit:** 100% = $45.05 **Extended Medicare Safety Net Cap:** $135.15 **Future End Date:**
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) (See para AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $11.00 **Benefit:** 100% = $11.00 **Extended Medicare Safety Net Cap:** $33.00 **Future End Date:**
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) (See para AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00 **Future End Date:**
91900	Phone attendance by a general practitioner to a patient registered under MyMedicare with the billing practice, 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; for one or more health related issues, with appropriate documentation (See para AN.1.1, MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.74 of explanatory notes to this Category) **Fee:** $87.10 **Benefit:** 100% = $87.10 **Extended Medicare Safety Net Cap:** $261.30 **Future End Date:**
91903	Phone attendance by a medical practitioner (not including a general practitioner) to a patient registered under MyMedicare with the billing practice, 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; for one or more health related issues, with appropriate documentation

	(See para AN.1.1, AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00 **Future End Date:**
91906	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, to a patient registered under MyMedicare with the billing practice, 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 preventive health care; for one or more health related issues, with appropriate documentation (See para AN.1.1, AN.7.2, MN.1.4, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $69.70 **Benefit:** 100% = $69.70 **Extended Medicare Safety Net Cap:** $209.10 **Future End Date:**
91910	Phone attendance by a general practitioner, to a patient registered under MyMedicare with the billing practice, 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 preventive health care; for one or more health related issues, with appropriate documentation (See para AN.1.1, MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9, AN.0.74 of explanatory notes to this Category) **Fee:** $128.35 **Benefit:** 100% = $128.35 **Extended Medicare Safety Net Cap:** $385.05 **Future End Date:**
91913	Phone attendance by a medical practitioner (not including a general practitioner), to a patient registered under MyMedicare with the billing practice, 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; for one or more health related issues, with appropriate documentation (See para AN.1.1, AN.7.2, MN.1.3, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	2. GENERAL PRACTICE PHONE SERVICES
91916	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, to a patient registered under MyMedicare with the billing practice, 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; for one or more health related issues, with appropriate documentation (See para AN.1.1, AN.7.2, MN.1.4, MN.1.5, MN.1.6, MN.1.7, MN.1.8, AN.0.9 of explanatory notes to this Category) **Fee:** $102.65 **Benefit:** 100% = $102.65 **Extended Medicare Safety Net Cap:** $307.95 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	3. FOCUSSED PSYCHOLOGICAL STRATEGIES - VIDEO SERVICES
	Group A40. Telehealth attendance services
	Subgroup 3. Focussed Psychological Strategies - Video 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. **Fee:** $111.00 **Benefit:** 100% = $111.00 **Extended Medicare Safety Net Cap:** $333.00 **Future End Date:**
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 **Fee:** $158.90 **Benefit:** 100% = $158.90 **Extended Medicare Safety Net Cap:** $476.70 **Future End Date:**
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

	Fee: $88.85 **Benefit:** 100% = $88.85 **Extended Medicare Safety Net Cap:** $266.55 **Future End Date:**
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 **Fee:** $127.10 **Benefit:** 100% = $127.10 **Extended Medicare Safety Net Cap:** $381.30 **Future End Date:**
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 **Fee:** $111.00 **Benefit:** 100% = $111.00 **Extended Medicare Safety Net Cap:** $333.00 **Future End Date:**
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 **Fee:** $158.90 **Benefit:** 100% = $158.90 **Extended Medicare Safety Net Cap:** $476.70 **Future End Date:**
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 **Fee:** $88.80 **Benefit:** 100% = $88.80 **Extended Medicare Safety Net Cap:** $266.40 **Future End Date:**
91863	Video attendance by a medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service:

A40. TELEHEALTH ATTENDANCE SERVICES	3. FOCUSSED PSYCHOLOGICAL STRATEGIES - VIDEO SERVICES
	(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 **Fee:** $127.10 **Benefit:** 100% = $127.10 **Extended Medicare Safety Net Cap:** $381.30 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	4. SPECIALIST ATTENDANCES VIDEO SERVICES
	Group A40. Telehealth attendance services
	Subgroup 4. Specialist attendances video 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 (See para AN.40.1, MN.10.1, AN.0.7, AN.0.25 of explanatory notes to this Category) **Fee:** $103.95 **Benefit:** 85% = $88.40 **Extended Medicare Safety Net Cap:** $311.85 **Future End Date:**
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 (See para AN.40.1, AN.3.1, MN.10.1, AN.0.7, AN.0.25, AN.0.70 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	5. CONSULTANT PHYSICIAN VIDEO SERVICES
	Group A40. Telehealth attendance services
	Subgroup 5. Consultant physician video 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 (See para AN.40.1, MN.10.1, AN.0.7, AN.0.24 of explanatory notes to this Category) **Fee:** $183.35 **Benefit:** 85% = $155.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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 (See para AN.40.1, AN.3.1, MN.10.1, AN.0.7, AN.0.25, AN.0.24, AN.0.70 of explanatory notes to this Category) **Fee:** $91.70 **Benefit:** 85% = $77.95 **Extended Medicare Safety Net Cap:** $275.10 **Future End Date:**
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 (See para AN.40.1, AN.3.1, MN.10.1, AN.0.7, AN.0.25, AN.0.24, AN.0.70 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
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 (See para AN.40.1, AN.0.7, AN.0.24 of explanatory notes to this Category) **Fee:** $320.55 **Benefit:** 85% = $272.50 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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 (See para AN.40.1, AN.0.7, AN.0.23 of explanatory notes to this Category) **Fee:** $160.50 **Benefit:** 85% = $136.45 **Extended Medicare Safety Net Cap:** $481.50 **Future End Date:**

	Group A40. Telehealth attendance services
	Subgroup 6. Consultant psychiatrist video 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 (See para MN.10.1, AN.0.30, AN.0.25, AN.0.31, AN.0.72, AN.0.75 of explanatory notes to this Category) **Fee:** $52.65 **Benefit:** 85% = $44.80 **Extended Medicare Safety Net Cap:** $157.95 **Future End Date:**
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 (See para MN.10.1, AN.0.25, AN.0.72 of explanatory notes to this Category) **Fee:** $105.05 **Benefit:** 85% = $89.30 **Extended Medicare Safety Net Cap:** $315.15 **Future End Date:**
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 (See para MN.10.1, AN.0.25, AN.0.72 of explanatory notes to this Category) **Fee:** $161.70 **Benefit:** 85% = $137.45 **Extended Medicare Safety Net Cap:** $485.10 **Future End Date:**
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 (See para MN.10.1, AN.0.25, AN.0.72 of explanatory notes to this Category) **Fee:** $223.15 **Benefit:** 85% = $189.70 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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 (See para MN.10.1, AN.0.30, AN.0.25, AN.0.31, AN.0.72, AN.0.75 of explanatory notes to this Category) **Fee:** $258.95 **Benefit:** 85% = $220.15 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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 (See para AN.0.25 of explanatory notes to this Category) **Fee:** $26.20 **Benefit:** 85% = $22.30 **Extended Medicare Safety Net Cap:** $78.60 **Future End Date:**
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 (See para AN.0.25 of explanatory notes to this Category) **Fee:** $52.65 **Benefit:** 85% = $44.80 **Extended Medicare Safety Net Cap:** $157.95 **Future End Date:**
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

	(See para AN.0.25 of explanatory notes to this Category) **Fee:** $81.05 **Benefit:** 85% = $68.90 **Extended Medicare Safety Net Cap:** $243.15 **Future End Date:**
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 (See para AN.0.25 of explanatory notes to this Category) **Fee:** $111.70 **Benefit:** 85% = $94.95 **Extended Medicare Safety Net Cap:** $335.10 **Future End Date:**
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 (See para AN.0.25 of explanatory notes to this Category) **Fee:** $129.50 **Benefit:** 85% = $110.10 **Extended Medicare Safety Net Cap:** $388.50 **Future End Date:**
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 (See para AN.0.25, AN.0.31 of explanatory notes to this Category) **Fee:** $223.15 **Benefit:** 85% = $189.70 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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 (See para AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $52.65 **Benefit:** 75% = $39.50 85% = $44.80 **Extended Medicare Safety Net Cap:** $157.95 **Future End Date:**

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 (See para AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $105.05 **Benefit:** 75% = $78.80 85% = $89.30 **Extended Medicare Safety Net Cap:** $315.15 **Future End Date:**
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 (See para AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $161.70 **Benefit:** 75% = $121.30 85% = $137.45 **Extended Medicare Safety Net Cap:** $485.10 **Future End Date:**
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 (See para AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $223.15 **Benefit:** 75% = $167.40 85% = $189.70 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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 (See para AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $258.95 **Benefit:** 75% = $194.25 85% = $220.15 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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 (See para AN.0.72 of explanatory notes to this Category) **Fee:** $320.55 **Benefit:** 85% = $272.50 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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 (See para AN.0.30, AN.0.75 of explanatory notes to this Category) **Fee:** $549.90 **Benefit:** 85% = $467.45 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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 (See para AN.0.30 of explanatory notes to this Category) **Fee:** $343.75 **Benefit:** 85% = $292.20 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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 (See para MN.10.1, AN.0.30, AN.0.25, AN.0.31, AN.0.72, AN.0.75 of explanatory notes to this Category) **Fee:** $316.30 **Benefit:** 85% = $268.90 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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 (See para MN.10.1, AN.0.25, AN.0.72 of explanatory notes to this Category)

	Fee: $59.85 **Benefit:** 85% = $50.90 **Extended Medicare Safety Net Cap:** $179.55 **Future End Date:**
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 (See para MN.10.1, AN.0.25, AN.0.72 of explanatory notes to this Category) **Fee:** $79.45 **Benefit:** 85% = $67.55 **Extended Medicare Safety Net Cap:** $238.35 **Future End Date:**
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 (See para MN.10.1, AN.0.25, AN.0.72 of explanatory notes to this Category) **Fee:** $117.65 **Benefit:** 85% = $100.05 **Extended Medicare Safety Net Cap:** $352.95 **Future End Date:**
Amend 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 more than one service to which this item or item 92479, 92480, 92481, 92482 or 92483 applies in the last seven days (H) (See para AN.8.1 of explanatory notes to this Category) **Fee:** $52.65 **Benefit:** 75% = $39.50 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	6. CONSULTANT PSYCHIATRIST VIDEO SERVICES
Amend 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 more than one service to which this item or item 92478, 92480, 92481, 92482 or 92483 applies in the last seven days (H) (See para AN.8.1 of explanatory notes to this Category) **Fee:** $105.05 **Benefit:** 75% = $78.80 **Future End Date:**
Amend 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 more than one service to which this item or item 92478, 92479, 92481, 92482 or 92483 applies in the last seven days (H) (See para AN.8.1 of explanatory notes to this Category) **Fee:** $161.70 **Benefit:** 75% = $121.30 **Future End Date:**
Amend 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 more than one service to which this item or item 92478, 92479, 92480, 92482 or 92483 applies in the last seven days (H) (See para AN.8.1 of explanatory notes to this Category) **Fee:** $223.15 **Benefit:** 75% = $167.40 **Future End Date:**
Amend 92482	Video attendance for an admitted patient by a consultant psychiatrist; if:

A40. TELEHEALTH ATTENDANCE SERVICES	6. CONSULTANT PSYCHIATRIST VIDEO SERVICES
	(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 more than one service to which this item or item 92478, 92479, 92480, 92481 or 92483 applies in the last seven days (H) (See para AN.8.1 of explanatory notes to this Category) **Fee:** $258.95 **Benefit:** 75% = $194.25 **Future End Date:**
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) **Fee:** $316.30 **Benefit:** 75% = $237.25 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	7. SPECIALIST ATTENDANCES PHONE SERVICES
	Group A40. Telehealth attendance services
	Subgroup 7. 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. (See para AN.40.1, AN.3.1, MN.10.1, AN.0.7, AN.0.25, AN.0.70 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**

	Group A40. Telehealth attendance services
	Subgroup 8. 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. (See para AN.40.1, AN.3.1, MN.10.1, AN.0.7, AN.0.25, AN.0.70 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
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 (See para AN.40.1 of explanatory notes to this Category) **Fee:** $91.70 **Benefit:** 85% = $77.95 **Extended Medicare Safety Net Cap:** $275.10 **Future End Date:**
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

A40. TELEHEALTH ATTENDANCE SERVICES	8. CONSULTANT PHYSICIAN PHONE SERVICES
	(See para AN.40.1 of explanatory notes to this Category) **Fee:** $160.50 **Benefit:** 85% = $136.45 **Extended Medicare Safety Net Cap:** $481.50 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	9. CONSULTANT PSYCHIATRIST PHONE SERVICES
	Group A40. Telehealth attendance services
	Subgroup 9. 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 (See para MN.10.1, AN.0.30, AN.0.25, AN.0.31, AN.0.72, AN.0.75 of explanatory notes to this Category) **Fee:** $52.65 **Benefit:** 85% = $44.80 **Extended Medicare Safety Net Cap:** $157.95 **Future End Date:**
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 (See para MN.10.1, AN.0.25, AN.0.72 of explanatory notes to this Category) **Fee:** $105.05 **Benefit:** 85% = $89.30 **Extended Medicare Safety Net Cap:** $315.15 **Future End Date:**
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

	(See para MN.10.1, AN.0.30, AN.0.25, AN.0.31, AN.0.72, AN.0.75 of explanatory notes to this Category) **Fee:** $161.70 **Benefit:** 85% = $137.45 **Extended Medicare Safety Net Cap:** $485.10 **Future End Date:**
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 (See para AN.0.25 of explanatory notes to this Category) **Fee:** $26.20 **Benefit:** 85% = $22.30 **Extended Medicare Safety Net Cap:** $78.60 **Future End Date:**
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 (See para AN.0.25 of explanatory notes to this Category) **Fee:** $52.65 **Benefit:** 85% = $44.80 **Extended Medicare Safety Net Cap:** $157.95 **Future End Date:**
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 (See para AN.0.25 of explanatory notes to this Category) **Fee:** $81.05 **Benefit:** 85% = $68.90 **Extended Medicare Safety Net Cap:** $243.15 **Future End Date:**
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

	(See para AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $52.65 **Benefit:** 75% = $39.50 85% = $44.80 **Extended Medicare Safety Net Cap:** $157.95 **Future End Date:**
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 (See para AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $105.05 **Benefit:** 75% = $78.80 85% = $89.30 **Extended Medicare Safety Net Cap:** $315.15 **Future End Date:**
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 (See para AN.0.32, AN.0.25 of explanatory notes to this Category) **Fee:** $161.70 **Benefit:** 75% = $121.30 85% = $137.45 **Extended Medicare Safety Net Cap:** $485.10 **Future End Date:**
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 (See para AN.40.1 of explanatory notes to this Category) **Fee:** $343.75 **Benefit:** 85% = $292.20 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

	Group A40. Telehealth attendance services
	Subgroup 10. Focussed Psychological Strategies phone services
91842	Phone attendance by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders if: (a) the practitioner is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service; and (b) the service lasts at least 30 minutes, but less than 40 minutes. (See para MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $111.00 **Benefit:** 100% = $111.00 **Extended Medicare Safety Net Cap:** $333.00 **Future End Date:**
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. (See para MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $158.90 **Benefit:** 100% = $158.90 **Extended Medicare Safety Net Cap:** $476.70 **Future End Date:**
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 (See para MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $88.85 **Benefit:** 100% = $88.85 **Extended Medicare Safety Net Cap:** $266.55 **Future End Date:**
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 (See para MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $127.10 **Benefit:** 100% = $127.10 **Extended Medicare Safety Net Cap:** $381.30 **Future End Date:**
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 (See para MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $111.00 **Benefit:** 100% = $111.00 **Extended Medicare Safety Net Cap:** $333.00 **Future End Date:**
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 (See para MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $158.90 **Benefit:** 100% = $158.90 **Extended Medicare Safety Net Cap:** $476.70 **Future End Date:**
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 (See para MN.7.5, AN.0.78 of explanatory notes to this Category)

A40. TELEHEALTH ATTENDANCE SERVICES	10. FOCUSSED PSYCHOLOGICAL STRATEGIES PHONE SERVICES
	Fee: $88.80 **Benefit:** 100% = $88.80 **Extended Medicare Safety Net Cap:** $266.40 **Future End Date:**
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 (See para MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $127.10 **Benefit:** 100% = $127.10 **Extended Medicare Safety Net Cap:** $381.30 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	11. HEALTH ASSESSMENTS FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE - VIDEO SERVICES
	Group A40. Telehealth attendance services
	Subgroup 11. Health Assessments for Aboriginal and Torres Strait Islander People - Video Services
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 records Applicable 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 (See para AN.0.43 of explanatory notes to this Category) **Fee:** $254.10 **Benefit:** 100% = $254.10 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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;

A40. TELEHEALTH ATTENDANCE SERVICES	11. HEALTH ASSESSMENTS FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE - VIDEO SERVICES
	(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, 715 or 92004 applies has not been provided to the patient in the preceding 9 months (See para AN.0.43 of explanatory notes to this Category) **Fee:** $203.25 **Benefit:** 100% = $203.25 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	13. GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS AND MULTIDISCIPLINARY CARE PLANS SERVICES – VIDEO SERVICES
	Group A40. Telehealth attendance services
	Subgroup 13. GP management plans, team care arrangements and multidisciplinary care plans services – Video Services
92026	Contribution by a general practitioner 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) (See para AN.36.2, AN.15.7, AN.15.3 of explanatory notes to this Category) **Fee:** $84.25 **Benefit:** 100% = $84.25 **Extended Medicare Safety Net Cap:** $252.75 **Future End Date:**
Amend 92027	Contribution by a general practitioner by video to: (a) a multidisciplinary care plan for a patient in a residential care home, prepared by that residential care home, or to a review of such a plan prepared by such a residential care home; 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) (See para AN.36.2, AN.15.8, AN.15.6, AN.15.3, AN.15.4 of explanatory notes to this Category) **Fee:** $84.25 **Benefit:** 100% = $84.25 **Extended Medicare Safety Net Cap:** $252.75 **Future End Date:**
92029	Video attendance by a general practitioner to prepare a GP chronic condition management plan for a patient (See para AN.36.2, AN.15.4, AN.15.5, AN.15.6, AN.15.3, AN.0.47 of explanatory notes to this Category) **Fee:** $160.60 **Benefit:** 100% = $160.60 **Extended Medicare Safety Net Cap:** $481.80 **Future End Date:**
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 (See para AN.36.2, AN.15.4, AN.15.5, AN.15.6, AN.15.3, AN.0.47 of explanatory notes to this Category) **Fee:** $160.60 **Benefit:** 100% = $160.60 **Extended Medicare Safety Net Cap:** $481.80 **Future End Date:**
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) (See para AN.36.2, AN.15.7, AN.15.3 of explanatory notes to this Category) **Fee:** $67.40 **Benefit:** 100% = $67.40 **Extended Medicare Safety Net Cap:** $202.20 **Future End Date:**
Amend 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 care home, prepared by that residential care home, or to a review of such a plan prepared by such a residential care home; 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) (See para AN.36.2, AN.15.4, AN.15.8, AN.15.6, AN.15.3 of explanatory notes to this Category) **Fee:** $67.40 **Benefit:** 100% = $67.40 **Extended Medicare Safety Net Cap:** $202.20 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	13. GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS AND MULTIDISCIPLINARY CARE PLANS SERVICES – VIDEO SERVICES
92060	Video attendance by a prescribed medical practitioner to prepare a GP chronic condition management plan for a patient (See para AN.36.2, AN.15.4, AN.15.5, AN.15.6, AN.15.3, AN.0.47 of explanatory notes to this Category) **Fee:** $128.55 **Benefit:** 100% = $128.55 **Extended Medicare Safety Net Cap:** $385.65 **Future End Date:**
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 (See para AN.36.2, AN.15.4, AN.15.5, AN.15.6, AN.15.3, AN.0.47 of explanatory notes to this Category) **Fee:** $128.55 **Benefit:** 100% = $128.55 **Extended Medicare Safety Net Cap:** $385.65 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	14. GP CHRONIC CONDITION MANAGEMENT PLANS SERVICES – PHONE SERVICES
	Group A40. Telehealth attendance services
	Subgroup 14. GP chronic condition management plans services – Phone Services
New 92033	Phone attendance by a general practitioner to prepare a GP chronic condition management plan for a patient (See para AN.0.47, AN.15.3, AN.15.4, AN.15.5, AN.15.6 of explanatory notes to this Category) **Fee:** $160.60 **Benefit:** 100% = $160.60 **Future End Date:**
New 92034	Phone attendance by a general practitioner to review a GP chronic condition management plan prepared by the general practitioner or an associated medical practitioner (See para AN.15.3, AN.15.4, AN.15.5, AN.15.6, AN.0.47 of explanatory notes to this Category) **Fee:** $160.60 **Benefit:** 100% = $160.60 **Future End Date:**
New 92063	Phone attendance by a prescribed medical practitioner to prepare a GP chronic condition management plan for a patient (See para AN.0.47, AN.15.3, AN.15.4, AN.15.5, AN.15.6 of explanatory notes to this Category) **Fee:** $128.55 **Benefit:** 100% = $128.55 **Future End Date:**
New 92064	Phone 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 (See para AN.15.6, AN.0.47, AN.15.3, AN.15.4, AN.15.5 of explanatory notes to this Category) **Fee:** $128.55 **Benefit:** 100% = $128.55 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	15. GP PREGNANCY SUPPORT COUNSELLING – VIDEO SERVICES
	Group A40. Telehealth attendance services
	Subgroup 15. GP Pregnancy Support Counselling – Video Services

A40. TELEHEALTH ATTENDANCE SERVICES	15. GP PREGNANCY SUPPORT COUNSELLING – VIDEO SERVICES
92136	Video attendance of at least 20 minutes in duration by a general practitioner who is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service for the purpose of providing non-directive pregnancy support counselling to a person who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item or items 792 or 4001 of the general medical services table, or item 81000, 81005 or 81010, or item 92137, 92138, 92139, 93026 or 93029 applies in relation to that pregnancy (See para MN.8.2, AN.0.66 of explanatory notes to this Category) **Fee:** $91.65 **Benefit:** 100% = $91.65 **Extended Medicare Safety Net Cap:** $274.95 **Future End Date:**
92137	Video attendance of at least 20 minutes in duration by a medical practitioner (not including a general practitioner, specialist or consultant physician) who is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service for the purpose of providing non-directive pregnancy support counselling to a person who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item or items 792 or 4001 of the general medical services table, or item 81000, 81005 or 81010, or item 92136, 92138, 92139, 93026 or 93029 applies in relation to that pregnancy (See para MN.8.2, AN.0.66 of explanatory notes to this Category) **Fee:** $73.35 **Benefit:** 100% = $73.35 **Extended Medicare Safety Net Cap:** $220.05 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	16. GP PREGNANCY SUPPORT COUNSELLING – PHONE SERVICE
	Group A40. Telehealth attendance services
	Subgroup 16. GP Pregnancy Support Counselling – Phone Service
92138	Phone attendance of at least 20 minutes in duration by a general practitioner who is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service for the purpose of providing non-directive pregnancy support counselling to a person who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item or item 792 or 4001 of the general medical services table, or item 81000, 81005 or 81010, or item 92136, 92137, 92139, 93026 or 93029 applies in relation to that pregnancy (See para MN.8.2, AN.0.66 of explanatory notes to this Category) **Fee:** $91.65 **Benefit:** 100% = $91.65 **Extended Medicare Safety Net Cap:** $274.95 **Future End Date:**
92139	Phone attendance of at least 20 minutes in duration by a medical practitioner (not including a general practitioner, specialist or consultant physician) who is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service for the purpose of providing non-directive pregnancy support counselling to a person who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item or item 792 or 4001 of the general medical services table, or item 81000, 81005 or 81010 or item 92136, 92137, 92138, 93026 or 93029 applies in relation to that pregnancy

A40. TELEHEALTH ATTENDANCE SERVICES	16. GP PREGNANCY SUPPORT COUNSELLING – PHONE SERVICE
	(See para MN.8.2, AN.0.66 of explanatory notes to this Category) **Fee:** $73.35 **Benefit:** 100% = $73.35 **Extended Medicare Safety Net Cap:** $220.05 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	17. GP, SPECIALIST AND CONSULTANT PHYSICIAN COMPLEX NEURODEVELOPMENTAL DISORDER OR DISABILITY SERVICE – VIDEO SERVICES
	Group A40. Telehealth attendance services
	Subgroup 17. GP, specialist and consultant physician complex neurodevelopmental disorder or disability service – Video Services
92140	Video attendance lasting at least 45 minutes by a consultant physician in the practice of the consultant physician's specialty of paediatrics, following referral of the patient to the consultant paediatrician by a referring practitioner, for a patient aged under 25, if the consultant paediatrician: (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, 92141, 92142 or 92434) Applicable only once per lifetime (See para AN.0.24 of explanatory notes to this Category) **Fee:** $320.55 **Benefit:** 85% = $272.50 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
92141	Video attendance lasting at least 45 minutes by a specialist or consultant physician (not including a general practitioner), following referral of the patient to the specialist or consultant physician by a referring practitioner, for a patient aged under 25, if the specialist or consultant physician:

	(a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of an eligible disability 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, 92142 or 92434) Applicable only once per lifetime (See para AR.29.1, AN.0.25 of explanatory notes to this Category) **Fee:** $320.55 **Benefit:** 85% = $272.50 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
92142	Video attendance lasting at least 45 minutes by a general practitioner (not including a specialist or consultant physician), for a patient aged under 25, if the general practitioner: (a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of an eligible disability 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 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 92434)

A40. TELEHEALTH ATTENDANCE SERVICES	17. GP, SPECIALIST AND CONSULTANT PHYSICIAN COMPLEX NEURODEVELOPMENTAL DISORDER OR DISABILITY SERVICE – VIDEO SERVICES
	Applicable only once per lifetime 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) (See para AR.29.1, AN.0.73 of explanatory notes to this Category) **Fee:** $161.05 **Benefit:** 100% = $161.05 **Extended Medicare Safety Net Cap:** $483.15 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	19. GP MENTAL HEALTH TREATMENT PLAN – VIDEO SERVICES
	Group A40. Telehealth attendance services
	Subgroup 19. GP Mental Health Treatment Plan – Video Services
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 (See para AN.0.56 of explanatory notes to this Category) **Fee:** $85.80 **Benefit:** 100% = $85.80 **Extended Medicare Safety Net Cap:** $257.40 **Future End Date:**
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 (See para AN.0.56 of explanatory notes to this Category) **Fee:** $126.35 **Benefit:** 100% = $126.35 **Extended Medicare Safety Net Cap:** $379.05 **Future End Date:**
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 (See para AN.0.56 of explanatory notes to this Category) **Fee:** $108.95 **Benefit:** 100% = $108.95 **Extended Medicare Safety Net Cap:** $326.85 **Future End Date:**
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 (See para AN.0.56 of explanatory notes to this Category) **Fee:** $160.50 **Benefit:** 100% = $160.50 **Extended Medicare Safety Net Cap:** $481.50 **Future End Date:**
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

A40. TELEHEALTH ATTENDANCE SERVICES	19. GP MENTAL HEALTH TREATMENT PLAN – VIDEO SERVICES
	Fee: $68.65 **Benefit:** 100% = $68.65 **Extended Medicare Safety Net Cap:** $205.95 **Future End Date:**
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 **Fee:** $101.05 **Benefit:** 100% = $101.05 **Extended Medicare Safety Net Cap:** $303.15 **Future End Date:**
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 **Fee:** $87.15 **Benefit:** 100% = $87.15 **Extended Medicare Safety Net Cap:** $261.45 **Future End Date:**
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 **Fee:** $128.45 **Benefit:** 100% = $128.45 **Extended Medicare Safety Net Cap:** $385.35 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	21. GP EATING DISORDER TREATMENT AND MANAGEMENT PLAN – VIDEO SERVICES
	Group A40. Telehealth attendance services
	Subgroup 21. GP Eating Disorder Treatment and Management Plan – Video Services
92146	Video attendance by 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 written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the general practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder. (See para AN.36.2 of explanatory notes to this Category) **Fee:** $85.80 **Benefit:** 100% = $85.80 **Extended Medicare Safety Net Cap:** $257.40

	Future End Date:
92147	Video attendance by a general practitioner who has not undertaken mental health skills training, of at least 40 minutes in duration for the preparation of a written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the general practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder. (See para AN.36.2 of explanatory notes to this Category) **Fee:** $126.35 **Benefit:** 100% = $126.35 **Extended Medicare Safety Net Cap:** $379.05 **Future End Date:**
92148	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 written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the general practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder. (See para AN.36.2 of explanatory notes to this Category) **Fee:** $108.95 **Benefit:** 100% = $108.95 **Extended Medicare Safety Net Cap:** $326.85 **Future End Date:**
92149	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 written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and

	(b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the general practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder. (See para AN.36.2 of explanatory notes to this Category) **Fee:** $160.50 **Benefit:** 100% = $160.50 **Extended Medicare Safety Net Cap:** $481.50 **Future End Date:**
92150	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 written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the medical practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder (See para AN.36.2 of explanatory notes to this Category) **Fee:** $68.65 **Benefit:** 100% = $68.65 **Extended Medicare Safety Net Cap:** $205.95 **Future End Date:**
92151	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 written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and

	(d) the medical practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder (See para AN.36.2 of explanatory notes to this Category) **Fee:** $101.05 **Benefit:** 100% = $101.05 **Extended Medicare Safety Net Cap:** $303.15 **Future End Date:**
92152	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 written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the medical practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder (See para AN.36.2 of explanatory notes to this Category) **Fee:** $87.15 **Benefit:** 100% = $87.15 **Extended Medicare Safety Net Cap:** $261.45 **Future End Date:**
92153	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 written eating disorder treatment and management plan for an eligible patient, if: (a) the plan includes an opinion on diagnosis of the patient's eating disorder; and (b) the plan includes treatment options and recommendations to manage the patient's condition for the following 12 months; and (c) the plan includes an outline of the referral options to allied health professionals for mental health and dietetic services, and specialists, as appropriate; and (d) the medical practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder (See para AN.36.2 of explanatory notes to this Category)

A40. TELEHEALTH ATTENDANCE SERVICES	21. GP EATING DISORDER TREATMENT AND MANAGEMENT PLAN – VIDEO SERVICES
	Fee: $128.45 **Benefit:** 100% = $128.45 **Extended Medicare Safety Net Cap:** $385.35 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	23. CONSULTANT PHYSICIAN AND PSYCHIATRIST - EATING DISORDER TREATMENT AND MANAGEMENT PLAN – VIDEO SERVICES
	Group A40. Telehealth attendance services
	Subgroup 23. Consultant Physician and Psychiatrist - Eating Disorder Treatment and Management Plan – Video Services
	Video attendance of at least 45 minutes in duration by a consultant physician in the practice of the consultant physician's specialty of psychiatry for the preparation of an eating disorder treatment and management plan for an eligible patient, if: (a) the patient has been referred by a referring practitioner; and (b) during the attendance, the consultant psychiatrist: (i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (c) within 2 weeks after the attendance, the consultant psychiatrist: (i) prepares a written diagnosis of the patient; and (ii) prepares a written management plan for the patient that: (A) covers the next 12 months; and (B) is appropriate to the patient's diagnosis; and (C) comprehensively evaluates the patient's biological, psychological and social issues; and (D) addresses the patient's diagnostic psychiatric issues; and (E) makes management recommendations addressing the patient's biological, psychological and social issues; and (iii) gives the referring practitioner a copy of the diagnosis and the management plan; and (iv) if clinically appropriate, explains the diagnosis and management plan, and a gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees.
92162	(See para AN.36.2 of explanatory notes to this Category)

A40. TELEHEALTH ATTENDANCE SERVICES	23. CONSULTANT PHYSICIAN AND PSYCHIATRIST - EATING DISORDER TREATMENT AND MANAGEMENT PLAN – VIDEO SERVICES
	Fee: $549.90 **Benefit:** 85% = $467.45 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
92163	Video attendance of at least 45 minutes in duration by a consultant physician in the practice of the consultant physician's specialty of paediatrics for the preparation of an eating disorder treatment and management plan for an eligible patient, if: (a) the patient has been referred by a referring practitioner; and (b) during the attendance, the consultant paediatrician undertakes an assessment 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 diagnoses; and (c) within 2 weeks after the attendance, the consultant paediatrician: (i) prepares a written diagnosis of the patient; and (ii) prepares a written management plan for the patient that involves: (A) an opinion on diagnosis and risk assessment; and (B) treatment options and decisions; and (C) medication recommendations; and (iii) gives the referring practitioner a copy of the diagnosis and the management plan; and (iv) if clinically appropriate, explains the diagnosis and management plan, and a gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees. (See para AN.36.2 of explanatory notes to this Category) **Fee:** $320.55 **Benefit:** 85% = $272.50 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	25. REVIEW OF AN EATING DISORDER PLAN – VIDEO SERVICES
	Group A40. Telehealth attendance services
	Subgroup 25. Review of an Eating Disorder Plan – Video Services

A40. TELEHEALTH ATTENDANCE SERVICES	25. REVIEW OF AN EATING DISORDER PLAN – VIDEO SERVICES
92170	Video attendance by a general practitioner to review an eligible patient's eating disorder treatment and management plan prepared by the general practitioner, an associated medical practitioner working in general practice, or a consultant physician practising in the specialty of psychiatry or paediatrics, if: (a) the general practitioner reviews the treatment efficacy of services provided under the eating disorder treatment and management plan, including a discussion with the patient regarding whether the eating disorders psychological treatment and dietetic services are meeting the patient's needs; and (b) modifications are made to the eating disorder treatment and management plan, recorded in writing, including: (i) recommendations to continue with treatment options detailed in the plan; or (ii) recommendations to alter the treatment options detailed in the plan, with the new arrangements documented in the plan; and (c) initiates referrals for a review by a consultant physician practising in the specialty of psychiatry or paediatrics, where appropriate; and (d) the general practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder. **Fee:** $85.80 **Benefit:** 100% = $85.80 **Extended Medicare Safety Net Cap:** $257.40 **Future End Date:**
92171	Video attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), to review an eligible patient's eating disorder treatment and management plan prepared by the medical practitioner, an associated medical practitioner working in general practice, or a consultant physician practising in the speciality of psychiatry or paediatrics, if: (a) the medical practitioner reviews the treatment efficacy of services provided under the eating disorder treatment and management plan, including a discussion with the patient regarding whether the eating disorders psychological treatment and dietetic services are meeting the patient's needs; and (b) modifications are made to the eating disorder treatment and management plan, recorded in writing, including: (i) recommendations to continue with treatment options detailed in the plan; or (ii) recommendations to alter the treatment options detailed in the plan, with the new arrangements documented in the plan; and (c) initiates referrals for a review by a consultant physician practising in the speciality of psychiatry or paediatrics, where appropriate; and (d) the medical practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and

	(ii) suitable education about the eating disorder **Fee:** $68.65 **Benefit:** 100% = $68.65 **Extended Medicare Safety Net Cap:** $205.95 **Future End Date:**
92172	Video attendance of at least 30 minutes in duration by a consultant physician in the practice of the consultant physician's specialty of psychiatry for an eligible patient, if: (a) the consultant psychiatrist reviews the treatment efficacy of services provided under the eating disorder treatment and management plan, including a discussion with the patient regarding whether the eating disorders psychological treatment and dietetic services are meeting the patient's needs; and (b) the patient has been referred by a referring practitioner; and (c) during the attendance, the consultant psychiatrist: (i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (iv) reviews the eating disorder treatment and management plan; and (d) within 2 weeks after the attendance, the consultant psychiatrist: (i) prepares a written diagnosis of the patient; and (ii) revises the eating disorder treatment and management; and (iii) gives the referring practitioner a copy of the diagnosis and the revised management plan; and (iv) if clinically appropriate, explains the diagnosis and the revised management plan, and gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees. **Fee:** $343.75 **Benefit:** 85% = $292.20 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
92173	Video attendance of at least 20 minutes in duration by a consultant physician in the practice of the consultant physician's specialty of paediatrics for an eligible patient, if: (a) the consultant paediatrician reviews the treatment efficacy of services provided under the eating disorder treatment and management plan, including a discussion with the patient regarding whether the eating disorders psychological treatment and dietetic services are meeting the patient's needs; and (b) the patient has been referred by a referring practitioner; and

A40. TELEHEALTH ATTENDANCE SERVICES	25. REVIEW OF AN EATING DISORDER PLAN – VIDEO SERVICES
	(c) during the attendance, the consultant paediatrician: (i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (iv) reviews the eating disorder treatment and management plan; and (d) within 2 weeks after the attendance, the consultant paediatrician: (i) prepares a written diagnosis of the patient; and (ii) revises the eating disorder treatment and management; and (iii) gives the referring practitioner a copy of the diagnosis and the revised management plan; and (iv) if clinically appropriate, explains the diagnosis and the revised management plan, and gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees **Fee:** $160.50 **Benefit:** 85% = $136.45 **Extended Medicare Safety Net Cap:** $481.50 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	26. REVIEW OF AN EATING DISORDER PLAN – PHONE SERVICE
	Group A40. Telehealth attendance services
	Subgroup 26. Review of an Eating Disorder Plan – Phone Service
92176	Phone attendance by a general practitioner to review an eligible patient's eating disorder treatment and management plan prepared by the general practitioner, an associated medical practitioner working in general practice, or a consultant physician practising in the specialty of psychiatry or paediatrics, if: (a) the general practitioner reviews the treatment efficacy of services provided under the eating disorder treatment and management plan, including a discussion with the patient regarding whether the eating disorders psychological treatment and dietetic services are meeting the patient's needs; and (b) modifications are made to the eating disorder treatment and management plan, recorded in writing, including: (i) recommendations to continue with treatment options detailed in the plan; or (ii) recommendations to alter the treatment options detailed in the plan, with the new arrangements documented in the plan; and (c) initiates referrals for a review by a consultant physician practising in the specialty of psychiatry or paediatrics, where appropriate; and

	(d) the general practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder. **Fee:** $85.80 **Benefit:** 100% = $85.80 **Extended Medicare Safety Net Cap:** $257.40 **Future End Date:**
92177	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician) to review an eligible patient's eating disorder treatment and management plan prepared by the medical practitioner, an associated medical practitioner working in general practice, or a consultant physician practising in the specialty of psychiatry or paediatrics, if: (a) the medical practitioner reviews the treatment efficacy of services provided under the eating disorder treatment and management plan, including a discussion with the patient regarding whether the eating disorders psychological treatment and dietetic services are meeting the patient's needs; and (b) modifications are made to the eating disorder treatment and management plan, recorded in writing, including: (i) recommendations to continue with treatment options detailed in the plan; or (ii) recommendations to alter the treatment options detailed in the plan, with the new arrangements documented in the plan; and (c) initiates referrals for a review by a consultant physician practising in the specialty of psychiatry or paediatrics, where appropriate; and (d) the medical practitioner offers the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees): (i) a copy of the plan; and (ii) suitable education about the eating disorder. **Fee:** $68.65 **Benefit:** 100% = $68.65 **Extended Medicare Safety Net Cap:** $205.95 **Future End Date:**
92441	Phone attendance of at least 30 minutes in duration by a consultant physician in the practice of the consultant physician's specialty of psychiatry for an eligible patient, if: (a) the consultant psychiatrist reviews the treatment efficacy of services provided under the eating disorder treatment and management plan, including a discussion with the patient regarding whether the eating disorders psychological treatment and dietetic services are meeting the patient's needs; and (b) the patient has been referred by a referring practitioner; and (c) during the attendance, the consultant psychiatrist: (i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (iv) reviews the eating disorder treatment and management plan; and (d) within 2 weeks after the attendance, the consultant psychiatrist: (i) prepares a written diagnosis of the patient; and (ii) revises the eating disorder treatment and management; and

A40. TELEHEALTH ATTENDANCE SERVICES	26. REVIEW OF AN EATING DISORDER PLAN – PHONE SERVICE
	(iii) gives the referring practitioner a copy of the diagnosis and the revised management plan; and (iv) if clinically appropriate, explains the diagnosis and the revised management plan, and gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees (See para AN.40.1 of explanatory notes to this Category) **Fee:** $343.75 **Benefit:** 85% = $292.20 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
92442	Phone attendance of at least 20 minutes in duration by a consultant physician in the practice of the consultant physician's specialty of paediatrics for an eligible patient, if: (a) the consultant paediatrician reviews the treatment efficacy of services provided under the eating disorder treatment and management plan, including a discussion with the patient regarding whether the eating disorders psychological treatment and dietetic services are meeting the patient's needs; and (b) the patient has been referred by a referring practitioner; and (c) during the attendance, the consultant paediatrician: (i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (iv) reviews the eating disorder treatment and management plan; and (d) within 2 weeks after the attendance, the consultant paediatrician: (i) prepares a written diagnosis of the patient; and (ii) revises the eating disorder treatment and management; and (iii) gives the referring practitioner a copy of the diagnosis and the revised management plan; and (iv) if clinically appropriate, explains the diagnosis and the revised management plan, and gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees (See para AN.40.1 of explanatory notes to this Category) **Fee:** $160.50 **Benefit:** 85% = $136.45 **Extended Medicare Safety Net Cap:** $481.50 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	27. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES – VIDEO SERVICES
	Group A40. Telehealth attendance services
	Subgroup 27. Eating Disorder Psychological Treatment Services – Video Services
92182	Video attendance by a general practitioner, for providing eating disorder psychological treatment services 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 in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan. (See para AN.36.2 of explanatory notes to this Category) **Fee:** $111.00 **Benefit:** 100% = $111.00 **Extended Medicare Safety Net Cap:** $333.00 **Future End Date:**
92184	Video attendance by a general practitioner, for providing eating disorder psychological treatment services by a general practitioner registered with the Chief Executive Medicare as meeting the

A40. TELEHEALTH ATTENDANCE SERVICES	27. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES – VIDEO SERVICES
	credentialling requirements for provision of this service, and lasting at least 40 minutes in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan. (See para AN.36.2 of explanatory notes to this Category) **Fee:** $158.90 **Benefit:** 100% = $158.90 **Extended Medicare Safety Net Cap:** $476.70 **Future End Date:**
92186	Video attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), for providing eating disorder psychological treatment services 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 in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan (See para AN.36.2 of explanatory notes to this Category) **Fee:** $88.85 **Benefit:** 100% = $88.85 **Extended Medicare Safety Net Cap:** $266.55 **Future End Date:**
92188	Video attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), for providing eating disorder psychological treatment services 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 in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan (See para AN.36.2 of explanatory notes to this Category) **Fee:** $127.10 **Benefit:** 100% = $127.10 **Extended Medicare Safety Net Cap:** $381.30 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	28. GP - EATING DISORDER FOCUSSED PSYCHOLOGICAL STRATEGIES – PHONE SERVICE
	Group A40. Telehealth attendance services
	Subgroup 28. GP - Eating Disorder Focussed Psychological Strategies – Phone Service
92194	Phone attendance by a general practitioner, for providing eating disorder psychological treatment services 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 in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan. (See para AN.36.2 of explanatory notes to this Category) **Fee:** $111.00 **Benefit:** 100% = $111.00 **Extended Medicare Safety Net Cap:** $333.00 **Future End Date:**
92196	Phone attendance by a general practitioner, for providing eating disorder psychological treatment services 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 in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan. (See para AN.36.2 of explanatory notes to this Category)

A40. TELEHEALTH ATTENDANCE SERVICES	28. GP - EATING DISORDER FOCUSSED PSYCHOLOGICAL STRATEGIES – PHONE SERVICE
	Fee: $158.90 **Benefit:** 100% = $158.90 **Extended Medicare Safety Net Cap:** $476.70 **Future End Date:**
92198	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), for providing eating disorder psychological treatment services 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 in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan (See para AN.36.2 of explanatory notes to this Category) **Fee:** $88.85 **Benefit:** 100% = $88.85 **Extended Medicare Safety Net Cap:** $266.55 **Future End Date:**
92200	Phone attendance by a medical practitioner (not including a general practitioner, specialist or consultant physician), for providing eating disorder psychological treatment services 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 in duration, for an eligible patient if treatment is clinically indicated under an eating disorder treatment and management plan. (See para AN.36.2 of explanatory notes to this Category) **Fee:** $127.10 **Benefit:** 100% = $127.10 **Extended Medicare Safety Net Cap:** $381.30 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	29. GP AND OTHER MEDICAL PRACTITIONER – URGENT AFTER HOURS SERVICE IN UNSOCIABLE HOURS – VIDEO SERVICES
	Group A40. Telehealth attendance services
	Subgroup 29. GP and Other Medical Practitioner – Urgent After Hours Service in Unsociable Hours – Video Services
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 **Fee:** $183.15 **Benefit:** 100% = $183.15 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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 **Fee:** $146.35 **Benefit:** 100% = $146.35

A40. TELEHEALTH ATTENDANCE SERVICES	29. GP AND OTHER MEDICAL PRACTITIONER – URGENT AFTER HOURS SERVICE IN UNSOCIABLE HOURS – VIDEO SERVICES
	Extended Medicare Safety Net Cap: $439.05 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	31. GERIATRIC MEDICINE – VIDEO SERVICES
	Group A40. Telehealth attendance services
	Subgroup 31. Geriatric Medicine – Video Services
92623	Video attendance of more than 60 minutes in duration 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 (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) all relevant aspects of the patient's health are evaluated in detail using appropriately validated assessment tools if indicated (the ***assessment***); and (ii) the patient's various health problems and care needs are identified and prioritised (the ***formulation***); and (iii) a detailed management plan is prepared (the ***management plan***) setting out: (A) the prioritised list of health problems and care needs; and (B) short and longer term management goals; and (C) recommended actions or intervention strategies to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient and the patient's family and carers; and (iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and (v) the management plan is communicated in writing to the referring practitioner; and (d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 of the general medical services table or item 91822, 91823, 91833, 91824, 91825, 91826, 91836 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 of the general medical services table applies has not been provided to the patient by the same practitioner in the preceding 12 months **Fee:** $549.90 **Benefit:** 85% = $467.45 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
92624	Video attendance of more than 30 minutes in duration by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine to review a

A40. TELEHEALTH ATTENDANCE SERVICES	31. GERIATRIC MEDICINE – VIDEO SERVICES
	management plan previously prepared by that consultant physician or specialist under item 141, 145 or 92623, 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, 145 or 92623 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 of the general medical services table or item 91822, 91823, 91833, 91824, 91825, 91826, 91836 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 of the general medical services table, or item 92623 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 or 147 of the general medical services table, or item 92448 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 **Fee:** $343.75 **Benefit:** 85% = $292.20 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	32. GERIATRIC MEDICINE – PHONE SERVICE
	Group A40. Telehealth attendance services
	Subgroup 32. Geriatric Medicine – Phone Service
92448	Phone attendance of more than 30 minutes in duration 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, 145 or 92623 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 of the general medical services table or items 92623 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 of the general medical services table or item 91822, 91823, 91833, 91824, 91825, 91826, 91836 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 of the general medical services table, or item 92623 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 or 147 of the general medical services table or item 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 (See para AN.40.1 of explanatory notes to this Category) **Fee:** $343.75 **Benefit:** 85% = $292.20 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

	Group A40. Telehealth attendance services
	Subgroup 33. Public health physician – Video 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 **Fee:** $23.75 **Benefit:** 85% = $20.20 **Extended Medicare Safety Net Cap:** $71.25 **Future End Date:**
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 **Fee:** $51.90 **Benefit:** 85% = $44.15 **Extended Medicare Safety Net Cap:** $155.70 **Future End Date:**
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;

A40. TELEHEALTH ATTENDANCE SERVICES	33. PUBLIC HEALTH PHYSICIAN – VIDEO SERVICES
	for one or more health-related issues, with appropriate documentation **Fee:** $100.50 **Benefit:** 85% = $85.45 **Extended Medicare Safety Net Cap:** $301.50 **Future End Date:**
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 **Fee:** $147.95 **Benefit:** 85% = $125.80 **Extended Medicare Safety Net Cap:** $443.85 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	34. PUBLIC HEALTH PHYSICIAN – PHONE SERVICES
	Group A40. Telehealth attendance services
	Subgroup 34. 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 **Fee:** $23.75 **Benefit:** 85% = $20.20 **Extended Medicare Safety Net Cap:** $71.25 **Future End Date:**
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 **Fee:** $51.90 **Benefit:** 85% = $44.15

A40. TELEHEALTH ATTENDANCE SERVICES	34. PUBLIC HEALTH PHYSICIAN – PHONE SERVICES
	Extended Medicare Safety Net Cap: $155.70 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	35. NEUROSURGERY ATTENDANCES – VIDEO SERVICES
	Group A40. Telehealth attendance services
	Subgroup 35. Neurosurgery attendances – Video 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) (See para AN.3.1 of explanatory notes to this Category) **Fee:** $157.40 **Benefit:** 85% = $133.80 **Extended Medicare Safety Net Cap:** $472.20 **Future End Date:**
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 (See para AN.3.1, AN.0.70 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
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 (See para AN.3.1, AN.0.70 of explanatory notes to this Category) **Fee:** $103.95 **Benefit:** 85% = $88.40 **Extended Medicare Safety Net Cap:** $311.85 **Future End Date:**
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 (See para AN.3.1, AN.0.70 of explanatory notes to this Category) **Fee:** $144.00 **Benefit:** 85% = $122.40 **Extended Medicare Safety Net Cap:** $432.00 **Future End Date:**
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 (See para AN.3.1, AN.0.70 of explanatory notes to this Category) **Fee:** $183.35 **Benefit:** 85% = $155.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	36. NEUROSURGERY ATTENDANCES – PHONE SERVICES
	Group A40. Telehealth attendance services
	Subgroup 36. 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 (See para AN.40.1 of explanatory notes to this Category) **Fee:** $103.95 **Benefit:** 85% = $88.40 **Extended Medicare Safety Net Cap:** $311.85 **Future End Date:**
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 (See para AN.40.1 of explanatory notes to this Category) **Fee:** $144.00 **Benefit:** 85% = $122.40 **Extended Medicare Safety Net Cap:** $432.00 **Future End Date:**
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 (See para AN.40.1 of explanatory notes to this Category) **Fee:** $183.35 **Benefit:** 85% = $155.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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. (See para AN.3.1, AN.0.70 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	37. SPECIALIST, ANAESTHESIA VIDEO SERVICES
	Group A40. Telehealth attendance services
	Subgroup 37. Specialist, anaesthesia video 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) **Fee:** $103.95 **Benefit:** 85% = $88.40 **Extended Medicare Safety Net Cap:** $311.85

A40. TELEHEALTH ATTENDANCE SERVICES	37. SPECIALIST, ANAESTHESIA VIDEO SERVICES
	Future End Date:

A40. TELEHEALTH ATTENDANCE SERVICES	39. GP BLOOD BORNE VIRUSES, SEXUAL OR REPRODUCTIVE HEALTH CONSULTATION – VIDEO SERVICE
	Group A40. Telehealth attendance services
	Subgroup 39. GP Blood Borne Viruses, Sexual or Reproductive Health Consultation – Video Service
92715	Video attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of not more than 5 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 preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5 of explanatory notes to this Category) **Fee:** $20.55 **Benefit:** 100% = $20.55 **Extended Medicare Safety Net Cap:** $61.65 **Future End Date:**
92716	Video attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician) of not more than 5 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 preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5 of explanatory notes to this Category) **Fee:** $11.00 **Benefit:** 100% = $11.00 **Extended Medicare Safety Net Cap:** $33.00 **Future End Date:**
92717	Video attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of not more than 5 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 preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items (See para AN.40.5 of explanatory notes to this Category) **Fee:** $16.50 **Benefit:** 100% = $16.50 **Extended Medicare Safety Net Cap:** $49.50 **Future End Date:**
92718	Video attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of more than 5 minutes in duration but not more than 20 minutes if the attendance includes 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 Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5 of explanatory notes to this Category) **Fee:** $45.05 **Benefit:** 100% = $45.05 **Extended Medicare Safety Net Cap:** $135.15 **Future End Date:**
92719	Video attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician) of more than 5 minutes in duration but not more than 20 minutes if the attendance includes 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 Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5 of explanatory notes to this Category) **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00 **Future End Date:**
92720	Video attendance for the provision of services related to blood borne viruses, sexual or reproductive health 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 20 minutes if the attendance includes 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 Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items (See para AN.40.5 of explanatory notes to this Category) **Fee:** $35.95 **Benefit:** 100% = $35.95 **Extended Medicare Safety Net Cap:** $107.85 **Future End Date:**
92721	Video attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of more than 20 minutes in duration but not more than 40 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 preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5 of explanatory notes to this Category) **Fee:** $87.10 **Benefit:** 100% = $87.10 **Extended Medicare Safety Net Cap:** $261.30 **Future End Date:**
92722	Video attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician) of more than 20 minutes in duration but not more than 40 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 preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5 of explanatory notes to this Category)

	Fee: $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00 **Future End Date:**
92723	Video attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of more than 20 minutes in duration but not more than 40 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 preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items (See para AN.40.5 of explanatory notes to this Category) **Fee:** $69.70 **Benefit:** 100% = $69.70 **Extended Medicare Safety Net Cap:** $209.10 **Future End Date:**
92724	Video attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner lasting at least 40 minutes in duration 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 preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5 of explanatory notes to this Category) **Fee:** $128.35 **Benefit:** 100% = $128.35 **Extended Medicare Safety Net Cap:** $385.05 **Future End Date:**
92725	Video attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician) lasting at least 40 minutes in duration 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;

A40. TELEHEALTH ATTENDANCE SERVICES	39. GP BLOOD BORNE VIRUSES, SEXUAL OR REPRODUCTIVE HEALTH CONSULTATION – VIDEO SERVICE
	(d) providing appropriate preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5 of explanatory notes to this Category) **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00 **Future End Date:**
92726	Video attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, lasting at least 40 minutes in duration 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 preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items (See para AN.40.5 of explanatory notes to this Category) **Fee:** $102.65 **Benefit:** 100% = $102.65 **Extended Medicare Safety Net Cap:** $307.95 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	40. GP BLOOD BORNE VIRUSES, SEXUAL OR REPRODUCTIVE HEALTH CONSULTATION – PHONE SERVICE
	Group A40. Telehealth attendance services
	Subgroup 40. GP Blood Borne Viruses, Sexual or Reproductive Health Consultation – Phone Service
92731	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of not more than 5 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 preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5 of explanatory notes to this Category) **Fee:** $20.55 **Benefit:** 100% = $20.55

	Extended Medicare Safety Net Cap: $61.65 **Future End Date:**
92732	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician) of not more than 5 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 preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5 of explanatory notes to this Category) **Fee:** $11.00 **Benefit:** 100% = $11.00 **Extended Medicare Safety Net Cap:** $33.00 **Future End Date:**
92733	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of not more than 5 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 preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items (See para AN.40.5 of explanatory notes to this Category) **Fee:** $16.50 **Benefit:** 100% = $16.50 **Extended Medicare Safety Net Cap:** $49.50 **Future End Date:**
92734	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of more than 5 minutes in duration but not more than 20 minutes if the attendance includes 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

	Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5 of explanatory notes to this Category) **Fee:** $45.05 **Benefit:** 100% = $45.05 **Extended Medicare Safety Net Cap:** $135.15 **Future End Date:**
92735	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician) of more than 5 minutes in duration but not more than 20 minutes if the attendance includes 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 Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5 of explanatory notes to this Category) **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00 **Future End Date:**
92736	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health 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 20 minutes if the attendance includes 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 Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items (See para AN.40.5 of explanatory notes to this Category) **Fee:** $35.95 **Benefit:** 100% = $35.95 **Extended Medicare Safety Net Cap:** $107.85 **Future End Date:**
92737	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner of more than 20 minutes in duration but not more than 40 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 preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5 of explanatory notes to this Category) **Fee:** $87.10 **Benefit:** 100% = $87.10 **Extended Medicare Safety Net Cap:** $261.30 **Future End Date:**
92738	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician) of more than 20 minutes in duration but not more than 40 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 preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5 of explanatory notes to this Category) **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00 **Future End Date:**
92739	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, of more than 20 minutes in duration but not more than 40 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 preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items (See para AN.40.5 of explanatory notes to this Category) **Fee:** $69.70 **Benefit:** 100% = $69.70 **Extended Medicare Safety Net Cap:** $209.10 **Future End Date:**

92740	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a general practitioner lasting at least 40 minutes in duration 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 preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5 of explanatory notes to this Category) **Fee:** $128.35 **Benefit:** 100% = $128.35 **Extended Medicare Safety Net Cap:** $385.05 **Future End Date:**
92741	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician) lasting at least 40 minutes in duration 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 preventive health care Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items. (See para AN.40.5 of explanatory notes to this Category) **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00 **Future End Date:**
92742	Phone attendance for the provision of services related to blood borne viruses, sexual or reproductive health by a medical practitioner (not including a general practitioner, specialist or consultant physician), in an eligible area, lasting at least 40 minutes in duration 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 preventive health care

A40. TELEHEALTH ATTENDANCE SERVICES	40. GP BLOOD BORNE VIRUSES, SEXUAL OR REPRODUCTIVE HEALTH CONSULTATION – PHONE SERVICE
	Note: Consultations related to assisted reproductive technology and antenatal care are outside the scope of these items and cannot be rendered under these items (See para AN.40.5 of explanatory notes to this Category) **Fee:** $102.65 **Benefit:** 100% = $102.65 **Extended Medicare Safety Net Cap:** $307.95 **Future End Date:**

A40. TELEHEALTH ATTENDANCE SERVICES	44. SPECIALIST AND CONSULTANT PHYSICIAN – TELEHEALTH SERVICES
	Group A40. Telehealth attendance services
	Subgroup 44. 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) an 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. (See para AN.40.1, AN.0.33 of explanatory notes to this Category) **Fee:** $103.95 **Benefit:** 85% = $88.40 **Extended Medicare Safety Net Cap:** $311.85 **Future End Date:**
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. (See para AN.40.1, AN.3.1, AN.0.33, AN.0.70 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
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. (See para AN.40.1, AN.3.1, AN.0.33, AN.0.70 of explanatory notes to this Category)

	Fee: $52.25 **Benefit:** 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
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) an 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. (See para AN.40.1, AN.0.58 of explanatory notes to this Category) **Fee:** $183.35 **Benefit:** 85% = $155.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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. (See para AN.40.1, AN.3.1, AN.0.58, AN.0.70 of explanatory notes to this Category) **Fee:** $91.70 **Benefit:** 85% = $77.95 **Extended Medicare Safety Net Cap:** $275.10 **Future End Date:**
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. (See para AN.40.1, AN.3.1, AN.0.58, AN.0.70 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
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. (See para AN.40.1, AN.3.1, AN.0.58, AN.0.70 of explanatory notes to this Category)

	Fee: $52.25 **Benefit:** 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
92755	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; (c) the attendance is an initial attendance in a single course of treatment; and (d) an 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. (See para AN.40.1, AN.0.58 of explanatory notes to this Category) **Fee:** $183.35 **Benefit:** 85% = $155.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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. (See para AN.40.1, AN.3.1, AN.0.58, AN.0.70 of explanatory notes to this Category) **Fee:** $91.70 **Benefit:** 85% = $77.95 **Extended Medicare Safety Net Cap:** $275.10 **Future End Date:**
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. (See para AN.40.1, AN.3.1, AN.0.58, AN.0.70 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
92758	Phone 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. (See para AN.40.1, AN.3.1, AN.0.58, AN.0.70 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
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. (See para AN.40.1 of explanatory notes to this Category) **Fee:** $183.35 **Benefit:** 85% = $155.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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, 92763 or 92443 in a single course of treatment. (See para AN.40.1, AN.3.1, AN.0.70 of explanatory notes to this Category) **Fee:** $91.70 **Benefit:** 85% = $77.95 **Extended Medicare Safety Net Cap:** $275.10 **Future End Date:**
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. (See para AN.40.1, AN.3.1, AN.0.70 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
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, 132, 133, 6018, 6019, 6023, 91824, 91825, 91826, 91836, 92422, 92423, 92440, 92443, 92759, 92760 or 92763 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 (See para AN.40.1 of explanatory notes to this Category) **Fee:** $320.55 **Benefit:** 85% = $272.50 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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, 6024, 91824, 91825, 91826, 91836, 92422, 92423, 92440, 92443, 92759, or 92760 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 or by a locum tenens; and (f) this item has not applied more than twice in any 12-month period. (See para AN.40.1 of explanatory notes to this Category) **Fee:** $160.50 **Benefit:** 85% = $136.45 **Extended Medicare Safety Net Cap:** $481.50 **Future End Date:**
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. (See para AN.40.1 of explanatory notes to this Category) **Fee:** $183.35 **Benefit:** 85% = $155.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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. (See para AN.40.1, AN.3.1, AN.0.70 of explanatory notes to this Category) **Fee:** $91.70 **Benefit:** 85% = $77.95 **Extended Medicare Safety Net Cap:** $275.10 **Future End Date:**
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. (See para AN.40.1, AN.3.1, AN.0.70 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
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, 92440, 92443, 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. (See para AN.40.1 of explanatory notes to this Category) **Fee:** $320.55 **Benefit:** 85% = $272.50 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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 two 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, 92440, 92443, 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 or by a locum tenens; and (f) neither this item nor item 6058 has not applied more than twice in any 12-month period. (See para AN.40.1 of explanatory notes to this Category) **Fee:** $160.50 **Benefit:** 85% = $136.45 **Extended Medicare Safety Net Cap:** $481.50 **Future End Date:**

	Group A48. General practitioner attendances—telehealth related
	Subgroup 1. General practitioner patient end support for video conferencing consultations with specialists or consultant physicians
2484	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 **Fee:** $65.55 **Benefit:** 100% = $65.55 **Future End Date:**
Amend 2485	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 care home; and (d) the medical practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $76.10 **Benefit:** 100% = $76.10 **Future End Date:**

A48. GENERAL PRACTITIONER ATTENDANCES—TELEHEALTH RELATED	1. GENERAL PRACTITIONER PATIENT END SUPPORT FOR VIDEO CONFERENCING CONSULTATIONS WITH SPECIALISTS OR CONSULTANT PHYSICIANS
Amend 2486	Professional attendance by a general practitioner, at a residential care home, 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 care home; and (d) the medical practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $65.55 **Benefit:** 100% = $65.55 **Future End Date:**
2487	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 **Fee:** $107.65 **Benefit:** 100% = $107.65 **Future End Date:**
Amend 2488	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 care home; and (d) the medical practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $118.15 **Benefit:** 100% = $118.15 **Future End Date:**
Amend 2489	Professional attendance by a general practitioner, at a residential care home, 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 care home; and (d) the medical practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $107.65 **Benefit:** 100% = $107.65 **Future End Date:**
2490	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 **Fee:** $148.85 **Benefit:** 100% = $148.85 **Future End Date:**
Amend 2491	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 care home; and (d) the medical practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $156.70 **Benefit:** 100% = $156.70 **Future End Date:**
Amend 2492	Professional attendance by a general practitioner, at a residential care home, 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 care home; and (d) the medical practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $148.85 **Benefit:** 100% = $148.85 **Future End Date:**
2493	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 **Fee:** $228.45 **Benefit:** 100% = $228.45 **Future End Date:**
Amend 2494	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 care home; and (d) the medical practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $238.95 **Benefit:** 100% = $238.95 **Future End Date:**
Amend 2495	Professional attendance by a general practitioner, at a residential care home, 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 care home; and (d) the medical practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $228.45 **Benefit:** 100% = $228.45 **Future End Date:**

CATEGORY 2: DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

SUMMARY OF CHANGES FROM 01/11/2026

The 01/11/2026 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

Description Amended
11607

Changes to general medical services

From 1 November 2026, changes will be made relating to general medical services. These changes include:

- Enabling participating nurse practitioners to refer patients for bone mineral densitometry services described in items 12306 to 12322;
- Expanding ambulatory blood pressure monitoring item 11607 to include child and adolescent blood pressure measurements and thresholds; and
- Administrative amendments to replace references to the term “residential aged care facility” with “residential care home” to align with terminology in the *Aged Care Act 2024*.

DIAGNOSTIC PROCEDURES AND INVESTIGATIONS NOTES

DN.1.1 Electroencephalography (EEG), Prolonged Recording - (item 11003)

Item 11003 covers an extended EEG recording of at least 3 hours duration, other than ambulatory or video recording.

DN.1.2 Electroencephalography (EEG), Ambulatory or Video - (Items 11004 and 11005)

Items 11004 and 11005 cover prolonged ambulatory or video EEG, recording of at least 3 hours duration for:

- Diagnosing the basis of episodic neurological dysfunction;
- Characterising the nature of a patient's epileptic seizures;
- Localising seizures in patients with uncontrolled epilepsy, with a view to surgery; or
- Assessing treatment response where subclinical seizures are suspected.

DN.1.3 Neuromuscular Diagnosis - (Item 11012)

Based on advice from the Australian Association of Neurologists, Medicare benefits are not payable under Item 11012 for quantitative sensory nerve testing using "Neurometer CPT" diagnostic devices. The advice indicated that the device was still in the evaluation and research stage and did not have widespread clinical application.

DN.1.4 Investigation of Central Nervous System Evoked Responses - (Items 11024 and 11027)

In the context of these items a study refers to one or more averaged samples of electrical activity recorded from one or more sites in the central nervous system in response to the same stimulus.

Second or subsequent studies refer to either stimulating the point of stimulation (e.g. right eye or left median nerve) with a different stimulus or stimulating another point of stimulation (e.g. left eye or right median nerve).

NOTE: Items 11024 and 11027 are not intended to cover bio-feedback techniques.

DN.1.5 Electroretinography - (Items 11204, 11205, 11210 and 11211)

Current professional guidelines and standards for electroretinography, electroculography and pattern retinography are produced by the International Society for Clinical Electrophysiology of Vision (ISCEV).

DN.1.6 Computerised Perimetry Printed Results - (Items 11221 and 11224)

Computerised perimetry performed by optometrists is covered by MBS items 10938, 10939, 10940 and 10941. Items 11221 and 11224 should not be used to repeat perimetry, where it has already been performed by an optometrist, if the results would not have any impact on the patient’s management.

DN.1.7 Computerised Perimetry - (Items 11221 and 11224)

Item 11221 for bilateral procedures cannot be claimed for patients who are totally blind in one eye. In this instance, item 11224 for unilateral procedures should be claimed, where appropriate.

DN.1.8 Orbital Contents - (Items 11240, 11241, 11242 and 11243)

Items 11240 and 11241 may only be utilised once per patient per practitioner. Where an additional service is necessary items 11242 and 11243 should be utilised.

Partial coherence interferometry may also be referred to as optical (or ocular) coherence biometry or laser Doppler interferometry.

DN.1.10 Electrocochleography - (Item 11304)

Item 11304 refers to electrocochleography with insertion of electrodes through the tympanic membrane.

DN.1.11 Non-determinate Audiometry - (Item 11306)

This refers to screening audiometry covering those services, one or more, referred to in Items 11309-11318 when not performed under the conditions set out in paragraph D1.12.

DN.1.12 Audiology Services - (Items 11309 to 11318)

A medical service specified in Items 11309 to 11318 should be rendered:

(a) in conditions that allow the establishment of determinate thresholds, including better ear threshold in free field testing;

(b) in a sound attenuated environment with background noise conditions that comply with Australian Standard AS/NZS 1269.3-2005; and

(c) using calibrated equipment that complies with Australian Standard AS IEC 60645.1-22002, AS IEC 60645.2-2002 and AS IEC 60645.3-2002.

DN.1.13 Oto-Acoustic Emission Audiometry - (Item 11332)

Medicare benefits are not payable under Item 11332 for routine screening of infants. The equipment used to provide this service must be capable of displaying the recorded emission and not just a pass/fail indicator.

DN.1.14 Respiratory Function Tests - (Item 11503)

Specialists and consultant physicians providing services under item 11503 should successfully complete a substantial course of study and training in the relevant test, which has been endorsed by a professional medical organisation. Specialists and consultant physicians should keep appropriate records of this training. Tests should be performed in a respiratory laboratory capable of performing all of, or the majority of the tests listed.

Fractional exhaled nitric oxide (FeNO) testing cannot be claimed under item 11503.

When laboratory based spirometry (item 11512) is performed on the same day as a test approved under item 11503, then only 11503 must be claimed. When spirometry is the only laboratory test performed then 11512 must be claimed.

Maximum inspiratory and expiratory flow-volume loop testing for the purpose of diagnosing central airways obstruction is to be performed under item 11512 not 11503. Item 11503 is not for the purpose of investigation of sleep disorders. Polygraphic data obtained as part of a sleep study item in the range 12203 to 12250 cannot be used for the purpose of claiming item 11503.

For the purposes of item 11503, (c) (iii) measurement of airway or pulmonary resistance by any method includes measurement of nasal resistance by rhinomanometry when performed in a respiratory laboratory.

DN.1.15 Capsule Endoscopy - (Item 11820 and 11823)

Capsule endoscopy is primarily used to view the small bowel, which cannot be viewed by upper gastrointestinal endoscopy and colonoscopy.

Capsule endoscopy imaging must be kept in a manner that facilitates retrieval on the basis of the patient's name and date of service. Records must be retained for a period of 2 years commencing on the day on which the service was rendered.

Conjoint committee

The Conjoint Committee comprises representatives from the Gastroenterological Society of Australia (GESA), the Royal Australasian College of Physicians (RACP) and the Royal Australasian College of Surgeons (RACS). For the purposes of Items 11820 and 11823, specialists or consultant physicians performing this procedure must have endoscopic training recognised by The Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy, and Services Australia has been notified of that recognition.

DN.1.16 Administration of Thyrotropin Alfa-rch for the Detection of Recurrent Well-differentiated Thyroid Cancer - (Item 12201)

Thyrotropin alfa-rch is a diagnostic agent that allows patients to remain on thyroid hormone therapy while being assessed for recurrent cancer. This item was introduced following an assessment by the Medical Services Advisory Committee (MSAC) of the available evidence relating to the safety, effectiveness and cost-effectiveness of thyrotropin alfa-rch. MSAC found that the use of thyrotropin alfa-rch is associated with a lower diagnostic accuracy than when the patient has withdrawn from thyroid hormone therapy. Accordingly, benefits are payable under the item only for patients in whom thyroid hormone therapy withdrawal is medically contraindicated and where concurrent whole body study using radioactive iodine and serum thyroglobulin are undertaken. Services provided to patients who do not demonstrate the indications set out in item 12201 do not attract benefits under the item.

"**Severe psychiatric illness**" is defined as patients with a severe pre-existing psychiatric illness who are currently under specialist psychiatric care.

The item includes the cost of supplying thyrotropin alfa-rch and the equivalent of a subsequent specialist attendance. "Administration" means an attendance by the specialist or consultant physician (the administering practitioner) that includes:

- an assessment that the patient meets the criteria prescribed by the item;

the supply of thyrotropin alfa-rch;

- ensuring that thyrotropin alfa-rch is injected (either by the administering practitioner or by another practitioner) in two doses at 24 hour intervals, with the second dose being administered 72 hours prior to whole body study with radioactive iodine and serum thyroglobulin test; and

- arranging the whole body radioactive iodine study and the serum thyroglobulin test.

Where thyrotropin alfa-rch is injected by the administering practitioner, benefits are not payable for an attendance on the day the second dose is administered. Where thyrotropin alfa-rch is injected by: a general practitioner - benefits are payable under a Level A consultation (item 3); other practitioners - benefits are payable under item 52.

DN.1.17 Investigations for sleep disorders in adults (Items 12203 to 12208 and 12250)

MBS Item	Service Type	Study Level [1]	Applicable Guidelines [2]
12203	Adult sleep study - attended	1	Australasian Sleep Association 2024 Guidelines for sleep studies in adults The American Academy of Sleep Medicine (AASM) Manual for the Scoring of Sleep and Associated Events: Rules, Terminology and Technical Specifications
12204			
12205			
12207			
12208			
12250	Adult sleep study - unattended	2	

			An Australasian Commentary on the AASM Manual for the Scoring of Sleep and Associated Events (2020)

[1] Currently there are no MBS items available for Level 3 or Level 4 sleep studies.

[2] As of 1 July 2026.

Current Professional Guidelines

Items 12203 to 12208 and 12250 require the continuous monitoring and recording of all listed parameters in accordance with current professional guidelines in force at the time the service is provided. Practitioners must refer to the most recent professional guidance issued by relevant professional bodies, including guidance that amends, replaces or supersedes earlier publications.

As of 1 July 2026, recognised sources of such guidance for adult sleep studies include:

- Australasian Sleep Association 2024 guidelines for sleep studies in adults, available on the ASA website (sleep.org.au) under Resources – Position statements.
- The American Academy of Sleep Medicine (AASM) Manual for the Scoring of Sleep and Associated Events: Rules, Terminology and Technical Specifications. Refer to the section on Sleep Staging Rules.
- An Australian Commentary on the AASM Manual for the Scoring of Sleep and Associated Events, available on the Australasian Sleep Association (ASA) website (sleep.org.au) under Resources – Position statements.

The permanent report issued on completion of an MBS-funded Level 1 or Level 2 adult sleep study should include, as applicable, the technical parameters, indices and findings specified in the current professional guidelines for the relevant study type.

Note: Home Sleep Apnoea Test (HSAT) requirements in the cited guidance are insufficient to satisfy the requirements of item 12250, which requires adherence to Level 2 standards.

Access pathways for items 12203 and 12250

Items 12203 and 12250 apply to patients who require a diagnostic sleep study. The items provide two access pathways, depending on how the need for the investigation is determined.

GP-initiated pathway based on clinical screening tools

Pathway (a)(i) enables GP-initiated access to diagnostic sleep studies while maintaining specialist oversight of eligibility. It is appropriate where validated screening questionnaires indicate that there is a high probability that a patient has symptomatic, moderate to severe obstructive sleep apnoea (OSA). In this case, a medical practitioner may refer a patient for a diagnostic sleep study without requiring clinical assessment by a sleep medicine specialist.

For this pathway:

- The initiating medical practitioner should administer screening questionnaires to the patient; and
- Provide the questionnaire responses and final scores to the sleep study provider.

Before the diagnostic sleep study can be undertaken, a qualified adult sleep medicine practitioner or a consultant respiratory physician must review the questionnaire results and determine that the patient meets the eligibility criteria specified in the item descriptor. This review and determination provide a threshold assessment of eligibility for a sleep study and do not constitute a specialist attendance, unless a separate consultation with the patient is arranged.

Pathway based on specialist clinical assessment of the patient

Under pathway (a)(ii), the need for a diagnostic sleep study is determined following a professional attendance (either face-to-face or by video conference) by a qualified adult sleep medicine practitioner or a consultant respiratory physician, where the practitioner determines, based on direct clinical assessment of the patient, that the investigation is necessary to confirm the diagnosis of a sleep disorder.

This professional attendance is not part of items 12203 or 12250, and a separate attendance item (e.g., item 110/91824 or 116/91825) may be payable, subject to the usual rules for the attendance item.

Clinical screening tools

For the purpose of items 12203 and 12250, a high probability of symptomatic, moderate to severe OSA is indicated by one of the following clinical screening tool outcomes:

An Epworth Sleepiness Scale score of 8 or more AND:

- A STOP-Bang score of 3 or more; OR
- An OSA50 score of 5 or more; OR
- A high-risk score on the Berlin Questionnaire.

The Epworth Sleepiness Scale and the STOP-Bang, OSA50 and Berlin questionnaires can be accessed at https://sleepcentral.org.au/Central/Contents/Questionnaires.aspx

Evidence of the screening questionnaires being administered to the patient in full, including their responses and test scores, must be included in the sleep study provider's clinical record for the patient, as this documentation may be subject to audit.

If questionnaire scores do not meet the thresholds for direct access to a sleep study, the direct GP-initiated access pathway cannot be used for a Medicare funded study. If a Medicare-funded study is required, a specialist consultation should be arranged, as per pathway (a)(ii). For a referred attendance item to be billed, the GP would need to provide a referral to the specialist.

Direct referrals made without (or with incomplete) screening questionnaires (Items 12203 and 12250)

If a patient has been directly referred for a sleep study without the use of screening questionnaires, the questionnaires may be administered to the patient by the sleep study provider (e.g., by a sleep technician or other practice staff), and the results used by the qualified sleep medicine practitioner or consultant respiratory physician to determine eligibility for a Medicare-funded sleep study under pathway (a)(i).

Where screening questionnaires are provided with the referral but are incomplete (for example, where a threshold score was reached before all questions were answered), it is at the sleep study provider's discretion whether they wish to contact the patient to obtain responses to the remaining questions. The sleep medicine practitioner or respiratory physician reviewing the results would still need to be satisfied that the threshold scores have been reached and the patient is eligible for a Medicare-funded sleep study.

Patient suitability for attended (Level 1) versus unattended (Level 2) sleep studies

For an MBS benefit to be paid, the service must be clinically relevant. Therefore, patients should receive the type of sleep study that will address the clinical question being asked, taking into account recognised contraindications for unattended sleep studies. The qualified adult sleep medicine practitioner or consultant respiratory physician who determines that the sleep study is necessary is also responsible for ensuring that the patient receives the most suitable study type (i.e., Level or Level 2).

Meaning of 'at least 8 hours'

The requirement ‘for at least 8 hours’ means the overnight investigation (including patient set-up time and actual period of recording) must be of at least 8 hours duration. Providers must keep evidence of the duration of the overnight investigation (including set-up time and period of recording) as part of their records for Medicare-funded sleep studies.

Treatment options following a diagnostic sleep study

The results and treatment options following any diagnostic sleep study should be discussed during a professional attendance with a medical practitioner before any therapy commences. If there is uncertainty about the significance of diagnostic sleep study results or appropriate management of the patient, then referral to a sleep medicine practitioner or consultant respiratory physician is recommended. This professional attendance is not part of the sleep study and may be billed separately.

Who can provide the service

MBS items 12203 to 12208 and item 12250 are designed to support delivery of sleep studies using established sleep laboratory and home-based models of care.

Technical components of the investigation (such as applying the equipment for polysomnography (PSG)), overnight monitoring and recording, and technical analysis and scoring of data) may be performed by appropriately trained personnel, where permitted by the item descriptor. Where parts of the service are performed by a person other than a medical practitioner, this must occur under the supervision of a medical practitioner and in accordance with accepted medical practice.

Where an item descriptor assigns a function to a particular type of medical practitioner (such as a qualified sleep medicine practitioner or consultant respiratory physician), that function must be personally performed by a medical practitioner with the specified qualifications. The adult sleep study items allocate distinct medical practitioner functions across the service pathway, including determining the need for the investigation, clinical supervision of the investigation, and interpretation of the recorded data and preparation of the permanent report. These functions need not be performed by the same individual; however, each function must be performed by a medical practitioner of the specified type(s).

For Medicare benefits to be payable, medical practitioners must be physically located in Australia when performing any component of the service assigned to them under the relevant item descriptor. Where a medical practitioner provides clinical supervision of the investigation, that practitioner must be in Australia during the period of the overnight sleep study. Where a medical practitioner interprets the recorded data and prepares the permanent report, they must be in Australia at the time the interpretation and report are prepared. As above, these need not be the same individual for a given sleep study.

Billing and record keeping for compliance purposes

Providers are responsible for ensuring Medicare services claimed using their provider number meet all legislative requirements. All Medicare claiming is subject to compliance checks and providers may be required to submit evidence about the services they bill. For sleep studies, this would include a full copy of the PSG record, including the raw data, and the permanent report issued on completion of the sleep study. This report should include all of the requirements specified in the relevant clinical guidelines for the sleep study level being billed. Providers should also retain records that demonstrate when practitioner-assigned components of the service were performed, including the date the permanent report was prepared. More information about the department’s compliance program can be found on its website at Medicare compliance.

Sleep study items 12203 to 12208 and 12250 may be billed only by qualified adult sleep medicine practitioners, as specified in the item descriptor. Other medical practitioners are not eligible to bill these items.

The date of service for the purposes of items 12203 to 12208 and item 12250 is deemed to be the day of the morning the overnight investigation is completed.

Note that sleep studies that fail for technical reasons, such as unacceptable signal loss, and cannot meet the item descriptor in full are not eligible for Medicare reimbursement. Billing for the service should therefore only occur once all of the requirements of the item have been fulfilled, including data interpretation and preparation of a permanent report.

Items 12203 to 12208 and item 12250 do not support a figurehead billing arrangement. Figurehead or 'headline' billing is where one practitioner's provider number is used to bill patients for the services provided by other practitioners.

While individual components of the sleep study do not need to be performed by the same qualified sleep medicine practitioner, the qualified sleep medicine practitioner who prepared the report on the results of the investigation should bill the relevant item. This reflects that the reporting practitioner is in a position to verify that the service has been completed to professional standards, matches the item being billed, and all elements of the item descriptor have been met.

Benefits are not payable for items 12203 to 12208 and item 12250 where the interpretation and preparation of a permanent report is provided by a technician or other supervised staff, or generated solely by artificial intelligence, rather than by a qualified sleep medicine practitioner.

Sleep studies may be billed privately or bulk billed. Where a medical practitioner chooses to bulk bill for an overnight sleep study, the practitioner undertakes to accept the relevant Medicare benefit as full payment for the service, and additional charges cannot be raised. These include, but are not limited to, booking (or other) fees to be paid prior to the service, any consumables required to perform the service, and overnight accommodation for attended sleep studies (see explanatory note GN.7.17 – Billing Procedures). Patients must not be charged separately by the billing practitioner, or any other person or entity involved in providing the service, for any component of a service for which the Medicare payment has been accepted as full payment (bulk billed).

Co-claiming restrictions

Only one sleep study item can be claimed in respect of a sleep study service. Where more than one item could potentially apply, the item claimed should be the one that best describes the service provided.

Overnight sleep study items in the range 12203 to 12208 and item 12250 are not to be used for Multiple Sleep Latency Testing (MSLT) and Maintenance of Wakefulness Testing (MWT). Separate items for MSLT (12254) and MWT (12258) provide for an overnight sleep study followed by relevant daytime investigations.

Polygraphic and other physiological data obtained as part of a sleep study item in the range 12203 to 12208, or item 12250, cannot be used for the purpose of claiming any of the following items:

- Group D1, Subgroup 1 – Neurology: 11000 to 11005
- Group D1, Subgroup 4 – Respiratory: 11503
- Group D1, Subgroup 6 - Cardiovascular: 11704 to 11717, 11723 and 11735

Where the date of service for a sleep study item is the same as the date of service of any items 11000 to 11005, 11503, 11704 to 11717, 11723 or 11735, for a benefit to be payable, there must be written notification on the account confirming that the service under any of those items was not part of the sleep study.

DN.1.18 Bone Densitometry - (Items 12306 to 12322)

Definitions

Low bone mineral density is present when the bone (organ) mineral density falls more than 1.5 standard deviations below the age matched mean or more than 2.5 standard deviations below the young normal mean at the same site and in the same gender.

Item 12321 is intended to allow for bone mineral density measurement following a significant change in therapy - e.g. a change in the class of drugs - rather than for a change in the dosage regimen.

Items 12320 and 12322 enable the payment of a Medicare benefit for a bone densitometry service performed on a patient aged 70 years or over. Patients 70 years and over are eligible for an initial screening study.

Patients assessed as having a normal study or mild osteopenia as measured by a t-score down to -1.5 are eligible for one scan every 5 years (item 12320).

Patients with moderate to marked osteopenia as measured by a T-score of -1.5 to -2.5 are eligible for one scan every two years (item 12322).

An examination under any of these items covers the measurement of 2 or more sites, interpretation and provision of a report; all performed by a specialist or consultant physician in the practice of his or her specialty. Two or more sites must include the measurement of bone density of the lumbar spine and proximal femur. The measurement of bone mineral density at either forearms or both heels or in combination is excluded for the purpose of Medicare benefit, unless necessary for specific clinical indications (see below).

Patients unable to have a lumbar spine or proximal femur measurement taken

The recommended alternative measurement for patients who have been referred for a dual energy x-ray absorptiometry (DEXA) bone densitometry scan who are unable to have a lumbar spine or proximal femur measurement taken is the distal forearm, e.g. patients with spinal fusions or bilateral hip prostheses. Patients unable to have a lumbar spine or proximal femur measurement taken who have been referred for a quantitative computed tomography (QCT) scan are not subject to the two site measurements requirement. For these patients one site for which a QCT measurement can be appropriately referenced is sufficient.

Professional Supervision and Interpretation and Reporting

The interpretation and report for all bone densitometry services must be provided by a specialist or consultant physician.

Items 12306, 12312, 12315, 12321 and Items 12320 and 12322 (when performed using Dual Energy X-ray Absorptiometry) must be performed by a:

(a) specialist or consultant physician; or

(b) person who holds a State or Territory radiation license, and who is under the supervision of a specialist or consultant physician.

Items 12320 and 12322 (when performed using Quantitative Computed Tomography) must be performed by a:

(a) specialist or consultant physician; or

(b) a radiation licence holder who is registered as a medical radiation practitioner under a law of a State or Territory; and the specialist or consultant physician is available to monitor and influence the conduct and diagnostic quality of the examination and, if necessary, to attend on the patient personally.

Referrals

Bone densitometry services are available on the basis of referral by a medical practitioner to a specialist or consultant physician. However, providers of bone densitometry to whom a patient is referred for management may determine that a bone densitometry service is required in line with the provisions of Items 12306, 12312, 12315, 12320, 12321 and 12322.

For Item 12306 the referral should specify the indication for the test, namely:

(a) 1 or more fractures occurring after minimal trauma; or

(b) monitoring of low bone mineral density proven by previous bone densitometry.

For Item 12312 the referral should specify the indication for the test, namely:

(a) prolonged glucocorticoid therapy;

(b) conditions associated with excess glucocorticoid secretion;

(c) male hypogonadism; or

(d) female hypogonadism lasting more than 6 months before the age of 45.

For Item 12315 the referral should specify the indication for the test, namely:

(a) primary hyperparathyroidism;

(b) chronic liver disease;

(c) chronic renal disease;

(d) proven malabsorptive disorders;

(e) rheumatoid arthritis; or

(f) conditions associated with thyroxine excess.

For Item 12312

(a) 'Prolonged glucocorticoid therapy' is defined as the commencement of a dosage of inhaled glucocorticoid equivalent to or greater than 800 micrograms beclomethasone dipropionate or budesonide per day; or

(b) a supraphysiological glucocorticoid dosage equivalent to or greater than 7.5 mg prednisolone in an adult taken orally per day;

for a period anticipated to last for at least 4 months.

Glucocorticoid therapy must be contemporaneous with the current scan. Patients no longer on steroids would not qualify for benefits.

For Item 12312

(a) Male hypogonadism is defined as serum testosterone levels below the age matched normal range.

(b) Female hypogonadism is defined as serum oestrogen levels below the age matched normal range.

For Item 12315

A malabsorptive disorder is defined as one or more of the following:

(a) malabsorption of fat, defined as faecal fat estimated at greater than 18 gm per 72 hours on a normal fat diet; or

(b) bowel disease with presumptive vitamin D malabsorption as indicated by a sub-normal circulating 25-hydroxyvitamin D level; or

(c) histologically proven Coeliac disease.

DN.1.19 Retinal Photography with a Non-Mydriatic Retinal Camera

This service is separated into two items, MBS item 12325 and MBS item 12326, in line with NHMRC guidelines' recommended frequency of repeat testing in persons of Aboriginal and Torres Strait Islander descent and the general population.

This item is intended for the provision of retinal photography with a non-mydriatic retinal camera. Mydriasis is permitted if adequate photographs cannot be obtained through an undilated pupil.

Presenting distance vision means unaided distance vision or the vision obtained with the current spectacles or contact lenses, if normally worn for distance vision.

Detection of any diabetic retinopathy should be followed by referral to an optometrist or ophthalmologist in accordance with the NHMRC guidelines.

Where images are inadequate quality for detection of diabetic retinopathy, referral to an optometrist or ophthalmologist for further assessment is indicated.

Any element(s) of the service may be performed by appropriately trained or qualified personnel under the direction of the medical practitioner co-ordinating the patient's care, who retains overall responsibility for claiming of the service.

DN.1.20 Spirometry (Items 11505, 11506 and 11512)

Specialists and consultant physicians providing services under item 11512 should successfully complete a substantial course of study and training in respiratory medicine, which has been endorsed by a professional medical organisation. Specialists and consultant physicians should keep appropriate records of this training.

Spirometry services billed to the MBS should meet international quality standards (Eur Respir J 2005; 26: 319–338).

The National Asthma Council's Australian Asthma Handbook (2016) and Lung Foundation Australia's and Thoracic Society of Australia and New Zealand's COPD-X Plan advise that properly performed spirometry is required to confirm airflow limitation and the diagnosis of asthma and/or COPD. Reversibility testing is the standard required for asthma diagnosis. The diagnosis of COPD is confirmed with post bronchodilator spirometry. Item 11505 should not be repeated when diagnosis has been previously confirmed by properly performed spirometry. To meet quality requirements patients must have three acceptable tests for each testing period (pre/post bronchodilator), and meet repeatability criteria with the best effort recorded. Spirometry should be performed by a person who has undergone training and is qualified to perform it to recommended standards (see Spirometry Handbook, National Asthma Council of Australia (https://www.nationalasthma.org.au/living-with-asthma/resources/health-professionals/information-paper/spirometry-handbook) and ATS/ERS Standardisation of spirometry paper (http://erj.ersjournals.com/content/erj/26/2/319.full.pdf).

DN.1.21 Fraction of Exhaled Nitric Oxide (Item 11507) and Cardiopulmonary Exercise Testing (Item 11508)

Services billed to item 11507 should meet the following quality standards:

- An Official ATS Clinical Practice Guideline: Interpretation of Exhaled Nitric Oxide Levels (FENO) for Clinical Applications: Am J Respir Crit Care Med Vol 184. pp 602–615, 2011 DOI: 10.1164/rccm.912011ST.
- ATS/ERS Recommendations for Standardized Procedures for the Online and Offline Measurement of Exhaled Lower Respiratory Nitric Oxide and Nasal Nitric Oxide, 2005: Am J Respir Crit Care Med Vol 171. pp 912–930, 2005 DOI: 10.1164/rccm.200406-710ST

Fewer than three traces will be accepted as billable under item 11507 if three reproducible loops are difficult to achieve for clinical reasons. The clinical reason(s) for not achieving three reproducible loops must be documented.

Services billed to item 11508 should meet the following quality standards:

- Radtke T, Crook S, Kaltsakas G, et al. ERS statement on standardisation of cardiopulmonary exercise testing in chronic lung diseases. Eur Respir Rev 2019; 28: 180101 [https://doi.org/10.1183/16000617.0101-2018]
- Hallstrand TS, Leuppi JD, Joos G, et al. ERS technical standard on bronchial challenge testing: pathophysiology and methodology of indirect airway challenge testing. Eur Respir J 2018; 52: 1801033 [https://doi.org/10.1183/13993003.01033-2018]

For perioperative indications, the test should be conducted according to international guidelines: Perioperative cardiopulmonary exercise testing (CPET): consensus clinical guidelines on indications, organization, conduct, and physiological interpretation for the purpose of preoperative assessment and optimisation for major surgery (published by the Perioperative Exercise and Training Society [POETTS]; British Journal of Anaesthesia, 2018).

Specialists and consultant physicians providing services under item 11508 should successfully complete a substantial course of study and training in cardiopulmonary exercise testing, which has been endorsed by a professional medical organisation. Specialists and consultant physicians should keep appropriate records of this training.

DN.1.22 Skin Prick Testing (items 12000-12005)

Skin prick testing and Intradermal testing should always be performed in a medical setting with the ready availability of medical practitioners competent to treat systemic allergic reactions, and appropriate resuscitation equipment. Because intradermal testing carries a higher risk of anaphylaxis it should only be performed in a hospital setting (or equivalent) by either a specialist or consultant physician with proficiency and experience in all aspects of skin testing for allergy.

Item 12003 should only be used by appropriately trained doctors such as allergist immunologists or equivalently trained medical practitioners. An alternative to Skin Prick Testing (SPT) is serum specific IgE food allergen testing. Serum specific IgE (ssIgE) allergy blood testing to food panels is not recommended.

Item 12004 should only be used by appropriately trained doctors such as allergist immunologists or equivalently trained medical practitioners.

Item 12005 should only be used by appropriately trained doctors such as allergist immunologists, anaesthetists or equivalently trained medical practitioners.

DN.1.23 Multiple sleep latency testing and Maintenance of wakefulness testing

Determination of the need for testing and testing procedures should be performed in accordance with current Australasian Sleep Association guidelines.

Current Professional Guidelines include:

· Guidelines for the performance of sleep studies in adults – a position statement of the Australasian Sleep Association. Refer to the document under the heading Sleep Studies in Adults - Position statements (sleep.org.au)

· The American Academy of Sleep Medicine (AASM) Manual for the Scoring of Sleep and Associated Events: rules, terminology and technical specifications (you will require an account to access this resource). Refer to the section Sleep Staging Rules in the AASM Scoring Manual - American Academy of Sleep Medicine

· An Australian Commentary on the AASM Manual for the Scoring of Sleep and Associated Events. Refer to the document under the heading Scoring of Sleep and Associated Events - Position statements (sleep.org.au)

Not to be used as part of an occupational health service or pre-employment assessment.

The date of service for the purposes of items 12254 to 12272 is deemed to be the day on which the daytime investigation component of the test is completed. Billing for the service must only occur once all of the requirements of the item have been fulfilled.

DN.1.24 Electroencephalography (item 11000)

Routine electroencephalography should not be performed for the following indications/presentations, except after discussion with a Neurologist. In some of these situations a routine EEG is of relatively low diagnostic value, while in others it would be more appropriate to refer the patient directly for a prolonged EEG, or to a Neurologist for consultation and possible further investigation:

- Suspected Psychogenic Non-Epileptic Seizures (PNES)
- Syncope
- Exclusion of a mass lesion
- Headache & migraine
- Behavioural disturbance/aggression
- Tics
- Postural dizziness
- Non-specific fatigue
- Intellectual impairment
- Paediatric simple febrile seizures
- Breath-holding spells
- Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

DN.1.26 Discussion of results

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

DN.1.27 Implanted ECG Loop Recording (Item 11731)

i. Also permissible for babies, young children and other patients, due to the patient's age, cognitive capacity or expressive language impairment, where symptoms have not been satisfactorily investigated by other methods.
ii. Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

DN.1.28 Indications considered appropriate & Discussion of Results (Item 11716)

Indications interpretation

The following indications would be considered appropriate even in patients who may not experience symptoms more often than once a week.

a. For the detection of asymptomatic atrial fibrillation (AF) following a transient ischaemic attack (TIA) or cryptogenic stroke.

b. For the surveillance of paediatric patients following cardiac surgeries that have an established risk of causing dysrhythmia.
c. For babies, young children and other patients where there is a demonstrable benefit for the documentation of heart rate or if a cardiac dysrhythmia is suspected, but due to the patient's age, cognitive capacity or expressive language impairment, it is not possible to accurately assess symptom frequency based on medical history.

Results

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

DN.1.29 Multi- channel ECG monitoring & recording 17 years & over (Item 11729)

Indication interpretation

Heritable arrhythmias include those defined in the CSANZ guidelines for the diagnosis and management of catecholaminergic polymorphic ventricular tachycardia, familial long QT syndrome and genetic investigation of young sudden unexplained death and resuscitated out of hospital cardiac arrest.

A calcium score of zero is normal and clinician judgement should be applied for scores of 0–10.

Results

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

DN.1.30 Multi-channel ECG monitoring & recording Under 17 years (Item 11730)

Indications interpretation

Heritable arrhythmias include those defined in the CSANZ guidelines for the diagnosis and management of catecholaminergic polymorphic ventricular tachycardia, familial long QT syndrome and genetic investigation of young sudden unexplained death and resuscitated out of hospital cardiac arrest.

Results

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

Paediatric Investigation and Consultation

For investigations performed by a specialist paediatric cardiologist, co-claiming of a consultation with the investigation is permitted even when a consultation was not specifically requested when:

- the paediatric patient was referred for an investigation; and
- the paediatric patient was not known to the provider; and

- the paediatric patient was not under the care of another paediatric cardiologist; and
- the findings on the investigation appropriately warranted a consultation.

DN.1.31 ECG Report (Items 11704, 11716, 11717, 11723 and 11735)

The formal report is separate to any letter and entails interpretation of the trace commenting on the significance of the trace findings and their relationship to clinical decision making for the patient in their clinical context, in addition to any measurements taken or automatically generated.

DN.1.32 Neuromuscular electrodiagnosis (items 11012, 11015 and 11018)

Nerve conduction studies and/or EMG should not be used in the following indications/situations. In some of these situations these tests would be of relatively low diagnostic value, while in others it would be more appropriate to refer the patient for alternative investigations first (e.g. magnetic resonance imaging [MRI] in mild radiculopathy)

- Muscle pain in the absence of other abnormalities on examination or laboratory testing

- A four limb needle EMG/nerve conduction study for neck and back pain after trauma

- EMG for low back pain without leg pain or sciatica.

DN.1.33 Requirement of Medical Practitioner

Performed where a medical practitioner is immediately available to attend the patient for the purposes of review and can have an impact of patient outcomes, where such testing is clinically indicated.

DN.1.34 Formal Report

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

DN.1.35 Treatment plan guidelines and additional claiming guidelines for ambulatory blood pressure monitoring

Treatment plan guidelines for ambulatory blood pressure monitoring

To fulfil the treatment plan of item 11607, a comprehensive written plan must be prepared describing:

a. the patient's diagnosis;

b. management goals with which the patient agrees;

c. appropriate interventions including lifestyle modification;

d. treatment the patient may need; and

f. arrangements to review the plan by a date specified in the plan.

In preparing the plan, the medical practitioner must:

a. explain to the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) the steps involved in preparing the plan; and

b. record the plan; and

c. record the patient's agreement to the preparation of the plan; and

d. offer a copy of the plan to the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees); and

e. add a copy of the plan to the patient's medical records.

Additional Claiming Guidelines for ambulatory blood pressure monitoring:

Blood pressure monitoring equipment:

Both the in-clinic blood pressure monitor and the ambulatory blood monitoring equipment (cuff and monitor) used for services under item 11607 must be listed on the Australian Register of Therapeutic Goods, with monitoring devices recalibrated at time intervals as per the manufacturer's recommendations.

Claiming separate consultations:

If a consultation is for the purpose of an Ambulatory blood pressure monitoring treatment plan, a separate and additional consultation should not be undertaken in conjunction with the Ambulatory blood pressure monitoring consultation, unless it is clinically indicated that a separate problem must be treated immediately.

Where a separate consultation is undertaken in conjunction with an Ambulatory blood pressure monitoring consultation, the patient's invoice or Medicare voucher (assignment of benefit agreement) for the separate consultation should be annotated (e.g. separate consultation clinically required/indicated).

DN.1.36 Audiology Services - (Items 11340, 11341 and 11343)

All vestibular assessment tests to be performed as indicated by standard clinical practice and must provide a quantifiable measure.

A single test is defined as one of the following:

• Video Head Impulse Test (vHIT) (up to all planes tested and +/- Suppression HIT);

• Ocular Vestibular Evoked Myogenic Potential (O VEMP) +/- threshold testing (air and/or bone conduction and/or skull-tap);

• Cervical Vestibular Evoked Myogenic Potential (C VEMP) +/- threshold testing (air and/or bone conduction and/or skull-tap);

• Videonystagmography (VNG) or Electronystagmography (ENG) to measure ocular-motor responses including spontaneous/gaze evoked nystagmus, optokinetic, saccade or smooth pursuit function;

• Videonystagmography (VNG) or Electronystagmography(ENG) to measure eye movement in response to positional testing +/- Dix-Hallpike +/- mechanical positioning;

• Videonystagmography (VNG) or Electronystagmography (ENG) to measure eye movement responses to stimuli such as pressure and sound (Tullio and/or Fistula testing), and/or hyperventilation and/or head shaking;

• Calorics, and/or Caloric Test of Labyrinth;

• Rotational testing including rotational chair;

• Subjective visual vertical/horizontal;

• Static posturography or Computerised Dynamic Posturography (CDP).

DN.1.37 Investigations for sleep disorders in children and adolescents (Items 12210 to 12219)

MBS Item	Service Type	Study Level [1]	Applicable Guidelines [2]
12210	Diagnostic sleep study (0-11 years) - attended	1	Australasian Sleep Association clinical practice guidelines for performing sleep studies in children (2017) The American Academy of Sleep Medicine (AASM) Manual for the Scoring of Sleep and Associated Events: Rules, Terminology and Technical Specifications
12213	Diagnostic sleep study (12-17 years) – attended		
12215	Further investigation (0-11 years) - attended		
12217	Further investigation (12-17 years) - attended		
12218	Diagnostic or further investigation (3-11 years) - unattended	2	
12219	Diagnostic or further investigation (12-17 years) - unattended		

[1] Currently there are no MBS items available for Level 3 or Level 4 sleep studies.
[2] As of 1 July 2026.

Current Professional Guidelines

Items 12210 to 12219 require the continuous monitoring and recording of all listed parameters in accordance with current professional guidelines in force at the time the service is provided. Practitioners must refer to the most recent professional guidance issued by relevant professional bodies, including guidance that amends, replaces or supersedes earlier publications.

As at 1 July 2026, recognised sources of such guidance for paediatric sleep studies include:

- Australasian Sleep Association clinical practice guidelines for performing sleep studies in children (2017), available on the ASA website (sleep.org.au) under Resources – Position statements.
- The American Academy of Sleep Medicine (AASM) Manual for the Scoring of Sleep and Associated Events: Rules, Terminology and Technical Specifications. Refer to the section on Sleep Staging Rules.

The permanent report issued on completion of an MBS-funded Level 1 or Level 2 paediatric sleep study should include, as applicable, the technical parameters, indices and findings specified in the current professional guidelines for the relevant study type.

Note: Home Sleep Apnoea Test (HSAT) requirements in the cited guidance are insufficient to satisfy the requirements of items 12218 and 12219, which require adherence to Level 2 standards.

Access pathways for paediatric sleep study items

For all paediatric sleep study items:

- The patient must be referred by a medical practitioner; and
- The need for the investigation must be determined by an appropriately qualified sleep medicine practitioner before the study is undertaken.

For unattended (Level 2) sleep study items 12218 and 12219, the qualified sleep medicine practitioner must make this determination following a professional attendance on the patient (either face-to-face or by video conference).

For attended (Level 1) sleep study items 12210 to 12217, the determination must still be made prior to the study, and reflects the requirement for specialist oversight in paediatric sleep medicine. Unlike the adult sleep study items, there is no direct access pathway for paediatric sleep studies based on use of clinical screening tools in primary care.

The referral need not specify whether a Level 1 or Level 2 sleep study is to be performed, as the qualified sleep medicine practitioner determines the appropriate study type. As specified in items 12218 and 12219, the practitioner may only determine that a patient is suitable for a Level 2 sleep study (i.e. that an out-of-laboratory setting is appropriate) following a professional attendance on the patient.

Children aged 0-11 years must be assessed by a qualified paediatric sleep medicine practitioner, while adolescents aged 12-17 years may be assessed by either a paediatric or adult sleep medicine practitioner. When a professional attendance is undertaken, that attendance is not part of items 12210 to 12219, and a separate attendance item (e.g., item 110/91824 or 116/91825) may be payable, subject to the usual rules for the attendance item.

Use of unattended (Level 2) sleep studies (Items 12218 and 12219)

Medicare-funded Level 2 sleep studies may only be undertaken for reasons that align with the purposes specified in the item descriptor. A repeat investigation to assess treatment effectiveness refers to a test that is clinically relevant due to concerns about residual disease following treatment initiation. Repeat studies are not intended for routine monitoring in the absence of such clinical indications. To support appropriate use of items 12218 and 12219, the purpose of the investigation must be documented.

Equipment set-up and overnight monitoring for unattended sleep studies (Items 12218 and 12219)

For paediatric unattended (Level 2) sleep study items, polysomnography (PSG) equipment may be applied to the patient in a range of settings prior to the overnight investigation, provided the requirements of the relevant item descriptor are met. Supported models of care include, but are not limited to:

- the patient attends a sleep clinic (or other appropriate facility) for equipment application by a sleep technician and then returns home for the overnight investigation; or
- a sleep technician attends the patient's home or other accommodation to apply the equipment; or
- a parent or caregiver applies the equipment at home with telehealth support from a sleep technician.

In-person equipment set-up by a sleep technician is preferable. However, telehealth-supported set-up is available to all patients regardless of geographic location, and use of this option does not require justification. Where telehealth is used, a sleep technician must provide continuous support throughout the set-up process, to ensure electrodes and other PSG equipment are correctly applied.

Videoconferencing is expected to be the default mode for telehealth support. Telephone may be used to supplement videoconferencing in geographic locations where video communication is difficult to establish or maintain.

Where used, telehealth support forms part of the sleep study service, and a separate attendance item may not be billed.

Meaning of 'at least 8 hours'

The requirement 'for at least 8 hours' means the overnight investigation (including patient set-up time and actual period of recording) must be of at least 8 hours duration. Providers must keep evidence of the duration of the overnight investigation (including set-up time and period of recording) as part of their records for Medicare-funded sleep studies.

Treatment options following a diagnostic sleep study

The results and treatment options following any diagnostic sleep study should be discussed during a professional attendance with a medical practitioner before any therapy commences. If there is uncertainty about the significance of diagnostic sleep study results or appropriate management of the patient, then referral to a sleep medicine

practitioner or consultant respiratory physician is recommended. This professional attendance is not part of the sleep study and may be billed separately.

Who can provide the service

MBS items 12210 to 12219 are designed to support delivery of sleep studies using established sleep laboratory and home-based models of care.

Technical components of the investigation (such as applying the equipment for PSG or providing telehealth support to parents/caregivers, providing telehealth support during overnight monitoring, and technical analysis and scoring of data) may be performed by appropriately trained personnel, where permitted by the item descriptor. Where parts of the service are performed by a person other than a medical practitioner, this must occur under the supervision of a medical practitioner and in accordance with accepted medical practice. For MBS item 12218, the supervising medical practitioner must be a qualified paediatric sleep medicine practitioner, and for MBS item 12219, either a qualified paediatric or adult sleep medicine practitioner.

Where an item descriptor assigns a function to a particular type of medical practitioner (such as a qualified paediatric or adult sleep medicine practitioner), that function must be personally performed by a medical practitioner with the specified qualifications. The paediatric sleep study items allocate distinct medical practitioner functions across the service pathway, including determining the need for the investigation and whether an out-of-laboratory setting is appropriate, clinical supervision of the investigation, and interpretation of the recorded data and preparation of the permanent report. These functions need not be performed by the same individual; however, each function must be performed by a medical practitioner of the specified type(s).

For Medicare benefits to be payable, medical practitioners must be physically located in Australia when performing any component of the service assigned to them under the relevant item descriptor. Where a medical practitioner provides clinical supervision of the investigation, that practitioner must be in Australia during the period of the overnight sleep study. Where a medical practitioner interprets the recorded data and prepares the permanent report, they must be in Australia at the time the interpretation and report are prepared.

Billing and record keeping for compliance purposes

Providers are responsible for ensuring Medicare services claimed using their provider number meet all legislative requirements. All Medicare claiming is subject to compliance checks and providers may be required to submit evidence about the services they bill. For sleep studies, this would include a full copy of the PSG record, including the raw data, and the permanent report issued on completion of the sleep study. This report should include all of the requirements specified in the relevant clinical guidelines for the sleep study level being billed. Providers should also retain records that demonstrate when practitioner-assigned components of the service were performed, including the date the permanent report was prepared. More information about the department's compliance program can be found on its website at Medicare compliance.

MBS items 12210, 12215 and 12218 may be billed only by a qualified paediatric adult sleep medicine practitioner, and items 12213, 12217 and 12219 by either an adult or paediatric sleep medicine practitioner, as specified in the item descriptor. Other medical practitioners are not eligible to bill these items.

The date of service for the purposes of items 12210 to 12219 is deemed to be the day of the morning the overnight investigation is completed.

Note that sleep studies that fail for technical reasons, such as unacceptable signal loss, and cannot meet the item descriptor in full are not eligible for Medicare reimbursement. Billing for the service should therefore only occur once all of the requirements of the item have been fulfilled, including data interpretation and preparation of a permanent report.

Items 12210 to 12219 do not support a figurehead billing arrangement. Figurehead or 'headline' billing is where one practitioner's provider number is used to bill patients for the services provided by other practitioners.

While individual components of the sleep study do not need to be performed by the same qualified sleep medicine practitioner, the qualified sleep medicine practitioner who prepared the report on the results of the investigation should bill the relevant item. This reflects that the reporting practitioner is in a position to verify that the service has been completed to professional standards, matches the item being billed, and all elements of the item descriptor have been met.

Benefits are not payable for items 12210 to 12219 where the interpretation and preparation of a permanent report is provided by a technician or other supervised staff, or generated solely by artificial intelligence, rather than by a qualified sleep medicine practitioner.

Sleep studies may be billed privately or bulk billed. Where a medical practitioner chooses to bulk bill for an overnight sleep study, the practitioner undertakes to accept the relevant Medicare benefit as full payment for the service, and additional charges cannot be raised. These include, but are not limited to, booking (or other) fees to be paid prior to the service, any consumables required to perform the service, overnight accommodation for attended sleep studies, professional services during equipment set up (either in person or via telehealth) and overnight monitoring, and return shipping of PSG equipment for unattended sleep studies (see explanatory note GN.7.17 – Billing Procedures). Patients must not be charged separately by the billing practitioner, or any other person or entity involved in providing the service, for any component of a service for which the Medicare payment has been accepted as full payment (bulk billed).

Co-claiming restrictions

Only one sleep study item can be claimed in respect of a sleep study service. Where more than one item could potentially apply, the item claimed should be the one that best describes the service provided.

Overnight sleep study items in the range 12210 to 12219 are not to be used for Multiple Sleep Latency Testing (MSLT) and Maintenance of Wakefulness Testing (MWT). Separate items for MSLT and MWT in the range 12261 to 12272 provide for an overnight sleep study followed by relevant daytime investigations.

Polygraphic and other physiological data obtained as part of a sleep study item in the range 12210 to 12219 cannot be used for the purpose of claiming any of the following items:

- Group D1, Subgroup 1 – Neurology: 11000 to 11005.
- Group D1, Subgroup 4 – Respiratory: 11503.
- Group D1, Subgroup 6 - Cardiovascular: 11704 to 11717, 11723 and 11735.

Where the date of service for a sleep study item is the same as, or the day following the date of service of any items 11000 to 11005, 11503, 11704 to 11717, 11723 or 11735, for a benefit to be payable, there must be written notification on the account confirming that the service under any of those items was not part of the sleep study.

DR.1.1 AECG requirements for claiming

Items 11716, 11717, 11723 or 11735 do not apply to a service unless:

(i) the patient is referred to a specialist or consultant physician by a referring practitioner; or
(ii) the service is requested by a requesting practitioner.

Admitted patient

Item 11716, 11717, 11723 or 11735 do not apply to a service if the patient is an admitted patient.

An “admitted patient” includes an episode of hospital treatment and an episode of hospital-substitute treatment where a benefit is paid from a private health insurer.

Referred services

For referred services to which items 11716, 11717, 11723 or 11735 apply, the specialist or consultant physician who renders the service must:

(i) manage the ongoing care of the patient; or
(ii) perform an attendance to determine that testing is necessary, where the need for the test has not otherwise been scheduled; or
(iii) perform an attendance immediately after the test has been performed, at which clinical management decisions are discussed with the patient.

A service is taken to be referred if the specialist or consultant physician who renders the service to which items 11716, 11717, 11723 or 11735 applies is the patient's treating practitioner, determines the need for a cardiac investigation that has not otherwise been scheduled, or performs a scheduled test but also provides an attendance where clinical management decisions are discussed with the patient. Services in all other circumstances are considered to be requested.

Requested services

(i) for requested services, items 11716, 11717, 11723 or 11735 do not apply to a service if the rendering specialist or consultant physician has performed a service to which an attendance applies for the same patient on the same day.

(ii) definition of 'requesting practitioner' when applied to items 11716, 11717, 11723 or 11735 is as follows:

a. a medical practitioner (other than a specialist or consultant physician) requests that a specialist or consultant physician provide the service.
b. a specialist or consultant physician requests that a separate specialist or consultant physician provide the service.

DR.1.2 Exercise ECG stress testing requirements for claiming - Item 11729

This service can be performed as an out-of-hospital service or for hospital treatment or hospital-substitute treatment.

Item 11729 does not apply to a service unless:

i. the patient is referred to a specialist or consultant physician by a referring practitioner; or
ii. the service is requested by a requesting practitioner.

Referred services

For referred services to which item 11729 applies, the specialist or consultant physician who renders the service must:

i. manage the ongoing care of the patient; or
ii. perform an attendance to determine that testing is necessary, where the need for the test has not otherwise been scheduled; or
iii. perform an attendance immediately after the test has been performed, at which clinical management decisions are discussed with the patient.

A service is taken to be referred if the specialist or consultant physician who renders the service to which item 11729 applies is the patient's treating practitioner, determines the need for a cardiac investigation that has not otherwise been scheduled, or performs a scheduled test but also provides an attendance where clinical management decisions are discussed with the patient. Services in all other circumstances are considered to be requested.

Requested services

For requested services, item 11729 does not apply to a service if the rendering medical practitioner has performed a service to which an attendance applies for the same patient on the same day unless **both** of the following apply:

i. another medical practitioner has requested the electrocardiogram service; and
ii. the attendance service is provided at the same time as, or after, the electrocardiogram service and is required because there is an urgent clinical need to make decisions about the patient's care as a result of the electrocardiogram service.

Definition of 'requesting practitioner' when applied to item 11729 is as follows:

i. a medical practitioner (other than a specialist or consultant physician) requests that a specialist or consultant physician provide the diagnostic service; or
ii. a specialist or consultant physician requests that a separate specialist or consultant physician provide the diagnostic service; or
iii. a medical practitioner (other than a specialist or consultant physician) requests that a medical practitioner (other than a specialist or consultant physician) provide the diagnostic service; or
iv. a specialist or consultant physician requests that a medical practitioner (other than a specialist or consultant physician) provide the diagnostic service.

Patient requirements

i. Item 11729 does not apply to a service unless:
the patient's body habitus, or other physical condition, is suitable for exercise stress testing or pharmacological induced stress testing; and
ii. the patient can complete the exercise sufficiently or respond adequately to pharmacological induced stress, to take the required measurements.

Item 11729 does not apply to a service performed on a patient who:
(i) is asymptomatic and has a normal cardiac examination; or
(ii) has a known cardiac disease but the absence of symptom evolution suggests the disease has not progressed and the service is used for monitoring; or
(iii) has an abnormal resting electrocardiography result which would prevent the interpretation of results.

Exercise testing and cardiopulmonary resuscitation

The Taskforce recommended changes to the performance of exercise or pharmacological electrocardiogram stress testing for optimal patient safety. For a service to be performed, the person performing the monitoring and recording must be:

a. in continuous attendance; and
b. trained in "exercise testing" and cardiopulmonary resuscitation; and
c. a second person trained in cardiopulmonary resuscitation must be located at the premise and available to attend the electrocardiogram stress testing in an emergency.

Please refer to the Cardiac Society of Australia and New Zealand position statement on clinical exercise stress testing: https://www.csanz.edu.au/

DR.1.3 Paediatric Exercise ECG stress testing claiming requirements

These services can be performed as an out-of-hospital service, hospital treatment or hospital-substitute treatment.

Items 11729, 11730 and 11732 do not apply to a service unless:

(i) the patient's body habitus, or other physical condition, is suitable for exercise stress testing or pharmacological induced stress testing; and

(ii) the patient can complete the exercise sufficiently or respond adequately to pharmacological induced stress, to take the required measurements; and

Items 11729 and 11730 do not apply to a service performed on a patient who is asymptomatic and has a normal cardiac examination.

Attendances and Exercise ECG stress testing

(1) An item in Part 2 of this Schedule does not apply to a service (the attendance service) provided by a specialist, consultant physician or medical practitioner to a patient on a day if an electrocardiogram service to which item 11729 or 11732 applies is provided by the specialist, consultant physician or medical practitioner to the patient on the same day.

(2) Subclause (1) does not apply if:

(a) the patient has been referred to the specialist, consultant physician or medical practitioner; or

(b) the patient is being provided with ongoing care by the specialist, consultant physician or medical practitioner; or

(c) both of the following apply:

(i) another medical practitioner has requested the electrocardiogram service;

(ii) the attendance service is provided at the same time as, or after, the electrocardiogram service and is required because there is an urgent clinical need to make decisions about the patient's care as a result of the electrocardiogram service.

Exercise testing and cardiopulmonary resuscitation

1. Items 11729, 11730 and 11732 apply to a service provided to a patient only if:

(a) the service is performed on premises equipped with resuscitation equipment, including a defibrillator; and

(b) a person trained in the matters mentioned in subclause (2) and cardiopulmonary resuscitation is in continuous personal attendance during the monitoring and recording; and

(c) at the time the service is performed, a second person trained in cardiopulmonary resuscitation is located at the premises and is immediately available to respond if required; and

(d) at least one of the persons mentioned in paragraphs (b) and (c) is a medical practitioner

2. For the purposes of paragraph (1)(b), the matters are:

(a) how to safely perform exercise or pharmacological stress monitoring and recording; and

(b) how to recognise the symptoms and signs of cardiac disease.

The Taskforce recommended changes to the performance of exercise or pharmacological electrocardiogram stress testing for optimal patient safety. For a service to be performed, the person performing the monitoring and recording must be:

i. in continuous attendance; and
ii. trained in "exercise testing" and cardiopulmonary resuscitation; and
iii. A second person trained in cardiopulmonary resuscitation must be located at the premise and available to attend the electrocardiogram stress testing in an emergency.

Please refer to the Cardiac Society of Australia and New Zealand position statement on clinical exercise stress testing: https://www.csanz.edu.au/

DR.1.4 12-lead electrocardiography requirements for claiming

There are four 12-lead electrocardiography items:

· Item 11704 for a trace and formal report service performed by a specialist or consultant physician.

· Item 11705 for a formal report service performed by a specialist or consultant physician, where the specialist reports on a trace.

· Item 11707 for a trace service performed by a medical practitioner, including general practitioners for the purpose of forwarding to a specialist or consultant physician for a formal report.

· Item 11714 for trace and clinical note service performed by any medical practitioner, including general practitioners, specialists and consultant physicians.

Hospital Treatment

Items 11704, 11707 and 11714 do not apply where a patient is receiving services as part of an episode of hospital treatment or hospital-substitute treatment. Item 11705 can be performed out-of-hospital or as hospital treatment or hospital-substitute treatment.

Requested service

a) Items 11704 and 11705 are requested services which require the rendering specialist or consultant physician to produce a written formal report which must be provided to the requesting practitioner. The rendering specialist or consultant physician cannot perform the service unless it has been requested by another medical practitioner.

b) As a requested service, it is generally not expected that items 11704 or 11705 would involve any clinical work beyond performing the formal report (and the trace for item 11704). The MBS Review Taskforce recommended that an attendance should not be co-claimed with a diagnostic cardiac investigation in these circumstances. Item 11704 cannot be claimed if the rendering specialist or consultant physician has performed an attendance on the same patient on the same day.

Generally, it is expected that item 11705 should not be co-claimed with an attendance, but in exceptional clinical circumstances an attendance can be performed i.e. an admitted patient requires a formal report (on a trace) to be provided by a cardiologist and the result of this reporting determines that an urgent attendance (life threatening) is required by the cardiologist to guide immediate treatment (particularly when there is only one cardiologist rostered on the shift).

Financial relationship

For services provided under items 11704 and 11705, the rendering specialist or consultant physician and the requesting practitioner cannot have a financial relationship. Definition of ‘financial relationship’: is where the requesting practitioner is a member of a group of practitioners of which the providing practitioners is a member (both the requestor and provider potentially financially benefit from the MBS service provided). The need for a request should be informed by a clinical decision only.

Item 11705

Only applicable for an ECG that has not been previously reported on.

Item 11707

Item 11707 is a trace only service for the purpose of forwarding to a specialist or consultant physician for a formal report and can be performed by any medical practitioner, including general practitioners.

Item 11714

Item 11714 is a trace and clinical note service. The trace and clinical note will ensure the service:

- has used the ECG to inform clinical decision making during an attendance (or immediately following an attendance);
- details the clinical indication for the service in the clinical note;
- includes the interpretation in the context of the indication for the service in the clinical note; and
- does not require a formal report.

The clinical note must include:

a. comments on the significance of:

i. the trace findings; and
ii. the relationship of the trace findings to clinical decision making for the patient in the clinical context; and

b. an interpretation that is not based solely on measurements or diagnoses automatically generated from the trace.

Item 11714 allows medical practitioners, including general practitioners, specialist and consultant physicians to perform an electrocardiography trace and interpret the results (in the form of producing a written clinical note) where they consider it necessary for the management or treatment of the patient. No request is required for this service. There is no limitation on the claiming of an attendance with item 11714, as the Taskforce agreed that performance of an electrocardiography was part of routine assessment for patients presenting to medical practitioners, including general practitioners, specialist and consultant physicians for management of their cardiac condition.

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	**1. NEUROLOGY**
	Group D1. Miscellaneous Diagnostic Procedures And Investigations
	Subgroup 1. 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; or (c) to which item 12218 or 12219 applies (Anaes.) (See para DN.1.24 of explanatory notes to this Category) **Fee:** $147.35 **Benefit:** 75% = $110.55 85% = $125.25 **Future End Date:**
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; or (e) to which item 12218 or 12219 applies (See para DN.1.1 of explanatory notes to this Category) **Fee:** $389.80 **Benefit:** 75% = $292.35 85% = $331.35 **Future End Date:**
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; or (c) to which item 12218 or 12219 applies (See para DN.1.2 of explanatory notes to this Category) **Fee:** $389.80 **Benefit:** 75% = $292.35 85% = $331.35 **Future End Date:**
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; or (c) to which item 12218 or 12219 applies (See para DN.1.2 of explanatory notes to this Category) **Fee:** $389.80 **Benefit:** 75% = $292.35 85% = $331.35 **Future End Date:**
11009	ELECTROCORTICOGRAPHY **Fee:** $389.80 **Benefit:** 75% = $292.35 85% = $331.35 **Future End Date:**
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) (See para DN.1.3, DN.1.32 of explanatory notes to this Category) **Fee:** $134.00 **Benefit:** 75% = $100.50 85% = $113.90 **Future End Date:**
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) (See para DN.1.32 of explanatory notes to this Category) **Fee:** $179.40 **Benefit:** 75% = $134.55 85% = $152.50 **Future End Date:**
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) (See para DN.1.32 of explanatory notes to this Category) **Fee:** $268.10 **Benefit:** 75% = $201.10 85% = $227.90 **Future End Date:**
11021	NEUROMUSCULAR ELECTRODIAGNOSIS repetitive stimulation for study of neuromuscular conduction OR electromyography with quantitative computerised analysis OR both of these examinations **Fee:** $179.40 **Benefit:** 75% = $134.55 85% = $152.50 **Future End Date:**
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 (See para DN.1.4 of explanatory notes to this Category) **Fee:** $136.25 **Benefit:** 75% = $102.20 85% = $115.85 **Future End Date:**
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 (See para DN.1.4 of explanatory notes to this Category) **Fee:** $202.05 **Benefit:** 75% = $151.55 85% = $171.75 **Future End Date:**

	Group D1. Miscellaneous Diagnostic Procedures And Investigations
	Subgroup 2. Ophthalmology
11200	PROVOCATIVE TEST OR TESTS FOR OPEN ANGLE GLAUCOMA, including water drinking **Fee:** $48.80 **Benefit:** 75% = $36.60 85% = $41.50 **Future End Date:**
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. (See para DN.1.5 of explanatory notes to this Category) **Fee:** $129.55 **Benefit:** 75% = $97.20 85% = $110.15 **Future End Date:**
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 (See para DN.1.5 of explanatory notes to this Category) **Fee:** $129.55 **Benefit:** 75% = $97.20 85% = $110.15 **Future End Date:**
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 (See para DN.1.5 of explanatory notes to this Category) **Fee:** $129.55 **Benefit:** 75% = $97.20 85% = $110.15 **Future End Date:**
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 (See para DN.1.5 of explanatory notes to this Category) **Fee:** $129.55 **Benefit:** 75% = $97.20 85% = $110.15 **Future End Date:**
11215	RETINAL ANGIOGRAPHY, multiple exposures of 1 eye with intravenous dye injection **Fee:** $147.20 **Benefit:** 75% = $110.40 85% = $125.15 **Future End Date:**
11218	RETINAL ANGIOGRAPHY, multiple exposures of both eyes with intravenous dye injection **Fee:** $181.90 **Benefit:** 75% = $136.45 85% = $154.65 **Future End Date:**
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 **Fee:** $47.80 **Benefit:** 75% = $35.85 85% = $40.65

	Future End Date:
	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. **Fee:** $47.80 **Benefit:** 75% = $35.85 85% = $40.65
11220	**Future End Date:**
	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 (See para DN.1.7, DN.1.6 of explanatory notes to this Category) **Fee:** $81.15 **Benefit:** 75% = $60.90 85% = $69.00
11221	**Future End Date:**
	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 (See para DN.1.7, DN.1.6 of explanatory notes to this Category) **Fee:** $48.85 **Benefit:** 75% = $36.65 85% = $41.55
11224	**Future End Date:**
	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 **Fee:** $146.85 **Benefit:** 75% = $110.15 85% = $124.85
11235	**Future End Date:**
	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 **Fee:** $97.50 **Benefit:** 75% = $73.15 85% = $82.90
11237	**Future End Date:**
	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. (See para DN.1.8 of explanatory notes to this Category) **Fee:** $97.50 **Benefit:** 75% = $73.15 85% = $82.90
11240	**Future End Date:**
	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 (See para DN.1.8 of explanatory notes to this Category) **Fee:** $124.10 **Benefit:** 75% = $93.10 85% = $105.50
11241	**Future End Date:**

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	2. OPHTHALMOLOGY
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 (See para DN.1.8 of explanatory notes to this Category) **Fee:** $95.95 **Benefit:** 75% = $72.00 85% = $81.60 **Future End Date:**
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 (See para DN.1.8 of explanatory notes to this Category) **Fee:** $95.95 **Benefit:** 75% = $72.00 85% = $81.60 **Future End Date:**
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. **Fee:** $92.15 **Benefit:** 75% = $69.15 85% = $78.35 **Future End Date:**

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	3. OTOLARYNGOLOGY
	Group D1. Miscellaneous Diagnostic Procedures And Investigations
	Subgroup 3. 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.) **Fee:** $230.40 **Benefit:** 75% = $172.80 85% = $195.85 **Future End Date:**
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 **Fee:** $230.40 **Benefit:** 75% = $172.80 85% = $195.85 **Future End Date:**
11303	ELECTROCOCHLEOGRAPHY, extratympanic method, 1 or both ears **Fee:** $230.40 **Benefit:** 75% = $172.80 85% = $195.85 **Future End Date:**
11304	ELECTROCOCHLEOGRAPHY, transtympanic membrane insertion technique, 1 or both ears (See para DN.1.10 of explanatory notes to this Category)

	Fee: $379.35 **Benefit:** 75% = $284.55 85% = $322.45 **Future End Date:**
11306	Non determinate audiometry, if a service to which item 82306 applies has not been performed on the patient on the same day. (See para DN.1.11 of explanatory notes to this Category) **Fee:** $26.20 **Benefit:** 75% = $19.65 85% = $22.30 **Future End Date:**
11309	Audiogram, air conduction, if a service to which item 82309 applies has not been performed on the patient on the same day. (See para DN.1.11, DN.1.12 of explanatory notes to this Category) **Fee:** $31.45 **Benefit:** 75% = $23.60 85% = $26.75 **Future End Date:**
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. (See para DN.1.11, DN.1.12 of explanatory notes to this Category) **Fee:** $44.45 **Benefit:** 75% = $33.35 85% = $37.80 **Future End Date:**
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 (See para DN.1.11, DN.1.12 of explanatory notes to this Category) **Fee:** $58.85 **Benefit:** 75% = $44.15 85% = $50.05 **Future End Date:**
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 (See para DN.1.11, DN.1.12 of explanatory notes to this Category) **Fee:** $72.70 **Benefit:** 75% = $54.55 85% = $61.80 **Future End Date:**
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 **Fee:** $23.75 **Benefit:** 75% = $17.85 85% = $20.20 **Future End Date:**
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 (See para DN.1.13 of explanatory notes to this Category) **Fee:** $70.15 **Benefit:** 75% = $52.65 85% = $59.65 **Future End Date:**
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 (See para DN.1.36 of explanatory notes to this Category) **Fee:** $222.80 **Benefit:** 75% = $167.10 85% = $189.40 **Future End Date:**
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 (See para DN.1.36 of explanatory notes to this Category) **Fee:** $446.65 **Benefit:** 75% = $335.00 85% = $379.70 **Future End Date:**
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 **Fee:** $184.25 **Benefit:** 85% = $156.65 **Future End Date:**
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:

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	3. OTOLARYNGOLOGY
	(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 (See para DN.1.36 of explanatory notes to this Category) **Fee:** $668.25 **Benefit:** 75% = $501.20 85% = $568.05 **Future End Date:**
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 **Fee:** $184.25 **Benefit:** 85% = $156.65 **Future End Date:**

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	4. RESPIRATORY
	Group D1. Miscellaneous Diagnostic Procedures And Investigations
	Subgroup 4. 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 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, 12218 or 12219 applies (See para DN.1.14 of explanatory notes to this Category) **Fee:** $165.95 **Benefit:** 75% = $124.50 85% = $141.10 **Future End Date:**
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 (See para DN.1.20 of explanatory notes to this Category) **Fee:** $49.30 **Benefit:** 75% = $37.00 85% = $41.95 **Future End Date:**
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 (See para DN.1.20 of explanatory notes to this Category) **Fee:** $24.60 **Benefit:** 75% = $18.45 85% = $20.95 **Future End Date:**
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 (See para DN.1.21 of explanatory notes to this Category) **Fee:** $119.95 **Benefit:** 75% = $90.00 85% = $102.00 **Future End Date:**
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 (See para DN.1.21 of explanatory notes to this Category) **Fee:** $348.05 **Benefit:** 75% = $261.05 85% = $295.85 **Future End Date:**
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 (See para DN.1.20 of explanatory notes to this Category) **Fee:** $73.95 **Benefit:** 75% = $55.50 85% = $62.90 **Future End Date:**

	Group D1. Miscellaneous Diagnostic Procedures And Investigations
	Subgroup 5. 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) (See para TN.1.10, TN.1.11 of explanatory notes to this Category) **Fee:** $82.95 **Benefit:** 75% = $62.25 **Future End Date:**
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 **Fee:** $69.10 **Benefit:** 75% = $51.85 85% = $58.75 **Extended Medicare Safety Net Cap:** $55.30 **Future End Date:**
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 **Fee:** $90.55 **Benefit:** 75% = $67.95 85% = $77.00 **Extended Medicare Safety Net Cap:** $72.45 **Future End Date:**
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 **Fee:** $90.55 **Benefit:** 75% = $67.95 85% = $77.00 **Future End Date:**
Amend 11607	Continuous ambulatory blood pressure recording for 24 hours or more for a patient if: (a) the patient has one or more of the following clinic blood pressure measurements (using a sphygmomanometer or a validated oscillometric blood pressure monitoring device): (i) a measurement of systolic blood pressure greater than or equal to 140 mmHg and less than or equal to 180 mmHg; (ii) a measurement of diastolic blood pressure greater than or equal to 90 mmHg and less than or equal to 110 mmHg; (iii) if the patient is aged 5 years or more and under 18 years—measurements, on consecutive clinic visits, of systolic blood pressure or diastolic blood pressure between the 95th percentile

	and 95th percentile - 30 mmHg based on limits appropriate to the patient's age, sex and height; 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, 92033, 92034, 92057, 92058, 92060, 92061, 92063 or 92064. Applicable only once in any 12 month period (See para DN.1.35 of explanatory notes to this Category) **Fee:** \$123.20 **Benefit:** 75% = \$92.40 85% = \$104.75 **Extended Medicare Safety Net Cap:** \$98.60 **Future End Date:**
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. **Fee:** \$76.25 **Benefit:** 75% = \$57.20 85% = \$64.85 **Extended Medicare Safety Net Cap:** \$61.00

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	5. VASCULAR
	Future End Date:
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. **Fee:** $76.25 **Benefit:** 75% = $57.20 85% = $64.85 **Future End Date:**
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. **Fee:** $134.50 **Benefit:** 75% = $100.90 85% = $114.35 **Future End Date:**
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 **Fee:** $90.55 **Benefit:** 75% = $67.95 85% = $77.00 **Future End Date:**
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. **Fee:** $90.75 **Benefit:** 75% = $68.10 85% = $77.15 **Future End Date:**
11627	Pulmonary artery pressure monitoring during open heart surgery, in a patient under 12 years of age (H) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $273.65 **Benefit:** 75% = $205.25 **Future End Date:**

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	6. CARDIOVASCULAR
	Group D1. Miscellaneous Diagnostic Procedures And Investigations
	Subgroup 6. 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; and (c) is not a service to which item 12218 or 12219 applies Note: the following are also requirements of the service:

	i. a formal report is completed; and ii. a copy of the formal report is provided to the requesting practitioner; and iii. the service is not provided to the patient as part of an episode of hospital treatment or hospital-substitute treatment; and iv. is not provided in association with an attendance item (Part 2 of the schedule); and v. the specialist or consultant physician who renders the service does not have a financial relationship with the requesting practitioner. (See para DR.1.4, DN.1.31 of explanatory notes to this Category) **Fee:** $37.40 **Benefit:** 85% = $31.80 **Extended Medicare Safety Net Cap:** $29.95 **Future End Date:**
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; and (c) is not a service to which item 12218 or 12219 applies Applicable not more than twice on the same day Note: the following are also requirements of the service: i. a formal report is completed; and ii. a copy of the formal report is provided to the requesting practitioner; and iii. the specialist or consultant physician who renders the service does not have a financial relationship with the requesting practitioner; and iv. is not provided in association with an attendance item (Part 2 of the schedule), unless there has been a significant change in the patient's clinical condition or care circumstances that necessitates the providing of the service. (See para DR.1.4, DN.1.31 of explanatory notes to this Category) **Fee:** $22.00 **Benefit:** 75% = $16.50 85% = $18.70 **Future End Date:**
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; and (c) the service is not a service to which item 12218 or 12219 applies Applicable not more than twice on the same day Note: the following are also requirements of the service: i. the service is not provided to the patient as part of an episode of hospital treatment; or ii. hospital-substitute treatment. (See para DR.1.4 of explanatory notes to this Category) **Fee:** $22.00 **Benefit:** 85% = $18.70 **Future End Date:**

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, other than a service to which item 12218 or 12219 applies **Fee:** $83.45 **Benefit:** 75% = $62.60 85% = $70.95 **Future End Date:**
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; and (e) the service is not a service to which item 12218 or 12219 applies Applicable not more than twice on the same day Note: the following are also requirements of the service: i. the clinical note for the service comments on the significance of the trace findings, the relationship of the trace findings to clinical decision making for the patient in the clinical context; and ii. the interpretation of the trace is not based solely on measurements or diagnoses automatically generated from the trace; and iii. a copy of the formal report is provided to the requesting practitioner; and iv. the service is not provided to the patient as part of an episode of hospital treatment or hospital-substitute treatment; and v. is not provided in association with an attendance item (Part 2 of the schedule) (See para DR.1.4 of explanatory notes to this Category) **Fee:** $29.00 **Benefit:** 85% = $24.65 **Future End Date:**
11716	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; and (f) is not a service to which item 12218 or 12219 applies Applicable only once in any 4 week period Note: the service is not provided to the patient as part of an episode: i. of hospital treatment; or ii. hospital-substitute treatment. (See para DR.1.1, DN.1.28, DN.1.31 of explanatory notes to this Category) **Fee:** $200.55 **Benefit:** 85% = $170.50 **Future End Date:**
11717	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: 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, 11723, 11735, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies; and (e) is not a service to which item 12218 or 12219 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: i. hospital treatment; or ii. hospital-substitute treatment.

	(See para DR.1.1, DN.1.26, DN.1.31 of explanatory notes to this Category) **Fee:** $117.85 **Benefit:** 85% = $100.20 **Future End Date:**
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 **Fee:** $79.95 **Benefit:** 75% = $60.00 85% = $68.00 **Future End Date:**
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. **Fee:** $79.95 **Benefit:** 75% = $60.00 85% = $68.00 **Future End Date:**
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 (See para DN.1.33, DN.1.34 of explanatory notes to this Category) **Fee:** $83.45 **Benefit:** 75% = $62.60 85% = $70.95 **Future End Date:**
11723	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; and (e) is not a service to which item 12218 or 12219 applies

	Applicable only once in any 3 month period Note: the service is not provided to the patient as part of an episode: i. of hospital treatment; or ii. hospital-substitute treatment. (See para DR.1.1, DN.1.26, DN.1.31 of explanatory notes to this Category) **Fee:** $62.20 **Benefit:** 85% = $52.90 **Future End Date:**
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 **Fee:** $202.05 **Benefit:** 75% = $151.55 85% = $171.75 **Future End Date:**
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 **Fee:** $226.85 **Benefit:** 75% = $170.15 85% = $192.85 **Future End Date:**
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. **Fee:** $113.40 **Benefit:** 75% = $85.05 85% = $96.40 **Future End Date:**
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 (See para DN.1.34 of explanatory notes to this Category) **Fee:** $113.40 **Benefit:** 75% = $85.05 85% = $96.40 **Future End Date:**
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 **Fee:** $41.60 **Benefit:** 75% = $31.20 85% = $35.40 **Future End Date:**
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 (See para DR.1.2, DR.1.3, DN.1.29 of explanatory notes to this Category) **Fee:** $182.15 **Benefit:** 75% = $136.65 85% = $154.85 **Future End Date:**
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 (See para DR.1.3, DN.1.30 of explanatory notes to this Category) **Fee:** $182.15 **Benefit:** 75% = $136.65 85% = $154.85 **Future End Date:**
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 (See para DN.1.27 of explanatory notes to this Category) **Fee:** $41.60 **Benefit:** 75% = $31.20 85% = $35.40 **Future End Date:**
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 (See para DR.1.3 of explanatory notes to this Category) **Fee:** $182.15 **Benefit:** 75% = $136.65 85% = $154.85 **Future End Date:**
11735	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; or (iii) to which item 12218 or 12219 applies Applicable not more than 4 times in any 12 month period Note: the service is not provided to the patient as part of an episode: i. of hospital treatment; or ii. hospital-substitute treatment. (See para DR.1.1, DN.1.26, DN.1.31 of explanatory notes to this Category) **Fee:** $153.15 **Benefit:** 85% = $130.20 **Future End Date:**
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

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	6. CARDIOVASCULAR
	(b) is not a service to which item 38288 applies Applicable not more than 4 times in any 12 month period **Fee:** $41.60 **Benefit:** 75% = $31.20 85% = $35.40 **Future End Date:**
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 **Fee:** $41.60 **Benefit:** 75% = $31.20 85% = $35.40 **Future End Date:**

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	7. GASTROENTEROLOGY & COLORECTAL
	Group D1. Miscellaneous Diagnostic Procedures And Investigations
	Subgroup 7. Gastroenterology & Colorectal
11800	OESOPHAGEAL MOTILITY TEST, manometric **Fee:** $208.75 **Benefit:** 75% = $156.60 85% = $177.45 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $314.85 **Benefit:** 75% = $236.15 **Future End Date:**
11810	CLINICAL ASSESSMENT of GASTRO-OESOPHAGEAL REFLUX DISEASE involving 24 hour pH monitoring, including analysis, interpretation and report and including any associated consultation

	Fee: $208.75 **Benefit:** 75% = $156.60 85% = $177.45 **Future End Date:**
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 (See para DN.1.15 of explanatory notes to this Category) **Fee:** $1,471.40 **Benefit:** 75% = $1103.55 85% = $1362.90 **Future End Date:**
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. (See para DN.1.15 of explanatory notes to this Category) **Fee:** $1,471.40 **Benefit:** 75% = $1103.55 85% = $1362.90 **Future End Date:**

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	7. GASTROENTEROLOGY & COLORECTAL
11830	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR involving anal manometry or measurement of anorectal sensation or measurement of the rectosphincteric reflex **Fee:** $223.55 **Benefit:** 75% = $167.70 85% = $190.05 **Future End Date:**
11833	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR and sphincter muscles involving electromyography or measurement of pudendal and spinal nerve motor latency **Fee:** $298.85 **Benefit:** 75% = $224.15 85% = $254.05 **Future End Date:**

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	8. GENITO/URINARY PHYSIOLOGICAL INVESTIGATIONS
	Group D1. Miscellaneous Diagnostic Procedures And Investigations
	Subgroup 8. Genito/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 **Fee:** $32.95 **Benefit:** 75% = $24.75 85% = $28.05 **Future End Date:**
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.) **Fee:** $236.40 **Benefit:** 75% = $177.30 85% = $200.95 **Future End Date:**
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.) **Fee:** $512.75 **Benefit:** 75% = $384.60 85% = $435.85 **Future End Date:**
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

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	8. GENITO/URINARY PHYSIOLOGICAL INVESTIGATIONS
	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.) **Fee:** $512.75 **Benefit:** 75% = $384.60 85% = $435.85 **Future End Date:**

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	9. ALLERGY TESTING
	Group D1. Miscellaneous Diagnostic Procedures And Investigations
	Subgroup 9. 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 (See para DN.1.22 of explanatory notes to this Category) **Fee:** $46.60 **Benefit:** 75% = $34.95 85% = $39.65 **Future End Date:**
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 (See para DN.1.22 of explanatory notes to this Category) **Fee:** $46.60 **Benefit:** 75% = $34.95 85% = $39.65 **Future End Date:**
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 (See para DN.1.22 of explanatory notes to this Category) **Fee:** $46.60 **Benefit:** 75% = $34.95 85% = $39.65 **Future End Date:**
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 (See para DN.1.22 of explanatory notes to this Category) **Fee:** $46.60 **Benefit:** 75% = $34.95 85% = $39.65 **Future End Date:**
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 (See para DN.1.22 of explanatory notes to this Category) **Fee:** $70.45 **Benefit:** 75% = $52.85 85% = $59.90

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	9. ALLERGY TESTING
	Future End Date:
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 (See para DN.1.22 of explanatory notes to this Category) **Fee:** $94.75 **Benefit:** 75% = $71.10 85% = $80.55 **Future End Date:**
12012	Epicutaneous patch testing in the investigation of allergic dermatitis using not more than 25 allergens **Fee:** $24.90 **Benefit:** 75% = $18.70 85% = $21.20 **Future End Date:**
12017	Epicutaneous patch testing in the investigation of allergic dermatitis using more than 25 allergens but not more than 50 allergens **Fee:** $84.05 **Benefit:** 75% = $63.05 85% = $71.45 **Future End Date:**
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 **Fee:** $138.20 **Benefit:** 75% = $103.65 85% = $117.50 **Future End Date:**
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 **Fee:** $162.25 **Benefit:** 75% = $121.70 85% = $137.95 **Future End Date:**
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 **Fee:** $184.90 **Benefit:** 75% = $138.70 85% = $157.20 **Future End Date:**

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	10. OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
	Group D1. Miscellaneous Diagnostic Procedures And Investigations
	Subgroup 10. Other Diagnostic Procedures And Investigations
12200	COLLECTION OF SPECIMEN OF SWEAT by iontophoresis **Fee:** $44.50 **Benefit:** 75% = $33.40 85% = $37.85

	Future End Date:
	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 (See para DN.1.16 of explanatory notes to this Category) **Fee:** $2,864.10 **Benefit:** 75% = $2148.10 85% = $2755.60
12201	**Future End Date:**
	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
12203	

	(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 (See para DN.1.17 of explanatory notes to this Category) **Fee:** $703.80 **Benefit:** 75% = $527.85 85% = $598.25 **Future End Date:**
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 (See para DN.1.17 of explanatory notes to this Category) **Fee:** $703.80 **Benefit:** 75% = $527.85 85% = $598.25 **Future End Date:**
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 (See para DN.1.17 of explanatory notes to this Category) **Fee:** $703.80 **Benefit:** 75% = $527.85 85% = $598.25 **Future End Date:**
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 (See para DN.1.17 of explanatory notes to this Category) **Fee:** $703.80 **Benefit:** 75% = $527.85 85% = $598.25 **Future End Date:**
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 (See para DN.1.17 of explanatory notes to this Category) **Fee:** $703.80 **Benefit:** 75% = $527.85 85% = $598.25 **Future End Date:**
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, 11713, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient For each particular patient—applicable only in relation to the first 3 investigations to which this item or item 12218 applies in any 12 month period (See para DN.1.37 of explanatory notes to this Category) **Fee:** $840.10 **Benefit:** 75% = $630.10 85% = $731.60 **Future End Date:**
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, 11713, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient For each particular patient—applicable only in relation to the first 3 investigations to which this item or item 12210, 12218 or 12219 applies in any 12 month period (See para DN.1.37 of explanatory notes to this Category) **Fee:** $756.80 **Benefit:** 75% = $567.60 85% = $648.30 **Future End Date:**
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 in which item 12210 or 12218 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 or 12218 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 or 12218 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, 11713, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient Applicable once in the 12 month period that starts when the first of the 3 studies mentioned in subparagraph (g)(i) or (ii) is provided (See para DN.1.37 of explanatory notes to this Category) **Fee:** $840.10 **Benefit:** 75% = $630.10 85% = $731.60 **Future End Date:**
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 in which item 12210, 12213, 12218 or 12219 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 any of items 12210, 12213, 12218 and 12219 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 any of items 12210, 12213, 12218 and 12219 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, 11713, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient Applicable once in the 12 month period that starts when the first of the 3 studies mentioned in subparagraph (g)(i) or (ii) is provided (See para DN.1.37 of explanatory notes to this Category) **Fee:** $756.80 **Benefit:** 75% = $567.60 85% = $648.30 **Future End Date:**
12218	Overnight investigation of sleep, for at least 8 hours, for a patient aged at least 3 years but less than 12 years, if: (a) the patient is referred by a medical practitioner to a qualified paediatric sleep medicine practitioner; and (b) following professional attendance on the patient (either face-to-face or by video conference), the qualified paediatric sleep medicine practitioner determines that: (i) the investigation is necessary for a purpose mentioned in paragraph (c); and (ii) an unattended sleep study is appropriate for the investigation; and (c) the purpose of the investigation is documented and is any of the following: (i) to confirm diagnosis of sleep apnoea; (ii) as a repeat investigation to assess treatment effectiveness;

(iii) as a repeat investigation to determine respiratory support needs following a significant change in clinical status; and

(d) during a period of sleep, there is continuous monitoring and recording of at least the following measures:

(i) airflow;

(ii) EMG;

(iii) ECG or heart rate;

(iv) EEG;

(v) EOG;

(vi) oxygen saturation;

(vii) respiratory effort; and

(e) the investigation is provided:

(i) under the supervision of a qualified paediatric sleep medicine practitioner; and

(ii) in accordance with current professional guidelines (including in relation to interpreting polygraphic data and preparing a report); and

(f) before the investigation commences, a parent or caregiver of the patient is given:

(i) written or video instructions on how to monitor the patient overnight; and

(ii) a way of contacting a sleep technician to enable trouble shooting overnight; and

(g) the equipment is applied to the patient by:

(i) a sleep technician; or

(ii) the parent or caregiver of the patient if:

(A) before the set-up process commences, the parent or caregiver is given written or video instructions for how to apply the equipment; and

(B) there is continuous telehealth support from a sleep technician throughout the set-up process; and

(C) the use of telehealth is documented; and

(h) polygraphic records are:

(i) analysed (for assessment of sleep stage, arousals, respiratory events and cardiac abnormalities) using 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

	(i) interpretation and preparation of a permanent report are 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 Applicable in relation to the first 3 investigations to which this item or item 12210 applies in any 12 month period (See para DN.1.37, AN.0.12 of explanatory notes to this Category) **Fee:** $489.90 **Benefit:** 85% = $416.45 **Future End Date:**
12219	Overnight investigation of sleep, 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 to a qualified sleep medicine practitioner; and (b) following professional attendance on the patient (either face-to-face or by video conference), the qualified sleep medicine practitioner determines that: (i) the investigation is necessary for a purpose mentioned in paragraph (c); and (ii) an unattended sleep study is appropriate for the investigation; and (c) the purpose of the investigation is documented and is any of the following: (i) to confirm diagnosis of sleep apnoea; (ii) as a repeat investigation to assess treatment effectiveness; (iii) as a repeat investigation to determine respiratory support needs following a significant change in clinical status; and (d) during a period of sleep, there is continuous monitoring and recording of at least the following measures: (i) airflow; (ii) EMG; (iii) ECG or heart rate; (iv) EEG; (v) EOG; (vi) oxygen saturation; (vii) respiratory effort; and (e) the investigation is provided: (i) under the supervision of a qualified sleep medicine practitioner; and (ii) in accordance with current professional guidelines (including in relation to interpreting polygraphic data and preparing a report); and (f) before the investigation commences, a parent or caregiver of the patient is given:

	(i) written or video instructions on how to monitor the patient overnight; and (ii) a way of contacting a sleep technician to enable trouble shooting overnight; and (g) the equipment is applied to the patient by: (i) a sleep technician; or (ii) the parent or caregiver of the patient if: (A) before the set-up process commences, the parent or caregiver is given written or video instructions for how to apply the equipment; and (B) there is continuous telehealth support from a sleep technician throughout the set-up process; and (C) the use of telehealth is documented; and (h) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events and cardiac abnormalities) using 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 (i) interpretation and preparation of a permanent report are provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient Applicable in relation to the first 3 investigations to which this item or item 12210, 12213 or 12218 applies in any 12 month period (See para DN.1.37, AN.0.12 of explanatory notes to this Category) **Fee:** $455.25 **Benefit:** 85% = $387.00 **Future End Date:**
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 (See para DN.1.17 of explanatory notes to this Category) **Fee:** $401.25 **Benefit:** 75% = $300.95 85% = $341.10 **Future End Date:**
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 (See para DN.1.23 of explanatory notes to this Category) **Fee:** $1,093.55 **Benefit:** 75% = $820.20 85% = $985.05 **Future End Date:**
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 (See para DN.1.23 of explanatory notes to this Category) **Fee:** $1,093.55 **Benefit:** 75% = $820.20 85% = $985.05 **Future End Date:**
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 (See para DN.1.23 of explanatory notes to this Category) **Fee:** $1,146.65 **Benefit:** 75% = $860.00 85% = $1038.15 **Future End Date:**
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 (See para DN.1.23 of explanatory notes to this Category) **Fee:** $1,146.65 **Benefit:** 75% = $860.00 85% = $1038.15 **Future End Date:**
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 (See para DN.1.23 of explanatory notes to this Category) **Fee:** $1,229.90 **Benefit:** 75% = $922.45 85% = $1121.40 **Future End Date:**
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 (See para DN.1.23 of explanatory notes to this Category) **Fee:** $1,229.90 **Benefit:** 75% = $922.45 85% = $1121.40 **Future End Date:**
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 (See para DN.1.18 of explanatory notes to this Category) **Fee:** $122.55 **Benefit:** 75% = $91.95 85% = $104.20 **Future End Date:**
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 (See para DN.1.18 of explanatory notes to this Category) **Fee:** $122.55 **Benefit:** 75% = $91.95 85% = $104.20 **Future End Date:**
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 (See para DN.1.18 of explanatory notes to this Category) **Fee:** $122.55 **Benefit:** 75% = $91.95 85% = $104.20 **Future End Date:**
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 (See para DN.1.18 of explanatory notes to this Category) **Fee:** $122.55 **Benefit:** 75% = $91.95 85% = $104.20 **Future End Date:**
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 (See para DN.1.18 of explanatory notes to this Category) **Fee:** $122.55 **Benefit:** 75% = $91.95 85% = $104.20 **Future End Date:**
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 (See para DN.1.18 of explanatory notes to this Category) **Fee:** $122.55 **Benefit:** 75% = $91.95 85% = $104.20 **Future End Date:**
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 (See para DN.1.19 of explanatory notes to this Category) **Fee:** $59.75 **Benefit:** 75% = $44.85 85% = $50.80 **Future End Date:**
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 (See para DN.1.19 of explanatory notes to this Category) **Fee:** $59.75 **Benefit:** 75% = $44.85 85% = $50.80 **Future End Date:**

D2. NUCLEAR MEDICINE (NON-IMAGING)

	Group D2. Nuclear Medicine (Non-Imaging)
12500	BLOOD VOLUME ESTIMATION **Fee:** $259.25 **Benefit:** 75% = $194.45 85% = $220.40 **Future End Date:**
12524	RENAL FUNCTION TEST (without imaging procedure) **Fee:** $189.55 **Benefit:** 75% = $142.20 85% = $161.15 **Future End Date:**
12527	RENAL FUNCTION TEST (with imaging and at least 2 blood samples)

D2. NUCLEAR MEDICINE (NON-IMAGING)	
	Fee: $101.65 **Benefit:** 75% = $76.25 85% = $86.45 **Future End Date:**
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 **Fee:** $101.25 **Benefit:** 75% = $75.95 85% = $86.10 **Future End Date:**

CATEGORY 3: THERAPEUTIC PROCEDURES

SUMMARY OF CHANGES FROM 01/11/2026

The 01/11/2026 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

Description Amended
14245 16408 18360 45515 45518

Changes to general medical services

From 1 November 2026, changes will be made relating to general medical services. These changes include:

- Enabling services provided under item 45518 to be performed outside of a hospital setting;
- Administrative amendments to reflect the new name of the committee that provides accreditation in relation to undertaking transcatheter aortic valve implantation and transcatheter mitral valve repair services, which is the Australian Transcatheter Valve Therapies Accreditation Committee;
- Enabling immunomodulating treatment item 14245 to be provided by a qualified health practitioner on behalf of the prescribing medical practitioner;
- Amending item 18360 to provide treating clinicians access to a third pharmaceutical option
- Amending clause 1.2.11 to enable proton beam therapy item 15990 to be administered by persons other than medical practitioners and removing rhinology item 41764 to restrict its provision by only a medical practitioner or a speech pathologist on behalf of an otolaryngology head and neck surgeon;
- (Xeomin) to treat patients with moderate and severe focal spasticity caused by a neurological disorder;
- Amending section 52 of the *Health Insurance Regulation 2018*, (which sets out prescribed particulars of a person rendering a service and a person claiming or receiving fees) to include reference to all items currently in Group T2 (Radiation Oncology) and Group T3 (Therapeutic Nuclear Medicine); and
- Administrative amendments to replace references to the term “residential aged care facility” with “residential care home” to align with terminology in the *Aged Care Act 2024*.

THERAPEUTIC PROCEDURES NOTES

TN.0.1 Use of new loading item 35501 for long-acting reversible contraceptives (LARCs)

Intention of this service

- New loading item 35501 is intended to support bulk billing of patients who are having a long-acting reversible contraceptive inserted or removed.
- Item 35501 provides a 'loading' of 40% of the fee for a relevant LARC insertion/removal item/s, when a patient's LARC insertion or removal service, and any associated services such as consultations, are bulk billed.
- For loading item 35501 to be payable, providers must:
    - ensure all item requirements are met,
    - bulk bill the patient for each MBS item they claim during the patient's LARC appointment which is related to the LARC insertion/removal, and
    - claim the relevant LARC item/s and
    - co-claim the loading item.

Services to which loading applies

- MBS loading item 35501 only applies where a service meeting one or more of the following is performed:
    - a hormonal implant implantation (MBS item 14206)
    - a hormonal implant removal (MBS item 30062)
    - an intra-uterine device (IUD) insertion/introduction (MBS item 35503); or
    - an IUD removal under a general anaesthetic (MBS item 35506)
- When anaesthetic is not required, IUD removal as a standalone procedure can be billed under any appropriate MBS attendance item. In this case item 35501 will not apply.
- A removal and insertion item may both be claimed if these services are conducted on the same day in the same appointment (for example removal and insertion of a new hormonal implant).

Claiming restrictions

- Item 35501 is only payable for relevant MBS LARC items when:
    - one or more relevant LARC insertion/removal items are claimed (MBS item 35503, 35506, 14206 or 30062),
    - the relevant MBS LARC item/s is bulk billed, and any other associated MBS services claimed such as consultations, are bulk billed together.
- Note that it is the treating practitioner's responsibility to consider the clinical circumstances of services rendered and determine the appropriate MBS item(s) to bill, if any. They should ensure their conduct in relation to rendering services and billing would be acceptable to their peers.

Additional information

- In line with relevant treatment guidelines relating to administration of LARC, providers should discuss and provide appropriate pain relief.
- Applicable clinical practice guidelines are available from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the Royal Australian College of General Practitioners (RACGP).
- As per MBS General Explanatory Note GN.7.17, if a practitioner bulk bills for a service, they undertake to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service cannot be raised. This includes but is not limited to:
    - any consumables that would be reasonably necessary to perform the service, including bandages and/or dressings;
    - record keeping fees;
    - a booking fee to be paid before each service, or;
    - an annual administration or registration fee.

- Should a clinician choose to privately charge a fee for any element of the service, item 35501 cannot be claimed.

Claiming the loading item

The loading item (35501) should be claimed immediately after the LARC insertion or removal item it is associated with.

If multiple LARC insertion or removal items are eligible to be claimed with the loading item, then the loading item should be claimed immediately after each of the LARC items it is associated with.

For example, for a claim involving LARC items 30062 for Implanon removal and 35503 for IUD insertion:

Implanon removal	30062
Loading item	35501
IUD insertion	35503
Loading item	35501

TN.1.1 Hyperbaric Oxygen Therapy - (Items 13015, 13020, 13025 and 13030)

Hyperbaric Oxygen Therapy not covered by these items would attract benefits on an attendance basis. For the purposes of these items, a comprehensive hyperbaric medicine facility means a separate hospital area that, on a 24 hour basis:

(a) is equipped and staffed so that it is capable of providing to a patient:

(i) hyperbaric oxygen therapy at a treatment pressure of at least 2.8 atmospheric pressure absolute (180 kilopascal gauge pressure); and

(ii) mechanical ventilation and invasive cardiovascular monitoring within a monoplace or multiplace chamber for the duration of the hyperbaric treatment; and

(b) is under the direction of at least 1 medical practitioner who is rostered, and immediately available, to the facility during the facility's ordinary working hours if the practitioner:

(i) is a specialist with training in diving and hyperbaric medicine; or

(ii) holds a Diploma of Diving and Hyperbaric Medicine of the South Pacific Underwater Medicine Society; and

(c) is staffed by:

(i) at least 1 medical practitioner with training in diving and hyperbaric medicine who is present in the facility and immediately available at all times when patients are being treated at the facility; and

(ii) at least 1 registered nurse with specific training in hyperbaric patient care to the published standards of the Hyperbaric Technicians and Nurses Association, who is present during hyperbaric oxygen therapy; and

(d) has admission and discharge policies in operation.

TN.1.2 Haemodialysis - (Items 13100 and 13103)

Item 13100 covers the supervision in hospital by a medical specialist for the management of dialysis, haemofiltration, haemoperfusion or peritoneal dialysis in the patient who is not stabilised where the total attendance time by the supervising medical specialist exceeds 45 minutes.

Item 13103 covers the supervision in hospital by a medical specialist for the management of dialysis, haemofiltration, haemoperfusion or peritoneal dialysis in a stabilised patient, or in the case of an unstabilised patient, where the total attendance time by the supervising medical specialist does not exceed 45 minutes.

TN.1.3 Consultant Physician Supervision of Home Dialysis - (Item 13104)

Item 13104 covers the planning and management of dialysis and the supervision of a patient on home dialysis by a consultant physician in the practice of his or her specialty of renal medicine. Planning and management would cover the consultant physician participating in patient management discussions coordinated by renal centres. Supervision of the patient at home can be undertaken by telephone or other electronic medium, and includes:

- Regular ordering, performance and interpretation of appropriate biochemical and haematological studies

(generally monthly);

- Feed-back of results to the home patient and his or her treating general physician;

- Adjustments to medications and dialysis therapies based upon these results;

- Co-ordination of regular investigations required to keep patient on active transplantation lists, where relevant;

- Referral to, and communication with, other specialists involved in the care of the patient; and

- Being available to advise the patient or the patient's agent.

A record of the services provided should be made in the patient's clinical notes.

The schedule fee equates to one hour of time spent undertaking these activities. It is expected that the item will be claimed once per month, to a maximum of 12 claims per year. The patient should be informed that he or she will incur a charge for which a Medicare benefit will be payable.

This item includes dialysis conducted in a residential aged care facility. In remote areas, where a patient's home is an unsuitable environment for home dialysis due to a lack of space, or the absence of telecommunication, electricity and water utilities, the item includes dialysis in a community facility such as the local primary health care clinic.

TN.1.4 Assisted Reproductive Technology ART Services - (Items 13200 to 13221)

Medicare benefits are not payable in respect of ANY other item in the Medicare Benefits Schedule, including Diagnostic Imaging and Pathology (with the exception of items 73384, 73385, 73386 and 73387) in lieu of or in connection with items 13200 - 13221. Specifically, Medicare benefits are not payable for these items in association with items 104, 105, 14203, 14206, 35631, 35632, 35637, 35641, pathology tests (not including pathology items 73384, 73385, 73386 and 73387) or diagnostic imaging.

A treatment cycle that is a series of treatments for the purposes of ART services is defined as beginning either on the day on which treatment by superovulatory drugs is commenced or on the first day of the patient's menstrual cycle, and ending either; not more than 30 days later, or if a service mentioned in item 13212, 13215 or 13221 is provided in connection with the series of treatments-on the day after the day on which the last of those services is provided.

The date of service in respect of treatment covered by Items 13200, 13201, 13203, 13209 and 13218 is **DEEMED** to be the **FIRST DAY** of the treatment cycle.

Items 13200, 13201, 13202 and 13203 are linked to the supply of hormones under the Section 100 (National Health Act) arrangements. Providers must notify Services Australia of Medicare card numbers of patients using hormones under this program, and hormones are only supplied for patients claiming one of these four items.

Medicare benefits are not payable for assisted reproductive services rendered in conjunction with surrogacy arrangements where surrogacy is defined as 'an arrangement whereby a woman agrees to become pregnant and to bear a child for another person or persons to whom she will transfer guardianship and custodial rights at or shortly after birth'.

NOTE: Items 14203 and 14206 are not payable for artificial insemination.

TN.1.5 Intracytoplasmic Sperm Injection - (Item 13251)

Item 13251 provides for intracytoplasmic sperm injection for male factor infertility under the following circumstances:

- where fertilisation with standard IVF is highly unlikely to be successful; or

- where in a previous cycle of IVF, the fertilisation rate has failed due to low or no fertilisation.

Item 13251 excludes a service to which item 13218 applies. Sperm retrieval procedures associated with intracytoplasmic sperm injection are covered under items 37605 and 37606.

Items 13251, 37605, 37606 do not include services provided in relation to artificial insemination using the husband's or donated sperm.

TN.1.6 Peripherally Inserted Central Catheters

Peripherally inserted central catheters (PICC) are an alternative to standard percutaneous central venous catheter placement or surgically placed intravenous catheters where long-term venous access is required for ongoing patient therapy.

Medicare benefits for PICC can be claimed under central vein catheterisation items 13318, 13319, 13815 and 22020.

These items are for central vein catheterisation (where the tip of the catheter is positioned in a central vein) and cannot be used for venous catheters where the tip is positioned in a peripheral vein.

TN.1.7 Administration of Blood or Bone Marrow already Collected (Item 13706)

Item 13706 is payable for the transfusion of blood, or platelets or white blood cells or bone marrow or gamma globulins. This item is not payable when gamma globulin is administered intramuscularly.

TN.1.9 Intensive Care Units - (Items 13870 to 13888)

TN.1.9 Intensive Care Units - (Items 13870 to 13888)

'Intensive Care Unit' means a separate hospital area that:

(a) is equipped and staffed so as to be capable of providing to a patient:

(i) mechanical ventilation for respiratory failure for at least 24 hours; and

(ii) invasive cardiovascular monitoring; and

(b) is supported by:

(i) at least one specialist in the specialty of intensive care who is immediately available and exclusively rostered to the ICU during normal working hours; and

(ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and

(iii) a registered nurse for at least 18 hours in each day; and

(c) has defined admission and discharge policies.

"immediately available" means that the intensivist must be predominantly present in the ICU during normal working hours. Reasonable absences from the ICU would be acceptable to attend conferences, meetings and other commitments, which might involve absences of up to 2 hours during the working day, provided suitable cover is available. Outside normal working hours the specialist must be immediately contactable and, if required, available to return to the ICU within a reasonable time.

"exclusively rostered" means that the specialist's sole clinical commitment is to intensive care.

For Neonatal Intensive Care Units an 'Intensive Care Unit' means a separate hospital area that:

(a) is equipped and staffed so as to be capable of providing to a patient, being a newly-born child:

(i) mechanical ventilation for a period of several days; and

(ii) invasive cardiovascular monitoring; and

(b) is supported by:

(i) at least one consultant physician in the specialty of paediatric medicine, appointed to manage the unit, and who is immediately available and exclusively rostered to the ICU during normal working hours; and

(ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and

(iii) a registered nurse for at least 18 hours in each day; and

(c) has defined admission and discharge policies.

Medicare benefits are payable under the 'management' items only once per day irrespective of the number of intensivists involved with the patient on that day. However, benefits are also payable for an attendance by another specialist/consultant physician who is not managing the patient but who has been asked to attend the patient. Where appropriate, accounts should be endorsed to the effect that the consultation was not part of the patient's intensive care management in order to identify which consultations should attract benefits in addition to the intensive care items.

In respect of Neonatal Intensive Care Units, as defined above, benefits are payable for admissions of babies who meet the following criteria:-

(i) all babies weighing less than 1000gms;

(ii) all babies with an endotracheal tube, and for the 24 hours following endotracheal tube removal;

(iii) all babies requiring Constant Positive Airway Pressure (CPAP) for acute respiratory instability;

(iv) all babies requiring more than 40% oxygen for more than 4 hours;

(v) all babies requiring an arterial line for blood gas or pressure monitoring; or

(vi) all babies having frequent seizures.

Cases may arise where babies admitted to a Neonatal Intensive Care Unit under the above criteria who, because they no longer satisfy the criteria are ready for discharge, in accordance with accepted discharge policies, but who are physically retained in the Neonatal Intensive Care Unit for other reasons. For benefit purposes such babies must be deemed as being discharged from the Neonatal Intensive Care Unit and not eligible for benefits under items 13870, 13873, 13876, 13881, 13882, 13885 and 13888.

Likewise, Medicare benefits are not payable under items 13870, 13873, 13876, 13881 13882, 13885 and 13888 in respect of babies not meeting the above criteria, but who, for whatever other reasons, are physically located in a Neonatal Intensive Care Unit.

Medicare benefits are payable for admissions to an Intensive Care Unit following surgery only where clear clinical justification for post-operative intensive care exists.

TN.1.10 Procedures Associated with Intensive Care - (Items 13815, 13818, 13832, 13834, 13835, 13837, 13838, 13840, 13842, 13848, 13851, 13854 and 13857)

TN.1.10 Procedures Associated with Intensive Care - (Items 13815, 13818, 13832, 13834, 13835, 13837, 13838, 13840, 13842, 13848, 13851, 13854 and 13857)

Item 13815 covers the insertion of a central vein catheter, including under ultrasound guidance where clinically appropriate. No separate ultrasound item is payable with item 13815.

Item 13818 covers the insertion of a right heart balloon flotation catheter. Benefits are payable under this item only once per day except where a second discrete operation is performed on that day.

Items 13832, 13834, 13835, 13837, 13838 and 13840

These items cover extracorporeal life support services in an ICU. Benefits are payable only once per calendar day for a patient, irrespective of the number of medical practitioners involved.

Items 13832 and 13840 include the use of ultrasound guidance where clinically appropriate. No separate ultrasound item is payable with these items.

Item 13839

Provides for collection of blood for diagnostic purposes by arterial puncture.

Medicare benefits are not payable for sampling by arterial puncture under item 13839 in addition to item 13870 and 13873 on the same day.

Item 13842

This item provides for intra-arterial cannulation (including ultrasound guidance) for either or both intra-arterial pressure monitoring or blood sampling.

If a service covered by item 13842 is provided outside of an ICU, in association with, for example, an anaesthetic, benefits are payable under item 13842 in addition to item 13870 and 13873 when performed on the same day.

Where this occurs, accounts should be endorsed "performed outside of an Intensive Care Unit" against item 13842.

Item 13848

Item 13848 covers management of counterpulsation by intraaortic balloon on each day and includes initial and subsequent consultations and monitoring of parameters. Insertion of the intraaortic balloon is covered under item 38609.

Items 13851 and 13854

Items 13851 and 13854 cover the management of ventricular assist devices in an ICU. Benefits are payable only once per calendar day per patient, irrespective of the number of medical practitioners involved.

Item 13851 covers management of ventricular assist devices on the first day where the ICU admission relates to the device implantation or complication. Management on each day subsequent to the first is covered under item 13854.

Item 13857

This item covers the establishment of airway access and initiation of ventilation on a patient outside intensive care for the purpose of subsequent ventilatory support in intensive care. Benefits are not payable under item 13857 where airway access and ventilation is initiated in the context of an anaesthetic for surgery even if it is likely that following surgery the patient will be ventilated in an ICU. In such cases the appropriate anaesthetic item/s should be utilised.

TN.1.11 Management and Procedures in Intensive Care Unit - (Items 13870, 13873, 13876, 13888 and 13899)

TN.1.11 Management and Procedures in Intensive Care Unit - (Items 13870, 13873, 13876, 13888 and 13899)

Medicare benefits are only payable for management and procedures in intensive care covered by items 13870, 13873, 13876, 13882, 13885 and 13888 where the service is provided by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care.

Items 13870 and 13873

Medicare Benefits Schedule fees for Items 13870 and 13873 represent global daily fees covering all attendances by the intensive care specialist in the ICU (and attendances provided by support medical personnel) and all electrocardiographic monitoring, arterial sampling and, bladder catheterisation performed on the patient on the one day. If a patient is transferred from one ICU to another it would be necessary for an arrangement to be made between the two ICUs regarding the billing of the patient.

Items 13870 and 13873 should be itemised on accounts according to each calendar day and not per 24 hour period. For periods when patients are in an ICU for very short periods (say less than 2 hours) with minimal ICU management during that time, a fee should not be raised.

Item 13876

Item 13876 covers the monitoring of pressures in an ICU. Benefits are paid only once for each type of pressure, up to a maximum of 4 pressures per patient per calendar day and irrespective of the number of medical practitioners involved in the monitoring of pressures within an ICU.

Item 11600

Item 11600 covers the monitoring of pressures outside the ICU by practitioners not associated with the ICU. Benefits are paid only once for each type of pressure, up to a maximum of 4 pressures per patient per calendar day and irrespective of the number of practitioners involved in monitoring the pressures.

Item 13899

Item 13899 covers the discussion and documentation of goals of care for a gravely ill patient lacking current goals of care by an intensive care specialist outside an Intensive Care Unit. Benefits are paid only once per patient admission (including instances of use of corresponding emergency medicine goals of care items 5039, 5041, 5042 and 5044), unless precipitated by a subsequent ICU referral or Cardiac Arrest/Medical Emergency Team call where the clinical circumstances change substantively with a resultant expectation that the original goals of care require amendment.

Item 13899 cannot be co-claimed with item 13870 or 13873 on the same day.

Notes:

“gravely ill patient lacking current goals of care” and “preparation of goals of care” are defined in the General Medical Services Table.

“gravely ill patient lacking current goals of care” means a patient to whom all of the following apply:

(a) the patient either:

(i) is suffering a life-threatening acute illness or injury; or

(ii) is suffering acute illness or injury and, apart from the illness or injury, has a high risk of dying within 12 months;

(b) one or more alternatives to management of the illness or injury are clinically appropriate for the patient;

(c) either:

(i) there is not a record of goals of care for the patient that can readily be retrieved by providers of health care for the patient and that identifies interventions that should, or should not, be made in care of the patient; or

(ii) there is such a record but it is reasonable to expect that, due to changes in the patient's condition, the goals recorded will change substantially.

"preparation of goals of care" for a patient, by a medical practitioner, means the carrying out of all of the following activities by the practitioner:

(a) comprehensively evaluating the patient's medical, physical, psychological and social issues;

(b) identifying major issues that require goals of care for the patient to be set;

(c) assessing the patient's capacity to make decisions about goals of care for the patient;

(d) discussing care of the patient with the patient, or a person (the surrogate) who can make decisions on the patient's behalf about care for the patient, and as appropriate with any of the following:

(i) members of the patient's family;

(ii) other persons who provide care for the patient;

(iii) other health practitioners;

(e) offering in that discussion reasonable options for care of the patient, including alternatives to intensive or escalated care;

(f) agreeing with the patient or the surrogate on goals of care for the patient that address all major issues identified;

(g) recording the agreed goals so that:

(i) the record can be readily retrieved by other providers of health care for the patient; and

(ii) interventions that should, or should not, be made in care of the patient are identified.

Patients could be assessed for "a life-threatening acute illness or injury" (and suspicion that alternatives to active management may be an appropriate clinical choice) through the use of tools that assist in predicting end-of-life, such as the Supportive and Palliative Care Indicators Tool (SPICTTM).

"offering reasonable options for care" means that the patient must be provided with reasonable alternatives to continued intensive/active treatment or escalation of care, including where the patient has not directly asked for such information (in recognition that patients may not ask if they are not aware of such alternatives).

"recording the agreed goals" should be undertaken using standard forms (where available) appropriate to the facility in which a patient is receiving care.

Patients with existing goals of care plans are eligible if such records cannot be readily retrieved by the medical practitioners; or if their condition has changed to the point the record does not reflect the patient's current medical condition and it is reasonable for new goals of care to be developed.

Providers of goals of care services should be appropriately trained to provide end-of-life care options and goals of care discussions.

Item 13899 should not be claimed where the goals of care are defined only in relation to a sub-set of the patient's major issues.

TN.1.12 Cytotoxic Chemotherapy Administration - (Item 13950)

Following a recommendation of a National Health and Medical Research Council review committee in 2005, Medicare benefits are no longer payable for professional services rendered for the purpose of administering microwave (UHF radiowave) cancer therapy, including the intravenous injection of drugs used in the therapy.

TN.1.14 PUVA or UVB Therapy - (Item 14050)

A component for any necessary subsequent consultation has been included in the Schedule fee for this item. However, the initial consultation preceding commencement of a course of therapy would attract benefits.

Phototherapy should only be used when:

- Topical therapy has failed or is inappropriate.
- The severity of the condition as assessed by specialist opinion (including symptoms, extent of involvement and quality of life impairment) warrants its use.

Narrow band UVB should be the preferred option for phototherapy unless there is documented evidence of superior efficacy of UVA phototherapy for the condition being treated.

Phototherapy treatment for psoriasis and palmoplantar pustulosis should consider the National Institute of Health and Care Excellence's Guidelines at www.nice.org.uk/guidance/cg153/chapter/Recommendations .

Involvement by a specialist in the specialty of dermatology at a minimum should include a letter stating the diagnosis, need for phototherapy, estimated time of treatment and review date.

TN.1.15 Laser Photocoagulation - (Items 14100 to 14124)

All laser equipment used for services under items 14100-14124 must be listed on the Australian Register of Therapeutic Goods.

The Australasian College of Dermatologists has advised that the following ranges (applicable to an average 4 year old child and an adult) should be used as a reference to the treatment areas specified in Items 14106 - 14124:

Entire forehead	50 -75 cm^2
Cheek	55 - 85 cm^2
Nose	10 -25 cm^2
Chin	10 - 30 cm^2
Unilateral midline anterior - posterior neck	60 - 220 cm^2
Dorsum of hand	25 - 80 cm^2
Forearm	100 - 250 cm^2
Upper arm	105 - 320 cm^2

TN.1.16 Facial Injections of Poly-L-Lactic Acid - (Items 14201 and 14202)

Poly-L-lactic acid is listed within the standard arrangements on the Pharmaceutical Benefits Scheme (PBS) as an Authority Required listing for initial and maintenance treatments, for facial administration only, of severe facial lipoatrophy caused by therapy for HIV infection.

TN.1.17 Hormone and Living Tissue Implantation - (Items 14203 and 14206)

Items 14203 and 14206 are not payable for artificial insemination.

TN.1.18 Implantable Drug Delivery System for the Treatment of Severe Chronic Spasticity - (Items 14227 to 14237)

Baclofen is provided under Section 100 of the Pharmaceutical Benefits Scheme for the following indications: Severe chronic spasticity, where oral agents have failed or have caused unacceptable side effects, in patients with chronic spasticity:

(a) of cerebral origin; or

(b) due to multiple sclerosis; or

(c) due to spinal cord injury; or

(d) due to spinal cord disease.

Items 14227, 14234 and 14237 should be used in accordance with these restrictions.

TN.1.19 Immunomodulating Agent - (Item 14245)

Item 14245 applies only to a service provided by, or on behalf of, a medical practitioner to administer an immunomodulating agent supplied under the pharmaceutical benefits scheme, by intravenous infusion lasting at least 2 hours. Item 14245 is applicable once per day.

These drugs are associated with risk of anaphylaxis which must be treated by a medical practitioner. For this reason a medical practitioner needs to be available at all times during the infusion in case of an emergency.

By or on behalf of

In modern practice, a nurse typically performs the administration of immunomodulating agent/s, with the medical practitioner maintaining the overall responsibility for the oversight and care of the patient.

The descriptor for item 14245 does not preclude remote or off-site administration of the immunomodulating agent. It is considered appropriate to bill item 14245 where the administration of the immunomodulating agent occurs at a location other than where the consultant physician or specialist is attending, so long as the claiming consultant physician or specialist is satisfied that the administration of the immunomodulating agent is being performed with the level of supervision which is generally accepted by the profession as necessary for the appropriate treatment of the patient. Supervision from outside of Australia is not acceptable [Refer to GN.12.31].

The specialist or consultant physician, who is undertaking or supervising the procedure, will bill the service using the provider number associated with the service location.

For item 14245, a service is taken to be rendered on behalf of a medical practitioner if, and only if, it is rendered by an appropriately qualified person who is not a medical practitioner, and who provides the service in accordance with accepted medical practice, and under the supervision of the medical practitioner.

TN.1.20 Therapeutic procedures may be provided by a specialist trainee (Items 13015 to 51318)

(1) Items 13015 to 51318 (excluding 13209 (T1) 16400 to 16500 (T4), 16590 to 16591 (T4), 17610 to 17690 (T6) and 18350 to 18373 (T11) apply to a medical service provided by;

(a) A medical practitioner, or;

(b) A specialist trainee under the direct supervision of a medical practitioner.

(2) For paragraph (1) (b), a medical service provided by a specialist trainee is taken to have been provided by the supervising medical practitioner.

(3) In this rule: Specialist trainee means a medical practitioner who is undertaking an Australian Medical Council (AMC) accredited Medical College Training Program. Direct Supervision means personal and continuous attendance for the duration of the service.

TN.1.22 Cryopreservation of semen (Item 13260)

A semen cycle collection process involves obtaining up to 3 semen samples on alternate days producing up to 50 cryopreserved straws of frozen sperm.

Maximum of two semen collection cycles, one cycle collected prior to a patient undergoing the first cytotoxic/radiation treatment and the second cycle to be collected if the patient has relapsed and requires treatment.

TN.1.23 MBS Item 13105 - Haemodialysis in very remote areas

The purpose of item 13105 is for the management of haemodialysis to a person with end-stage renal disease. The service is provided in very remote areas (defined as Modified Monash 7) 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. The service is supervised by a medical practitioner (either in person or remotely).

As a condition of receiving the Medicare-funded dialysis treatment, the patient's care must be managed by a nephrologist, with the patient being treated or reviewed by the nephrologist every 3 to 6 months (either in person or remotely).

The patient is not an admitted patient of a hospital, and the service is provided in a primary care setting.

Item 13104 should not be claimed if item 13105 is claimed.

TN.1.24 Emergency Medicine Therapeutic and Procedural Services (Items 14255 to 14288)

Items 14255, 14256, 14257, 14258, 14259, 14260, 14263, 14264, 14265, 14266, 14270, 14272, 14277, 14278, 14280, 14283, 14285 and 14288 relate to therapeutic and procedural services commonly performed in the emergency medicine setting rendered by medical practitioners who are holders of the Fellowship of the Australasian College for Emergency Medicine (FACEM) and who participate in, and meet the requirements for, quality assurance and maintenance of professional standards by the Australasian College for Emergency Medicine (ACEM).

Mirror emergency medicine therapeutic and procedural items are provided within the structure for medical practitioners who are not emergency physicians to ensure a consistent framework for all emergency services, regardless of provider type.

Group T1, Subgroup 14 items 14255 to 14288 (excluding items 14277 and 14278) must be performed in conjunction with and in addition to an emergency attendance (items 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036) by the practitioner under Group A21.

Items 14277 and 14288 (chemical or physical restraints) may be performed as a standalone service or in conjunction with an emergency attendance service in Group A21.

The following notes are provided to assist emergency physicians and medical practitioners in selecting the appropriate therapeutic or procedural item number for Medicare benefit purposes.

Resuscitation (Items 14255, 14256, 14257, 14258 and 14259)

These items include common procedures and processes involved in a resuscitation, which may include ANY of the following - rapid IV access, administration of fluid, vasopressors (via bolus or infusion), adrenaline nebulisers, use of point-of-care ultrasound in conjunction with focused assessment with sonography for trauma (FAST scan), central line access, arterial puncture and or access, ventilation, nasogastric tube insertion and in-dwelling urinary catheter insertion.

Examples of patients requiring resuscitation include: cardiac/respiratory arrest, generalised seizures, undifferentiated shock, severe sepsis +/- shock, anaphylaxis, STEMI, unstable cardiac dysrhythmias, acute stroke, perforated viscus, aortic dissection / ruptured aortic aneurysm, severe electrolyte/endocrine abnormalities (for example, DKA, hyperkalaemia).

Patients requiring resuscitation routinely require a second doctor to assist with access, airway management or other procedures as required. It is the expectation that, in cases where a second doctor is required to provide the resuscitation service, only one Group A21 emergency medicine attendance item may be billed with either the primary or secondary doctor billing a resuscitation item.

Minor Procedure (Items 14263 and 14265) and Procedures (Items 14264 and 14266)

These items account for minor procedures (14263 and 14265) and procedures (14264 and 14266) provided in conjunction with an attendance item under Group A21 and may be claimed for each minor procedure or procedure performed. Where multiple procedures are performed per patient attendance, the relevant procedure item/s may be billed more than once where clinically relevant for the appropriate treatment of the patient.

"minor procedures" could include simple foreign body removal (eg. corneal, intranasal, otic), superifical wound closure (<7cm, not of the face or neck), drainage of small abscess, incision and drainage abscess / cyst / haematoma (including Bartholin's), pulp space drainage, removal of nail of finger/ thumb/ toe, incision of thrombosed external haemorrhoid, rectal prolapse reduction, bladder aspiration (suprapubic tap), passage of urethral sounds, paraphimosis reduction, sigmoidoscopy, simple wound dressings, burns dressings (<5% BSA)

"procedures" could include removal of foreign body from the ear or subcutaneous tissue (incision / closure), superficial laceration repair of the face / neck (including ear, eyelid, lip, nose) or of >7cm elsewhere on body, management of deep/ contaminated wound requiring debridement under general anaesthetic or field block, femoral nerve block, epistaxis cautery / packing, suprapubic cystotomy / catheter, cardioversion / defibrillation, thoracic cavity aspiration for diagnostic purposes, intercostal drain insertion, PEG tube replacement, laryngoscopy (including fibreoptic), nasendoscopy, priapism decompression, abdominal paracentesis, complex wound dressings, burns dressings (>5% BSA)

Management of Fractures (Items 14270 and 14272)

Items 14270 and 14272 are for fracture or dislocation diagnosis and management, excluding aftercare and performed in conjunction with an attendance item under Group A21.

All fractures are billed the same EXCEPT for fractures that are managed as soft tissue injuries which are NOT billed (for example, phalangeal tuft fractures, lateral malleolar tip avulsions). More complex fractures (for example, stable spinal fractures and multiple rib fractures) are included as fractures for billing purposes due to the multiple facets required to manage these injuries.

For fracture/dislocations requiring reduction (in addition to cast immobilisation) then a procedure item (14263, 14264, 14265 or 14266) may also be billed.

Where a patient presents with multiple fractures, the relevant fracture item/s may be billed more than once per attendance where clinically relevant for the appropriate treatment of the patient.

Chemical or Physical Restraints (Items 14277 and 14278)

Items 14277 and 14278 are for the application of chemical or physical restraints, where an acute severe behavioural disturbance necessitates involuntary management with a team-based approach and chemical and / or physical restraints (limited) and / or one on one nursing care to ensure the safety of the patient. Chemical or physical

restraints may be performed as a standalone service or in conjunction with an emergency attendance item under Group A21.

Anaesthesia (Items 14280 and 14283) and Emergent Intubation (Items 14285 and 14288)

The anaesthesia items (14280 and 14283) account for all services that would otherwise be billed under the anaesthetic items in the MBS, including the pre anaesthetic consultation, the associated procedure, and any loadings / add-ons (such as duration of anaesthesia or the ASA classification of the patient). Anaesthesia items assume an average of 20 minutes anaesthesia, and an average ASA 3 classification, in an emergent and / or after-hours context.

Emergent intubation items (14285 and 14288) include endotracheal intubation, LMA insertion, front-of-neck access, and insertion of adjunctive airway devices (oro/nasopharyngeal airways).

Patients requiring procedural sedation or emergent intubation/airway management routinely require a second doctor to assist with access, airway management or other procedures as required. It is the expectation that, in cases where a second doctor is required to provide the anaesthesia or intubation service, only one Group A21 emergency medicine attendance item may be billed with either the primary or secondary doctor billing the procedural item.

Items under Subgroup 14 with the 'Anaesthesia' notation allow for Medicare benefits to be paid for a second medical practitioner to provide the anaesthesia service. Where the anaesthesia service is provided by an emergency physician or medical practitioner, anaesthesia items 14280 and 14283 would be claimed. Specialist anaesthetists may not claim items 14280 and 14283 but would provide the service under a relative value guide episode in T7 or T10 of the GMST.

TN.1.25 Extracorporeal photopheresis for treatment of cutaneous T-cell lymphoma

A response, for the purposes of administering MBS item 14249, is defined as attaining a reduction of at least 50% in the overall skin lesion score from baseline, for at least 4 consecutive weeks. Refer to the Product Information for methoxsalen for directions on calculating an overall skin lesion score. The definition of a clinically significant reduction in the Product Information differs to the 50% requirement for MBS-subsidy. Response only needs to be demonstrated after the first six months of treatment.

TN.1.26 In vitro processing with cryopreservation of bone marrow or peripheral blood

MBS benefits for autologous stem cell transplantation are only available for patients with aggressive malignancy or one which has proven refractory to prior treatment. Patients should also meet the criteria for treatment according to:

Updated Indications for Immune Effector Cell Therapy: 2023 Guidelines from the American Society for Transplantation and Cellular Therapy

Indications for haematopoietic cell transplantation for haematological diseases, solid tumours and immune disorders: current practice in Europe, 2022

In addition, the treatment should be authorised and overseen by a multidisciplinary cancer team.

TN.1.27 Appropriate billing of item 13950 – parenteral administration of antineoplastic agents

Intent

The intent for item 13950 is to provide services through Medicare for private patients undergoing antineoplastic therapy. Specifically, Medicare benefits will be paid under item 13950 where the patient is administered with an antineoplastic agent or agents via parenteral route, by or on behalf of a specialist or consultant physician, for antineoplastic treatment (including; cytotoxic chemotherapy and monoclonal antibody therapy).

Item 13950 is not intended for treatment via the administration of agents used in anti-resorptive bone therapy or hormonal therapy.

For the purpose of claiming benefits under MBS item 13950, administration of antineoplastic agent/s commences with the establishment of the parenteral route, and ends with the disconnection of the infusion, regardless of the time expired between the commencement and end.

Irrespective of the number of antineoplastic agents administered, medical practitioners can only bill item 13950 once each time the patient presents for treatment, but may be billed on successive treatment days.

Further information relating to antineoplastic therapy services listed on the MBS can be directed to the Department of Health, Disability and Ageing's AskMBS e-mail service at askmbs@health.gov.au. AskMBS responds to enquiries from providers who seek advice on interpretation of MBS items, explanatory notes and associated legislation. The advice is intended to assist health professionals, practice managers and others to understand and comply with MBS billing requirements. AskMBS works closely with policy areas within the Department of Health, Disability and Ageing, and with Services Australia, to ensure enquirers receive accurate, authoritative and up-to-date information.

Administration
Parenteral administration refers to the delivery of a therapeutic agent via injection, as opposed to administration via the alimentary tract or topically (e.g. application of creams or ointments).

Examples of suitable parenteral routes for the administration of cytotoxic chemotherapy and/or monoclonal antibody therapy include:

intravascular;
intramuscular;
subcutaneous;
intrathecal; and
intracavitary.

Multiple instances of administration in a single day
Item 13950 covers the administration of one or more antineoplastic agents, and whilst it is not expected that there would be multiple claims for item 13950 on the one day, there are clinical instances where this might occur. In these circumstances, the medical practitioner will need to assure themselves that these instances represent separate and distinctly relevant services and annotate the patients account or Medicare claim form that the services were 'separate occasion', 'separate attendance' or 'separate times' for multiple services provided on the same day'.

Irrespective of the number of antineoplastic agents administered, medical practitioners can only bill item 13950 once each time the patient presents for treatment.

Professional Attendances
An appropriate professional attendance item (such as item 116 for example) may be co-claimed with item 13950, so long as the provisions of the professional attendance are met. For example, in situations where the patient requires ongoing medical practitioner oversight, as a result of ongoing clinical consequences or side effects of the antineoplastic therapy, then the billing of a professional attendance item would be considered appropriate.

Item 13950 should not be claimed in circumstances where the physical act of parenteral administration of antineoplastic agents does not take place. For example, where a patient is admitted to hospital for a period of several days, the oversight of the patient, post administration of an antineoplastic agent/s, is more appropriately covered under a professional attendance item (so long as the provisions of the professional attendance item are met).

By or on behalf of
In modern practice, a nurse typically performs the administration of antineoplastic agent/s, with the medical practitioner maintaining the overall responsibility for the oversight and care of the patient.

The descriptor for item 13950 does not preclude remote or off-site administration of antineoplastic therapy. It is considered appropriate to bill item 13950 where the administration of the antineoplastic agent or agents occurs at a location other than where the consultant physician or specialist is attending, so long as the claiming consultant physician or specialist is satisfied that the administration of the antineoplastic therapy is being performed with the

level of supervision which is generally accepted by the profession as necessary for the appropriate treatment of the patient. Supervision from outside of Australia is not acceptable [Refer to GN.12.31].

The specialist or consultant physician, who is undertaking or supervising the procedure, will bill the service using the provider number associated with the service location.

For item 13950, a service is taken to be rendered on behalf of a medical practitioner if, and only if, it is rendered by another person who is not a medical practitioner, and who provides the service in accordance with accepted medical practice, and under the supervision of the medical practitioner.

Accessing long-term implanted delivery devices
Accessing a long-term implanted device, such as a peripherally inserted central catheter (PICC) line, for the purpose of administering an antineoplastic agent at the time of administering the antineoplastic agent, is considered an integral component of this service, and therefore should not receive a separate MBS benefit. Item 14221 cannot be claimed in these circumstances.

Providers should note that the fee for item 13950 includes a component for accessing a long-term implanted drug delivery device when administering antineoplastic agents, and should be mindful of this when billing patients for services not specifically listed on the MBS. Note that billing against item 14221, for any reason (e.g. flushing or taking of bloods), is not permitted when the device is accessed for the purpose of delivering the service associated with item 13950.

However, it is recognised that the clinical need for access to an implanted device exists beyond the administration of antineoplastic therapy, for example, flushing a long-term intravascular access device in order to maintain patency during prolonged periods of disuse or giving antibiotic therapy or transfusing blood products or taking a blood sample. Billing against item 14221, in these situations, is considered clinically relevant and appropriate, so long as these services are not associated with the visit by the patient for a course of antineoplastic therapy under item 13950.

Where item 14221 is claimed on the same day as item 13950 for a separate and distinct clinically relevant service, the account for item 14221 must be annotated with ‘separate attendance’ or ‘separate service’ to enable the claim to be appropriately assessed. It would be expected that the account would be annotated with time of the attendances to demonstrate that separate services were provided to the patient.

Pumps and other devices
The loading of pumps, reservoirs or ambulatory drug delivery devices can be billed under item 13950 (so long as the conditions described in the item descriptor are met). For the purpose of claiming benefits under MBS item 13950, administration of antineoplastic agent/s commences with the establishment of the parenteral route, and ends with the disconnection of the infusion, regardless of the time expired between the commencement and end.

Irrespective of the number of antineoplastic agents administered, medical practitioners can only bill item 13950 once each time the patient presents for treatment.

Under the MBS, there is no item that specifically covers the disconnection of a pump or device as part of or following the administration of antineoplastic agents.

Item 14221 was amended on 1 November 2020 to clarify that it cannot be claimed in association with the administration of antineoplastic agents for which item 13950 is being claimed, as the MBS fee for item 13950 contains a component to cover accessing of a long-term implanted device for delivery of therapeutic agents.

Item 13950 cannot be claimed where the patient is receiving the infusion at home via a pre-loaded pump or ambulatory delivery device.

If, at the attendance to disconnect a pump or device, the practitioner further administers antineoplastic agents under a service described by item 13950, then item 13950 may be claimed for that episode of treatment. The administration of antineoplastic agents during the attendance to disconnect the pump or device is considered a separate attendance from the claim associated with the initial loading of the pump or device. Item 14221 cannot be claimed in these circumstances, as item 14221 cannot be claimed in association with a claim for item 13950.

Alternatively, if at the attendance to disconnect a pump or device there is no service provided under item 13950 (i.e. no further administration of antineoplastic agents), then item 14221 may be claimed for a service associated with the accessing of a long-term implanted device for delivery of therapeutic agents, but only under circumstances where the long-term implanted device is accessed for the purpose of delivery of therapeutic agents (e.g. line maintenance for future access). Item 14221 should not be claimed merely for the disconnection of the device.

Therapies
The parenteral administration of antineoplastic agents, including cytotoxic chemotherapy and monoclonal antibody therapy, can be claimed under item 13950.

Item 13950 cannot be used for claims related to the administration of pharmaceuticals used as part of hormonal therapy nor for the administration of colony-stimulating factors. Also, the administration of anti-resorptive bone therapy is not covered under item 13950.

The administration of pharmaceuticals given as part of a treatment regimen for a non-malignant disease cannot be claimed under item 13950. For example, item 13950 cannot be used for claims related to the treatment of multiple sclerosis or for the treatment of arthritis.

TN.1.28 Repetitive Transcranial Magnetic Stimulation items 14216, 14217, 14219 and 14220

TN.1.28 Repetitive Transcranial Magnetic Stimulation (rTMS) therapy items (14216, 14217, 14219 and 14220)

Items for Initial course of repetitive transcranial magnetic stimulation (rTMS):

· Item 14216 - prescription and treatment mapping of an initial course of treatment provided by a psychiatrist with appropriate training in rTMS.

· Item 14217 - delivery of an initial course of rTMS treatment of up to 35 sessions provided by, or on behalf of, a psychiatrist with appropriate training in rTMS.

Items for retreatment course of rTMS:

· Item 14219 - prescription and mapping of a retreatment course of rTMS treatment by a psychiatrist with appropriate training in rTMS.

· Item 14220 - delivery of a retreatment course of rTMS treatment of up to 15 sessions provided by, or on behalf of, a psychiatrist with appropriate training in rTMS.

Referral

Referral for item 14216 should be through a GP or a psychiatrist. Where there is an existing therapeutic relationship between the patient and the rTMS-trained psychiatrist, no additional referral is required.

Patient Eligibility

Practitioners should have regard to the relevant diagnostic criteria set out in the International Statistical Classification of Diseases and Related Health Problems – 11th Revision (ICD-11) and the Diagnostic and Statistical Manual of the American Psychiatric Association – Fifth Edition (DSM-5). Major Depressive Disorder is defined as an episode of depression that lasts at least two weeks with marked impairment.

Eligibility for item 14216 requires trialling of each antidepressant medication at the recommended therapeutic dose for a minimum of 3 weeks. While this is the minimum period required, practitioners should have regard to the RANZCP's clinical guidance, noting trialling of each antidepressant medication at the recommended therapeutic dose for a minimum of 4 weeks (with no response) and 6-8 weeks (where there has been a partial response).

Practice should further be guided by the RANZCP Professional Practice Guidelines for the administration of repetitive transcranial magnetic stimulation.

Where can rTMS services be provided?

While clinical advice indicates that the majority of rTMS services will not require hospital treatment and can be provided on an outpatient basis or in consultation rooms, there will be circumstances where some patients may require hospital treatment. Medicare benefits will apply in both circumstances for eligible patients.

Where rTMS treatment is to be provided as part of hospital treatment (i.e. as an inpatient), the psychiatrist will need to provide written certification that hospital treatment is required for the patient in order for hospital accommodation and other private health insurance benefits to be paid. This is an important requirement under the *Private Health Insurance (Benefit Requirements) Rules 2011* (the Rules).

The rTMS MBS items have a 'Type C' private health insurance procedure classification. Type C procedures are those not normally requiring hospital treatment under the Rules. However, the Rules allow for hospital accommodation and other private health insurance benefits to be paid for Type C procedures if certification is provided.

The medical practitioner (psychiatrist) providing the professional service must certify in writing that, because of the medical condition of the patient or because of the special circumstances specified, it would be contrary to accepted medical practice to provide the procedure to the patient except as hospital treatment in a hospital.

To assist psychiatrists, the Department has published further guidance on the type of information required in a Type C certification on the MBS online website found at MBSonline.

Provider Eligibility and Training Requirements

Providers who can bill these items

These MBS services may only be provided by a psychiatrist, or health care professional on behalf of a psychiatrist, who has undertaken rTMS training.

Prescription and mapping services (items 14216 and 14219) must be personally performed by the psychiatrist trained in rTMS.

Treatment services (14217 and 14220) can be performed by a psychiatrist trained in rTMS, or a health care professional on behalf of the psychiatrist.

Requirements of the health care professional providing rTMS on behalf of the psychiatrist:

A health care professional may include a nurse practitioner, practice nurse or an allied health professional who is trained in the provision of rTMS treatment.

The health care professional performing rTMS treatment services "on behalf of" the psychiatrist should either:

- Be employed by the psychiatrist, or
- Supervised by the psychiatrist, in accordance with accepted medical practice.

It is the responsibility of the prescribing psychiatrist trained in rTMS to ensure that the health professional providing the treatment on behalf of the psychiatrist is appropriately and formally trained in rTMS. Records must be kept to demonstrate that all health care professionals providing rTMS services are appropriately trained.

In line with good practice, the psychiatrist should be available to provide advice as required during treatment and this supervision could be provided from a physician distance (this could be by phone). When rTMS services are provided on behalf the psychiatrist, the psychiatrist continues to remain responsible for planning and monitoring treatment outcomes.

Training requirements

The training requirements for psychiatrists have been endorsed through the Royal Australian and New Zealand College of Psychiatrists (RANZCP). RANZCP-endorsed training courses can be found on the RANZCP website here.

All providers will be subject to ongoing Continuing Professional Development (CPD) requirements set by the RANZCP.

Co-claiming with other items

The following services may be claimed on the same day:

· Prescription and mapping of an initial course of treatment (14216) and the first service in the delivery of treatment (14217).

· Prescription and mapping of a course of retreatment (14219) and the first service in the delivery of retreatment (14220).

MBS item 14217 can be claimed more than once on the same day if deemed clinically appropriate and in line with RANZCP Professional Practice Guidelines.

MBS item 14220 can be claimed more than once on the same day if deemed clinically appropriate and in line with RANZCP Professional Practice Guidelines.

Further Information

Further information about the MBS items and provision of rTMS services is available on the MBS Online website at MBS Online under 'Fact Sheets'. The information on the website may be updated from time to time in response to questions or feedback from providers, patients and other stakeholders.

TN.1.29 Extracorporeal Photopheresis (ECP) for Chronic Graft Versus Host Disease (cGVHD)

For the purpose of administering MBS item 13761 the phrase 'treatment cycle' usually refers to a 12-week time period and item 13762 usually refers to a 6-week time period. A 'treatment session' is an attendance for ECP, which occurs two or three times per week.

A cycle of treatment funded under item 13762 can be preceded by a cycle funded by either item 13761 or by item 13762, provided at least a partial organ response occurs. A response, for the purposes of administering MBS item 13762, is defined as attaining a complete or partial response in at least one organ according to National Institutes of Health (NIH) criteria. A response only needs to be demonstrated after the first 12 weeks of treatment.

Patient Requirements

For the purpose of administering MBS item 13761 and item 13762, steroid-refractory or steroid-dependent disease is defined as one of the following:

a. A lack of response or disease progression after a minimum of prednisone 1 mg/kg/day or equivalent for at least 1 week, OR
b. Disease persistence without improvement despite continued treatment with prednisone at > 0.5 mg/kg/day or 1 mg/kg every day or equivalent other day for at least 4 weeks, OR
c. Increase to prednisolone dose to > 0.25 mg/kg/day or equivalent after 2 unsuccessful attempts to taper the dose.

TN.2.1 Meaning of megavoltage complexity levels

Level 1.1 Items (Simple or Single Field)

In items 15902 and 15930: Simple or single-field complexity external beam radiation therapy is localised, planned and delivered through a clinical mark-up process without the requirements of simulation, computer or volumetric

dosimetry and beam modulation. Patient stabilisation is simple using standard devices. Determination of the treatment volume is by clinical assessment and mark-up with the prescribed dose identified on the surface or at depth. Single-field delivery via wide margins determined through the clinical assessment process will not require image verification. The final dosimetry plan is validated by a radiation therapist or medical physicist, using quality assurance processes, with the plan approved by the radiation oncologist prior to delivery.

Level 1.2 Items (Two-Dimensional Simple or Multiple Field)

In items 15904 and 15932: Simple or multiple-field complexity external beam radiation therapy is localised through a process of either two-dimensional simulation or three-dimensional simulation from an appropriate imaging dataset to identify the treatment region. Patient stabilisation is simple using standard devices.

Planning is based on two-dimensional planning processes with simple beam shaping but no modulation or inverse planning requirements, optimisation is not required on organs at risk. Multiple-field delivery via multileaf collimator (MLC) shaped beams requires verification. The final dosimetry plan is validated by a radiation therapist or medical physicist, using quality assurance processes, with the plan approved by the radiation oncologist prior to delivery.

Level 2.1 Items (Three-Dimensional without motion management)

In items 15906 and 15934: Three-dimensional standard or multiple-field complexity external beam radiation therapy is localised through a process of three-dimensional simulation (plain film views or volumetric delineation) to identify the treatment region and organs at risk.

Planning is based on three-dimensional planning processes with simple beam shaping and simple modulation (large-segment field in field, wedges, MLCs or tissue compensation) to deliver a conformal dose distribution and assessment of dose to organs at risk. Multiple-field delivery via MLC shaped beams requires image verification. Examples include three-dimensional planned spine treatments (single or opposed fields) breast tangents without target volumes definition, and image-based planning for electrons. The final dosimetry plan is validated by a radiation therapist or medical physicist, using quality assurance processes, with the plan approved by the radiation oncologist prior to delivery.

Level 2.2 Items (Three-Dimensional with motion management)

In items 15908 and 15936: Three-dimensional complex or multiple-field complexity external beam radiation therapy is localised through a process of three or four-dimensional (three-dimensional volumetric delineation or four-dimensional volumetric delineation with consideration of tumour and organs at risk excursion) simulation to identify the treatment region and organs at risk. Patient stabilisation requires the use of devices to support positional reproducibility. Motion management includes four-dimensional CT, deep inspiration breath hold, deep expiration breath hold, use of manual compression and other methods to account for tumour movement.

Planning is based on three or four-dimensional planning processes with complex beam shaping and modulation (MLC or small-segment field in field) to deliver a conformal dose distribution and assessment and management of dose to organs at risk. Multiple-field delivery via MLC shaped beams requires daily image verification prior to treatment delivery. Consideration for re-planning is not required. The final dosimetry plan is validated by a radiation therapist or medical physicist, using quality assurance processes, with the plan approved by the radiation oncologist prior to delivery.

Level 3.1 Items (Standard IMRT Multiple Field)

In items 15910 and 15938: Standard inverse planned intensity modulated radiation therapy (IMRT) to a single dose level prescription and without motion management is localised through a three-dimensional imaging dataset to identify clinical and planning targets, organs at risk and normal tissue.

Planning is based on delivery to a single-dose level target and includes optimisation of the dose based on assessment of organs at risk doses. This technique involves very sharp dose gradients adjacent to both targets and organs at risk, increasing the consequences of any geometric uncertainty, making daily treatment image verification (Image-guided radiation therapy—IGRT) an essential component of quality IMRT. It is the tumour location, adjacent organs and

dosimetry that define the appropriate role for IMRT and support an approach where the clinical circumstances, rather than specific diagnoses, are the most important determinants for using IMRT. Final dosimetry plan is validated by both the radiation therapist and medical physicist, using quality assurance processes, with the plan approved by the radiation oncologist prior to treatment delivery.

Level 3.2 Items (Complex IMRT Multiple Field)

In items 15914 and 15940: Complex inverse planned intensity modulated radiation therapy (IMRT) to multiple-dose level prescription or IMRT with motion management is localised through three or four dimensional (volumetric imaging) to identify clinical and planning targets, organs at risk and normal tissue (and tumour and organs at risk excursion in the case of four-dimensional applications).

Planning is based on delivery to multiple-dose level targets or IMRT with motion management and includes optimisation of the dose based on assessment of organs at risk. This technique involves very sharp dose gradients adjacent to both targets and organs at risk, increasing the consequences of any geometric uncertainty, making daily treatment verification (Image-guided radiation therapy—IGRT) an essential component of quality IMRT. In the case of four-dimensional applications, treatment delivery utilises some form of motion management and further complicates the planning, delivery and quality assurance processes. Motion management includes four-dimensional volumetric imaging, deep inspiration breath hold, deep expiration breath hold, use of manual compression and other methods to account for tumour movement. It is the tumour location, adjacent organs and dosimetry that define the appropriate role for IMRT and support an approach where the clinical circumstances, rather than specific diagnoses, are the most important determinants for using IMRT. Pre-treatment quality assurance validation will be required and consideration for re-planning is included. Final dosimetry plan is validated by both the radiation therapist and medical physicist, using quality assurance processes, with the plan approved by the radiation oncologist prior to treatment delivery. Small-field fractionated treatment strategies (using either an IMRT or multiple, non-coplanar, rotational or fixed beam delivery) are included in this complexity level.

Level 4 Items (Intracranial Stereotactic Radiation Therapy)

In items 15918 and 15942: Stereotactic radiation therapy delivered using a Therapeutic Goods Administration approved device using specifically calibrated small fields. Dedicated and customised patient positioning, immobilisation and imaging for identification of the treatment volume, surrounding organs at risk and normal tissue. Where relevant formal structured assessment of motion and patient suitability for complex and lengthy delivery may include fixed head frame. Lengthy treatment sessions may require patient education to support positional and physiological control requirements. Dosimetry delivers small-field collimation and shaping of the dose to complex targets. Pre-treatment quality assurance validation will be required and consideration for re-planning is included. Very tight margins and steep dose gradients mandates the use of daily IGRT. Final dosimetry plan is validated by both the appropriately qualified radiation therapist and medical physicist, using quality assurance processes, with the plan approved by the radiation oncologist prior to treatment delivery.

Level 4 Items (Stereotactic Body Radiation Therapy)

In items 15920 and 15944: Stereotactic body external beam radiation therapy with or without motion management is localised through a three or four-dimensional simulation to identify clinical and planning targets, organs at risk and normal tissue (and excursion of tumour and organs at risk in the case of four-dimensional applications). Requires dedicated and personalised patient positioning and immobilisation and multi-modality image based targeted identification of the treatment volume, surrounding organs at risk and normal tissue. Lengthy treatment sessions may require patient education to support positional and physiological control requirements. Motion management includes four-dimensional CT, deep inspiration breath hold, deep expiration breath hold, use of manual compression and other methods to account for tumour movement.

Stereotactic body radiation therapy (SBRT) and stereotactic ablative radiation therapy (SABR) are used interchangeably and are defined as high precision, image-guided radiation therapy (IGRT) dose delivery with highly conformal dose and steep dose gradients, with larger doses per fraction, fewer treatments as determined by standard clinical protocols, eg. 5 for prostate treatments or 8 for central lung treatments and including intrafraction motion management where applicable.

For stereotactic treatments this requires on the first day of treatment, a radiation oncologist or trained delegate with documented competencies in stereotactic treatments must be present at the start of the treatment fraction (prior to irradiation) to verify the integrity of the patient set-up at the treatment machine, patient repositioning using image guidance, and directly manage any clinical issues. For subsequent fractions in the same course, the radiation oncologist must be immediately available for critical decision making. Patient specific pre-treatment quality assurance validation may be required and consideration for re-planning and is included. Very tight margins and steep dose gradients mandates the use of daily IGRT. Final dosimetry plan is validated by both the appropriately qualified radiation therapist and medical physicist, using quality assurance processes, with the plan approved by the radiation oncologist prior to delivery.

Level 5 Items (Specialised)

In items 15924, 15926, 15946 and 15948: Patient acuity requires multidisciplinary medical and technical support during the simulation and treatment processes (for example, general anaesthetic for complex cases or monitoring for patients receiving Total Body Irradiation). Complex dosimetry requirements are driven by large field or large volume requirements in total skin electron therapy (TSE) or total body irradiation (TBI) cases and highly personalised dosimetry requirements with younger paediatric patients, and patients requiring general anaesthetic or supervised sedation. Clinical and Technical complexity requires prolonged, complex multidisciplinary team involvement and direct involvement in the treatment delivery process; including in vivo dosimetry. Patient specific complex quality assurance validation pre-treatment and during treatment is required and consideration for re-planning is included. Final dosimetry plan is validated by both the radiation therapist and medical physicist, using quality assurance processes, with the plan approved by the radiation oncologist prior to delivery.

Radiation therapy treatment and replanning to correspond with planning

The complexity level of the treatment regimen must be appropriate for the plan (or replan). Accordingly, treatment items must not be billed at higher levels than the complexity level associated with planning (or replanning) item for that site.

Where planning/replanning/treatment is for multiple sites, each site must be clearly identified and differentiated by name in billing notes.

TN.2.2 Megavoltage planning

Megavoltage planning

Megavoltage radiation therapy planning – multiple sites (items 15902 – 15910, 15914, 15920, 15924, 15926)

One plan only will attract Medicare benefits in a course of treatment. Benefits are payable however for further planning items where planning is undertaken for a synchronous primary or different tumour site to that (or those) specified in the original prescription by the radiation oncologist. Sites must be uniquely identified in billing notes.

For intracranial stereotactic planning (item 15918), ‘intracranial’ is considered to be a single site.

Megavoltage radiation therapy re-planning (items 15912, 15916, 15922, 15928)

Only one dosimetry re-plan is payable during the treatment course (at 50% of the Schedule Fee for the associated item) and the clinical need for re-planning must be consistent with the guidance provided in the item descriptor and clearly documented in the patient’s record.

Protocols for documenting quality assurance processes for treatment plans

Treatment plans should be produced using quality assurance processes to ensure, where appropriate:

a. Data within the oncology information system is accurate; and
b. Data transfer to the Oncology Information System has been completed without any loss of data integrity; and

c. The plan is deliverable without loss of dosimetric accuracy on the radiation therapy apparatus which will be used for clinical delivery (including particular consideration given to geometric accuracy where tight margins or steep dose gradient are employed); and
d. The dose calculation of the treatment plan (including on the patient planning images) is accurate; and
e. The accuracy of any image fusions performed; and
f. The final treatment plan is validated by a radiation therapist or medical physicist, using quality assurance processes, with the plan approved by the radiation oncologist prior to delivery.

The quality assurance processes should be established, maintained and performed by radiation therapists and medical physicists and should be formally documented.

Protocols for documenting quality assurance processes for treatment re-plans

In addition to protocols for documenting quality assurance processes for treatment plans, treatment re-plans can only be performed if:

a. An initial treatment plan has been prepared in accordance with an item descriptor of the same complexity or higher; and
b. Treatment adjustments to the original plan are inadequate to satisfy treatment protocol requirements.

Image Fusion

Where appropriate, when determining the target volumes and organs at risk for treatment, relevant multi-modality imaging should be used to delineate targets and organs at risk.

TN.2.3 Megavoltage treatment

Treatment of multiple sites at one attendance (15930 - 15940, 15948)

Where patients are being treated with radiation therapy to multiple separate sites of disease at one attendance, each treatment site must be documented in a separately prescribed plan. Sites must be clearly identified and differentiated with a unique name in billing notes.

Intracranial stereotactic radiation therapy (item 15942) is applicable once per day.

Stereotactic body radiation therapy (item 15944) is applicable once per day per site, for a maximum of 2 sites. When multiple plans are to be delivered to more than 2 sites in the same time frame, treatments to additional sites can be billed if delivered on different days.

Definition of multiple treatment sites

1. locoregional and/or distant disease under one diagnosis treated under multiple separate prescription plans, or
2. synchronous primaries with each treatment prescribed under separate diagnosis.

Twice-daily treatments of the same site (15930 - 15940, 15948)

Where a patient is required to have two treatments to the same site using the same treatment plan on the same day, the second treatment is only payable where the treatments are separated by an appropriate time interval. There must be clinical justification documented in the patient's medical record. Examples include where patients are being treated with accelerated radiation therapy protocols or to compensate for missed treatment days.

Treatments requiring general anaesthetic

Items 15924 and 15946 apply to all patients requiring general anaesthetic or sedation supervised by an anaesthetist for treatment delivery. For patients who do not require general anaesthetic or supervised sedation, other appropriate items should be used.

Radiation oncologist attendance

For all treatments, a radiation oncologist should be available to physically review patients when required.

For complex treatments, a radiation oncologist should be immediately available for critical decision making.

For highly complex treatments, such as stereotactic treatments, a radiation oncologist or trained delegate with documented competencies in stereotactic treatments should be present at the start of the treatment fraction (prior to irradiation) to verify the integrity of the patient set-up at the treatment machine, patient repositioning using image guidance, and directly manage any clinical issues. If delegated to a competent non-radiation oncologist, a competent radiation oncologist must be immediately available for critical decision making.

Motion management

Motion management is the use of additional technology to ensure the dose to the target is not compromised by physiological motion, or the dose to a critical organ-at-risk adjacent to the target is minimised. This includes:

a. Reducing physiological motion (for example breath hold); or
b. Quantifying physiological motion (for example 4D-CT or 4D-CBCT); or
c. Using technology to detect motion and actively control treatment or simulation.

Treatment and planning are defined as using motion management only when they are used to manage clinically relevant motion of the target or organs at risk. In the absence of clinically relevant physiological motion of the target or organs at risk being managed, motion management should not be used to define higher planning or treatment complexity. Set-up strategies and immobilisation are not considered motion management.

For example, gated treatment as management for liver motion is considered motion management. However, strategies to reduce intrafraction and set up variability for a bone metastasis in the pelvis are not considered motion management.

TN.2.4 Kilovoltage planning and treatment

Planning and treatment of multiple sites (items 15950, 15952, 15954)

Where patients are being treated with radiation therapy to multiple separate sites of disease at one attendance, each treatment site must be documented in a separately prescribed plan. Each site must be clearly identified and differentiated with a unique name in billing notes.

Kilovoltage treatment (15952, 15954, 15956)

15952 is billed when one site only is being treated at the attendance.

Treatment to 2 or more sites during the same attendance should be billed as follows:

- 15952 for the first site, and
- 15954 for each additional site

15956 is billed when treatment is delivered to orbital structures where there is placement of an internal eye shield. Items 15952 and 15954 cannot be billed for treatment to orbital structures.

Planning validation

The final treatment plan is validated by a radiation therapist or medical physicist, using robust quality assurance processes, with the plan approved by the radiation oncologist prior to delivery.

TN.2.5 Brachytherapy items 15958-15984

Multiple services per attendance

For each attendance multiple services may be delivered, including:

a. insertion of the applicator;
b. simulation and dosimetry;
c. treatment;
d. verification; and
e. re-planning, if required.

Final dosimetry plans must be independently validated and documented by two qualified staff (radiation therapist or medical physicist), using quality assurance processes, with the plan approved by the radiation oncologist prior to the delivery, which must include ensuring data transfer is acceptable and validation checks are completed.

Multi-disciplinary team involvement in applicator insertion – Items 15958-15968

Multi-disciplinary team involvement may be required for items relating to applicator insertion (Items 15958-15968). This may include a:

a. Gynaecological oncologist; or
b. Urologist; or
c. Breast surgeon; or
d. Thoracic surgeon; or
e. Vascular surgeon; or
f. Gastro-intestinal surgeon; or
g. Plastic surgeon; or
h. General surgeon; or
i. Interventional radiologist; or
j. Ophthalmic surgeon.

Brachytherapy examples

15962 – an example of an endocavity applicator could be a single channel rectal tube

15964 - an example of a hybrid intracavitary and interstitial or multi-catheter applicators, could be a multi-channel cylinder for vaginal or rectal treatment.

15968 - radioactive sources for permanent implants, for example lung.

15970 – Examples of simple level dosimetry plans prescribed to surface or depth from catheter and library plans, could include:

a. intracavitary vaginal vault with cylinder or ovoids or ring; or
b. intracavitary cervix 1, 2 or 3 channels; or
c. intraluminal single lines, for example, for treatment of carcinoma of the bronchus.

15974 - Intermediate level dosimetry is for plans that have three-dimensional image datasets acquired as part of simulation, and could include any of the following:

a. intracavitary intrauterine tubes and vaginal ovoids (T&O); or
b. intracavitary intrauterine tubes and vaginal ring (T&R); or
c. intracavitary intrauterine tubes and vaginal cylinder (T&Cyl); or
d. intracavitary vaginal cylinder; or
e. intracavitary vaginal mould; or
f. Intracavity vaginal ovoids; or
g. endocavity: single catheter balloon, single channel applicator; or
h. intraluminal brachytherapy; or
i. endovascular brachytherapy; or
j. surface (simple mould) brachytherapy.

15978 - Complex level dosimetry is for plans that contain multiple needles or catheters or radiation sources, for example:

a. hybrid intracavitary and interstitial applicators using:
    i. intrauterine tubes and vaginal ovoids (T&O) with needles; or
    ii. intrauterine tube and vaginal ring (T&R) with needles; or
    iii. intrauterine tubes and vaginal multichannel cylinder (T & VMC); or
b. vaginal multichannel cylinder (VMC); or
c. endocavity brachytherapy using a multi-catheter strut device or rectal multi-catheter device; or
d. interstitial brachytherapy, including anatomical sites such as vagina, prostate, breast, soft tissue; or
e. surface brachytherapy, including complex circumferential moulds or moulds with undulating or uneven contours.

TN.2.6 Low dose rate brachytherapy – Item 15966

Low dose rate brachytherapy prostate implants must be performed at an approved site in association with a urologist.

Item 15966 may be claimed for the implantation of low dose rate brachytherapy prostate implants when the service is performed at an approved site in association with a urologist. A radiation oncologist must be present in person in addition to the urologist at the time of the service.

TN.2.10 Guidance for claiming multi-site and twice-daily radiation therapy items

This guidance provides details on billing information required by Services Australia to support the processing of Medicare claims for twice-daily treatments and claims for planning and treating multiple sites.

Claiming planning items for multiple sites (megavoltage items 15902-15910, 15914, 15920, 15924, 15926 and kilovoltage item 15950)

One plan only will attract Medicare benefits in a course of treatment.

Benefits are payable however for further planning items where planning is undertaken for another tumour site to that (or those) specified in the original prescription by the radiation oncologist.

To attract Medicare benefits, the claim for each planning item must uniquely identify the tumour site in the corresponding claiming/billing note for that claim (see below).

For intracranial stereotactic planning (item 15918), ‘intracranial’ is considered to be a single site (the cranium being defined as everything inside the bones of the skull).

Structures outside the cranium – including the bones of the skull, the scalp, and skin overlying the scalp - may have multiple sites requiring separate plans.

Claiming treatment items for multiple sites at one attendance (megavoltage items 15930-15940, 15944, 15946, 15948, and kilovoltage item 15954)

Where patients are being treated with radiation therapy to multiple sites of disease at one attendance, the claim for each treatment item must uniquely identify the tumour site in the corresponding claiming/billing note for that claim (see below).

Stereotactic treatment items (15942 and 15944)

- Intracranial stereotactic radiation therapy (15942) is applicable once per day.
- Stereotactic body radiation therapy (item 15944) is applicable once per day per site, for a maximum of 2 sites. When multiple plans are to be delivered to more than 2 sites in the same time frame, treatments to additional sites can be billed if delivered on different days.

Unique identification of sites in claiming/billing notes

Where multiple sites are involved, claims for both planning and treatment items must clearly identify a unique site of less than 30 characters (including spaces) in corresponding claiming/billing notes.

Please do not number each site or include terms such as 'multiple sites'.

The full name of a body part must be specified. Abbreviations will not be accepted.

To differentiate site location in the same body part, terms may include: anterior, posterior, medial, lateral, proximal, distal, upper, middle, lower etc.

Examples of claims/billing notes required when submitting claims for planning and treatment items:

		Required claiming/billing notes
Single site	Claim for planning/treatment	-

		Required claiming/billing notes
Multiple sites	Claim for planning/treatment site 1	*Bowel*
	Claim for planning/treatment site 2	*Liver*
	Claim for planning/treatment site 3	*Lung*

Claiming twice-daily treatments (items 15930-15940 and 15948)

The Medicare claims system is hard-wired to identify duplicate claims on the same day. When two legitimate claims are submitted for treatment to the same site on the same day, it is important to distinguish one claim from the other so that one of the claims is not treated as a duplicate.

Please observe the following claiming practices:

i. Include the word "first" in claiming/billing notes for the first treatment of the day.

ii. Include the word "second" in claiming/billing notes for the second treatment of the day.

Examples of claims/billing notes required when submitting claims for twice-daily, single-site treatment items:

		Required claiming/billing notes
Single site	Claim for treatment 1	*First*
	Claim for treatment 2	*Second*

Twice daily treatments to multiple sites on the same day

iii. When treating multiple sites on the same day, the claim for each treatment item must clearly identify a unique site in the claim/billing note (see above).

iv. Additionally, if one or more of the sites are being treated twice on the same day, identify the first and second treatments on the same day in claims/billing notes, as detailed in (i) and (ii).

Examples of claims/billing notes required when submitting claims for twice-daily treatments of multiple sites:

		Required claiming/billing notes
Multiple sites	Claim for site 1 / treatment 1	*Bowel, first*
	Claim for site 1 / treatment 2	*Bowel, second*

	Claim for site 2 / treatment 1	*Liver, first*
	Claim for site 2 / treatment 2	*Liver, second*
	Claim for site 3 / treatment 1	*Lung, first*
	Claim for site 3 / treatment 2	*Lung, second*

TN.2.11 Proton beam dosimetry, and proton-photon comparative plan

MBS item 15990 is available for proton beam dosimetry and the preparation of a proton-photon comparative plan report, which applies to a service provided by a radiation oncologist for assessing an applicant's eligibility for Proton Beam Therapy under the Medical Treatment Overseas Program (MTOP).

This item cannot be used to support proton-photon comparison planning for patients who will not be eligible for MTOP treatment. Cases that are considered palliative, experimental, or part of a clinical trial are not eligible for financial assistance under MTOP. Information about MTOP eligibility can be found at Medical Treatment Overseas Program | Australian Government Department of Health, Disability and Ageing.

The item is not intended to replace billing for photon services provided in Australia. If the patient does require photon treatment in Australia, eligible Megavoltage planning and treatment items may be billed for relevant services.

Planning validation

The final proton dosimetry plan should be:

(i) validated by a radiation therapist and a medical physicist, using quality assurance processes; and

(ii) approved by the radiation oncologist.

The photon component does not require a validated quality assurance processes for comparative planning.

Bulk billing

As outlined in the item descriptor, MBS item 15990 must be bulk-billed.

TN.3.1 Therapeutic Dose of Yttrium 90 - (Item 16003)

This item cannot be claimed for selective internal radiation therapy (SIRT).

See items 35404, 35406 and 35408 for SIRT using SIR_Spheres (yttrium-90 microspheres).

TN.3.2 Definition of 'disease progression' for the continuation of 177Lutetium PSMA therapy (MBS Item 16055)

Continuing 177Lutetium PSMA therapy (MBS Item 16055) should not be claimed if disease progression has occurred while receiving 177Lutetium PSMA for metastatic castrate-resistant prostate cancer.

Response assessment can be made by utilising diagnostic imaging modalities including, but not limited to, PSMA PET or LuPSMA SPECT, and/or other clinically relevant markers. For Item 16055, disease progression is defined as:

- a rise in PSA of >2ng/mL confirmed by two tests a minimum of two weeks apart, and/or
- evidence of new soft tissue or bone metastases on diagnostic imaging computed tomography as per established guidelines (such as the Response Evaluation Criteria in Solid Tumours (RECIST) criteria, as published by the European Organisation for Research and Treatment of Cancer available at www.eortc.org, or the Response Evaluation Criteria in PSMA-Imaging (RECIP) Criteria, available at www.recip-criteria.com.

TN.3.3 Item 16060 – 177Lutetium-DOTA-somatostatin receptor agonist treatment for neuroendocrine neoplasm

177Lutetium-DOTA-somatostatin receptor agonist treatment is a type of peptide receptor radionuclide therapy which is given in multiple individual cycles over a period of time, with a period of recovery between cycles (typically 6-8 weeks). When a treatment cycle is repeated multiple times on a regular schedule, it is called a course of treatment.

An eligibility requirement for Item 16060 is that patients must be considered suitable for a course of 177Lutetium-DOTA-somatostatin receptor agonist therapy by a formally convened neuroendocrine neoplasm (NEN) multidisciplinary board.

For the purposes of Item 16060, a formally convened NEN multidisciplinary board is a formal board of relevant practitioners, including specialists in medical oncology and nuclear medicine with experience in managing NEN, endocrinology and surgery specialists, as well as medical practitioners from different areas of medical practice (including general practitioners). Allied health practitioners relevant to NEN treatment may be part of the board. The board must include at least one oncologist and one surgeon.

For Item 16060, the item refers to an individual treatment cycle and is inclusive of the following components of the service:

a. patient preparation required prior to the administration of the radiopharmaceutical in the treatment cycle (including the administration of the necessary prophylactic amino acid infusions and antiemetics),
b. the cost, preparation and administration of the radiopharmaceutical,
c. patient monitoring during the administration of the treatment (including the risk of carcinoid crisis and other severe hormonal flare syndromes) and immediate patient aftercare required for the safe discharge of the patient post-infusion,
d. a consultation with the supervising theranostic specialist within 36 hours of the time the treatment cycle occurred, to monitor patient progress and confirm individual medication and monitoring requirements with adjustments where necessary, and
e. post-infusion single photon emission tomography if performed.

Training requirements

Service providers administering this item should have the appropriate training and competency to deliver the service. Attendance of healthcare professionals skilled in the administration of therapeutic radiopharmaceuticals and associated patient care is required for this service. Remote supervision is not appropriate for this item.

The Australasian Association of Nuclear Medicine Specialists has published recommendations for therapeutic nuclear medicine training requirements in the AANMS Position Statement: Practice of Theranostics in Australia and provides theranostics training courses.

Additionally, the Royal Australian and New Zealand College of Radiologists has developed Competencies for Professional Development in Theranostics for radiologists.

TN.4.1 Antenatal Service Provided by a Nurse, Midwife or an Aboriginal and Torres Strait Islander health practitioner - (Item 16400)

Item 16400 can only be claimed by a medical practitioner (including a vocationally registered or non-vocationally registered GP, a specialist or a consultant physician) where an antenatal service is provided to a patient by a midwife, nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of the medical practitioner at, or from an eligible practice location in a regional, rural or remote area.

A regional, rural or remote area is classified as a RRMA 3-7 area under the Rural Remote Metropolitan Areas classification system.

Evidence based national or regional guidelines should be used in the delivery of this antenatal service.

An eligible practice location is the place associated with the medical practitioner's Medicare provider number from which the service has been provided. If you are unsure if the location is in an eligible area you can call Services Australia on 132 150.

A midwife means a registered midwife who holds a current practising certificate as a midwife issued by a State or Territory regulatory authority and who is employed by, or whose services are otherwise retained by, the medical practitioner or their practice.

A nurse means a registered or enrolled nurse who holds a current practising certificate as a nurse issued by a State or Territory regulatory authority and who is employed by, or whose services are otherwise retained by, the medical practitioner or their practice. The nurse must have appropriate training and skills to provide an antenatal service.

An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the *Health Insurance Act 1973*.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

The midwife, nurse or Aboriginal and Torres Strait Islander health practitioner must also comply with any relevant legislative or regulatory requirements regarding the provision of the antenatal service.

The medical practitioner under whose supervision the antenatal service is provided retains responsibility for the health, safety and clinical outcomes of the patient. The medical practitioner must be satisfied that the midwife, nurse or Aboriginal and Torres Strait Islander health practitioner is appropriately registered, qualified and trained, and covered by indemnity insurance to undertake antenatal services.

Supervision at a distance is recognised as an acceptable form of supervision. This means that the medical practitioner does not have to be physically present at the time the service is provided. However, the medical practitioner should be able to be contacted if required.

The medical practitioner is not required to see the patient or to be present while the antenatal service is being provided by the midwife, nurse or Aboriginal and Torres Strait Islander health practitioner. It is up to the medical practitioner to decide whether they need to see the patient. Where a consultation with the medical practitioner has taken place prior to or following the antenatal service, the medical practitioner is entitled to claim for their own professional service, but item 16400 cannot be claimed in these circumstances.

Item 16400 cannot be claimed in conjunction with another antenatal attendance item for the same patient, on the same day by the same practitioner.

A bulk billing incentive item (10990, 10991 or 10992) cannot be claimed in conjunction with item 16400. An incentive payment is incorporated into the schedule fee.

Item 16400 can only be claimed 10 times per pregnancy.

Item 16400 cannot be claimed for an admitted patient of a hospital.

TN.4.2 Items for Initial and Subsequent Obstetric Attendances (Items 16401 and 16404)

16401 and 16404 replace items 104 and 105 for any specialist obstetric attendance relating to pregnancy. This includes any initial and subsequent attendance with a specialist obstetrician for discussion of pregnancy or

pregnancy related conditions or complications, or any postnatal care provided to the patient subsequent to the expiration of normal aftercare period. Item 16500 is still claimed for routine antenatal attendances. These items are subject to Extended Medicare Safety Net caps.

TN.4.3 Antenatal Care - (Item 16500)

In addition to routine antenatal attendances covered by Item 16500 the following services, where rendered during the antenatal period, attract benefits:-

(a) Items 16501, 16502, 16505, 16508, 16509 (but not normally before the 24th week of pregnancy), 16511, 16512, 16514, 16533, 16534 and 16600 to 16627.

(b) The initial consultation at which pregnancy is diagnosed.

(c) The first referred consultation by a specialist obstetrician when called in to advise on the pregnancy.

(d) All other services, excluding those in Category 1 and Group T4 of Category 3 not mentioned above.

(e) Treatment of an intercurrent condition not directly related to the pregnancy.

Item 16514 relates to antenatal cardiotocography in the management of high risk pregnancy. Benefits for this service are not attracted when performed during the course of the labour and birth.

TN.4.4 External Cephalic Version for Breech Presentation - (Item 16501)

Contraindications for this item are as follows:

- antepartum haemorrhage (APH)
- multiple pregnancy,
- fetal anomaly,
- fetal growth restriction,
- caesarean section scar,
- uterine anomalies,
- obvious cephalopelvic disproportion,
- isoimmunization,
- premature rupture of the membranes.

TN.4.5 Labour and Birth - (Items 16515, 16518, 16519, 16530 and 16531)

Benefits for management of labour and birth covered by Items 16515, 16518, 16519, 16530 and 16531 includes the following (where indicated):-

- surgical and/or intravenous infusion induction of labour;
- forceps or vacuum extraction;
- evacuation of products of conception by manual removal (not being an independent procedure);

- episiotomy or repair of tears.

Item 16519 covers birth by any means including Caesarean section. If, however, a patient is referred, or her care is transferred to another medical practitioner for the specific purpose of birth by Caesarean section, whether because of an emergency situation or otherwise, then Item 16520 would be the appropriate item.

In some instances the obstetrician may not be able to be present at all stages of confinement. In these circumstances, Medicare benefits are payable under Item 16519 provided that the doctor attends the patient as soon as possible during the confinement and assumes full responsibility for the mother and baby.

Two items in Group T9 provide benefits for assistance by a medical practitioner at a Caesarean section. Item 51306 relates to those instances where the Caesarean section is the only procedure performed, while Item 51309 applies when other operative procedures are performed at the same time.

Where, during labour, a medical practitioner hands the patient over to another medical practitioner, benefits are payable under Item 16518 for the referring practitioner's services. The second practitioner's services would attract benefits under Item 16515 (i.e., management of vaginal birth) or Item 16520 (Caesarean section). If another medical practitioner is called in for the management of the labour and birth, benefits for the referring practitioner's services should be assessed under Item 16500 for the routine antenatal attendances and on a consultation basis for the postnatal attendances, if performed.

At a high risk birth benefits will be payable for the attendance of any medical practitioner (called in by the doctor in charge of the birth) for the purposes of resuscitation and subsequent supervision of the neonate. Examples of high risk births include cases of difficult vaginal birth, Caesarean section or the birth of babies with Rh problems and babies of toxaemic mothers.

TN.4.6 Caesarean Section - (Item 16520)

Benefits under this item are attracted only where the patient has been specifically referred to another medical practitioner for the management of the birth by Caesarean section and the practitioner carrying out the procedure has not rendered any antenatal care. Caesarean sections performed in any other circumstances attract benefits under Item 16519.

TN.4.7 Complicated Confinement - (Item 16522)

A record of the clinical indication/s that constitute billing under item 16522 should be retained on the patient’s medical record.

TN.4.8 Labour and Birth Where Care is Transferred by a Participating Midwife - (Items 16527 to 16528)

Where the intrapartum care of a patient is transferred to a medical practitioner by a participating midwife for the management of birth, item 16527 or 16528 would apply depending on the service provided.

Where care is transferred by a participating midwife prior to the commencement of labour, items 16519 or 16522 would apply.

TN.4.9 Items for Planning and Management of a Pregnancy (Item 16590 and 16591)

Item 16590 is intended to provide for the planning and management of pregnancy that has progressed beyond 28 weeks, where the medical practitioner is intending to undertake the birth for a privately admitted patient.

Item 16591 is for the planning and management of a pregnancy that has progressed beyond 28 weeks and the medical practitioner is providing shared antenatal care and is not intending to undertake the birth.

Items 16590 and 16591 are to include the provision of a mental health assessment of the patient. Both items are subject to Extended Medicare Safety Net caps and should only be claimed by a patient once per pregnancy.

TN.4.10 Post-Partum Care - (Items 16515 to 16520 and 16564 to 16573)

The Schedule fees and benefits payable for Items 16519 and 16520 cover all postnatal attendances on the mother and the baby, except in the following circumstances:-

(i) where the medical services rendered are outside those covered by a consultation, e.g., blood transfusion;

(ii) where the condition of the mother and/or baby is such as to require the services of another practitioner (e.g., paediatrician, gynaecologist, etc);

(iii) where the patient is transferred, at arms length, to another medical practitioner for routine post-partum, care (eg mother and/or baby returning from a larger centre to a country town or transferring between hospitals following confinement). In such cases routine postnatal attendances attract benefits on an attendance basis. The transfer of a patient within a group practice would not qualify for benefits under this arrangement except in the case of Items 16515 and 16518. These items cover those occasions when a patient is handed over while in labour from the practitioner who under normal circumstances would have delivered the baby, but because of compelling circumstances decides to transfer the patient to another practitioner for the birth;

(iv) where during the postnatal period a condition occurs which requires treatment outside the scope of normal postnatal care;

(v) in the management of premature babies (i.e. babies born prior to the end of the 37th week of pregnancy or where the birth weight of the baby is less than 2500 grams) during the period that close supervision is necessary.

Normal postnatal care by a medical practitioner would include:-

(i) uncomplicated care and check of

- lochia
- fundus
- perineum and vulva/episiotomy site
- temperature
- bladder/urination
- bowels

(ii) advice and support for establishment of breast feeding

(iii) psychological assessment and support

(iv) Rhesus status

(v) Rubella status and immunisation

(vi) contraception advice/management

Examinations of apparently normal newborn infants by consultant or specialist paediatricians do not attract benefits

Items 16564 to 16573 relate to postnatal complications and should not be itemised in respect of a normal birth. To qualify for benefits under these items, the patient is required to be transferred to theatre, or be administered general anaesthesia or epidural injection for the performance of the procedure. Utilisation of the items will be closely monitored to ensure appropriate usage.

TN.4.11 Interventional Techniques - (Items 16600 to 16627, 35518 and 35674)

For Items 16600 to 16627, 35518 and 35674 there is no component in the Schedule fee for the associated ultrasound. Benefits are attracted for the ultrasound under the appropriate items in Group I1 *Health Insurance (Diagnostic Imaging Services Table) Regulations (No. 2) 2020*. If diagnostic ultrasound is performed on a separate occasion to the procedure, benefits would be payable under the appropriate ultrasound item.

Item 51312 and 93722 provides a benefit for assistance by a medical practitioner or a participating nurse practitioner respectively at interventional techniques covered by Items 16606, 16609, 16612, 16615, and 16627.

TN.4.13 Mental Health Assessments for Obstetric Patients (Items 16590, 16591, 16407)

Items for the planning and management of pregnancy (16590 and 16591) and for a postnatal attendance between 4 and 8 weeks after birth (16407), include a mental health assessment of the patient, including screening for drug and alcohol use and domestic violence, to be performed by the clinician or another suitably qualified health professional on behalf of the clinician. A mental health assessment must be offered to each patient, however, if the patient chooses not to undertake the assessment, this does not preclude a benefit being payable for these items.

It is recommended that mental health assessments associated with items 16590, 16591, and 16407 be conducted in accordance with the National Health and Medical Research Council (NHMRC) endorsed guideline: *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline* – October 2017, Centre for Perinatal Excellence.

Results of the mental health assessment must be recorded in the patient's medical record. A record of a patient's decision not to undergo a mental health assessment must be recorded in the patient's clinical notes.

TN.4.14 Extended Medicare Safety Net (EMSN) for Obstetric Services (Items 16531, 16533 and 16534)

The Extended Medicare Safety Net (EMSN) benefit is capped at 65% of the schedule fee for obstetric items 16531, 16533, and 16534. However, as these items are for in-hospital services only, the EMSN does not apply

TN.4.15 Obstetric MBS Telehealth (video and phone) attendance items

MBS telehealth (video and phone) attendance items by obstetricians, general practitioners, midwives, nurse and Aboriginal and Torres Strait Islander health practitioners.

The intent of these items is to allow practitioners to provide certain MBS attendances remotely (by videoconference or telephone). This can only be done where it is safe, in accordance with relevant professional standards and clinically appropriate to do so.

MBS video services by videoconference is the preferred approach for substituting a face-to-face consultation. However, providers will also be able to offer phone (audio-only) services via telephone if clinically relevant, for which there are separate items.

MBS TELEHEALTH (video and phone) ITEMS

OBSTETRICIANS, GPs, MIDWIVES, NURSES OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONERS ATTENDANCES (from 13 March 2020)

Bulk billing of specialist services is at the discretion of the provider, so long as informed financial consent is obtained prior to the provision of the service.

Service	**Existing Items** *face to face*	**Video Items** -*via video conference*	**Phone items** - *via telephone for when video conferencing is not available*
Antenatal Service provided by a Nurse, Midwife or an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner	16400	91850	91855
Postnatal attendance by an obstetrician or GP	16407	91851	91856
Postnatal attendance 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	16408	91852	91857
Antenatal attendance	16500	91853	91858

Further information related to services rendered by an obstetrician/general practitioner/midwife/nurse or Aboriginal and Torres Strait Islander health practitioner can be found in the telehealth factsheets published at MBSonline.gov.au.

All MBS items for referred attendances require a valid referral. However, if the obstetrician has previously seen the patient under a referral that is still valid, there is no need to obtain a specific referral for the purposes of claiming the items.

Restrictions

- The video and phone attendance items are to be billed **instead** of the usual face to face MBS items.
- Services do not apply to admitted patients.

Relevant definitions and requirements

For the purposes of these items, **admitted patient** means a patient who is receiving a service that is provided:

a. as part of an episode of hospital treatment; or
b. as part of an episode of hospital substitute treatment in respect of which the person to whom the treatment is provided chooses to receive a benefit from a private health insurer.

Note: "hospital treatment" and "hospital-substitute treatment" have the meaning given by subsection 3(1) of the *Health Insurance Act 1973*.

Mental Health Assessments for Obstetric Patients (Items 91851 and 91856)

The telehealth (video and phone) items for a postnatal attendance between 4 and 8 weeks after birth (91851 and 91856) include a mental health assessment of the patient, including screening for drug and alcohol use and domestic violence. A mental health assessment must be offered to each patient, however, if the patient chooses not to undertake the assessment, this does not preclude a benefit being payable for these items.

It is recommended that mental health assessments associated with items 91851 and 91856 be conducted in accordance with the National Health and Medical Research Council (NHMRC) endorsed guideline: Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline – 2023 revision, Centre for Perinatal Excellence.

It is expected that the results of the mental health assessment be recorded in the patient's medical record. A record of a patient's decision not to undergo a mental health assessment should also be recorded in the patient's clinical notes

Technical Requirements

The services can be provided by video, or when clinically appropriate, by phone.

Video attendance means a professional attendance by video conference where the health practitioner:

a. has the capacity to provide the full service through this means safely and in accordance with relevant professional standards; and
b. is satisfied that it is clinically appropriate to provide the service to the patient; and
c. maintains a visual and audio link with the patient; and
d. is satisfied that the software and hardware used to deliver the service meets the applicable laws for security and privacy.

Note –only the time where both a visual and audio link is maintained between the patient and the provider can be counted in meeting the relevant item descriptor for video items.

No specific equipment is required to provide Medicare-compliant telehealth services. Practitioners must ensure that their chosen telecommunications solution meets their clinical requirements and satisfies privacy laws. Information on how to select a web conferencing solution is available on the Australian Cyber Security Centre website.

Phone attendance means a professional attendance by telephone where the health practitioner:

a. has the capacity to provide the full service through this means safely and in accordance with professional standards; and
b. is satisfied that it is clinically appropriate to provide the service to the patient; and
c. maintains an audio link with the patient.

Note: To support quality patient outcomes, telehealth (video and phone) attendances are to be performed when it is clinically relevant and in accordance with the relevant clinical guidelines.

There are no geographic restrictions on telehealth services using items 91851, 91852, 91853, 91856, 91857, 91858.

Where there are restrictions on the number of services for the face to face items these restrictions will also apply to the telehealth items.

Recording Clinical Notes

In relation to the time taken in recording appropriate details of the service, only clinical details recorded at the time of the attendance count towards the time of consultation. It does not include information added later, such as reports of investigations.

Clinicians should retain for their records the date, time and duration of the consultation.

Creating and Updating a My Health Record

The time spent by a medical practitioner on the following activities may be counted towards the total consultation time:

- Reviewing a patient's clinical history, in the patient's file and/or the My Health Record, and preparing or updating a Shared Health Summary where it involves the exercise of clinical judgement about what aspects of the clinical history are relevant to inform ongoing management of the patient's care by other providers; or
- Preparing an Event Summary for the episode of care.

Preparing or updating a Shared Health Summary and preparing an Event Summary are clinically relevant activities. When either of these activities are undertaken with any form of patient history taking and/or the other clinically relevant activities that can form part of a consultation, the item that can be billed is the one with the time period that matches the total consultation time.

MBS benefits are not available for creating or updating a Shared Health Summary as a standalone service.

Antenatal Care - (Items 91853 and 91858)

In addition to routine antenatal attendances covered by items 91853 and 91858, the following services, where rendered during the antenatal period, attract benefits:

a. Items 16501, 16502, 16505, 16508, 16509 (but not normally before the 24th week of pregnancy), 16511, 16512, 16514, 16533, 16534 and 16600 to 16627.
b. The initial consultation at which pregnancy is diagnosed.
c. The first referred consultation by a specialist obstetrician when called in to advise on the pregnancy.
d. All other services, excluding those in Category 1 and Group T4 of Category 3 not mentioned above.
e. Treatment of an intercurrent condition not directly related to the pregnancy.

Item 16514 relates to antenatal cardiotocography in the management of high risk pregnancy. Benefits for this service are not attracted when performed during the course of the labour and birth.

Antenatal Service Provided by a Nurse, Midwife or an Aboriginal and Torres Strait Islander health practitioner - (Items 91850 and 91855)

Items 91850 and 91855 can only be claimed by a medical practitioner (including a vocationally registered or non-vocationally registered GP, a specialist or a consultant physician) where an antenatal service is provided to a patient by a midwife, nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of the medical practitioner.

Evidence based national or regional guidelines should be used in the delivery of this antenatal service.

A midwife means a registered midwife who holds a current practising certificate as a midwife issued by a State or Territory regulatory authority and who is employed by, or whose services are otherwise retained by, the medical practitioner or a practice operated by a medical practitioner.

A nurse means a registered or enrolled nurse who holds a current practising certificate as a nurse issued by a State or Territory regulatory authority and who is employed by, or whose services are otherwise retained by, the medical practitioner or their practice. The nurse must have appropriate training and skills to provide an antenatal service.

An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the *Health Insurance Act 1973*.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner. The midwife, nurse or Aboriginal and

Torres Strait Islander health practitioner must also comply with any relevant legislative or regulatory requirements regarding the provision of the antenatal service. The medical practitioner under whose supervision the antenatal service is provided retains responsibility for the health, safety and clinical outcomes of the patient. The medical practitioner must be satisfied that the midwife, nurse or Aboriginal and Torres Strait Islander health practitioner is appropriately registered, qualified and trained, and covered by indemnity insurance to undertake antenatal services.

Supervision at a distance is recognised as an acceptable form of supervision. This means that the medical practitioner does not have to be physically present at the time the service is provided. However, the medical practitioner should be able to be contacted if required.

The medical practitioner is not required to see the patient or to be present while the antenatal service is being provided by the midwife, nurse or Aboriginal and Torres Strait Islander health practitioner. It is up to the medical practitioner to decide whether they need to consult with the patient. Where a consultation with the medical practitioner has taken place prior to or following the antenatal service, the medical practitioner is entitled to claim for their own professional service, but items 91850 and 91855 cannot be claimed in these circumstances.

Items 91850 and 91855 cannot be claimed in conjunction with another antenatal attendance item for the same patient, on the same day by the same practitioner.

A bulk billing incentive item (10990, 10991 or 10992) cannot be claimed in conjunction with items 91850 and 91855. An incentive payment is incorporated into the schedule fee.

Items 91850 and 91855 can only be claimed 10 times per pregnancy in total, including services claimed under item 16400.

None of the items, including 91850 and 91855, can be claimed for an admitted patient of a hospital.

TN.6.1 Pre-anaesthesia Consultations by an Anaesthetist - (Items 17610 to 17625)

Pre-anaesthesia consultations are covered by items in the range 17610 - 17625.

Pre-anaesthesia consultations comprise 4 time-based items utilising 15 minute increments up to and exceeding 45 minutes, in conjunction with content-based descriptors. A pre-anaesthesia consultation will attract benefits under the appropriate items based on **BOTH** the duration of the consultation **AND** the complexity of the consultation in accordance with the requirements outlined in the content-based item descriptions.

Whether or not the proposed procedure proceeds, the pre-anaesthetic attendance will attract benefits under the appropriate consultation item in the range 17610 - 17625, as determined by the duration and content of the consultation.

The following provides further guidance on utilisation of the appropriate items in common clinical situations:

(i) Item 17610 (15 mins or less) - a pre-anaesthesia consultation of a straightforward nature occurring prior to investigative procedures and other routine surgery. This item covers routine pre-anaesthesia consultation services including the taking of a brief history, a limited examination of the patient including the cardio-respiratory system and brief discussion of an anaesthesia plan with the patient.

(ii) Item 17615 (16-30 mins) - a pre-anaesthesia consultation of between 16 to 30 minutes duration AND of significantly greater complexity than that required under item 17610. To qualify for benefits patients will be undergoing advanced surgery or will have complex medical problems. The consultation will involve a more extensive examination of the patient, for example: the cardio-respiratory system, the upper airway, anatomy relevant to regional anaesthesia and invasive monitoring. An anaesthesia plan of management should be formulated, of which there should be a written record included in the patient notes.

(iii) Item 17620 (31-45 mins) - a pre-anaesthesia consultation of high complexity involving all of the requirements of item 17615 and of between 31 to 45 minutes duration. The pre-anaesthesia consultation will also involve evaluation of relevant patient investigations and the formulation of an anaesthesia plan of management of which there should be a written record in the patient notes.

(iv) Item 17625 (more than 45 mins) - a pre-anaesthesia consultation of high complexity involving all of the requirements of item 17615 and item 17620 and of more than 45 minutes duration. The pre-anaesthesia consultation will also involve evaluation of relevant patient investigations as well as discussion of the patient's medical condition and/or anaesthesia plan of management with other relevant healthcare professionals. An anaesthesia plan of management should be formulated, of which there should be a written record included in the patient notes.

Some examples of advanced surgery that may require a longer consultation under items 17615-17625 would include:

· Bowel resection

· Caesarean section

· Neonatal surgery

· Major laparotomies

· Radical cancer resection

· Major reconstructive surgery eg free flap transfers, breast reconstruction

· major joint arthroplasty

· joint reconstruction

· Thoracotomy

· Craniotomy

· Spinal surgery eg spinal fusion, discectomy

· Major vascular surgery eg aortic aneurysm repair, arterial bypass surgery, carotid artery endarterectomy

Some examples of complex medical problems in relation to items 17615-17625 would include:

· Major cardiac problems - e.g cardiomyopathy, unstable ischaemic heart disease, heart failure

· Major respiratory disease - e.g COPD, respiratory failure, acute lung conditions eg. infection and asthma,

· Major neurological conditions - CVA, intra/extra cerebral haemorrhage, cerebral palsy and/or major intellectual disability, degenerative conditions of the CNS

· Major metabolic conditions - e.g unstable diabetes, uncontrolled hyperthyroidism, renal failure, liver failure, immune deficiency

· Anaesthetic problems - eg past history of awareness, known or anticipated difficulty with securing the airway, malignant hyperpyrexia, drug allergy,

· Other conditions -

- patients with history of stroke/TIA's presenting for vascular surgery

- patients on anti-platelet agents presenting for major surgery requiring management of anticoagulant status

- patients with poor respiratory/cardiac function presenting for major surgery requiring management of perioperative medications, analgaesia and monitoring

NOTE I:

It is important to note that:

· patients undergoing the types of advanced surgery listed above but who are otherwise of reasonable health and who, therefore, do not require a longer pre-anaesthesia consultation as provided for under items 17615-17625, would qualify for benefits under item 17610; and

· not all patients with complex medical problems will qualify for a longer consultation under items 17615-17625. For example, patients who have reasonably stable diabetes may only require a short consultation, covered under item 17610. Similarly, patients with reasonably well controlled emphysema (COPD) undergoing minor surgery may only require a short pre-anaesthesia consultation (item 17610), whereas the same patient scheduled for an upper abdominal laparotomy and with recent onset angina with the possible need for ICU postoperatively may require a longer consultation.

NOTE II:

· Consultation services covered by pain specialists items in the range 2801-3000 cannot be claimed in conjunction with items 17610-17625

· The consultation time under items 17610 - 17625 only applies to the period of active attendance on the patient and does not include time spent in discussion with other health care practitioners.

· The requirement of a written patient management plan in items 17615-17625 or the discussion of the management plan with other health care professions, where this occurs, does not relate to and cannot be claimed in conjunction GP Management Plans, Team Care Arrangements, Multidisciplinary Care Plans or Case Conference items in Group A15 of the MBS.

TN.6.2 Referred Anaesthesia Consultations - (Items 17640 to 17655)

Referred anaesthesia consultations (other than pre-anaesthesia attendances) where the patient is referred will be covered by new items in the range 17640 - 17655. These new items replace the use of specialist referred items 104 and 105. Items 104 and 105 will no longer apply to referred anaesthesia consultations provided by specialist anaesthetists.

Referred anaesthesia consultations comprise 4 time-based items utilising 15 minute increments up to and exceeding 45 minutes, in conjunction with content-based descriptors. Services covered by these specialist referred items include consultations in association with the following:

(i) Acute pain management

· Postoperative, utilising specialised techniques eg Patient Controlled Analgesia System (PCAS)

· as an independent service eg pain control following fractured ribs requiring nerve blocks

· obstetric pain management

(ii) Perioperative management of patients

· postoperative management of cardiac, respiratory and fluid balance problems following major surgery

· vascular access procedures (other than intra-operative peripheral vascular access procedures)

Items 17645 - 17655 will involve the examination of multiple systems and the formulation of a written management plan. Items 17650 and 17655 would also entail the ordering and/or evaluation of relevant patient investigations.

NOTE :

· It should be noted that the consultation time under items 17640 - 17655 only applies to the period of active attendance on the patient and does not include time spent in discussion with other health care practitioners.

· Consultation services covered by pain medicine specialist items in the range 2801-3000 cannot be claimed in conjunction with items 17640 - 17655.

· The requirement of a written patient management plan in items 17645-17655 or the discussion of the management plan with other health care professions, where this occurs, does not relate to and cannot be claimed in conjunction GP Management Plans, Team Care Arrangements, Multidisciplinary Care Plans or Case Conference items in Group A15 of the MBS.

It would be expected that in the vast majority of cases, the insertion of a peripheral venous cannula (other than in association with anaesthesia) where the patient is referred, would attract benefit under item 17640. However, in exceptional clinical circumstances, where the procedure is considerably more difficult and exceeds 15 minutes, such as for patients with chronic disease undergoing long term intravenous therapy, paediatric patients or patients having chemotherapy, item 17645 would apply.

TN.6.3 Anaesthetist Consultations - Other - (Items 17680, 17690)

A consultation occurring immediately before the institution of major regional blockade for a patient in labour is covered by item 17680.

Item 17690 can only be claimed where all of the conditions set out in (a) to (d) of item 17690 have been met.

Item 17690 can only be claimed in conjunction with a service covered by items 17615, 17620, or 17625.

Item 17690 cannot be claimed where the pre-anaesthesia consultation covered by items 17615, 17620 or 17625 is provided on the same day as admission to hospital for the subsequent episode of care involving anaesthesia services.

NOTE: Consultation services covered by pain medicine specialist items in the range 2801-3000 cannot be claimed in conjunction with anaesthesia consultation items 17610 - 17690.

TN.7.1 Regional or Field Nerve Blocks - General

A nerve block is interpreted as the anaesthetising of a substantial segment of the body innervated by a large nerve or an area supplied by a smaller nerve where the technique demands expert anatomical knowledge and a high degree of precision.

Where anaesthesia combines a regional nerve block with general anaesthesia for an operative procedure, benefit will be paid only under the relevant anaesthesia item as set out in Group T10.

Where a regional or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block attracts benefits under the Group T10 anaesthesia item and not the block item in Group T7.

If not stipulated in the item descriptor, when a regional nerve block or field nerve block covered by an item in Group T7 of the Schedule is administered by a medical practitioner in the course of a surgical procedure undertaken by the same medical practitioner, then such a block will attract benefit under the appropriate item in Group T7.

If stipulated in the item descriptor, when a regional nerve block or field nerve block covered by an item in Group T7 of the Schedule is administered by a medical practitioner in the course of a surgical procedure the block will not attract benefit under the relevant item in Group T7 unless the block has been performed using a targeted

percutaneous approach. If the block has been performed using a targeted percutaneous approach this must be noted on the Medicare claim.

When a block is carried out in cases not associated with an operation, such as for pain or during labour, the service falls under Group T7.

Digital ring analgesia, local infiltration into tissue surrounding a lesion or paracervical (uterine) analgesia are not eligible for the payment of Medicare benefits under items within Group T7. Where procedures are carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure.

TN.7.2 Maintenance of Regional or Field Nerve Block - (Items 18222 and 18225)

Medicare benefit is attracted under these items only when the service is performed other than by the operating surgeon. This does not preclude benefits for an obstetrician performing an epidural block during labour.

When the service is performed by the operating surgeon during the post-operative period of an operation it is considered to be part of the normal aftercare. In these circumstances a Medicare benefit is not attracted.

TN.7.3 Intrathecal or Epidural Injection - (Items 18230 and 18232)

Items 18230 and 18232 cover caudal infusion/injection.

Item 18230 includes the intrathecal or epidural injection of a neurolytic substance for the palliative treatment of pain.

TN.7.4 Intrathecal or Epidural Infusion - (Items 18226 and 18227)

Items 18226 and 18227 apply where intrathecal or epidural analgesia is required for obstetric patients in the after hours period. For these items, the after hours period is defined as the period from 8pm to 8am on any weekday, or any time on a Saturday, Sunday or a public holiday.

Medicare benefits are only payable under item 18227 where more than 50% of the service is provided in the after hours period, otherwise benefits would be payable under item 18219.

TN.7.5 Regional or Field Nerve Blocks - (Items 18234 to 18298)

Items in the range 18234 - 18298 are intended to cover the injection of anaesthetic into the nerve or nerve sheath and not for the treatment of carpal tunnel or similar compression syndromes.

Paravertebral nerve block item 18276 covers the provision of regional anaesthesia for surgical and related procedures for the management acute pain or of chronic pain related to radiculopathy. Blockade of lumbar paravertebral nerves should be claimed under 18276. Infiltration of the soft tissue of the paravertebral area for the treatment of other pain symptoms does not attract benefit under this item. Additionally, item 18276 does not cover zygo-apophyseal joint blocks/injections. This procedure is covered under item 39013.

Item 18292 may not be claimed for the injection of botulinum toxin, but may be claimed where a neurolytic agent (such as phenol) is used to treat the obturator nerve in patients receiving botulinum toxin injections under item 18354 for a dynamic foot deformity.

TN.7.6 Services performed under image guidance (Items 18290, 18292, 18294, 18296, 39013, 39014, 39100)

These services must be performed under image guidance.

Imaging items can be co-claimed with these items when indicated.

TN.8.1 Surgical Operations

Many items in Group T8 of the Schedule are qualified by one of the following phrases:

· "as an independent procedure";

· "not being a service associated with a service to which another item in this Group applies"; or

· "not being a service to which another item in this Group applies"

An explanation of each of these phrases is as follows.

As an Independent Procedure

The inclusion of this phrase in the description of an item precludes payment of benefits when:-

(i) a procedure so qualified is associated with another procedure that is performed through the same incision, e.g. nephrostomy (Item 36552) in the course of an open operation on the kidney for another purpose;

(ii) such procedure is combined with another in the same body area, e.g. direct examination of larynx (Item 41501) with another operation on the larynx or trachea;

(iii) the procedure is an integral part of the performance of another procedure, e.g. removal of foreign body (Item 30068) in conjunction with debridement of deep or extensive contaminated wound of soft tissue, including suturing of that wound when performed under general anaesthetic (Item 30023).

Not Being a Service Associated with a Service to which another Item in this Group Applies

"Not being a service associated with a service to which another item in this Group applies" means that benefit is not payable for any other item in that Group when it is performed on the same occasion as this item. eg item 30666.

"Not being a service associated with a service to which Item ..... applies" means that when this item is performed on the same occasion as the reference item no benefit is payable. eg item 31526.

Not Being a Service to which another Item in this Group Applies

"Not being a service to which another item in this Group applies" means that this item may be itemised if there is no specific item relating to the service performed, e.g. Item 37351 URETHROPLASTY, not being a service to which another item in this Group applies. Benefits may be attracted for an item with this qualification as well as benefits for another service during the course of the same operation.

TN.8.2 Multiple Operation Rule

The fees for two or more operations, listed in Group T8 (other than Subgroup 12 of that Group), performed on a patient on the one occasion are calculated by the following rule:-

- 100% for the item with the greatest Schedule fee

plus 50% for the item with the next greatest Schedule fee

plus 25% for each other item.

Note:

(a) Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents.

(b) Where two or more operations performed on the one occasion have Schedule fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.

(c) The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

(d) For these purposes the term "operation" only refers to all items in Group T8 (other than Subgroup 12 of that Group).

This rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient if the medical practitioner who performed the operation did not also perform or assist at the other operation or any of the other operations, or administer the anaesthetic. In such cases the fees specified in the Schedule apply.

Where two medical practitioners operate independently and either performs more than one operation, the method of assessment outlined above would apply in respect of the services performed by each medical practitioner.

If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

There are a number of items in the Schedule where the description indicates that the item applies only when rendered in association with another procedure. The Schedule fees for such items have therefore been determined on the basis that they would always be subject to the "multiple operation rule".

Where the need arises for the patient to be returned to the operating theatre on the same day as the original procedure for further surgery due to post-operative complications, which would not be considered as normal aftercare - see note TN.8.4, such procedures would generally not be subject to the "multiple operation rule". Accounts should be endorsed to the effect that they are separate procedures so that a separate benefit may be paid.

Extended Medicare Safety Net Cap

The Extended Medicare Safety Net (EMSN) benefit cap for items subject to the multiple operations rule, where all items in that claim are subject to a cap are calculated from the abated (reduced) schedule fee.

For example, if an item has a Schedule fee of $100 and an EMSN benefit cap equal to 80 per cent of the schedule fee, the calculated EMSN benefit cap would be $80. However, if the schedule fee for the item is reduced by 50 per cent in accordance with the multiple operations rule provisions, and all items in that claim carry a cap, the calculated EMSN benefit cap for the item is $40 (50% of $100*80%).

TN.8.3 Procedure Performed with Local Infiltration or Digital Block

It is to be noted that where a procedure is carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure and an additional benefit is therefore not payable.

TN.8.4 Aftercare (Post-operative Treatment)

Definition

Section 3(5) of the *Health Insurance Act 1973* states that services included in the Schedule (other than attendances) include all professional attendances necessary for the purposes of post-operative treatment of the patient. For the purposes of this book, post-operative treatment is generally referred to as "aftercare".

Aftercare is deemed to include all post-operative treatment rendered by medical specialists and consultant physicians, and includes all attendances until recovery from the operation, the final check or examination, regardless of whether the attendances are at the hospital, private rooms, or the patient's home. Aftercare need not necessarily be limited to treatment given by the surgeon or to treatment given by any one medical practitioner.

If the initial procedure is performed by a general practitioner, normal aftercare rules apply to any post-operative service provided by the same practitioner.

The medical practitioner determines each individual aftercare period depending on the needs of the patient as the amount and duration of aftercare following an operation may vary between patients for the same operation, as well as between different operations.

Private Patients

Medicare will not normally pay for any consultations during an aftercare period as the Schedule fee for most operations, procedures, fractures and dislocations listed in the MBS item includes a component of aftercare.

There are some instances where the aftercare component has been excluded from the MBS item and this is clearly indicated in the item description.

There are also some minor operations that are merely stages in the treatment of a particular condition. As such, attendances subsequent to these services should not be regarded as aftercare but rather as a continuation of the treatment of the original condition and attract benefits. Likewise, there are a number of services which may be performed during the aftercare period for pain relief which would also attract benefits. This includes all items in Groups T6 and T7, and items 39013, 39100, 39110, 39014, 39111, 39116, 39117, 39118, 39119, 39121, 39127, 39130, 39133, 39136, 39324 and 39327.

Where there may be doubt as to whether an item actually does include the aftercare, the item description includes the words "including aftercare".

If a service is provided during the aftercare phase for a condition not related to the operation, then this can be claimed, provided the account identifies the service as 'Not normal aftercare', with a brief explanation of the reason for the additional services.

If a patient was admitted as a private patient in a public hospital, then unless the MBS item does not include aftercare, no Medicare benefits are payable for aftercare.

Medicare benefits are not payable for surgical procedures performed primarily for cosmetic reasons. However, benefits are payable for certain procedures when performed for specific medical reasons, such as breast reconstruction following mastectomy. Surgical procedures not listed on the MBS do not attract a Medicare benefit.

Where an initial or subsequent consultation relates to the assessment and discussion of options for treatment and, a cosmetic or other service which do not attract a benefit are discussed, this would be considered a service which can attract a benefit under Medicare. Where a consultation relates entirely to a cosmetic or other non-Medicare benefit service (either before or after that service has taken place), then that consultation is not able to be claimed under Medicare. Any aftercare associated with a cosmetic or non-Medicare benefit service is also not able to be claimed under Medicare.

Public Patients

All care directly related to a public in-patient's care should be provided free of charge. Where a patient has received in-patient treatment in a hospital as a public patient (as defined in Section 3(1) of the *Health Insurance Act 1973*), routine and non-routine aftercare directly related to that episode of admitted care will be provided free of charge as part of the public hospital service, regardless of where it is provided, on behalf of the state or territory as required by the National Health Reform Agreement. In this case no Medicare benefit is payable.

Notwithstanding this, where a public patient independently chooses to consult a private medical practitioner for aftercare, then the clinically relevant service provided during this professional attendance will attract Medicare benefits.

Where a public patient independently chooses to consult a private medical practitioner for aftercare following treatment from a public hospital emergency department, then the clinically relevant service provided during this professional attendance will attract Medicare benefits.

Fractures

Where the aftercare for fractures is delegated to a doctor at a place other than where the initial reduction was carried out, then Medicare benefits may be apportioned on a 50:50 basis rather than on the 75:25 basis for surgical operations.

Where the reduction of a fracture is carried out by hospital staff in the out-patient or emergency department of a public hospital, and the patient is then referred to a private practitioner for aftercare, Medicare benefits are payable for the aftercare on an attendance basis.

The following table shows the period which has been adopted as reasonable for the after-care of fractures:-

Treatment of fracture of	After-care Period
Terminal phalanx of finger or thumb	6 weeks
Proximal phalanx of finger or thumb	6 weeks
Middle phalanx of finger	6 weeks
One or more metacarpals not involving base of first carpometacarpal joint	6 weeks
First metacarpal involving carpometacarpal joint (Bennett's fracture)	8 weeks
Carpus (excluding navicular)	6 weeks
Navicular or carpal scaphoid	3 months
Colles'/Smith/Barton's fracture of wrist	3 months
Distal end of radius or ulna, involving wrist	8 weeks
Radius	8 weeks
Ulna	8 weeks
Both shafts of forearm or humerus	3 months
Clavicle or sternum	4 weeks
Scapula	6 weeks
Pelvis (excluding symphysis pubis) or sacrum	4 months
Symphysis pubis	4 months
Femur	6 months
Fibula or tarsus (excepting os calcis or os talus)	8 weeks
Tibia or patella	4 months

Both shafts of leg, ankle (Potts fracture) with or without dislocation, os calcis (calcaneus) or os talus	4 months
Metatarsals - one or more	6 weeks
Phalanx of toe (other than great toe)	6 weeks
More than one phalanx of toe (other than great toe)	6 weeks
Distal phalanx of great toe	8 weeks
Proximal phalanx of great toe	8 weeks
Nasal bones, requiring reduction	4 weeks
Nasal bones, requiring reduction and involving osteotomies	4 weeks
Maxilla or mandible, unilateral or bilateral, not requiring splinting	6 weeks
Maxilla or mandible, requiring splinting or wiring of teeth	3 months
Maxilla or mandible, circumosseous fixation of	3 months
Maxilla or mandible, external skeletal fixation of	3 months
Zygoma	6 weeks
Spine (excluding sacrum), transverse process or bone other than vertebral body requiring immobilisation in plaster or traction by skull calipers	3 months
Spine (excluding sacrum), vertebral body, without involvement of cord, requiring immobilisation in plaster or traction by skull calipers	6 months
Spine (excluding sacrum), vertebral body, with involvement of cord	6 months

Note: This list is a guide only and each case should be judged on individual merits.

TN.8.5 Abandoned surgery - (Item 30001)

Item 30001 applies when a procedure has commenced, but is then discontinued for medical reasons, or for other reasons which are beyond the surgeon's control (eg equipment failure).

An operative procedure commences when:

a) The patient is in the procedure room or on the bed or operation table where the procedure is to be performed; and

b) The patient is anaesthetised or operative site is sufficiently anaesthetised for the procedure to commence; and

c) The patient is positioned or the operative site which is prepared with antiseptic or draping.

Where an abandoned procedure eligible for a benefit under item 30001 attracts an assistant under the provisions of the items listed in Group T9 (Assistance at Operations), the fee for the surgical assistant is calculated as 50% of the assistance fee that would have applied under the relevant item from Group T9.

Practitioners claiming an assistant fee for abandoned surgery should itemise their accounts with the relevant item from group T9. Such claims should include an account endorsement "assistance at abandoned surgery" or similar.

Under the *Health Insurance Act 1973* the Chief Executive Medicare does not require claims for this item to be accompanied by details of the proposed surgery and the reasons why the operation was discontinued. However, practitioners must maintain a clinical record of this information, which may be subject to audit.

TN.8.6 Repair of Wound - (Items 30023 to 30049)

The repair of wound referred to in these items must be undertaken by suture, tissue adhesive resin (such as methyl methacrylate) or clips. These items do not cover repair of wound at time of surgery.

Item 30023 covers debridement of traumatic, "deep or extensively contaminated" wound. Benefits are not payable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures.

For the purpose of items 30026 to 30049 the term 'superficial' means affecting skin and subcutaneous tissue including fat and the term 'deeper tissue' means all tissues deep to but not including subcutaneous tissue such as fascia and muscle.

TN.8.7 Biopsy for Diagnostic Purposes - (Items 30071 to 30094 and 30820)

Needle aspiration biopsy attracts benefits on an attendance basis and not under item 30078.

Item 30071 (diagnostic biopsy of the skin) or 30072 (diagnostic biopsy of mucous membrane) should be used when a biopsy (including shave) of a lesion is required to confirm a diagnosis and would facilitate the appropriate management of that lesion. If the shave biopsy results in a definitive excision of the lesion, only 30071 or 30072 can be claimed.

Items 30071-30094 and 30820 require that the specimen be sent for pathological examination.

The aftercare period for item 30071 or 30072 is 2 days rather than the standard aftercare period for skin excision of 10 days.

TN.8.8 Lipectomy - (Items 30166, 30169, 30177 and 30179)

Lipectomy is not intended as a primary bariatric procedure to correct obesity. MBS benefits are not available for surgery performed for cosmetic purposes.

For the purpose of informing patient eligibility for lipectomy items (30166, 30169, 30177 and 30179) for the management of significant weight loss (SWL), SWL is defined as a weight loss equivalent to at least five body mass index (BMI) units. Weight must have been stable for at least six months prior to lipectomy, following SWL.

For SWL that has occurred following pregnancy, the products of conception must not be included in the calculation of baseline weight to measure weight loss against.

The lipectomy items cannot be claimed in association with items 45530, 45531, 45564, 45565 and 45567. Where the abdomen requires surgical closure with reconstruction of the umbilicus following free tissue transfer (45564, 45565, 45567) or breast reconstruction (45530, 45531), item 45571 is to be claimed.

TN.8.9 Treatment of Keratoses, Warts etc (Items 30187, 30189, 30192 and 36815)

Treatment of seborrheic keratoses by any means, attracts benefits on an attendance basis only.

Treatment of fewer than 10 solar keratoses by ablative techniques such as cryotherapy attracts benefits on an attendance basis only. Where 10 or more solar keratoses are treated by ablative techniques, benefits are payable under item 30192.

Warts and molluscum contagiosum where treated by any means attract benefits on an attendance basis except where:

(a) admission for treatment in an operating theatre of an accredited day surgery facility or hospital is required. In this circumstance, benefits are paid under item 30189 where a definitive removal of the wart or molluscum contagiosum is to be undertaken.

(b) benefits have been paid under item 30189, and recurrence occurs.

(c) palmar and plantar warts are treated by laser and require treatment in an operating theatre of an accredited day surgery facility or hospital. In this circumstance, benefits are paid under item 30187.

TN.8.10 Cryotherapy and Serial Curettage Excision - (Items 30196 and 30202)

In item 30196, serial curettage excision, as opposed to simple curettage, refers to the technique where the margin having been defined, the lesion is carefully excised by a skin curette using a series of dissections and cauterisations so that all extensions and infiltrations of the lesion are removed.

For the purposes of items 30196 and 30202, the requirement for histopathological proof of malignancy is satisfied where multiple lesions are to be removed from the one anatomical region if a single lesion from that region is histologically tested and proven for malignancy.

For the purposes of items 30196 and 30202, an anatomical region is defined as: hand, forearm, upper arm, shoulder, upper trunk or chest (anterior and posterior), lower trunk (anterior or posterior) or abdomen (anterior lower trunk), buttock, genital area/perineum, upper leg, lower leg and foot, neck, face (six sections: left/right lower, left/right mid and left/right upper third) and scalp.

For Medicare benefits to be payable for item 30196 and 30202, the provider performing the service must also retain documented evidence that malignancy has either been proven by histopathology or confirmed by opinion of a specialist in the specialty of dermatology or plastic surgery.

Guidelines are available on the Department of Health, Disability and Ageing website at https://www.health.gov.au/sites/default/files/2025-08/guideline-for-substantiating-proof-of-malignancy_0.pdf where required for MBS items.

TN.8.14 Laparotomy and Other Procedures on the Abdominal Viscera - (Items 30622 and 30722)

Procedures on the abdominal viscera may be performed by laparotomy or laparoscopically. Both items 30622 and 30722 cover several operations on abdominal viscera. Where more than one of the procedures referred to in these items are performed during the one operation, each procedure may be itemised according to the multiple operation formula.

TN.8.15 Diagnostic Laparoscopy - (Items 30390 and 30627)

If a diagnostic laparoscopy procedure is performed at a different time on the same day to another laparoscopic service, the procedures are considered to be un-associated services. The claim for benefits should be annotated to indicate that the two services were performed on separate occasions, otherwise the claims will be considered to be a single service.

TN.8.17 Gastrointestinal Endoscopic Procedures - (Items 30473 to 30481, 30484, 30485, 30490 to 30494, 30664, 30665, 30680 to 32023, 32084 to 32095, 32106, 32232 and 32222 to 32229)

The following are guidelines for appropriate minimum standards for the performance of GI endoscopy in relation to (a) cleaning, disinfection and sterilisation procedures, and (b) anaesthetic and resuscitation equipment.

These guidelines are based on the advice of the Gastroenterological Society of Australia, the Sections of HPB and Upper GI and of Colon and Rectal Surgery of the Royal Australasian College of Surgeons, and the Colorectal Surgical Society of Australia.

Cleaning, disinfection and sterilisation procedures
Endoscopic procedures should be performed in facilities where endoscope and accessory reprocessing protocols follow procedures outlined in:

i. Infection Control in Endoscopy, Gastroenterological Society of Australia and Gastroenterological Nurses College of Australia , 2011;
ii. Australian Guidelines for the Prevention and Control of Infection in Healthcare (NHMRC, 2010);
iii. Australian Standard AS 4187-2014 (and Amendments), Standards Association of Australia.

Anaesthetic and resuscitation equipment
Where the patient is anaesthetised, anaesthetic equipment, administration and monitoring, and post-operative and resuscitation facilities should conform to the standards outlined in 'Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures' (PS09), Australian & New Zealand College of Anaesthetists, Gastroenterological Society of Australia and Royal Australasian College of Surgeons.

Single operator, single use peroral cholangiopancreatoscopy (POCPS) item 30665

For the purposes of item 30665 a treatment cycle, for a patient, means a series of treatments for the patient that:

(a) begins on the day of the initial failed attempt at biliary stone removal via endoscopic retrograde cholangiopancreatography (ERCP) extraction techniques; and
(b) ends at the conclusion of the aftercare period for the procedure, being either the lithotripsy procedure or a definitive surgical management procedure, that has resulted in removal of the biliary stones.

Conjoint Committee

For the purposes of Items 32023, 30664 and 30665 the procedure is to be performed by a surgeon or gastroenterologist with ERCP training recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy.

TN.8.19 Anti reflux Operations - (Items 30529 to 30533, 30756 and 31466)

These items cover various operations for reflux oesophagitis. Where the only procedure performed is the simple closure of a diaphragmatic hiatus benefit would be attracted under Item 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).

TN.8.20 Radiofrequency ablation of mucosal metaplasia for the treatment of Barrett's Oesophagus (Item 30687)

The diagnosis of high grade dysplasia is recommended to be confirmed by two expert pathologists with experience in upper gastrointestinal pathology.

A multidisciplinary team should review treatment options for patients with high grade dysplasia and would typically include upper gastrointestinal surgeons and/or interventional gastroenterologists.

TN.8.21 Endoscopic or Endobronchial Ultrasound +/- Fine Needle Aspiration - (Items 30688 - 30694, 38416 - 38417)

For the purposes of these items the following definitions apply:

Biopsy means the removal of solid tissue by core sampling or forceps

FNA means aspiration of cellular material from solid tissue via a small gauge needle.

The provider should make a record of the findings of the ultrasound imaging in the patient's notes for any service claimed against items 30688 to 30694, 38416 and 38417.

Endoscopic ultrasound is an appropriate investigation for patients in whom there is a strong clinical suspicion of pancreatic neoplasia with negative imaging (such as CT scanning). Scenarios include, but are not restricted to:

- A middle aged or elderly patient with a first attack of otherwise unexplained (eg negative abdominal CT) first episode of acute pancreatitis; or

- A patient with biochemical evidence of a neuroendocrine tumour.

The procedure is not claimable for periodic surveillance of patients at increased risk of pancreatic cancer, such as chronic pancreatitis. However, EUS would be appropriate for a patient with chronic pancreatitis in whom there was a clinical suspicion of pancreatic cancer (eg: a pancreatic mass occurring on a background of chronic pancreatitis).

TN.8.22 Removal of Skin Lesions - (Items 31356 to 31388)

The excision of warts and seborrheic keratoses attracts benefits on an attendance basis with the exceptions outlined in TN.8.9 of the explanatory notes to this category. Excision of pre-malignant lesions including solar keratoses where clinically indicated are covered by items 31357, 31360, 31362, 31364, 31366, 31368 and 31370.

The excision of pigmented lesions which are clinically suspicious for melanoma attracts benefits under items 31377, 31378, 31379, 31380, 31381, 31382 or 31383.

Excision of malignant tumours are covered by items 31356, 31358, 31359, 31361, 31363, 31365, 31367, 31369, 31371 to 31376, 31386, 31387 and 31388.

Items 31386, 31387 and 31388 should be used for very large, fungating skin cancers.

Items 31357, 31360, 31362, 31364, 31366, 31368, 31370, 31377, 31378, 31379, 31380, 31381, 31382 and 31383 *require* that the specimen be sent for histological examination. Items 31356, 31358, 31359, 31361, 31363, 31365, 31367, 31369, 31371-31376, 31386, 31387 and 31388 also require that a specimen has been sent for histological confirmation of malignancy, and any subsequent specimens are sent for histological examination. Confirmation of malignancy *must* be received before itemisation of accounts for Medicare benefits purposes, except in the case of items 31377, 31378, 31379, 31380, 31381, 31382 or 31383.

An incomplete surgical excision of a malignant skin lesion with curative intent should be billed as a malignant skin lesion excision item even when further surgery is needed.

Where histological results are available at the time of issuing accounts, the histological diagnosis will decide the appropriate itemisation for excised lesions. If the histological report shows the lesion to be benign, items 31357, 31360, 31362, 31364, 31366, 31368 or 31370 should be used.

Practitioners should retain copies of histological reports.

TN.8.23 Removal of Skin Lesion From Face - (Items 31245, 31361 to 31364, 31372, 31373, 31379 and 31380)

For the purposes of these items, the face is defined as that portion of the head anterior to the hairline and above the jawline.

TN.8.24 Dissection of Lymph Nodes of Neck - (Items 30618, 31423 to 31438)

For the purposes of these items, the lymph node levels referred to are as follows:

Level I	Submandibular and submental lymph nodes
Level II	Lymph nodes of the upper aspect of the neck including the jugulodigastric node, upper jugular chain nodes and upper spinal accessory nodes
Level III	Lymph nodes deep to the middle third of the sternomastoid muscle consisting of mid jugular chain nodes, the lower most of which is the jugulo-omohyoid node, lying at the level where the omohyoid muscle crosses the internal jugular vein
Level IV	Lower jugular chain nodes, including those nodes overlying the scalenus anterior muscle
Level V	Posterior triangle nodes, which are usually distributed along the spinal accessory nerve in the posterior triangle

Comprehensive dissection involves all 5 neck levels while ***selective*** dissection involves the removal of only certain lymph node groups, for example:-

Item 31426 (removal of 3 lymph node levels) - e.g. supraomohyoid neck dissection (levels I-III) or lateral neck dissection (levels II-IV).

Item 31429 (removal of 4 lymph node levels) - e.g. posterolateral neck dissection (levels II-V) or anterolateral neck dissection (levels I-IV)

Other combinations of node levels may be removed according to clinical circumstances.

TN.8.25 Excision of Breast Lesions, Abnormalities or Tumours - Malignant or Benign - (Items 31500 to 31515)

Therapeutic biopsy or excision of breast lesions, abnormalities or tumours under Items: 31500, 31503, 31506, 31509, 31512, 31515 either singularly or in combination should not be claimed when using the Advanced Breast Biopsy Instrumentation (ABBI) procedure, or any other large core breast biopsy device.

TN.8.26 Breast Biopsy Items – items 31533 (Fine Needle Aspiration) and 31548 (Mechanical Device Biopsy)

Breast abnormalities requiring biopsy should be assessed by core biopsy or vacuum-assisted core biopsy. If a service has access to high-quality cytology with immediate reporting, then fine needle aspiration (FNA) may be used in addition to mechanical device biopsy, but not instead of it. In exceptional cases, based on a clinician's judgement, FNA may be used alone if mechanical device biopsy is not possible.

FNA is indicated for patients with a suspected breast abscess or a symptomatic simple breast cyst.

In relation to item 31533 (FNA) an impalpable lesion includes those lesions that clinically require definition by ultrasound or mammography for accurate or safe sampling, eg. lesions in association with breast prostheses or in areas of breast thickening.

TN.8.29 Bariatric Procedures - (Items 31569 to 31581, anaesthesia item 20791)

Items 31569 to 31581 and item 20791 provide for surgical treatment of clinically severe obesity and the accompanying anaesthesia service (or similar). The term clinically severe obesity generally refers to a patient with a Body Mass Index (BMI) of 40kg/m^2 or more, or a patient with a BMI of 35kg/m^2 or more with other major medical co-morbidities (such as diabetes, cardiovascular disease, cancer). The BMI values in different population groups may vary due, in part, to different body proportions which affect the percentage of body fat and body fat distribution. Consequently, different ethnic groups may experience major health risks at a BMI that is below the 35-

40 kg/m^2 provided for in the definition. The decision to undertake obesity surgery remains a matter for the clinical judgment of the surgeon.

If crural repair taking 45 minutes or less is performed in association with the bariatric procedure, additional hernia repair items cannot be claimed for the same service.

Practitioners providing items 31569, 31572, 31575 and 31581 should be registered with and provide relevant data to the Bariatric Surgery Registry.

TN.8.30 Surgical reversal of a bariatric procedure including revision or conversion surgery (item 31584)

Item 31584 includes the surgical reversal of a previous bariatric procedure and conversion to an alternative bariatric procedure when clinically appropriate.

TN.8.31 Per Anal Excision of Rectal Tumour using Rectoscopy - (Items 32232 and 32106)

Surgeons performing these procedures should be colorectal surgeons and have undergone appropriate training which is recognised by the Colorectal Surgical Society of Australasia.

Items 32232 and 32106 cannot be claimed in conjunction with each other or with anterior resection items 32024 or 32025 for the same patient, on the same day, by any practitioner.

TN.8.32 Varicose veins (Items 32500 to 32517) and Peripheral Arterial or Venous Embolisation (Item 35321)

Under the *Health Insurance (General Medical Services Table) Regulations*, items 32500 to 32517 and 35321 do not apply to services mentioned in those items if the services are delivered by:

a. endovenous laser treatment (ELT); or
b. radiofrequency diathermy; or
c. radiofrequency ablation for varicose veins.

It is recommended that a practitioner who intends to bill ELT, radiofrequency diathermy or radiofrequency ablation for varicose veins on the same occasion as providing items 32500 to 32517 or 35321 contact the Services Australia provider information line on 132 150 to confirm requirements for correct itemisation of services on a single invoice.

Services Australia monitors billing practices associated with MBS items. Services for ELT, radiofrequency diathermy or radiofrequency ablation for varicose veins provided on the same occasion as items 32500 to 32517 or 35321 must be itemised separately on the invoice, showing the full fees for each service separately to the fees billed against these MBS items.

TN.8.33 Varicose Vein Intervention

Claiming Guide for the following procedures:

1. Sclerotherapy (Item 32500)
2. Surgical Dissection and Ligation (Items 32507, 32508, 32511, 32514, 32517)
3. Endovenous Laser Therapy (Items 32520 and 32522)
4. Radiofrequency Ablation (Items 32523 and 32526)
5. Cyanoacrylate adhesive (Items 32528 and 32529)

It is recommended that the medical practitioner performing the above procedures has successfully completed a substantial course of study and training in duplex ultrasound and the management of venous disease, which has been endorsed by their relevant professional organisation.

It is recommended that providers familiarise themselves with the symptoms to be used to assess the severity of chronic venous disease as indicated in the item descriptor. Providers should also refer to the latest Clinical impact, Etiology/Aetiology, Anatomy and Pathophysiology (CEAP) classification description for symptoms, to help determine when intervention is required.

TN.8.34 Uterine Artery Embolisation - (Item 35410)

This item was introduced on an interim basis in November 2006 following a recommendation of the Medical Services Advisory Committee (MSAC), pending the outcome of clinical trials and further consideration by the MSAC. The requirement for specialist referral by a gynaecologist for uterine artery embolisation was a MSAC recommendation. Providers should retain the instrument of specialist referral for each patient from the date of the procedure, as this may be subject to audit by Services Australia.

TN.8.35 Endovascular Coiling of Intracranial Aneurysms - (Item 35412)

This service includes balloon angioplasty and insertion of stents (assisted coiling) associated with intracranial aneurysm coiling. The use of liquid embolics alone is not covered by this item. Digital Subtraction Angiography (DSA) done to diagnose the aneurysm (items 60009 and either 60072, 60075 or 60078) is claimable, however this must be clearly noted on the claim and in the clinical notes as separate from the intra-operative DSA done with the coiling procedure.

TN.8.36 Arterial and Venous Patches - (Items 33545 to 33551and 34815)

Vascular surgery items have been constructed on the basis that arteriotomy and venotomy wounds are closed by simple suture without the use of a patch.

Where a patch angioplasty is used to enlarge a narrowed vein, artery or arteriovenous fistula, the correct item would be 34815 or 34518. If the vein is harvested for the patch through a separate incision, Item 33551 would also apply, in accordance with the multiple operation rule.

If a patch graft is involved in conjunction with an operative procedure included in Items 33500 - 33542, 33803, 33806, 33815, 33833 or 34142, the patch graft would attract benefits under Item 33545 or 33548 in addition to the item for the primary operation (under the multiple operation rule). Where vein is harvested for the patch through a separate incision Item 33551 would also apply.

TN.8.37 Carotid Disease - (Item 32700, 32703, 32760, 33500, 33545, 33548, 33551, 33554, 35303, 35307)

Interventional procedures for the management of carotid disease should be performed in accordance with the NHMRC endorsed *Clinical Guidelines for Stroke Management 2010*.

Carotid Percutaneous Transluminal Angioplasty with Stenting (CPTAS), under item 35307 is only funded under the MBS for patients who meet the criteria for carotid endarterectomy but are unfit for open surgery.

TN.8.38 Peripheral Arterial or Venous Catheterisation - (Item 35317)

Item 35317 is restricted to the regional delivery of thrombolytic, vasoactive or chemotherapeutic oncologic agents in association with a radiological service. This item is not intended for infusions with systemic affect.

TN.8.40 Selective Internal Radiation Therapy (SIRT) using SIR-Spheres - (Items 35404, 35406 and 35408)

These items were introduced into the Schedule on an interim basis in May 2006 following a recommendation of the Medical Services Advisory Committee (MSAC) pending the outcome of clinical trials and further consideration by the MSAC. SIRT should not be performed in an outpatient or day patient setting to ensure patient and radiation safety requirements are met.

TN.8.42 Colposcopic Examination - (Item 35614)

It should be noted that colposcopic examination (screening) of a person during the course of a consultation does not attract Medicare benefits under Item 35614 except in the following circumstances:

(a) where the patient has had an abnormal cervical screen result;

(b) where there is a history of ingestion of oestrogen by the patient's mother during their pregnancy; or

(c) where the patient has been referred by another medical practitioner because of suspicious signs of genital cancer.

TN.8.43 Hysteroscopy - (Item 35626)

Hysteroscopy undertaken in outpatient settings, consulting suites or offices can be claimed under this item where the conditions set out in the description of the item are met.

TN.8.44 Curettage of Uterus under GA or Major Nerve Block - (Items 35639 and 35640)

Uterine scraping or biopsy using small curettes (e.g. Sharman's or Zeppelin's) and requiring minimal dilatation of the cervix, not necessitating a general anaesthesia, does not attract benefits under these items but would be paid under Item 35620 where malignancy is suspected, or otherwise on an attendance basis.

TN.8.45 Neoplastic Changes of the Cervix - (Items 35644-35648)

The term "previously confirmed intraepithelial neoplastic changes of the cervix" in these items refers to diagnosis made by either cytologic, colposcopic or histologic methods. This may also include persistent human papilloma virus (HPV) changes of the cervix.

TN.8.46 Sterilisation of Minors - Legal Requirements - (Items 35637, 35687, 35688, 35691, 37622 and 37623)

(i) It is unlawful throughout Australia to conduct a sterilisation procedure on a minor which is not a by-product of surgery appropriately carried out to treat malfunction or disease (eg malignancies of the reproductive tract) unless legal authorisation has been obtained.

(ii) Practitioners are liable to be subject to criminal and civil action if such a sterilisation procedure is performed on a minor (a person under 18 years of age) which is not authorised by the Family Court of Australia or another court or tribunal with jurisdiction to give such authorisation.

(iii) Parents/guardians have no legal authority to consent on behalf of minors to such sterilisation procedures. Medicare Benefits are only payable for sterilisation procedures that are clinically relevant professional services as defined in Section 3 (1) of the *Health Insurance Act 1973.*

TN.8.47 Debulking of Uterus - (Item 35658)

Benefits are payable under Item 35658, using the multiple operation rule, in addition to hysterectomy.

TN.8.50 Sacral Nerve Stimulation (items 36663-36668)

A two-stage process of testing and treatment is required to ensure suitability for Sacral Nerve Stimulation for detrusor overactivity or non obstructive urinary retention where urethral obstruction has been urodynamically excluded. The testing phase involves acute and sub-chronic testing. The first stage includes peripheral nerve evaluation and patients who achieve greater than 50% improvement in urinary incontinence or retention episodes during testing will be eligible to receive permanent SNS treatment.

TN.8.51 Ureteroscopy - (Item 36803)

Item 36803 refers to ureteroscopy of one ureter when performed for the purpose of inspection alone. It may not be used when one of the other ureteroscopy numbers (Items 36806 or 36809) or pyeloscopy numbers (Items 36652, 36654 or 36656) is used for a ureteroscopic procedure performed in the same ureter or collecting system. It may be used when inspection alone is carried out in one ureter independently from a ureteroscopic or pyeloscopic procedure in another ureter or collecting system. If Item number 36803 is used with one of the other above 5 numbers, it must be specified that item number 36803 refers to ureteroscopy performed in another ureter eg 36654 (Right side) and 36803 (Left side). 36803 may also be used in this way if there is a partial or complete duplex collecting system eg 36809 (Lower pole moiety ureter, Left side) and 36803 (Upper pole moiety ureter, Left side).

Item numbers 36806 and 36809 may only be used together when 2 independent ureteroscopic procedures are performed in separate ureters. These separate ureters may be components of a complete or partial duplex system. If both these numbers are used together, the Regulations require qualification of these item numbers by the site, as is necessary with 36803 eg 36806 (Right side) and 36809 (Left side).

TN.8.53 Transurethral Needle Ablation (TUNA) of the Prostate - (Item 37201)

Moderate to severe lower urinary tract symptoms are defined using the American Urological Association (AUA) Symptom Score or the International Prostate Symptom Score (IPSS).

Patients not medically fit for transurethral resection of the prostate (TURP) can be defined as:

(i) Those patients who have a high risk of developing a serious complication from the surgery. Retrograde ejaculation is **not** considered to be a serious complication of TURP.

(ii) Those patients with a co-morbidity which may substantially increase the risk of TURP or the risk of the anaesthetic necessary for TURP.

TN.8.54 Fiducial Markers into the Prostate - (Item 37217)

Item 37217 is for the insertion of fiducial markers into the prostate or prostate surgical bed as markers for radiotherapy. The service can not be claimed under item 37218 or any other surgical item.

This item is introduced into the Schedule on an interim basis pending the outcome of an evaluation being undertaken by the Medical Services Advisory Committee (MSAC).

Further information on the review of this service is available from the MSAC Secretariat.

TN.8.55 Brachytherapy of the Prostate - (Item 37220)

One of the requirements of item 37220 is that patients have a Gleason score of less than or equal to 7 (Grade Group 1-3). However, where the patient has a score of 7, comprising a primary score of 4 and a secondary score of 3 (ie. 4+3=7; Grade Group 3), it is recommended that low dose rate brachytherapy form part of a combined modality treatment.

Low dose rate brachytherapy of the prostate should be performed in patients, with favourable anatomy allowing adequate access to the prostate without pubic arch interference, and who have a life expectancy of greater than 10 years.

An 'approved site' for the purposes of this item is one at which radiation oncology services may be performed lawfully under the law of the State or Territory in which the site is located.

TN.8.56 High Dose Rate Brachytherapy - (Item 37227)

Item 37227 covers the service undertaken by an urologist or radiation oncologist as part of the High Dose Rate Brachytherapy procedure, in association with a radiation oncologist. If the service is undertaken by an urologist, a radiation oncologist must be present in person at the time of the service. The removal of the catheters following completion of the Brachytherapy is also covered under this item.

TN.8.57 Radical or Debulking Operation for Ovarian Tumour - (Item 35720)

This item refers to the operation for carcinoma of the ovary where the bulk of the tumour and the omentum are removed. Where this procedure is undertaken in association with hysterectomy benefits are payable under both item numbers with the application of the multiple operation formula.

TN.8.58 Transcutaneous Sperm Retrieval - (Item 37605)

Item 37605 covers transcutaneous sperm retrieval for the purposes of intracytoplasmic sperm injection (item 13251) for male factor infertility, in association with assisted reproductive technologies.

Item 37605 provides for the procedure to be performed unilaterally. Where it is clinically necessary to perform the service bilaterally, the multiple operation rule would apply, in accordance with point T8.5 of these Explanatory Notes.

Where the procedure is carried out under local infiltration as the means of anaesthesia, additional benefit is not payable for the anaesthesia component as this is considered to be part of the procedure.

TN.8.59 Surgical Sperm Retrieval, by Open Approach - (Item 37606)

Item 37606 covers open sperm retrieval for the purposes of intracytoplasmic sperm injection (item 13251) for male factor infertility, in association with assisted reproductive technologies. Item 37606 provides for the procedure to be performed unilaterally. Where it is clinically necessary to perform the service bilaterally, the multiple operation rule would apply.

Benefits for item 37606 may be claimed in conjunction with a service or services provided under item 37605, where an open approach is clinically necessary following an unsuccessful percutaneous approach. Likewise, such services would be subject to the multiple operation rule.

Benefit is not payable for item 37606 in conjunction with item 37604.

TN.8.60 Cardiac Pacemaker Insertion - (Items 38209, 38212, 38350, 38353 and 38356)

The fees for the insertion of a pacemaker (Items 38350, 38353 and 38356) cover the testing of cardiac conduction or conduction threshold, etc related to the pacemaker and pacemaker function.

Accordingly, additional benefits are not payable for such routine testing under Item 38209 or 38212 (Cardiac electrophysiological studies).

TN.8.61 Implantable ECG Loop Recorder - (Item 38285)

The fee for implantation of the loop recorder (item 38285) covers the initial programming and testing of the device for satisfactory rhythm capture. Benefits are payable only once per day.

The term "recurrent" refers to more than one episode of syncope, where events occur at intervals of 1 week or longer. The term "other available cardiac investigations" includes the following:

- a complete history and physical examination that excludes a primary neurological cause of syncope and does not exclude a cardiac cause;
- *electrocardiography (ECG) (items 11704, 11705, 11707, 11714);*
- *echocardiography (items 55126, 55127, 55128, 55129, 55132, 55133, 55134);*
- *continuous ECG recording or ambulatory ECG monitoring (items 11716, 11717, 11723, 11735);*
- *up-right tilt table test (item 11724); and*
- cardiac electrophysiological study, unless there is reasonable medical reason to waive this requirement (item 38209).

TN.8.63 Permanent Cardiac Synchronisation Device (Items 38365 & 38368)

Items 38365 and 38368 apply only to patients who meet the criteria listed in the item descriptor, and to patients who do not meet the criteria listed in the descriptor but have previously had a CRT device and transvenous left ventricular electrode inserted and who prior to its insertion met the criteria and now need the device replaced.

TN.8.64 Intravascular Extraction of Permanent Pacing Leads - (Item 38358)

For the purposes of Item 38358 specialists or consultant physicians claiming this item must have training recognised by the Lead Extraction Certification Committee (LECC) under Cardiac Accreditation Services Limited (CASL), and Services Australia has been notified of that recognition. The procedure should only be undertaken in a hospital capable of providing cardiac surgery.

TN.8.67 Cardiac and Thoracic Surgical Items - (Items 38470 to 38766, 38817 to 38818)

Items 38470 to 38766 and 38817 to 38818 must be performed using open exposure or minimally invasive surgery which excludes percutaneous and transcatheter techniques unless otherwise stated in the item.

TN.8.70 Skull Base Surgery - (Items 39638 to 39656)

The surgical management of lesions involving the skull base (base of anterior, middle and posterior fossae) often requires the skills of several surgeons or a number of surgeons from different surgical specialties working together or in tandem during the operative session. These operations are usually not staged because of the need for definitive closure of the dura, subcutaneous tissues, and skin to avoid serious infections such as osteomyelitis and/or meningitis.

Items 39638 to 39656 cover the removal of the tumour, which would normally be performed by a neurosurgeon or an otolaryngology surgeon. Other items are available to cover procedures performed as a part of skull base surgery by practitioners in other specialities, such as plastic and reconstructive surgery.

TN.8.71 Intradiscal Injection of Chymopapain - (Item 40336)

The fee for this item includes routine post-operative care. Associated radiological services attract benefits under the appropriate item in Group I3.

TN.8.72 Removal of Ventilating Tube from Ear - (Item 41500)

Benefits are not payable under Item 41500 for removal of ventilating tube. This service attracts benefits on an attendance basis.

TN.8.73 Meatoplasty - (Item 41515)

When this procedure is associated with Item 41530, 41548, 41557, 41560 or 41563 the multiple operation rule applies.

TN.8.74 Reconstruction of Auditory Canal - (Item 41524)

When associated with Item 41557, 41560 or 41563 the multiple operation rule applies.

TN.8.75 Removal of Nasal Polyp or Polypi - (Items 41662 and 41668)

Item 41662 is intended to cover the removal of simple nasal polyp or polypi. Simple nasal polyp or polypi are those confined to the middle meatus, the equivalent of Grade 0, 1 or 2 in any accepted clinical nasal polyp grading system.

Item 41668 is intended to cover the removal of nasal polyp or polypi extending beyond the middle meatus, the equivalent of Grade 3 or beyond in any accepted clinical nasal polyp grading system.

Appropriate documentation, ideally with photographic and / or recordings and / or diagnostic imaging evidence demonstrating the grade should be collected and retained to demonstrate the clinical need for the service as this may be subject to audit. Where photographic or diagnostic imaging is not retained, the reasons for this should be clearly documented.

TN.8.76 Larynx, Direct Examination - (Item 41501)

Benefit is not attracted under this item when an anaesthetist examines the larynx during the course of administration of a general anaesthetic.

TN.8.78 Imbedded Foreign Body - (Item 42644)

For the purpose of item 42644, an imbedded foreign body is one that is sub-epithelial or intra-epithelial and is completely removed using a hypodermic needle, foreign body gouge or similar surgical instrument with magnification provided by a slit lamp biomicroscope, loupe or similar device.

Item 42644 also provides for the removal of rust rings from the cornea, which requires the use of a dental burr, foreign body gouge or similar instrument with magnification by a slit lamp biomicroscope.

Where the imbedded foreign body is not completely removed, benefits are payable under the relevant attendance item.

TN.8.79 Corneal Incisions - (Item 42672)
The description of this item refers to two sets of calculations, one performed some time prior to the operation, the other during the course of the operation. Both of these measurements are included in the Schedule fee and benefit for Item 42672.

TN.8.80 Cataract surgery (Items 42698 and 42701)
Items 42698 and 42701 provide for intraocular lens extraction and replacement as a separate procedure to be used in instances when lens removal and replacements are contraindicated at the same operation, such as in patients presenting with proliferative diabetic retinopathy or recurrent uveitis.

TN.8.82 Cyclodestructive Procedures - (Items 42770)
Item 42770 is restricted to a maximum of 2 treatments in a 2 year period.

TN.8.83 Insertion of glaucoma drainage device (Item 42752)
Item 42752 provides for the insertion of a glaucoma drainage device for the treatment of glaucoma patients who are at high risk of failure of trabeculectomy (such as patients who have aggressive neovascular glaucoma or extensive conjunctival scarring); have iridocorneal endothelial syndrome; inflammatory (uveitic) glaucoma; or aphakic glaucoma.

TN.8.84 Laser Trabeculoplasty - (Item 42782)
Item 42782 is restricted to a maximum of 4 treatments in a 2 year period.

TN.8.85 Laser Iridotomy - (Item 42785)
Item 42785 is restricted to a maximum of 3 treatments in a 2 year period.

TN.8.86 Laser Capsulotomy - (Items 42788)
Item 42788 is restricted to a maximum of 2 treatments in a 2 year period.

TN.8.87 Laser Vitreolysis or Corticolysis of Lens Material or Fibrinolysis - (Item 42791)
Item 42791 is restricted to a maximum of 3 treatments in a 2 year period.

TN.8.88 Division of Suture by Laser - (Item 42794)
Benefits under this item are restricted to a maximum of 2 treatments in a 2 year period. There is no provision for additional treatments in that period.

TN.8.89 Ophthalmic Sutures - (Item 42845)

This item refers to the occasion when readjustment has to be made to the sutures to vary the angle of deviation of the eye. It does not cover the mere tightening of the loosely tied sutures without repositioning, or adjustment performed prior to the patient leaving the operating theatre.

TN.8.91 Abrasive Therapy/Resurfacing - (Items 45021 to 45026)

For the purpose of items 45025 and 45026, one aesthetic area is any of the following of the whole face (considered to be divided into six segments): forehead; right cheek; left cheek; nose; upper lip; and chin.

Item 45021 covers abrasive therapy only. For the purpose of this item, abrasive therapy requires the removal of the epidermis and into the deeper papillary dermis. Services performed using a laser are not eligible for benefits under this item.

Items 45025 and 45026 do not cover the use of fractional laser therapy.

TN.8.92 Escharotomy - (Item 45054)

Benefits are payable once only under Item 45054 for each limb (or chest) regardless of the number of incisions to each of these areas.

TN.8.93 Local Skin Flap - Definition

Medicare benefits for flaps are only payable when clinically appropriate. Clinically appropriate in this instance means that the flap or graft is required to close the defect because the defect cannot be closed directly, or because the flap is required to adapt scar position optimally with regard to skin creases or landmarks, maintain contour on the face or neck, or prevent distortion of adjacent structures or apertures.

A local skin flap is an area of skin and subcutaneous tissue designed to be elevated from the skin adjoining a defect requiring closure. The flap remains partially attached by its pedicle and is moved into the defect by rotation, advancement or transposition, or a combination of these manoeuvres. A benefit is only payable when the flap is required for adequate wound closure. A secondary defect will be created which may be closed by direct suture, skin grafting or sometimes a further local skin flap. This later procedure will also attract benefit if closed by graft or flap repair but not when closed by direct suture.

By definition, direct wound closure (e.g. by suture) does not constitute skin flap repair. Similarly, angled, curved or trapdoor incisions which are used for exposure and which are sutured back in the same position relative to the adjacent tissues are not skin flap repairs. Undermining of the edges of a wound prior to suturing is considered a normal part of wound closure and is not considered a skin flap repair.

A "Z" plasty is a particular type of transposition flap repair. Although 2 flaps are created, benefit will be paid on the basis of Item 45201, claimable once per defect. Additional flaps are to be claimed under Item 45202, if clinically indicated.

Note: refer to TN.8.126 for MBS item 45202 for circumstances where other services might involve flap repair.

TN.8.95 Revision of Scar - (Items 45510 to 45518)

For the purposes of items 45510 to 45518, revision of scar refers to modification of existing scars (traumatic, surgical or pathological) that is designed to decrease scar width, adapt scar position with regard to skin creases and landmarks, release scars from adhering to underlying structures, improve scar contour in keeping with undamaged skin or restore the shape of facial aperture. Scar modification is defined as excisional scar revision, and must involve cutting beneath the skin.

Items 45510 to 45518 are only claimable when performed by a specialist in the practice of the specialist's specialty or where undertaken in the operating theatre of a hospital.

Only items 45510 and 45512, for the face and neck, can be claimed in association with items providing for graft or flap services.

For excision of scar services which do not meet the requirements of the revision of scar items as defined, the appropriate item in the range 31206 to 31225 should be claimed.

TN.8.96 Augmentation Mammaplasty - breast volume (45524)

Where volume differences of breasts are referenced, it is expected that volumetric measurement of the breasts is performed using a recognised technique published in a peer-reviewed journal article. Breast volumes and volume differences should be recorded in the patient case notes.

TN.8.97 Breast Reconstruction - Large Muscle or Myocutaneous Flap - (Items 45530 and 45531)

When a prosthesis or prostheses are inserted in conjunction with this operation, benefit would be attracted under Item 45527 or 45529. Benefits would also be payable for nipple reconstruction (Item 45545) when performed.

When claiming item 45530 for a pedicled rectus abdominis flap; item 45571 should be claimed for closure of the abdomen and reconstruction of the umbilicus, including repair of the musculoaponeurotic layer of abdomen. When claiming item 45530 for a latissimus dorsi flap, no item for the closure of the musculoaponeurotic layer should be claimed as it is expected that repair will be by direct suture.

Lipectomy items 30166, 30169, 30177 and 30179 and radical abdominoplasty items 30175 and 30176 should not be claimed in association with post-mastectomy breast reconstruction items 45530 and 45531.

TN.8.98 Breast Prosthesis, Removal and Replacement of - (Items 45553 and 45554)

It is generally expected that the replacement prosthesis will be the same size as the prosthesis that is removed. Medicare benefits are not payable for services under items 45553-45554 where the procedure is performed solely to increase breast size.

Where the original implant was not inserted in the context of breast cancer or developmental abnormality, intra-operative photographs of the patient in the supine position need to demonstrate unacceptable deformity in the form of a discrete concavity to justify use of 45553 or 45554.

In the context of eligibility for item 45553 and 45554, an unacceptable deformity would not include asymmetry caused as a result of removal of one implant out of a pair of implants.

Where a rupture has been established through imaging and reported, items 45553 and 45554 will still apply even if intra-operatively the implant is found to be structurally intact.

Full clinical details must be documented in patient notes, including pre-operative photographic and / or diagnostic imaging evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.99 Breast Ptosis - (Items 45556 and 45558)

For the purposes of item 45556, Medicare benefit is only payable for the correction of breast ptosis when performed unilaterally, in the context of breast cancer or developmental breast abnormality to match the position of the contralateral breast. This item is payable only once per patient. Additional benefit is not payable if this procedure is also performed on the contralateral breast.

Item 45558 applies where correction of breast ptosis is indicated because at least two-thirds of the breast tissue, including the nipple, lies inferior to the infra-mammary fold where the nipple is located at the most dependent, inferior part of the breast contour.

Item 45556 should not be used with the insertion of any prosthesis on the same side.

Item 45558 should not be used with the insertion of any prosthesis.

Full clinical details must be documented in patient notes, including pre-operative photographic evidence (including anterior, left lateral and right lateral views) as specified in the item descriptor which demonstrates the clinical need for the service, as this may be subject to audit.

TN.8.100 Nipple and/or Areola Reconstruction - (Items 45545 and 45546)

Item 45545 involves the taking of tissue from, for example, the other breast, the ear lobe and the inside of the upper thigh with or without local flap.

Item 45546 covers the non-surgical creation of nipple or areola by intradermal colouration.

TN.8.101 Liposuction - (Items 45584 and 45585)

Medicare benefits for liposuction are generally attracted under item 45584, that is for the treatment of post-traumatic pseudolipoma. Such trauma must be significant and result in large haematoma and localised swelling. Only on very rare occasions would benefits be payable for bilateral liposuction.

Where liposuction is indicated for the treatment of Barraquer-Simons Syndrome, lymphoedema or macrodystrophia lipomatosa, or the reduction of buffalo hump, item 45585 applies. One regional area is defined as one limb or trunk. If liposuction is required on more than one limb, item 45585 can be claimed once per limb.

Full clinical details must be documented in patient notes, including pre-operative photographic and / or diagnostic imaging evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.102 Meloplasty for Correction of Facial Asymmetry - (Items 45587 and 45588)

Benefits are payable under items 45587 and 45588 for face lift operations performed in hospital to correct soft tissue abnormalities of the face due to causes other than the ageing process, including trauma, a congenital condition or disease.

Where bilateral meloplasty is indicated because of congenital malformation for conditions such as drooling from the angles of the mouth and deep pitting of the skin resulting from disease or trauma (but not as a result of previous cosmetic surgery), item 45588 applies.

Full clinical details must be documented in patient notes, including pre-operative photographic and/or diagnostic imaging evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.103 Reduction of Eyelids - (Items 45617 and 45620)
Where a reduction is performed for a medical condition of one eyelid, it may be necessary to undertake a similar compensating procedure on the other eyelid to restore symmetry. The latter operation would also attract benefits.

Medicare benefits are not payable for non-therapeutic cosmetic services. Full clinical details must be documented in patient notes, including clear photographic evidence of eyelid skin prolapsing over the lashes in a relaxed straight-ahead gaze, causing visual field obstruction. The clinical need for the service must be demonstrated as this may be subject to audit.

TN.8.104 Rhinoplasty - (Items 45632 to 45644, and 45650)
Benefits are payable for septoplasty (item 41671) where performed in conjunction with rhinoplasty.

A Medicare benefit for items 45632 – 45644 and 45650 is payable where the indication for surgery is for:

(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.

The NOSE Scale refers to the Nasal Obstruction Symptom Evaluation Scale, as published in:

Stewart, M.G., Witsell, D.L., Smith, T.L., Weaver, E.M., Yueh, B. and Hannley, M.T. (2004), Development and Validation of the Nasal Obstruction Symptom Evaluation (NOSE) Scale. Otolaryngology–Head and Neck Surgery, 130: 157-163.

Full clinical details must be documented in patient notes, including pre-operative photographic and / or NOSE Scale evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.105 Contour Restoration - (Item 45718)
For the purpose of item 45718, a region in relation to the face is defined as either being upper left or right, mid left or right or lower left or right. Accounts should be annotated with region/s to which the service applies.

TN.8.106 Vermilionectomy - (Item 45669)
Item 45669 covers treatment of the entire lip.

TN.8.107 Osteotomy of Jaw - (Items 46150 to 46158)
The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site. Bone grafts taken from a separate site, eg iliac crest, would attract additional benefit under the relevant bone graft item in the range of 48248 to 48257.

For the purposes of these items, a reference to maxilla includes any procedure involving the adjacent zygoma.

Item 75621 for the provision of fitting of surgical templates may be claimed in association with the appropriate orthognathic surgical items in the range of 46150 to 46158 for dental patients with eligible conditions under Cleft and Craniofacial Services.

TN.8.108 Genioplasty - (Item 45761)
Genioplasty attracts benefit once only although a section is made on both sides of the symphysis of the mandible.

TN.8.109 Tumour, Cyst, Ulcer or Scar - (Items 45801 to 45813)
It is recognised that odontogenic keratocysts, although not neoplastic, often require the same surgical management as benign tumours.

TN.8.111 Reduction of Dislocation or Fracture
Closed reduction means treatment of a dislocation or fracture by non-operative reduction, and includes the use of percutaneous fixation or external splintage by cast or splints.

Open reduction means treatment of a dislocation or fracture by either operative exposure including the use of any internal or external fixation; or non-operative (closed reduction) where intra-medullary or external fixation is used.

Where the treatment of a fracture requires reduction on more than one occasion to achieve an adequate alignment, benefits are payable for each separate occasion at which reduction is performed under the appropriate item covering the fracture being treated.

The treatment of fractures/dislocations not specifically covered by an item in Subgroup 15 (Orthopaedic) attracts benefits on an attendance basis.

TN.8.117 Autologous Chondrocyte Implantation in the Knee
The Medical Services Advisory Committee (MSAC) evaluated the available evidence and did not support public funding for matrix-induced autologous chondrocyte implantation (MACI) or autologous chondrocyte implantation (ACI) for the treatment of chondral defects in the knee and other joints, due to the increased cost compared to existing procedures and the lack of evidence showing short term or long-term improvements in clinical outcomes. Medicare benefits are not payable in association with this technology as per GN.13.33.

TN.8.118 Paediatric Patients - (Items 50450 to 50658)
For the purpose of Medicare benefits a paediatric patient is considered to be a patient under the age of eighteen years, except in those instances where an item provides further specifications (i.e. fracture items for paediatric patients which state "with open growth plates").

TN.8.119 Treatment of Fractures in Paediatric Patients - (Items 50500 to 50588)
Items 50552 and 50560 apply to fractures that may arise during delivery and at an age when anaesthesia poses a significant risk and thus reduction is usually performed in the neonatal unit or nursery.

Item 50576 provides for closed reduction in the skeletally immature patient and will require application of a hip spica cast and related aftercare.

Medicare benefits are payable for services that specify reduction with or without internal fixation by open or percutaneous means, where reduction is carried out on the growth plate or joint surface or both.

TN.8.120 Unresectable primary malignant tumour of the liver destruction of by open or laparoscopic ablation (Item 50952)
A multi-disciplinary team for the purposes of item 50952 would include a hepatobilliary surgeon, interventional radiologist and a gastroenterologist or oncologist.

TN.8.121 Paracentesis and intravitreal eye injections - (Items 43030, 43032, 43034, 43036, 43038, 43040)

Items 43030, 43032, 43034 and 43036 provide for paracentesis for the injection of therapeutic substances and/or the removal of aqueous and/or vitreous, when undertaken as an independent procedure. That is, not in conjunction with other intraocular surgery on the same eye.

Inclusion of the words ‘independent procedure’ means that Medicare benefits are not payable for these items and another procedure where either:
- the procedure is associated with another procedure that is performed through the same incision;
- the procedure is combined with another in the same body area;
- one procedure is an integral part of another procedure.

Items 43038 and 43040 provides for intravitreal injection of therapeutic substances and/or the removal of vitreous for diagnostic purposes when performed in conjunction with other intraocular surgery, including with a service to which Item 42809 (retinal photocoagulation) applies.

In alignment with Explanatory Note TN.8.1, items 43030, 43032, 43034, 43036, 43038 and 43040 can only be claimed once for the same eye. This is regardless of the number of procedures, as covered by each item, provided, i.e. paracentesis and/or injection of therapeutic substances and/or removal of humour.

For clarity biodegradable implants are covered by the reference to ‘therapeutic substances’ for the purpose of administering items 43030, 43032, 43034, 43036, 43038 and 43040.

Items 43034 and 43036 should be claimed for patients requiring the administration of anaesthetic by an anaesthetist for the procedure. The administration of oral sedation is not sufficient justification for the use of items 43034, 43036 and items 43030, 43032 are applicable in those circumstances. Advice from the Royal Australian and New Zealand College of Ophthalmologists is that independent injections require only topical anaesthesia, with or without subconjunctival anaesthesia, except in specific circumstances as outlined below where the administration of anaesthetic by an anaesthetist may be indicated:
- nystagmus or eye movement disorder;
- cognitive impairment precluding safe intravitreal injection without sedation;
- a patient under the age of 18 years;
- a patient unable to tolerate intravitreal injection under local anaesthetic without sedation; or
- endophthalmitis or other inflammation requiring more extensive anaesthesia (e.g. peribulbar).

GP anaesthetists are expected to meet the Joint Consultative Committee on Anaesthesia (JCCA) Continuing Professional Development (CPD) Standard which defines the minimum recommended requirements for all general practitioners providing anaesthesia services.

Practitioners billing items 43034 and 43036 must keep clinical notes outlining the basis of the requirement for the administration of anaesthetic by an anaesthetist.

TN.8.123 Vulvoplasty and Labioplasty - (Items 35533 and 35534)

Item 35533 is intended to cover the surgical repair of female genital mutilation or a major congenital anomaly of the uro-gynaecological tract which is not covered by existing MBS items. For example, this item would apply where a patient who has previously received treatment for cloacal extrophy, bladder exstrophy or congenital adrenal hyperplasia requires additional or follow-up treatment.

Item 35534 is intended to cover services for a structural abnormality causing significant functional impairment and is restricted to patients aged 18 years and over.

A detailed clinical history outlining the structural abnormality and the medical need for surgery of the vulva and/or labia must be included in patient notes, as this may be subject to audit.

Medicare benefits are not payable for non-therapeutic cosmetic services.

TN.8.124 Treatment of Wrist and Finger Fractures - (Items 47301 to 47319, and 47361 to 47373)

- For the purposes of these items, fixation includes internal and external.
- Regarding item 47362, major regional anaesthesia includes bier block.

TN.8.125 Removal of Skin Lesions - Necessary Excision Diameter - (Items 31356 to 31388)

The necessary excision diameter (or defect size) refers to the lesion size plus a clinically appropriate margin of healthy tissue required with the intent of complete surgical excision. Measurements should be taken prior to excision. Margin size should be determined in line with current NHMRC guidelines.

For the purpose of items 31356 to 31388, the defect size is calculated by the average of the width and the length of the skin lesion and an appropriate margin. The necessary excision diameter is calculated as shown in the Factsheet at this link: Determining lesion size for MBS selection

Practitioners must retain copies of histological reports and any other supporting evidence (patient notes, photographs etc). Photographs should include scale.

An episode of care includes both the excision and closure for the same defect, even when excision and closure occur at separate attendances. If secondary intention is used instead of primary closure, an episode of care includes excision and all attendances for wound management.

The initial excision of a suspected melanoma may be claimed using item 31377, 31378, 31379, 31380, 31381, 31382 or 31383, depending on the location of the malignancy and the size of the excision diameter. Wide excision of the primary tumour bed following histological confirmation of melanoma, appendageal carcinoma, malignant connective tissue or merkel cell carcinoma of the skin may be claimed using item 31371, 31372, 31373, 31374, 31375 or 31376, depending on the location of the malignancy and the size of the excision diameter.

For items 31356 to 31370, 31386, 31387 and 31388, a malignant skin lesion is defined as a basal cell carcinoma; a squamous cell carcinoma (including keratoacanthoma); a cutaneous deposit of lymphoma; or a cutaneous metastasis from an internal malignancy.

TN.8.126 Flap Repair - (Item 45202)

Practitioners must only perform a muscle or skin flap repair where clinical need can be clearly evidenced (i.e. where a patient has severe pre-existing scarring, severe skin atrophy, sclerodermoid changes or where the defect is contiguous with a free margin).

Clinical evidence may be supported by patient notes, photographs of the affected area and pathology reports.

TN.8.127 Interpretation of femoroacetabular impingement (FAI) restriction (item 49366)

Patients presenting with hip dysplasia, Perthes Disease and Slipped Upper Femoral Epiphysis (SUFE) are eligible for treatment under item 49366.

TN.8.132 Transcatheter occlusion of left atrial appendage for stroke prevention (item 38276)

Eligibility requirements for Item 38276

This item is intended for use in patients where an independent medical practitioner has documented an absolute and permanent contraindication to oral coagulation. The medical practitioner who has documented this contraindication should not have been involved in any decision to provide the service or the actual provision of the service, and is not engaged in the same or a similar group of practitioners.

The following list provides examples of the conditions for which this item is intended:

i. A previous major bleeding complication experienced whilst undergoing treatment with oral anticoagulation therapy without remedial cause, or
ii. History of intracranial, intraocular, spinal, retroperitoneal or atraumatic intra-articular bleeding, or
iii. Chronic, irreversible, recurrent gastrointestinal bleeding of any cause (eg, radiation proctitis, gut angiodysplasia, hereditary haemorrhagic telangiectasia, gastric antral vascular ectasia (GAVE), portal hypertensive gastropathy, refractory radiation proctitis, obscure source), or
iv. Life-long spontaneous impairment of haemostasis, or
v. A vascular abnormality predisposing to potentially life threatening haemorrhage, or
vi. Irreversible hepatic disease with coagulopathy and increased bleeding risk (Child Pugh B and C), or
vii. Receiving concomitant medications with strong inhibitors of both CYP3A4 and P-glycoprotein (P-gp), or
viii. Severe renal impairment defined as creatinine clearance (CrCL) < 15 ml/min or undergoing dialysis and where warfarin is inappropriate, or
ix. Known hypersensitivity to the direct oral anticoagulant (DOAC) or to any of the excipients.

This item is not intended for use in patients with a relative contraindication to oral anticoagulation.

TN.8.133 Endoscopic upper gastrointestinal strictures (item 30475)

Endoscopic upper GI stricture services 41819 and 41820 have been consolidated under item 30475. This consolidated item will allow any endoscopic technique to be performed for oesophageal through to gastroduodenal procedures and will include imaging intensification if done. The fee is the same as item 41819 which higher than item 30475 but lower than 41820.

TN.8.134 Application of items 32084 and 32087

If a service to which item 32084 or 32087 applies is provided by a practitioner to a patient on more than one occasion on a day, the second service is taken to be a separate service for the purposes of the item if the second service is provided under a second episode of anaesthesia or other sedation.

TN.8.135 Transcatheter Aortic Valve Implantation (Item 38495)

Items 38495 (high-risk), 38514 (intermediate-risk) and 38522 (low-risk with native calcific aortic stenosis) apply only to a service for Transcatheter Aortic Valve Implantation (TAVI) for the treatment of symptomatic severe aortic stenosis (items 38495 & 38514) and Transcatheter Aortic Valve Implantation (TAVI) for the treatment of symptomatic severe native calcific aortic stenosis, that is to be provided in a TAVI Hospital by a TAVI Practitioner on a TAVI patient.

TAVI Hospital

For items 38495, 38514 and 38522 a TAVI Hospital means a hospital, as defined by subsection 121-5(5) of the *Private Health Insurance Act 2007*, that is clinically accepted as being a suitable hospital in which the service described in items 38495, 38514 or 38522 may be performed.

The Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners developed by Cardiac Accreditation Services Limited provides guidance on what are considered by the sector as minimum requirements that must be met in order to be a clinically acceptable facility that is suitable for TAVI procedures to be performed at.

Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners can be accessed via www.tavi.org.au.

TAVI Practitioner

For items 38495, 38514 and 38522 a TAVI Practitioner is either a cardiothoracic surgeon or interventional cardiologist who is accredited by Cardiac Accreditation Services Limited.

Accreditation by Cardiac Accreditation Services Limited must be valid prior to the service being undertaken in order for benefits to be payable under items 38495, 38514 and 38522.

The process for accreditation and re-accreditation is outlined in the *Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners*, issued by Cardiac Accreditation Services Limited, and is available on the Cardiac Accreditation Services Limited website, *www.tavi.org.au.*

Cardiac Accreditation Services Limited is a national body comprising representatives from the Australian & New Zealand Society of Cardiac & Thoracic Surgeons (ANZSCTS) and the Cardiac Society of Australia and New Zealand (CSANZ).

TAVI Patient

A TAVI Patient means a patient who, as a result of a TAVI Case Conference, has been assessed as having one of the following:

A. an unacceptably high risk for surgical aortic valve replacement and is recommended as being suitable to receive the service described in item 38495; or
B. has been assessed as having an intermediate risk for surgical aortic valve replacement and is recommended as being suitable to receive the service described in item 38514; or
C. has been assessed as having a low risk for surgical aortic valve replacement (with native calcific aortic stenosis) and is recommended as being suitable to receive the service described in item 38522

A TAVI Case Conference is a process by which:

(a) there is a team of 3 or more participants, where:

(i) the first participant is a cardiothoracic surgeon; and

(ii) the second participant is an interventional cardiologist; and

(iii) the third participant is a specialist or consultant physician who does not perform a service described in items 38495, 38514 or 38522 for the patient being assessed; and

(iv) either the first or the second participant is also a TAVI Practitioner; and

(b) the team assesses a patient's risk and technical suitability to receive the service described in item 38495, item 38514 or item 38522, taking into account matters such as:

(i) the patient's risk and technical suitability for a surgical aortic valve replacement; and

(ii) the patient's cognitive function and frailty; and

(c) the result of the assessment is that the team makes a recommendation about whether or not the patient is suitable to receive the service described in item 38495, 38514 or 38522; and

(d) the particulars of the assessment and recommendation are recorded in writing.

While benefits are payable for an eligible TAVI Case Conference under Items 6080 and 6081, a claim for these services does not have to be made in order for a benefit to be paid under items 38495, 38514 or 38522. Item 38495, item 38514 or item 38522 are only payable once per patient in a five year period. E.g. if a patient has received a benefit for item 38495 then they cannot receive a benefit for items 38495, 38514 or 38522 for 5 years.

TN.8.136 Corneal Collagen Cross Linking (Item 42652)

Evidence of progression in patients over the age of twenty five is determined by the patient history including an objective change in tomography or refraction over time. Evidence of progression in patients aged twenty five years

or younger is determined by patient history including an objective change in tomography or refraction over time and/or posterior elevation data and objective documented progression at a subclinical level.

TN.8.137 Thyroidectomy and hemithyroidectomy procedures (items 30296, 30306, and 30310)

Total thyroidectomy or total hemithyroidectomy are the most appropriate procedures in the majority of circumstances when a thyroidectomy is required. The preferred procedure for thyrotoxicosis is total thyroidectomy (item 30296). Item 30310 is to be used only in uncommon circumstances where a subtotal or partial thyroidectomy is indicated and includes a subtotal lobectomy, nodulectomy, or isthmusectomy or equivalent partial thyroidectomy.

TN.8.138 Re-exploratory thyroid surgery (item 30297)

Item 30297 is for re-exploratory thyroid surgery where prior thyroid surgery and associated scar tissue increases the complexity of surgery. For completion hemithyroidectomy on the contralateral side to a previous hemithyroidectomy for thyroid cancer, item 30306 is the appropriate item.

TN.8.139 Personal performance of a Synacthen Stimulation Test (item 30097)

A 0900h serum cortisol (0830-0930) less than 100 nmol/L indicates adrenal deficiency and a Synacthen Test is not required.

A 0900h serum cortisol (0830-0930) greater than 400 nmol/L indicates adrenal sufficiency and a Synacthen Test is not required. An exception to this is when testing women on oral contraception where cortisol levels may be higher due to increases in cortisol-binding globulin and this threshold may not exclude women with adrenal insufficiency.

TN.8.140 Excision of graft material - Items 35581 and 35582

For items 35581 and 35582 the size of the excised graft material must be histologically tested and confirmed.

TN.8.141 Application of items 51011 to 51171 (Sub-group 17)

Spinal surgery items 51011 to 51171 cannot be performed in conjunction with any other item (outside of subgroup 17) in Group T8 of the MBS (surgical operation items 30001 to 50952), when that surgical item is related to spinal surgery. Items 50600 to 50644 - spine surgery for scoliosis and kyphosis in paediatric patients - are excepted from this rule when claimed in conjunction with items 51113 and 51114.

Meaning of Motion Segment

Motion segment is defined as including all anatomical structures (including traversing and exiting nerve roots) between and including the top of the pedicle above to the bottom of the pedicle below.

Combined Anterior and Posterior Surgery

Combined anterior/ posterior surgery items 51061, 51062, 51063, 51064, 51065 and 51066 cannot be claimed with any item between 51020 and 51045 (i.e. items for spinal instrumentation, posterior bone graft and/or anterior column fusion).

Spinal instrumentation

Spinal instrumentation items 51021 to 51026 cannot be claimed for vertebral body tethering for the treatment of scoliosis. Medicare benefits are not payable for this procedure.

Full clinical details should be documented in the patient notes, including the number of motion segments fused, which demonstrates the clinical need for the service, as this may be subject to audit.

Interpretation of Lumbar Spinal Fusion

Lumbar spinal fusion may not be claimed for chronic low back pain for which a diagnosis has not been made.

TN.8.142 Spinal Decompression - Items 51011 to 51015

Items 51011 to 51015 are for services which include discectomy, decompression of central spinal canal by laminectomy or partial corpectomy (vertebral spurs and osteophytes; less than 50% of the vertebral body), and decompression of the subfacetal recess, the exit foramen and far lateral (intertransverse) space.

Items 51011 to 51015 should only be used for direct decompression, and not where decompression occurs as an indirect result of the procedure performed. Direct decompression enables the cord and exiting nerve roots to be visualised, and the neural structures decompressed.

Through the anterior approach to the cervical spine, direct decompression can be performed with the resection of the annulus and posterior longitudinal ligament (PLL) and/or uncovertebral joints, the removal of herniated nucleus pulposa (HNP) or osteophytes. In the anterior lumbar interbody space, direct decompression can occur with resection of the posterior annulus and PLL, and removal of the HNP or osteophytes to visualise the cauda equina and decompress the neural structures.

With XLIF and OLIF, decompression can only be indirect.

For decompression procedures, only one item is selected from 51011 to 51015.

For posterolateral spinal fusion without instrumentation, if a decompression procedure is combined with the fusion, two item numbers can be selected: one from 51011 to 51015 and one from 51031 to 51036.

For posterolateral spinal fusion with instrumentation, two item numbers can be selected: one from 51020 to 51026 and one from 51031 to 51036. If decompression is also performed, three items can be selected: one from 51011 to 51015, one from 51020 to 51026 and one from 51031 to 51036.

For instrumented spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers can be selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

If more than 50% of a vertebral body is resected (piecemeal vertebrectomy) an item from 51051 to 51059 can be selected in addition to an item from 51011 to 51015.

Items 51011 to 51015 can be used when the purpose of the laminectomy is exposure or posterior spinal release.

TN.8.143 Spinal Instrumentation (cervical, thoracic and lumbar) - Items 51020 to 51026

Items 51020 to 51026 are intended for spinal instrumentation at any level. The appropriate item is determined by the number of motion segments instrumented, barring item 51020 which applies to one vertebra.

The use of items (51021 to 51026) excludes vertebral body tethering for the treatment of scoliosis.

Full clinical details should be documented in the patient notes, including the number of motion segments fused, which demonstrates the clinical need for the service, as this may be subject to audit.

For posterolateral spinal fusion with instrumentation, two item numbers are selected: one from 51020 to 51026 and one from 51031 to 51036. If decompression is also performed, three items are selected: one from 51011 to 51015, one from 51020 to 51026 and one from 51031 to 51036.

For instrumented spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers are selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

TN.8.144 Posterior and/or Posterolateral (intertransverse or facet joint) bone graft (cervical, thoracic and lumbar) - Items 51031 to 51036

Items 51031 to 51036 are for services which include local morcellized, artificial or harvested bone graft with or without bone morphogenic protein (BMP).

For posterolateral spinal fusion without instrumentation, if a decompression is combined with the fusion, two item numbers are selected: one from 51011 to 51015 and one from 51031 to 51036.

For posterolateral spinal fusion with instrumentation, two item numbers are selected: one from 51020 to 51026 and one from 51031 to 51036. If decompression is also performed, three items are selected: one from 51011 to 51015, one from 51020 to 51026 and one from 51031 to 51036.

For instrumental spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers are selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

TN.8.145 Anterior column fusion, with or without implant, or limited vertebrectomy (less than 50%) and anterior fusion (cervical, thoracic and lumbar) - Items 51041 to 51045

Items 51041 to 51045 are for services which include placement of local morcellized, artificial, harvested bone graft, bone morphogenic protein (BMP) and prosthetic devices into the invertebral space. Artificial bone grafting materials must be used in accordance with the manufacturer’s instructions.

Items 51041 to 51045 are to be selected irrespective of surgical approach (anterior, direct lateral or posterior via open or minimally invasive techniques).

For instrumented spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers are selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

For and instrumented anterior cervical decompression and fusion, (with or without cage) three items are selected: one from 51011 to 51015, one from 51020 to 51026, and one from 51041 to 51045.

Items 51041 to 51045 cannot be claimed with any item between 51051 and 51059 if performed at the same motion segment.

If an assisting surgeon is used at any time during the procedure, then 51160 or 51165 should be used in isolation by the assisting surgeon. If the assisting surgeon needs to perform complex non-spinal surgery, they may use a more appropriate item from outside the spinal surgery schedule.

TN.8.146 Spinal Osteotomy and/or vertebrectomy - Items 51051 to 51059

Items 51051 to 51059 are intended for spinal osteotomy and/or vertebrectomy at any level.

For the purpose of items 51054, 51055 and 51056, the definition of piecemeal or subtotal excision is the removal of at least 50% of the vertebral body.

Items 51051 to 51059 cannot be claimed with any item between 51041 and 51045 if performed at the same motion segment.

TN.8.147 Anterior and Posterior (combined) Spinal fusion under one anaesthetic via separate incisions - Items 51061 to 51066

Only one of these items should be billed for any appropriate combined anterior and posterior surgeries which are completed under one anaesthetic. The appropriate item is determined by the number of motion segments to which grafting and fusion occur.

These items cannot be claimed with any item between 51020 to 51026, 51031 to 51036 and 51041 to 51045.

If a laminectomy is included, an item from 51011 to 51015 can also be used appropriate to the level of decompression.

If spinal osteotomy or vertebrectomy (>50%) is performed as part of the combined anterior/posterior approach, it is appropriate to claim one item between 51051 to 51056 in addition to an item between 51061 to 51066.

TN.8.148 Odontoid Screw fixation – Item 51103

This item is not for use when another item is claimed for the management of the odontoid fracture.

TN.8.149 Application of items 51160 and 51165

If the spine surgeon performs their own exposure to the thoracic or lumbar spine then 51160 or 51165 can be added to the claim for the overall surgery. If an assisting surgeon is used at any time during the procedure, then 51160 or 51165 should be used in isolation by the assisting surgeon. If the assisting surgeon needs to perform complex non-spinal surgery, they may use a more appropriate item but not in combination with 51160 or 51165. If an exposure surgeon claims a number from any section of the MBS schedule, the spinal surgeon cannot claim 51160 or 51165.

TN.8.150 Correction of Developmental Breast Abnormality - (Items 45060 to 45062)

Full clinical details must be documented in patient notes, including pre-operative photographic and / or diagnostic imaging evidence as specified in the item descriptor which demonstrates the clinical need for the service, as this may be subject to audit.

Volumetric measurement of the breasts should be performed using a technique which has been reported in a published study.

TN.8.151 Mohs surgery service caseload

Services under items 31000, 31001 and 31002 should make up at least 90% of a Mohs surgeon's caseload of items 31000-31005 annually.

TN.8.152 Colonoscopy Items (items 32222-32229)

It is expected that clinicians using the MBS items for colonoscopy also refer to the updated National Health and Medical Research Council (NHMRC) approved Clinical practice guidelines for the prevention, early detection, and management of colorectal cancer: Risk and screening based on family history (the Guidelines, 2023); and the clinical practice guidelines for surveillance colonoscopy (2019).

The 2023 Guidelines recommend that age-appropriate patients with a near-average risk (no family history of colorectal cancer) or above average, but less than twice the average risk (only one first degree relative with colorectal cancer diagnosed at age 60 or older), are offered biennial screening using an immunochemical faecal occult blood test (iFOBT). For patients who fall under the above risk categories, the guidelines **do not** support the use of colonoscopy unless the patient has symptoms or a positive iFOBT.

When colonoscopy is considered clinically appropriate, general practitioners should ensure colonoscopy referral practices align with applicable national guidelines, including the Royal Australian College of General Practitioners' guidelines for preventive activities in general practice (the Red Book). Additionally, surveillance colonoscopy protocols should be determined based on high-quality endoscopy in a well-prepared colon using known histology information from most recent and previous procedures.

Colonoscopy to the caecum

Items 32219, 32222-32228 specify endoscopic examination to the caecum. If preparation is inadequate to allow visualisation to the caecum, item 32084 should be billed. The 'to the caecum' requirements for colonoscopy examinations do not apply to patients who have no caecum following right hemi colectomy. For these patients the examination should be to the anastomosis.

Colonoscopy following a positive faecal occult blood test (FOBT)
Item 32219 should be used for colonoscopies following a positive result from a FOBT undertaken for screening purposes. A FOBT is considered to be a screening test when the patient is asymptomatic.
If a patient has presented to their practitioner with symptoms and subsequently receives a positive FOBT result as part of their diagnostic work up, these patients should be billed for their colonoscopy under item 32222. Providers are encouraged to register their patients' results and engage with the National Cancer Screening Register for more information www.ncsr.gov.au. Patients who have previously had a colonoscopy relating to a positive FOBT should not have a repeat colonoscopy outside the intervals unless determined clinically relevant. Where a provider deems a repeat colonoscopy necessary outside the schedule, item 32228 should be used, which is available once per patient per lifetime.

Colonoscopy where a polyp/polyps are removed
Items 32219, 32222-32226 and 32228 provide for diagnostic colonoscopy when claimed alone. Where a polyp or polyps are removed during the colonoscopy, item 32229 should also be claimed in association with the appropriate colonoscopy item.

Where polyps >= 25 mm are removed via endoscopic mucosal resection (EMR), item 32230 should be billed and is inclusive of the service described in colonoscopy items 32219, 32222-32226 and 32228.

Colonoscopy where a patient has a moderate or high risk of colorectal cancer due to family history
Item 32223 should be used for patients considered at moderate or high risk of colorectal cancer due to family history.

Moderate risk is defined by the risk of developing colorectal cancer being at least two times higher than average, but could be up to four times higher than average if they have any of the following:
- one first degree relative less than 60 years of age at diagnosis; OR
- two first degree relatives with a history of colorectal cancer; OR
- one first degree relative and one or more second degree relatives with a history of colorectal cancer.

Colonoscopy should be offered every five years starting at 10 years earlier than the earliest age of diagnosis of colorectal cancer in a first-degree relative or age 50, whichever is earlier, to 74.

High Risk is defined by the risk of developing colorectal cancer being at least four times higher than average, but could be up to 20 times higher than average, if they have any of the following:

- two first-degree relatives AND one second-degree relative with colorectal cancer, with at least one diagnosed before the age of 50; OR

- two first-degree relatives AND two or more second-degree relatives with colorectal cancer diagnosed at any age; OR

- three or more first degree relatives with colorectal cancer diagnosed at any age.

Colonoscopy should be offered every five years starting at 10 years younger than the earliest age of diagnosis of colorectal cancer in a first-degree relative or age 40, whichever is earlier, to age 74.

Definition of previous history (items 32223-32225)
For items 32223-32225 the most appropriate item to be billed is determined by the previous history of the patient. Previous history for the purpose of these items is defined by number, size, and type of adenomas removed during any previous colonoscopy.

Although a patient is eligible for a colonoscopy every five years under item 32223, clinical guidelines indicate that colonoscopy every 10 years is sufficient if they have a previous history of 1-2 low risk adenomas.

Exception item (item 32228)
Where the clinician is unable to access sufficient patient information to enable a colonoscopy to be performed under items 32222-32226, but in their opinion, there is a clinical need for a colonoscopy, then item 32228 should be used. This item is available once per patient per lifetime.

Timing of colonoscopy following polypectomy should conform to the recommended surveillance intervals set out in clinical guidelines, taking into account individualised risk assessment. In the absence of reliable clinical history, clinicians should use their best clinical judgement to determine the interval between testing and the item that best suits the condition of the patient.

Time intervals
Items 32223, 32224, 32225 and 32226 have time intervals for repeat colonoscopy which are consistent with guidelines. These services are payable under Medicare only when provided in accordance with the approved intervals.

Patients may fit several categories and the most appropriate fit is a matter for clinician judgement with the highest risk indicating what subsequent colonoscopy intervals are appropriate. The examples provided below show that the result of the histopathology will not lengthen the surveillance intervals (in the case of patient with familial adenomatous polyposis (FAP) or Lynch syndrome) and may actually shorten the surveillance intervals.

Example 1
A patient at high risk of colorectal cancer with FAP or Lynch syndrome has a number of polyps removed at a surveillance colonoscopy. Item 32226 and 32229 are the appropriate items to bill. If the histology result returns 1-2 adenomas for patients at low to moderate risk then the next surveillance colonoscopy is recommended in 5 years. However, the patient's familial condition means that a shorter interval (12 months) is recommended and payable.

Example 2
A patient at moderate risk of colorectal cancer because of family history has a number of polyps removed at a surveillance colonoscopy. Item 32223 and 32229 are the appropriate items to bill based on the patient's family history. If the histology testing returns showing an adenoma with high-risk histological features then the next surveillance colonoscopy is recommended in 3 years instead of 5 years.

How to use the items with new patients who have undergone previous colonoscopy

For new patients, practitioners should make reasonable efforts to establish a patient's previous colonoscopy history. Patients whose care continues within one practice should have the relevant history readily available to guide decision making. Information can be sourced from My Health Record, the records department of the hospital where the previous procedure occurred, the GP, or the patient. The patient's MBS claims history for colonoscopy services will also assist with this.

For audit purposes it is important to record the most appropriate item. In accordance with good practice, clinicians are required to maintain records that include pathology results which must be made available to the patient or other practitioners as required.

The Australian Commission on Safety and Quality in Health Care's Colonoscopy Clinical Care Standard states all facilities and clinicians delivering colonoscopy services must provide a timely copy of the colonoscopy report and

histology result to the patient and their GP. For National Bowel Cancer Screening Program patients, outcome reporting should be provided to the National Cancer Screening Register. Compliance with the Colonoscopy Clinical Care Standard is mandatory under the Australian Health Service Safety and Quality Accreditation Scheme.

Patient eligibility for colonoscopy services
All patients who require a colonoscopy will be eligible for a service. However, MBS benefits will not be claimable for services which do not meet the clinical indications and the item requirements for a colonoscopy or a repeat colonoscopy where the interval is specified in the item. Practitioners should ensure that their practice conforms to the approved clinical guidelines.

Practitioners providing colonoscopy services can call Services Australia on 132 150 to check a patient's claiming history. The patient's Medicare card number will be required together with the range of item numbers to be checked. For example, the new item numbers for colonoscopy services are in the range 32223-32229. The operator will interrogate the patient's claiming history and provide advice on any claims paid for a colonoscopy service within the range of items specified and the date of the service. They will also be able to confirm any restriction on the frequency of the item claimed which would prevent a benefit from being paid if the service was provided again within the restricted period. Providers can also check a patient's eligibility via Health Professional Online Services (HPOS). HPOS will be able to return advice on whether a service is payable or not payable.

Patients can also seek clarification from Services Australia by calling **132 011** or access their own claiming history through My Health Record or by establishing a Medicare online account through myGov or the Express Plus Medicare mobile app.

The Services Australia enquiry lines for providers and for patients is available 24 hours a day, seven days a week. Further information can be found on the Services Australia website.

TN.8.153 Urology Oncology: Intestinal Conduit - (Items 36600 and 36603)
Patients undergoing these procedures should ideally be treated at a facility adequately resourced for stoma therapy support, where High Dependency Units or Intensive Care Units, experienced nursing staff, and stomal therapy is available.

TN.8.154 Urology Oncology: Nephrectomy and Nephroureterectomy - (Items 36516, 36519, 36522, 36528, 36529, 36531, 36532, 36533 and 36576)
Best practice in treating kidney cancer patients with an estimated glomerular filtration rate (eGFR) $<60ml/min/1.73m^2$ involves multi-disciplinary management in collaboration with a nephrologist.

TN.8.155 Paediatric and reconstructive urology: Pyeloplasty - (Item 36567)
Where laparoscopic surgery is used, this should allow for retroperitoneal as well as abdominal approaches.

TN.8.156 Paediatric and reconstructive urology: Ureterolysis - (Item 36615)
Item 36615 should be used only where there is radiological evidence of obstruction or proximal dilatation of the ureter at surgery. Routine dissection of ureter as part of another operation is not considered ureterolysis for ureteric obstruction.

TN.8.157 Urology Oncology: Bladder Excision or Transection - (Items 37000 and 37014)
Best practice in management of invasive bladder cancer is to discuss cases at multi-disciplinary meetings to determine the role of neo-adjuvant chemotherapy prior to surgery or radiation therapy with or without chemotherapy. Information and management decisions on patient care from the multi-disciplinary meeting should be communicated to the referring GP in a timely manner.

TN.8.158 Urology Oncology: Cystoscopy - (Item 36842)
The co-claiming restrictions for 36842 with items 36812, 36827 to 36863 and 37203, prevent the restricted items from being co-claimed as part of the same procedure, but do not prevent the restricted items from being claimed as separate procedures on the same day.

TN.8.159 General Urology: Bladder repair and Cystotomy - (Item 37011)
Co-claiming of this item is reasonable in urgent situations that cannot be resolved with a urethral catheter alone.

TN.8.160 Urology Oncology: Prostate Biopsy - (Item 37216 and 37219)
Best practice is to ensure patients are informed of the uncommon but serious risk of severe infection when a transrectal needle biopsy is performed, and that alternative methods of biopsy are available that reduces this risk. Practitioners are to ensure that the referring GP is informed of the biopsy result as soon as possible (optimally 2-4 weeks) after the biopsy. This ensures that GPs will be informed early after diagnosis of prostate cancer, and will be in a better position to support the patient after diagnosis.

TN.8.161 Urology Oncology: Prostatectomy - (Items 37210, 37211, 37213 and 37214)
Best practice prior to claiming for a 37210, 37211, 37213 and 37214 would be for the operating surgeon to have a long consult with the patient within 6 months prior to surgery to discuss and provide patients with written information about all guideline-endorsed treatment options for their condition. A thorough consult discussing all available treatment modalities, is required to ensure patients make well-informed decision about their treatment.

Multi-disciplinary management constitutes clinical best practice in patients with intermediate risk or advanced prostate cancer. As such, patients should ideally be reviewed by a multi-disciplinary team before a treatment decision is made. Multi-disciplinary teams involve radiation oncologists (for alternate radical treatments), medical oncologists (for adjuvant or therapeutic approaches) and other disciplines (e.g. urology nurses, exercise physiotherapists, exercise physiologists, physiotherapists, psychologists, pathologists, radiologists). Recommendations from multi-disciplinary reviews should be documented in writing and provided to the patient and referring GP.

Men in whom curative treatment for prostate cancer is recommended, should be offered and encouraged to discuss treatment options with a urologist and a radiation oncologist prior to any treatment, as part of fully informed decision making. A record of a patient's decision not to accept a referral to a radiation oncologist (from the urologist or general practitioner) should be clearly documented in the patient's medical record.

TN.8.162 Prostate: Benign prostatic hyperplasia and prostatectomy - (Item 37200)
The laparoscopic or robotic assisted approaches to prostatectomy may include trans-peritoneal or extra-peritoneal access.

TN.8.164 General Urology: Lengthening of penis - (Item 37423)
The partial penectomy or penile epispadias secondary repair does not need to occur during the same episode that item 37423 is claimed.

TN.8.165 General Urology: Lymph Node Dissection - (Item 37607 and 37610)
Items 37607 and 37610 should be performed using a bilateral template.

TN.8.166 Item 40803 - co-claiming restrictions
Items 39015, 39503, 39906 and 40104 do not apply to a service if the service is provided in conjunction with the service described in item 40803.

TN.8.167 Breast Prosthesis Removal (Item 45551)

Providers should note that 45551 is intended to be claimed when there is a medical indication for performing capsulectomy, such as capsular contracture, presence of a mass within the capsule (seen on pre-operative imaging or intraoperatively) or evidence of Breast Implant Associated Anaplastic Large Cell Lymphoma or other malignancy. If this item is claimed the capsule must be sent for histopathology.

TN.8.168 Procedure for osteotomy (47501, 48400 - 48427)

An osteotomy is a planned bone cut that is intended to realign the bone or alter the length of a bone.

TN.8.169 Procedure for the treatment of unicameral bone cysts (Item 47900)

The item is for the treatment of unicameral bone cysts and is not to be used for the treatment of other cystic lesions of bone such as geodes, subchondral cysts, arthritis associated cysts, or cysts associated with anterior cruciate ligament grafts.

TN.8.171 Procedure for neoplastic mass lesions - intralesional or marginal excision of bone tumour (Items 50203 - 50209)

- The items 50203, 50206 and 50209 are not for removal of a subchondral cyst (geode).
- The items include all aspects of the surgical approach, the resection, and the subsequent reconstruction (as required).
- The resection of a tumour and associated reconstruction includes any neurolysis, arthrotomy, synovectomy, joint stabilisation, ligamentous stabilisation or reconstruction, tendon transfer of any kind, use of any arthroscopic procedure, osteotomy or osteectomy (with or without bone grafting and / or internal fixation), bone grafting (with or without internal fixation), arthroplasty, arthrodesis, internal fixation by any technique, rhizolysis, laminectomy, or spinal fixation, fusion or grafting.

TN.8.173 Procedure for neoplastic mass lesions - wide excision of bone tumour (Items 50212 - 50224)

The histological diagnosis of the aggressive or malignant nature of the tumour should have been previously documented.

TN.8.174 Procedure for neoplastic mass lesions - wide excision of bone tumour (Item 50212)

- The item includes all aspects of the surgical approach, the resection, and the subsequent reconstruction by the same surgeon (as required).
- The resection of a tumour and associated reconstruction includes any bony or soft tissue procedures.
- A second surgeon may claim additional items used in soft-tissue reconstruction associated with tumour resections.

TN.8.175 Procedure for neoplastic mass lesions - wide excision of bone tumour (Items 50215 - 50224)

- The items include all aspects of the surgical approach, the resection, and the subsequent reconstruction by the same surgeon (as required).
- The resection of a tumour and associated reconstruction includes any bony or soft tissue procedures, except for bone grafting items which may be co-claimed where appropriate.
- A second surgeon may claim additional items used in soft-tissue reconstruction associated with tumour resections.

TN.8.176 Procedure for neoplastic mass lesions - amputation (Items 50233 - 50239)

- The histological diagnosis of the aggressive or malignant nature of the tumour should have been previously documented. The item includes all aspects of the surgical approach, the resection, and the subsequent reconstruction by the same surgeon (as required).
- The resection of a tumour and associated reconstruction includes any bony or soft tissue procedures.

- A second surgeon may claim additional items used in soft-tissue reconstruction associated with tumour resections.

TN.8.177 Procedure for bone graft (Items 48245 - 48257)

- Bone grafts may be free, meaning the bone flap is not vascularised.
- Bone harvested with a vascular pedicle would be referred to as a pedicled bone flap.
- Item 48254 covers harvesting and insertion of a pedicled bone flap.
- Item 48254 does not cover free bone flaps, however alternative MBS items may be appropriate, for example 48245 or 48248.

TN.8.178 Procedure for bone graft using bone graft substitutes (Item 48257)

'Other graft substitute' does not include demineralised bone matrix or bone graft substitutes such as synthetic materials, ceramics (bone void fillers), collagen composites, composite cement materials, bone morphogenetic protein, or recombinant human bone morphogenetic protein.

TN.8.179 Procedure for removal of internal fixation (Item 47924 - 47929)

- Items 47924, 47927 and 47929 are appropriate to be claimed once per bone.
- Where an implant crosses a joint, or multiple bones, the item should be claimed once, using one of the items, rather than multiple claims of items 47924 and 47927 and 47929.

TN.8.180 Procedure for tendon repair (Item 47954)

For the purpose of item 47954:

1. the service is per tendon if it is the primary procedure; and
2. where a tendon is conjoined or has common origin, it is considered one tendon.

TN.8.182 Procedure for ligament repair, reconstruction and associated intra-articular surgery (Items 49536 and 49542)

- These items are intended to cover all knee ligament repair and reconstruction procedures and associated intra-articular surgery, including (but not limited to), meniscal surgery, notchplasty, chondroplasty and removal of loose bodies.
- Repair is reattachment of a displaced structure and reconstruction is surgery that modifies or augments underlying anatomy. Each item is intended to cover all aspects of the surgery.
- In rare circumstances, patients may require additional osteotomy or patella-femoral stabilisation and in these instances, the relevant item numbers can also be claimed.

TN.8.183 Procedure for arthroscopic knee surgery (Items 49570 - 49590)

- Only a single arthroscopy item for each procedure may be utilised per knee.
- This item must be for the most complex procedure undertaken and must not be utilised in conjunction with any other knee arthroscopy item. Refer to the Australian Orthopaedic Association guidelines for appropriate use.
- Osteoarthritis is a progressive disease involving structural and compositional changes of the whole joint. Multiple clinical trials have demonstrated that knee arthroscopic procedures have no clinically meaningful benefit in patients with uncomplicated osteoarthritis.
- Uncomplicated osteoarthritis is defined as a circumstance where the patient's symptoms or illness are not due to obstructive atraumatic chondral, meniscal or chondral lesions, or repairable menisci, sepsis, neoplasia or inflammatory disorders.
- For patients with uncomplicated osteoarthritis, arthroscopy should only be performed in patients with surgeon-confirmed obstructive symptoms (locked or locking knee), or where the identified pathology is atraumatic chondral, meniscal or chondral lesions that are causative of the symptoms.

- Patient selection for knee arthroscopy in the presence of osteoarthritis should conform to the October 2016 Position statement from the Australian Knee Society on arthroscopic surgery of the knee, including reference to the presence of osteoarthritis or degenerative joint disease, or such standards that supersede these.

TN.8.184 Procedure for synovectomy (Items 46335 and 46340)

Item 46340 is intended to be used at wrist level, while item 46335 is intended to be used distal to the wrist.

TN.8.185 Procedure for synovectomy (Items 46335, 46339, 46340 and 46341)

- Procedures 46335, 49339, 46340 and 46341, if performed, include tenoplasty, tenolysis, tendon nodules removal, and neurolysis.
- Item 46339, for flexor tendon synovectomy, includes carpal tunnel release, if performed.
- Items 46340 and 46341 may be for either flexor or extensor tendon synovectomy.
    - Where the procedure is for flexor tendon synovectomy, these items include carpal tunnel release, if performed.
    - Where the procedure is for extensor tendon synovectomy only, carpal tunnel release is not included and may be separately clamed under item 39331 if performed.
- Item 46335, for extensor tendon synovectomy, does not include carpal tunnel release, if performed.
- The item claimed should be chosen based on the tendons being treated rather than the site of the incision.

TN.8.186 Procedure for neurolysis (Item 39329)

“Extensive” neurolysis should include scar tissue involvement of greater than 5 cm and / or post traumatic adhesions not isolated to a local point of decompression.

TN.8.187 Procedure for pulp re-innervation and soft tissue cover (Item 46504)

- Item 46504 includes all steps of the surgical procedure.
- Reconstruction of the secondary defect by direct closure or a split or full thickness graft is also covered by this item.

TN.8.188 Procedure for reconstruction of nail bed (Item 46489)

'Reconstruction' refers to a late secondary procedure.

TN.8.189 Procedure for nerve transposition (Item 39321)

The item may be claimed in elective or trauma contexts in association with fractures.

TN.8.190 Definitions - Hand and Wrist Items

- **Ray:** From the tip of the digit to proximal metacarpal base of that digit, including phalanges and metacarpal.
- **Index ray:** First web in Dupuytren contracture releases is considered part of the index ray.
- **Primary:** Acute injury and first management of a pathology.
- **Secondary:** Delayed or subsequent to primary treatment, or occurring after normal expected relevant tissue healing time.
- **Vascular graft:** Harvesting of graft, insetting and anastomosis of both ends of graft.
- **Nerve graft:** Harvesting of graft, insetting and neurorrhaphy at both ends of graft.
- **Tendon graft:** Harvesting of graft, insetting and tensioning of graft and tendon weave/repair at both ends of graft.
- **Transcarpal amputation:** Includes the hand through the radiocarpal, midcarpal or carpometacarpal joints.
- **Wrist joint:** Includes radiocarpal, midcarpal and radioulnar joints, which are not to be billed independently.

- **Z-plasty:** Raising, transfer, insetting and suturing of both components (flaps) of the Z-plasty procedure.
- **Flexor tendon:** A tendon on the volar aspect of the digits, hand or wrist.
  – Treatment of only two flexors can be claimed per digit/ray.
  – The two slips of flexor digitorum superficialis (FDS) inserting to the middle phalanx are not to be claimed as two tendons and are to be billed as part of the single FDS tendon.
- **Nerve Trunk:** A bundle of nerve fibres enclosed in a connective tissue sheath.

TN.8.191 Procedure for hip arthroplasty (Items 49318, 49319, 49372 - 49398)

For the purpose of acetabular bone grafting:

1. Minor bone grafting is intended to cover Paprosky 1 and 2A defects (i.e. minor acetabular derangement / bone loss).
2. Major bone grafting is intended to cover Paprosky 2B, 2C, 3A and 3B defects (i.e. major acetabular derangement / bone loss). Outside of the acetabulum, a major bone graft is considered to be structural in nature, such as a substantive impaction femoral graft, a strut allograft, or equivalent.

TN.8.192 Procedure for adjustment of a fixator (Item 50310)

It is expected that the item 50310 is used in cases where three or more struts or equivalent hardware is adjusted, or in cases where the adjustment of ring fixator or similar device is undertaken with a minimum duration of 30 minutes, in a clinic setting without anaesthetic.

TN.8.193 Procedure for the application or adjustment of a fixator (Item 50300 - 50309)

Each item can only be used once per bone per treatment episode.

TN.8.194 Procedure for the correction of hallux valgus deformity (Items 49821 - 49838)

- Correction of a hallux valgus deformity involves realignment of the joint using soft tissue stabilization and osteotomy of the metatarsal as needed.
- The following items are not to be used on the same joint: arthroscopy (49730 or 49732), bone removal or osteotomy (48430, 48400 or 48403), joint interposition (49821, 49824 or 49783-49788), arthrodesis procedure, ganglion excision, neurolysis (39330), wound debridement (30023) or joint stabilization unless the procedure is performed at a site separate to the 1st metatarsal.

TN.8.195 Procedure for ligamentous stabilisation (Item 49709)

- The item is intended to be claimed once per ligament complex. In most cases, this will correspond to one incision.
- Where multiple incisions are used to access the same ligament complex, this item should only be claimed once.

TN.8.196 Procedure for osteotomy (Items 48400 - 48421 and 48430)

- Removal of prominent bone or osteophytes can be billed as an isolated procedure under 48430 or when through a separate incision to other procedures.
- When an osteotomy is performed through the bone to correct a deformity then the appropriate number is chosen from 48400, 48403, 48406, 48409, 48418 or 48421.
- Not to be used when performing joint arthroscopy (49703, 49730 or 49732), bunion correction (49827, 49830, 49833, 49836, 49837 or 49838), neurolysis (39330), wound debridement (30023) or an arthrodesis procedure unless performed at a site separate to the excluded items.

TN.8.197 Procedure for plantar fascia release (Items 49818 and 49854)

Item 49818 is for simple release of the plantar fascia and item 49854 is for extensive plantar fascia release.

TN.8.199 Definitions - Foot and Ankle Items

- **Ray:** From the tip of a digit to the proximal metatarsal base of that digit, including phalanges and metatarsal bones.
- **Hindfoot joints:** Consist of subtalar, talonavicular and calcaneocuboid joints.
- **Hindfoot bones:** Consist of the calcaneus, talus, navicular and cuboid.
- **Midfoot joints:** Consist of naviculocuneiform and tarsometatarsal joints.
- **Midfoot bones:** Consist of cuneiforms.
- **Major ankle tendons:** Consist of the Achilles', tibialis anterior, tibialis posterior, peroneal (both longus and brevis), extensor hallucis longus and flexor hallucis longus tendons.
- **Flexor tendon:** Both the flexor digitorum longus and flexor digitorum brevis tendons.
- **Extensor tendon:** Both the extensor digitorum longus and extensor digitorum brevis tendons.
- **Reconstruction of a tendon:** Treatment of a degenerative tendon where more than end-to-end repair of tendon rupture is involved.
- **Transtarsal amputation:** Involves amputation of the foot through the tarsal or metatarsal bones, or through the tarsometatarsal joints.
- **Joint debridement:** Removal of osteophytes, removal of part of the joint, and removal of intervening soft tissue, loose bone ossicles or fragments from one or both sides of a joint.
- **Primary treatment:** Acute and first management of an injury or pathology.
- **Delayed or secondary treatment:** Subsequent to primary treatment, or occurring after the normal expected healing time for the relevant tissue.
- **Revision procedure:** A repeat operation to replace or compensate for a failed implant, correct a painful non-union of fracture or fusion, correct malunion, reconstruct a failed soft tissue procedure, or correct undesirable complications of previous surgery.
- **Operative exposure:** Includes (if performed) arthrotomy and/or arthroscopy of joint, washout of joint, removal of loose fragments or loose bodies, synovectomy of neurovascular bundle and closure of capsule.
- **Radical plantar fasciotomy or fasciectomy:** Involves the partial or complete removal of the plantar fascia, but does not involve simple release of the fascia.

TN.8.200 Procedure for arthrodesis in the foot and ankle

- An arthrodesis consists of joint preparation, removal of surrounding osteophytes, intraarticular joint correction and fixation by any means.
- Bone procedure items (48430, 48400, 48403, 48406, 48409, 48419, or 48420) are not to be claimed unless performed at a separate site to the arthrodesis.
- Neurolysis (39330), wound debridement (30023) and ganglion excision (30107) items are not to be claimed unless performed at a site separate to the arthrodesis site.

TN.8.201 Procedures for excisional and interpositional arthroplasty in the foot and ankle

- Items for excisional or interposition arthroplasty procedures are indicated for use when items 49734, 48430, 49860, or 49812 do not represent the complete procedure performed.
- Not to be used on the same joint undergoing arthroscopy (49730 or 49732), bunion correction (49827, 49830, 49833, 49836, 49837 or 49838) or an arthrodesis procedure for stabilisation.

TN.8.202 Procedure for arthroscopy in the foot and ankle (Items 49703, 49730 and 49732)

- Arthroscopy of joint includes associated intraarticular pathology treatment, such as treatment of cartilage, loose bodies, synovectomy, scar removal, and excision of exostosis by arthroscopic means.
- In cases of inflammatory synovitis or osteochondral defect >1.5cm^2, it is appropriate to use item 50312.

TN.8.204 Procedures for tendon transfer (Items 49724 and 49736)

- An adjacent tendon transfer is defined as a side to side repair or transfer of an adjacent tendon to the tendon being reconstructed and covered under 49724.

- When a tendon is harvested from a site separate to the reconstructed tendon or moved to the contralateral side of the foot then item 49736 can be combined.

TN.8.205 Peritonectomy surgery - (item 30732)

Item 30732 (peritonectomy of duration greater than 5 hours, including hyperthermic intra-peritoneal chemotherapy) represents a complete medical service and is inclusive of all procedures performed as part of peritonectomy surgery and chemotherapy. Accordingly, item 30732 cannot be co-claimed with the MBS items for the individual procedures performed as part of the surgery or chemotherapy items.

Note the time requirement for item 30732 refers to operative time only, not overall theatre utilisation time.

On the occasion that peritonectomy surgery is completed in less than 5 hours, and therefore not meeting the item requirements for item 30732, it may be appropriate for relevant individual procedure and chemotherapy items to be claimed, if the requirements of these items are met, with application of the multiple operations rule.

TN.8.206 Exploration of pancreas or duodenum for endocrine tumour (Item 30810)

Extensive exploration includes full surgical exposure of the pancreas with intraoperative ultrasound or endoscopy as required.

TN.8.207 Excision of pilonidal sinus - (item 30676)

Where a fasciocutaneous flap is required to close the pilonidal sinus excision defect item 45203 (single stage local flap to repair defect) can be co-claimed with item 30676.

TN.8.208 Cholangiography and cholecystectomy items (items 30439, 30442, 30445)

An Intraoperative ultrasound of the biliary tract or operative cholangiography (30439) can be claimed in association with a cholecystectomy (item 30448 or 30449).

A choledochoscopy (item 30442) can be claimed in association with a cholecystectomy (30448).

For item 30445 an attempt at cholangiography requires use of a cholangiography catheter and presence of radiography staff and equipment in theatre.

TN.8.209 Procedure for diagnostic biopsy of bone tumour (Items 50200 and 50201)

- For items 50200 and 50201 histological proof of either the benign, the aggressive benign, or the malignant nature of the process should be obtained.
- Histological proof may be obtained in conjunction with items 50203, 50206 or 50209. It may be obtained at the time of the procedure (e.g. by intraoperative frozen section analysis of the tumour tissue).

TN.8.210 Eligibility for Paediatric Conditions

This item may be claimed without evidence of right heart overload in highly rare paediatric conditions.

TN.8.211 In and Out of Hospital

Claiming Guidance

- The service to which item 38285 applies may be claimed for the insertion of an implanted loop recorder (ILR) rendered to a patient as part of an episode of hospital treatment, including services provided in hospital outpatient settings.
- Private health insurers are required to pay benefits for products listed on the Prostheses List, if the product is rendered to a patient with the appropriate level of cover, as part of an episode of hospital treatment or hospital substitute treatment.
- When the ILR is inserted in the outpatient setting (the specialist or consultant physicians private rooms/clinic) the private insurer may opt to cover the cost of the device, but is not required to do so.

TN.8.213 Congenital surgery alternative

For congenital surgery, alternative dissolvable options may be used instead of the insertion of permanent fixed rings which may result in negative long term outcomes.

TN.8.214 International guidelines and claiming guide for extraction of leads

International guidelines for chronic lead extraction state that delays from injury to open access to the heart of more than 5–10 minutes are often associated with a fatal outcome. Preparations for this procedure should provide for this rare but life threatening circumstance.

Claiming guide chronic lead extraction:

When the service to which item 38358 applies is provided to a patient by an accredited **interventional cardiologist** the following claiming will apply:

- Item 38358 is to be claimed by the accredited interventional cardiologist; and
- Item 90300 is to be claimed by the standby cardiothoracic surgeon.

When the service to which item 38358 applies is provided to a patient by an accredited **cardiothoracic surgeon** the following claiming will apply:

- Item 38358 is to be claimed by the accredited cardiothoracic surgeon only

Claiming guide leadless pacemaker extraction (for an interventional cardiologist):

When the service to which item 38374 or 38375 applies is provided to a patient by an accredited **interventional cardiologist** the following claiming will apply:

- Item 38374 is to be claimed by the accredited interventional cardiologist; and
- Item 90300 is to be claimed by the standby cardiothoracic surgeon.

When the service to which item 38375 applies is provided to a patient by an **accredited cardiothoracic surgeon** the following claiming will apply:

- Item 38375 is to be claimed by the accredited cardiothoracic surgeon only

Claiming guide TAVI intermediate risk (38514) or TAVI low risk (38522):

When the service to which item 38514 or 38522 applies is provided to a patient by an accredited **interventional cardiologist** the following claiming will apply:

- Item 38514 or 38522 is to be claimed by the accredited interventional cardiologist; and
- Item 90300 is to be claimed by the standby cardiothoracic surgeon.

When the service to which item 38514 or 38522 applies is provided to a patient by an accredited **cardiothoracic surgeon** the following claiming will apply:

- Item 38514 or 38522 is to be claimed by the accredited cardiothoracic surgeon only

TN.8.215 Discussions of Findings and Abandoned Procedures

Discussions of the results

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

Abandoned T8 Surgical Procedures and Selective Coronary Angiography

The new selective coronary angiography items now have time restrictions applied whether claimed by the same or different providers. It is important for the patient that if a provider cannot complete (abandoned) a comprehensive diagnostic angiography that appropriately informs the diagnosis and treatment pathway or is discontinued due to the clinical status of the patient, item 30001 is claimed. This will allow claiming by the provider who subsequently completes the entire diagnostic angiography service taking into consideration the time restrictions for each of the selective angiography items.

TN.8.216 Claiming restrictions to graft patients

Claiming Guidance

This item is only claimable when the patient has graft arteries present and has undergone angiographic investigation of the native coronary arteries and any graft arteries, which can include but is not limited to free coronary grafts attached to the aorta or direct internal mammary artery grafts.

TN.8.217 Staging rules for PCI for acute

Staging

- If a staged procedure is appropriately performed over multiple days, items 38316, 38317 or 38319 must be used for subsequent stages.
- For subsequent stages of an acute percutaneous coronary intervention completed up to 3 months after the initial procedure, it is expected that the patient would receive the subsequent stage/s of the intervention based on the qualifying indication for the initial procedure

Vascular Territories

- The item number claimed should reflect the number of coronary vascular territories (Left Anterior Descending, Circumflex or Right Coronary Artery distribution) that are treated during the procedure, not the total number of treated territories the patient has received to date.
- For isolated Left Main (no involvement of the bifurcation), a single territory should be claimed but if the treated segment involves the bifurcation then 2 territories should be claimed.
- The Intermediate Artery when treated in isolation is single territory, when treated with the Left Anterior Descending or Circumflex or both, should be claimed as two territories.
- A single lesion in a bypass graft should be claimed as single territory regardless of how many vascular territories are supplied by that graft. If the graft has multiple lesions and those lesions are in separate skip portions to a different territory, then an additional territory may be claimed.

TN.8.218 Percutaneous Coronary Intervention (PCI) for stable patients

Stable Angina or Angina Equivalent

- Stable angina or angina equivalent includes chest pain, chest discomfort and/or shortness of breath due to myocardial ischaemia.
- Limiting angina includes patients with symptoms that are Canadian Cardiovascular Society (CCS) class II, III or IV.

Staging

- If a staged procedure is appropriately performed over multiple days, items 38320, 38322 or 38323 should be used for subsequent stages.
- For subsequent stages of a stable percutaneous coronary intervention completed up to 3 months after the initial procedure, it is expected that the patient would receive the subsequent stage/s of the intervention based on the qualifying indication for the initial procedure

Coronary Vascular Territories

- The item number claimed should reflect the number of coronary vascular territories (Left Anterior Descending, Circumflex or Right Coronary Artery distribution) that are treated during the procedure, not the total number of treated territories the patient has received to date.
- The number of coronary vascular territory refers to any of the 3 major arteries (Left Anterior Descending, Circumflex or Right Coronary Artery) or their branches. The item number claimed should reflect the number of coronary vascular territories that are treated during the procedure, not the total number of diseased territories.
- For isolated Left Main (no involvement of the bifurcation), a single territory should be claimed but if the treated segment involves the bifurcation then 2 territories should be claimed.
- The intermediate artery when treated in isolation is considered a single territory, however when treated with the Left Anterior Descending or Circumflex or both, it can be claimed as two territories.
- A single lesion in a bypass graft should be claimed as a single territory regardless of how many vascular territories are supplied by that graft. If the graft has multiple lesions and those lesions are in separate skip portions to a different territory, then an additional territory may be claimed.

TN.8.219 Complex coronary artery disease definition

Complex Coronary Artery Disease

Complex coronary artery disease is defined as

a. a stenosis >50% in the left main coronary artery; or
b. >90% in the proximal left anterior coronary artery; or
c. bifurcation lesions involving side branches with a diameter >2.75mm; or
d. chronic vessel occlusions (>3 months); or
e. severely angulated or severely calcified lesions; or
f. SYNTAX score >23.

Such disease should only undergo PCI with a documented recommendation from a Heart Team Conference.

TN.8.220 Co-claiming a consultation for Paediatric patient

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

TN.8.221 Paediatric conditions exemption

Claiming Guidance

This item may be claimed without evidence of right heart overload in highly rare paediatric conditions such as abnormal development of the right heart. Additionally, in patients under 16 years old, risk of paradoxical embolism is sufficient.

TN.8.222 Indications for Percutaneous transluminal coronary rotational atherectomy

Percutaneous transluminal coronary rotational atherectomy is suitable for revascularisation of stenoses in heavily calcified coronary arteries in the absence of significant lesion angulation or vessel tortuosity in patients for whom coronary artery bypass graft surgery is not indicated.

Item 38309 describes an episode of care and can only be claimed once in a single episode.

TN.8.223 Procedures for stabilisation in the foot and ankle (Items 49734, 48400, 48403, 49809 and 49812)

- Items for stabilisation of a joint procedure are indicated for use when items 49734, 48400, 48403, 49809 or 49812 do not represent the complete procedure performed.
- Not to be used on the same joint undergoing arthroscopy (49730 or 49732), bunion correction (49827, 49830, 49833, 49836, 49837 or 49838) or an arthrodesis procedure for stabilisation.

TN.8.224 Procedure for revision arthrodesis in the hindfoot (Item 49776)

Item 49776 is claimable once per joint.

TN.8.225 Percutaneous Coronary Intervention (PCI) Acute/Unstable

Staging of acute/unstable PCI

- Staging of acute PCI is permissible when clinically appropriate.
- An example of appropriate Acute Coronary Syndrome (ACS) staging could include intervention on an occluded proximal lesion in the context of an ST elevation myocardial infarction (STEMI) and a decision is made not to intervene on a distal lesion as it is difficult to determine whether it is a real lesion (possibly a thrombus) or the patient's haemodynamic status remains compromised (clinically unsafe to continue).

Requirements of subsequent stages of a staged acute/unstable PCI

- The qualifying indication for the initial procedure is to be used as the qualifier for the relevant subsequent stages.
- Subsequent stages are required to be completed within 3 months of the initial procedure otherwise the patient will need to requalify under the appropriate indication (if applicable).
- It would generally be expected that subsequent stages would be completed as soon as is practicable proceeding the initial intervention.
- For subsequent stages of an acute/unstable PCI it is implied that diagnostic angiography has been completed in the previous 3 months and therefore it is only permissible to claim items 38316, 38317 or 38319 for subsequent stages.

Multiple Providers of one episode of care (acute/unstable or stable) PCI – Separate interventional sites or Same interventional site

One of the primary intentions of the changes to selective coronary angiography and PCI items, is to encourage the provision of the entire intervention in a single episode of care. Therefore, the provider should consider that there will be a reasonable need to intervene (revascularise), noting that in some cases intervention is not required (e.g. pressure testing – FFR result does not support the need for stenting).

However, it is recognised that some providers of interventional cardiology services only provide selective coronary angiography (diagnostic) and require a secondary provider to undertake angioplasty, stenting and/or atherectomy.

Non-interventional – selective angiography providers (clinical assessment suggests intervention required)

Acute/Unstable patients

- Acute/Unstable patients should undergo both selective coronary angiography and PCI by an accredited PCI provider in a single episode of care, unless staging is clinically required.
- Rare exceptions might include rural or remote sites that offer diagnostic angiography as a triage service prior to limited availability PCI.
- It would be expected that the non-interventional cardiologist (non-PCI accredited) has a limited role in the management of acute/unstable patients.

Separate hospital/procedural sites (Acute/Unstable or Stable)

- The first provider undertakes the diagnostic angiography and either makes an independent decision or following discussion with the interventional cardiologist refers to the secondary provider at another site for the purposes of revascularisation (e.g. referral from a rural or regional hospital to a metropolitan hospital); therefore
- In this scenario there is a clear delineation between the angiography and revascularisation services due to the different geographical locations (separate episodes of care). Example claiming is as follows:

Acute (ACS) - claiming example

- Provider 1 – site 1 (diagnostic angiography) claims item 38244 (ACS – selective angiography). Provider 2 – site 2 (PCI) claims item 38316 (ACS – PCI single territory)

Abandoned T8 Surgical Procedures and Acute or Stable Percutaneous Coronary Intervention (PCI) – Excluding appropriate staging

The new acute PCI items have time restrictions applied whether claimed by the same or different providers. It is important for the patient that if a provider cannot complete (abandoned) the PCI and rescue PCI needs to be conducted by another provider, item 30001 is claimed. This will allow claiming by the provider who subsequently completes the rescue PCI, taking into consideration the time restrictions for each of the selective angiography items.

The new stable PCI items do not have time restrictions. However, it is important for the patient that if a provider cannot complete (abandoned) the PCI and rescue PCI needs to be conducted by another provider, item 30001 is claimed. This will allow claiming by the provider who subsequently completes the rescue PCI, taking into consideration the time restrictions for each of the selective angiography items.

TN.8.226 Staging Rules for Stable PCI

Staging of non-acute (stable) PCI

- Staging of stable PCI is permissible when clinically appropriate. An example of appropriate stable staging could include intervention on the primary target lesion and a decision is made not to intervene on secondary lesions (in triple vessel disease) due to the patient's deteriorating haemodynamic status (clinically unsafe to continue).

Requirements of subsequent stages of a staged stable PCI

- The qualifying indication for the initial procedure is to be used as the qualifier for the relevant subsequent stages. Subsequent stages are expected to be completed within a reasonable time period following the initial intervention.
- For subsequent stages of a stable PCI it is implied that diagnostic angiography has been completed in the previous 3 months and therefore it is only permissible to claim items 38320, 38322 or 38323 (standalone PCI items) for subsequent stages.
- **Note:** For patients who meet the criteria in subclause (2)(b) of note TR.8.4 in 3 vascular territories (triple vessel disease), whether treated in an initial procedure (items 38314 or 38323) or in subsequent stages (items 38311, 38313, 38320 or 38322) it is expected that the patient must meet the criteria for (2)(b) of note TR.8.4 for each territory for each subsequent stage. This requirement ensures that the patient who has triple vessel disease must meet the criteria for (2)(b) for each territory when staged or completed in an initial procedure.

The Department will be closely monitoring claiming patterns for staged procedures, particularly where volumes for staged procedures at the same site are not consistent with the broader provider claiming base.

Multiple Providers of one episode of care (stable) PCI – Separate interventional sites or Same interventional site.

One of the primary intentions of the changes to selective coronary angiography and PCI items, is to encourage the provision of the entire intervention in a single episode of care. Therefore, the provider should consider that there will be a reasonable need to intervene (revascularise), noting that in some cases intervention is not required (e.g. pressure testing – FFR result does not support the need for stenting).

It is recognised that some providers of interventional cardiology services only provide selective coronary angiography (diagnostic) and require a secondary provider to undertake angioplasty, stenting and/or atherectomy.

Non-interventional – selective angiography providers (clinical assessment suggests intervention required)

Stable patients

It is accepted clinical practice that the following patient pathways for stable PCI service provision (other than a complete service by an accredited PCI cardiologist) may occur when considering the role of the non-interventional cardiologist (non-PCI accredited) as follows:

Ad-hoc PCI:

- Provider 1 completes the selective angiography and hands over to provider 2 to perform the PCI while the patient is still on the cardiac catheterisation table with the arterial access still in place.
- Similar to the acute items, this scenario would likely be rare for e.g. dissection of a coronary artery caused by the angiography catheter that may convert the patient from stable to unstable.
- It is current accepted practice that the selective coronary angiography component of the service can be performed by a non-interventional cardiologist and the PCI component (when required) completed by a PCI accredited provider.
- Ideally ad-hoc stable PCI should be completed by a PCI accredited provider and therefore consideration should be given to current practice site arrangements going forward.

Delayed PCI:

- Provider 1 completes ICA and refers the patient to provider 2, who performs the PCI later on the same day.
- In the stable patient this scenario presents the opportunity to pause and consider whether optimal medical therapy, PCI or coronary artery bypass may be the preferred option in consultation with a PCI accredited cardiologist and/or cardiothoracic surgeon; and
- It also allows for a further opportunity to obtain informed consent from the patient for the proposed intervention.

- In most cases this would involve maintaining the arterial access with an indwelling arterial sheath to avoid repuncture.

Elective PCI:

- Provider 1 completes ICA and refers the patient to provider 2, who performs the PCI on the next day, or any subsequent day.
- Similar to delayed PCI, however the PCI accredited cardiologist may not be available on the same day as when the selective coronary angiography was completed; or
- A short trial of optimal medical therapy is recommended; or
- Further non-invasive functional testing is recommended.

The Department will be closely monitoring claiming patterns, particularly at the same site where selective angiography is completed by a non-accredited cardiologist and the PCI component completed by a PCI accredited provider.

The following provides guidance for when the provider can only undertake the selective angiography component of a complete PCI service (PCI non-accredited provider):

Separate hospital/procedural sites (Stable)

The first provider undertakes the diagnostic angiography and either makes an independent decision or following discussion with the interventional cardiologist refers to the secondary provider at another site for the purposes of revascularisation (e.g. referral from a rural or regional hospital to a metropolitan hospital). In this scenario there is a clear delineation between the angiography and revascularisation services due to the different geographical locations (separate episodes of care). Example claiming is as follows:

- Stable - example
  Provider 1 – site 1 (diagnostic angiography) claims item 38248 stable – selective angiography). Provider 2 – site 2 (PCI) claims item 38320 (stable – PCI single territory)

Same hospital/procedural site (Stable)

- The first provider undertakes the diagnostic angiography and either makes an independent decision or following discussion with the interventional cardiologist requesting that the secondary provider undertakes the revascularisation component.
- Please note that the underlying intention of a complete PCI service is that the entire service, including diagnostic angiography is completed by a single provider where possible.

Abandoned T8 Surgical Procedures and Acute or Stable Percutaneous Coronary Intervention (PCI) – Excluding appropriate staging

The new acute PCI items have time restrictions applied whether claimed by the same or different providers. It is important for the patient that if a provider cannot complete (abandoned) the PCI and rescue PCI needs to be conducted by another provider, item 30001 is claimed. This will allow claiming by the provider who subsequently completes the rescue PCI, taking into consideration the time restrictions for each of the selective angiography items.

The new stable PCI items do not have time restrictions. However, it is important for the patient that if a provider cannot complete (abandoned) the PCI and rescue PCI needs to be conducted by another provider, item 30001 is claimed. This will allow claiming by the provider who subsequently completes the rescue PCI, taking into consideration the time restrictions for each of the selective angiography items.

TN.8.227 Vertebroplasty MBS Service Monitor (item 35401)

For item 35401 practitioners should be registered with and provide relevant service data to the Vertebroplasty MBS Service Monitor, managed by the Interventional Radiology Society of Australasia (IRSA).

IRSA can be contacted via e-mail at secretariat@irsa.com.au for enquiries.

TN.8.228 Varicose Vein Intervention and Proximal Reflux (item 32500)

Claiming Guide for the following procedures:

1. Sclerotherapy (32500)
2. Surgical Dissection and Ligation (Items 32507, 32508, 32511, 32514, 32517)
3. Endovenous Laser Therapy (Items 32520 and 32522)
4. Radiofrequency Ablation (Items 32523 and 32526)
5. Cyanoacrylate adhesive (Items 32528 and 32529)

It is recommended that the medical practitioner performing the above procedures has successfully completed a substantial course of study and training in duplex ultrasound and the management of venous disease, which has been endorsed by their relevant professional organisation.

It is recommended that providers familiarise themselves with the symptoms to be used to assess the severity of chronic venous disease as indicated in the item descriptor. Providers should also refer to the latest Clinical impact, Etiology/Aetiology, Anatomy and Pathophysiology (CEAP) classification description for symptoms, to help determine when intervention is required.

Definition of Proximal Reflux (item 32500)

For the purposes of item 32500, proximal reflux can include: truncal, perforating or other sources of ultrasound demonstrated reflux into the vein/s being treated.

TN.8.229 Appropriate Documentation

Appropriate documentation, ideally with photographic and/or histological evidence, is to be collected and retained to demonstrate the complexity of the procedure performed. Where photographic evidence is not retained, the reasons for this should be clearly documented.

TN.8.230 Hydrotubation (Item 35703)

It is expected that this item should only be billed once per patient per lifetime unless clinically indicated in cases where a successful pregnancy has been achieved following hydrotubation of fallopian tubes or another intervening and documented condition has occurred such a tubal infection, an episode of surgery or conservative treatment of an ectopic pregnancy.

TN.8.231 Hysterectomy (Items 35750, 35751, 35753, 35754, 35756)

Procedure may be undertaken using laparoscopy with any number of ports or by any approach as clinically indicated.

A laparoscopically assisted vaginal hysterectomy is defined as the introduction of the laparoscope to assess the pelvis and commence the procedure taking the round ligaments, adnexal attachments as indicated and to the level of the uterine arteries with the uterine arteries and uterosacral pedicles secured vaginally.

A total laparoscopic hysterectomy is defined as the introduction of the laparoscope to assess the pelvis and complete the procedure laparoscopically including securing the uterine arteries and uterosacral pedicles.

The complex hysterectomy items 35753 and 35754 are intended to cover procedures with increased complexity. 35753 is to be used for the excision of moderate endometriosis. 35754 is to be used for the excision of extensive endometriosis and when side wall dissection is required.

TN.8.232 Documentation collection
Appropriate documentation is to be collected and retained to demonstrate the complexity of the procedure performed.

TN.8.233 National Cervical Screening Program
The procedure should only be performed if a patient satisfies the criteria according to the current National Cervical Screening Program.

TN.8.234 Cervical ablation (Item 35644 and 35645)
- Not for use in patients with a type 3 transformation zone.

- A second ablative treatment for a HSIL (CIN2/3) should NOT be performed (an excisional treatment is indicated in this situation).

- Treatment of high-grade lesions (CIN 2/3) in an immunocompromised patients should be by excisional methods only.

TN.8.235 Gynaecological Oncologist or MDT Review
If the procedure is for glandular high grade abnormality or any suspected invasive cancer the procedure should be performed by a gynaecological oncologist or only after discussion with, or review by, a gynaecological oncologist or gynaecological oncology multidisciplinary team (MDT).

TN.8.236 Radical Debulking with abdominal cavity involvement (Item 35721)
This procedure should be undertaken by a person with appropriate training in line with the National Framework for Gynaecological Cancer Control.

This item includes the extensive dissection and removal of the peritoneum from organs contained in the abdominal/pelvic cavity, including bowel, bladder, spleen, pancreas or liver.

This item does not include resection of bowel, bladder, spleen, pancreas or liver.

This item should not be used for staging procedures for gynaecological malignancy.

This item should not be used for a lymph node recurrence without involvement of peritoneal surfaces.

TN.8.237 Excision of benign vaginal tumours (Item 35557)
This item should not to be used for the sole purpose of vaginal biopsy, drainage or Gartner duct cysts, cautery of granulation tissue, or removal of vaginal polyps.

Item 35615 should be used for vaginal biopsies.

Item 35611 should be used for vaginal polyp removal.

TN.8.238 Partial Vaginectomy (Item 35548)
This item not to be used for vaginal biopsy or polypectomy.

Item 35615 should be used for vaginal biopsies.

Item 35611 should be used for vaginal polyp removal.

TN.8.239 Radical Vulvectomy (Item 35548)

Co-claiming with a relevant flap procedure is permitted. However, deep tissue mobilisation is included in this item.

TN.8.240 Intra-articular injection (Item 39013)

This service must be performed under image guidance. Imaging items can be co-claimed with item 39013 when indicated.

Where intra-articular zygapophyseal joint injection provides a short term effect that is repeatedly observed, consideration should be given to longer lasting pain management techniques.

TN.8.241 Placement of peripheral nerve leads for the management of chronic intractable neuropathic pain (Items 39129 and 39138)

Items 39129 and 39138 are for the insertion of leads that are intended to remain in situ long term. Percutaneous Electrical Nerve Stimulation (PENS) is not to be claimed under these items.

The use of PENS for the management of chronic pain has not been assessed by the Medical Services Advisory Committee (MSAC) or recommended for public funding. Therefore, PENS procedures for management of chronic pain cannot be billed under the MBS, including items 39129 and 39138.

Item 39138 is the appropriate item to claim when surgical lead placement is required for a trial procedure prior to longer term placement. Item 39129 is the appropriate item for the percutaneous placement of leads, including for trial procedures.

Items 39129 and 39138 provide for the insertion of one or multiple leads. There is no intention to change current billing practices for these items, e.g. where more than one lead is inserted as part of an episode then the item can be billed once per lead.

TN.8.244 Implanted device items

As with all interventions, implant procedures should be performed in the context of clinical best practice. This is of particular importance given the high cost of the devices. Current clinical best practice for use of these item numbers includes:

- All procedures being performed in the context of a comprehensive pain management approach with a multidisciplinary team.

- Patients should be appropriately selected for the procedure, including, but not limited to assessment of physical and psychological function prior to implantation with findings documented in the medical record.

- Outcome evaluation pre and post implantation.

- Appropriate follow up and ongoing management of implanted medical devices should be ensured.

Implantable devices require ongoing monitoring and management. If the person providing the implantation service is not the ongoing physician manager of the device, they are responsible for ensuring that appropriate ongoing management has been arranged.

Items 39130 and 39139 provide for the insertion of one or multiple leads. There is no intention to change current billing practices for these items, e.g. where more than one lead is inserted as part of an episode then the item can be billed once per lead.

Item 39133 can be billed twice per attendance where services are separate procedures. Accompanying text is required for these claims such as one item is for the removal of an infusion pump and one item is for the removal or repositioning of a spinal catheter.

TN.8.245 Percutaneous denervation (Items 39110, 39111, 39116 to 39119, 39323)

In the majority of circumstances, thermal radiofrequency should be the modality of choice. Pulsed radiofrequency should only be used in limited cases, such as when an anatomic abnormality precludes the correct positioning of a thermal radiofrequency probe.

Prior to commencing treatment, the patient should be made aware of:

(a) which modality is being used and why;

(b) what longevity of response is expected;

(c) the mechanism involved;

(d) technical details such as the temperature used;

(e) the evidence base for the modality recommended; and

(f) cost

Clear distinctions should be made between thermal (continuous) radiofrequency neurotomy and pulsed radiofrequency of the medial branch of the dorsal rami of spinal nerves for treatment of zygapophyseal pain.

Items 39110, 39111, 39116, 39117, 39118, 39119

There are six MBS items applicable to percutaneous neurotomy (items 39110, 39111, 39116, 39117, 39118 and 39119). The items relate to six regions of the spine (lumbar, thoracic, and cervical divided into left and right sides). These items commenced on 1 March 2022.

Effective 11 April 2022, there are new frequency claiming restrictions for these items.

A patient can now receive percutaneous neurotomy treatment in up to three episodes of care in a 12-month period. An episode of care means one or more percutaneous neurotomy services performed in a single attendance, where clinically relevant.

The percutaneous neurotomy items are claimable per joint treated, not per nerve or lesion.

For compliance purposes, practitioner should record the name of the joint/s that are being treated during an attendance in the patient's clinical notes.

More than one joint in the same region can be treated and claimed on the same day (i.e. as part of the same episode), and joints in another region can also be treated in the same episode.

The Multiple Operation Rule will continue to apply when more than one joint is being treated in the same episode.

The 12-month period is a rolling period, commencing on the date of the first episode (for treatment provided on or after 11 April 2022), to a maximum of three episodes over the next 12 months. For example, if the first episode of treatment is provided on 20 April 2022, up to two further episodes of treatment can be provided up to 19 April 2023.

Treatment provided under these items from 1 March 2022 to 10 April 2022 (inclusive) will not be counted in the 12-month period for the patient.

Treatment of the T12/L1 zygapophyseal joint should be classified as a thoracic region procedure. Accordingly, the thoracic items 39116 or 39117 would be appropriate for such a procedure.

The C7/T1 facet joint is innervated by the medial branches of C7 and C8 (cervical region). Accordingly, the relevant cervical items 39118 or 39119 would be appropriate for such a procedure.

Item 39323

Item 39323 is limited to 6 services for a given nerve per 12-month period. The 12-month period will start from the first time the item has been claimed on or after 1 March 2022 and will continue on a rolling 12-month basis.

For compliance purposes, the applicable nerve name must be documented in the patient record and noted on Medicare claims for item 39323 e.g. '39323 - Right Genicular nerve.'

TN.8.246 Rectal Resection (items 32025, 32026 and 32028)

These rectal resection procedures should be performed with the following requirements:
• in an appropriate setting with High Dependency Unit or Intensive Care Unit availability;
• include multidisciplinary team discussion of patient;
• have patient managed using Enhanced Recovery after Surgery (ERAS) principles; and
• in a setting with adequate access to stomal therapy nurse services.

In addition, item 32028 is appropriately used by 1 surgeon incorporating transanal total mesorectal excision.

TN.8.247 Faecal incontinence management items (32213, 32216 and 32237)

These services may be performed using fluoroscopic guidance.
The relevant fluoroscopic guidance item can be co-claimed with items 32213, 32216 and 32237 when indicated.

TN.8.248 Endometriosis classification system

For the purposes of any item in which an endometriosis grading is referenced the equivalent grade under the American Fertility Society (rAFS) endometriosis classification system is as follows:
Minimal endometriosis is the equivalent of stage I.
Mild endometriosis is the equivalent stage II.
Moderate endometriosis is the equivalent to stage III.
Severe endometriosis is the equivalent stage IV or higher.

TN.8.249 Hysteroscopy (Items 35633 and 35635)

For the purposes of item 35633, minor intrauterine adhesions means Grade 1 under the European Society for Hysteroscopy (ESH) classification system. For the purposes of item 35635, moderate to severe intrauterine adhesions means Grade 2 or higher under the ESH classification system.

TN.8.250 Multi-disciplinary team for cryoablation for renal cell carcinoma

For the purpose of item 36530, a multi-disciplinary team typically includes a urologist, interventional radiologist and oncologist. Patients eligible for Medicare-funded cryoablation need to be considered by the multi-disciplinary team as not suitable for partial nephrectomy and typically have one or more of the following characteristics:

- Elderly and/or frailty;
- High surgical risk;
- Poor renal function;
- Solitary kidney;
- Bilateral kidney tumours.

TN.8.251 Interventional radiologist for renal cell carcinoma cryoablation

For the purpose of item 36530, the procedure is to be performed by an interventional radiologist specially trained for the procedure. Percutaneous cryoablation should be the preferred approach unless the percutaneous approach is considered not suitable for the individual patient by the multi-disciplinary team.

TN.8.252 Circumcision Revision items (items 30661 and 30662)

Items 30661 and 30662 provide for clinically relevant revision surgery following a circumcision procedure (performed on a previous occasion).

A minor repair procedure (item 30661) would apply to the removal of redundant skin, or the correction of minor scarring where there is a clinical need for revision.

A major repair (item 30662) applies to the correction of major scarring where there is a deformity, pain, significant loss of tissue or functional disability.

TN.8.253 Reprogramming of a neurostimulator for the treatment of chronic pain or pain from refractory angina pectoris (items 39131 and 39141)

Items 39131 (in person service) and 39141 (remote service by video conference) provide for the reprogramming of an implanted neurostimulator when this has been deemed clinically relevant for the care of a patient by the treating practitioner.

Item 39131 should be billed if the medical practitioner attends in person, and item 39141 should be billed if the medical practitioner attends remotely by video conference. Item 39141 cannot be provided by phone. Only one service can be billed for a patient on a particular day.

Items 39131 and 39141 should not be billed with each other on the same day, or with another attendance item on the same day unless the consultation pertains to a condition other than chronic neuropathic pain, or pain from refractory angina pectoris.

TN.8.254 Parotid gland surgery - (Items 30247 - 30253)

Exposure of the facial nerve and the great auricular nerve with or without mobilisation are considered integral parts of parotid gland surgery and hence part of the complete procedure for items 30247, 30250, 30251 and 30253. As such, co-claiming of items 39321, 39324, 39327, 39330 is not appropriate.

TN.8.255 Otology - (Item 41647)

Item 41647 applies where use of an operating microscope or endoscope is clinically necessary, such as where examination by conventional means (hand-held or spectacle-mounted auroscope) does not provide sufficient detail.

In addition, item 41647 cannot be claimed for the removal of uncomplicated wax in the absence of other disorders of the ear.

The removal of uncomplicated wax in the absence of other disorders of the ear by operating microscope or endoscope, or the removal of wax by microsuction or syringing using any visualisation method may be claimed as part of an MBS general attendance item provided all other requirements of the item have been met.

TN.8.256 Rhinology - (Items 41707 and 41725)

It is not expected that this item would be claimed with routine endoscopic sinus surgery procedures. It may be legitimately claimed in some advanced sinonasal or tumour procedures.

TN.8.257 Rhinology - (Item 41764)

Item 41764 can be performed on a patient by an eligible speech pathologist on behalf of a specialist in the speciality of otolaryngology head and neck surgery, if:

(a) the service is performed following a written request made by the specialist to assist the specialist in the diagnosis, treatment or management of a laryngeal condition or related disorder in the patient; and

(b) the service is performed in a medical facility; and

(c) the service is performed on the patient individually and in person; and

(d) after the service is performed, the eligible speech pathologist gives the specialist:

(i) recorded dynamic images of, and a copy of the results of, the service; and

(ii) relevant written comments, prepared by the eligible speech pathologist, about those results; and

(e) a service to which item 41764 applies has not been performed on the same patient on the same day.

For the purposes of item 41764, a medical facility may include medical or allied health consulting rooms, hospitals (including outpatient clinics and wards), community health facilities, and residential care homes (as defined in the *Aged Care Act 2024*).

TN.8.258 Laryngology - (Items 41837 and 41840)

Items 41837 and 41840 may be claimed for both open procedures and endoscopic equivalents. In the case of endoscopic procedures, it is required that the extent of the resection be anatomically equivalent to open procedures excepting resection of thyroid cartilage. This item can only be claimed once per provider, per patient per lifetime.

TN.8.259 Repair or radical correction of pectus excavatum or pectus carinatum

Item 38846 - **Repair or radical correction of pectus excavatum or pectus carinatum**

Where the repair or correction of the condition requires the insertion of a device, the insertion of the device is included in the procedure.

TN.8.260 Plating of ribs

Item 38859 - **Plating of ribs**

This item allows for the plating of multiple ribs for flail segment in the circumstance of failure to wean from mechanical ventilation. Internal fixation of a single rib can be performed under item 48409.

TN.8.261 Radical excision of intra-oral tumour - (Item 30275)

Item 30275 only applies when both an intra-oral resection and a lymph node dissection are performed during the same procedure. The procedure may, or may not, include the resection of the mandible.

TN.8.262 Revision of Breast Prosthesis Pocket – (Item 45547)

Item 45547 provides for the reinsertion of an existing prosthesis and not for insertion of a new prosthesis. Items 45553 and 45554 provide for the removal of a prosthesis and replacement with a new prosthesis.

TN.8.263 Terminology for Vascular Anomalies – (Items 45027 to 45045)

For further guidance on terminology used for vascular anomalies, providers are encouraged to consult the classification of the *International Society for the Study of Vascular Anomalies (ISSVA)* 2018 at https://www.issva.org/classification.

Where a haemangioma has been medically treated and there is only a residuum present, the appropriate MBS item should relate to the size of the residuum and not the size of the original haemangioma.

TN.8.264 Terminology for “maxilla” – (Items 45596 and 45597)
Historically, the term “maxilla” referred to one of the two identical bones that form the upper jaw with the “maxillae” meeting in the midline of the face. Currently the “maxilla” is considered a double structure or one bone (i.e. the entire upper jaw).

A “hemimaxillectomy” refers to the surgical removal of one side of the upper jaw while a “total maxillectomy” refers to the removal of all of the “maxilla” (i.e. both sides). For item 45597, the term "bilateral" will be included in recognition that some practitioners still conduct their practice using the historical terminology, however, it is expected that most providers will use the current terminology.

TN.8.265 Oncoplastic Breast Surgery – (Items 31513 and 31514)
For guidance, item 31513 provides for simple oncoplastic breast surgery using simple glandular flaps, while item 31514 provides for breast reduction and/or mastopexy techniques to reshape the breast.

TN.8.266 Free Grafting - Split Skin and Full Thickness - (Items 45440, 45443, and 45451)
In relation to items 45440, 45443 and 45451, each site where there is an excision of a lesion and a skin graft (or a skin graft without an excision at the same sitting), is considered a separate procedure. The site of each procedure should be clearly documented in the patient records.

Item 45451 is not to be used for small punch grafts. Defects with an average diameter of less than 5 mm can generally be closed by direct suturing.

TN.8.267 Bony Reshaping - (Item 45609)
Item 45609 applies when in conjunction with a bone-containing free flap (i.e. in association with items 46060 to 46068).

TN.8.268 Dissection of Perforator Flaps - (Items 46050 and 46052)
Item 46050 represents a complete stand-alone procedure.
Item 46052 should be performed alongside a microsurgical procedure.

TN.8.269 Advancement, Retrusion or Alteration of Tilt by Osteotomy in Standard Planes - (Items 46150, 46151, 46152 and 46153)
Examples of mandible and maxilla (bimaxillary) procedures for advancement, retrusion or alteration of tilt by osteotomies in standard planes include sagittal split of mandible and horizontal osteotomy of maxilla.

TN.8.270 Procedures for Thoracic Outlet Syndrome - (Items 46170 - 46185)
Items 46174 and 46175 may be used as a standalone item or in conjunction with items 46177 to 46185.

Item 46176 may be used as a standalone item or in conjunction with items 46170 to 46173.

For items 46177, 46178 and 46179, an example of “single cord or trunk” is the upper trunk. These items should not be used for reconstruction of peripheral nerves.

For items 46177 to 46185, examples of appropriate methods of reconstruction include nerve grafts, vascularised nerve conduit and nerve transfers.

TN.8.271 Direct and Indirect Flap - (Item 45209 and 45212)
Item 45209, for the first stage of multistage flap repair procedure, should be performed in hospital.

Item 45212, for the second or third stage of multistage flap repair procedure, would generally be performed under sedation or general anaesthetic in hospital, with the exceptional of flap division, which can be performed under local anaesthetic out of hospital.

TN.8.273 Modifier Item for Burns Involving Hands, Face or Anterior Neck - (Item 46100)

Item 46100 is a modifier item that provides extra funding for burns involving the hands, face and anterior neck.

The modifier item can be co-claimed for the excision of burnt tissue items 46101 to 46111, the immediate closure items 46113 to 46123 and the delayed definitive closure items 46130 to 46135, where excision of burnt tissue or definitive burn wound closure involves greater than 1% of the hands, face or anterior neck.

The modifier item does not apply to whole of face burns items 46112, 46124 or 46136. This is because the fee for items 46112, 46124 and 46136 was set at a level that incorporates the additional complexity of whole of face procedures.

The derived fee for claims including the modifier item will be an additional 40% of the fee for the co-claimed service.

There may be circumstances where a whole of face burns item (46112, 46124 or 46136) can be claimed in the same procedure as a combination of the modifier item (46100) and a co-claimed service covered by clause (b) of item 46100.

For example, a patient may have burns that require excision and immediate definitive closure for the whole of face as well as the anterior neck. The treating surgeon could claim items 46112 and 46124 for the excision and closure of the whole of face. In addition, the surgeon could claim item 46103 for the excision of the anterior neck with the modifier item (46100) and item 46115 for the definitive closure of the anterior neck with the modifier item (46100), because the excision and closure on the anterior neck involves at least 3% but less than 10% of the total body surface area.

Claiming the modifier item

The modifier item (46100) should be claimed immediately after the burns excision or closure item it is associated with.

If multiple burns excision/closure item are eligible to be claimed with the modifier items (i.e. the excision of burnt tissue and definitive burn wound closure involves greater than 1% of the hands, face or anterior neck for multiple items) then the modifier item should be claimed immediately after each of the burns excision/closure items it is associated with. However, where multiple burns excision/closure items are claimed, the modifier item may not necessarily apply to each of the items.

For example, for a claim involving burns excision and closure items 46102, 46114 and 46125, where the modifier item only applies to items 46102 and 46114, the following items should be claimed:

Excision of burnt tissue item	46102
Modifier item	46100
Immediate closure item	46114
Modifier item	46100
Non-excisional debridement item	46125

When claiming the modifier item with one of the burns excision or closure items:

- the modifier item and the associated burns excision or closure item is treated as one service for the purpose of the Multiple Operation Rule
- the derived fee resulting from claiming the modifier item is calculated before the Multiple Operation Rule is applied/calculated.

TN.8.274 Rules for Burns Excision and Closure Items - (Items 46100 to 46136)

Only one item can be claimed from the excision of burnt tissue items (items 46101 to 46111) for one provider in one operation, based on the total percentage excised by that provider.

Item 46112, for excision of burnt tissue involving the whole of face, may be claimed by one provider with one excision of burnt tissue item (items 46101 to 46111), based on the percentage of total body surface area excised by that provider (excluding the face).

Only one item can be claimed from the immediate closure items (items 46113 to 46123) for one provider in one operation, based on the total percentage treated by that provider.

Item 46124, for immediate closure of the whole of face, may be claimed by one provider with one immediate closure item (items 46113 to 46123), based on the percentage of total body surface area treated by that provider (excluding the face).

Only one item can be claimed from the delayed definitive closure items (items 46125 to 46135) for one provider in one operation, based on the total percentage treated by that provider.

Item 46136, for delayed definitive closure of the whole of face, may be claimed by one provider with one delayed definitive closure item (46125 to 46135), based on the percentage of total body surface area treated by that provider (excluding the face).

For any size of burn, each surgeon can work with another surgeon, and each surgeon chooses the excision or closure item based on the area that they, as an individual surgeon, have treated.

Where two surgeons are claiming excision or closure items, the sum of items of each of the surgeons should match the percentage of total body surface area excised or closed for that patient during the procedure.

Excision of burnt tissue items (items 46101 to 46112) can be co-claimed with immediate closure items (items 46113 to 46124), but not with delayed definitive closure items (items 46130 to 46136).

When immediate closure is being performed, if it is indicated, both an immediate closure item (items 46113 to 46124) and a non-excisional debridement item (items 46125 to 46129) can be claimed.

Delayed definitive closure items (items 46130 to 46136) cannot be co-claimed with excision of burnt tissue items (items 46101 to 46112), immediate closure items (items 46113 to 46124) or non-excisional debridement items (items 46125 to 46129).

TN.8.275 Aftercare - (item 46108)

Item 46108 excludes aftercare and therefore professional attendances necessary for the purposes of post-operative treatment of the patient can be claimed.

TN.8.276 Abdominoplasty for abdominal wall defects - (Items 30175)

In the context of eligibility for item 30175, acceptable examples of conservative non-surgical treatment must include physiotherapy, however could also include symptomatic management with pain medication, lower back braces, lifestyle changes and/or exercise.

MBS benefits are not available for surgery performed for cosmetic purposes.

Diagnostic imaging refers to imaging provided by a radiology provider. Diagnostic imaging reports, symptoms of pain and discomfort, and failure to respond to non-surgical conservative treatment must be documented in patient notes.

TN.8.277 Contraindications for an artificial bowel sphincter (item 32221)

An artificial bowel sphincter under item 32221 is contraindicated in:

(a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degenerative diseases or a scarred or fragile perineum; and

(b) patients who have had an adverse reaction to radiopaque solution; and

(c) patients who engage in receptive anal intercourse.

TN.8.278 Balloon valvuloplasty co-claiming restriction with Transcatheter Aortic Valve Implantation (TAVI) items

The services performed under TAVI items (38495, 38514 and 38522) are complete medical services and include balloon valvuloplasty as part of the TAVI procedural service. MBS item 38270 for balloon valvuloplasty cannot be co-claimed with the TAVI items for the same occasion of service.

Accompanying text is required for claims where a TAVI item and item 38270 are performed on the same day at separate occasions. Suitable texts could include "separate attendances" or "10 AM and 3PM".

Providers are legally responsible for services billed under their provider number or their own name. This includes any incorrect billing of services that result in overpayment of Medicare benefits, regardless of who does the billing or receives the benefit.

TN.8.279 Minimally invasive ventral rectopexy (item 32118)

Surgeons performing minimally invasive ventral rectopexy procedures should be colorectal surgeons or general surgeons with a sub-specialist interest in colorectal surgery, with experience in the procedure.

TN.8.280 Localisation of lesions in the breast and or axilla (items 31536 and 31537)

MBS item 31536 is for the preoperative insertion of a hookwire (or a similar device) into the breast or axilla to mark the site of a lesion, when the insertion is not associated with a breast biopsy. The hookwire (or similar device) is to be inserted under imaging which is billed under a separate MBS item.

MBS item 31537 is for the insertion of a marker clip (or tissue marker) into the breast and/or axilla, to mark the site of lesion that has been totally or almost removed at biopsy and requires localisation. It is intended that the schedule fee for this item is inclusive of all components in delivering the service.

In accordance with accepted clinical practice guidelines, marker clips (or tissue markers) are not required for every biopsy and the particular occasions where they should be inserted are listed in MBS item 31537 (a) – (f). Please note the requirement at d) includes where neoadjuvant therapy may occur prior to future interventions on the breast and there is potential lack of lesion conspicuity following completion of neoadjuvant therapy.

Providers are required to use imaging when inserting the marker clip(s), however, the appropriate imaging modality can be determined by the practitioner and the imaging component is to be claimed under the relevant diagnostic imaging item.

When it is clinically relevant to insert more than one marker clip, the Multiple Operation Rule (MOR) will apply. The MOR will apply to all clips that are inserted at breast biopsy, regardless of site. This means the MOR will apply to all clips that are inserted as part of the same patient episode.

For further information practitioners could refer to the accepted clinical guidance for the use of marker clips that is provided by BreastScreen Australia and Assessment Services.

TN.8.281 Operative treatment of non-union or malunion in the arms and lower limbs (items 48446-48454)

Items 48446-48454 include bone grafting as a mandatory component. The nature of the bone grafting required should be consistent with items 48248-48257.

These items are inclusive of any bone graft harvesting and insertion, arthrotomy, debridement, osteotomy, removal of hardware, or internal fixation performed on that bone. Claiming a bone grafting item (48245-48257) and non-union item on the same occasion on the same bone is not permitted. This does not prevent MBS items that include bone grafting from being claimed for surgery undertaken on another bone on the same occasion.

These items are not inclusive of additional procedures required for the treatment of osteomyelitis. In circumstances where patients require additional surgical treatment for osteomyelitis, the relevant item numbers (43527, 43530, or 43533) can also be claimed.

These items are claimable once per bone treated. For the purposes of item 48446, repair of non-union or malunion located in the left and/or right side of the pelvic bone, sacrum and coccyx can be claimed as separate bones provided all item requirements are met for each bone.

TN.8.282 Operative treatment of non-union or malunion in the hand (items 46401, 48456)

Items 48456 includes bone grafting as a mandatory component. The nature of the bone grafting required should be consistent with items 48248-48257.

Items 46401 and 48456 are both for the operative treatment of non-union of the phalanx or metacarpal of hand. 46401 should be claimed where no bone grafting meeting the threshold of 48248-48257 has been performed.

Item 48456 is inclusive of any bone graft harvesting and insertion, arthrotomy, debridement, osteotomy, removal of hardware, or internal fixation performed on that bone. Claiming a bone grafting item (48245-48257) and item 48456 on the same occasion on the same bone is not permitted. This does not prevent MBS items that include bone grafting from being claimed for surgery undertaken on another bone on the same occasion.

Item 48456 is not inclusive of additional procedures required for the treatment of osteomyelitis. In circumstances where patients require additional surgical treatment for osteomyelitis in the hand, item 43527 can also be claimed.

Item 48456 is claimable once per bone treated.

TN.8.283 Procedures involving wound debridement (item 30023) on the same occasion as some orthopaedic or neurosurgical procedures

Items 39303, 39309-39315, 39329-39345, 46335, 46339-46341, 46348-46360, 46364, 46387, 46390-46395, 46408, 46414, 46423, 46434, 46450, 46453, 46522, 46525, 49717, 49740, 49744, 49771-49776, 49782, 49866, 49881-49890 all include the phrase "other than a service associated with a service to which item 30023 applies that is performed at the same site".

This indicates that an additional benefit is not payable for debridement of a soft tissue wound under item 30023 where it is performed at the same site on the same occasion.

These procedures are considered to be performed at the same site as the wound debridement (item 30023) where:

- Any incision for the orthopaedic or neurosurgical procedures involves the wound that is debrided.
- Debridement of the wound is required as part of the surgical approach and is considered an inherent part of the orthopaedic or neurosurgical procedure.

TN.8.284 Trigger finger release and flexor tendon procedures (items 46348, 46351, 46354, 46357, 46360, 46363, 46498)

Item 46363, for trigger finger release, should not be claimed in addition to any of items 46348, 46351, 46354, 46357, 46360, or 46498 where it is performed on one of the same rays as those procedures.

TN.8.285 Complex primary knee arthroplasty (items 49521, 49524)

Item 49521 is for a complex primary arthroplasty of the knee where revision components to either the tibia or the femur are used.

Item 49524 is for a complex primary arthroplasty of the knee where revision components to both the tibia and the femur are used.

Item 49524 may also be used in rare circumstances where an anatomic-specific allograft is required as part of a complex primary arthroplasty of the knee.

TN.8.286 Primary hip arthroplasty (items 49318, 49321)

A 'complex hip arthroplasty' procedure is one that requires additional pre-operative planning or interoperative management that extends beyond a traditional hip arthroplasty, secondary to underlying abnormalities with bone or soft tissue or systemic health issues. This may include, but is not limited to:

- patients with previous hip surgery or fractures;
- femoral head dysplasia or deformities;
- known skeletal dysplasia or neuromuscular conditions; or
- the presence of infection.

TN.8.287 Shoulder replacement with bone graft (item 48919)

Bone grafting is a mandatory component of item 48919 and should not be separately claimed. Where the only bone grafting performed is minor grafting within the surgical site of the shoulder replacement, 48918 is the appropriate item.

A bone graft harvested from the excised humeral head and inserted into the glenoid during a shoulder replacement procedure is not considered to be minor grafting and will allow the requirements of this item to be met.

TN.8.288 Removal or revision of radial head replacement (items 49113, 49114)

Where radial head revision or radial head prosthesis removal is a component of a more comprehensive procedure performed at the same time, for example an elbow arthroplasty or revision arthroplasty (items 49115, 49116, or 49117), items 49113 and 49114 are not to be claimed in addition to the items corresponding to those procedures.

TN.8.289 Arthroplasty of the shoulder, elbow, acromioclavicular, or sternoclavicular joints (items 48925, 48932, 49127)

These items are for arthroplasty procedures, including interpositional arthroplasties, of the shoulder joint (48925), acromioclavicular joint (48932), sternoclavicular joint (48932), or elbow joint (49127) for which no other MBS items are applicable.

These items should not be claimed together with another arthroplasty item of the same joint.

The removal of exostoses, where performed, is an inherent part of these items and should not be separately claimed for the same joint.

TN.8.290 Open tenotomy in the shoulder and elbow region (items 47968, 47970, 47973)

Where an open tenotomy is part of a more comprehensive procedure, items 47968-47973 should not be claimed in addition to the item for said procedure.

These items should also not be claimed on the same occasion as item 47960, for subcutaneous tenotomy, unless they are performed at separate sites.

TN.8.291 Excision of exostoses in the hand, wrist, arm, or shoulder (items 48436, 48438, 48440)

Items 48436, 48438, and 48440 each provide for the removal of one or more exostoses when undertaken via the same incision.

Where multiple incisions are made to access the same exostosis, the relevant item should only be claimed once.

For the removal of exostoses in the hand and wrist on the same occasion:

- Where exostoses are removed from the hand and wrist via separate incisions, items 48436 and 48438 may both be claimed.
- Where exostoses are removed from the hand and wrist via a single, common incision, only item 48436 should be claimed.

For the removal of exostoses in the arm and wrist on the same occasion:

- Where exostoses are removed from the arm and wrist via separate incisions, items 48438 and 48440 may both be claimed.
- Where exostoses are removed from the arm and wrist via a single, common incision, only item 48438 should be claimed.

These items are not to be used in addition to an item for another arthroscopy, arthrodesis, arthroplasty, osteotomy, or removal of hardware where those procedures are performed on the same joint or bone.

TN.8.292 Excision of exostoses in the hip or leg (items 48442, 48444)

Items 48442 and 48444 each provide for the removal of one or more exostoses when undertaken via the same incision.

Where multiple incisions are made to access the same exostosis, the relevant item should only be claimed once.

For the removal of exostoses in the hip and leg on the same occasion:

- Where exostoses are removed from the hip and leg via separate incisions, items 48442 and 48444 may both be claimed.
- Where exostoses are removed from the hip and leg via a single, common incision, only item 48444 should be claimed.

Services for the removal of exostoses in the foot and ankle should be claimed under item 48430. For the removal of exostoses in the leg and ankle on the same occasion:

- Where exostoses are removed from the leg and ankle via separate incisions, items 48444 and 48430 may both be claimed.
- Where exostoses are removed from the leg and ankle via a single, common incision, only item 48430 should be claimed.

These items are not to be used in addition to an item for another arthroscopy, arthrodesis, arthroplasty, osteotomy, or removal of hardware where those procedures are performed on the same joint or bone.

TN.8.293 Endoscopic Mucosal Resection (item 32230)

Endoscopic mucosal resection (EMR) item 32230 is inclusive of the colonoscopy service described in items 32222, 32223, 32224, 32225, 32226 and 32228.

There is a same day, same provider, same patient restriction with claiming any of the colonoscopy items 32222, 32223, 32224, 32225, 32226 and 32228 with item 32230. This co claiming restriction also applies to sigmoidoscopy or colonoscopy items 32084 and 32087 with item 32230.

EMR item 32230 is also inclusive of the removal of any additional polyp/s <=25mm that occurs during the procedure and cannot be co-claimed with polypectomy item 32229.

Scenario 1

Should identification of a polyp >= 25 mm occur at time of colonoscopy and the provider is sufficiently skilled and the location of the procedure (facility) appropriately resourced, the polyp may be removed (resected) in situ at time of initial colonoscopy provided adequate consent was obtained by the endoscopist before the procedure.

Where this is the case, the provider will no longer bill a colonoscopy item 32222, 32223, 32224, 32225, 32226 or 32228, rather they will bill item 32230. Where additional polyp/s <=25mm are also removed during the EMR procedure, this is included under item 32230. The provider is not able to co-claim polypectomy item 32229.

Scenario 2

Where the provider is unable to remove the polyp/s >=25 mm, and the patient is required to return to have the polyp removed, then the initial procedure identifying the polyp and thus the need for EMR would be billed to either 32222, 32223, 32224, 32225, 32226 or 32228 and the subsequent resection procedure to 32230.

TN.8.294 Augmentation Mammaplasty and the use of prosthesis/prostheses (items 45524 and 45528))

Services under augmentation mammaplasty items 45524 and 45528 involve the insertion of a breast prosthesis/prostheses.

Autologous fat grafting in the context of breast cancer or developmental disorders can be claimed under items 45534 and 45535.

TN.8.295 Endoscopic Thoracic Sympathectomy

Appropriate Use Guidance

Hyperhidrosis

Sympathectomy can be a valuable treatment for a limited number of patients with hyperhidrosis who have tried and failed to respond to non-surgical intervention. Non-surgical options include but are not limited to:

- Topical aluminium chloride hexahydrate or aluminium chloral hydrate (antiperspirants)
- Botulinum toxin A injection of the sweat glands
- Iontophoresis
- Topical anticholinergic creams, gels and sprays, or prescription underarm wipes
- Oral anticholinergics for e.g. propantheline bromide, glycopyrrolate, oxybutynin, and methantheline bromide
- Laser therapy to the affected area
- Microwave therapy to the affected area

It would be expected that a patient with treatment resistant hyperhidrosis would be under the care of a Dermatologist and the decision to undertake surgical sympathectomy would involve the patient's general practitioner, dermatologist and the treating surgeon.

Refractory Cardiac Arrhythmias

Sympathectomy may be performed on patients as an adjunct to lifelong optimal medical therapy for refractory cardiac arrhythmias including, but not limited to:

- Congenital long QT syndrome
- Extreme non-congenital prolonged QT syndrome
- Catecholaminergic polymorphic ventricular tachycardia (CPVT)

Vascular Indications

Sympathectomy may be performed on patients as an adjunct to lifelong optimal medical therapy for the management of treatment resistant (but not limited to):

- small vessel vasospastic pathology related to:

- Raynaud's disease

- Scleroderma

- Acrocyanosis

- Livedo reticularis

- Upper limb ischaemia pain (e.g. thromboangiitis obliterans)
- Chronic regional pain syndrome

TN.8.296 Implantation of a micro-bypass glaucoma surgery device or devices (Item 42504 and 42705)

Item 42504 provides for a standalone procedure for the implantation of micro-bypass glaucoma surgery device or devices into the suprachoroidal space or trabecular meshwork for the treatment of glaucoma patients if conservative therapies have failed, are likely to fail, or are contraindicated.

Item 42705 can provide for the implantation of a micro-bypass glaucoma surgery device or devices into the suprachoroidal space or trabecular meshwork, however 42504 is for a standalone procedure.

The suprachoroidal and supraciliary spaces are contiguous and are potential spaces opened by surgery to allow drainage of aqueous humour, and the terms are used interchangeably.

TN.8.297 Healing by secondary intention

Healing by secondary intention is when a wound is left open to heal, instead of repairing the wound by suture, skin flap or skin graft.

Items 31356, 31357, 31358, 31360, 31363, 31364, 31369, 31370, 31371, 31373, 31376, 31377, 31378, 31379, 31380, 31381, 31382 and 31383 allow for healing by secondary intention.

The episode of care includes excision and all attendances for wound management. Therefore, when a wound is left open to heal, only the relevant skin excision item should be claimed.

TN.8.298 Training Requirements - Cardiac Ablation

Providers of the services associated with items 38209, 38212, 38287, 38290 and 38293 should meet the Electrophysiologist fellowship training requirements described in the Cardiac Society of Australia and New Zealand Expert Position Statement on Catheter and Surgical Ablation for Atrial Fibrillation or equivalent. https:/https://www.csanz.edu.au/resource?resource=48/www.csanz.edu.au/resource?resource=48

TN.8.299 Training Guidelines for Items 38372 and 38373

Providers of the services associated with items 38372 and 38373 should meet the Electrophysiologist fellowship training requirements described in the Cardiac Society of Australia and New Zealand Guidelines for advanced sub-

specialty training in Cardiac Implantable Electronic Devices (CIEDs): selection, implantation and follow-up. Updated March 2017.

Guidelines for advanced sub-specialty training in CIEDs (2017): https://cmsuat.csanz.edu.au/wp-content/uploads/2017/03/Sub-spec-Training-CIED_2017-March.pdf

TN.8.300 Imaging related to certain biliary items

A service described in items 30440, 30451, 30492 or 30495 does not include imaging.

Note: The imaging services associated with these services are described in the diagnostic imaging services table and can be billed separately.

TN.8.301 Burn Wound Closure Involving Autologous Skin Cell Suspension (items 46113 to 46124 and 46130 to 46136)

Autologous skin cell suspension (ASCS) can be used on its own or in conjunction with autologous skin grafting for definitive burn wound closure (either immediate or delayed) where the total burn area being treated in the procedure (by one or multiple surgeons) is:

- at least 10% of total body surface for a patient aged less than 15 years; or
- at least 20% of total body surface for a patient aged 15 years or over; or
- for the whole of face.

The percentage of total body surface treated can be either performed solely by one surgeon or collectively by multiple surgeons.

For example, a single surgeon performs immediate definitive burn wound closure under item 46115 on 6% of total body surface for a patient aged less than 15 years. At the same time, another surgeon performs immediate definitive burn wound closure under item 46115 on 6% of total body surface for the same patient. Because the total area being treated in this procedure is at least 10% of total body surface, ASCS or ASCS in conjunction with autologous skin grafting can be used.

TN.9.1 Assistance at Operations - (Items 51300 to 51318)

Items covering operations which are eligible for benefits for surgical assistance under items 51300 and 51303 have been identified by the inclusion of the word "Assist." in the item description.

Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified, with the exception of items 51306, 51309, 51312, 51315 and 51318.

Items 51306, 51309, 51312, 51315 and 51318 provide for surgical assistance at operations under the specific circumstances set out in their item descriptors.

For items 51300 to 51318:

- The assistance must be rendered by a medical practitioner other than the surgeon, the anaesthetist or the assistant anaesthetist.
- Where more than one person (whether medical practitioners, participating nurse practitioners or a combination thereof) provides assistance to a surgeon, no additional benefits are payable. Only one benefit is payable irrespective of the number of people assisting.

Assistance at Multiple Operations

Where surgical assistance is provided at two or more operations performed on a patient on the one occasion the multiple operation formula is applied to all the operations to determine the surgeon's fee for Medicare benefit purposes. The multiple-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for surgical assistance is payable to determine the abated fee level for assistance. The

abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Item 51300 or 51303).

Multiple Operation Rule - Surgeon	Multiple Operation Rule - Assistant
Item A - $300@100%	Item A (Assist.) - $300@100%
Item B - $250@50%	Item B (No Assist.)
Item C - $200@25%	Item C (Assist.) - $200@50%
Item D - $150@25%	Item D (Assist.) - $150@25%

The derived fee applicable to items 51303, 51309 and 51312 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery which attracts an assistance benefit.

Surgeons Operating Independently

Where two surgeons operate independently (ie neither assists the other or administers the anaesthetic) the procedures they perform are considered as two separate operations, and therefore, where a surgical assistant is engaged by each, or one of the surgeons, benefits for surgical assistance are payable in the same manner as if the surgeons were operating separately.

See MN.33.1 for surgical assistance provided by nurse practitioners

TN.9.2 Benefits Payable under Item 51300

Medicare benefits are payable under item 51300 for assistance rendered at any operation identified by the word "Assist." for which the fee does not exceed the fee threshold specified in the item descriptor, or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee threshold specified in the item descriptor has not been exceeded.

TN.9.3 Benefits Payable Under Item 51303

Medicare benefits are payable under item 51303 for assistance rendered at any operation identified by the word "Assist." for which the fee exceeds the fee threshold specified in the item descriptor or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee exceeds the threshold specified in the item descriptor.

TN.9.4 Benefits Payable Under Item 51309

Medicare benefits are payable under item 51309 for assistance rendered at any operation identified by the word "Assist." or a series or combination of operations identified by the word "Assist." and assistance at a birth involving Caesarean section.

Where assistance is provided at a Caesarean section birth and at a procedure or procedures which have not been identified by the word "Assist.", benefits are payable under item 51306.

TN.9.5 Assistance at Cataract and Intraocular Lens Surgery - (Item 51315 and 51318)

Medicare benefits are payable for surgical assistance provided at cataract and intraocular lens surgery under items 51315 and 51318.

Under item 51315, Medicare benefits are payable for 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.

Under items 51318, Medicare benefits are payable for assistance at cataract and intraocular lens surgery where the clinical requirements set out under item 51318 are met.

In addition, if in the same episode of care, clinically relevant items are claimed that include the word "Assist." in the item description, Medicare benefits are also payable for assistance under items 51300 or 51303.

For example, Medicare benefits are also payable for assistance under items 51300 or 51303 when provided in association with items 42551 to 42569, 42653, 42656, 42725, 42746, 42749, 42752, 42776 or 42779, as these items include the word "Assist." in the item description.

Claiming guidance
When two different surgical assistance items are claimed for the same episode of care, e.g. 51315 or 51318 with 51300 or 51303, the Medicare claim should transmit each surgical assistance item separately, to allow Medicare staff to process the claim correctly. Please contact Services Australia if you need further guidance on submitting a claim.

TN.10.1 Relative Value Guide For Anaesthetics - (Group T10)

Overview of the RVG

The RVG groups anaesthesia services within anatomical regions. These items are listed in the MBS under Group T10, Subgroups 1-16 Anaesthesia for radiological and other therapeutic and diagnostic services are grouped separately under Subgroup 17. Also included in the RVG format are certain additional monitoring and therapeutic services, such as blood pressure monitoring (item 22012) and central vein catheterisation (item 22020) when performed in association with the administration of anaesthesia. These services are listed at subgroup 19. The RVG also provides for assistance at anaesthesia under certain circumstances. These items are listed at subgroup 26.

Details of the billing requirements for the RVG are available from Services Australia's website.

The RVG is based on an anaesthesia unit system reflecting the complexity of the service and the total time taken for the service. Each unit has been assigned a dollar value.

Under the RVG, the MBS fee for anaesthesia in connection with a procedure is comprised of up to three components:

1. The basic units allocated to each anaesthetic procedure, reflecting the complexity of the procedure (an item in the range 20100-21997);

2. The time unit allocation reflecting the total time of the anaesthesia (an item in the range 23010-24136); and

3. Where appropriate, modifying units recognising certain added complexities in anaesthesia (an item/s in the range 25000-25020).

Assistance at anaesthesia

To establish the fee for the assistant service items 25200 and 25205, both services have been allocated a number of base units. The total time that the assistant anaesthetist was in active attendance on the patient is then added, along with modifiers as appropriate to determine the MBS fee.

Whole body perfusion

Where whole body perfusion is performed, the MBS fee is determined by adding together the following:

1. The base units allocated to the service (item 22060);

2. The time unit allocation reflecting the total time of the perfusion (an item in the range 23010 - 24136); and

3. Where appropriate, modifying units recognising certain added complexities in perfusion (an item/s in the range 25000 – 25020).

TN.10.2 Eligible Services

Generally, a Medicare benefit is only payable for anaesthesia which is performed in connection with an "eligible" service. An "eligible" service is defined as a clinically relevant professional service which is listed in the Schedule and which has been identified as attracting an anaesthetic fee**.**

TN.10.3 RVG Unit Values

As per clause 5.9.5 of Schedule 1 of the GMST, all RVG items 23010 to 24136 apply to a service provided to a patient under anaesthesia, but only if the anaesthesia start and end times are recorded in writing.

Basic Units

The RVG basic unit allocation represents the complexity of the anaesthetic procedure relative to the anatomical site and physiological impact of the surgery.

Time Units

The number of time units is calculated from the total time of the anaesthesia service, the assistant at anaesthesia service or the whole body perfusion service:

- *for anaesthesia*, time is considered to begin when the anaesthetist commences exclusive and continuous care of the patient for anaesthesia. Time ends when the anaesthetist is no longer in professional attendance, that is, when the patient is safely placed under the supervision of other personnel;

- *for assistance at anaesthesia*, time is taken to be the period that the assistant anaesthetist is in active attendance on the patient during anaesthesia; and

- *for perfusion*, perfusion time begins with the commencement of anaesthesia and finishes with the closure of the chest.

For up to and including the first - 2 hours of time, each 15 minutes (or part thereof) constitutes 1 time unit. For time beyond 2 hours, each time unit equates to 10 minutes (or part thereof).

Modifying Units (25000 - 25050)

Modifying units have been included in the RVG to recognise added complexities in anaesthesia or perfusion, associated with the patient's age, physical status or the requirement for emergency surgery. These cover the following clinical situations:

ASA physical status indicator 3 - A patient with severe systemic disease that significantly limits activity (item 25000). This would include: severely limiting heart disease; severe diabetes with vascular complications or moderate to severe degrees of pulmonary insufficiency.

Some examples of clinical situations to which ASA 3 would apply are:

- a patient with ischaemic heart disease such that they encounter angina frequently on exertion thus significantly limiting activities;

- a patient with chronic airflow limitation who gets short of breath such that the patient cannot complete one flight of stairs without pausing;

- a patient who has suffered a stroke and is left with a residual neurological deficit to the extent that is significantly limits normal activity, such as hemiparesis; or

- a patient who has renal failure requiring regular dialysis.

ASA physical status indicator 4 - A patient with severe systemic disease which is a constant threat to life (item 25005). This covers patients with severe systemic disorders that are already life-threatening, not always correctable by an operation. This would include: patients with heart disease showing marked signs of cardiac failure; persistent angina or advanced degrees of pulmonary, hepatic, renal or endocrine insufficiency.

ASA physical status indicator 4 would be characterised by the following clinical examples:

- a person with coronary disease such that they get angina daily on minimum exertion thus severely curtailing their normal activities;

- a person with end stage emphysema who is breathless on minimum exertion such as brushing their hair or walking less than 20 metres; or

- a person with severe diabetes which affects multiple organ systems where they may have one or more of the following examples:

- severe visual impairment or significant peripheral vascular disease such that they may get intermittent claudication on walking less than 20 metres; or

- severe coronary artery disease such that they suffer from cardiac failure and/or angina whereby they are limited to minimal activity.

ASA physical status indicator 5 - a moribund patient who is not expected to survive for 24 hours with or without the operation (item 25010). This would include: a burst abdominal aneurysm with profound shock; major cerebral trauma with rapidly increasing intracranial pressure or massive pulmonary embolus.

The following are some examples that would equate to ASA physical status indicator 5

- a burst abdominal aneurysm with profound shock;

- major cerebral trauma with increasing intracranial pressure; or

- massive pulmonary embolus.

NOTE: It should be noted that the Medicare Benefits Schedule does NOT include modifying units for patients assessed as ASA physical status indicator 2. Some examples of ASA 2 would include:

- A patient with controlled hypertension which has no affect on the patient's normal lifestyle;

- A patient with coronary artery disease that results in angina occurring on substantial exertion but not limiting normal activity; or

- A patient with insulin dependant diabetes which is well controlled and has minimal effect on normal lifestyle.

- Where the patient is aged under 4 years old (item 25013) or at least 75 years (item 25014).

- For anaesthesia, assistance at anaesthesia or a perfusion service in association with an *emergency procedure (item 25020).

- For anaesthesia or assistance at anaesthesia in association with an *after hours emergency procedure (items 25025 and 25030).

- For a perfusion service in association with *after hours emergency surgery (item 25050).

*** NOTE:** It should be noted that the emergency modifier and the after hours emergency modifiers cannot both be claimed in the one anaesthesia assistance at anaesthesia or perfusion episode.

It should also be noted that modifiers are not stand alone services and can only be claimed in association with anaesthesia, assistance at anaesthesia or with a perfusion service covered by item 22060.

Definition of Emergency

For the purposes of both the emergency modifier and the after hours emergency modifiers, emergency is defined as existing where the patient requires immediate treatment without which there would be significant threat to life or body part.

Definition of After Hours

For the purposes of the after hours emergency modifier items, the after hours period is defined as being the period from 8pm to 8am on any weekday or at any time on a Saturday, a Sunday or a public holiday. Benefit for the After Hours Emergency Modifiers is only payable where more than 50% of the time for the emergency anaesthesia, the assistance at emergency anaesthesia or the perfusion service is provided in the after hours period. In situations where less than the 50% of the time for the service falls in the after hours period, the emergency modifier rather than the after hours emergency modifier applies. For information about deriving the fee for the service where the after hours emergency modifier applies.

TN.10.4 Deriving the Schedule Fee under the RVG

The Schedule fee for each component of anaesthesia (base items, time items and modifier items) in the RVG Schedule is derived by applying the unit value to the total number of anaesthesia units for each component. For example:

ITEM	DESCRIPTION	UNITS	SCHEDULE FEE (Units x $20.10)
20840	Anaesthesia for resection of perforated bowel	6	$120.60
23200	Time - 4 hours 40 minutes	24	$482.40
25000	Modifier - Physical status	1	$20.10
22012	Central Venous Pressure Monitoring	3	$60.30
	TOTAL	**34**	**$683.40**

After Hours Emergency Services

When deriving the fee for the after hours emergency modifier for anaesthesia or assistance at anaesthesia, the 50% loading applies to the anaesthesia or assistance service from Group T10 and to any additional clinically relevant therapeutic or diagnostic service from Group T10, Subgroup 18, provided during the anaesthesia episode. For example:

ITEM	DESCRIPTION	UNITS	SCHEDULE FEE (Units x $20.10)
20840	Anaesthesia for resection of perforated bowel	6	$120.60
23200	Time - 4 hours 40 minutes	24	$482.40
25000	Modifier - Physical status	1	$20.10
22012	Central Venous Pressure Monitoring	3	$60.30
	TOTAL	**34**	**Schedule fee = $683.40**
25025	Anaesthesia After Hours Emergency Modifier		Schedule Fee $683.40 x 50% = $341.70

Definition of Radical Surgery for the RVG

Where the term radical appears in an item description, it refers to an extensive surgical procedure, performed for the treatment of malignancy. It usually denotes extensive block dissection not only of the malignant tissue, but also of the surrounding tissue, particularly fat and lymphatic drainage systems. See notes T10.18 and T10.22 which clarify the definitions of the words "extensive" and "radical" used in items 20192 and 20474.

Multiple Anaesthesia Services

Where anaesthesia is provided for services covered by multiple items in the RVG, Medicare benefit is only payable for the RVG item with the highest basic unit value. However, the time component should include the total anaesthesia time taken for all services. For example:

ITEM	DESCRIPTION	UNITS	SCHEDULE FEE
20790	Anaesthesia for open Cholecystectomy	8	$160.80
20752	Incisional Hernia	6	(lower value than 20790 = 20752 schedule fee not payable) $120.60
23111	Time - 2hrs 30mins	11	$221.10
25014	Physical Status - 75 or over	1	$20.10
	TOTAL	**20**	**$402.00**

Prolonged Anaesthesia

Under the RVG, the previous rules that related to prolonged anaesthesia no longer apply. Where anaesthesia is prolonged beyond that which an anaesthetist would normally encounter for a particular service, the RVG provides for the anaesthetist to claim the total anaesthesia time for the procedure/s.

TN.10.5 Minimum Requirements for Claiming Benefits under Items in the RVG (including sedation)

Medicare benefits for RVG services (including sedation) are only payable where both the staffing and the facility in which the service was rendered meets the following minimum guidelines. These guidelines are based on protocols established by the Australian and New Zealand College of Anaesthetists.

Staffing

- Techniques intended to produce loss of consciousness must not be used unless an anaesthetist is present to care exclusively for the patient;
- Where the patient is a young child, is elderly or has any serious medical condition (such as significant cardio-respiratory disease or danger of airway compromise), an anaesthetist should be present to administer sedation and monitor the patient;
- In all other cases, an appropriately trained medical practitioner, other than the proceduralist, is required to be in exclusive attendance on the patient during the procedure, to administer sedation and to monitor the patient; and
- There must be sufficient equipment (including oxygen, suction and appropriate medication), to enable resuscitation should it become necessary.

Facilities

The procedure must be performed in a location which is adequate in size and staffed and equipped to deal with a cardiopulmonary emergency. This must include:

- An operating table, trolley or chair which can be readily tilted;
- Adequate uncluttered floor space to perform resuscitation, should this become necessary;
- Adequate suction and room lighting;
- A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient;

- A self inflating bag suitable for artificial ventilation together with a range of equipment for advance airway management;
- Appropriate drugs for cardiopulmonary resuscitation;
- A pulse oximeter; and
- Ready access to a defibrillator.

These requirements apply equally to dental anaesthesia or sedation services provided under items in Group T10, Subgroup 20 of the RVG.

TN.10.6 Account Requirements

Before a benefit will be paid for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of details additional to those set out in the General Explanatory Notes of the Medicare Benefits Schedule are required on the anaesthetist's account:

- **the anaesthetist's account** must show the name/s of the medical practitioner/s who performed the associated operation/s. In addition, where the after hours emergency modifier applies to the anaesthesia service, the account must include the start time, the end time and total time of the anaesthetic.
- **the assistant anaesthetist's account** must show the names/s of the medical practitioners who performed the associated operation/s, as well as the name of the principal anaesthetist. In addition, where the after hours emergency modifier applies, the assistant anaesthetist's account must record the start time, the end time and the total time for which he or she was providing professional attention to the patient during the anaesthetic.
- **the perfusionist's account** must record the start time, end time and total time of the perfusion service where the after hours emergency modifier is claimed.

TN.10.7 General Information

The *Health Insurance Act 1973* provides that where anaesthesia is administered to a patient, the premedication of the patient in preparation for anaesthesia is deemed to form part of the administration of anaesthesia. The administration of anaesthesia also includes the pre-anaesthesia consultation with the patient in preparation for that administration, except where such consultation entails a separate attendance carried out at a place other than an operating theatre or an anaesthesia induction room. The pre-anaesthesia consultation for a patient should be performed in association with a clinically relevant service.

Except in special circumstances, a benefit is not payable for the administration of anaesthesia listed in Subgroups 1-18, unless the anaesthesia is administered by a medical practitioner other than the medical practitioner who renders the medical service in connection with which anaesthesia is administered.

Fees and benefits for anaesthesia services under the RVG cover all essential components in the administration of the anaesthesia service. Separate benefits may be attracted, however, for complementary services such as central venous pressure and direct arterial pressure monitoring (see note TN.10.8).

It should be noted that an additional benefit is not payable for intravenous infusion or electrocardiographic monitoring, provision for which has been made in the value determined for the anaesthetic units.

The Medicare benefit derived under the RVG for the administration of anaesthesia is the benefit payable for that service irrespective of whether one or more than one medical practitioner administers it. However, a benefit is provided under Subgroup 26 for the services of one assistant anaesthetist (who must not be either the surgeon or assistant surgeon (see Note TN.10.9)).

Where a regional nerve block or field nerve block is administered by a medical practitioner, other than the practitioner carrying out the operation, the block is assessed as an anaesthesia item according to the advice in

paragraph TN.7.1. When a block is carried out in cases not associated with an operation, such as for pain or during labour, the service falls under Group T7.

If not stipulated in the item descriptor, when a regional nerve block or field nerve block covered by an item in Group T7 of the Schedule is administered by a medical practitioner in the course of a surgical procedure undertaken by the same medical practitioner, then such a block will attract a benefit under the appropriate item in Group T7.

If stipulated in the item descriptor, when a regional nerve block or field nerve block covered by an item in Group T7 of the Schedule is administered by a medical practitioner in the course of a surgical procedure the block will not attract benefits under the relevant item in Group T7 unless the block has been performed using a targeted percutaneous approach. If the block has been performed using a targeted percutaneous approach this must be noted on the Medicare claim.

It should be noted that where a procedure is carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure and an additional benefit is therefore not payable.

It may happen that the professional service for which the anaesthesia is administered does not itself attract a benefit because it is part of the after-care of an operation. This does not, however, affect the benefit payable for the anaesthesia service. A benefit is payable for anaesthesia administered in connection with such a professional service (or combination of services) even though no benefit is payable for the associated professional service.

The administration of epidural anaesthesia during labour is covered by items 18216 or 18219 (18226 and 18227 for after hours) in Group T7 of the Schedule whether administered by the medical practitioner undertaking the confinement or by another medical practitioner. Subsequent "top-ups" are covered by Item 18222 or 18225.

For the purposes of items 18216 and 18226, one attendance means that the medical practitioner cannot claim either of these items if the additional attendance is to optimise the initial treatment. Optimise means extension or improvement in analgesic quality of an existing block, without the insertion of a new block as a separate procedure.

TN.10.8 Additional Services Performed in Connection with Anaesthesia - Subgroup 19

Included in the RVG format are a number of additional or complementary services which may be provided in connection with anaesthesia such as blood pressure monitoring (item 22012) and intra-arterial cannulation (item 22025).

These items (with the exception of peri-operative nerve blocks (22031-22042)) and perfusion services (22055-22075) have also been retained in the MBS in the non-RVG format, for use by practitioners who provide these services other than in association with anaesthesia.

Item 22002

The amendment to item 22002 is for the transfusion of blood and/or for intraoperative transfusion of red cells collected by cell saver in association with administration of anaesthesia.

Items 22012 and 22014

Benefits are payable under items 22012 and 22014 only once for each type of pressure, up to a maximum of 4 pressures per patient per calendar day, and irrespective of the number of practitioners involved in monitoring the pressures.

Items 22012, 22014 and 22025

A patient who is categorised as having a high risk of complications is one where clinical indications allow for the following items to be claimed (in conjunction with items 22012, 22014 and 22025) with item 25000, item 25005 or item 25010 modifiers, and/or item 25013, and/or item 25014, and/or items 25020, 25025 and/or when the basic surgical item value is 10 or more units, and/or is conjunction with items in group T10 Subgroup 13 (Shoulder and

Axilla), or with items 23170 – 24136 (for procedures of greater than four hours duration) noting this is not an exhaustive list.

Item 22042

This item can be co-claimed with item 20142 (anaesthesia for lens surgery), when anaesthesia or sedation was also provided by the same anaesthetist.

Item 22042 cannot be co-claimed with item 20142, 20144, 20145 and 20147 when a general anaesthetic is the primary anaesthetic approach.

TN.10.9 Assistance in the Administration of Anaesthesia

The RVG provides for a separate benefit to be paid for the services of an assistant anaesthetist in connection with an operation or series of operations in specified circumstances, as outlined below. This benefit is payable only in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

Therapeutic and Diagnostic services covered by Subgroup 19 items (such as blood transfusion, pressure monitoring, insertion of CVC, etc) are payable only once per patient per anaesthetic episode. Where these services are provided by the assistant anaesthetist these services are eligible for Medicare benefits only where the same service is not also claimed by the primary anaesthetist.

Assistance at anaesthesia in connection with emergency treatment (Item 25200)

Item 25200 provides for assistance at anaesthesia where the patient is in imminent danger of death. Situations where imminent danger of death requiring an assistant anaesthetist might arise include: complex airway problems, anaphylaxis or allergic reactions, malignant hyperpyrexia, neonatal and complicated paediatric anaesthesia, massive blood loss and subsequent resuscitation, intra-operative cardiac arrest, critically ill patients from intensive care units or inability to wean critically ill patients from pulmonary bypass.

Assistance in the administration of elective anaesthesia (Item 25205)

A separate benefit is payable under Item 25205 for the services of an assistant anaesthetist in connection with elective anaesthesia in the circumstances outlined in the item descriptor. This benefit is only payable in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

For the purposes of Item 25205, a 'complex paediatric case' involves one or more of the following:

- the need for invasive monitoring (intravascular or transoesophageal); or
- organ transplantation; or
- craniofacial surgery; or
- major tumour resection; or
- separation of conjoint twins.

TN.10.10 Perfusion Services - (Items 22055 to 22075)

Perfusion services covered by items 22055-22075 have been included in the RVG format.

As with anaesthesia, where whole body perfusion is performed, the Schedule fee is determined on the base units allocated to the service (item 22060), the total time for the perfusion, and modifying units, as appropriate, i.e.

(a) the basic units allocated to whole body perfusion under item 22060:

22060	**WHOLE BODY PERFUSION, CARDIAC BYPASS**, where the heart-lung machine or equivalent is continuously operated by a medical perfusionist, other than a service associated with anaesthesia to which

	an item in Subgroup 21 applies. (20 basic units) *(See para TN.10.10 of explanatory notes to this Category)*

(b) plus, the time unit allocation reflecting the total time of the perfusion (an item in the range 23010 - 24136), for example:

23170	4:01 HOURS TO 4:10 HOURS (21 basic units)

plus, where appropriate

(c) modifying units recognising certain added complexities in perfusion (an item/s in the range 25000 - 25020), for example:

25014	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is aged 75 years or more (1 basic unit)

The time component for item 22060 is defined as beginning with the commencement of anaesthesia and finishing with the closure of the chest.

Item 22065 may only be used in association with item 22060.

Medicare benefits are not payable for perfusion unless the perfusion is performed by a medical practitioner other than the medical practitioner who renders the associated service in Group T8 or the medical practitioner who administers the anaesthesia listed in the RVG in Group T10.

The medical practitioner providing the service must comply with the training requirements in the Australian and New Zealand College of Anaesthetists *Guidelines for Major Extracorporeal Perfusion* (PS27).

Benefits are not payable if another person primarily and/or continuously operates the Heart Lung Machine.

TN.10.12 Discontinued Procedure - (Item 21990)

Item 21990 applies when a patient has been anaesthetised but the proposed procedure has been abandoned prior to surgery commencing.

Claims should include notation of the surgery or procedure which had been proposed.

Under the *Health Insurance Act 1973* the Chief Executive Medicare does not require claims for this item to be accompanied by details of the proposed surgery and the reasons why the operation was discontinued. However, practitioners must maintain a clinical record of this information, which may be subject to audit.

TN.10.13 Anaesthesia in Connection with a Procedure not Identified as Attracting a Medicare Benefit for Anaesthesia - (Item 21997)

Payment of benefit for Item 21997 is not restricted to the service being performed in connection with a surgical service in Group T8. Item 21997 may be performed with any item in the Medicare Benefits Schedule that has not been identified as attracting a Medicare benefit for anaesthesia (including attendances) in circumstances where anaesthesia is considered clinically necessary.

TN.10.14 Anaesthesia in Connection with a Dental Service - (Items 22900 and 22905)

Items 22900 and 22905 cover the administration of anaesthesia in connection with a dental service that is not a service covered by an item in the Medicare Benefits Schedule i.e removal of teeth and restorative dental work. Therefore, the requirement that anaesthesia be performed in association with an 'eligible' service (as defined in point T10.2) does not apply to dental anaesthesia items 22900 and 22905.

TN.10.15 Anaesthesia in Connection with Cleft Lip and Cleft Palate Repair - (Items 20102 and 20172)

Anaesthesia associated with cleft lip and cleft palate repair is covered in Subgroup 1 of the RVG Schedule, under items 20102 and 20172.

TN.10.16 Anaesthesia in Connection with an Oral and Maxillofacial Service - (Category 4 of the Medicare Benefits Schedule)

Benefit for anaesthesia provided by a medical practitioner in association with an Oral and Maxillofacial service (Category 4 of the Medicare Benefits Schedule) is derived using the RVG. Benefit for anaesthesia for oral and maxillofacial services should be claimed under the appropriate RVG item from Subgroup 1 or 2.

TN.10.17 Nerve or Plexus Blocks for Post Operative Pain - (Items 22031 to 22041)

Items 22031 to 22041

Benefits are only payable for intra-operative nerve or plexus blocks performed for the management of post-operative pain that are specifically catered for under items 22031 to 22041.

Items 22031 and 22036

For items 22031 and 22036, postoperative pain management means that the injected therapeutic substance is expected to prolong the analgesic effect of the epidural or intrathecal technique.

Item 22031 (initial intrathecal or epidural injection)

Benefits are payable under item 22031 for the initial intrathecal or epidural injection of a therapeutic substance/s, in association with anaesthesia and surgery, for the control of post-operative pain. Benefit is not payable for subsequent intra-operative intrathecal and epidural injection (item 22036) in the same anaesthetic episode. Where subsequent infusion is provided post operatively, to maintain analgesia, benefit would be payable under items 18222 or 18225.

Item 22032 (continuous nerve block)

Benefits are payable under item 22032 for perioperative introduction of a plexus or nerve block to a peripheral nerve, using an in situ catheter in association with anaesthesia and surgery, for continuous post operative pain management.

Benefit is not payable under this item for ultrasound guidance for injection or catheter insertion for anaesthesia.

Item 22036 (subsequent intrathecal or epidural injection)

Benefits are payable under item 22036 for subsequent intrathecal or epidural injection of a therapeutic substance/s, in association with anaesthesia and surgery, performed intra-operatively, for postoperative pain management, where the catheter is already in-situ. Benefits are not payable under this item where the initial injection was performed intra-operatively, under item 22031, in the same anaesthetic episode.

Item 22041 (plexus or nerve block)

Benefits are payable under item 22041 in addition to the general anaesthesia for the related procedure.

TN.10.18 Anaesthesia in Connection with Extensive Surgery on Facial Bones - (Item 20192)

The term 'extensive' in relation to this item is defined as major facial bone surgery or reconstruction including major resection or osteotomies or osteectomies of mandibles and/or maxillae, surgery for prognathism or surgery for Le Fort II or III fractures.

TN.10.22 Anaesthesia for Radical Procedures on the Chest Wall - (Item 20474)

Radical procedures on the chest wall referred to in item 20474 would include procedures such as pectus excavatum.

TN.10.23 Anaesthesia for Extensive Spine or Spinal Cord Procedures - (Item 20670)

This item covers major spinal surgery involving multiple levels of the spinal cord and spinal fusion where performed. Procedures covered under this item would include the Harrington Rod technique. Surgery on individual spinal levels would be covered under items 20600, 20620 and 20630.

TN.10.24 Anaesthesia for Femoral Artery Embolectomy - (Item 21274)

Item 21274 covers anaesthesia for femoral artery embolectomy. Grafts involving intra-abdominal vessels would be covered under item 20880.

TN.10.25 Anaesthesia for Cardiac Catheterisation - (Item 21941)

Item 21941 does not include either central vein catheterisation or insertion of right heart balloon catheter. Anaesthesia for these procedures is covered under item 21943.

TN.10.27 Anaesthesia for Services on the Upper and Lower Abdomen - (Subgroups 6 and 7)

Establishing whether an RVG anaesthetic item pertains to the upper or lower abdomen, depends on whether the majority of the associated surgery was performed in the region above or below the umbilicus.

Some examples of upper abdomen would be:

- laparoscopy on upper abdominal viscera;
- laparoscopy with operative focus superior to the umbilical port;
- surgery to the liver, gallbladder and ducts, stomach, pancreas, small bowel to DJ flexure;
- the kidneys in their normal location (as opposed to pelvic kidney); or
- spleen or bowel (where it involves a diaphragmatic hernia or adhesions to gallbladder bed).

Some examples of lower abdomen would be:

- abdominal wall below the umbilicus;
- laparoscopy on lower abdominal viscera;
- laparoscopy with operative focus inferior to the umbilical port;
- surgery on the jejunum, ileum, or colon;
- surgery on the appendix; or
- surgery associated with the female reproductive system.

TN.10.28 Anaesthesia for Microvascular Free Tissue Flap Surgery - (Items 20230, 20355, 20475, 20704, 20804, 20905, 21155, 21275, 21455, 21535, 21685, 21785 and 21865)

Benefits are only payable where complete free tissue flap surgery is undertaken involving microsurgical arterial and venous anastomoses. Benefits do not apply for microsurgical rotation flaps or for re-implementation of digits or either the hand or the foot.

TN.10.29 Anaesthesia for Endoscopic Ureteric Surgery - Including Laser Procedure - (Item 20911)

Benefits are not payable under item 20911 for diagnostic ureteroscopy.

TN.10.30 Credentialing for peri-operative cardiac ultrasound services (22051)

Item 22051 should be performed by a provider who is appropriately credentialed to provide the particular service, by a recognised body for the credentialing of peri-operative cardiac ultrasound services. Credentialing must be based on criteria consistent with those recommended by the Australian and New Zealand College of Anaesthetists in the current version of their Professional Document PS46 "Guidelines on Training and Practice of Perioperative Cardiac Ultrasound in Adults.

TN.11.1 Botulinum Toxin - (Items 18350 to 18379)

The Therapeutic Goods Administration (TGA) assesses each indication for the therapeutic use of botulinum toxin on an individual basis. There are currently three botulinum toxin agents with TGA registration (Botox®, Dysport® and Xeomin®). Each has undergone a separate evaluation of its safety and efficacy by the TGA as they are neither bioequivalent, nor dose equivalent. When claiming under an item for the injection of botulinum toxin, only the botulinum toxin agent specified in the item can be used. Benefits are not payable where an agent other than that specified in the item is used.

The TGA assesses each indication for the therapeutic use of botulinum toxin by assessment of clinical evidence for its use in paediatric or adult patients. Where an indication has been assessed for adult use, data has generally been assessed using patients over 12 years of age. Paediatric indications have been assessed using data from patients under 18 years of age. Botulinum toxin should only be administered to patients under the age of 18 where an item is for a paediatric indication, and patients over 12 years of age where the item is for an adult indication, unless otherwise specified.

Items for the administration of botulinum toxin can only be claimed by a medical practitioner who is recognised as an eligible medical practitioner for the relevant indication under the arrangements under Section 100 of the *National Health Act 1953* (the Act) relating to the use and supply of botulinum toxin. The specialist qualifications required to administer botulinum toxin vary across the indications for which the medicine is listed on the PBS, and are detailed within the relevant PBS restrictions available at: www.pbs.gov.au/browse/section100-mf

Item 18354 for the treatment of equinus, equinovarus or equinovalgus is limited to a maximum of 4 injections per patient on any day (2 per limb). Accounts should be annotated with the limb which has been treated. Item 18292 may not be claimed for the injection of botulinum toxin, but may be claimed where a neurolytic agent (such as phenol) is used, in addition to botulinum toxin injection(s), to treat the obturator nerve in patients with a dynamic foot deformity.

Treatment under item 18375 or 18379 can only continue if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline from the start of week 6 through to the end of week 12 after the first treatment. The term 'continue' means the patient can be retreated under item 18375 or 18379 at some point after the 12 week period (for example; 6 to 12 months after the first treatment). This requirement is in line with the PBS listing for the supply of the medicine for this indication under Section 100 of the *Act*.

Item 18362 for the treatment of severe primary axillary hyperhidrosis allows for a maximum number of 3 treatments per patient in a 12 month period, with no less than 4 months to elapse between treatments.

Botulinum toxin which is not supplied and administered in accordance with the arrangements under Section 100 of the *Act* is not required to be provided free of charge to patients. Where a charge is made for the botulinum toxin administered, it must be separately listed on the account and not billed to Medicare. Since 1 September 2015, PBS patient co-payments have applied to botulinum toxin supplied and administered in accordance with the arrangements under Section 100 of the Act.

Services Australia (SA), in consultation with the Department of Health, Disability and Ageing, has developed a Health Practitioner Guideline to substantiate that a patient had a pre-existing condition at the time of the service which is located on the Department of Health, Disability and Ageing's website.

TR.3.1 Provider restriction for items in Group T3

Medicare benefits for items in Group T3 are only payable when the service is provided by a specialist or consultant physician with training in nuclear medicine.

TR.8.1 Mechanical thrombectomy - (Item 35414)

For the purposes of this item, ***eligible stroke centre*** means a facility that:

(a) has a designated stroke unit;

(b) is equipped and has staff available or on call so that it is capable of providing the following to a patient on a 24-hour basis:

(i) the services of a specialist or consultant physician who has the training required under paragraph (b) of item 35414;

(ii) diagnostic imaging services using advanced imaging techniques, which must include computed tomography, computed tomography angiography, digital subtraction angiography, magnetic resonance imaging, and magnetic resonance angiography; and

(iii) care from a team of health practitioners which includes a stroke physician, a neurologist, a neurosurgeon, a radiologist, an anaesthetist, an intensive care unit specialist, a medical imaging technologist, and a nurse;

(c) has dedicated endovascular angiography facilities; and

(d) has written procedures for assessing and treating patients who have, or may have, experienced a stroke.

Note: A health practitioner may fulfil the role of more than one of the types of health practitioner specified in paragraph (b)(iii). For example, a neurologist may also be a stroke physician.

Conjoint Committee for Recognition of Training in Interventional Neuroradiology (CCINR)

CCINR comprises representatives from the Australian and New Zealand Society of Neuroradiology (ANZSNR), the Neurosurgical Society of Australasia (NSA) and the Australian and New Zealand Association of Neurologists (ANZAN). For the purposes of this item, specialists or consultant physicians performing this procedure must have training recognised by CCINR, and Services Australia has been notified of that recognition.

TR.8.2 Selective Coronary Angiography Indications

Clause 5.10.17A Items 38244, 38247, 38307, 38308, 38310, 38316, 38317 and 38319—patient eligibility and timing

(1) A patient is eligible for a service to which item 38244, 38247, 38307, 38308, 38310, 38316, 38317 or 38319 applies if:

(a) subclause (2) applies to the patient; and

(b) a service to which the item applies has not been provided to the patient in the previous 3 months, unless:

(i) the patient experiences a new acute coronary syndrome or angina, as described in paragraph (2)(a), (b) or (c), in that period; or

(ii) for a service to which item 38316, 38317 or 38319 applies—the service was provided to the patient in that period as a subsequent stage following an initial primary percutaneous coronary intervention procedure.

(2) This subclause applies to a patient who has:

(a) an acute coronary syndrome evidenced by any of the following:

(i) ST segment elevation;

(ii) new left bundle branch block;

(iii) troponin elevation above the local upper reference limit;

(iv) new resting wall motion abnormality or perfusion defect;

(v) cardiogenic shock;

(vi) resuscitated cardiac arrest;

(vii) ventricular fibrillation;

(viii) sustained ventricular tachycardia; or

(b) unstable angina or angina equivalent with a crescendo pattern, rest pain or other high-risk clinical features, such as hypotension, dizziness, pallor, diaphoresis or syncope occurring at a low threshold; or

(c) either of the following, detected on computed tomography coronary angiography:

(i) significant left main coronary artery disease with greater than 50% stenosis or a cross-sectional area of less than 6 mm2;

(ii) severe proximal left anterior descending coronary artery disease (with stenosis of more than 70% or a cross-sectional area of less than 4 mm2 before the first major diagonal branch).

TR.8.3 Acute Coronary Syndrome - Selective Coronary Angiography and Percutaneous Coronary Intervention Indications

Clause 5.10.17B Items 38248 and 38249—patient eligibility

(1) A patient is eligible for a service to which item 38248 or 38249 applies if:

(a) subclause (2) applies to the patient; or

(b) the patient is recommended for coronary angiography as a result of a heart team conference that meets the requirements of subclause (3).

(2) This subclause applies to a patient who has:

(a) limiting angina or angina equivalent, despite an adequate trial of optimal medical therapy; or

(b) high risk features, including at least one of the following:

(i) myocardial ischaemia demonstrated on functional imaging;

(ii) ST segment elevation, sustained ST depression, hypotension or a Duke treadmill score of minus 11 or less, demonstrated by stress electrocardiogram testing;

(iii) computed tomography coronary angiography evidence of one or more coronary arteries with stenosis of 70% or more; or

(iv) left ventricular dysfunction with an ejection fraction of less than 40% or segmental wall motion abnormality at rest

(3) For the purposes of paragraph (1)(b), the requirements for a heart team conference are as follows:

(a) the conference must be conducted by a team of specialists or consultant physicians practising in the speciality of cardiology or cardiothoracic surgery, including each of the following:

(i) an interventional cardiologist;

(ii) a non-interventional cardiologist;

(iii) a specialist or consultant physician; and

(b) the team must:

(i) assess the patient's risk and technical suitability to receive the service; and

(ii) make a recommendation about whether or not the patient is suitable for invasive coronary angiography; and

(c) a record of the conference must be created, and must include the following:

(i) the particulars of the assessment of the patient during the conference;

(ii) the recommendations made as a result of the conference;

(iii) the names of the members of the team making the recommendations.

TR.8.4 Stable - Percutaneous Coronary Intervention Indications

Clause 5.10.17C Items 38311, 38313, 38314, 38320, 38322 and 38323—patient eligibility

(1) A patient is eligible for a service to which item 38311, 38313, 38314, 38320, 38322 or 38323 applies if:

(a) subclause (2) applies to the patient; or

(b) the patient is recommended for the service as a result of a heart team conference that meets the requirements of subclause (4).

(2) This subclause applies to a patient if:

(a) the patient has any of the following:

(i) limiting angina or angina equivalent despite an adequate trial of optimal medical therapy;

(ii) myocardial ischaemia demonstrated on functional imaging;

(iii) high risk features such as ST segment elevation, sustained ST depression, hypotension or a Duke treadmill score of minus 11 or less, demonstrated by stress electrocardiogram testing; and

(b) the patient has either of the following in a vascular territory treated:

(i) a stenosis of 70% or more;

(ii) a fractional flow reserve of 0.80 or less, or non-hyperaemic pressure ratios distal to the lesions of 0.89 or less; and

(c) for items 38314 and 38323—either:

(i) the patient does not have diabetes mellitus and the multi-vessel coronary artery disease of the patient meets the criterion in subclause (3); or

(ii) despite a recommendation that surgery is preferable, the patient has expressed a preference for catheter-based intervention.

(3) For the purposes of subparagraph (2)(c)(i), the criterion for the multi-vessel coronary artery disease is that the disease does not involve any of the following:

(a) stenosis of more than 50% in the left main coronary artery;

(b) bifurcation lesions involving side branches with a diameter of more than 2.75 mm;

(c) chronic vessel occlusions for more than 3 months;

(d) severely angulated or calcified lesions;

(e) a SYNTAX score of more than 23.

(4) For the purposes of paragraph (1)(b), the requirements for a heart team conference are as follows:

(a) the conference must be conducted by a team of specialists or consultant physicians practising in the speciality of cardiology or cardiothoracic surgery, including each of the following:

(i) an interventional cardiologist;

(ii) a specialist or consultant physician;

(iii) for items 38314 and 38323—a cardiothoracic surgeon;

(iv) for items 38311, 38313, 38320 and 38322—a cardiothoracic surgeon or a non-interventional cardiologist; and

(b) the team must:

(i) assess the patient's risk and technical suitability to receive the service; and

(ii) make a recommendation about whether or not the patient is suitable for percutaneous coronary intervention; and

(c) a record of the conference must be created, and must include the following:

(i) the particulars of the assessment of the patient during the conference;

(ii) the recommendations made as a result of the conference;

(iii) the names of the members of the team making the recommendations.

TR.8.5 Selective Coronary Angiography and Percutaneous Coronary Intervention - Documentation Requirements

Clause 5.10.17D Restriction on items 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38320, 38322, 38323, 38316, 38317 and 38319—reports and clinical notes

Items 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38320, 38322, 38323, 38316, 38317 and 38319 apply to a service provided to a patient only if a report or clinical note:

(a) is prepared for the service; and

(b) includes documentation that demonstrates how the item applies to the service, including how the patient is eligible for the service.

TR.8.6 Heart Team Conferences - Items 38248, 38249, 38311, 38313, 38320, 38322 and 57364

Definition of a heart team conference: relevant to items 38248, 38249, 38311, 38313, 38320, 38322 and 57364

(a) A heart team conference is a team of 3 or more participants who are cardiac specialists; where:

i. the first participant is a specialist or consultant physician who is an interventional cardiologist; and
ii. the second participant is a specialist or consultant who is a non-interventional cardiologist; and
iii. the third participant is a specialist or consultant physician; and

(b) the team assesses a patient's risk and technical suitability to receive the service; and

(c) the result of the heart team conference's assessment is that the team makes a recommendation about whether or not the patient is suitable for selective coronary angiography (for items 38248, 38249, 38320) or percutaneous coronary intervention (for items 38311, 38313, 38320, 38322) ; and

(d) the particulars of the assessment and recommendation/s, and the names of those providers making the recommendation/s are recorded in writing.

Note: For non-complex stable triple vessel disease, providers are encouraged to include a cardiothoracic surgeon in the heart team.

TR.8.7 Heart Team Conferences for items 38314 and 38323

Definition of a heart team conference: relevant to items 38314 and 38323

(a) A heart team conference is a team of 3 or more participants who are cardiac specialists, where:

i. the first participant is a specialist or consultant physician who is an interventional cardiologist; and
ii. the second participant is a specialist or consultant who is a cardiothoracic surgeon; and
iii. the third participant is a specialist or consultant who is a non-interventional cardiologist ; and

(b) the team assesses a patient's risk and technical suitability to receive the service; and

(c) the result of the heart team conference's assessment is that the team makes a recommendation about whether or not the patient is suitable for percutaneous coronary intervention; and

(d) the particulars of the assessment and recommendation/s, and the names of those providers making the recommendation/s are recorded in writing.

TR.8.8 Claiming Guidance

1. For lesions at least 28mm in length, including lesions in the left main artery, item 38326 cannot be claimed in association with a service provided under item 38325 for the same occasion of service.
2. For left main coronary artery biurfication lesions item 38326 is claimable.
3. For left main coronary artery lesions (other than the biurfication) it is not permissible to claim item 38326. For these types of lesions it is only permissible to claim item 38325.

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	1. HYPERBARIC OXYGEN THERAPY
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 1. 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) (See para TN.1.1 of explanatory notes to this Category) **Fee:** $304.95 **Benefit:** 75% = $228.75 **Future End Date:**
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) (See para TN.1.1 of explanatory notes to this Category) **Fee:** $309.80 **Benefit:** 75% = $232.35 **Future End Date:**
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) (See para TN.1.1 of explanatory notes to this Category) **Fee:** $138.45 **Benefit:** 75% = $103.85 **Future End Date:**
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) (See para GN.1.2, TN.1.1 of explanatory notes to this Category) **Fee:** $195.55 **Benefit:** 75% = $146.70 **Future End Date:**

	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 2. 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) (See para GN.1.2, TN.1.2 of explanatory notes to this Category) **Fee:** $163.60 **Benefit:** 75% = $122.70 **Future End Date:**
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) (See para GN.1.2, TN.1.2 of explanatory notes to this Category) **Fee:** $85.25 **Benefit:** 75% = $63.95 **Future End Date:**
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 (See para TN.1.3, TN.1.23 of explanatory notes to this Category) **Fee:** $177.05 **Benefit:** 85% = $150.50 **Future End Date:**
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 (See para TN.1.23 of explanatory notes to this Category) **Fee:** $708.55 **Benefit:** 100% = $708.55 **Future End Date:**
13106	DECLOTTING OF AN ARTERIOVENOUS SHUNT **Fee:** $145.20 **Benefit:** 75% = $108.90 85% = $123.45 **Future End Date:**
13109	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS INSERTION AND FIXATION OF (Anaes.) **Fee:** $272.55 **Benefit:** 75% = $204.45 85% = $231.70

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	2. DIALYSIS
	Future End Date:
13110	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS , removal of (including catheter cuffs) (Anaes.) **Fee:** $273.50 **Benefit:** 75% = $205.15 85% = $232.50 **Future End Date:**

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	3. ASSISTED REPRODUCTIVE SERVICES
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 3. Assisted Reproductive Services
13200	Assisted reproductive technologies superovulated treatment cycle proceeding to oocyte retrieval, involving the use of drugs to induce superovulation and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, transfer of frozen embryos or donated embryos or ova or a service to which item 13201, 13202, 13203 or 13218 applies, being services rendered during one treatment cycle—initial cycle in a single calendar year (See para TN.1.4 of explanatory notes to this Category) **Fee:** $3,723.25 **Benefit:** 75% = $2792.45 85% = $3614.75 **Extended Medicare Safety Net Cap:** $2,118.30 **Future End Date:**
13201	Assisted reproductive technologies superovulated treatment cycle proceeding to oocyte retrieval, involving the use of drugs to induce superovulation and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, transfer of frozen embryos or donated embryos or ova or a service to which item 13200, 13202, 13203 or 13218 applies, being services rendered during one treatment cycle—each cycle after the first in a single calendar year (See para TN.1.4 of explanatory notes to this Category) **Fee:** $3,482.70 **Benefit:** 75% = $2612.05 85% = $3374.20 **Extended Medicare Safety Net Cap:** $3,074.90 **Future End Date:**
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 (See para TN.1.4 of explanatory notes to this Category) **Fee:** $557.20 **Benefit:** 75% = $417.90 85% = $473.65 **Extended Medicare Safety Net Cap:** $81.90 **Future End Date:**
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 (See para TN.1.4 of explanatory notes to this Category)

	Fee: $582.50 **Benefit:** 75% = $436.90 85% = $495.15 **Extended Medicare Safety Net Cap:** $136.50 **Future End Date:**
13207	Biopsy of an embryo, from a patient who is eligible for a service described in item 73384 under clause 2.7.3A of the pathology services table (see PR.7.1), for the purpose of providing a sample for pre-implantation genetic testing—applicable to one or more tests performed in one assisted reproductive treatment cycle (See para PR.7.1 of explanatory notes to this Category) **Fee:** $132.25 **Benefit:** 75% = $99.20 85% = $112.45 **Future End Date:**
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 (See para TN.1.4 of explanatory notes to this Category) **Fee:** $101.30 **Benefit:** 75% = $76.00 85% = $86.15 **Extended Medicare Safety Net Cap:** $13.60 **Future End Date:**
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.) (See para TN.1.4 of explanatory notes to this Category) **Fee:** $424.25 **Benefit:** 75% = $318.20 85% = $360.65 **Extended Medicare Safety Net Cap:** $88.70 **Future End Date:**
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.) (See para TN.1.4 of explanatory notes to this Category) **Fee:** $133.05 **Benefit:** 75% = $99.80 85% = $113.10 **Extended Medicare Safety Net Cap:** $61.40 **Future End Date:**
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.) (See para TN.1.5, TN.1.4 of explanatory notes to this Category) **Fee:** $949.75 **Benefit:** 75% = $712.35 85% = $841.25 **Extended Medicare Safety Net Cap:** $888.30 **Future End Date:**
13221	Preparation of semen for the purpose of artificial insemination—only if rendered in connection with a service to which item 13203 applies (See para TN.1.4 of explanatory notes to this Category) **Fee:** $60.80 **Benefit:** 75% = $45.60 85% = $51.70 **Extended Medicare Safety Net Cap:** $27.30 **Future End Date:**
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

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	3. ASSISTED REPRODUCTIVE SERVICES
	male factor infertility, not being a service associated with a service to which item 13218 or 37604 applies (H) (Anaes.) (See para TN.8.2 of explanatory notes to this Category) **Fee:** $1,017.40 **Benefit:** 75% = $763.05 **Future End Date:**
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 (See para TN.1.5 of explanatory notes to this Category) **Fee:** $500.30 **Benefit:** 75% = $375.25 85% = $425.30 **Extended Medicare Safety Net Cap:** $136.50 **Future End Date:**
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. (See para TN.1.22 of explanatory notes to this Category) **Fee:** $496.70 **Benefit:** 75% = $372.55 85% = $422.20 **Extended Medicare Safety Net Cap:** $322.90 **Future End Date:**
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 **Fee:** $244.40 **Benefit:** 75% = $183.30 85% = $207.75 **Future End Date:**

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	4. PAEDIATRIC & NEONATAL
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 4. Paediatric & Neonatal
13300	Umbilical or scalp vein catheterisation in a neonate with or without infusion or cannulation of a vein (H) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $68.15 **Benefit:** 75% = $51.15 **Future End Date:**
13303	Umbilical artery catheterisation with or without infusion (H) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $101.00 **Benefit:** 75% = $75.75 **Future End Date:**
13306	Blood transfusion with venesection and complete replacement of blood, including collection from donor (H) (See para GN.1.2 of explanatory notes to this Category)

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	4. PAEDIATRIC & NEONATAL
	Fee: $399.90 **Benefit:** 75% = $299.95 **Future End Date:**
13309	Blood transfusion with venesection and complete replacement of blood, using blood already collected (H) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $340.95 **Benefit:** 75% = $255.75 **Future End Date:**
13312	BLOOD for pathology test, collection of, BY FEMORAL OR EXTERNAL JUGULAR VEIN PUNCTURE IN INFANTS **Fee:** $34.05 **Benefit:** 75% = $25.55 85% = $28.95 **Future End Date:**
13318	Central vein catheterisation by open exposure, in a patient under 12 years of age (H) (Anaes.) (See para GN.1.2, TN.1.6 of explanatory notes to this Category) **Fee:** $272.20 **Benefit:** 75% = $204.15 **Future End Date:**
13319	Central vein catheterisation in a neonate via peripheral vein (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $272.20 **Benefit:** 75% = $204.15 **Future End Date:**

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	5. CARDIOVASCULAR
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 5. Cardiovascular
13400	Restoration of cardiac rhythm by electrical stimulation (cardioversion), other than in the course of cardiac surgery (H) (Anaes.) **Fee:** $115.95 **Benefit:** 75% = $87.00 **Future End Date:**

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	6. GASTROENTEROLOGY
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 6. Gastroenterology
13506	Gastro-oesophageal balloon intubation for control of bleeding from gastric oesophageal varices (H) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $220.75 **Benefit:** 75% = $165.60 **Future End Date:**

	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 8. Haematology
13700	Harvesting of homologous (including allogeneic) or autologous bone marrow for the purpose of transplantation (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $398.95 **Benefit:** 75% = $299.25 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.95 **Benefit:** 75% = $107.25 **Future End Date:**
13706	Transfusion of blood or bone marrow already collected (See para GN.1.2, TN.1.7 of explanatory notes to this Category) **Fee:** $99.75 **Benefit:** 75% = $74.85 85% = $84.80 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $163.60 **Benefit:** 75% = $122.70 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $163.60 **Benefit:** 75% = $122.70 **Future End Date:**
13757	THERAPEUTIC VENESECTION for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda **Fee:** $87.30 **Benefit:** 75% = $65.50 85% = $74.25 **Future End Date:**
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) (See para TN.1.26 of explanatory notes to this Category) **Fee:** $912.80 **Benefit:** 75% = $684.60 **Future End Date:**
13761	Extracorporeal photopheresis for the treatment of chronic graft-versus-host disease, if: (a) the person is: (i) has received allogeneic haematopoietic stem cell transplantation; and (ii) has been diagnosed with chronic graft versus host disease following the transplantation; and (iii) steroid treatment is clinically unsuitable as the disease is steroid refractory or the person is steroid-dependent or steroid-intolerant; and (b) the person has not previously received extracorporeal photopheresis treatment; and (c) the service is delivered using an integrated, closed extracorporeal photopheresis system; and (d) the service is provided in combination with the use of methoxsalen that is listed on the Pharmaceutical Benefits Scheme; and (e) the service is provided by, or on behalf of, a specialist or consultant physician who: (i) is practising in the speciality of haematology or oncology; and (ii) has experience with allogeneic bone marrow transplantation. Applicable once per treatment session (H) (See para GN.1.2, TN.1.29 of explanatory notes to this Category) **Fee:** $2,195.20 **Benefit:** 75% = $1646.40 **Future End Date:**
13762	Extracorporeal photopheresis for the treatment of chronic graft-versus-host disease, if: (a) the person is: (i) has received allogeneic haematopoietic stem cell transplantation; and (ii) has been diagnosed with chronic graft versus host disease following the transplantation; and (iii) steroid treatment is clinically unsuitable as the disease is steroid refractory or the person is steroid-dependent or steroid-intolerant; and (b) the person has previously received an extracorporeal photopheresis treatment cycle and had a partial or complete response in at least one organ in response to treatment; and (c) the person requires further extracorporeal photopheresis; and

	(d) the service is delivered using an integrated, closed extracorporeal photopheresis system; and (e) the service is provided in combination with the use of methoxsalen that is listed on the Pharmaceutical Benefits Scheme; and (f) the service is provided by, or on behalf of, a specialist or consultant physician who: (i) is practising in the speciality of haematology or oncology; and (ii) has experience with allogeneic bone marrow transplantation. Applicable once per treatment session (H) (See para GN.1.2, TN.1.29 of explanatory notes to this Category) **Fee:** $2,195.20 **Benefit:** 75% = $1646.40 **Future End Date:**

	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 9. 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.) (See para GN.1.2, TN.1.6, TN.1.10 of explanatory notes to this Category) **Fee:** $136.05 **Benefit:** 75% = $102.05 **Future End Date:**
13818	Right heart balloon catheter, insertion of, including pulmonary wedge pressure and cardiac output measurement (H) (Anaes.) (See para GN.1.2, TN.1.10 of explanatory notes to this Category) **Fee:** $136.10 **Benefit:** 75% = $102.10 **Future End Date:**
13830	Intracranial pressure, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician—each day (H) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $90.15 **Benefit:** 75% = $67.65 **Future End Date:**
13832	Peripheral cannulation, including under ultrasound guidance where clinically appropriate, for veno-arterial cardiopulmonary extracorporeal life support (H) (See para GN.1.2, TN.1.10 of explanatory notes to this Category) **Fee:** $1,055.40 **Benefit:** 75% = $791.55 **Future End Date:**
13834	Veno–arterial cardiopulmonary extracorporeal life support, management of—the first day (H) (See para GN.1.2, TN.1.10 of explanatory notes to this Category) **Fee:** $590.80 **Benefit:** 75% = $443.10

	Future End Date:
13835	Veno–arterial cardiopulmonary extracorporeal life support, management of—each day after the first (H) (See para GN.1.2, TN.1.10 of explanatory notes to this Category) **Fee:** $137.45 **Benefit:** 75% = $103.10 **Future End Date:**
13837	Veno-venous pulmonary extracorporeal life support, management of—the first day (H) (See para GN.1.2, TN.1.10 of explanatory notes to this Category) **Fee:** $590.80 **Benefit:** 75% = $443.10 **Future End Date:**
13838	Veno-venous pulmonary extracorporeal life support, management of—each day after the first (H) (See para GN.1.2, TN.1.10 of explanatory notes to this Category) **Fee:** $137.45 **Benefit:** 75% = $103.10 **Future End Date:**
13839	ARTERIAL PUNCTURE and collection of blood for diagnostic purposes **Fee:** $27.65 **Benefit:** 75% = $20.75 85% = $23.55 **Future End Date:**
13840	Peripheral cannulation, including under ultrasound guidance where clinically appropriate, for veno-venous pulmonary extracorporeal life support (H) (See para GN.1.2, TN.1.10 of explanatory notes to this Category) **Fee:** $707.10 **Benefit:** 75% = $530.35 **Future End Date:**
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 (See para TN.1.10 of explanatory notes to this Category) **Fee:** $111.95 **Benefit:** 75% = $84.00 85% = $95.20 **Future End Date:**
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) (See para GN.1.2, TN.1.10 of explanatory notes to this Category) **Fee:** $186.85 **Benefit:** 75% = $140.15 **Future End Date:**
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) (See para GN.1.2, TN.1.10 of explanatory notes to this Category) **Fee:** $590.80 **Benefit:** 75% = $443.10 **Future End Date:**

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT
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) (See para GN.1.2, TN.1.10 of explanatory notes to this Category) **Fee:** $137.45 **Benefit:** 75% = $103.10 **Future End Date:**
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 (See para TN.1.10 of explanatory notes to this Category) **Fee:** $175.25 **Benefit:** 75% = $131.45 85% = $149.00 **Future End Date:**

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	10. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 10. Management And Procedures Undertaken In An Intensive Care Unit
13870	*(Note: See para T1.8 of Explanatory Notes to this Category for definition of an Intensive Care Unit)* MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation - management on the first day (H) (See para TN.1.9, TN.1.10, TN.1.11 of explanatory notes to this Category) **Fee:** $433.45 **Benefit:** 75% = $325.10 **Future End Date:**
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) (See para TN.1.9, TN.1.11 of explanatory notes to this Category) **Fee:** $321.45 **Benefit:** 75% = $241.10 **Future End Date:**
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) (See para TN.1.9, TN.1.10, TN.1.11 of explanatory notes to this Category) **Fee:** $92.05 **Benefit:** 75% = $69.05 **Future End Date:**
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) (See para TN.1.9 of explanatory notes to this Category) **Fee:** $175.25 **Benefit:** 75% = $131.45 **Future End Date:**
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) (See para TN.1.9, TN.1.11 of explanatory notes to this Category) **Fee:** $137.95 **Benefit:** 75% = $103.50 **Future End Date:**
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) (See para TN.1.9, TN.1.11 of explanatory notes to this Category) **Fee:** $183.90 **Benefit:** 75% = $137.95 **Future End Date:**
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) (See para TN.1.9, TN.1.11 of explanatory notes to this Category) **Fee:** $92.05 **Benefit:** 75% = $69.05 **Future End Date:**
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 (See para TN.1.11 of explanatory notes to this Category) **Fee:** $320.55 **Benefit:** 75% = $240.45 85% = $272.50 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	11. CHEMOTHERAPEUTIC PROCEDURES
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 11. 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 (See para TN.1.12, TN.1.27 of explanatory notes to this Category) **Fee:** $129.30 **Benefit:** 75% = $97.00 85% = $109.95 **Future End Date:**

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	12. DERMATOLOGY
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 12. 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 (See para TN.1.14 of explanatory notes to this Category) **Fee:** $63.20 **Benefit:** 75% = $47.40 85% = $53.75 **Future End Date:**
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.) (See para TN.1.15 of explanatory notes to this Category) **Fee:** $182.45 **Benefit:** 75% = $136.85 85% = $155.10 **Extended Medicare Safety Net Cap:** $146.00 **Future End Date:**
14106	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), if the abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12 month period—area of treatment less than 150 cm^2 (Anaes.) (See para TN.1.15 of explanatory notes to this Category)

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	12. DERMATOLOGY
	Fee: $191.70 **Benefit:** 75% = $143.80 85% = $162.95 **Future End Date:**
14115	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12 month period—area of treatment 150 cm^2 to 300 cm^2 (Anaes.) (See para TN.1.15 of explanatory notes to this Category) **Fee:** $307.00 **Benefit:** 75% = $230.25 85% = $260.95 **Future End Date:**
14118	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14115 apply) in any 12 month period—area of treatment more than 300 cm^2 (Anaes.) (See para TN.1.15 of explanatory notes to this Category) **Fee:** $389.85 **Benefit:** 75% = $292.40 85% = $331.40 **Future End Date:**
14124	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, if: (a) a seventh or subsequent session (including any sessions to which this item or any of items 14100 to 14118 apply) is indicated in a 12 month period commencing on the day of the first session; and (b) photographic evidence demonstrating the need for this service is documented in the patient notes (Anaes.) (See para TN.1.15 of explanatory notes to this Category) **Fee:** $182.45 **Benefit:** 75% = $136.85 85% = $155.10 **Future End Date:**

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	13. OTHER THERAPEUTIC PROCEDURES
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 13. 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 (See para TN.1.16 of explanatory notes to this Category) **Fee:** $283.50 **Benefit:** 75% = $212.65 85% = $241.00 **Extended Medicare Safety Net Cap:** $42.55 **Future End Date:**

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 (See para TN.1.16 of explanatory notes to this Category) **Fee:** $143.50 **Benefit:** 75% = $107.65 85% = $122.00 **Extended Medicare Safety Net Cap:** $21.55 **Future End Date:**
14203	HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture (Anaes.) (See para TN.1.17, TN.1.4 of explanatory notes to this Category) **Fee:** $61.20 **Benefit:** 75% = $45.90 85% = $52.05 **Future End Date:**
14206	Hormone or living tissue implantation—by cannula (See para TN.1.17, TN.1.4, TN.0.1 of explanatory notes to this Category) **Fee:** $103.00 **Benefit:** 75% = $77.25 85% = $87.55 **Future End Date:**
14212	Intussusception, management of fluid or gas reduction for (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $221.70 **Benefit:** 75% = $166.30 **Future End Date:**
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 (See para TN.1.28 of explanatory notes to this Category) **Fee:** $214.45 **Benefit:** 75% = $160.85 85% = $182.30 **Extended Medicare Safety Net Cap:** $617.70 **Future End Date:**

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 (See para TN.1.28 of explanatory notes to this Category) **Fee:** $184.00 **Benefit:** 75% = $138.00 85% = $156.40 **Extended Medicare Safety Net Cap:** $391.10 **Future End Date:**
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 (See para TN.8.244 of explanatory notes to this Category) **Fee:** $117.25 **Benefit:** 75% = $87.95 85% = $99.70 **Future End Date:**
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) (See para TN.1.28 of explanatory notes to this Category) **Fee:** $214.45 **Benefit:** 75% = $160.85 85% = $182.30 **Extended Medicare Safety Net Cap:** $617.70 **Future End Date:**
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 (See para TN.1.28 of explanatory notes to this Category) **Fee:** $184.00 **Benefit:** 75% = $138.00 85% = $156.40 **Extended Medicare Safety Net Cap:** $391.10 **Future End Date:**
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 **Fee:** $62.85 **Benefit:** 75% = $47.15 85% = $53.45 **Future End Date:**
14224	Electroconvulsive therapy, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (H) (Anaes.) **Fee:** $184.00 **Benefit:** 75% = $138.00 **Future End Date:**
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 (See para TN.1.18 of explanatory notes to this Category) **Fee:** $117.25 **Benefit:** 75% = $87.95 85% = $99.70 **Future End Date:**
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.) (See para TN.1.18 of explanatory notes to this Category) **Fee:** $433.15 **Benefit:** 75% = $324.90 **Future End Date:**
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.) (See para TN.1.18 of explanatory notes to this Category) **Fee:** $789.80 **Benefit:** 75% = $592.35 **Future End Date:**
Amend 14245	Immunomodulating agent supplied under the pharmaceutical benefits scheme, administration of, by intravenous infusion lasting at least 2 hours—applicable once per day (See para TN.1.19 of explanatory notes to this Category) **Fee:** $117.25 **Benefit:** 75% = $87.95 85% = $99.70 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $2,215.00 **Benefit:** 75% = $1661.25 **Future End Date:**
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) (See para GN.1.2, TN.1.25 of explanatory notes to this Category) **Fee:** $2,215.00 **Benefit:** 75% = $1661.25 **Future End Date:**

	Group T1. Miscellaneous Therapeutic Procedures

	Subgroup 14. 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.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $177.55 **Benefit:** 75% = $133.20 85% = $150.95 **Future End Date:**
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.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $341.50 **Benefit:** 75% = $256.15 85% = $290.30 **Future End Date:**
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.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $680.15 **Benefit:** 75% = $510.15 85% = $578.15 **Future End Date:**
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.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $133.30 **Benefit:** 75% = $100.00 85% = $113.35 **Future End Date:**
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.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $256.15 **Benefit:** 75% = $192.15 85% = $217.75 **Future End Date:**
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.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $510.10 **Benefit:** 75% = $382.60 85% = $433.60 **Future End Date:**

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.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $62.55 **Benefit:** 75% = $46.95 85% = $53.20 **Future End Date:**
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.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60 **Future End Date:**
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.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $46.85 **Benefit:** 75% = $35.15 85% = $39.85 **Future End Date:**
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.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $105.50 **Benefit:** 75% = $79.15 85% = $89.70 **Future End Date:**
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.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $157.75 **Benefit:** 75% = $118.35 85% = $134.10 **Future End Date:**
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.) (See para TN.1.24 of explanatory notes to this Category) **Fee:** $118.35 **Benefit:** 75% = $88.80 85% = $100.60 **Future End Date:**

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 (See para TN.1.24 of explanatory notes to this Category) **Fee:** $177.55 **Benefit:** 75% = $133.20 85% = $150.95 **Future End Date:**
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 (See para TN.1.24 of explanatory notes to this Category) **Fee:** $133.30 **Benefit:** 75% = $100.00 85% = $113.35 **Future End Date:**
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 (See para TN.1.24 of explanatory notes to this Category) **Fee:** $177.55 **Benefit:** 75% = $133.20 85% = $150.95 **Future End Date:**
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 (See para TN.1.24 of explanatory notes to this Category) **Fee:** $133.30 **Benefit:** 75% = $100.00 85% = $113.35 **Future End Date:**
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 (See para TN.1.24 of explanatory notes to this Category) **Fee:** $177.55 **Benefit:** 75% = $133.20 85% = $150.95 **Future End Date:**
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

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES	14. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN EMERGENCY DEPARTMENT
	(See para TN.1.24 of explanatory notes to this Category) **Fee:** $133.30 **Benefit:** 75% = $100.00 85% = $113.35 **Future End Date:**

T2. RADIATION ONCOLOGY	10. TARGETED INTRAOPERATIVE RADIATION THERAPY
	Group T2. Radiation Oncology
	Subgroup 10. Targeted intraoperative radiation therapy
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 3 cm 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) **Fee:** $299.20 **Benefit:** 75% = $224.40 **Future End Date:**

T2. RADIATION ONCOLOGY	11. MEGAVOLTAGE POST 1 JULY 2024
	Group T2. Radiation Oncology
	Subgroup 11. 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

(See para TN.2.1, TN.2.2, TN.2.10 of explanatory notes to this Category)
Fee: $762.15 **Benefit:** 75% = $571.65 85% = $653.65
Future End Date:

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

15904

	Applicable once per course of treatment (See para TN.2.1, TN.2.2, TN.2.10 of explanatory notes to this Category) **Fee:** $1,116.65 **Benefit:** 75% = $837.50 85% = $1008.15 **Future End Date:**
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 (See para TN.2.1, TN.2.2, TN.2.10 of explanatory notes to this Category) **Fee:** $1,721.70 **Benefit:** 75% = $1291.30 85% = $1613.20 **Future End Date:**
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

(See para TN.2.1, TN.2.2, TN.2.10 of explanatory notes to this Category)
Fee: $2,783.40 **Benefit:** 75% = $2087.55 85% = $2674.90
Future End Date:

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

15910

	Applicable once per course of treatment (See para TN.2.1, TN.2.2, TN.2.10 of explanatory notes to this Category) **Fee:** $4,352.40 **Benefit:** 75% = $3264.30 85% = $4243.90 **Future End Date:**
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 (See para TN.2.1, TN.2.2, TN.2.10 of explanatory notes to this Category) **Fee:** $2,176.20 **Benefit:** 75% = $1632.15 85% = $2067.70 **Future End Date:**
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 (See para TN.2.1, TN.2.2, TN.2.10 of explanatory notes to this Category) **Fee:** $6,255.35 **Benefit:** 75% = $4691.55 85% = $6146.85 **Future End Date:**
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 (See para TN.2.1, TN.2.2, TN.2.10 of explanatory notes to this Category) **Fee:** $3,127.65 **Benefit:** 75% = $2345.75 85% = $3019.15 **Future End Date:**
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 (See para TN.2.1, TN.2.2, TN.2.10 of explanatory notes to this Category) **Fee:** $7,013.95 **Benefit:** 75% = $5260.50 85% = $6905.45 **Future End Date:**
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 (See para TN.2.1, TN.2.2, TN.2.10 of explanatory notes to this Category) **Fee:** $7,013.95 **Benefit:** 75% = $5260.50 85% = $6905.45 **Future End Date:**
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 (See para TN.2.1, TN.2.2, TN.2.10 of explanatory notes to this Category) **Fee:** $3,507.00 **Benefit:** 75% = $2630.25 85% = $3398.50 **Future End Date:**
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.) (See para TN.2.1, TN.2.2, TN.2.10 of explanatory notes to this Category) **Fee:** $7,403.00 **Benefit:** 75% = $5552.25 85% = $7294.50 **Future End Date:**
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 (See para TN.2.1, TN.2.2, TN.2.10 of explanatory notes to this Category) **Fee:** $7,403.00 **Benefit:** 75% = $5552.25 85% = $7294.50 **Future End Date:**

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.) (See para TN.2.1, TN.2.2, TN.2.10 of explanatory notes to this Category) **Fee:** $3,701.50 **Benefit:** 75% = $2776.15 85% = $3593.00 **Future End Date:**
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 (See para TN.2.1, TN.2.3, TN.2.10 of explanatory notes to this Category) **Fee:** $95.90 **Benefit:** 75% = $71.95 85% = $81.55 **Future End Date:**
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 (See para TN.2.1, TN.2.3, TN.2.10 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 75% = $89.60 85% = $101.55 **Future End Date:**
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 (See para TN.2.1, TN.2.3, TN.2.10 of explanatory notes to this Category) **Fee:** $268.90 **Benefit:** 75% = $201.70 85% = $228.60 **Future End Date:**
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 (See para TN.2.1, TN.2.3, TN.2.10 of explanatory notes to this Category) **Fee:** $292.50 **Benefit:** 75% = $219.40 85% = $248.65 **Future End Date:**
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 (See para TN.2.1, TN.2.3, TN.2.10 of explanatory notes to this Category) **Fee:** $292.50 **Benefit:** 75% = $219.40 85% = $248.65 **Future End Date:**
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 (See para TN.2.1, TN.2.3, TN.2.10 of explanatory notes to this Category) **Fee:** $321.75 **Benefit:** 75% = $241.35 85% = $273.50 **Future End Date:**
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 (See para TN.2.1, TN.2.3, TN.2.10 of explanatory notes to this Category) **Fee:** $829.30 **Benefit:** 75% = $622.00 85% = $720.80 **Future End Date:**
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 per site, for a maximum of 2 sites (See para TN.2.1, TN.2.3, TN.2.10 of explanatory notes to this Category) **Fee:** $829.30 **Benefit:** 75% = $622.00 85% = $720.80 **Future End Date:**
15946	Megavoltage treatment—level 5

T2. RADIATION ONCOLOGY	11. MEGAVOLTAGE POST 1 JULY 2024
	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 (See para TN.2.1, TN.2.3, TN.2.10 of explanatory notes to this Category) **Fee:** $953.70 **Benefit:** 75% = $715.30 85% = $845.20 **Future End Date:**
15948	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, 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 (See para TN.2.1, TN.2.3, TN.2.10 of explanatory notes to this Category) **Fee:** $953.70 **Benefit:** 75% = $715.30 85% = $845.20 **Future End Date:**

T2. RADIATION ONCOLOGY	12. KILOVOLTAGE
	Group T2. Radiation Oncology
	Subgroup 12. 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;

T2. RADIATION ONCOLOGY	12. KILOVOLTAGE
	(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 (See para TN.2.4 of explanatory notes to this Category) **Fee:** $214.00 **Benefit:** 75% = $160.50 85% = $181.90 **Future End Date:**
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) (See para TN.2.4 of explanatory notes to this Category) **Fee:** $57.60 **Benefit:** 75% = $43.20 85% = $49.00 **Future End Date:**
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) (See para TN.2.4 of explanatory notes to this Category) **Fee:** $23.15 **Benefit:** 75% = $17.40 85% = $19.70 **Future End Date:**
15956	Delivery of kilovoltage radiation therapy (50 kV to 500 kV range) to orbital structures where there is placement of an internal eye shield (See para TN.2.4 of explanatory notes to this Category) **Fee:** $70.85 **Benefit:** 75% = $53.15 85% = $60.25 **Future End Date:**

T2. RADIATION ONCOLOGY	13. BRACHYTHERAPY POST 1 JULY 2024
	Group T2. Radiation Oncology
	Subgroup 13. 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 (See para TN.2.5 of explanatory notes to this Category) **Fee:** $111.80 **Benefit:** 75% = $83.85 85% = $95.05 **Future End Date:**
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

	(See para TN.2.5 of explanatory notes to this Category) **Fee:** $154.20 **Benefit:** 75% = $115.65 85% = $131.10 **Future End Date:**
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.) (See para TN.2.5 of explanatory notes to this Category) **Fee:** $335.30 **Benefit:** 75% = $251.50 85% = $285.05 **Future End Date:**
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.) (See para TN.2.5 of explanatory notes to this Category) **Fee:** $447.15 **Benefit:** 75% = $335.40 85% = $380.10 **Future End Date:**
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.) (See para TN.2.5, TN.2.6 of explanatory notes to this Category) **Fee:** $558.85 **Benefit:** 75% = $419.15 85% = $475.05 **Future End Date:**
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.)

	(See para TN.2.5 of explanatory notes to this Category) **Fee:** $876.00 **Benefit:** 75% = $657.00 85% = $767.50 **Future End Date:**
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 (See para TN.2.5 of explanatory notes to this Category) **Fee:** $145.35 **Benefit:** 75% = $109.05 85% = $123.55 **Future End Date:**
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 (See para TN.2.5 of explanatory notes to this Category) **Fee:** $72.70 **Benefit:** 75% = $54.55 85% = $61.80 **Future End Date:**
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 (See para TN.2.5 of explanatory notes to this Category) **Fee:** $974.70 **Benefit:** 75% = $731.05 85% = $866.20 **Future End Date:**
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 (See para TN.2.5 of explanatory notes to this Category) **Fee:** $487.40 **Benefit:** 75% = $365.55 85% = $414.30

	Future End Date:
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 (See para TN.2.5 of explanatory notes to this Category) **Fee:** $1,132.65 **Benefit:** 75% = $849.50 85% = $1024.15 **Future End Date:**
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 (See para TN.2.5 of explanatory notes to this Category) **Fee:** $566.40 **Benefit:** 75% = $424.80 85% = $481.45 **Future End Date:**
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 (See para TN.2.5 of explanatory notes to this Category) **Fee:** $424.70 **Benefit:** 75% = $318.55 85% = $361.00 **Future End Date:**
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;

T2. RADIATION ONCOLOGY	13. BRACHYTHERAPY POST 1 JULY 2024
	(ii) item 15982 (See para TN.2.5 of explanatory notes to this Category) **Fee:** $156.45 **Benefit:** 75% = $117.35 85% = $133.00 **Future End Date:**

T2. RADIATION ONCOLOGY	15. PROTON BEAM THERAPY
	Group T2. Radiation Oncology
	Subgroup 15. Proton Beam Therapy
15990	Proton beam dosimetry, and proton-photon comparative plan reporting, to assess eligibility for proton beam therapy via the Medical Treatment Overseas Program if: (a) proton planning is required to calculate dose to single or multiple-target structures and requires a dose-volume histogram to complete the planning process; and (b) the proton planning process optimises the differential between target dose, organs at risk, and normal tissue dose, based on review and assessment by a radiation oncologist; and (c) all relevant gross tumour volumes, clinical target volumes and organs at risk are rendered as volumes and nominated with planning dose objectives; and (d) organs at risk are nominated as planning dose constraints; and (e) dose calculations and dose-volume histograms are generated in an inverse planned process, using a specialised calculation algorithm, with prescription and plan details approved and recorded with the plan; and (f) a three-dimensional or four-dimensional image volume dataset is used for the relevant region to be planned and verified; and (g) the final proton dosimetry plan is: (i) validated by a radiation therapist and a medical physicist, using quality assurance processes; and (ii) approved by the radiation oncologist; and (h) a proton-photon comparative plan report is generated; and (i) the service is bulk-billed (See para TN.2.11 of explanatory notes to this Category) **Fee:** $7,728.65 **Benefit:** 75% = $5796.50 85% = $7620.15 **Future End Date:**

T3. THERAPEUTIC NUCLEAR MEDICINE	1. ADMINISTRATION OF NUCLEAR MEDICINE
	Group T3. Therapeutic Nuclear Medicine
	Subgroup 1. Administration of Nuclear Medicine

T3. THERAPEUTIC NUCLEAR MEDICINE	1. ADMINISTRATION OF 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.) (See para TR.3.1, TN.3.1 of explanatory notes to this Category) **Fee:** $1,698.50 **Benefit:** 75% = $1273.90 85% = $1590.00 **Future End Date:**
16006	Administration of a therapeutic dose of Iodine 131 for thyroid cancer by single dose technique (See para TR.3.1 of explanatory notes to this Category) **Fee:** $1,144.95 **Benefit:** 75% = $858.75 85% = $1036.45 **Future End Date:**
16009	Administration of a therapeutic dose of Iodine 131 for thyrotoxicosis by single dose technique (See para TR.3.1 of explanatory notes to this Category) **Fee:** $554.65 **Benefit:** 75% = $416.00 85% = $471.50 **Future End Date:**
16012	Intravenous administration of a therapeutic dose of Phosphorous 32 (See para TR.3.1 of explanatory notes to this Category) **Fee:** $3,185.75 **Benefit:** 75% = $2389.35 85% = $3077.25 **Future End Date:**
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. (See para TR.3.1 of explanatory notes to this Category) **Fee:** $4,890.05 **Benefit:** 75% = $3667.55 85% = $4781.55 **Future End Date:**
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. (See para TR.3.1 of explanatory notes to this Category) **Fee:** $5,261.65 **Benefit:** 75% = $3946.25 85% = $5153.15 **Future End Date:**

T3. THERAPEUTIC NUCLEAR MEDICINE	2. THERANOSTICS
	Group T3. Therapeutic Nuclear Medicine
	Subgroup 2. Theranostics

T3. THERAPEUTIC NUCLEAR MEDICINE	2. THERANOSTICS
16050	Administration of Lutetium 177 PSMA, followed within 36 hours by whole body Lu-PSMA SPECT, for treatment of a patient with metastatic castrate resistant prostate cancer who is: (a) PSMA-positive as determined by PSMA PET (defined as SUVmax >15 at a single site of disease and SUVmax >10 at all sites of measurable disease) after disease progression and (b) prior treatment includes at least one taxane chemotherapy and at least one androgen receptor signalling inhibitor. Applicable once per cycle, up to a maximum of 2 cycles in the initial treatment phase. (See para TR.3.1 of explanatory notes to this Category) **Fee:** $8,208.00 **Benefit:** 75% = $6156.00 85% = $8099.50 **Future End Date:**
16055	Administration of Lutetium 177 PSMA, followed within 36 hours by whole body Lu-PSMA SPECT, for treatment of a patient with metastatic castrate resistant prostate cancer, if: (a) a service to which item 16050 applies has been provided; and (b) the patient has not developed disease progression while receiving Lutetium 177 PSMA for this condition. Applicable once per cycle, up to a maximum of 4 cycles in the continuing treatment phase. (See para TR.3.1 of explanatory notes to this Category) **Fee:** $8,208.00 **Benefit:** 75% = $6156.00 85% = $8099.50 **Future End Date:**
16060	^{177}Lutetium-DOTA-somatostatin receptor agonist treatment cycle for patients with histologically confirmed and inoperable neuroendocrine neoplasm (NEN), either locally advanced or metastatic, with documented disease progression or uncontrolled symptoms related to their NEN despite standard therapy who: a) have high tumour somatostatin receptor expression demonstrated on whole body 68Ga DOTA somatostatin agonist PET study; and b) are considered suitable for a course of 177Lutetium-DOTA-somatostatin receptor agonist therapy by a formally convened NEN multidisciplinary board. Includes the necessary patient preparation, administration and treatment, immediate patient aftercare required for the treatment cycle, consultation with the supervising specialist within 36 hours of treatment, and a post-infusion SPECT if performed. (See para TR.3.1 of explanatory notes to this Category) **Fee:** $9,999.95 **Benefit:** 75% = $7500.00 85% = $9891.45 **Future End Date:**

T4. OBSTETRICS	
	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

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	(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 (See para TN.4.1, TN.4.15 of explanatory notes to this Category) **Fee:** $32.65 **Benefit:** 85% = $27.80 **Extended Medicare Safety Net Cap:** $13.80 **Future End Date:**
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 (See para TN.4.2 of explanatory notes to this Category) **Fee:** $102.35 **Benefit:** 75% = $76.80 85% = $87.00 **Extended Medicare Safety Net Cap:** $69.30 **Future End Date:**
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 (See para AN.3.1, TN.4.2, AN.0.70 of explanatory notes to this Category) **Fee:** $51.50 **Benefit:** 75% = $38.65 85% = $43.80 **Extended Medicare Safety Net Cap:** $41.40 **Future End Date:**
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 **Fee:** $160.35 **Benefit:** 75% = $120.30 85% = $136.30 **Extended Medicare Safety Net Cap:** $136.50 **Future End Date:**
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 (See para TN.4.13, TN.4.15 of explanatory notes to this Category) **Fee:** $85.80 **Benefit:** 75% = $64.35 85% = $72.95 **Extended Medicare Safety Net Cap:** $55.80 **Future End Date:**

T4. OBSTETRICS	
Amend 16408	Postnatal attendance (other than attendance at consulting rooms, a hospital or a residential care home 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 (See para TN.4.15 of explanatory notes to this Category) **Fee:** $63.90 **Benefit:** 85% = $54.35 **Extended Medicare Safety Net Cap:** $41.55 **Future End Date:**
16500	Antenatal attendance (See para TN.4.3, TN.4.15 of explanatory notes to this Category) **Fee:** $56.45 **Benefit:** 75% = $42.35 85% = $48.00 **Extended Medicare Safety Net Cap:** $41.40 **Future End Date:**
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 (See para TN.4.3, TN.4.4 of explanatory notes to this Category) **Fee:** $168.20 **Benefit:** 75% = $126.15 85% = $143.00 **Extended Medicare Safety Net Cap:** $83.00 **Future End Date:**
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 (See para TN.4.3 of explanatory notes to this Category) **Fee:** $56.45 **Benefit:** 75% = $42.35 85% = $48.00 **Extended Medicare Safety Net Cap:** $27.60 **Future End Date:**
16505	Threatened abortion, threatened miscarriage or hyperemesis gravidarum, requiring admission to hospital, treatment of—an attendance that is not a routine antenatal attendance (See para TN.4.3 of explanatory notes to this Category) **Fee:** $56.45 **Benefit:** 75% = $42.35 85% = $48.00

T4. OBSTETRICS	
	Extended Medicare Safety Net Cap: $27.60 **Future End Date:**
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 (See para TN.4.3 of explanatory notes to this Category) **Fee:** $56.45 **Benefit:** 75% = $42.35 85% = $48.00 **Extended Medicare Safety Net Cap:** $27.60 **Future End Date:**
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 (See para TN.4.3 of explanatory notes to this Category) **Fee:** $56.45 **Benefit:** 75% = $42.35 85% = $48.00 **Extended Medicare Safety Net Cap:** $27.60 **Future End Date:**
16511	Cervix, purse string ligation of (Anaes.) (See para TN.4.3 of explanatory notes to this Category) **Fee:** $263.15 **Benefit:** 75% = $197.40 85% = $223.70 **Extended Medicare Safety Net Cap:** $138.40 **Future End Date:**
16512	Cervix, removal of purse string ligature of (Anaes.) (See para TN.4.3 of explanatory notes to this Category) **Fee:** $76.00 **Benefit:** 75% = $57.00 85% = $64.60 **Extended Medicare Safety Net Cap:** $41.40 **Future End Date:**
16514	Antenatal cardiotocography in the management of high risk pregnancy (not during the course of the confinement) (See para TN.4.3 of explanatory notes to this Category) **Fee:** $43.85 **Benefit:** 75% = $32.90 85% = $37.30 **Extended Medicare Safety Net Cap:** $20.70 **Future End Date:**
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.) (See para TN.4.5, TN.4.10 of explanatory notes to this Category) **Fee:** $755.05 **Benefit:** 75% = $566.30 85% = $646.55 **Extended Medicare Safety Net Cap:** $221.80 **Future End Date:**
16518	Management of labour, incomplete, if the patient's care has been transferred to another medical practitioner for completion of the birth (Anaes.) (See para TN.4.5, TN.4.10 of explanatory notes to this Category) **Fee:** $539.30 **Benefit:** 75% = $404.50 85% = $458.45 **Extended Medicare Safety Net Cap:** $221.80 **Future End Date:**

T4. OBSTETRICS	
16519	Management of labour and birth by any means (including Caesarean section) including post-partum care for 5 days (Anaes.) (See para TN.4.5, TN.4.6, TN.4.10 of explanatory notes to this Category) **Fee:** $830.60 **Benefit:** 75% = $622.95 85% = $722.10 **Extended Medicare Safety Net Cap:** $415.80 **Future End Date:**
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.) (See para TN.4.6, TN.4.10 of explanatory notes to this Category) **Fee:** $755.05 **Benefit:** 75% = $566.30 **Future End Date:**
16522	Management of labour and birth, or birth alone, (including caesarean section), on or after 23 weeks gestation, if in the course of antenatal supervision or intrapartum management one or more of the following conditions is present, including postnatal care for 7 days: (a) fetal loss; (b) multiple pregnancy; (c) antepartum haemorrhage that is: (i) of greater than 200 ml; or (ii) associated with disseminated intravascular coagulation; (d) placenta praevia on ultrasound in the third trimester with the placenta within 2 cm of the internal cervical os; (e) baby with a birth weight less than or equal to 2,500 g; (f) trial of vaginal birth in a patient with uterine scar where there has been a planned vaginal birth after caesarean section; (g) trial of vaginal breech birth where there has been a planned vaginal breech birth; (h) prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress as evidenced by cervical dilatation at less than 1 cm/hr in the active phase of labour (after 3 cm cervical dilatation and effacement until full dilatation of the cervix); (i) acute fetal compromise evidenced by: (i) scalp pH less than 7.15; or (ii) scalp lactate greater than 4.0; (j) acute fetal compromise evidenced by at least one of the following significant cardiotocograph abnormalities: (i) prolonged bradycardia (less than 100 bpm for more than 2 minutes); (ii) absent baseline variability (less than 3 bpm);

T4. OBSTETRICS	
	(iii) sinusoidal pattern; (iv) complicated variable decelerations with reduced (3 to 5 bpm) or absent baseline variability; (v) late decelerations; (k) pregnancy induced hypertension of at least 140/90 mm Hg associated with: (i) at least 2+ proteinuria on urinalysis; or (ii) protein-creatinine ratio greater than 30 mg/mmol; or (iii) platelet count less than 150 x 10^9/L; or (iv) uric acid greater than 0.36 mmol/L; (l) gestational diabetes mellitus requiring at least daily blood glucose monitoring; (m) mental health disorder (whether arising prior to pregnancy, during pregnancy or postpartum) that is demonstrated by: (i) the patient requiring hospitalisation; or (ii) the patient receiving ongoing care by a psychologist or psychiatrist to treat the symptoms of a mental health disorder; or (iii) the patient having a GP mental health treatment plan; or (iv) the patient having a management plan prepared in accordance with item 291; (n) disclosure or evidence of domestic violence; (o) any of the following conditions either diagnosed pre-pregnancy or evident at the first antenatal visit before 20 weeks gestation: (i) pre-existing hypertension requiring antihypertensive medication prior to pregnancy; (ii) cardiac disease (co-managed with a specialist physician and with echocardiographic evidence of myocardial dysfunction); (iii) previous renal or liver transplant; (iv) renal dialysis; (v) chronic liver disease with documented oesophageal varices; (vi) renal insufficiency in early pregnancy (serum creatinine greater than 110 mmol/L); (vii) neurological disorder that confines the patient to a wheelchair throughout pregnancy; (viii) maternal height of less than 148 cm; (ix) a body mass index greater than or equal to 40; (x) pre-existing diabetes mellitus on medication prior to pregnancy;

T4. OBSTETRICS	
	(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.) (See para TN.4.7 of explanatory notes to this Category) **Fee:** $1,950.10 **Benefit:** 75% = $1462.60 **Future End Date:**
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.) (See para TN.4.8 of explanatory notes to this Category) **Fee:** $755.05 **Benefit:** 75% = $566.30 85% = $646.55 **Extended Medicare Safety Net Cap:** $221.80 **Future End Date:**
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.) (See para TN.4.8 of explanatory notes to this Category) **Fee:** $755.05 **Benefit:** 75% = $566.30 **Future End Date:**
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.) (See para TN.4.5 of explanatory notes to this Category) **Fee:** $460.00 **Benefit:** 75% = $345.00 85% = $391.00 **Extended Medicare Safety Net Cap:** $299.00 **Future End Date:**
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.) (See para TN.4.5, TN.4.14 of explanatory notes to this Category) **Fee:** $920.00 **Benefit:** 75% = $690.00 **Future End Date:**
16533	Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy,

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	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 (See para TN.4.3, TN.4.14 of explanatory notes to this Category) **Fee:** $126.35 **Benefit:** 75% = $94.80 **Future End Date:**
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 (See para TN.4.3, TN.4.14 of explanatory notes to this Category) **Fee:** $126.35 **Benefit:** 75% = $94.80 **Future End Date:**
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.) (See para TN.4.10 of explanatory notes to this Category) **Fee:** $260.90 **Benefit:** 75% = $195.70 **Future End Date:**
16567	Management of postpartum haemorrhage by special measures such as packing of uterus, as an independent procedure (H) (Anaes.) (See para TN.4.10 of explanatory notes to this Category) **Fee:** $381.55 **Benefit:** 75% = $286.20 **Extended Medicare Safety Net Cap:** $277.20 **Future End Date:**
16570	Acute inversion of the uterus, vaginal correction of, as an independent procedure (H) (Anaes.) (See para TN.4.10 of explanatory notes to this Category) **Fee:** $498.05 **Benefit:** 75% = $373.55 **Extended Medicare Safety Net Cap:** $277.20 **Future End Date:**
16571	Cervix, repair of extensive laceration or lacerations (Anaes.) (See para TN.4.10 of explanatory notes to this Category) **Fee:** $381.55 **Benefit:** 75% = $286.20 85% = $324.35 **Extended Medicare Safety Net Cap:** $277.20 **Future End Date:**
16573	Third degree tear, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (H) (Anaes.) (See para TN.4.10 of explanatory notes to this Category) **Fee:** $310.90 **Benefit:** 75% = $233.20 **Future End Date:**
16590	Planning and management, by a practitioner, of a pregnancy if: (a) the practitioner intends to take primary responsibility for management of the pregnancy and any complications, and to be available for the birth; and

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	(b) the patient intends to be privately admitted for the birth; and (c) the pregnancy has progressed beyond 28 weeks gestation; and (d) the practitioner has maternity privileges at a hospital or birth centre; and (e) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (f) a service to which item 16591 applies is not provided in relation to the same pregnancy Applicable once for a pregnancy (See para TN.4.13, TN.4.9 of explanatory notes to this Category) **Fee:** $446.15 **Benefit:** 75% = $334.65 85% = $379.25 **Extended Medicare Safety Net Cap:** $277.20 **Future End Date:**
16591	Planning and management, by a practitioner, of a pregnancy if: (a) the pregnancy has progressed beyond 28 weeks gestation; and (b) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (c) a service to which item 16590 applies is not provided in relation to the same pregnancy Applicable once for a pregnancy (See para TN.4.13, TN.4.9 of explanatory notes to this Category) **Fee:** $170.75 **Benefit:** 75% = $128.10 85% = $145.15 **Extended Medicare Safety Net Cap:** $138.40 **Future End Date:**
16600	Amniocentesis, diagnostic (See para TN.4.3, TN.4.11 of explanatory notes to this Category) **Fee:** $76.00 **Benefit:** 75% = $57.00 85% = $64.60 **Extended Medicare Safety Net Cap:** $41.40 **Future End Date:**
16603	Chorionic villus sampling, by any route (See para TN.4.3, TN.4.11 of explanatory notes to this Category) **Fee:** $145.90 **Benefit:** 75% = $109.45 85% = $124.05 **Extended Medicare Safety Net Cap:** $83.00 **Future End Date:**
16606	Fetal blood sampling, using interventional techniques from umbilical cord or fetus, including fetal neuromuscular blockade and amniocentesis (Anaes.) (See para TN.4.3, TN.4.11 of explanatory notes to this Category) **Fee:** $291.15 **Benefit:** 75% = $218.40 85% = $247.50 **Extended Medicare Safety Net Cap:** $166.30 **Future End Date:**
16609	Fetal intravascular blood transfusion, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling

T4. OBSTETRICS	
	(H) (Anaes.) (See para TN.4.3, TN.4.11 of explanatory notes to this Category) **Fee:** $593.65 **Benefit:** 75% = $445.25 **Extended Medicare Safety Net Cap:** $319.00 **Future End Date:**
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.) (See para TN.4.3, TN.4.11 of explanatory notes to this Category) **Fee:** $467.10 **Benefit:** 75% = $350.35 85% = $397.05 **Future End Date:**
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.) (See para TN.4.3, TN.4.11 of explanatory notes to this Category) **Fee:** $248.80 **Benefit:** 75% = $186.60 **Future End Date:**
16618	Amniocentesis, therapeutic, when indicated because of polyhydramnios with at least 500 ml being aspirated (H) (See para TN.4.3, TN.4.11 of explanatory notes to this Category) **Fee:** $248.80 **Benefit:** 75% = $186.60 **Extended Medicare Safety Net Cap:** $131.60 **Future End Date:**
16621	Amnioinfusion, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios (H) (See para GN.1.2, TN.4.3, TN.4.11 of explanatory notes to this Category) **Fee:** $248.80 **Benefit:** 75% = $186.60 **Future End Date:**
16624	Fetal fluid filled cavity, drainage of (H) (See para TN.4.3, TN.4.11 of explanatory notes to this Category) **Fee:** $358.15 **Benefit:** 75% = $268.65 **Future End Date:**
16627	Feto-amniotic shunt, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis (H) (See para TN.4.3, TN.4.11 of explanatory notes to this Category) **Fee:** $728.90 **Benefit:** 75% = $546.70 **Future End Date:**

T4. OBSTETRICS	1. OBSTETRIC VIDEO SERVICES
	Group T4. Obstetrics
	Subgroup 1. Obstetric video services
91850	Antenatal video service provided by a practice midwife, nurse or an Aboriginal and Torres Strait Islander health practitioner, to a maximum of 10 services per pregnancy, if:

	(a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and (b) 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 **Fee:** $32.65 **Benefit:** 85% = $27.80 **Extended Medicare Safety Net Cap:** $13.80 **Future End Date:**
91851	Postnatal video attendance by an obstetrician or general practitioner (other than a service to which any other item applies) if: (a) is between 4 and 8 weeks after the birth; and (b) lasts at least 20 minutes in duration; and (c) includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (d) is for a pregnancy in relation to which a service to which item 82140 applies is not provided. Applicable once for a pregnancy **Fee:** $85.80 **Benefit:** 85% = $72.95 **Extended Medicare Safety Net Cap:** $55.80 **Future End Date:**
91852	Postnatal video attendance (other than a service to which any other item applies) if: (a) the attendance is rendered by: (i) a practice 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 of the *Health Insurance (Section 3C Midwife and Nurse Practitioner Services) Determination 2020* or item 91214, 91215, 91221 or 91222 is not provided. Applicable once for a pregnancy **Fee:** $63.90 **Benefit:** 85% = $54.35 **Extended Medicare Safety Net Cap:** $41.55

T4. OBSTETRICS	1. OBSTETRIC VIDEO SERVICES
	Future End Date:
91853	Antenatal video attendance **Fee:** $56.45 **Benefit:** 85% = $48.00 **Extended Medicare Safety Net Cap:** $41.40 **Future End Date:**

T4. OBSTETRICS	2. OBSTETRIC PHONE SERVICES
	Group T4. Obstetrics
	Subgroup 2. Obstetric phone services
91855	Antenatal phone service provided by a practice midwife, nurse or an Aboriginal and Torres Strait Islander health practitioner, to a maximum of 10 services per pregnancy, if: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and (b) 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. **Fee:** $32.65 **Benefit:** 85% = $27.80 **Extended Medicare Safety Net Cap:** $13.80 **Future End Date:**
91856	Postnatal phone attendance by an obstetrician or general practitioner (other than a service to which any other item applies) if: (a) is between 4 and 8 weeks after the birth; and (b) lasts at least 20 minutes in duration; and (c) includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (d) is for a pregnancy in relation to which a service to which item 82140 applies is not provided. Applicable once for a pregnancy **Fee:** $85.80 **Benefit:** 85% = $72.95 **Extended Medicare Safety Net Cap:** $55.80 **Future End Date:**
91857	Postnatal phone attendance (other than a service to which any other item applies) if:

T4. OBSTETRICS	2. OBSTETRIC PHONE SERVICES
	(a) the attendance is rendered by: (i) a practice 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 of the *Health Insurance (Section 3C Midwife and Nurse Practitioner Services) Determination 2020* or item 91214, 91215, 91221 or 91222 is not provided. Applicable once for a pregnancy **Fee:** $63.90 **Benefit:** 85% = $54.35 **Extended Medicare Safety Net Cap:** $41.55 **Future End Date:**
91858	Antenatal phone attendance. **Fee:** $56.45 **Benefit:** 85% = $48.00 **Extended Medicare Safety Net Cap:** $41.40 **Future End Date:**

T6. ANAESTHETICS	1. ANAESTHESIA CONSULTATIONS
	Group T6. Anaesthetics
	Subgroup 1. Anaesthesia Consultations
	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
17610	(See para TN.6.1 of explanatory notes to this Category)

	Fee: $52.25 **Benefit:** 75% = $39.20 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
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 (See para TN.6.1 of explanatory notes to this Category) **Fee:** $103.95 **Benefit:** 75% = $78.00 85% = $88.40 **Extended Medicare Safety Net Cap:** $311.85 **Future End Date:**
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 (See para TN.6.1 of explanatory notes to this Category) **Fee:** $144.00 **Benefit:** 75% = $108.00 85% = $122.40 **Extended Medicare Safety Net Cap:** $432.00 **Future End Date:**
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 (See para TN.6.1 of explanatory notes to this Category) **Fee:** $183.35 **Benefit:** 75% = $137.55 85% = $155.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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

	(See para TN.6.2 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 75% = $39.20 85% = $44.45 **Extended Medicare Safety Net Cap:** $156.75 **Future End Date:**
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. (See para TN.6.2 of explanatory notes to this Category) **Fee:** $103.95 **Benefit:** 75% = $78.00 85% = $88.40 **Extended Medicare Safety Net Cap:** $311.85 **Future End Date:**
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 (See para TN.6.2 of explanatory notes to this Category) **Fee:** $144.00 **Benefit:** 75% = $108.00 85% = $122.40 **Extended Medicare Safety Net Cap:** $432.00 **Future End Date:**
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. (See para TN.6.2 of explanatory notes to this Category) **Fee:** $183.35 **Benefit:** 75% = $137.55 85% = $155.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
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. (See para TN.6.3 of explanatory notes to this Category)

T6. ANAESTHETICS	1. ANAESTHESIA CONSULTATIONS
	Fee: $103.95 **Benefit:** 75% = $78.00 85% = $88.40 **Extended Medicare Safety Net Cap:** $311.85 **Future End Date:**
	- 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. (See para TN.6.3 of explanatory notes to this Category) **Fee:** $48.00 **Benefit:** 75% = $36.00 85% = $40.80 **Extended Medicare Safety Net Cap:** $144.00
17690	**Future End Date:**

T7. REGIONAL OR FIELD NERVE BLOCKS	
	Group T7. Regional Or Field Nerve Blocks
18213	Intravenous regional anaesthesia of limb by retrograde perfusion of local anaesthetic agent **Fee:** $106.05 **Benefit:** 75% = $79.55 85% = $90.15 **Future End Date:**
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.) (See para GN.1.2, TN.10.7 of explanatory notes to this Category) **Fee:** $227.30 **Benefit:** 75% = $170.50 **Future End Date:**
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.) (See para GN.1.2, TN.10.7 of explanatory notes to this Category)

T7. REGIONAL OR FIELD NERVE BLOCKS	
	Derived Fee: The fee for item 18216 plus $22.75 for each additional 15 minutes or part thereof beyond the first hour of attendance by the medical practitioner. **Future End Date:**
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 (See para TN.7.2, TN.10.7 of explanatory notes to this Category) **Fee:** $45.10 **Benefit:** 75% = $33.85 85% = $38.35 **Future End Date:**
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 (See para TN.7.2, TN.10.7 of explanatory notes to this Category) **Fee:** $59.85 **Benefit:** 75% = $44.90 85% = $50.90 **Future End Date:**
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) (See para GN.1.2, TN.7.4, TN.10.7 of explanatory notes to this Category) **Fee:** $340.90 **Benefit:** 75% = $255.70 **Future End Date:**
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) (See para GN.1.2, TN.7.4, TN.10.7 of explanatory notes to this Category) **Derived Fee:** The fee for item 18226 plus $34.25 for each additional 15 minutes or part there of beyond the first hour of attendance by the medical practitioner. **Future End Date:**
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 (See para TN.7.1 of explanatory notes to this Category) **Fee:** $74.85 **Benefit:** 75% = $56.15 85% = $63.65 **Future End Date:**
18230	Intrathecal or epidural injection of neurolytic substance (not contrast agent) by any route, including transforaminal route (Anaes.) (See para TN.7.3 of explanatory notes to this Category) **Fee:** $285.35 **Benefit:** 75% = $214.05 85% = $242.55 **Future End Date:**
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

T7. REGIONAL OR FIELD NERVE BLOCKS	
	(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.) (See para TN.7.3, TN.7.1 of explanatory notes to this Category) **Fee:** $227.30 **Benefit:** 75% = $170.50 85% = $193.25 **Future End Date:**
18233	EPIDURAL INJECTION of blood for blood patch (Anaes.) **Fee:** $227.30 **Benefit:** 75% = $170.50 85% = $193.25 **Future End Date:**
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.) (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $149.45 **Benefit:** 75% = $112.10 85% = $127.05 **Future End Date:**
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.) (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $74.85 **Benefit:** 75% = $56.15 85% = $63.65 **Future End Date:**
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 (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $45.10 **Benefit:** 75% = $33.85 85% = $38.35 **Future End Date:**
18240	RETROBULBAR OR PERIBULBAR INJECTION of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $112.00 **Benefit:** 75% = $84.00 85% = $95.20 **Future End Date:**
18242	GREATER OCCIPITAL NERVE, injection of an anaesthetic agent (Anaes.) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $45.10 **Benefit:** 75% = $33.85 85% = $38.35 **Future End Date:**
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 (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $120.70 **Benefit:** 75% = $90.55 85% = $102.60 **Future End Date:**
18248	PHRENIC NERVE, injection of an anaesthetic agent

T7. REGIONAL OR FIELD NERVE BLOCKS	
	(See para TN.7.5 of explanatory notes to this Category) **Fee:** $106.05 **Benefit:** 75% = $79.55 85% = $90.15 **Future End Date:**
18250	SPINAL ACCESSORY NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $74.85 **Benefit:** 75% = $56.15 85% = $63.65 **Future End Date:**
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 (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $120.70 **Benefit:** 75% = $90.55 85% = $102.60 **Future End Date:**
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 (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $120.70 **Benefit:** 75% = $90.55 85% = $102.60 **Future End Date:**
18256	SUPRASCAPULAR NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $74.85 **Benefit:** 75% = $56.15 85% = $63.65 **Future End Date:**
18258	INTERCOSTAL NERVE (single), injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $74.85 **Benefit:** 75% = $56.15 85% = $63.65 **Future End Date:**
18260	INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $106.05 **Benefit:** 75% = $79.55 85% = $90.15 **Future End Date:**
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.) (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $74.85 **Benefit:** 75% = $56.15 85% = $63.65 **Future End Date:**
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 (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $120.70 **Benefit:** 75% = $90.55 85% = $102.60 **Future End Date:**

T7. REGIONAL OR FIELD NERVE BLOCKS	
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 (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $74.85 **Benefit:** 75% = $56.15 85% = $63.65 **Future End Date:**
18268	OBTURATOR NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $106.05 **Benefit:** 75% = $79.55 85% = $90.15 **Future End Date:**
18270	FEMORAL NERVE, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $106.05 **Benefit:** 75% = $79.55 85% = $90.15 **Extended Medicare Safety Net Cap:** $84.85 **Future End Date:**
18272	SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent (See para TN.7.5 of explanatory notes to this Category) **Fee:** $74.85 **Benefit:** 75% = $56.15 85% = $63.65 **Extended Medicare Safety Net Cap:** $59.90 **Future End Date:**
18276	PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels) (See para TN.7.5 of explanatory notes to this Category) **Fee:** $149.45 **Benefit:** 75% = $112.10 85% = $127.05 **Future End Date:**
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 (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $106.05 **Benefit:** 75% = $79.55 85% = $90.15 **Future End Date:**
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.) (See para TN.7.5, TN.7.1 of explanatory notes to this Category) **Fee:** $149.45 **Benefit:** 75% = $112.10 85% = $127.05 **Future End Date:**
18282	Carotid sinus, injection of an anaesthetic agent, as an independent percutaneous procedure (H) (See para GN.1.2, TN.7.5 of explanatory notes to this Category) **Fee:** $120.70 **Benefit:** 75% = $90.55 **Future End Date:**
18284	Cervical or thoracic sympathetic chain, injection of an anaesthetic agent (H) (Anaes.) (See para GN.1.2, TN.7.5 of explanatory notes to this Category) **Fee:** $176.70 **Benefit:** 75% = $132.55 **Future End Date:**

T7. REGIONAL OR FIELD NERVE BLOCKS	
18286	Lumbar or pelvic sympathetic chain, injection of an anaesthetic agent (H) (Anaes.) (See para GN.1.2, TN.7.5 of explanatory notes to this Category) **Fee:** $176.70 **Benefit:** 75% = $132.55 **Future End Date:**
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.) (See para GN.1.2, TN.7.5 of explanatory notes to this Category) **Fee:** $176.70 **Benefit:** 75% = $132.55 **Future End Date:**
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.) (See para TN.7.6 of explanatory notes to this Category) **Fee:** $298.85 **Benefit:** 75% = $224.15 85% = $254.05 **Future End Date:**
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.) (See para TN.7.6, TN.7.5 of explanatory notes to this Category) **Fee:** $149.45 **Benefit:** 75% = $112.10 85% = $127.05 **Future End Date:**
18294	Coeliac plexus or splanchnic nerves, destruction by a neurolytic agent under image guidance (H) (Anaes.) (See para GN.1.2, TN.7.6 of explanatory notes to this Category) **Fee:** $210.70 **Benefit:** 75% = $158.05 **Future End Date:**
18296	Lumbar or pelvic sympathetic chain, destruction by a neurolytic agent under image guidance (H) (Anaes.) (See para GN.1.2, TN.7.6 of explanatory notes to this Category) **Fee:** $180.15 **Benefit:** 75% = $135.15 **Future End Date:**
18297	Assistance at the administration of an epidural blood patch (a service to which item 18233 applies) by another medical practitioner **Fee:** $71.00 **Benefit:** 75% = $53.25 85% = $60.35 **Future End Date:**
18298	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.) **Fee:** $210.70 **Benefit:** 75% = $158.05 85% = $179.10 **Future End Date:**

T8. SURGICAL OPERATIONS	1. GENERAL
	Group T8. Surgical Operations

	Subgroup 1. General
30001	OPERATIVE PROCEDURE, not being a service to which any other item in this Group applies, being a service to which an item in this Group would have applied had the procedure not been discontinued on medical grounds (See para TN.8.5 of explanatory notes to this Category) **Derived Fee:** 50% of the fee which would have applied had the procedure not been discontinued **Future End Date:**
30003	Burns, involving 1% or more but less than 3% of total body surface, dressing of (including redressing of any related donor site, if required), without anaesthesia, if medical practitioner is present—each attendance at which the procedure is performed Not applicable for skin reactions secondary to radiotherapy **Fee:** $43.50 **Benefit:** 75% = $32.65 85% = $37.00 **Future End Date:**
30006	Burns, involving 3% or more but less than 10% of total body surface, dressing of (including redressing of any related donor site, if required), without anaesthesia, if medical practitioner is present—each attendance at which the procedure is performed Not applicable for skin reactions secondary to radiotherapy **Fee:** $55.60 **Benefit:** 75% = $41.70 85% = $47.30 **Future End Date:**
30007	Burns, involving 10% or more of total body surface, dressing of (including redressing of any related donor site, if required), without anaesthesia, if medical practitioner is present—each attendance at which the procedure is performed Not applicable for skin reactions secondary to radiotherapy **Fee:** $186.00 **Benefit:** 75% = $139.50 85% = $158.10 **Future End Date:**
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.) **Fee:** $88.50 **Benefit:** 75% = $66.40 **Future End Date:**
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.) **Fee:** $186.00 **Benefit:** 75% = $139.50 **Future End Date:**
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.) **Fee:** $279.00 **Benefit:** 75% = $209.25 **Future End Date:**

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.) **Fee:** $418.45 **Benefit:** 75% = $313.85 **Future End Date:**
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.) (See para TN.8.6, TN.8.200, TN.8.283 of explanatory notes to this Category) **Fee:** $390.25 **Benefit:** 75% = $292.70 85% = $331.75 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $390.25 **Benefit:** 75% = $292.70 **Future End Date:**
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 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $62.55 **Benefit:** 75% = $46.95 85% = $53.20 **Future End Date:**
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 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $107.75 **Benefit:** 75% = $80.85 85% = $91.60 **Future End Date:**
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 7 CM LONG), superficial (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $98.70 **Benefit:** 75% = $74.05 85% = $83.90 **Future End Date:**
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 7 CM LONG), involving deeper tissue (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60 **Future End Date:**
30038	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.)

	(See para TN.8.6 of explanatory notes to this Category) **Fee:** $107.75 **Benefit:** 75% = $80.85 85% = $91.60 **Future End Date:**
30042	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, other than on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue, other than a service to which another item in Group T4 applies (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $222.10 **Benefit:** 75% = $166.60 85% = $188.80 **Future End Date:**
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 7 CM LONG), superficial (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60 **Future End Date:**
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 7 CM LONG), involving deeper tissue (Anaes.) (See para TN.8.6 of explanatory notes to this Category) **Fee:** $222.10 **Benefit:** 75% = $166.60 85% = $188.80 **Future End Date:**
30052	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.) **Fee:** $304.00 **Benefit:** 75% = $228.00 85% = $258.40 **Future End Date:**
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.) **Fee:** $88.50 **Benefit:** 75% = $66.40 85% = $75.25 **Future End Date:**
30058	Post-operative haemorrhage, control of, under general anaesthesia, as an independent procedure (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $172.80 **Benefit:** 75% = $129.60 **Future End Date:**
30061	SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from cornea or sclera), as an independent procedure (Anaes.) **Fee:** $28.15 **Benefit:** 75% = $21.15 85% = $23.95 **Future End Date:**
30062	Etonogestrel subcutaneous implant, removal of (Anaes.) (See para TN.0.1 of explanatory notes to this Category) **Fee:** $107.90 **Benefit:** 75% = $80.95 85% = $91.75 **Future End Date:**

30064	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes.) **Fee:** $131.55 **Benefit:** 75% = $98.70 85% = $111.85 **Future End Date:**
30068	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60 **Future End Date:**
30071	Diagnostic biopsy of skin, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $62.55 **Benefit:** 75% = $46.95 85% = $53.20 **Extended Medicare Safety Net Cap:** $50.05 **Future End Date:**
30072	Diagnostic biopsy of mucous membrane, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $62.55 **Benefit:** 75% = $46.95 85% = $53.20 **Future End Date:**
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.) **Fee:** $179.25 **Benefit:** 75% = $134.45 85% = $152.40 **Future End Date:**
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.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $57.95 **Benefit:** 75% = $43.50 85% = $49.30 **Future End Date:**
30081	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using open approach, where the biopsy specimen is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $131.55 **Benefit:** 75% = $98.70 85% = $111.85 **Future End Date:**
30084	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using percutaneous approach where the biopsy is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $70.40 **Benefit:** 75% = $52.80 85% = $59.85 **Future End Date:**
30087	DIAGNOSTIC BIOPSY OF BONE MARROW by aspiration or PUNCH BIOPSY OF SYNOVIAL MEMBRANE, where the biopsy is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $35.20 **Benefit:** 75% = $26.40 85% = $29.95 **Future End Date:**

30090	DIAGNOSTIC BIOPSY OF PLEURA, PERCUTANEOUS 1 or more biopsies on any 1 occasion, where the biopsy is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $153.85 **Benefit:** 75% = $115.40 85% = $130.80 **Future End Date:**
30093	DIAGNOSTIC NEEDLE BIOPSY OF VERTEBRA, where the biopsy is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $205.35 **Benefit:** 75% = $154.05 85% = $174.55 **Future End Date:**
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.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $226.75 **Benefit:** 75% = $170.10 85% = $192.75 **Future End Date:**
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: a. 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 b. in a patient who is acutely unwell and adrenal insufficiency is suspected. (See para TN.8.139 of explanatory notes to this Category) **Fee:** $116.30 **Benefit:** 75% = $87.25 85% = $98.90 **Future End Date:**
30099	SINUS, excision of, involving superficial tissue only (Anaes.) **Fee:** $107.75 **Benefit:** 75% = $80.85 85% = $91.60 **Future End Date:**
30103	SINUS, excision of, involving muscle and deep tissue (Anaes.) **Fee:** $220.15 **Benefit:** 75% = $165.15 85% = $187.15 **Future End Date:**
30104	Pre-auricular sinus, excision of, on a patient 10 years of age or over (Anaes.) **Fee:** $151.95 **Benefit:** 75% = $114.00 85% = $129.20 **Future End Date:**
30105	Pre-auricular sinus, excision of, on a patient under 10 years of age (H) (Anaes.) **Fee:** $197.45 **Benefit:** 75% = $148.10 **Future End Date:**
30107	Excision of ganglion, other than a service associated with a service to which another item in this Group applies (Anaes.)

	Fee: $263.15 **Benefit:** 75% = $197.40 85% = $223.70 **Future End Date:**
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.) (See para TN.8.8, TN.8.97 of explanatory notes to this Category) **Fee:** $897.70 **Benefit:** 75% = $673.30 **Future End Date:**
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.) (See para TN.8.8, TN.8.97 of explanatory notes to this Category) **Fee:** $718.15 **Benefit:** 75% = $538.65 **Future End Date:**
30175	Radical abdominoplasty, with repair of rectus diastasis, excision of skin and subcutaneous tissue, and transposition of umbilicus, not being a laparoscopic procedure, if: (a) the patient has an abdominal wall defect as a consequence of pregnancy; and (b) the patient: (i) has a diastasis of at least 3cm measured by diagnostic imaging prior to this service; and (ii) has either or both of the following: (A) at least moderately severe pain or discomfort at the site of the diastasis in the abdominal wall during functional use and the pain or discomfort has been documented in the patient's records by the practitioner providing the service; (B) low back pain or urinary symptoms likely due to rectus diastasis and the pain or symptoms have been documented in the patient's records by the practitioner providing the service; and (iii) has failed to respond to non-surgical conservative treatment, that must have included physiotherapy; and (iv) has not been pregnant in the last 12 months; and (c) the service is not a service associated with a service to which item 30166, 30169, 30176, 30177, 30179, 30651, 30655, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070, 46072, 46080, 46082, 46084, 46086, 46088 or 46090 applies Applicable once per lifetime (H) (Anaes.) (Assist.) (See para TN.8.276, TN.8.8, TN.8.97 of explanatory notes to this Category) **Fee:** $1,161.05 **Benefit:** 75% = $870.80 **Future End Date:**
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.) (See para TN.8.97 of explanatory notes to this Category) **Fee:** $1,179.70 **Benefit:** 75% = $884.80 **Future End Date:**
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.) (See para TN.8.8, TN.8.97 of explanatory notes to this Category) **Fee:** $1,179.70 **Benefit:** 75% = $884.80 **Future End Date:**
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.) (See para TN.8.8, TN.8.97 of explanatory notes to this Category) **Fee:** $1,452.00 **Benefit:** 75% = $1089.00 **Future End Date:**
30180	AXILLARY HYPERHIDROSIS, partial excision for (Anaes.) **Fee:** $163.40 **Benefit:** 75% = $122.55 85% = $138.90 **Future End Date:**
30183	Axillary hyperhidrosis, total excision of sweat gland bearing area (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $295.10 **Benefit:** 75% = $221.35

	Future End Date:
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.) (See para TN.8.9 of explanatory notes to this Category) **Fee:** $307.60 **Benefit:** 75% = $230.70 85% = $261.50 **Future End Date:**
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.) (See para TN.8.9 of explanatory notes to this Category) **Fee:** $176.25 **Benefit:** 75% = $132.20 **Future End Date:**
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.) **Fee:** $476.00 **Benefit:** 75% = $357.00 85% = $404.60 **Future End Date:**
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. **Fee:** $76.00 **Benefit:** 75% = $57.00 85% = $64.60 **Future End Date:**
30192	PREMALIGNANT SKIN LESIONS (including solar keratoses), treatment of, by ablative technique (10 or more lesions) (Anaes.) (See para TN.8.9 of explanatory notes to this Category) **Fee:** $47.30 **Benefit:** 75% = $35.50 85% = $40.25 **Future End Date:**
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.) (See para TN.8.10 of explanatory notes to this Category) **Fee:** $151.10 **Benefit:** 75% = $113.35 85% = $128.45 **Future End Date:**

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 (See para TN.8.10 of explanatory notes to this Category) **Fee:** $57.80 **Benefit:** 75% = $43.35 85% = $49.15 **Future End Date:**
30207	Skin lesions, multiple injections with glucocorticoid preparations (Anaes.) **Fee:** $53.35 **Benefit:** 75% = $40.05 85% = $45.35 **Future End Date:**
30210	Keloid and other skin lesions, extensive, multiple injections of glucocorticoid preparations, if undertaken in the operating theatre of a hospital (H) (Anaes.) **Fee:** $195.05 **Benefit:** 75% = $146.30 **Future End Date:**
30216	HAEMATOMA, aspiration of (Anaes.) **Fee:** $32.75 **Benefit:** 75% = $24.60 85% = $27.85 **Extended Medicare Safety Net Cap:** $26.20 **Future End Date:**
30219	HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital - INCISION WITH DRAINAGE OF (excluding aftercare) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $32.75 **Benefit:** 75% = $24.60 85% = $27.85 **Extended Medicare Safety Net Cap:** $26.20 **Future End Date:**
30223	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $195.05 **Benefit:** 75% = $146.30 **Future End Date:**
30224	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $284.35 **Benefit:** 75% = $213.30 85% = $241.70 **Future End Date:**
30225	ABSCESS DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $320.35 **Benefit:** 75% = $240.30 85% = $272.30 **Future End Date:**
30226	MUSCLE, excision of (LIMITED), or fasciotomy (Anaes.) **Fee:** $179.25 **Benefit:** 75% = $134.45 85% = $152.40 **Future End Date:**
30229	Muscle, excision of (extensive) (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $326.70 **Benefit:** 75% = $245.05

	Future End Date:
30232	MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes.) **Fee:** $267.60 **Benefit:** 75% = $200.70 85% = $227.50 **Future End Date:**
30235	Muscle, ruptured, repair of (extensive), not associated with external wound (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $353.90 **Benefit:** 75% = $265.45 **Future End Date:**
30238	FASCIA, DEEP, repair of, FOR HERNIATED MUSCLE (Anaes.) **Fee:** $179.25 **Benefit:** 75% = $134.45 85% = $152.40 **Future End Date:**
30241	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $426.55 **Benefit:** 75% = $319.95 85% = $362.60 **Future End Date:**
30244	STYLOID PROCESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.) **Fee:** $426.55 **Benefit:** 75% = $319.95 **Future End Date:**
30246	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.) **Fee:** $825.65 **Benefit:** 75% = $619.25 **Future End Date:**
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.) (See para TN.8.254 of explanatory notes to this Category) **Fee:** $884.90 **Benefit:** 75% = $663.70 **Future End Date:**
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.) (See para TN.8.254 of explanatory notes to this Category) **Fee:** $1,497.40 **Benefit:** 75% = $1123.05 **Future End Date:**
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.) (See para TN.8.254 of explanatory notes to this Category) **Fee:** $2,300.20 **Benefit:** 75% = $1725.15 **Future End Date:**
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.) (See para TN.8.254 of explanatory notes to this Category) **Fee:** $998.30 **Benefit:** 75% = $748.75 **Future End Date:**
30255	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.) **Fee:** $1,329.35 **Benefit:** 75% = $997.05 **Future End Date:**
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.) **Fee:** $533.15 **Benefit:** 75% = $399.90 **Future End Date:**
30257	Sialendoscopy, of submandibular or parotid duct, with or without removal of calculus or treatment of stricture (Anaes.) **Fee:** $598.40 **Benefit:** 75% = $448.80 85% = $508.65 **Future End Date:**
30259	Sublingual gland, extirpation of (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.65 **Benefit:** 75% = $178.25 **Future End Date:**
30262	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes.) **Fee:** $70.40 **Benefit:** 75% = $52.80 85% = $59.85 **Future End Date:**
30266	Salivary gland, removal of calculus from duct or meatotomy or marsupialisation, 1 or more such procedures. (Anaes.) **Fee:** $179.25 **Benefit:** 75% = $134.45 85% = $152.40 **Future End Date:**
30269	Salivary gland, repair of cutaneous fistula of (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $179.25 **Benefit:** 75% = $134.45 **Future End Date:**

30272	Tongue, partial excision of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $353.90 **Benefit:** 75% = $265.45 **Future End Date:**
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.) (See para TN.8.261 of explanatory notes to this Category) **Fee:** $2,109.80 **Benefit:** 75% = $1582.35 **Future End Date:**
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.) **Fee:** $55.60 **Benefit:** 75% = $41.70 85% = $47.30 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.95 **Benefit:** 75% = $107.25 85% = $121.55 **Future End Date:**
30283	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.) **Fee:** $245.00 **Benefit:** 75% = $183.75 85% = $208.25 **Future End Date:**
30286	Branchial cyst, removal of, on a patient 10 years of age or over (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $476.20 **Benefit:** 75% = $357.15 **Future End Date:**
30287	Branchial cyst, removal of, on a patient under 10 years of age (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $619.15 **Benefit:** 75% = $464.40 **Future End Date:**
30289	Branchial fistula, removal of, on a patient 10 years of age or over (Anaes.) (Assist.) **Fee:** $601.15 **Benefit:** 75% = $450.90 **Future End Date:**
30293	Cervical oesophagostomy, or closure of cervical oesophagostomy with or without plastic repair (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $533.15 **Benefit:** 75% = $399.90 **Future End Date:**

30294	CERVICAL OESOPHAGECTOMY with tracheostomy and oesophagostomy, with or without plastic reconstruction; or LARYNGOPHARYNGECTOMY with tracheostomy and plastic reconstruction (Anaes.) (Assist.) **Fee:** $2,109.80 **Benefit:** 75% = $1582.35 **Future End Date:**
30296	THYROIDECTOMY, total (Anaes.) (Assist.) (See para TN.8.137 of explanatory notes to this Category) **Fee:** $1,225.30 **Benefit:** 75% = $919.00 **Future End Date:**
30297	THYROIDECTOMY following previous thyroid surgery (Anaes.) (Assist.) (See para TN.8.138 of explanatory notes to this Category) **Fee:** $1,225.30 **Benefit:** 75% = $919.00 **Future End Date:**
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.) **Fee:** $850.05 **Benefit:** 75% = $637.55 **Future End Date:**
30305	Sentinel lymph node biopsy or biopsies for breast cancer, involving dissection along internal mammary chain (H) (Anaes.) (Assist.) **Fee:** $850.10 **Benefit:** 75% = $637.60 **Future End Date:**
30306	TOTAL HEMITHYROIDECTOMY (Anaes.) (Assist.) (See para TN.8.137, TN.8.138 of explanatory notes to this Category) **Fee:** $955.85 **Benefit:** 75% = $716.90 **Future End Date:**
30310	Partial or subtotal thyroidectomy (Anaes.) (Assist.) (See para TN.8.137 of explanatory notes to this Category) **Fee:** $955.85 **Benefit:** 75% = $716.90 **Future End Date:**
30311	Sentinel lymph node biopsy or biopsies for cutaneous melanoma, using preoperative lymphoscintigraphy and/or lymphotropic dye injection, if: (a) the primary lesion is greater than 1.0 mm in depth (or at least 0.8 mm in depth in the presence of ulceration); and (b) appropriate excision of the primary melanoma has occurred; and (c) the service is not associated with a service to which item 30075, 30078, 30299, 30305, 30329, 30332, 30618, 30820, 31423, 52025 or 52027 applies Applicable to only one lesion per occasion on which the service is provided (H) (Anaes.) (Assist.) **Fee:** $745.00 **Benefit:** 75% = $558.75 **Future End Date:**
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.)

	Fee: $547.35 **Benefit:** 75% = $410.55 **Future End Date:**
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.) **Fee:** $1,364.35 **Benefit:** 75% = $1023.30 **Future End Date:**
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.) **Fee:** $1,633.60 **Benefit:** 75% = $1225.20 **Future End Date:**
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.) **Fee:** $1,364.35 **Benefit:** 75% = $1023.30 **Future End Date:**
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.) **Fee:** $1,633.60 **Benefit:** 75% = $1225.20 **Future End Date:**
30323	Excision of phaeochromocytoma or extraadrenal paraganglioma via endoscopic or open approach. (Anaes.) (Assist.) **Fee:** $1,633.60 **Benefit:** 75% = $1225.20 **Future End Date:**
30324	Excision of an adrenocortical tumour or hyperplasia via endoscopic or open approach. (Anaes.) (Assist.) **Fee:** $1,633.60 **Benefit:** 75% = $1225.20 **Future End Date:**
30326	Thyroglossal cyst or fistula or both, radical removal of, including thyroglossal duct and portion of hyoid bone, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $711.65 **Benefit:** 75% = $533.75 **Future End Date:**

30329	LYMPH NODES of GROIN, limited excision of (Anaes.) **Fee:** $295.55 **Benefit:** 75% = $221.70 85% = $251.25 **Future End Date:**
30330	LYMPH NODES of GROIN, radical excision of (Anaes.) (Assist.) **Fee:** $860.25 **Benefit:** 75% = $645.20 **Future End Date:**
30332	Lymph nodes of axilla, limited excision of (H) (Anaes.) (Assist.) **Fee:** $415.00 **Benefit:** 75% = $311.25 **Future End Date:**
30336	Lymph nodes of axilla, complete excision of (H) (Anaes.) (Assist.) **Fee:** $1,245.05 **Benefit:** 75% = $933.80 **Future End Date:**
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.) **Fee:** $1,564.25 **Benefit:** 75% = $1173.20 **Future End Date:**
30384	Open or minimally invasive excision of a retroperitoneal mass, 4 cm or greater in largest dimension, lasting more than 3 hours, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.) **Fee:** $1,633.60 **Benefit:** 75% = $1225.20 **Future End Date:**
30385	Unplanned return to theatre for laparotomy or laparoscopy for control or drainage of intra-abdominal haemorrhage following abdominal surgery (H) (Anaes.) (Assist.) **Fee:** $674.30 **Benefit:** 75% = $505.75 **Future End Date:**
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.) **Fee:** $760.00 **Benefit:** 75% = $570.00 **Future End Date:**
30388	Laparotomy for abdominal trauma, including control of haemorrhage (with or without packing) and containment of contamination (H) (Anaes.) (Assist.) **Fee:** $1,274.80 **Benefit:** 75% = $956.10 **Future End Date:**
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.) (See para TN.8.15 of explanatory notes to this Category) **Fee:** $263.15 **Benefit:** 75% = $197.40 **Future End Date:**

30392	RADICAL OR DEBULKING OPERATION for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure (Anaes.) (Assist.) **Fee:** $807.35 **Benefit:** 75% = $605.55 **Future End Date:**
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.) **Fee:** $1,216.70 **Benefit:** 75% = $912.55 **Future End Date:**
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.) **Fee:** $278.05 **Benefit:** 75% = $208.55 **Future End Date:**
30399	Laparostomy, final closure of wound made at previous operation, after removal of dressings or packs (Anaes.) (Assist.) **Fee:** $382.45 **Benefit:** 75% = $286.85 **Future End Date:**
30400	LAPAROTOMY WITH INSERTION OF PORTACATH for administration of cytotoxic therapy including placement of reservoir (Anaes.) (Assist.) **Fee:** $757.00 **Benefit:** 75% = $567.75 **Future End Date:**
30406	PARACENTESIS ABDOMINIS (Anaes.) **Fee:** $62.55 **Benefit:** 75% = $46.95 85% = $53.20 **Future End Date:**
30408	PERITONEOVENOUS shunt, insertion of (Anaes.) (Assist.) **Fee:** $469.30 **Benefit:** 75% = $352.00 **Future End Date:**
30409	LIVER BIOPSY, percutaneous (Anaes.) **Fee:** $208.75 **Benefit:** 75% = $156.60 85% = $177.45 **Future End Date:**
30411	LIVER BIOPSY by wedge excision when performed in conjunction with another intraabdominal procedure (Anaes.) **Fee:** $106.30 **Benefit:** 75% = $79.75 **Future End Date:**
30412	Liver biopsy by core needle, when performed in conjunction with another intra-abdominal procedure (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $62.70 **Benefit:** 75% = $47.05 **Future End Date:**
30414	LIVER, subsegmental resection of, (local excision), other than for trauma (Anaes.) (Assist.)

	Fee: $825.65 **Benefit:** 75% = $619.25 **Future End Date:**
30415	LIVER, segmental resection of, other than for trauma (Anaes.) (Assist.) **Fee:** $1,651.05 **Benefit:** 75% = $1238.30 **Future End Date:**
30416	Liver cysts, greater than 5 cm in diameter, marsupialisation of 4 or less (Anaes.) (Assist.) **Fee:** $896.40 **Benefit:** 75% = $672.30 **Future End Date:**
30417	Liver cysts, greater than 5 cm in diameter, marsupialisation of 5 or more (Anaes.) (Assist.) **Fee:** $1,344.55 **Benefit:** 75% = $1008.45 **Future End Date:**
30418	LIVER, lobectomy of, other than for trauma (Anaes.) (Assist.) **Fee:** $1,912.15 **Benefit:** 75% = $1434.15 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $978.00 **Benefit:** 75% = $733.50 **Future End Date:**
30421	Liver, extended lobectomy of, or central resections of segments 4, 5 and 8, other than for trauma (Anaes.) (Assist.) **Fee:** $2,389.75 **Benefit:** 75% = $1792.35 **Future End Date:**
30422	LIVER, repair of superficial laceration of, for trauma (Anaes.) (Assist.) **Fee:** $808.30 **Benefit:** 75% = $606.25 **Future End Date:**
30425	LIVER, repair of deep multiple lacerations of, or debridement of, for trauma (Anaes.) (Assist.) **Fee:** $1,564.25 **Benefit:** 75% = $1173.20 **Future End Date:**
30427	LIVER, segmental resection of, for trauma (Anaes.) (Assist.) **Fee:** $1,868.40 **Benefit:** 75% = $1401.30 **Future End Date:**
30428	Liver, lobectomy of, for trauma (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,998.80 **Benefit:** 75% = $1499.10 **Future End Date:**
30430	Liver, extended lobectomy of, or central resections of segments 4, 5 and 8, for trauma (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category)

	Fee: $2,780.65 **Benefit:** 75% = $2085.50 **Future End Date:**
30431	Liver abscess, single, open or minimally invasive abdominal drainage of, excluding aftercare (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $623.95 **Benefit:** 75% = $468.00 **Future End Date:**
30433	Liver abscess, multiple, open or minimally invasive abdominal drainage of, excluding aftercare (Anaes.) (Assist.) **Fee:** $869.00 **Benefit:** 75% = $651.75 **Future End Date:**
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.) (See para TN.8.208 of explanatory notes to this Category) **Fee:** $222.10 **Benefit:** 75% = $166.60 **Future End Date:**
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.) (See para GN.1.2, TN.8.300 of explanatory notes to this Category) **Fee:** $630.05 **Benefit:** 75% = $472.55 **Future End Date:**
30441	Intraoperative ultrasound for staging of intra-abdominal tumours (Anaes.) **Fee:** $163.15 **Benefit:** 75% = $122.40 **Future End Date:**
30442	CHOLEDOCHOSCOPY in conjunction with another procedure (Anaes.) (See para TN.8.208 of explanatory notes to this Category) **Fee:** $222.10 **Benefit:** 75% = $166.60 **Future End Date:**
30443	Cholecystectomy, by any approach, without cholangiogram (Anaes.) (Assist.) **Fee:** $768.90 **Benefit:** 75% = $576.70 **Future End Date:**
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.) (See para TN.8.208 of explanatory notes to this Category) **Fee:** $995.95 **Benefit:** 75% = $747.00 **Future End Date:**
30448	Cholecystectomy, by any approach, involving removal of common duct calculi via the cystic duct, with or without stent insertion (Anaes.) (Assist.)

	(See para TN.8.208 of explanatory notes to this Category) **Fee:** $1,164.55 **Benefit:** 75% = $873.45 **Future End Date:**
30449	Cholecystectomy with removal of common duct calculi via choledochotomy, by any approach, with or without insertion of a stent (Anaes.) (Assist.) (See para TN.8.208 of explanatory notes to this Category) **Fee:** $1,294.85 **Benefit:** 75% = $971.15 **Future End Date:**
30450	Calculus of biliary tract, extraction of, using interventional imaging techniques (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $627.65 **Benefit:** 75% = $470.75 **Future End Date:**
30451	Biliary drainage tube, exchange of, using interventional imaging techniques, other than a service associated with a service to which item 30440 applies (Anaes.) (Assist.) (See para TN.8.300, TN.8.2 of explanatory notes to this Category) **Fee:** $320.35 **Benefit:** 75% = $240.30 85% = $272.30 **Future End Date:**
30452	CHOLEDOCHOSCOPY with balloon dilation of a stricture or passage of stent or extraction of calculi (Anaes.) (Assist.) **Fee:** $451.80 **Benefit:** 75% = $338.85 **Future End Date:**
30454	Choledochotomy without cholecystectomy, with or without removal of calculi (Anaes.) (Assist.) **Fee:** $1,577.80 **Benefit:** 75% = $1183.35 **Future End Date:**
30455	Choledochotomy with cholecystectomy, with removal of calculi, including biliary intestinal anastomosis (Anaes.) (Assist.) **Fee:** $1,577.80 **Benefit:** 75% = $1183.35 **Future End Date:**
30457	Choledochotomy, intrahepatic, involving removal of intrahepatic bile duct calculi (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,651.05 **Benefit:** 75% = $1238.30 **Future End Date:**
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.) **Fee:** $1,213.65 **Benefit:** 75% = $910.25 **Future End Date:**
30460	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior biliary surgery performed (Anaes.) (Assist.) **Fee:** $1,032.30 **Benefit:** 75% = $774.25 **Future End Date:**

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.) **Fee:** $1,769.45 **Benefit:** 75% = $1327.10 **Future End Date:**
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.) **Fee:** $2,172.65 **Benefit:** 75% = $1629.50 **Future End Date:**
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.) **Fee:** $2,607.10 **Benefit:** 75% = $1955.35 **Future End Date:**
30469	Biliary stricture, repair of, after one or more operations on the biliary tree (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $2,059.75 **Benefit:** 75% = $1544.85 **Future End Date:**
30472	Repair of bile duct injury, including immediate reconstruction, other than a service associated with a service to which item 30584 applies (Anaes.) (Assist.) **Fee:** $1,595.40 **Benefit:** 75% = $1196.55 **Future End Date:**
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.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $211.95 **Benefit:** 75% = $159.00 85% = $180.20 **Future End Date:**
30475	Endoscopic dilatation of stricture of upper gastrointestinal tract (including the use of imaging intensification if clinically indicated) (H) (Anaes.) (See para GN.1.2, TN.8.133, TN.8.17 of explanatory notes to this Category) **Fee:** $417.70 **Benefit:** 75% = $313.30 **Future End Date:**
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.) (See para GN.1.2, TN.8.17 of explanatory notes to this Category) **Fee:** $293.95 **Benefit:** 75% = $220.50 **Future End Date:**
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.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $569.80 **Benefit:** 75% = $427.35 85% = $484.35

	Future End Date:
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.) (See para GN.1.2, TN.8.17, TN.8.2 of explanatory notes to this Category) **Fee:** $427.30 **Benefit:** 75% = $320.50 **Future End Date:**
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.) **Fee:** $303.85 **Benefit:** 75% = $227.90 85% = $258.30 **Future End Date:**
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.) **Fee:** $211.90 **Benefit:** 75% = $158.95 85% = $180.15 **Future End Date:**
30484	Endoscopic retrograde cholangiopancreatography, other than a service to which item 30664 or 30665 applies (H) (Anaes.) (See para GN.1.2, TN.8.17 of explanatory notes to this Category) **Fee:** $436.80 **Benefit:** 75% = $327.60 **Future End Date:**
30485	Endoscopic sphincterotomy with or without extraction of stones from common bile duct (H) (Anaes.) (See para GN.1.2, TN.8.17 of explanatory notes to this Category) **Fee:** $674.30 **Benefit:** 75% = $505.75 **Future End Date:**
30488	Small bowel intubation—as an independent procedure (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $107.75 **Benefit:** 75% = $80.85 **Future End Date:**
30490	Oesophageal prosthesis, insertion of, including endoscopy and dilatation (H) (Anaes.) (See para GN.1.2, TN.8.17 of explanatory notes to this Category) **Fee:** $630.05 **Benefit:** 75% = $472.55 **Future End Date:**

30491	Bile duct, endoscopic stenting of (including endoscopy and dilatation) (H) (Anaes.) (See para GN.1.2, TN.8.17 of explanatory notes to this Category) **Fee:** $664.75 **Benefit:** 75% = $498.60 **Future End Date:**
30492	Bile duct, percutaneous stenting of (including dilatation when performed), using interventional imaging techniques (H) (Anaes.) (See para TN.8.300, TN.8.2 of explanatory notes to this Category) **Fee:** $942.35 **Benefit:** 75% = $706.80 **Future End Date:**
30494	ENDOSCOPIC BILIARY DILATATION (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $503.30 **Benefit:** 75% = $377.50 **Future End Date:**
30495	Percutaneous biliary dilatation for biliary stricture using interventional imaging techniques (H) (Anaes.) (See para TN.8.300, TN.8.2 of explanatory notes to this Category) **Fee:** $942.35 **Benefit:** 75% = $706.80 **Future End Date:**
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.) **Fee:** $843.05 **Benefit:** 75% = $632.30 **Future End Date:**
30517	Revision of gastroenterostomy, pyloroplasty or gastroduodenostomy (Anaes.) (Assist.) **Fee:** $1,103.75 **Benefit:** 75% = $827.85 **Future End Date:**
30518	Partial gastrectomy, not being a service associated with a service to which any of items 31569 to 31581 apply (Anaes.) (Assist.) **Fee:** $1,181.95 **Benefit:** 75% = $886.50 **Future End Date:**
30520	Gastric tumour, 2 cm or greater in diameter, removal of, by local excision, by laparoscopic or open approach, including any associated anastomosis, excluding polypectomy, other than a service to which item 30518 applies (Anaes.) (Assist.) **Fee:** $1,016.90 **Benefit:** 75% = $762.70 **Future End Date:**
30521	GASTRECTOMY, TOTAL, for benign disease (Anaes.) (Assist.) **Fee:** $1,729.30 **Benefit:** 75% = $1297.00 **Future End Date:**
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.) **Fee:** $2,580.85 **Benefit:** 75% = $1935.65 **Future End Date:**
30529	ANTIREFLUX operation by fundoplasty, with OESOPHAGOPLASTY for stricture or short oesophagus (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $1,564.25 **Benefit:** 75% = $1173.20 **Future End Date:**
30530	ANTIREFLUX operation by cardiopexy, with or without fundoplasty (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $938.65 **Benefit:** 75% = $704.00 **Future End Date:**
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.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $1,077.70 **Benefit:** 75% = $808.30 **Future End Date:**
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.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $1,281.90 **Benefit:** 75% = $961.45 **Future End Date:**
30559	Oesophagus, local excision for tumour of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,016.90 **Benefit:** 75% = $762.70 **Future End Date:**
30560	Oesophageal perforation, repair of, by abdominal or thoracic approach, including thoracic drainage (Anaes.) (Assist.) **Fee:** $1,129.55 **Benefit:** 75% = $847.20 **Future End Date:**
30562	Enterostomy or colostomy, closure of (not involving resection of bowel), on a patient 10 years of age or over (Anaes.) (Assist.) **Fee:** $712.05 **Benefit:** 75% = $534.05 **Future End Date:**
30563	Colostomy or ileostomy, refashioning of, on a patient 10 years of age or over (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $712.05 **Benefit:** 75% = $534.05 **Future End Date:**

30565	SMALL INTESTINE, resection of, without anastomosis (including formation of stoma) (Anaes.) (Assist.) **Fee:** $1,042.85 **Benefit:** 75% = $782.15 **Future End Date:**
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.) **Fee:** $73.75 **Benefit:** 75% = $55.35 **Future End Date:**
30577	Initial pancreatic necrosectomy by open, laparoscopic or endoscopic approach, excluding aftercare (Anaes.) (Assist.) **Fee:** $1,303.65 **Benefit:** 75% = $977.75 **Future End Date:**
30583	Distal pancreatectomy with splenic preservation, by open or minimally invasive approach (Anaes.) (Assist.) **Fee:** $1,860.45 **Benefit:** 75% = $1395.35 **Future End Date:**
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.) **Fee:** $3,590.65 **Benefit:** 75% = $2693.00 **Future End Date:**
30589	PANCREATICO-JEJUNOSTOMY for pancreatitis or trauma (Anaes.) (Assist.) **Fee:** $1,497.40 **Benefit:** 75% = $1123.05 **Future End Date:**
30590	PANCREATICO-JEJUNOSTOMY following previous pancreatic surgery (Anaes.) (Assist.) **Fee:** $1,651.05 **Benefit:** 75% = $1238.30 **Future End Date:**
30593	Pancreatectomy, near total or total (including duodenum), with or without splenectomy (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $2,259.40 **Benefit:** 75% = $1694.55 **Future End Date:**
30594	PANCREATECTOMY for pancreatitis following previously attempted drainage procedure or partial resection (Anaes.) (Assist.) **Fee:** $2,607.10 **Benefit:** 75% = $1955.35 **Future End Date:**
30596	SPLENORRHAPHY OR PARTIAL SPLENECTOMY (Anaes.) (Assist.) **Fee:** $1,073.95 **Benefit:** 75% = $805.50

	Future End Date:
30599	SPLENECTOMY, for massive spleen (weighing more than 1500 grams) or involving thoraco-abdominal incision (Anaes.) (Assist.) **Fee:** $1,564.25 **Benefit:** 75% = $1173.20 **Future End Date:**
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.) **Fee:** $930.15 **Benefit:** 75% = $697.65 **Future End Date:**
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.) **Fee:** $1,145.90 **Benefit:** 75% = $859.45 **Future End Date:**
30606	PORTAL HYPERTENSION, oesophageal transection via stapler or oversew of gastric varices with or without devascularisation (Anaes.) (Assist.) **Fee:** $1,329.50 **Benefit:** 75% = $997.15 **Future End Date:**
30608	Small intestine, resection of, with anastomosis, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $1,506.00 **Benefit:** 75% = $1129.50 **Future End Date:**
30611	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 under 10 years of age, 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.) **Fee:** $674.35 **Benefit:** 75% = $505.80 85% = $573.20 **Future End Date:**
30615	Strangulated, incarcerated or obstructed hernia, repair of, without bowel resection, on a patient 10 years of age or over (Anaes.) (Assist.) **Fee:** $623.95 **Benefit:** 75% = $468.00 **Future End Date:**
30618	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 under 10 years of age (H) (Anaes.) (Assist.) (See para GN.1.2, TN.8.24 of explanatory notes to this Category) **Fee:** $625.10 **Benefit:** 75% = $468.85 **Future End Date:**
30619	Laparoscopic splenectomy, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $1,120.65 **Benefit:** 75% = $840.50 **Future End Date:**

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.) **Fee:** $487.75 **Benefit:** 75% = $365.85 **Future End Date:**
30622	Caecostomy, enterostomy, colostomy, enterotomy, colotomy, cholecystostomy, gastrostomy, gastrotomy, reduction of intussusception, removal of Meckel's diverticulum, suture of perforated peptic ulcer, simple repair of ruptured viscus, reduction of volvulus, pyloroplasty or drainage of pancreas, on a patient under 10 years of age (Anaes.) (Assist.) (See para TN.8.14 of explanatory notes to this Category) **Fee:** $811.15 **Benefit:** 75% = $608.40 **Future End Date:**
30623	Laparotomy involving division of peritoneal adhesions (if no other intra-abdominal procedure is performed), on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $811.15 **Benefit:** 75% = $608.40 **Future End Date:**
30626	Laparotomy involving division of adhesions in association with another intra-abdominal procedure if the time taken to divide the adhesions is between 45 minutes and 2 hours, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $814.90 **Benefit:** 75% = $611.20 **Future End Date:**
30627	Laparoscopy, diagnostic, if no other intra-abdominal procedure is performed, on a patient under 10 years of age (H) (Anaes.) (See para TN.8.15 of explanatory notes to this Category) **Fee:** $342.20 **Benefit:** 75% = $256.65 **Future End Date:**
30628	HYDROCELE, tapping of **Fee:** $42.60 **Benefit:** 75% = $31.95 85% = $36.25 **Future End Date:**
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.) **Fee:** $623.95 **Benefit:** 75% = $468.00 **Future End Date:**
30630	Insertion of testicular prosthesis, at least 6 months following orchidectomy (H) (Anaes.) (Assist.) **Fee:** $567.05 **Benefit:** 75% = $425.30 **Future End Date:**
30631	Hydrocele, removal of, other than a service associated with a service to which item 30641, 30642 or 30644 applies (H) (Anaes.)

	(See para GN.1.2, GN.10.26 of explanatory notes to this Category) **Fee:** $283.25 **Benefit:** 75% = $212.45 **Future End Date:**
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.) **Fee:** $349.25 **Benefit:** 75% = $261.95 **Future End Date:**
30636	Gastrostomy button, caecostomy antegrade enema device (chait etc.) or stomal indwelling device, non-endoscopic insertion of, or non-endoscopic replacement of, on a patient under 10 years of age (Anaes.) **Fee:** $279.10 **Benefit:** 75% = $209.35 85% = $237.25 **Future End Date:**
30637	Enterostomy or colostomy, closure of (not involving resection of bowel), on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $925.90 **Benefit:** 75% = $694.45 **Future End Date:**
30639	Colostomy or ileostomy, refashioning of, on a patient under 10 years of age (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $925.90 **Benefit:** 75% = $694.45 **Future End Date:**
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.) **Fee:** $1,095.10 **Benefit:** 75% = $821.35 **Future End Date:**
30641	Orchidectomy, simple or subcapsular, unilateral with or without insertion of testicular prosthesis (H) (Anaes.) (Assist.) **Fee:** $487.75 **Benefit:** 75% = $365.85 **Future End Date:**
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.) **Fee:** $907.45 **Benefit:** 75% = $680.60 **Future End Date:**
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.) **Fee:** $811.15 **Benefit:** 75% = $608.40 **Future End Date:**
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.) **Fee:** $623.95 **Benefit:** 75% = $468.00

	Future End Date:
30645	Appendicectomy, on a patient under 10 years of age, other than a service to which item 30574 applies (Anaes.) (Assist.) **Fee:** $692.95 **Benefit:** 75% = $519.75 **Future End Date:**
30646	Laparoscopic appendicectomy, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $692.95 **Benefit:** 75% = $519.75 **Future End Date:**
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.) **Fee:** $556.05 **Benefit:** 75% = $417.05 **Future End Date:**
30649	Haemorrhage, arrest of, following circumcision requiring general anaesthesia, on a patient under 10 years of age (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $224.65 **Benefit:** 75% = $168.50 **Future End Date:**
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.) **Fee:** $623.95 **Benefit:** 75% = $468.00 **Future End Date:**
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.) **Fee:** $623.95 **Benefit:** 75% = $468.00 **Future End Date:**
30654	Circumcision of the penis, with topical or local analgesia, other than a service to which item 30658 applies **Fee:** $55.60 **Benefit:** 75% = $41.70 85% = $47.30 **Future End Date:**
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.) **Fee:** $1,095.10 **Benefit:** 75% = $821.35 **Future End Date:**
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.) **Fee:** $1,559.40 **Benefit:** 75% = $1169.55

	Future End Date:
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.) **Fee:** $169.90 **Benefit:** 75% = $127.45 85% = $144.45 **Future End Date:**
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.) (See para TN.8.252 of explanatory notes to this Category) **Fee:** $459.15 **Benefit:** 75% = $344.40 **Future End Date:**
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.) (See para TN.8.252 of explanatory notes to this Category) **Fee:** $918.05 **Benefit:** 75% = $688.55 **Future End Date:**
30663	Haemorrhage, arrest of, following circumcision requiring general anaesthesia, on a patient 10 years of age or over (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $172.80 **Benefit:** 75% = $129.60 **Future End Date:**
30664	Endoscopic retrograde cholangiopancreatography (ERCP), with single operator, single use peroral cholangiopancreatoscopy (POCPS) and biopsy, for the diagnosis of biliary strictures for a patient for whom: (a) a previous ERCP service has been provided; and (b) results from guided brush cytology or intraductal biopsy (or both) are indeterminate Applicable not more than 2 times in a 12 month period, or not more than 3 times in a 12 month period if the patient has been diagnosed with primary sclerosing cholangitis (PSC) (H) (Anaes.) (Assist.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $700.70 **Benefit:** 75% = $525.55 **Future End Date:**
30665	Endoscopic retrograde cholangiopancreatography (ERCP), with single operator, single use peroral cholangiopancreatoscopy (POCPS) and electrohydraulic or laser lithotripsy for the removal of biliary stones that are: (a) greater than 10mm in diameter; or (b) proximal to a stricture; for a patient for whom there has been at least one failed attempt at removal via ERCP extraction techniques

	Applicable not more than 2 times per treatment cycle (H) (Anaes.) (Assist.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $980.15 **Benefit:** 75% = $735.15 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $56.80 **Benefit:** 75% = $42.60 **Future End Date:**
30672	COCCYX, excision of (Anaes.) (Assist.) **Fee:** $533.15 **Benefit:** 75% = $399.90 **Future End Date:**
30676	Pilonidal sinus or cyst, or sacral sinus or cyst, definitive excision of (H) (Anaes.) (See para GN.1.2, TN.8.207 of explanatory notes to this Category) **Fee:** $453.70 **Benefit:** 75% = $340.30 **Future End Date:**
30679	Pilonidal sinus, injection of sclerosant fluid under anaesthesia (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $115.25 **Benefit:** 75% = $86.45 **Future End Date:**
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.) (See para GN.1.2, TN.8.17 of explanatory notes to this Category) **Fee:** $1,400.40 **Benefit:** 75% = $1050.30 **Future End Date:**
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.)

	(See para GN.1.2, TN.8.17 of explanatory notes to this Category) **Fee:** $1,400.40 **Benefit:** 75% = $1050.30 **Future End Date:**
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.) (See para GN.1.2, TN.8.17 of explanatory notes to this Category) **Fee:** $1,723.30 **Benefit:** 75% = $1292.50 **Future End Date:**
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.) (See para GN.1.2, TN.8.17 of explanatory notes to this Category) **Fee:** $1,723.30 **Benefit:** 75% = $1292.50 **Future End Date:**
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.) (See para GN.1.2, TN.8.20, TN.8.17 of explanatory notes to this Category) **Fee:** $569.80 **Benefit:** 75% = $427.35 **Future End Date:**
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.) (See para GN.1.2, TN.8.21, TN.8.17 of explanatory notes to this Category) **Fee:** $436.80 **Benefit:** 75% = $327.60 **Future End Date:**
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.) (See para GN.1.2, TN.8.21, TN.8.17 of explanatory notes to this Category) **Fee:** $674.30 **Benefit:** 75% = $505.75 **Future End Date:**
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.) (See para GN.1.2, TN.8.21, TN.8.17 of explanatory notes to this Category) **Fee:** $436.80 **Benefit:** 75% = $327.60 **Future End Date:**
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.) (See para GN.1.2, TN.8.21, TN.8.17 of explanatory notes to this Category) **Fee:** $674.30 **Benefit:** 75% = $505.75 **Future End Date:**
30720	Appendicectomy, on a patient 10 years of age or over, whether performed by: (a) laparoscopy or right iliac fossa open incision; or (b) conversion of a laparoscopy to an open right iliac fossa incision; other than a service to which item 30574 applies (Anaes.) (Assist.) **Fee:** $533.15 **Benefit:** 75% = $399.90 **Future End Date:**
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.) **Fee:** $578.40 **Benefit:** 75% = $433.80 **Future End Date:**
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.)

	(See para TN.8.14 of explanatory notes to this Category) **Fee:** $623.95 **Benefit:** 75% = $468.00 **Future End Date:**
30723	Laparotomy, laparoscopy or extra-peritoneal approach, for drainage of an intra-abdominal, pancreatic or retroperitoneal collection or abscess (Anaes.) (Assist.) **Fee:** $623.95 **Benefit:** 75% = $468.00 **Future End Date:**
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.) **Fee:** $626.85 **Benefit:** 75% = $470.15 **Future End Date:**
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; or b) 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.) **Fee:** $1,110.90 **Benefit:** 75% = $833.20 **Future End Date:**
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.) **Fee:** $1,158.45 **Benefit:** 75% = $868.85 **Future End Date:**
30731	Intraoperative enterotomy for visualisation of the small intestine by endoscopy, including endoscopic examination using a flexible endoscope, with or without biopsies (Anaes.) (Assist.) **Fee:** $869.00 **Benefit:** 75% = $651.75 **Future End Date:**
30732	Peritonectomy, lasting more than 5 hours, including hyperthermic intra-peritoneal chemotherapy (Anaes.) (Assist.) (See para TN.8.205 of explanatory notes to this Category) **Fee:** $4,757.75 **Benefit:** 75% = $3568.35 **Future End Date:**
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.) **Fee:** $2,468.35 **Benefit:** 75% = $1851.30 **Future End Date:**
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.) **Fee:** $2,468.35 **Benefit:** 75% = $1851.30 **Future End Date:**
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.) **Fee:** $1,851.20 **Benefit:** 75% = $1388.40 **Future End Date:**
30753	Oesophagectomy, by any approach, including: (a) gastric reconstruction by abdominal mobilisation, thoracotomy or thoracoscopy; and (b) anastomosis in the neck or chest One surgeon (Anaes.) (Assist.) **Fee:** $2,059.75 **Benefit:** 75% = $1544.85 **Future End Date:**
30754	Oesophagectomy, by any approach, including: (a) gastric reconstruction by abdominal mobilisation, thoracotomy or thoracoscopy; and (b) anastomosis in the neck or chest Conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $2,059.75 **Benefit:** 75% = $1544.85 **Future End Date:**
30755	Oesophagectomy by any approach, including: (a) gastric reconstruction by abdominal mobilisation, thoracotomy or thoracoscopy; and (b) anastomosis in the neck or chest Conjoint surgery, co-surgeon (Anaes.) (Assist.) **Fee:** $1,544.80 **Benefit:** 75% = $1158.60 **Future End Date:**
30756	Antireflux operation by fundoplasty, with or without cardiopexy, by any approach, with or without closure of the diaphragmatic hiatus, other than a service to which item 30601 applies (Anaes.) (Assist.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $1,042.85 **Benefit:** 75% = $782.15 **Future End Date:**
30760	Vagotomy, with or without gastroenterostomy, pyloroplasty or other drainage procedure (Anaes.) (Assist.) **Fee:** $703.95 **Benefit:** 75% = $528.00 **Future End Date:**
30761	Bleeding peptic ulcer, control of, by laparoscopy or laparotomy, involving suture of bleeding point or wedge excision (with or without gastric resection), including either of the following (if performed): (a) vagotomy and pyloroplasty; (b) gastroenterostomy (Anaes.) (Assist.) **Fee:** $908.15 **Benefit:** 75% = $681.15 **Future End Date:**

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.) **Fee:** $1,990.10 **Benefit:** 75% = $1492.60 **Future End Date:**
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.) **Fee:** $808.30 **Benefit:** 75% = $606.25 **Future End Date:**
30770	Hydatid cyst of liver, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles, with omentoplasty or myeloplasty (Anaes.) (Assist.) **Fee:** $1,001.00 **Benefit:** 75% = $750.75 **Future End Date:**
30771	Portal hypertension, porto-caval, meso-caval or selective spleno-renal shunt for (Anaes.) (Assist.) **Fee:** $2,019.00 **Benefit:** 75% = $1514.25 **Future End Date:**
30780	Intrahepatic biliary bypass of left or right hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.) **Fee:** $1,681.50 **Benefit:** 75% = $1261.15 **Future End Date:**
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.) **Fee:** $839.35 **Benefit:** 75% = $629.55 **Future End Date:**
30791	Pancreatic necrosectomy, by open, laparoscopic or endoscopic approach, excluding aftercare, subsequent procedure (Anaes.) (Assist.) **Fee:** $521.50 **Benefit:** 75% = $391.15 **Future End Date:**
30792	Distal pancreatectomy with splenectomy, by open or minimally invasive approach (Anaes.) (Assist.) **Fee:** $1,429.40 **Benefit:** 75% = $1072.05 **Future End Date:**
30800	Splenectomy, by open or minimally invasive approach, other than a service to which item 30792 applies (Anaes.) (Assist.) **Fee:** $862.05 **Benefit:** 75% = $646.55 **Future End Date:**
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.) (See para TN.8.206 of explanatory notes to this Category)

	Fee: $1,373.10 **Benefit:** 75% = $1029.85 **Future End Date:**
30820	Lymph node of neck, biopsy of, by open procedure, if the specimen excised is sent for pathological examination (Anaes.) (See para TN.8.7 of explanatory notes to this Category) **Fee:** $220.15 **Benefit:** 75% = $165.15 85% = $187.15 **Future End Date:**
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.) (See para TN.8.151 of explanatory notes to this Category) **Fee:** $695.30 **Benefit:** 75% = $521.50 85% = $591.05 **Future End Date:**
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.) (See para TN.8.151 of explanatory notes to this Category) **Fee:** $869.00 **Benefit:** 75% = $651.75 85% = $760.50 **Future End Date:**
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.) (See para TN.8.151 of explanatory notes to this Category) **Fee:** $1,042.85 **Benefit:** 75% = $782.15 85% = $934.35 **Future End Date:**
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.) (See para TN.8.151 of explanatory notes to this Category) **Fee:** $695.30 **Benefit:** 75% = $521.50 85% = $591.05 **Future End Date:**
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.) (See para TN.8.151 of explanatory notes to this Category)

	Fee: $869.00 **Benefit:** 75% = $651.75 85% = $760.50 **Future End Date:**
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.) (See para TN.8.151 of explanatory notes to this Category) **Fee:** $1,042.85 **Benefit:** 75% = $782.15 85% = $934.35 **Future End Date:**
31206	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if: (a) the lesion size is not more than 10 mm in diameter; and (b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) the specimen excised is sent for histological examination (Anaes.) **Fee:** $114.30 **Benefit:** 75% = $85.75 85% = $97.20 **Future End Date:**
31211	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if: (a) the lesion size is more than 10 mm, but not more than 20 mm, in diameter; and (b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) the specimen excised is sent for histological examination (Anaes.) **Fee:** $147.35 **Benefit:** 75% = $110.55 85% = $125.25 **Future End Date:**
31216	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if: (a) the lesion size is more than 20 mm in diameter; and (b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) the specimen excised is sent for histological examination (Anaes.) **Fee:** $171.90 **Benefit:** 75% = $128.95 85% = $146.15 **Future End Date:**
31220	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), lipomas, cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of 4 to 10 lesions and suture, if: (a) the size of each lesion is not more than 10 mm in diameter; and

	(b) each removal is from cutaneous or subcutaneous tissue by surgical excision (other than by shave excision); and (c) all of the specimens excised are sent for histological examination (Anaes.) **Fee:** $256.70 **Benefit:** 75% = $192.55 85% = $218.20 **Future End Date:**
31221	Tumours, cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of 4 to 10 lesions, if: (a) the size of each lesion is not more than 10 mm in diameter; and (b) each removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) each site of excision is closed by suture; and (d) all of the specimens excised are sent for histological examination (Anaes.) **Fee:** $256.70 **Benefit:** 75% = $192.55 85% = $218.20 **Future End Date:**
31225	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), lipomas, cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of more than 10 lesions, if: (a) the size of each lesion is not more than 10 mm in diameter; and (b) each removal is from cutaneous or subcutaneous tissue or mucous membrane by surgical excision (other than by shave excision); and (c) each site of excision is closed by suture; and (d) all of the specimens excised are sent for histological examination (Anaes.) **Fee:** $456.40 **Benefit:** 75% = $342.30 85% = $387.95 **Future End Date:**
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.) **Fee:** $160.30 **Benefit:** 75% = $120.25 85% = $136.30 **Future End Date:**
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.) (See para GN.1.2, TN.8.23 of explanatory notes to this Category) **Fee:** $441.60 **Benefit:** 75% = $331.20 **Future End Date:**

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.) **Fee:** $441.60 **Benefit:** 75% = $331.20 85% = $375.40 **Future End Date:**
31340	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, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383 is excised (Anaes.) **Derived Fee:** 75% of the fee for excision of malignant tumour **Future End Date:**
31344	Lipoma, removal of, by surgical excision or liposuction, if: (a) the lesion: (i) is subcutaneous and 150mm or more in diameter; or (ii) is submuscular, intramuscular or involves dissection of a named nerve or vessel and is 50 mm or more in diameter; and (b) a specimen of the excised lipoma is sent for histological confirmation of diagnosis (H) (Anaes.) (Assist.) **Fee:** $756.10 **Benefit:** 75% = $567.10 **Future End Date:**
31345	Lipoma, removal of, by surgical excision or liposuction, if: (a) the lesion is: (i) subcutaneous and 50 mm or more in diameter but less than 150 mm in diameter; or (ii) sub fascial; and (b) the specimen excised is sent for histological confirmation of diagnosis (Anaes.) **Fee:** $252.50 **Benefit:** 75% = $189.40 85% = $214.65 **Future End Date:**
31346	Liposuction (suction assisted lipolysis) to one regional area for contour problems of abdominal, upper arm or thigh fat because of repeated insulin injections, if: (a) the lesion is subcutaneous; and (b) the lesion is 50 mm or more in diameter; and (c) photographic and/or diagnostic imaging evidence demonstrating the need for this service is documented in the patient notes (Anaes.) (See para TN.8.101 of explanatory notes to this Category) **Fee:** $252.50 **Benefit:** 75% = $189.40 85% = $214.65 **Future End Date:**

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.) **Fee:** $518.65 **Benefit:** 75% = $389.00 85% = $440.90 **Future End Date:**
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.) **Fee:** $855.20 **Benefit:** 75% = $641.40 85% = $746.70 **Future End Date:**
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 6 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) (See para TN.8.22, TN.8.297, TN.8.125 of explanatory notes to this Category) **Fee:** $264.90 **Benefit:** 75% = $198.70 85% = $225.20 **Future End Date:**
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 6 mm; and (c) the excised specimen is sent for histological examination; not in association with item 45201 (Anaes.) (See para TN.8.22, TN.8.297, TN.8.125 of explanatory notes to this Category) **Fee:** $131.25 **Benefit:** 75% = $98.45 85% = $111.60 **Future End Date:**
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 6 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) (See para TN.8.22, TN.8.297, TN.8.125 of explanatory notes to this Category) **Fee:** $324.20 **Benefit:** 75% = $243.15 85% = $275.60 **Future End Date:**
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.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $395.15 **Benefit:** 75% = $296.40 **Future End Date:**
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 6 mm or more; and (c) the excised specimen is sent for histological examination (Anaes.) (See para TN.8.22, TN.8.297, TN.8.125 of explanatory notes to this Category) **Fee:** $201.10 **Benefit:** 75% = $150.85 85% = $170.95 **Future End Date:**
31361	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and

	(b) the necessary excision diameter is less than 14 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) (See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $223.45 **Benefit:** 75% = $167.60 85% = $189.95 **Future End Date:**
31362	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is less than 14 mm; and (c) the excised specimen is sent for histological examination; not in association with item 45201 (Anaes.) (See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $160.30 **Benefit:** 75% = $120.25 85% = $136.30 **Future End Date:**
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 14 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) (See para TN.8.23, TN.8.22, TN.8.297, TN.8.125 of explanatory notes to this Category) **Fee:** $292.35 **Benefit:** 75% = $219.30 85% = $248.50 **Future End Date:**
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 14 mm or more; and (c) the excised specimen is sent for histological examination (Anaes.) (See para TN.8.23, TN.8.22, TN.8.297, TN.8.125 of explanatory notes to this Category) **Fee:** $201.10 **Benefit:** 75% = $150.85 85% = $170.95 **Future End Date:**
31365	Malignant skin lesion (other than a malignant skin lesion covered by item 31369, 31370, 31371, 31372, 31373, 31377, 31378 or 31379), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is less than 15 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $189.45 **Benefit:** 75% = $142.10 85% = $161.05 **Future End Date:**
31366	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31357, 31360, 31362 or 31364; and (b) the necessary excision diameter is less than 15 mm; and (c) the excised specimen is sent for histological examination; not in association with item 45201 (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $114.30 **Benefit:** 75% = $85.75 85% = $97.20 **Future End Date:**
31367	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy;

	not in association with item 45201 (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $255.70 **Benefit:** 75% = $191.80 85% = $217.35 **Future End Date:**
31368	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31357, 31360, 31362 or 31364; and (b) the necessary excision diameter is at least 15 mm but not more than 30mm; and (c) the excised specimen is sent for histological examination; not in association with item 45201 (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $150.30 **Benefit:** 75% = $112.75 85% = $127.80 **Future End Date:**
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 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) (See para TN.8.22, TN.8.297, TN.8.125 of explanatory notes to this Category) **Fee:** $294.30 **Benefit:** 75% = $220.75 85% = $250.20 **Future End Date:**
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 30 mm; and (c) the excised specimen is sent for histological examination (Anaes.) (See para TN.8.22, TN.8.297, TN.8.125 of explanatory notes to this Category) **Fee:** $171.90 **Benefit:** 75% = $128.95 85% = $146.15 **Future End Date:**

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 6 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) (See para TN.8.22, TN.8.297, TN.8.125 of explanatory notes to this Category) **Fee:** $427.30 **Benefit:** 75% = $320.50 85% = $363.25 **Future End Date:**
31372	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, including excision of the primary tumour bed, if: (a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is less than 14 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with a service to which item 45201 applies (Anaes.) (See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $369.50 **Benefit:** 75% = $277.15 85% = $314.10 **Future End Date:**
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 14 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) (See para TN.8.23, TN.8.22, TN.8.297, TN.8.125 of explanatory notes to this Category) **Fee:** $427.05 **Benefit:** 75% = $320.30 85% = $363.00 **Future End Date:**

31374	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, including excision of the primary tumour bed, if: (a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and (b) the necessary excision diameter is less than 15 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with a service to which item 45201 applies (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $337.40 **Benefit:** 75% = $253.05 85% = $286.80 **Future End Date:**
31375	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, including excision of the primary tumour bed, if: (a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and (b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with a service to which item 45201 applies (Anaes.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $363.10 **Benefit:** 75% = $272.35 85% = $308.65 **Future End Date:**
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 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.) (See para TN.8.22, TN.8.297, TN.8.125 of explanatory notes to this Category) **Fee:** $420.85 **Benefit:** 75% = $315.65 85% = $357.75 **Future End Date:**
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 6 mm; and (c) the excised specimen is sent for histological examination; not in association with a service to which item 45201 applies (Anaes.) (See para TN.8.297, TN.8.125 of explanatory notes to this Category) **Fee:** $131.25 **Benefit:** 75% = $98.45 85% = $111.60 **Future End Date:**
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 6 mm or more; and (c) the excised specimen is sent for histological examination (Anaes.) (See para TN.8.297, TN.8.125 of explanatory notes to this Category) **Fee:** $201.10 **Benefit:** 75% = $150.85 85% = $170.95 **Future End Date:**
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 14 mm; and (c) the excised specimen is sent for histological examination; not in association with a service to which item 45201 applies (Anaes.) (See para TN.8.297, TN.8.125 of explanatory notes to this Category) **Fee:** $160.30 **Benefit:** 75% = $120.25 85% = $136.30 **Future End Date:**
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 14 mm or more; and

	(c) the excised specimen is sent for histological examination (Anaes.) (See para TN.8.297, TN.8.125 of explanatory notes to this Category) **Fee:** $201.10 **Benefit:** 75% = $150.85 85% = $170.95 **Future End Date:**
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 15 mm; and (c) the excised specimen is sent for histological examination; not in association with a service to which item 45201 applies (Anaes.) (See para TN.8.297, TN.8.125 of explanatory notes to this Category) **Fee:** $114.30 **Benefit:** 75% = $85.75 85% = $97.20 **Future End Date:**
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 15 mm but not more than 30 mm; and (c) the excised specimen is sent for histological examination; not in association with a service to which item 45201 applies (Anaes.) (See para TN.8.297, TN.8.125 of explanatory notes to this Category) **Fee:** $150.30 **Benefit:** 75% = $112.75 85% = $127.80 **Future End Date:**
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 30 mm; and (c) the excised specimen is sent for histological examination (Anaes.) (See para TN.8.297, TN.8.125 of explanatory notes to this Category) **Fee:** $171.90 **Benefit:** 75% = $128.95 85% = $146.15

	Future End Date:
31386	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 the head or neck; and (b) the necessary excision diameter is more than 50 mm; and (c) the excision involves at least 2 critical areas (eyelid, nose, ear, mouth); and (d) the excised specimen is sent for histological examination; and (e) malignancy is confirmed from the excised specimen or previous biopsy; and (f) the service is not covered by item 31387 (H) (Anaes.) (Assist.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $855.20 **Benefit:** 75% = $641.40 **Future End Date:**
31387	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 the head or neck; and (b) the necessary excision diameter is more than 70 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; and (e) the service is not covered by item 31386 (H) (Anaes.) (Assist.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $769.55 **Benefit:** 75% = $577.20 **Future End Date:**
31388	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 the trunk or limbs; and (b) the necessary excision diameter is more than 120 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (H) (Anaes.) (Assist.) (See para TN.8.22, TN.8.125 of explanatory notes to this Category) **Fee:** $692.55 **Benefit:** 75% = $519.45 **Future End Date:**
31400	Malignant upper aerodigestive tract tumour (other than tumour of the lip), excision of, if: (a) the tumour is not more than 20 mm in diameter; and (b) histological confirmation of malignancy is obtained (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $312.50 **Benefit:** 75% = $234.40 **Future End Date:**

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.) **Fee:** $360.65 **Benefit:** 75% = $270.50 **Future End Date:**
31406	Malignant upper aerodigestive tract tumour more than 40 mm in diameter (excluding tumour of the lip), excision of, if histological confirmation of malignancy has been obtained (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $601.05 **Benefit:** 75% = $450.80 **Future End Date:**
31409	PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.) **Fee:** $1,867.35 **Benefit:** 75% = $1400.55 **Future End Date:**
31412	RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.) **Fee:** $2,300.20 **Benefit:** 75% = $1725.15 **Future End Date:**
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.) (See para GN.1.2, TN.8.24 of explanatory notes to this Category) **Fee:** $480.95 **Benefit:** 75% = $360.75 **Future End Date:**
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.) (See para TN.8.24 of explanatory notes to this Category) **Fee:** $961.65 **Benefit:** 75% = $721.25 **Future End Date:**
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.) (See para TN.8.24 of explanatory notes to this Category) **Fee:** $1,498.70 **Benefit:** 75% = $1124.05 **Future End Date:**
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.) (See para TN.8.24 of explanatory notes to this Category) **Fee:** $1,602.85 **Benefit:** 75% = $1202.15 **Future End Date:**

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.) (See para TN.8.24 of explanatory notes to this Category) **Fee:** $1,178.10 **Benefit:** 75% = $883.60 **Future End Date:**
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.) (See para TN.8.24 of explanatory notes to this Category) **Fee:** $1,867.35 **Benefit:** 75% = $1400.55 **Future End Date:**
31454	Laparoscopy or laparotomy with drainage of bile, as an independent procedure (H) (Anaes.) (Assist.) **Fee:** $674.30 **Benefit:** 75% = $505.75 **Future End Date:**
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.) **Fee:** $293.95 **Benefit:** 75% = $220.50 **Future End Date:**
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.) **Fee:** $352.65 **Benefit:** 75% = $264.50 **Future End Date:**
31460	PERCUTANEOUS GASTROSTOMY TUBE, jejunal extension to, including any associated imaging services (Anaes.) (Assist.) **Fee:** $427.30 **Benefit:** 75% = $320.50 **Future End Date:**
31462	OPERATIVE FEEDING JEJUNOSTOMY performed in conjunction with major upper gastro-intestinal resection (Anaes.) (Assist.) **Fee:** $623.95 **Benefit:** 75% = $468.00 **Future End Date:**
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.) (See para TN.8.19 of explanatory notes to this Category) **Fee:** $1,564.30 **Benefit:** 75% = $1173.25 **Future End Date:**
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.) **Fee:** $1,718.55 **Benefit:** 75% = $1288.95

	Future End Date:
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.) **Fee:** $1,610.20 **Benefit:** 75% = $1207.65 **Future End Date:**
31500	Breast, benign lesion up to and including 50 mm in diameter, including simple cyst, fibroadenoma or fibrocystic disease, open surgical biopsy or excision of, with or without frozen section histology (H) (Anaes.) (See para GN.1.2, TN.8.25, TN.8.280 of explanatory notes to this Category) **Fee:** $311.20 **Benefit:** 75% = $233.40 **Future End Date:**
31503	Breast, benign lesion more than 50 mm in diameter, excision of (H) (Anaes.) (Assist.) (See para GN.1.2, TN.8.25, TN.8.280 of explanatory notes to this Category) **Fee:** $415.00 **Benefit:** 75% = $311.25 **Future End Date:**
31506	BREAST, ABNORMALITY detected by mammography or ultrasound where guidewire or other localisation procedure is performed, excision biopsy of (Anaes.) (Assist.) (See para TN.8.25, TN.8.280 of explanatory notes to this Category) **Fee:** $466.95 **Benefit:** 75% = $350.25 **Future End Date:**
31509	Breast, malignant tumour, open surgical biopsy of, with or without frozen section histology (H) (Anaes.) (See para GN.1.2, TN.8.25, TN.8.280 of explanatory notes to this Category) **Fee:** $415.00 **Benefit:** 75% = $311.25 **Future End Date:**
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.) **Fee:** $778.15 **Benefit:** 75% = $583.65 **Future End Date:**
31513	Breast, malignant tumour, complete local excision of, with simultaneous reshaping of the breast parenchyma using techniques such as round block or rotation flaps, other than a service associated with a service to which: (a) item 45523 or 45558 applies; and (b) item 31512, 31514, 45520, 45522 or 45556 applies on the same side (H) (Anaes.) (Assist.) (See para TN.8.265 of explanatory notes to this Category) **Fee:** $1,017.40 **Benefit:** 75% = $763.05 **Future End Date:**
31514	Breast, malignant tumour, complete local excision of, with simultaneous ipsilateral pedicled breast reduction, including repositioning of the nipple, other than a service associated with a service to which:

	(a) item 45523 or 45558 applies; and (b) item 31512, 31513, 45520, 45522 or 45556 applies on the same side (H) (Anaes.) (Assist.) (See para TN.8.265 of explanatory notes to this Category) **Fee:** $1,466.75 **Benefit:** 75% = $1100.10 **Future End Date:**
31515	BREAST, TUMOUR SITE, re-excision of following open biopsy or incomplete excision of malignant tumour (Anaes.) (Assist.) (See para TN.8.25, TN.8.280 of explanatory notes to this Category) **Fee:** $522.10 **Benefit:** 75% = $391.60 **Future End Date:**
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.) **Fee:** $1,037.70 **Benefit:** 75% = $778.30 **Future End Date:**
31519	Total mastectomy (unilateral) (H) (Anaes.) (Assist.) **Fee:** $881.05 **Benefit:** 75% = $660.80 **Future End Date:**
31520	Total mastectomy (bilateral) (H) (Anaes.) (Assist.) **Fee:** $1,541.65 **Benefit:** 75% = $1156.25 **Future End Date:**
31522	Skin sparing mastectomy (unilateral) (H) (Anaes.) (Assist.) **Fee:** $1,245.05 **Benefit:** 75% = $933.80 **Future End Date:**
31523	Skin sparing mastectomy (bilateral) (H) (Anaes.) (Assist.) **Fee:** $2,178.90 **Benefit:** 75% = $1634.20 **Future End Date:**
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.) **Fee:** $622.35 **Benefit:** 75% = $466.80

	Future End Date:
31526	Mastectomy for gynaecomastia (bilateral), 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.) **Fee:** $1,089.20 **Benefit:** 75% = $816.90 **Future End Date:**
31528	Nipple sparing mastectomy (unilateral) (H) (Anaes.) (Assist.) **Fee:** $1,245.05 **Benefit:** 75% = $933.80 **Future End Date:**
31529	Nipple sparing mastectomy (bilateral) (H) (Anaes.) (Assist.) **Fee:** $2,178.90 **Benefit:** 75% = $1634.20 **Future End Date:**
31530	Breast, biopsy of solid tumour or tissue of, using a vacuum-assisted breast biopsy device under imaging guidance, for histological examination, if imaging has demonstrated: (a) microcalcification of lesion; or (b) impalpable lesion less than one cm in diameter; including pre-operative localisation of lesion, if performed, other than a service associated with a service to which item 31548 applies **Fee:** $712.95 **Benefit:** 75% = $534.75 85% = $606.05 **Future End Date:**
31533	FINE NEEDLE ASPIRATION of an impalpable breast lesion detected by mammography or ultrasound, imaging guided - but not including imaging (Anaes.) (See para TN.8.26 of explanatory notes to this Category) **Fee:** $165.05 **Benefit:** 75% = $123.80 85% = $140.30 **Future End Date:**
31536	Breast, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques, but not including imaging (Anaes.) (See para TN.8.280 of explanatory notes to this Category) **Fee:** $226.75 **Benefit:** 75% = $170.10 85% = $192.75 **Future End Date:**
31537	Insertion of a marker clip into a breast, including axilla, following a breast biopsy and using imaging (but not including the associated imaging), if additional surgery, neoadjuvant systemic therapy, follow up imaging or radiation may be required and the insertion is for any of the following reasons: (a) to mark the site of a lesion that has been totally or almost completely removed; (b) to confirm biopsy site if multiple lesions are present; (c) to confirm biopsy site of an ill-defined lesion; (d) future surgery or preoperative localisation is considered to be potentially difficult due to lesion conspicuity;

	(e) preoperative localisation is likely to be carried out using a modality different from the biopsy modality; (f) for correlation across modalities for diagnostic reasons (Anaes.) (See para TN.8.280, TN.8.2 of explanatory notes to this Category) **Fee:** $226.75 **Benefit:** 75% = $170.10 85% = $192.75 **Future End Date:**
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.) (See para TN.8.26 of explanatory notes to this Category) **Fee:** $239.35 **Benefit:** 75% = $179.55 85% = $203.45 **Future End Date:**
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.) **Fee:** $259.40 **Benefit:** 75% = $194.55 **Future End Date:**
31554	BREAST, microdochotomy of, for benign or malignant condition (Anaes.) (Assist.) **Fee:** $518.80 **Benefit:** 75% = $389.10 **Future End Date:**
31557	Breast central ducts, excision of, for benign condition (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $415.00 **Benefit:** 75% = $311.25 **Future End Date:**
31560	ACCESSORY BREAST TISSUE, excision of (Anaes.) (Assist.) **Fee:** $415.00 **Benefit:** 75% = $311.25 85% = $352.75 **Extended Medicare Safety Net Cap:** $332.00 **Future End Date:**
31563	Inverted nipple, surgical eversion of, with or without flap repair, if the nipple cannot readily be everted manually (Anaes.) **Fee:** $310.85 **Benefit:** 75% = $233.15 85% = $264.25 **Future End Date:**
31566	ACCESSORY NIPPLE, excision of (Anaes.) **Fee:** $155.55 **Benefit:** 75% = $116.70 85% = $132.25 **Future End Date:**
31585	Removal of adjustable gastric band (Anaes.) (Assist.) **Fee:** $995.95 **Benefit:** 75% = $747.00 **Future End Date:**
	BARIATRIC

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.) (See para TN.8.29 of explanatory notes to this Category) **Fee:** $1,016.90 **Benefit:** 75% = $762.70 **Future End Date:**
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.) (See para TN.8.29 of explanatory notes to this Category) **Fee:** $1,251.25 **Benefit:** 75% = $938.45 **Future End Date:**
31575	Sleeve gastrectomy, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.) (See para TN.8.29 of explanatory notes to this Category) **Fee:** $1,016.90 **Benefit:** 75% = $762.70 **Future End Date:**
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.) (See para TN.8.29 of explanatory notes to this Category) **Fee:** $1,016.90 **Benefit:** 75% = $762.70 **Future End Date:**
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.) (See para TN.8.29 of explanatory notes to this Category) **Fee:** $1,251.25 **Benefit:** 75% = $938.45 **Future End Date:**
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 procedure other than a service associated with a service to which item 31585 applies (Anaes.) (Assist.) (See para TN.8.30 of explanatory notes to this Category) **Fee:** $1,842.25 **Benefit:** 75% = $1381.70 **Future End Date:**
31587	Adjustment of gastric band as an independent procedure including any associated consultation **Fee:** $117.25 **Benefit:** 75% = $87.95 85% = $99.70 **Future End Date:**
31590	Adjustment of gastric band reservoir, repair, revision or replacement of (Anaes.) (Assist.) **Fee:** $301.40 **Benefit:** 75% = $226.05 85% = $256.20 **Future End Date:**

	Group T8. Surgical Operations
	Subgroup 2. Colorectal
32000	LARGE INTESTINE, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Anaes.) (Assist.) **Fee:** $1,234.40 **Benefit:** 75% = $925.80 **Future End Date:**
32003	LARGE INTESTINE, resection of, with anastomosis, including right hemicolectomy (Anaes.) (Assist.) **Fee:** $1,291.15 **Benefit:** 75% = $968.40 **Future End Date:**
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.) **Fee:** $1,376.90 **Benefit:** 75% = $1032.70 **Future End Date:**
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.) **Fee:** $1,555.40 **Benefit:** 75% = $1166.55 **Future End Date:**
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.) **Fee:** $1,376.90 **Benefit:** 75% = $1032.70 **Future End Date:**
32009	TOTAL COLECTOMY AND ILEOSTOMY (Anaes.) (Assist.) **Fee:** $1,633.25 **Benefit:** 75% = $1224.95 **Future End Date:**
32012	TOTAL COLECTOMY AND ILEORECTAL ANASTOMOSIS (Anaes.) (Assist.) **Fee:** $1,804.10 **Benefit:** 75% = $1353.10 **Future End Date:**
32015	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY 1 surgeon (Anaes.) (Assist.) **Fee:** $2,217.30 **Benefit:** 75% = $1663.00 **Future End Date:**
32018	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; ABDOMINAL RESECTION (including aftercare) (Anaes.) (Assist.) **Fee:** $1,880.20 **Benefit:** 75% = $1410.15 **Future End Date:**
32021	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; PERINEAL RESECTION (Assist.)

	Fee: $674.30 **Benefit:** 75% = $505.75 **Future End Date:**
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.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $664.75 **Benefit:** 75% = $498.60 **Future End Date:**
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.) **Fee:** $1,633.25 **Benefit:** 75% = $1224.95 **Future End Date:**
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.) (See para TN.8.246 of explanatory notes to this Category) **Fee:** $2,184.65 **Benefit:** 75% = $1638.50 **Future End Date:**
32026	Rectum, ultra-low restorative resection, with or without covering stoma and with or without colonic reservoir, if the anastomosis is sited in the anorectal region and is 6 cm or less from the anal verge, not being a service associated with a service to which item 32000, 32030, 32106, 32117 or 32232 applies (H) (Anaes.) (Assist.) (See para TN.8.246 of explanatory notes to this Category) **Fee:** $2,446.30 **Benefit:** 75% = $1834.75 **Future End Date:**
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.) (See para TN.8.246 of explanatory notes to this Category) **Fee:** $2,598.55 **Benefit:** 75% = $1948.95 **Future End Date:**
32030	RECTOSIGMOIDECTOMY, including formation of stoma (H) (Anaes.) (Assist.) **Fee:** $1,234.40 **Benefit:** 75% = $925.80 **Future End Date:**
32033	RESTORATION OF BOWEL continuity following rectosigmoidectomy or similar operation, including dismantling of the stoma (H) (Anaes.) (Assist.) **Fee:** $1,804.10 **Benefit:** 75% = $1353.10 **Future End Date:**

32036	SACROCOCCYGEAL AND PRESACRAL TUMOUR excision of (Anaes.) (Assist.) **Fee:** $2,288.25 **Benefit:** 75% = $1716.20 **Future End Date:**
32039	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF 1 surgeon (Anaes.) (Assist.) **Fee:** $1,837.25 **Benefit:** 75% = $1377.95 **Future End Date:**
32042	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION abdominal resection (Anaes.) (Assist.) **Fee:** $1,547.75 **Benefit:** 75% = $1160.85 **Future End Date:**
32045	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION perineal resection (Assist.) **Fee:** $579.30 **Benefit:** 75% = $434.50 **Future End Date:**
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.) **Fee:** $895.15 **Benefit:** 75% = $671.40 **Future End Date:**
32047	PERINEAL PROCTECTOMY (Anaes.) (Assist.) **Fee:** $1,042.85 **Benefit:** 75% = $782.15 **Future End Date:**
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.) **Fee:** $2,772.70 **Benefit:** 75% = $2079.55 **Future End Date:**
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.) **Fee:** $2,544.85 **Benefit:** 75% = $1908.65 **Future End Date:**
32057	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir conjoint surgery, perineal surgeon (Assist.) **Fee:** $674.30 **Benefit:** 75% = $505.75 **Future End Date:**
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.) **Fee:** $2,772.70 **Benefit:** 75% = $2079.55 **Future End Date:**

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.) **Fee:** $2,544.85 **Benefit:** 75% = $1908.65 **Future End Date:**
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.) **Fee:** $674.30 **Benefit:** 75% = $505.75 **Future End Date:**
32069	ILEOSTOMY RESERVOIR, continent type, creation of, including conversion of existing ileostomy where appropriate (Anaes.) **Fee:** $2,051.05 **Benefit:** 75% = $1538.30 **Future End Date:**
32072	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), with or without biopsy **Fee:** $57.25 **Benefit:** 75% = $42.95 85% = $48.70 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $89.85 **Benefit:** 75% = $67.40 **Future End Date:**
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 32219, 32222 to 32228 or 32230 applies (H) (Anaes.) (See para GN.1.2, TN.8.134, TN.8.17 of explanatory notes to this Category) **Fee:** $133.35 **Benefit:** 75% = $100.05 **Future End Date:**
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 32219, 32222 to 32228 or 32230 applies (H) (Anaes.) (See para GN.1.2, TN.8.134, TN.8.17 of explanatory notes to this Category) **Fee:** $245.00 **Benefit:** 75% = $183.75 **Future End Date:**
32094	ENDOSCOPIC DILATATION OF COLORECTAL STRICTURES including colonoscopy (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Fee:** $660.50 **Benefit:** 75% = $495.40 **Future End Date:**
32095	Endoscopic examination of small bowel with flexible endoscope passed by stoma, with or without biopsies (H) (Anaes.) (See para GN.1.2, TN.8.17 of explanatory notes to this Category) **Fee:** $153.00 **Benefit:** 75% = $114.75 **Future End Date:**

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.) **Fee:** $307.60 **Benefit:** 75% = $230.70 **Future End Date:**
32105	Anorectal carcinoma—per anal full thickness excision of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $579.30 **Benefit:** 75% = $434.50 **Future End Date:**
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.) (See para GN.1.2, TN.8.31, TN.8.17 of explanatory notes to this Category) **Fee:** $1,633.25 **Benefit:** 75% = $1224.95 **Future End Date:**
32108	RECTAL TUMOUR, transsphincteric excision of (Kraske or similar operation) (Anaes.) (Assist.) **Fee:** $1,196.50 **Benefit:** 75% = $897.40 **Future End Date:**
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.) **Fee:** $1,503.55 **Benefit:** 75% = $1127.70 **Future End Date:**
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.) (See para TN.8.279 of explanatory notes to this Category) **Fee:** $1,763.25 **Benefit:** 75% = $1322.45 **Future End Date:**
32123	Anal stricture, anoplasty for (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $398.85 **Benefit:** 75% = $299.15 **Future End Date:**

32129	ANAL SPHINCTER, repair (H) (Anaes.) (Assist.) **Fee:** $759.65 **Benefit:** 75% = $569.75 **Future End Date:**
32131	RECTOCELE, transanal repair of rectocele (Anaes.) (Assist.) **Fee:** $638.70 **Benefit:** 75% = $479.05 **Future End Date:**
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.) **Fee:** $80.80 **Benefit:** 75% = $60.60 85% = $68.70 **Future End Date:**
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.) **Fee:** $440.10 **Benefit:** 75% = $330.10 **Future End Date:**
32147	PERIANAL THROMBOSIS, incision of (Anaes.) **Fee:** $53.95 **Benefit:** 75% = $40.50 85% = $45.90 **Future End Date:**
32150	Operation for anal fissure, including excision or sphincterotomy, excluding dilatation (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $307.60 **Benefit:** 75% = $230.70 **Future End Date:**
32156	Anal fistula, subcutaneous, excision of (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $157.60 **Benefit:** 75% = $118.20 **Future End Date:**
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.) **Fee:** $398.85 **Benefit:** 75% = $299.15 **Future End Date:**
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.) **Fee:** $579.30 **Benefit:** 75% = $434.50 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $759.65 **Benefit:** 75% = $569.75 **Future End Date:**
32166	ANAL FISTULA - readjustment of Seton (Anaes.)

	Fee: $246.85 **Benefit:** 75% = $185.15 85% = $209.85 **Future End Date:**
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.) **Fee:** $106.30 **Benefit:** 75% = $79.75 **Future End Date:**
32174	INTR-AANAL, perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.) **Fee:** $106.30 **Benefit:** 75% = $79.75 85% = $90.40 **Future End Date:**
32175	INTRA-ANAL, PERIANAL or ISCHIO-RECTAL ABSCESS, draining of, undertaken in the operating theatre of a hospital (excluding aftercare) (Anaes.) **Fee:** $194.70 **Benefit:** 75% = $146.05 **Future End Date:**
32183	INTESTINAL SLING PROCEDURE prior to radiotherapy (Anaes.) (Assist.) **Fee:** $672.25 **Benefit:** 75% = $504.20 **Future End Date:**
32186	COLONIC LAVAGE, total, intra operative (Anaes.) (Assist.) **Fee:** $672.25 **Benefit:** 75% = $504.20 **Future End Date:**
32212	ANO-RECTAL APPLICATION OF FORMALIN in the treatment of radiation proctitis, where performed in the operating theatre of a hospital, excluding aftercare (Anaes.) **Fee:** $163.15 **Benefit:** 75% = $122.40 **Future End Date:**
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.) (See para TN.8.247 of explanatory notes to this Category) **Fee:** $791.05 **Benefit:** 75% = $593.30 **Future End Date:**
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 **Fee:** $150.10 **Benefit:** 75% = $112.60 85% = $127.60 **Future End Date:**
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.)

	(See para TN.8.247 of explanatory notes to this Category) **Fee:** $710.45 **Benefit:** 75% = $532.85 **Future End Date:**
32218	Sacral nerve lead or leads, removal (H) (Anaes.) **Fee:** $187.05 **Benefit:** 75% = $140.30 **Future End Date:**
32219	Endoscopic examination of the colon to the caecum by colonoscopy, for an asymptomatic patient following a positive result from a faecal occult blood test undertaken for screening purposes Applicable once per day under a single episode of anaesthesia or other sedation (H) (Anaes.) (See para TN.8.152 of explanatory notes to this Category) **Fee:** $400.20 **Benefit:** 75% = $300.15 **Future End Date:**
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.) (See para GN.1.2, TN.8.277 of explanatory notes to this Category) **Fee:** $1,081.85 **Benefit:** 75% = $811.40 **Future End Date:**
32222	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient: (a) who has symptoms consistent with pathology of the colonic mucosa; or (b) who has anaemia or iron deficiency; or (c) for whom diagnostic imaging has shown an abnormality of the colon; or (d) who is undergoing the first examination following surgery for colorectal cancer; or (e) who is undergoing pre-operative evaluation; or (f) for whom a repeat colonoscopy is required due to inadequate bowel preparation for the patient's previous colonoscopy; or (g) 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.) (See para GN.1.2, TN.8.293, TN.8.17, TN.8.152, TN.8.2 of explanatory notes to this Category) **Fee:** $400.20 **Benefit:** 75% = $300.15 **Future End Date:**
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 10 mm 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 10 mm 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.) (See para GN.1.2, TN.8.293, TN.8.17, TN.8.152, TN.8.2 of explanatory notes to this Category) **Fee:** $400.20 **Benefit:** 75% = $300.15 **Future End Date:**
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 10 mm or greater in diameter; or (ii) had villous features; or (iii) had high grade dysplasia; or (b) having had a previous colonoscopy that revealed: (i) 5 to 9 adenomas, each of which was less than 10 mm in diameter, had no villous features and had no high grade dysplasia; or (ii) one or 2 sessile serrated lesions, each of which was 10 mm or greater in diameter or had dysplasia; or (iii) a hyperplastic polyp that was 10 mm or greater in diameter; or (iv) 3 or more sessile serrated lesions, each of which was less than 10 mm in diameter and had no dysplasia; or (v) 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.) (See para GN.1.2, TN.8.293, TN.8.17, TN.8.152, TN.8.2 of explanatory notes to this Category) **Fee:** $400.20 **Benefit:** 75% = $300.15 **Future End Date:**
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.) (See para GN.1.2, TN.8.293, TN.8.17, TN.8.152, TN.8.2 of explanatory notes to this Category) **Fee:** $400.20 **Benefit:** 75% = $300.15 **Future End Date:**
32226	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient who has a high risk of colorectal cancer due to: (a) having either: (i) a known or suspected familial condition, such as familial adenomatous polyposis, Lynch syndrome or serrated polyposis syndrome; or (ii) a genetic mutation associated with hereditary colorectal cancer; or (b) having had a previous colonoscopy that revealed: (i) 5 or more sessile serrated lesions, each of which was less than 10 mm in diameter and had no dysplasia; or (ii) 3 or more sessile serrated lesions, one or more of which was 10 mm or greater in diameter or had dysplasia; or (iii) 3 or more traditional serrated adenomas, of any size; other than a service associated with a service to which item 32230 applies Applicable once in any 12 month period (H) (Anaes.) (See para GN.1.2, TN.8.293, TN.8.17, TN.8.152, TN.8.2 of explanatory notes to this Category) **Fee:** $400.20 **Benefit:** 75% = $300.15 **Future End Date:**
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.) (See para GN.1.2, TN.8.17, TN.8.152, TN.8.2 of explanatory notes to this Category) **Fee:** $561.55 **Benefit:** 75% = $421.20 **Future End Date:**
32228	Endoscopic examination of the colon to the caecum by colonoscopy, other than: (a) a service to which item 32219, 32222, 32223, 32224, 32225 or 32226 applies; or

	(b) a service associated with a service to which item 32230 applies Applicable once (H) (Anaes.) (See para GN.1.2, TN.8.293, TN.8.17, TN.8.152, TN.8.2 of explanatory notes to this Category) **Fee:** $400.20 **Benefit:** 75% = $300.15 **Future End Date:**
32229	Removal of one or more polyps during colonoscopy, in association with a service to which item 32219, 32222, 32223, 32224, 32225, 32226 or 32228 applies (H) (Anaes.) (See para GN.1.2, TN.8.293, TN.8.17, TN.8.152, TN.8.2 of explanatory notes to this Category) **Fee:** $322.80 **Benefit:** 75% = $242.10 **Future End Date:**
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.) (See para TN.8.293, TN.8.152 of explanatory notes to this Category) **Fee:** $799.70 **Benefit:** 75% = $599.80 **Future End Date:**
32231	Rectal tumour, per anal excision of (H) (Anaes.) (Assist.) **Fee:** $398.85 **Benefit:** 75% = $299.15 **Future End Date:**
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.) (See para TN.8.31, TN.8.17 of explanatory notes to this Category) **Fee:** $1,081.40 **Benefit:** 75% = $811.05 **Future End Date:**
32233	Perineal repair of rectal prolapse, not being a service associated with a service to which item 32139 applies (H) (Anaes.) (Assist.) **Fee:** $768.00 **Benefit:** 75% = $576.00 **Future End Date:**
32234	Rectal stricture, treatment of (H) (Anaes.) **Fee:** $151.90 **Benefit:** 75% = $113.95 **Future End Date:**
32235	Anal skin tags or anal polyps, excision of one or more of (Anaes.) **Fee:** $146.55 **Benefit:** 75% = $109.95 85% = $124.60 **Future End Date:**
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.) **Fee:** $208.55 **Benefit:** 75% = $156.45 **Future End Date:**

T8. SURGICAL OPERATIONS	2. COLORECTAL
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.) **Fee:** $338.25 **Benefit:** 75% = $253.70 **Future End Date:**

T8. SURGICAL OPERATIONS	3. VASCULAR
	Group T8. Surgical Operations
	Subgroup 3. Vascular
	VARICOSE VEINS
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.) (See para TN.8.33, TN.8.4, TN.8.228, TN.8.32 of explanatory notes to this Category) **Fee:** $131.45 **Benefit:** 75% = $98.60 85% = $111.75 **Extended Medicare Safety Net Cap:** $144.60 **Future End Date:**
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.) (See para TN.8.32 of explanatory notes to this Category) **Fee:** $320.35 **Benefit:** 75% = $240.30 85% = $272.30 **Extended Medicare Safety Net Cap:** $256.30 **Future End Date:**
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.) (See para TN.8.33, TN.8.32 of explanatory notes to this Category) **Fee:** $638.70 **Benefit:** 75% = $479.05 **Future End Date:**
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.) (See para TN.8.33, TN.8.32 of explanatory notes to this Category) **Fee:** $638.70 **Benefit:** 75% = $479.05 **Future End Date:**
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.) (See para TN.8.33, TN.8.32 of explanatory notes to this Category) **Fee:** $949.50 **Benefit:** 75% = $712.15 **Future End Date:**
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.) (See para TN.8.33, TN.8.32 of explanatory notes to this Category) **Fee:** $1,109.30 **Benefit:** 75% = $832.00 **Future End Date:**
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.) (See para TN.8.33, TN.8.32 of explanatory notes to this Category) **Fee:** $1,428.45 **Benefit:** 75% = $1071.35 **Future End Date:**
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.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $638.70 **Benefit:** 75% = $479.05 85% = $542.90 **Extended Medicare Safety Net Cap:** $95.85 **Future End Date:**
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.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $949.50 **Benefit:** 75% = $712.15 85% = $841.00 **Extended Medicare Safety Net Cap:** $94.95 **Future End Date:**
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.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $638.70 **Benefit:** 75% = $479.05 85% = $542.90 **Extended Medicare Safety Net Cap:** $95.85 **Future End Date:**
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.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $949.50 **Benefit:** 75% = $712.15 85% = $841.00 **Extended Medicare Safety Net Cap:** $94.95 **Future End Date:**
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.)

(See para TN.8.33 of explanatory notes to this Category)
Fee: $638.70 **Benefit:** 75% = $479.05 85% = $542.90
Extended Medicare Safety Net Cap: $95.85
Future End Date:

	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.) (See para TN.8.33 of explanatory notes to this Category) **Fee:** $949.50 **Benefit:** 75% = $712.15 85% = $841.00 **Extended Medicare Safety Net Cap:** $94.95
32529	**Future End Date:**

	BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTERIAL DISEASE
32700	ARTERY OF NECK, bypass using vein or synthetic material (Anaes.) (Assist.) **Fee:** $1,719.10 **Benefit:** 75% = $1289.35 **Future End Date:**
32703	INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy (Anaes.) (Assist.) **Fee:** $1,422.15 **Benefit:** 75% = $1066.65 **Future End Date:**
32708	AORTIC BYPASS for occlusive disease using a straight non-bifurcated graft (Anaes.) (Assist.) **Fee:** $1,701.20 **Benefit:** 75% = $1275.90 **Future End Date:**
32710	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliac arteries (Anaes.) (Assist.) **Fee:** $1,890.25 **Benefit:** 75% = $1417.70 **Future End Date:**
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.) **Fee:** $2,079.30 **Benefit:** 75% = $1559.50 **Future End Date:**
32712	ILIO-FEMORAL BYPASS GRAFTING (Anaes.) (Assist.) **Fee:** $1,503.15 **Benefit:** 75% = $1127.40 **Future End Date:**
32715	AXILLARY or SUBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL ARTERIES (Anaes.) (Assist.) **Fee:** $1,503.15 **Benefit:** 75% = $1127.40 **Future End Date:**
32718	FEMORO-FEMORAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes.) (Assist.) **Fee:** $1,422.15 **Benefit:** 75% = $1066.65 **Future End Date:**
32721	RENAL ARTERY, bypass grafting to (Anaes.) (Assist.) **Fee:** $2,258.95 **Benefit:** 75% = $1694.25 **Future End Date:**
32724	RENAL ARTERIES (both), bypass grafting to (Anaes.) (Assist.) **Fee:** $2,565.10 **Benefit:** 75% = $1923.85 **Future End Date:**
32730	MESENTERIC VESSEL (single), bypass grafting to (Anaes.) (Assist.) **Fee:** $1,944.15 **Benefit:** 75% = $1458.15 **Future End Date:**
32733	MESENTERIC VESSELS (multiple), bypass grafting to (Anaes.) (Assist.)

	Fee: $2,258.95 **Benefit:** 75% = $1694.25 **Future End Date:**
32736	INFERIOR MESENTERIC ARTERY, operation on, when performed in conjunction with another intra-abdominal vascular operation (Anaes.) (Assist.) **Fee:** $495.00 **Benefit:** 75% = $371.25 **Future End Date:**
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.) **Fee:** $1,548.10 **Benefit:** 75% = $1161.10 **Future End Date:**
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.) **Fee:** $1,773.20 **Benefit:** 75% = $1329.90 **Future End Date:**
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.) **Fee:** $2,025.05 **Benefit:** 75% = $1518.80 **Future End Date:**
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.) **Fee:** $2,196.10 **Benefit:** 75% = $1647.10 **Future End Date:**
32751	FEMORAL ARTERY BYPASS GRAFTING using synthetic graft, with lower anastomosis above or below the knee (Anaes.) (Assist.) **Fee:** $1,422.15 **Benefit:** 75% = $1066.65 **Future End Date:**
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.) **Fee:** $1,773.20 **Benefit:** 75% = $1329.90 **Future End Date:**
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.) **Fee:** $495.00 **Benefit:** 75% = $371.25 **Future End Date:**
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.) **Fee:** $485.95 **Benefit:** 75% = $364.50

	Future End Date:
32763	ARTERIAL BYPASS GRAFTING, using vein or synthetic material, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,422.15 **Benefit:** 75% = $1066.65 **Future End Date:**
32766	ARTERIAL OR VENOUS ANASTOMOSIS, not being a service to which another item in this Sub-group applies, as an independent procedure (Anaes.) (Assist.) **Fee:** $945.15 **Benefit:** 75% = $708.90 **Future End Date:**
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.) **Fee:** $327.55 **Benefit:** 75% = $245.70 **Future End Date:**
	BYPASS, REPLACEMENT, LIGATION OF ANEURYSMS
33050	BYPASS GRAFTING to replace a popliteal aneurysm using vein, including harvesting vein (when it is the ipsilateral long saphenous vein) (Anaes.) (Assist.) **Fee:** $1,741.90 **Benefit:** 75% = $1306.45 **Future End Date:**
33055	BYPASS GRAFTING to replace a popliteal aneurysm using a synthetic graft (Anaes.) (Assist.) **Fee:** $1,396.85 **Benefit:** 75% = $1047.65 **Future End Date:**
33070	Aneurysm in the extremities, ligation, suture closure or excision of, without bypass grafting (H) (Anaes.) (Assist.) **Fee:** $1,007.75 **Benefit:** 75% = $755.85 **Future End Date:**
33075	ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,281.95 **Benefit:** 75% = $961.50 **Future End Date:**
33080	INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,564.85 **Benefit:** 75% = $1173.65 **Future End Date:**
33100	Aneurysm of common or internal carotid artery, or both, replacement by graft of vein or synthetic material (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,719.10 **Benefit:** 75% = $1289.35 **Future End Date:**

33103	THORACIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $2,412.15 **Benefit:** 75% = $1809.15 **Future End Date:**
33109	Thoraco-abdominal aneurysm, replacement by graft including re-implantation of arteries (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $2,916.25 **Benefit:** 75% = $2187.20 **Future End Date:**
33112	SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.) **Fee:** $2,529.10 **Benefit:** 75% = $1896.85 **Future End Date:**
33115	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft, not being a service associated with a service to which item 33116 applies (Anaes.) (Assist.) **Fee:** $1,701.20 **Benefit:** 75% = $1275.90 **Future End Date:**
33116	Infrarenal abdominal aortic aneurysm (repair), replacement by tube graft using endovascular repair procedure, excluding associated radiological services (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,674.50 **Benefit:** 75% = $1255.90 **Future End Date:**
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.) **Fee:** $1,890.25 **Benefit:** 75% = $1417.70 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,860.65 **Benefit:** 75% = $1395.50 **Future End Date:**
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.) **Fee:** $2,079.30 **Benefit:** 75% = $1559.50 **Future End Date:**
33124	ANEURYSM OF ILIAC ARTERY (common, external or internal), replacement by graft - unilateral (Anaes.) (Assist.) **Fee:** $1,449.20 **Benefit:** 75% = $1086.90 **Future End Date:**
33127	Aneurysms of iliac arteries (common, external or internal), replacement by graft—bilateral (H) (Anaes.) (Assist.)

	(See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,899.30 **Benefit:** 75% = $1424.50 **Future End Date:**
33130	ANEURYSM OF VISCERAL ARTERY, excision and repair by direct anastomosis or replacement by graft (Anaes.) (Assist.) **Fee:** $1,656.15 **Benefit:** 75% = $1242.15 **Future End Date:**
33133	ANEURYSM OF VISCERAL ARTERY, dissection and ligation of arteries without restoration of continuity (Anaes.) (Assist.) **Fee:** $1,242.00 **Benefit:** 75% = $931.50 **Future End Date:**
33136	FALSE ANEURYSM, repair of, at aortic anastomosis following previous aortic surgery (Anaes.) (Assist.) **Fee:** $3,132.00 **Benefit:** 75% = $2349.00 **Future End Date:**
33139	FALSE ANEURYSM, repair of, in iliac artery and restoration of arterial continuity (Anaes.) (Assist.) **Fee:** $1,899.30 **Benefit:** 75% = $1424.50 **Future End Date:**
33142	False aneurysm, repair of, in femoral artery and restoration of arterial continuity (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,773.20 **Benefit:** 75% = $1329.90 **Future End Date:**
33145	RUPTURED THORACIC AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $3,051.10 **Benefit:** 75% = $2288.35 **Future End Date:**
33148	RUPTURED THORACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $3,789.15 **Benefit:** 75% = $2841.90 **Future End Date:**
33151	RUPTURED SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $3,600.25 **Benefit:** 75% = $2700.20 **Future End Date:**
33154	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft (Anaes.) (Assist.) **Fee:** $2,664.10 **Benefit:** 75% = $1998.10 **Future End Date:**
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.) **Fee:** $2,970.10 **Benefit:** 75% = $2227.60 **Future End Date:**

33160	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (Anaes.) (Assist.) **Fee:** $2,970.10 **Benefit:** 75% = $2227.60 **Future End Date:**
33163	RUPTURED ILIAC ARTERY ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $2,520.30 **Benefit:** 75% = $1890.25 **Future End Date:**
33166	Ruptured aneurysm of visceral artery, replacement by anastomosis or graft (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $2,520.30 **Benefit:** 75% = $1890.25 **Future End Date:**
33169	RUPTURED ANEURYSM OF VISCERAL ARTERY, simple ligation of (Anaes.) (Assist.) **Fee:** $1,962.15 **Benefit:** 75% = $1471.65 **Future End Date:**
33172	ANEURYSM OF MAJOR ARTERY, replacement by graft, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,530.05 **Benefit:** 75% = $1147.55 **Future End Date:**
33175	RUPTURED ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,410.10 **Benefit:** 75% = $1057.60 **Future End Date:**
33178	RUPTURED ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,793.15 **Benefit:** 75% = $1344.90 **Future End Date:**
33181	RUPTURED INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $2,192.35 **Benefit:** 75% = $1644.30 **Future End Date:**
	ENDARTERECTOMY AND ARTERIAL PATCH
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.) **Fee:** $1,358.95 **Benefit:** 75% = $1019.25 **Future End Date:**
33506	INNOMINATE OR SUBCLAVIAN ARTERY, endarterectomy of, including closure by suture (Anaes.) (Assist.) **Fee:** $1,521.10 **Benefit:** 75% = $1140.85 **Future End Date:**

33509	AORTIC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the aorta (Anaes.) (Assist.) **Fee:** $1,701.20 **Benefit:** 75% = $1275.90 **Future End Date:**
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.) **Fee:** $1,890.25 **Benefit:** 75% = $1417.70 **Future End Date:**
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.) **Fee:** $2,079.30 **Benefit:** 75% = $1559.50 **Future End Date:**
33518	Iliac endarterectomy, including closure by suture, other than a service associated with another procedure on the iliac artery (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,521.10 **Benefit:** 75% = $1140.85 **Future End Date:**
33521	ILIO-FEMORAL ENDARTERECTOMY (1 side), including closure by suture (Anaes.) (Assist.) **Fee:** $1,646.95 **Benefit:** 75% = $1235.25 **Future End Date:**
33524	RENAL ARTERY, endarterectomy of (Anaes.) (Assist.) **Fee:** $1,944.15 **Benefit:** 75% = $1458.15 **Future End Date:**
33527	RENAL ARTERIES (both), endarterectomy of (Anaes.) (Assist.) **Fee:** $2,258.95 **Benefit:** 75% = $1694.25 **Future End Date:**
33530	COELIAC OR SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.) **Fee:** $1,944.15 **Benefit:** 75% = $1458.15 **Future End Date:**
33533	COELIAC AND SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.) **Fee:** $2,258.95 **Benefit:** 75% = $1694.25 **Future End Date:**
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.) **Fee:** $1,611.15 **Benefit:** 75% = $1208.40 **Future End Date:**
33539	ARTERY OF EXTREMITIES, endarterectomy of, including closure by suture (Anaes.) (Assist.) **Fee:** $1,160.95 **Benefit:** 75% = $870.75 **Future End Date:**

33542	EXTENDED DEEP FEMORAL ENDARTERECTOMY where the endarterectomy is at least 7cms long (Anaes.) (Assist.) **Fee:** $1,656.15 **Benefit:** 75% = $1242.15 **Future End Date:**
33545	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is less than 3cm long (Anaes.) (Assist.) (See para TN.8.36 of explanatory notes to this Category) **Fee:** $327.55 **Benefit:** 75% = $245.70 **Future End Date:**
33548	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is 3cm long or greater (Anaes.) (Assist.) (See para TN.8.36 of explanatory notes to this Category) **Fee:** $666.20 **Benefit:** 75% = $499.65 **Future End Date:**
33551	VEIN, harvesting of from leg or arm for patch when not performed through same incision as operation (Anaes.) (Assist.) (See para TN.8.36 of explanatory notes to this Category) **Fee:** $327.55 **Benefit:** 75% = $245.70 **Future End Date:**
33554	ENDARTERECTOMY, in conjunction with an arterial bypass operation to prepare the site for anastomosis - each site (Anaes.) (Assist.) **Fee:** $326.05 **Benefit:** 75% = $244.55 **Future End Date:**
	EMBOLECTOMY, THROMBECTOMY AND VASCULAR TRAUMA
33800	Embolus, removal of, from artery of neck (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,413.10 **Benefit:** 75% = $1059.85 **Future End Date:**
33803	EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of an artery or bypass graft of trunk (Anaes.) (Assist.) **Fee:** $1,350.20 **Benefit:** 75% = $1012.65 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $972.10 **Benefit:** 75% = $729.10 **Future End Date:**
33810	Inferior vena cava or iliac vein, closed thrombectomy by catheter via the femoral vein (H) (Anaes.) (Assist.) (See para GN.1.2, GN.10.26 of explanatory notes to this Category) **Fee:** $709.15 **Benefit:** 75% = $531.90

	Future End Date:
33811	INFERIOR VENA CAVA OR ILIAC VEIN, open removal of thrombus or tumour (Anaes.) (Assist.) **Fee:** $2,111.05 **Benefit:** 75% = $1583.30 **Future End Date:**
33812	Thrombus, removal of, from femoral or other similar large vein (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,116.00 **Benefit:** 75% = $837.00 **Future End Date:**
33815	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.) **Fee:** $1,026.00 **Benefit:** 75% = $769.50 **Future End Date:**
33818	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.) **Fee:** $1,197.15 **Benefit:** 75% = $897.90 **Future End Date:**
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.) **Fee:** $1,368.05 **Benefit:** 75% = $1026.05 **Future End Date:**
33824	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.) **Fee:** $1,304.95 **Benefit:** 75% = $978.75 **Future End Date:**
33827	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.) **Fee:** $1,530.05 **Benefit:** 75% = $1147.55 **Future End Date:**
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.) **Fee:** $1,755.00 **Benefit:** 75% = $1316.25 **Future End Date:**
33833	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by lateral suture (Anaes.) (Assist.) **Fee:** $1,593.30 **Benefit:** 75% = $1195.00 **Future End Date:**
33836	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by direct anastomosis (Anaes.) (Assist.) **Fee:** $1,899.30 **Benefit:** 75% = $1424.50 **Future End Date:**

33839	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by means of interposition graft (Anaes.) (Assist.) **Fee:** $2,223.10 **Benefit:** 75% = $1667.35 **Future End Date:**
33842	ARTERY OF NECK, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (Anaes.) (Assist.) **Fee:** $1,098.05 **Benefit:** 75% = $823.55 **Future End Date:**
33845	LAPAROTOMY for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (Anaes.) (Assist.) **Fee:** $765.20 **Benefit:** 75% = $573.90 **Future End Date:**
33848	EXTREMITY, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no other procedure is performed (Anaes.) (Assist.) **Fee:** $765.20 **Benefit:** 75% = $573.90 **Future End Date:**
	LIGATION, EXCISION, ELECTIVE REPAIR, DECOMPRESSION OF VESSELS
34100	MAJOR ARTERY OF NECK, elective ligation or exploration of, not being a service associated with any other vascular procedure (Anaes.) (Assist.) **Fee:** $846.15 **Benefit:** 75% = $634.65 **Future End Date:**
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.) **Fee:** $495.00 **Benefit:** 75% = $371.25 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $349.15 **Benefit:** 75% = $261.90 **Extended Medicare Safety Net Cap:** $279.35 **Future End Date:**
34109	TEMPORAL ARTERY, biopsy of (Anaes.) (Assist.) **Fee:** $405.00 **Benefit:** 75% = $303.75 85% = $344.25 **Future End Date:**
34112	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and ligation (Anaes.) (Assist.) **Fee:** $1,026.00 **Benefit:** 75% = $769.50 **Future End Date:**

34115	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and ligation (Anaes.) (Assist.) **Fee:** $1,160.95 **Benefit:** 75% = $870.75 **Future End Date:**
34118	Arterio-venous fistula of the abdomen, dissection and ligation (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,656.15 **Benefit:** 75% = $1242.15 **Future End Date:**
34121	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) **Fee:** $1,323.00 **Benefit:** 75% = $992.25 **Future End Date:**
34124	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) **Fee:** $1,449.20 **Benefit:** 75% = $1086.90 **Future End Date:**
34127	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) **Fee:** $1,899.30 **Benefit:** 75% = $1424.50 **Future End Date:**
34130	Surgically created arterio-venous fistula of an extremity, closure of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $593.95 **Benefit:** 75% = $445.50 **Future End Date:**
34133	SCALENOTOMY (Anaes.) (Assist.) **Fee:** $666.20 **Benefit:** 75% = $499.65 **Future End Date:**
34136	FIRST RIB, resection of portion of (Anaes.) (Assist.) **Fee:** $1,070.90 **Benefit:** 75% = $803.20 **Future End Date:**
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.) **Fee:** $1,070.90 **Benefit:** 75% = $803.20 **Future End Date:**
34142	COELIAC ARTERY, decompression of, for coeliac artery compression syndrome, as an independent procedure (Anaes.) (Assist.) **Fee:** $1,323.00 **Benefit:** 75% = $992.25 **Future End Date:**
34145	POPLITEAL ARTERY, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (Anaes.) (Assist.) **Fee:** $963.00 **Benefit:** 75% = $722.25 **Future End Date:**

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.) **Fee:** $1,719.10 **Benefit:** 75% = $1289.35 **Future End Date:**
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.) **Fee:** $2,349.05 **Benefit:** 75% = $1761.80 **Future End Date:**
34154	Recurrent carotid associated tumour, resection of, with or without repair or replacement of portion of internal or common carotid arteries (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $2,799.25 **Benefit:** 75% = $2099.45 **Future End Date:**
34157	NECK, excision of infected bypass graft, including closure of vessel or vessels (Anaes.) (Assist.) **Fee:** $1,422.15 **Benefit:** 75% = $1066.65 **Future End Date:**
34160	AORTO-DUODENAL FISTULA, repair of, by suture of aorta and repair of duodenum (Anaes.) (Assist.) **Fee:** $2,664.10 **Benefit:** 75% = $1998.10 **Future End Date:**
34163	AORTO-DUODENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum (Anaes.) (Assist.) **Fee:** $3,420.15 **Benefit:** 75% = $2565.15 **Future End Date:**
34166	AORTO-DUODENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo-bifemoral grafting (Anaes.) (Assist.) **Fee:** $3,420.15 **Benefit:** 75% = $2565.15 **Future End Date:**
34169	INFECTED BYPASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes.) (Assist.) **Fee:** $1,899.30 **Benefit:** 75% = $1424.50 **Future End Date:**
34172	INFECTED AXILLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of arteries (Anaes.) (Assist.) **Fee:** $1,548.10 **Benefit:** 75% = $1161.10 **Future End Date:**
34175	INFECTED BYPASS GRAFT FROM EXTREMITIES, excision of including closure of arteries (Anaes.) (Assist.) **Fee:** $1,422.15 **Benefit:** 75% = $1066.65 **Future End Date:**
	OPERATIONS FOR VASCULAR ACCESS

34500	Arteriovenous shunt, external, insertion of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $369.20 **Benefit:** 75% = $276.90 **Future End Date:**
34503	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, in conjunction with another venous or arterial operation (Anaes.) (Assist.) **Fee:** $495.00 **Benefit:** 75% = $371.25 **Future End Date:**
34506	ARTERIOVENOUS SHUNT, EXTERNAL, removal of (Anaes.) (Assist.) **Fee:** $251.85 **Benefit:** 75% = $188.90 **Future End Date:**
34509	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, not in conjunction with another venous or arterial operation (Anaes.) (Assist.) **Fee:** $1,170.00 **Benefit:** 75% = $877.50 **Future End Date:**
34512	ARTERIOVENOUS ACCESS DEVICE, insertion of (Anaes.) (Assist.) **Fee:** $1,287.20 **Benefit:** 75% = $965.40 **Future End Date:**
34515	ARTERIOVENOUS ACCESS DEVICE, thrombectomy of (Anaes.) (Assist.) **Fee:** $917.95 **Benefit:** 75% = $688.50 **Future End Date:**
34518	STENOSIS OF ARTERIOVENOUS FISTULA OR PROSTHETIC ARTERIOVENOUS ACCESS DEVICE, correction of (Anaes.) (Assist.) **Fee:** $1,538.95 **Benefit:** 75% = $1154.25 **Future End Date:**
34521	INTRA-ABDOMINAL ARTERY OR VEIN, cannulation of, for infusion chemotherapy, by open operation (excluding aftercare) (Anaes.) (Assist.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $945.55 **Benefit:** 75% = $709.20 **Future End Date:**
34524	ARTERIAL CANNULATION for infusion chemotherapy by open operation, not being a service to which item 34521 applies (excluding after-care) (Anaes.) (Assist.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $495.00 **Benefit:** 75% = $371.25 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $660.25 **Benefit:** 75% = $495.20 **Future End Date:**

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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $326.05 **Benefit:** 75% = $244.55 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $858.35 **Benefit:** 75% = $643.80 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $244.40 **Benefit:** 75% = $183.30 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,484.90 **Benefit:** 75% = $1113.70 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $423.90 **Benefit:** 75% = $317.95 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $326.05 **Benefit:** 75% = $244.55 **Future End Date:**
34539	TUNNELLED CUFFED CATHETER, OR SIMILAR DEVICE, removal of, by open surgical procedure (Anaes.) **Fee:** $244.40 **Benefit:** 75% = $183.30 85% = $207.75 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $317.75 **Benefit:** 75% = $238.35 **Future End Date:**
	COMPLEX VENOUS OPERATIONS

34800	Inferior vena cava, plication, ligation, or application of caval clip (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $972.10 **Benefit:** 75% = $729.10 **Future End Date:**
34803	INFERIOR VENA CAVA, reconstruction of or bypass by vein or synthetic material (Anaes.) (Assist.) **Fee:** $2,142.30 **Benefit:** 75% = $1606.75 **Future End Date:**
34806	CROSS LEG BYPASS GRAFTING, saphenous to iliac or femoral vein (Anaes.) (Assist.) **Fee:** $1,160.95 **Benefit:** 75% = $870.75 **Future End Date:**
34809	SAPHENOUS VEIN ANASTOMOSIS to femoral or popliteal vein for femoral vein bypass (Anaes.) (Assist.) **Fee:** $1,160.95 **Benefit:** 75% = $870.75 **Future End Date:**
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.) **Fee:** $1,404.05 **Benefit:** 75% = $1053.05 **Future End Date:**
34815	VEIN STENOSIS, patch angioplasty for, (excluding vein graft stenosis)-using vein or synthetic material (Anaes.) (Assist.) (See para TN.8.36 of explanatory notes to this Category) **Fee:** $1,160.95 **Benefit:** 75% = $870.75 **Future End Date:**
34818	VENOUS VALVE, plication or repair to restore valve competency (Anaes.) (Assist.) **Fee:** $1,278.10 **Benefit:** 75% = $958.60 **Future End Date:**
34821	Vein transplant to restore valvular function (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,737.15 **Benefit:** 75% = $1302.90 **Future End Date:**
34824	EXTERNAL STENT, application of, to restore venous valve competency to superficial vein - 1 stent (Anaes.) (Assist.) **Fee:** $593.95 **Benefit:** 75% = $445.50 **Future End Date:**
34827	EXTERNAL STENTS, application of, to restore venous valve competency to superficial vein or veins - more than 1 stent (Anaes.) (Assist.) **Fee:** $720.15 **Benefit:** 75% = $540.15 **Future End Date:**
34830	External stent, application of, to restore venous valve competency to deep vein—one stent (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category)

	Fee: $846.15 **Benefit:** 75% = $634.65 **Future End Date:**
34833	EXTERNAL STENTS, application of, to restore venous valve competency to deep vein or veins (more than 1 stent) (Anaes.) (Assist.) **Fee:** $1,098.05 **Benefit:** 75% = $823.55 **Future End Date:**
	SYMPATHECTOMY
35000	Lumbar sympathectomy (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $846.15 **Benefit:** 75% = $634.65 **Future End Date:**
35003	CERVICAL OR UPPER THORACIC SYMPATHECTOMY by any surgical approach (Anaes.) (Assist.) (See para TN.8.295 of explanatory notes to this Category) **Fee:** $1,098.05 **Benefit:** 75% = $823.55 **Future End Date:**
35006	CERVICAL OR UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (Anaes.) (Assist.) (See para TN.8.295 of explanatory notes to this Category) **Fee:** $1,377.15 **Benefit:** 75% = $1032.90 **Future End Date:**
35009	LUMBAR SYMPATHECTOMY, where operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (Anaes.) (Assist.) **Fee:** $1,070.90 **Benefit:** 75% = $803.20 **Future End Date:**
35012	SACRAL or PRE-SACRAL SYMPATHECTOMY (Anaes.) (Assist.) **Fee:** $846.15 **Benefit:** 75% = $634.65 **Future End Date:**
	DEBRIDEMENT AND AMPUTATIONS FOR VASCULAR DISEASE
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.) **Fee:** $441.15 **Benefit:** 75% = $330.90 **Future End Date:**
35103	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (Anaes.) **Fee:** $280.75 **Benefit:** 75% = $210.60 **Future End Date:**
	MISCELLANEOUS VASCULAR PROCEDURES
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.) **Fee:** $205.30 **Benefit:** 75% = $154.00 **Future End Date:**

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.) **Fee:** $978.00 **Benefit:** 75% = $733.50 **Future End Date:**
	ENDOVASCULAR INTERVENTIONAL PROCEDURES
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $616.85 **Benefit:** 75% = $462.65 **Future End Date:**
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.) **Fee:** $790.85 **Benefit:** 75% = $593.15 **Future End Date:**
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.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $730.00 **Benefit:** 75% = $547.50 **Future End Date:**
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.) (See para TN.8.37 of explanatory notes to this Category) **Fee:** $1,341.90 **Benefit:** 75% = $1006.45 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $912.40 **Benefit:** 75% = $684.30 **Future End Date:**
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.) **Fee:** $1,034.15 **Benefit:** 75% = $775.65

	Future End Date:
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.) **Fee:** $1,034.15 **Benefit:** 75% = $775.65 **Future End Date:**
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.) (See para TN.8.38 of explanatory notes to this Category) **Fee:** $425.85 **Benefit:** 75% = $319.40 85% = $362.00 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $763.30 **Benefit:** 75% = $572.50 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,025.35 **Benefit:** 75% = $769.05 **Future End Date:**
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.) (See para GN.1.2, TN.8.32 of explanatory notes to this Category) **Fee:** $973.45 **Benefit:** 75% = $730.10 **Future End Date:**
35324	ANGIOSCOPY not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $365.05 **Benefit:** 75% = $273.80 **Future End Date:**
35327	ANGIOSCOPY combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $489.25 **Benefit:** 75% = $366.95

	Future End Date:
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.) (See para GN.1.2, GN.10.26 of explanatory notes to this Category) **Fee:** $616.85 **Benefit:** 75% = $462.65 **Future End Date:**
35331	RETRIEVAL OF INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (Anaes.) **Fee:** $709.15 **Benefit:** 75% = $531.90 **Future End Date:**
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.) **Fee:** $991.25 **Benefit:** 75% = $743.45 **Future End Date:**
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.) **Fee:** $850.10 **Benefit:** 75% = $637.60 **Future End Date:**
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.) **Fee:** $709.15 **Benefit:** 75% = $531.90 **Future End Date:**
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.) **Fee:** $568.15 **Benefit:** 75% = $426.15 **Future End Date:**

	INTERVENTIONAL RADIOLOGY PROCEDURES
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.) **Fee:** $817.25 **Benefit:** 75% = $612.95 **Future End Date:**
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. (See para TN.3.1, TN.8.40 of explanatory notes to this Category) **Fee:** $414.85 **Benefit:** 75% = $311.15 **Future End Date:**
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.) (See para TN.3.1, TN.8.40 of explanatory notes to this Category) **Fee:** $973.45 **Benefit:** 75% = $730.10 **Future End Date:**
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.) (See para TN.3.1, TN.8.40 of explanatory notes to this Category) **Fee:** $730.20 **Benefit:** 75% = $547.65 **Future End Date:**
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.) (See para GN.1.2, TN.8.34 of explanatory notes to this Category) **Fee:** $973.45 **Benefit:** 75% = $730.10 **Future End Date:**
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.) (See para GN.1.2, TN.8.35 of explanatory notes to this Category) **Fee:** $3,420.15 **Benefit:** 75% = $2565.15 **Future End Date:**
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.) (See para TR.8.1 of explanatory notes to this Category) **Fee:** $4,189.15 **Benefit:** 75% = $3141.90 **Future End Date:**

	Group T8. Surgical Operations
	Subgroup 4. Gynaecological
35500	Gynaecological examination under anaesthesia, other than a service associated with a service to which another item in this Group applies (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $97.30 **Benefit:** 75% = $73.00 **Future End Date:**

35501	A medical service to which item 35503, 35506, 14206 or 30062 applies, if the service is bulk-billed in relation to the fees for: (a) that item; and (b) any other item in this Schedule applying to the service (See para TN.0.1 of explanatory notes to this Category) **Derived Fee:** 40% of the fee for the co-claimed service - performed in conjunction with a service (the co-claimed service) to which any of items 35503, 35506, 14206 and/or 30062 apply. **Future End Date:**
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.) (See para TN.0.1 of explanatory notes to this Category) **Fee:** $221.55 **Benefit:** 75% = $166.20 85% = $188.35 **Future End Date:**
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.) (See para GN.1.2, TN.0.1 of explanatory notes to this Category) **Fee:** $137.95 **Benefit:** 75% = $103.50 **Future End Date:**
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.) **Fee:** $208.75 **Benefit:** 75% = $156.60 **Future End Date:**
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.) **Fee:** $307.60 **Benefit:** 75% = $230.70 **Future End Date:**
35509	HYMENECTOMY (Anaes.) **Fee:** $107.10 **Benefit:** 75% = $80.35 85% = $91.05 **Future End Date:**
35513	Bartholin's abscess, cyst or gland, excision of (Anaes.) **Fee:** $265.35 **Benefit:** 75% = $199.05 85% = $225.55 **Future End Date:**
35517	Bartholin's abscess, cyst or gland, marsupialisation of (Anaes.) **Fee:** $174.85 **Benefit:** 75% = $131.15 85% = $148.65 **Future End Date:**
35518	Ovarian cyst aspiration, for cysts of at least 4 cm in diameter in a premenopausal patient and at least 2 cm in diameter in a postmenopausal patient, by abdominal or vaginal route, using interventional

	imaging techniques and not associated with services provided for assisted reproductive techniques, and not in cases of suspected or possible malignancy (Anaes.) (See para TN.4.11 of explanatory notes to this Category) **Fee:** $248.80 **Benefit:** 75% = $186.60 85% = $211.50 **Future End Date:**
35527	Urethral caruncle, symptomatic excision of, if: (a) conservative management has failed; or (b) there is a suspicion of malignancy (H) (Anaes.) **Fee:** $174.85 **Benefit:** 75% = $131.15 **Future End Date:**
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.) (See para TN.8.123 of explanatory notes to this Category) **Fee:** $418.70 **Benefit:** 75% = $314.05 **Future End Date:**
35534	Vulvoplasty or labioplasty, in a patient aged 18 years or more, performed by a specialist in the practice of the specialist's specialty, for a structural abnormality that is causing significant functional impairment, if the patient's labium extends more than 8 cm below the vaginal introitus while the patient is in a standing resting position (Anaes.) (See para TN.8.123 of explanatory notes to this Category) **Fee:** $418.70 **Benefit:** 75% = $314.05 **Future End Date:**
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.) (See para GN.1.2, TN.8.235 of explanatory notes to this Category) **Fee:** $417.05 **Benefit:** 75% = $312.80 **Future End Date:**
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.) **Fee:** $326.70 **Benefit:** 75% = $245.05 85% = $277.70 **Future End Date:**
35545	Colposcopically directed laser therapy for condylomata, unsuccessfully treated by other methods (Anaes.) **Fee:** $219.70 **Benefit:** 75% = $164.80 85% = $186.75 **Future End Date:**

35548	VULVECTOMY, radical, for malignancy (H) (Anaes.) (Assist.) (See para TN.8.235, TN.8.239 of explanatory notes to this Category) **Fee:** $1,497.40 **Benefit:** 75% = $1123.05 **Future End Date:**
35551	Pelvic lymph nodes, radical excision of, unilateral, or sentinel node dissection (including any pre-operative injection) (Anaes.) (Assist.) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 **Future End Date:**
35552	Pelvic lymph nodes, radical excision of, unilateral or sentinel node dissection, following similar previous dissection, radiation or chemotherapy (H) (Anaes.) (Assist.) **Fee:** $1,665.05 **Benefit:** 75% = $1248.80 **Future End Date:**
35554	VAGINA, DILATATION OF, as an independent procedure including any associated consultation (Anaes.) **Fee:** $52.00 **Benefit:** 75% = $39.00 85% = $44.20 **Future End Date:**
35557	Vagina, complete excision of benign tumour (including Gartner duct cyst), with histological documentation (Anaes.) (See para TN.8.237 of explanatory notes to this Category) **Fee:** $256.65 **Benefit:** 75% = $192.50 85% = $218.20 **Future End Date:**
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.) (See para TN.8.235, TN.8.238 of explanatory notes to this Category) **Fee:** $818.60 **Benefit:** 75% = $613.95 **Future End Date:**
35561	VAGINECTOMY, radical, for proven invasive malignancy - 1 surgeon (H) (Anaes.) (Assist.) (See para TN.8.235 of explanatory notes to this Category) **Fee:** $1,837.25 **Benefit:** 75% = $1377.95 **Future End Date:**
35562	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - abdominal surgeon (including aftercare) (H) (Anaes.) (Assist.) (See para TN.8.235 of explanatory notes to this Category) **Fee:** $1,547.75 **Benefit:** 75% = $1160.85 **Future End Date:**
35564	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - perineal surgeon (H) (Assist.) (See para TN.8.235 of explanatory notes to this Category) **Fee:** $773.90 **Benefit:** 75% = $580.45 **Future End Date:**

35565	VAGINAL RECONSTRUCTION for congenital absence, gynatresia or urogenital sinus (Anaes.) (Assist.) **Fee:** $818.60 **Benefit:** 75% = $613.95 **Future End Date:**
35566	VAGINAL SEPTUM, excision of, for correction of double vagina (Anaes.) (Assist.) **Fee:** $475.45 **Benefit:** 75% = $356.60 **Future End Date:**
35568	Procedures for the management of symptomatic upper vaginal (vault or cervical) prolapse by sacrospinous or ilococcygeus fixation (H) (Anaes.) (Assist.) **Fee:** $747.55 **Benefit:** 75% = $560.70 **Future End Date:**
35569	PLASTIC REPAIR TO ENLARGE VAGINAL ORIFICE (Anaes.) **Fee:** $192.55 **Benefit:** 75% = $144.45 **Future End Date:**
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.) **Fee:** $662.95 **Benefit:** 75% = $497.25 **Future End Date:**
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.) **Fee:** $662.95 **Benefit:** 75% = $497.25 **Future End Date:**
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.)

	Fee: $994.45 **Benefit:** 75% = $745.85 **Future End Date:**
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.) **Fee:** $807.35 **Benefit:** 75% = $605.55 **Future End Date:**
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.) **Fee:** $807.35 **Benefit:** 75% = $605.55 **Future End Date:**
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.) (See para TN.8.140 of explanatory notes to this Category) **Fee:** $662.95 **Benefit:** 75% = $497.25 **Future End Date:**
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.) (See para TN.8.140 of explanatory notes to this Category) **Fee:** $994.45 **Benefit:** 75% = $745.85 **Future End Date:**
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.)

	Fee: $1,763.25 **Benefit:** 75% = $1322.45 **Future End Date:**
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.) (See para TN.8.2 of explanatory notes to this Category) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 **Future End Date:**
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.) (See para TN.8.2 of explanatory notes to this Category) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 **Future End Date:**
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.) **Fee:** $747.55 **Benefit:** 75% = $560.70 **Future End Date:**
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.) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 **Future End Date:**
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.) **Fee:** $1,763.25 **Benefit:** 75% = $1322.45 **Future End Date:**
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.) **Fee:** $907.10 **Benefit:** 75% = $680.35 **Future End Date:**
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.) **Fee:** $76.55 **Benefit:** 75% = $57.45 85% = $65.10 **Future End Date:**
35609	Cervix, cone biopsy or amputation (H) (Anaes.) (See para TN.8.233, TN.8.235, TN.8.2 of explanatory notes to this Category) **Fee:** $260.90 **Benefit:** 75% = $195.70 **Future End Date:**
35610	Cervix, cone biopsy for histologically proven malignancy (H) (Anaes.) (See para TN.8.233, TN.8.235, TN.8.2 of explanatory notes to this Category) **Fee:** $456.60 **Benefit:** 75% = $342.45

	Future End Date:
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.) **Fee:** $76.55 **Benefit:** 75% = $57.45 85% = $65.10 **Future End Date:**
35612	Cervix, residual stump, removal of, by abdominal approach for non-malignant lesions (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $605.60 **Benefit:** 75% = $454.20 **Future End Date:**
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 (See para TN.8.42, TN.8.233 of explanatory notes to this Category) **Fee:** $76.45 **Benefit:** 75% = $57.35 85% = $65.00 **Future End Date:**
35615	Vulva or vagina, biopsy of, when performed in conjunction with a service to which item 35614 applies **Fee:** $84.25 **Benefit:** 75% = $63.20 85% = $71.65 **Future End Date:**
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.) **Fee:** $538.10 **Benefit:** 75% = $403.60 **Future End Date:**
35620	Endometrial biopsy for pathological assessment in women with abnormal uterine bleeding or post-menopausal bleeding (Anaes.) **Fee:** $63.85 **Benefit:** 75% = $47.90 85% = $54.30 **Future End Date:**
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.) **Fee:** $721.10 **Benefit:** 75% = $540.85 **Future End Date:**
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.) **Fee:** $980.60 **Benefit:** 75% = $735.45 **Future End Date:**

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 (See para TN.8.43 of explanatory notes to this Category) **Fee:** $268.25 **Benefit:** 75% = $201.20 85% = $228.05 **Future End Date:**
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.) **Fee:** $219.05 **Benefit:** 75% = $164.30 **Future End Date:**
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.) (See para TN.1.4, TN.8.248, TN.8.229, TN.8.2 of explanatory notes to this Category) **Fee:** $851.65 **Benefit:** 75% = $638.75 **Future End Date:**
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.) (See para TN.1.4, TN.8.248, TN.8.229, TN.8.2 of explanatory notes to this Category) **Fee:** $1,064.40 **Benefit:** 75% = $798.30 **Future End Date:**
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.) (See para TN.8.249 of explanatory notes to this Category) **Fee:** $260.90 **Benefit:** 75% = $195.70 85% = $221.80 **Future End Date:**
35635	Hysteroscopy involving division of: (a) a uterine septum; or (b) moderate to severe intrauterine adhesions (H) (Anaes.) (See para TN.8.249 of explanatory notes to this Category) **Fee:** $358.50 **Benefit:** 75% = $268.90 **Future End Date:**
35636	Hysteroscopy, resection of myoma or myoma and uterine septum (if both are performed) (H) (Anaes.) **Fee:** $518.30 **Benefit:** 75% = $388.75 **Future End Date:**

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.) (See para TN.1.4, TN.8.46, TN.8.248, TN.8.229 of explanatory notes to this Category) **Fee:** $486.65 **Benefit:** 75% = $365.00 **Future End Date:**
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.) (See para TN.8.44 of explanatory notes to this Category) **Fee:** $219.05 **Benefit:** 75% = $164.30 85% = $186.20 **Future End Date:**
35641	Severe endometriosis, laparoscopic resection of, involving 2 of the following procedures: (a) resection of the pelvic side wall including dissection of endometriosis or scar tissue from the ureter; (b) resection of the Pouch of Douglas; (c) resection of an ovarian endometrioma greater than 2 cm in diameter; (d) dissection of bowel from uterus from the level of the endocervical junction or above (H) (Anaes.) (Assist.) (See para TN.1.4, TN.8.248, TN.8.229 of explanatory notes to this Category) **Fee:** $1,487.40 **Benefit:** 75% = $1115.55 **Future End Date:**
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.) **Fee:** $260.90 **Benefit:** 75% = $195.70 85% = $221.80 **Future End Date:**
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.) (See para TN.8.45, TN.8.234 of explanatory notes to this Category) **Fee:** $243.75 **Benefit:** 75% = $182.85 85% = $207.20 **Future End Date:**

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.) (See para TN.8.45, TN.8.234 of explanatory notes to this Category) **Fee:** $381.45 **Benefit:** 75% = $286.10 85% = $324.25 **Future End Date:**
35647	Cervix, complete excision of the endocervical transformation zone, using large loop or laser therapy, including any local anaesthesia and biopsies (Anaes.) (See para TN.8.45, TN.8.233, TN.8.235 of explanatory notes to this Category) **Fee:** $243.75 **Benefit:** 75% = $182.85 85% = $207.20 **Future End Date:**
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.) (See para TN.8.45, TN.8.233, TN.8.235 of explanatory notes to this Category) **Fee:** $381.45 **Benefit:** 75% = $286.10 85% = $324.25 **Future End Date:**
35649	Myomectomy, one or more myomas, when undertaken by an open abdominal approach (H) (Anaes.) (Assist.) **Fee:** $641.50 **Benefit:** 75% = $481.15 **Future End Date:**
35653	Hysterectomy, abdominal, with or without removal of fallopian tubes and ovaries (H) (Anaes.) (Assist.) (See para TN.8.232 of explanatory notes to this Category) **Fee:** $807.60 **Benefit:** 75% = $605.70 **Future End Date:**
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.) **Fee:** $807.60 **Benefit:** 75% = $605.70 **Future End Date:**
35658	Uterus (at least equivalent in size to a 10 week gravid uterus), debulking of, prior to vaginal or laparoscopic removal at hysterectomy or myoma of at least 4 cm removed by laparoscopy when retrieved from the abdomen (H) (Anaes.) (Assist.) (See para TN.8.47, TN.8.229 of explanatory notes to this Category) **Fee:** $498.05 **Benefit:** 75% = $373.55 **Future End Date:**
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.) (See para TN.8.232 of explanatory notes to this Category) **Fee:** $2,019.20 **Benefit:** 75% = $1514.40 **Future End Date:**
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.) (See para TN.8.235 of explanatory notes to this Category) **Fee:** $1,907.25 **Benefit:** 75% = $1430.45 **Future End Date:**
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.) (See para TN.8.235, TN.8.2 of explanatory notes to this Category) **Fee:** $2,215.80 **Benefit:** 75% = $1661.85 **Future End Date:**
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.) (See para TN.8.2 of explanatory notes to this Category) **Fee:** $2,215.80 **Benefit:** 75% = $1661.85 **Future End Date:**
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.) (See para TN.8.2 of explanatory notes to this Category) **Fee:** $1,738.20 **Benefit:** 75% = $1303.65 **Future End Date:**
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.) **Fee:** $907.00 **Benefit:** 75% = $680.25 **Future End Date:**
35674	Ultrasound guided needling and injection of ectopic pregnancy (H)

	(See para TN.4.11 of explanatory notes to this Category) **Fee:** $248.80 **Benefit:** 75% = $186.60 **Future End Date:**
35680	Bicornuate uterus, plastic reconstruction for (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $696.60 **Benefit:** 75% = $522.45 **Future End Date:**
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.) (See para TN.8.46 of explanatory notes to this Category) **Fee:** $189.90 **Benefit:** 75% = $142.45 **Future End Date:**
35694	Tuboplasty (salpingostomy or salpingolysis), unilateral or bilateral, one or more procedures (H) (Anaes.) (Assist.) **Fee:** $763.20 **Benefit:** 75% = $572.40 **Future End Date:**
35697	Microsurgical or laparoscopic tuboplasty (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.) **Fee:** $1,132.50 **Benefit:** 75% = $849.40 **Future End Date:**
35700	FALLOPIAN TUBES, unilateral microsurgical or laparoscopic anastomosis of (H) (Anaes.) (Assist.) **Fee:** $873.90 **Benefit:** 75% = $655.45 **Future End Date:**
35703	HYDROTUBATION OF FALLOPIAN TUBES as a nonrepetitive procedure (Anaes.) (See para TN.8.230 of explanatory notes to this Category) **Fee:** $80.80 **Benefit:** 75% = $60.60 85% = $68.70 **Future End Date:**
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.) (See para TN.8.232 of explanatory notes to this Category) **Fee:** $1,021.15 **Benefit:** 75% = $765.90 **Future End Date:**
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.) (See para TN.8.57, TN.8.235 of explanatory notes to this Category) **Fee:** $1,909.00 **Benefit:** 75% = $1431.75 **Future End Date:**
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.) (See para TN.8.235, TN.8.236, TN.8.2 of explanatory notes to this Category) **Fee:** $3,817.95 **Benefit:** 75% = $2863.50 **Future End Date:**
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.) (See para TN.8.233, TN.8.235 of explanatory notes to this Category) **Fee:** $1,660.15 **Benefit:** 75% = $1245.15 **Future End Date:**
35724	Para-aortic lymph node dissection (pelvic or above the aortic bifurcation) after prior similar dissection, radiotherapy or chemotherapy for malignancy (H) (Anaes.) (Assist.) (See para TN.8.233, TN.8.235, TN.8.2 of explanatory notes to this Category) **Fee:** $2,497.65 **Benefit:** 75% = $1873.25 **Future End Date:**
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.) **Fee:** $578.25 **Benefit:** 75% = $433.70 **Future End Date:**
35729	OVARIAN TRANSPOSITION out of the pelvis, in conjunction with radical hysterectomy for invasive malignancy (Anaes.) **Fee:** $260.70 **Benefit:** 75% = $195.55 **Future End Date:**
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.)

	Fee: $260.70 **Benefit:** 75% = $195.55 **Future End Date:**
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.) (See para TN.8.231, TN.8.229 of explanatory notes to this Category) **Fee:** $939.10 **Benefit:** 75% = $704.35 **Future End Date:**
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.) (See para TN.8.231, TN.8.229, TN.8.2 of explanatory notes to this Category) **Fee:** $939.10 **Benefit:** 75% = $704.35 **Future End Date:**
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.) (See para TN.8.231, TN.8.229 of explanatory notes to this Category) **Fee:** $1,038.35 **Benefit:** 75% = $778.80 **Future End Date:**
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.) (See para TN.8.231, TN.8.229 of explanatory notes to this Category) **Fee:** $2,006.55 **Benefit:** 75% = $1504.95 **Future End Date:**
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.) (See para TN.8.231, TN.8.229 of explanatory notes to this Category) **Fee:** $1,712.60 **Benefit:** 75% = $1284.45 **Future End Date:**
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.) **Fee:** $674.30 **Benefit:** 75% = $505.75 **Future End Date:**

	Group T8. Surgical Operations
	Subgroup 5. Urological
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.) **Fee:** $828.85 **Benefit:** 75% = $621.65 **Future End Date:**
37226	Prostate or prostatic bed, needle biopsy of, using prostatic magnetic resonance imaging techniques and obtaining 1 or more prostatic specimens. (Anaes.) (See para TN.8.2 of explanatory notes to this Category) **Fee:** $336.20 **Benefit:** 75% = $252.15 85% = $285.80 **Future End Date:**
	GENERAL
36502	PELVIC LYMPHADENECTOMY, open or laparoscopic, or both, unilateral or bilateral (Anaes.) (Assist.) **Fee:** $818.60 **Benefit:** 75% = $613.95 **Future End Date:**
36503	RENAL TRANSPLANT (not being a service to which item 36506 or 36509 applies) (Anaes.) (Assist.) **Fee:** $1,665.05 **Benefit:** 75% = $1248.80 **Future End Date:**
36506	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together vascular anastomosis including aftercare (Anaes.) (Assist.) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 **Future End Date:**
36509	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together ureterovesical anastomosis including aftercare (Assist.) **Fee:** $937.15 **Benefit:** 75% = $702.90 **Future End Date:**
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.) (See para TN.8.154 of explanatory notes to this Category) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 **Future End Date:**
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.) (See para TN.8.154 of explanatory notes to this Category) **Fee:** $1,545.35 **Benefit:** 75% = $1159.05 **Future End Date:**

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.) (See para TN.8.154 of explanatory notes to this Category) **Fee:** $1,326.15 **Benefit:** 75% = $994.65 **Future End Date:**
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/1.73m^2; other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) **Fee:** $1,884.40 **Benefit:** 75% = $1413.30 **Future End Date:**
36528	Nephrectomy, radical, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10 cm in diameter, other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) (See para TN.8.154 of explanatory notes to this Category) **Fee:** $1,545.35 **Benefit:** 75% = $1159.05 **Future End Date:**
36529	Nephrectomy, radical, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, with or without adrenalectomy: (a) for a tumour 10 cm or more in diameter; or (b) if complicated by previous open or laparoscopic surgery on the same kidney; other than a service associated with a service to which item 30390 or 30627 applies (Anaes.) (Assist.) (See para TN.8.154 of explanatory notes to this Category) **Fee:** $1,907.25 **Benefit:** 75% = $1430.45 **Future End Date:**
36530	Renal cell carcinoma, not more than 4 cm in diameter, destruction of, by percutaneous, laparoscopic or open cryoablation (including any associated imaging services), if: (a) malignancy has previously been confirmed by histopathological examination; and (b) a multi-disciplinary team has reviewed treatment options for the patient and assessed that partial nephrectomy is not suitable; and (c) the service is not a service associated with a service to which item 36522 or 36525 applies (H) (Anaes.) **Fee:** $969.25 **Benefit:** 75% = $726.95 **Future End Date:**

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.) (See para TN.8.154 of explanatory notes to this Category) **Fee:** $1,385.85 **Benefit:** 75% = $1039.40 **Future End Date:**
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.) (See para TN.8.154 of explanatory notes to this Category) **Fee:** $1,989.05 **Benefit:** 75% = $1491.80 **Future End Date:**
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.) (See para TN.8.154 of explanatory notes to this Category) **Fee:** $2,350.95 **Benefit:** 75% = $1763.25 **Future End Date:**
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.) **Fee:** $827.50 **Benefit:** 75% = $620.65 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,545.35 **Benefit:** 75% = $1159.05 **Future End Date:**
36546	Extracorporeal shock wave lithotripsy (ESWL) to urinary tract and post-treatment care for 3 days, including pre-treatment consultations, unilateral (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $827.50 **Benefit:** 75% = $620.65 **Future End Date:**
36549	Ureterolithotomy, by open, laparoscopic or robot-assisted approach (Anaes.) (Assist.) **Fee:** $997.15 **Benefit:** 75% = $747.90 **Future End Date:**
36552	NEPHROSTOMY or pyelostomy, open, as an independent procedure (Anaes.) (Assist.) **Fee:** $887.45 **Benefit:** 75% = $665.60 **Future End Date:**
36558	Renal cyst or cysts, excision or unroofing of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category)

	Fee: $777.75 **Benefit:** 75% = $583.35 **Future End Date:**
36561	Renal biopsy, performed under image guidance (closed) (Anaes.) **Fee:** $206.45 **Benefit:** 75% = $154.85 85% = $175.50 **Future End Date:**
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.) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 **Future End Date:**
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.) (See para TN.8.155 of explanatory notes to this Category) **Fee:** $1,216.45 **Benefit:** 75% = $912.35 **Future End Date:**
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.) **Fee:** $1,545.35 **Benefit:** 75% = $1159.05 **Future End Date:**
36573	DIVIDED URETER, repair of (Anaes.) (Assist.) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 **Future End Date:**
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.) (See para TN.8.154 of explanatory notes to this Category) **Fee:** $1,385.85 **Benefit:** 75% = $1039.40 **Future End Date:**
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.) **Fee:** $887.45 **Benefit:** 75% = $665.60 **Future End Date:**
36585	URETER, transplantation of, into skin (Anaes.) (Assist.) **Fee:** $887.45 **Benefit:** 75% = $665.60 **Future End Date:**

36588	URETER, reimplantation into bladder (Anaes.) (Assist.) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 **Future End Date:**
36591	URETER, reimplantation into bladder with psoas hitch or Boari flap or both (Anaes.) (Assist.) **Fee:** $1,326.15 **Benefit:** 75% = $994.65 **Future End Date:**
36594	URETER, transplantation of, into intestine (Anaes.) (Assist.) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 **Future End Date:**
36597	URETER, transplantation of, into another ureter (Anaes.) (Assist.) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 **Future End Date:**
36600	Ureter, transplantation of, into isolated intestinal segment, unilateral (H) (Anaes.) (Assist.) (See para GN.1.2, TN.8.153 of explanatory notes to this Category) **Fee:** $1,326.15 **Benefit:** 75% = $994.65 **Future End Date:**
36603	URETERS, transplantation of, into isolated intestinal segment, bilateral (Anaes.) (Assist.) (See para TN.8.153 of explanatory notes to this Category) **Fee:** $1,545.35 **Benefit:** 75% = $1159.05 **Future End Date:**
36604	Ureteric stent, passage of through percutaneous nephrostomy tube, using interventional radiology techniques, but not including imaging (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $320.35 **Benefit:** 75% = $240.30 **Future End Date:**
36606	INTESTINAL URINARY RESERVOIR, continent, formation of, including formation of nonreturn valves and implantation of ureters (1 or both) into reservoir (Anaes.) (Assist.) **Fee:** $2,771.80 **Benefit:** 75% = $2078.85 **Future End Date:**
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.) **Fee:** $826.75 **Benefit:** 75% = $620.10 **Future End Date:**

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.) **Fee:** $320.35 **Benefit:** 75% = $240.30 **Future End Date:**
36609	Intestinal urinary conduit, reservoir or ureterostomy, revision of (Anaes.) (Assist.) **Fee:** $887.45 **Benefit:** 75% = $665.60 **Future End Date:**
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.) **Fee:** $2,124.55 **Benefit:** 75% = $1593.45 **Future End Date:**
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.) **Fee:** $3,351.00 **Benefit:** 75% = $2513.25 **Future End Date:**
36612	URETER, exploration of, with or without drainage of, as an independent procedure (Anaes.) (Assist.) **Fee:** $777.75 **Benefit:** 75% = $583.35 **Future End Date:**
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.) (See para TN.8.156 of explanatory notes to this Category) **Fee:** $887.45 **Benefit:** 75% = $665.60 **Future End Date:**
36618	REDUCTION URETEROPLASTY (Anaes.) (Assist.) **Fee:** $777.75 **Benefit:** 75% = $583.35 **Future End Date:**
36621	CLOSURE OF CUTANEOUS URETEROSTOMY (Anaes.) (Assist.) **Fee:** $556.05 **Benefit:** 75% = $417.05 **Future End Date:**
36624	Nephrostomy, percutaneous, using interventional radiology techniques, but not including imaging (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $668.05 **Benefit:** 75% = $501.05 **Future End Date:**

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.) **Fee:** $827.50 **Benefit:** 75% = $620.65 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $887.45 **Benefit:** 75% = $665.60 **Future End Date:**
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.) **Fee:** $478.65 **Benefit:** 75% = $359.00 **Future End Date:**
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.) **Fee:** $997.15 **Benefit:** 75% = $747.90 **Future End Date:**
36645	NEPHROSCOPY, percutaneous, with removal or destruction of a stone greater than 3 cm in any dimension, or for 3 or more stones (Anaes.) (Assist.) **Fee:** $1,276.30 **Benefit:** 75% = $957.25 **Future End Date:**
36649	Nephrostomy drainage tube, exchange of, using interventional radiology techniques, but not including imaging (Anaes.) (Assist.) **Fee:** $320.35 **Benefit:** 75% = $240.30 85% = $272.30 **Future End Date:**
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.) **Fee:** $179.20 **Benefit:** 75% = $134.40 **Future End Date:**
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.) **Fee:** $777.75 **Benefit:** 75% = $583.35 **Future End Date:**
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.) **Fee:** $997.15 **Benefit:** 75% = $747.90 **Future End Date:**

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.) **Fee:** $1,276.30 **Benefit:** 75% = $957.25 **Future End Date:**
	OPERATIONS ON BLADDER
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.) (See para GN.1.2, TN.8.2 of explanatory notes to this Category) **Fee:** $352.85 **Benefit:** 75% = $264.65 **Future End Date:**
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.) (See para TN.8.2 of explanatory notes to this Category) **Fee:** $277.30 **Benefit:** 75% = $208.00 85% = $235.75 **Future End Date:**
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.) (See para GN.1.2, TN.8.2 of explanatory notes to this Category) **Fee:** $464.55 **Benefit:** 75% = $348.45 **Future End Date:**
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 2 cm in diameter, not being a service to which item 36845 applies (H) (Anaes.) (See para GN.1.2, TN.8.2 of explanatory notes to this Category) **Fee:** $905.40 **Benefit:** 75% = $679.05 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $791.05 **Benefit:** 75% = $593.30 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $710.45 **Benefit:** 75% = $532.85 **Future End Date:**
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 **Fee:** $150.10 **Benefit:** 75% = $112.60 85% = $127.60 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $399.80 **Benefit:** 75% = $299.85 **Future End Date:**
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.) **Fee:** $187.05 **Benefit:** 75% = $140.30 85% = $159.00 **Future End Date:**
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.) **Fee:** $187.05 **Benefit:** 75% = $140.30 85% = $159.00 **Future End Date:**
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 **Fee:** $239.35 **Benefit:** 75% = $179.55 85% = $203.45 **Future End Date:**
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 **Fee:** $239.35 **Benefit:** 75% = $179.55 85% = $203.45 **Future End Date:**
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 **Fee:** $239.35 **Benefit:** 75% = $179.55 85% = $203.45 **Future End Date:**
36800	BLADDER, catheterisation of, where no other procedure is performed (Anaes.) **Fee:** $33.00 **Benefit:** 75% = $24.75 85% = $28.05 **Future End Date:**
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.) (See para GN.1.2, TN.8.51 of explanatory notes to this Category) **Fee:** $558.15 **Benefit:** 75% = $418.65 **Future End Date:**
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.) **Fee:** $777.75 **Benefit:** 75% = $583.35 **Future End Date:**
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.) **Fee:** $997.15 **Benefit:** 75% = $747.90 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $387.05 **Benefit:** 75% = $290.30 **Future End Date:**
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.) (See para TN.8.158 of explanatory notes to this Category) **Fee:** $199.50 **Benefit:** 75% = $149.65 85% = $169.60 **Future End Date:**
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.) (See para TN.8.9 of explanatory notes to this Category) **Fee:** $284.70 **Benefit:** 75% = $213.55 85% = $242.00 **Future End Date:**
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.) (See para GN.1.2, GN.10.26 of explanatory notes to this Category) **Fee:** $331.05 **Benefit:** 75% = $248.30 **Future End Date:**

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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $386.85 **Benefit:** 75% = $290.15 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $552.45 **Benefit:** 75% = $414.35 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $635.20 **Benefit:** 75% = $476.40 **Future End Date:**
36824	Cystoscopy with ureteric catheterisation, unilateral or bilateral, other than a service associated with a service to which item 36818 applies (H) (Anaes.) (See para GN.1.2, GN.10.26 of explanatory notes to this Category) **Fee:** $255.10 **Benefit:** 75% = $191.35 **Future End Date:**
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.) (See para GN.1.2, TN.8.158 of explanatory notes to this Category) **Fee:** $275.15 **Benefit:** 75% = $206.40 **Future End Date:**
36830	CYSTOSCOPY, with ureteric meatotomy (Anaes.) (See para TN.8.158 of explanatory notes to this Category) **Fee:** $243.30 **Benefit:** 75% = $182.50 **Future End Date:**

36833	Cystoscopy with removal of ureteric stent or other foreign body in the lower urinary tract, unilateral (Anaes.) (See para GN.1.2, TN.8.158 of explanatory notes to this Category) **Fee:** $331.05 **Benefit:** 75% = $248.30 85% = $281.40 **Future End Date:**
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.) (See para GN.1.2, TN.8.2, TN.8.158 of explanatory notes to this Category) **Fee:** $275.15 **Benefit:** 75% = $206.40 85% = $233.90 **Future End Date:**
36840	Cystoscopy, with diathermy, resection or visual laser destruction of bladder tumour or other lesion of the bladder, for: (a) a tumour or lesion in only one quadrant of the bladder; or (b) a solitary tumour of not more than 2 cm in diameter; other than a service associated with a service to which item 36845 applies (H) (Anaes.) (See para GN.1.2, TN.8.158 of explanatory notes to this Category) **Fee:** $386.85 **Benefit:** 75% = $290.15 **Future End Date:**
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.) (See para TN.8.158 of explanatory notes to this Category) **Fee:** $389.20 **Benefit:** 75% = $291.90 **Future End Date:**
36845	Cystoscopy, with diathermy, resection or visual laser destruction of: (a) multiple tumours in 2 or more quadrants of the bladder; or (b) a solitary bladder tumour of more than 2 cm in diameter (H) (Anaes.) (See para GN.1.2, TN.8.158 of explanatory notes to this Category) **Fee:** $827.50 **Benefit:** 75% = $620.65 **Future End Date:**
36848	CYSTOSCOPY, with resection of ureterocele (Anaes.) (See para TN.8.158 of explanatory notes to this Category) **Fee:** $275.15 **Benefit:** 75% = $206.40 **Future End Date:**
36851	Cystoscopy, with injection into bladder wall, other than a service associated with a service to which item 18375 or 18379 applies (H) (Anaes.) (See para TN.8.158 of explanatory notes to this Category) **Fee:** $275.15 **Benefit:** 75% = $206.40 **Future End Date:**

36854	CYSTOSCOPY, with endoscopic incision or resection of external sphincter, bladder neck or both (Anaes.) (See para TN.8.158 of explanatory notes to this Category) **Fee:** $558.15 **Benefit:** 75% = $418.65 **Future End Date:**
36860	Endoscopic examination of intestinal conduit or reservoir (H) (Anaes.) (See para GN.1.2, TN.8.158 of explanatory notes to this Category) **Fee:** $199.50 **Benefit:** 75% = $149.65 **Future End Date:**
36863	Litholapaxy, with or without cystoscopy (Anaes.) (See para TN.8.158 of explanatory notes to this Category) **Fee:** $558.15 **Benefit:** 75% = $418.65 **Future End Date:**
37000	BLADDER, partial excision of (Anaes.) (Assist.) (See para TN.8.157 of explanatory notes to this Category) **Fee:** $887.45 **Benefit:** 75% = $665.60 **Future End Date:**
37004	BLADDER, repair of rupture (Anaes.) (Assist.) **Fee:** $777.75 **Benefit:** 75% = $583.35 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $498.50 **Benefit:** 75% = $373.90 **Future End Date:**
37011	Suprapubic stab cystotomy, other than a service associated with a service to which item 36827 applies (Anaes.) (See para TN.8.159 of explanatory notes to this Category) **Fee:** $111.70 **Benefit:** 75% = $83.80 85% = $94.95 **Future End Date:**
37014	BLADDER, total excision of (Anaes.) (Assist.) (See para TN.8.157 of explanatory notes to this Category) **Fee:** $1,276.30 **Benefit:** 75% = $957.25 **Future End Date:**
37015	Bladder, total excision of, following previous open, laparoscopic or robot-assisted surgery, or radiation therapy or chemotherapy to the pelvis (Anaes.) (Assist.) **Fee:** $1,531.50 **Benefit:** 75% = $1148.65

	Future End Date:
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.) **Fee:** $2,388.05 **Benefit:** 75% = $1791.05 **Future End Date:**
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.) **Fee:** $3,582.25 **Benefit:** 75% = $2686.70 **Future End Date:**
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.) **Fee:** $2,385.40 **Benefit:** 75% = $1789.05 **Future End Date:**
37020	BLADDER DIVERTICULUM, excision or obliteration of (Anaes.) (Assist.) **Fee:** $887.45 **Benefit:** 75% = $665.60 **Future End Date:**
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.) **Fee:** $3,577.95 **Benefit:** 75% = $2683.50 **Future End Date:**
37023	VESICAL FISTULA, cutaneous, operation for (Anaes.) **Fee:** $498.50 **Benefit:** 75% = $373.90 **Future End Date:**
37026	CUTANEOUS VESICOSTOMY, establishment of (Anaes.) (Assist.) **Fee:** $498.50 **Benefit:** 75% = $373.90 **Future End Date:**
37029	VESICOVAGINAL FISTULA, closure of, by abdominal approach (Anaes.) (Assist.) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 **Future End Date:**
37038	VESICOINTESTINAL FISTULA, closure of, excluding bowel resection (Anaes.) (Assist.) **Fee:** $827.90 **Benefit:** 75% = $620.95 **Future End Date:**
37039	Bladder stress incontinence, sling procedure for, using a non-autologous biological sling (Anaes.) (Assist.) **Fee:** $807.35 **Benefit:** 75% = $605.55 **Future End Date:**

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.) **Fee:** $1,090.75 **Benefit:** 75% = $818.10 **Future End Date:**
37041	BLADDER ASPIRATION by needle **Fee:** $55.75 **Benefit:** 75% = $41.85 85% = $47.40 **Future End Date:**
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.) **Fee:** $1,090.75 **Benefit:** 75% = $818.10 **Future End Date:**
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.) **Fee:** $927.70 **Benefit:** 75% = $695.80 **Future End Date:**
37045	CONTINENT CATHETERISATION BLADDER STOMAS (eg. Mitrofanoff), formation of (Anaes.) (Assist.) **Fee:** $1,710.00 **Benefit:** 75% = $1282.50 **Future End Date:**
37047	BLADDER ENLARGEMENT using intestine (Anaes.) (Assist.) **Fee:** $1,994.10 **Benefit:** 75% = $1495.60 **Future End Date:**
37048	Bladder neck closure for the management of urinary incontinence (Anaes.) (Assist.) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 **Future End Date:**
37050	BLADDER EXSTROPHY CLOSURE, not involving sphincter reconstruction (Anaes.) (Assist.) **Fee:** $887.45 **Benefit:** 75% = $665.60 **Future End Date:**
37053	BLADDER TRANSECTION AND RE-ANASTOMOSIS TO TRIGONE (Anaes.) (Assist.) **Fee:** $1,025.35 **Benefit:** 75% = $769.05 **Future End Date:**
	OPERATIONS ON PROSTATE
37200	Prostatectomy, by open, laparoscopic or robot-assisted approach (Anaes.) (Assist.) (See para TN.8.162 of explanatory notes to this Category) **Fee:** $1,216.45 **Benefit:** 75% = $912.35 **Future End Date:**
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.) (See para TN.8.53 of explanatory notes to this Category) **Fee:** $992.10 **Benefit:** 75% = $744.10 **Future End Date:**
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.) (See para TN.8.158 of explanatory notes to this Category) **Fee:** $1,247.30 **Benefit:** 75% = $935.50 **Future End Date:**
37204	Cystoscopy with insertion of prostatic implants for the treatment of benign prostatic hyperplasia (H) (Anaes.) **Fee:** $953.40 **Benefit:** 75% = $715.05 **Future End Date:**
37205	Prostate, ablation by water vapour with or without cystoscopy and with or without urethroscopy (H) (Anaes.) **Fee:** $387.05 **Benefit:** 75% = $290.30 **Future End Date:**
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.) **Fee:** $1,247.30 **Benefit:** 75% = $935.50 **Future End Date:**
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.) **Fee:** $668.05 **Benefit:** 75% = $501.05 **Future End Date:**
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.) **Fee:** $1,545.35 **Benefit:** 75% = $1159.05 **Future End Date:**
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.) (See para TN.8.161 of explanatory notes to this Category) **Fee:** $1,907.25 **Benefit:** 75% = $1430.45 **Future End Date:**

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.) (See para TN.8.161 of explanatory notes to this Category) **Fee:** $2,316.20 **Benefit:** 75% = $1737.15 **Future End Date:**
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.) (See para TN.8.161 of explanatory notes to this Category) **Fee:** $2,860.60 **Benefit:** 75% = $2145.45 **Future End Date:**
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.) (See para TN.8.161 of explanatory notes to this Category) **Fee:** $3,474.65 **Benefit:** 75% = $2606.00 **Future End Date:**
37215	Prostate, biopsy of, endoscopic, with or without cystoscopy (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $498.50 **Benefit:** 75% = $373.90 **Future End Date:**

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.) (See para TN.8.160 of explanatory notes to this Category) **Fee:** $168.10 **Benefit:** 75% = $126.10 85% = $142.90 **Future End Date:**
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.) (See para TN.8.54 of explanatory notes to this Category) **Fee:** $165.55 **Benefit:** 75% = $124.20 85% = $140.75 **Future End Date:**
37218	Prostate, injection into, one or more, excluding insertion of fiduciary markers (Anaes.) (See para TN.8.54 of explanatory notes to this Category) **Fee:** $165.55 **Benefit:** 75% = $124.20 85% = $140.75 **Future End Date:**
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.) (See para TN.8.160 of explanatory notes to this Category) **Fee:** $403.45 **Benefit:** 75% = $302.60 85% = $342.95 **Future End Date:**
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.) (See para TN.8.55 of explanatory notes to this Category) **Fee:** $1,249.80 **Benefit:** 75% = $937.35 **Future End Date:**
37221	Prostatic abscess, endoscopic drainage of (Anaes.) **Fee:** $558.15 **Benefit:** 75% = $418.65 **Future End Date:**

37223	PROSTATIC COIL, insertion of, under ultrasound control (Anaes.) **Fee:** $246.90 **Benefit:** 75% = $185.20 **Future End Date:**
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.) (See para GN.1.2, GN.10.26 of explanatory notes to this Category) **Fee:** $386.85 **Benefit:** 75% = $290.15 **Future End Date:**
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) (See para GN.1.2, TN.8.56 of explanatory notes to this Category) **Fee:** $677.20 **Benefit:** 75% = $507.90 **Future End Date:**
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.) **Fee:** $1,510.65 **Benefit:** 75% = $1133.00 **Future End Date:**
	OPERATIONS ON URETHRA, PENIS OR SCROTUM
37300	URETHRAL SOUNDS, passage of, as an independent procedure (Anaes.) **Fee:** $55.75 **Benefit:** 75% = $41.85 85% = $47.40 **Future End Date:**
37303	URETHRAL STRICTURE, dilatation of (Anaes.) **Fee:** $88.70 **Benefit:** 75% = $66.55 85% = $75.40 **Future End Date:**
37306	URETHRA, repair of rupture of distal section (Anaes.) (Assist.) **Fee:** $777.75 **Benefit:** 75% = $583.35 **Future End Date:**
37309	URETHRA, repair of rupture of prostatic or membranous segment (Anaes.) (Assist.) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 **Future End Date:**
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.) **Fee:** $331.05 **Benefit:** 75% = $248.30 **Future End Date:**

37321	URETHRAL MEATOTOMY, EXTERNAL (Anaes.) **Fee:** $111.70 **Benefit:** 75% = $83.80 85% = $94.95 **Future End Date:**
37324	Urethrotomy or urethrostomy, internal or external (Anaes.) (Assist.) **Fee:** $275.15 **Benefit:** 75% = $206.40 **Future End Date:**
37327	URETHROTOMY, optical, for urethral stricture (Anaes.) (Assist.) **Fee:** $386.85 **Benefit:** 75% = $290.15 **Future End Date:**
37330	URETHRECTOMY, partial or complete, for removal of tumour (Anaes.) (Assist.) **Fee:** $777.75 **Benefit:** 75% = $583.35 **Future End Date:**
37333	URETHROVAGINAL FISTULA, closure of (Anaes.) (Assist.) **Fee:** $668.05 **Benefit:** 75% = $501.05 **Future End Date:**
37336	URETHRORECTAL FISTULA, closure of (Anaes.) (Assist.) **Fee:** $887.45 **Benefit:** 75% = $665.60 **Future End Date:**
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.) **Fee:** $1,090.75 **Benefit:** 75% = $818.10 **Future End Date:**
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.) **Fee:** $287.15 **Benefit:** 75% = $215.40 85% = $244.10 **Future End Date:**
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.) **Fee:** $1,090.75 **Benefit:** 75% = $818.10 **Future End Date:**
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.) **Fee:** $1,090.75 **Benefit:** 75% = $818.10 **Future End Date:**
37342	URETHROPLASTY single stage operation (Anaes.) (Assist.)

	Fee: $997.15 **Benefit:** 75% = $747.90 **Future End Date:**
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.) **Fee:** $1,665.05 **Benefit:** 75% = $1248.80 **Future End Date:**
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.) **Fee:** $1,090.75 **Benefit:** 75% = $818.10 **Future End Date:**
37345	URETHROPLASTY 2 stage operation first stage (Anaes.) (Assist.) **Fee:** $827.50 **Benefit:** 75% = $620.65 **Future End Date:**
37348	URETHROPLASTY 2 stage operation second stage (Anaes.) (Assist.) **Fee:** $827.50 **Benefit:** 75% = $620.65 **Future End Date:**
37351	URETHROPLASTY, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $331.05 **Benefit:** 75% = $248.30 **Future End Date:**
37354	HYPOSPADIAS, meatotomy and hemicircumcision (Anaes.) (Assist.) **Fee:** $386.85 **Benefit:** 75% = $290.15 **Future End Date:**
37369	URETHRA, excision of prolapse of (Anaes.) **Fee:** $223.35 **Benefit:** 75% = $167.55 **Future End Date:**
37372	Urethral diverticulum, excision of (Anaes.) (Assist.) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 **Future End Date:**
37375	URETHRAL SPHINCTER, reconstruction by bladder tubularisation technique or similar procedure (Anaes.) (Assist.) **Fee:** $1,385.85 **Benefit:** 75% = $1039.40 **Future End Date:**
37381	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, perineal approach (Anaes.) (Assist.) **Fee:** $887.45 **Benefit:** 75% = $665.60 **Future End Date:**
37384	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, abdominal approach (Anaes.) (Assist.) **Fee:** $1,385.85 **Benefit:** 75% = $1039.40 **Future End Date:**

37387	ARTIFICIAL URINARY SPHINCTER, insertion of pressure regulating balloon and pump (Anaes.) (Assist.) **Fee:** $386.85 **Benefit:** 75% = $290.15 **Future End Date:**
37388	Artificial urinary sphincter, sterile, percutaneous adjustment of filling volume **Fee:** $117.25 **Benefit:** 75% = $87.95 85% = $99.70 **Future End Date:**
37390	ARTIFICIAL URINARY SPHINCTER, revision or removal of, with or without replacement (Anaes.) (Assist.) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 **Future End Date:**
37393	PRIAPISM, decompression by glanular stab cavernosospongiosum shunt or penile aspiration with or without lavage (Anaes.) **Fee:** $275.15 **Benefit:** 75% = $206.40 85% = $233.90 **Future End Date:**
37396	PRIAPISM, shunt operation for, not being a service to which item 37393 applies (Anaes.) (Assist.) **Fee:** $887.45 **Benefit:** 75% = $665.60 **Future End Date:**
37402	PENIS, partial amputation of (Anaes.) (Assist.) **Fee:** $558.15 **Benefit:** 75% = $418.65 **Future End Date:**
37405	PENIS, complete or radical amputation of (Anaes.) (Assist.) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 **Future End Date:**
37408	PENIS, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.) (Assist.) **Fee:** $558.15 **Benefit:** 75% = $418.65 **Future End Date:**
37411	Penis, repair of avulsion (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 **Future End Date:**
37415	Penis, injection of, for the investigation and treatment of erectile dysfunction. Applicable not more than twice in a 36-month period **Fee:** $55.75 **Benefit:** 75% = $41.85 85% = $47.40 **Future End Date:**
37417	Penis, correction of chordee by plication techniques including Nesbit's corporoplasty (Anaes.) (Assist.) **Fee:** $668.05 **Benefit:** 75% = $501.05 **Future End Date:**

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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $887.45 **Benefit:** 75% = $665.60 **Future End Date:**
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.) (See para TN.8.164 of explanatory notes to this Category) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 **Future End Date:**
37426	PENIS, artificial erection device, insertion of, into 1 or both corpora (Anaes.) (Assist.) **Fee:** $1,166.45 **Benefit:** 75% = $874.85 **Future End Date:**
37429	PENIS, artificial erection device, insertion of pump and pressure regulating reservoir (Anaes.) (Assist.) **Fee:** $386.85 **Benefit:** 75% = $290.15 **Future End Date:**
37432	PENIS, artificial erection device, complete or partial revision or removal of components, with or without replacement (Anaes.) (Assist.) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 **Future End Date:**
37435	PENIS, frenuloplasty as an independent procedure (Anaes.) **Fee:** $111.70 **Benefit:** 75% = $83.80 85% = $94.95 **Future End Date:**
37438	Scrotum, partial excision of, for histologically proven malignancy or infection (Anaes.) (Assist.) **Fee:** $331.05 **Benefit:** 75% = $248.30 85% = $281.40 **Future End Date:**
	OPERATIONS ON TESTES, VASA OR SEMINAL VESICLES
37601	SPERMATOCELE OR EPIDIDYMAL CYST, excision of, 1 or more of, on 1 side (Anaes.) **Fee:** $331.05 **Benefit:** 75% = $248.30 85% = $281.40 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $331.05 **Benefit:** 75% = $248.30 **Future End Date:**
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.) (See para TN.1.5, TN.8.58 of explanatory notes to this Category) **Fee:** $447.00 **Benefit:** 75% = $335.25 85% = $379.95 **Future End Date:**

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.) (See para GN.1.2, TN.1.5, TN.8.59 of explanatory notes to this Category) **Fee:** $663.70 **Benefit:** 75% = $497.80 **Future End Date:**
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.) (See para TN.8.165 of explanatory notes to this Category) **Fee:** $1,660.15 **Benefit:** 75% = $1245.15 **Future End Date:**
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.) (See para TN.8.165 of explanatory notes to this Category) **Fee:** $2,497.65 **Benefit:** 75% = $1873.25 **Future End Date:**
37613	Epididymectomy (H) (Anaes.) **Fee:** $331.05 **Benefit:** 75% = $248.30 **Future End Date:**
37616	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, using operating microscope, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.) **Fee:** $827.50 **Benefit:** 75% = $620.65 **Future End Date:**
37619	Vasovasostomy or vasoepididymostomy, unilateral, other than a service associated with sperm harvesting for IVF (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $331.05 **Benefit:** 75% = $248.30 **Future End Date:**
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.) (See para TN.8.46 of explanatory notes to this Category) **Fee:** $275.15 **Benefit:** 75% = $206.40 85% = $233.90 **Future End Date:**
	PAEDIATRIC GENITURINARY SURGERY
37800	PATENT URACHUS, excision of, on a patient 10 years of age or over. (Anaes.) (Assist.) **Fee:** $623.95 **Benefit:** 75% = $468.00 **Future End Date:**

37801	PATENT URACHUS, excision of, when performed on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $811.15 **Benefit:** 75% = $608.40 **Future End Date:**
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.) **Fee:** $623.95 **Benefit:** 75% = $468.00 **Future End Date:**
37804	UNDESCENDED TESTIS, orchidopexy for, not being a service to which item 37807 applies, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $811.15 **Benefit:** 75% = $608.40 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $720.85 **Benefit:** 75% = $540.65 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $937.15 **Benefit:** 75% = $702.90 **Future End Date:**
37809	UNDESCENDED TESTIS, revision orchidopexy for, on a patient 10 years of age or over. (Anaes.) (Assist.) **Fee:** $720.85 **Benefit:** 75% = $540.65 **Future End Date:**
37810	UNDESCENDED TESTIS, revision orchidopexy for, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $937.15 **Benefit:** 75% = $702.90 **Future End Date:**
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.) **Fee:** $665.40 **Benefit:** 75% = $499.05 **Future End Date:**
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.) **Fee:** $865.05 **Benefit:** 75% = $648.80 **Future End Date:**
37815	HYPOSPADIAS, examination under anaesthesia with erection test on a patient 10 years of age or over. (Anaes.) **Fee:** $111.00 **Benefit:** 75% = $83.25 **Future End Date:**

37816	HYPOSPADIAS, examination under anaesthesia with erection test, on a patient under 10 years of age (Anaes.) **Fee:** $144.35 **Benefit:** 75% = $108.30 **Future End Date:**
37818	Hypospadias, glanuloplasty incorporating meatal advancement, on a patient 10 years of age or over (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $588.25 **Benefit:** 75% = $441.20 **Future End Date:**
37819	Hypospadias, glanuloplasty incorporating meatal advancement, on a patient under 10 years of age (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $764.70 **Benefit:** 75% = $573.55 **Future End Date:**
37821	HYPOSPADIAS, distal, 1 stage repair, on a patient 10 years of age or over. (Anaes.) (Assist.) **Fee:** $997.15 **Benefit:** 75% = $747.90 **Future End Date:**
37822	HYPOSPADIAS, distal, 1 stage repair, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $1,296.35 **Benefit:** 75% = $972.30 **Future End Date:**
37824	HYPOSPADIAS, proximal, 1 stage repair, on a patient 10 years of age or over (Anaes.) (Assist.) **Fee:** $1,386.40 **Benefit:** 75% = $1039.80 **Future End Date:**
37825	HYPOSPADIAS, proximal, 1 stage repair, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $1,802.25 **Benefit:** 75% = $1351.70 **Future End Date:**
37827	HYPOSPADIAS, staged repair, first stage, on a patient 10 years of age or over (Anaes.) (Assist.) **Fee:** $638.70 **Benefit:** 75% = $479.05 **Future End Date:**
37828	HYPOSPADIAS, staged repair, first stage, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $830.25 **Benefit:** 75% = $622.70 **Future End Date:**
37830	Hypospadias, staged repair, second stage, on a patient 10 years of age or over (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $827.50 **Benefit:** 75% = $620.65 **Future End Date:**
37831	Hypospadias, staged repair, second stage, on a patient under 10 years of age (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,075.90 **Benefit:** 75% = $806.95 **Future End Date:**

T8. SURGICAL OPERATIONS	5. UROLOGICAL
37833	Hypospadias, repair of urethral fistula, on a patient 10 years of age or over (Anaes.) (Assist.) **Fee:** $394.90 **Benefit:** 75% = $296.20 **Future End Date:**
37834	Hypospadias, repair of urethral fistula, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $513.50 **Benefit:** 75% = $385.15 **Future End Date:**
37836	EPISPADIAS, staged repair, first stage (Anaes.) (Assist.) **Fee:** $831.80 **Benefit:** 75% = $623.85 **Future End Date:**
37839	EPISPADIAS, staged repair, second stage (Anaes.) (Assist.) **Fee:** $942.65 **Benefit:** 75% = $707.00 **Future End Date:**
37842	Exstrophy of bladder or epispadias, primary or secondary repair with or without bladder neck tightening, with or without ureteric reimplantation (Anaes.) (Assist.) **Fee:** $1,830.15 **Benefit:** 75% = $1372.65 **Future End Date:**
37845	Congenital disorder of sexual differentiation with urogenital sinus, external genitoplasty, with or without endoscopy (Anaes.) (Assist.) **Fee:** $831.80 **Benefit:** 75% = $623.85 **Future End Date:**
37848	Congenital disorder of sexual differentiation with urogenital sinus, external genitoplasty with endoscopy and vaginoplasty (Anaes.) (Assist.) **Fee:** $1,497.35 **Benefit:** 75% = $1123.05 **Future End Date:**
37851	Congenital disorder of sexual differentiation, vaginoplasty for, with or without endoscopy (Anaes.) (Assist.) **Fee:** $1,109.30 **Benefit:** 75% = $832.00 **Future End Date:**
37854	Urethral valve, destruction of, including cystoscopy and urethroscopy (Anaes.) **Fee:** $438.55 **Benefit:** 75% = $328.95 **Future End Date:**

T8. SURGICAL OPERATIONS	6. CARDIO-THORACIC
	Group T8. Surgical Operations
	Subgroup 6. Cardio-Thoracic
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.) (See para TR.8.8 of explanatory notes to this Category) **Fee:** $553.15 **Benefit:** 75% = $414.90 **Future End Date:**
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.) **Fee:** $754.35 **Benefit:** 75% = $565.80 **Future End Date:**
38426	Trachea or bronchus, dilatation of stricture and endoscopic insertion of stent (Anaes.) (Assist.) **Fee:** $542.60 **Benefit:** 75% = $406.95 **Future End Date:**
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.) **Fee:** $1,131.50 **Benefit:** 75% = $848.65 **Future End Date:**
38619	Surgical removal of a left sided intravascular microaxial ventricular assist device (H) (Anaes.)

	Fee: $678.70 **Benefit:** 75% = $509.05 **Future End Date:**
	CARDIOLOGY PROCEDURES
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.) (See para GN.1.2, TN.8.220 of explanatory notes to this Category) **Fee:** $533.15 **Benefit:** 75% = $399.90 **Future End Date:**
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.) (See para GN.1.2, TN.8.220 of explanatory notes to this Category) **Fee:** $636.25 **Benefit:** 75% = $477.20 **Future End Date:**
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.) (See para GN.1.2, TN.8.220 of explanatory notes to this Category) **Fee:** $769.15 **Benefit:** 75% = $576.90 **Future End Date:**
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.) (See para GN.1.2, TN.8.60, TN.8.298 of explanatory notes to this Category) **Fee:** $987.65 **Benefit:** 75% = $740.75 **Future End Date:**
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.) (See para GN.1.2, TN.8.60, TN.8.298 of explanatory notes to this Category) **Fee:** $1,642.65 **Benefit:** 75% = $1232.00 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $489.25 **Benefit:** 75% = $366.95 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $562.10 **Benefit:** 75% = $421.60 **Future End Date:**
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.) (See para GN.1.2, TR.8.2, TR.8.5, TN.8.215 of explanatory notes to this Category) **Fee:** $1,058.20 **Benefit:** 75% = $793.65 **Future End Date:**
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.) (See para GN.1.2, TR.8.2, TR.8.5, TN.8.215, TN.8.216, IN.2.1 of explanatory notes to this Category) **Fee:** $1,695.45 **Benefit:** 75% = $1271.60 **Future End Date:**
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.) (See para GN.1.2, TR.8.6, TR.8.3, TR.8.5, TN.8.215 of explanatory notes to this Category) **Fee:** $1,058.20 **Benefit:** 75% = $793.65 **Future End Date:**
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.) (See para GN.1.2, TR.8.6, TR.8.3, TR.8.5, TN.8.215, TN.8.216, IN.2.1 of explanatory notes to this Category) **Fee:** $1,695.45 **Benefit:** 75% = $1271.60 **Future End Date:**

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.) (See para GN.1.2, TR.8.5, TN.8.215 of explanatory notes to this Category) **Fee:** $1,058.20 **Benefit:** 75% = $793.65 **Future End Date:**
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.)

	(See para GN.1.2, TR.8.5, TN.8.215, TN.8.216, IN.2.1 of explanatory notes to this Category) **Fee:** $1,695.45 **Benefit:** 75% = $1271.60 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $533.15 **Benefit:** 75% = $399.90 **Future End Date:**
38256	Temporary transvenous pacemaking electrode, insertion of (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $319.85 **Benefit:** 75% = $239.90 **Future End Date:**
38270	Balloon valvuloplasty or isolated atrial septostomy, including cardiac catheterisations before and after balloon dilatation (H) (Anaes.) (Assist.) (See para GN.1.2, TN.8.278 of explanatory notes to this Category) **Fee:** $1,091.90 **Benefit:** 75% = $818.95 **Future End Date:**
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.) (See para GN.1.2, TN.8.221 of explanatory notes to this Category) **Fee:** $1,091.90 **Benefit:** 75% = $818.95 **Future End Date:**

38273	Patent ductus arteriosus, transcatheter closure of, including cardiac catheterisation and any imaging associated with the service (Anaes.) (Assist.) **Fee:** $1,091.90 **Benefit:** 75% = $818.95 **Future End Date:**
38274	Ventricular septal defect, transcatheter closure of, with cardiac catheterisation, excluding imaging (H) (Anaes.) (Assist.) **Fee:** $894.50 **Benefit:** 75% = $670.90 **Future End Date:**
38275	Myocardial biopsy, by cardiac catheterisation (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $356.90 **Benefit:** 75% = $267.70 **Future End Date:**
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.) (See para TN.8.132 of explanatory notes to this Category) **Fee:** $1,091.90 **Benefit:** 75% = $818.95 **Future End Date:**
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.) (See para TN.8.61, TN.8.211 of explanatory notes to this Category) **Fee:** $184.65 **Benefit:** 75% = $138.50 85% = $157.00 **Future End Date:**
38286	Removal of implantable ECG loop recorder (Anaes.) (See para TN.8.211 of explanatory notes to this Category) **Fee:** $166.30 **Benefit:** 75% = $124.75 85% = $141.40 **Future End Date:**
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.) **Fee:** $230.95 **Benefit:** 75% = $173.25 85% = $196.35 **Future End Date:**
	CATHETER BASED ARRHYTHMIA ABLATION
38287	Ablation of arrhythmia circuit or focus or isolation procedure involving one atrial chamber (H) (Anaes.) (Assist.) (See para GN.1.2, TN.8.298 of explanatory notes to this Category) **Fee:** $2,511.75 **Benefit:** 75% = $1883.85 **Future End Date:**
38290	ABLATION OF ARRHYTHMIA CIRCUITS OR FOCI, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Anaes.) (Assist.)

	(See para TN.8.298 of explanatory notes to this Category) **Fee:** $3,198.10 **Benefit:** 75% = $2398.60 **Future End Date:**
38293	Ventricular arrhythmia with mapping and ablation, including all associated electrophysiological studies performed on the same day (H) (Anaes.) (Assist.) (See para GN.1.2, TN.8.298 of explanatory notes to this Category) **Fee:** $3,432.75 **Benefit:** 75% = $2574.60 **Future End Date:**
	ENDOVASCULAR INTERVENTIONAL PROCEDURES
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.) (See para GN.1.2, TR.8.2, TR.8.5, TN.8.217, TN.8.225 of explanatory notes to this Category) **Fee:** $2,121.75 **Benefit:** 75% = $1591.35 **Future End Date:**
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.) (See para GN.1.2, TR.8.2, TR.8.5, TN.8.217, TN.8.225 of explanatory notes to this Category) **Fee:** $2,441.10 **Benefit:** 75% = $1830.85 **Future End Date:**
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.) (See para GN.1.2, TN.8.222 of explanatory notes to this Category) **Fee:** $1,438.65 **Benefit:** 75% = $1079.00 **Future End Date:**
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.) (See para GN.1.2, TR.8.2, TR.8.5, TN.8.217, TN.8.225 of explanatory notes to this Category) **Fee:** $2,760.60 **Benefit:** 75% = $2070.45 **Future End Date:**
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.) (See para GN.1.2, TR.8.6, TR.8.4, TR.8.5, TN.8.226, TN.8.218 of explanatory notes to this Category) **Fee:** $2,121.75 **Benefit:** 75% = $1591.35 **Future End Date:**
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.) (See para GN.1.2, TR.8.6, TR.8.4, TR.8.5, TN.8.226, TN.8.218 of explanatory notes to this Category) **Fee:** $2,441.10 **Benefit:** 75% = $1830.85 **Future End Date:**
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.) (See para GN.1.2, TR.8.7, TR.8.4, TR.8.5, TN.8.226, TN.8.218, TN.8.219 of explanatory notes to this Category) **Fee:** $2,760.60 **Benefit:** 75% = $2070.45 **Future End Date:**
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.) (See para GN.1.2, TR.8.2, TR.8.5, TN.8.217, TN.8.225 of explanatory notes to this Category) **Fee:** $1,896.80 **Benefit:** 75% = $1422.60 **Future End Date:**
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.) (See para GN.1.2, TR.8.2, TR.8.5, TN.8.217, TN.8.225 of explanatory notes to this Category) **Fee:** $2,402.75 **Benefit:** 75% = $1802.10 **Future End Date:**

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.) (See para GN.1.2, TR.8.2, TR.8.5, TN.8.217, TN.8.225 of explanatory notes to this Category) **Fee:** $2,722.10 **Benefit:** 75% = $2041.60 **Future End Date:**
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.) (See para GN.1.2, TR.8.6, TR.8.4, TR.8.5, TN.8.226, TN.8.218 of explanatory notes to this Category) **Fee:** $1,896.80 **Benefit:** 75% = $1422.60 **Future End Date:**
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.) (See para GN.1.2, TR.8.6, TR.8.4, TR.8.5, TN.8.226, TN.8.218 of explanatory notes to this Category) **Fee:** $2,402.75 **Benefit:** 75% = $1802.10 **Future End Date:**
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.) (See para GN.1.2, TR.8.7, TR.8.4, TR.8.5, TN.8.226, TN.8.218, TN.8.219 of explanatory notes to this Category) **Fee:** $2,722.10 **Benefit:** 75% = $2041.60 **Future End Date:**
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 2.5 mm 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) (See para TR.8.8 of explanatory notes to this Category) **Fee:** $553.15 **Benefit:** 75% = $414.90 **Future End Date:**
	MISCELLANEOUS CARDIAC PROCEDURES
38350	SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) **Fee:** $764.40 **Benefit:** 75% = $573.30 **Future End Date:**

38353	PERMANENT CARDIAC PACEMAKER, insertion, removal or replacement of, not for cardiac resynchronisation therapy, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) **Fee:** $305.75 **Benefit:** 75% = $229.35 **Future End Date:**
38356	DUAL CHAMBER PERMANENT TRANSVENOUS ELECTRODES, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) **Fee:** $1,002.20 **Benefit:** 75% = $751.65 **Future End Date:**
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.) (See para TN.8.214, TN.8.64 of explanatory notes to this Category) **Fee:** $3,432.75 **Benefit:** 75% = $2574.60 **Future End Date:**
38359	PERICARDIUM, paracentesis of (excluding aftercare) (Anaes.) **Fee:** $159.90 **Benefit:** 75% = $119.95 85% = $135.95 **Future End Date:**
38362	Intra-aortic balloon pump, percutaneous insertion of (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $460.65 **Benefit:** 75% = $345.50 **Future End Date:**
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.) (See para TN.8.63 of explanatory notes to this Category) **Fee:** $305.75 **Benefit:** 75% = $229.35 **Future End Date:**
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.) (See para TN.8.63 of explanatory notes to this Category) **Fee:** $1,465.75 **Benefit:** 75% = $1099.35 **Future End Date:**
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.) (See para TN.8.299 of explanatory notes to this Category) **Fee:** $902.85 **Benefit:** 75% = $677.15 **Future End Date:**
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.) (See para TN.8.299, TN.8.214 of explanatory notes to this Category) **Fee:** $902.85 **Benefit:** 75% = $677.15 **Future End Date:**
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.) (See para TN.8.214 of explanatory notes to this Category) **Fee:** $902.85 **Benefit:** 75% = $677.15 **Future End Date:**
38375	Leadless permanent cardiac pacemaker, single-chamber ventricular, explantation of, by open surgical approach (H) (Anaes.) (Assist.) **Fee:** $3,378.70 **Benefit:** 75% = $2534.05 **Future End Date:**
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.)

	Fee: $1,259.90 **Benefit:** 75% = $944.95 **Future End Date:**
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.) **Fee:** $344.55 **Benefit:** 75% = $258.45 **Future End Date:**
	THORACIC SURGERY
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.) (See para GN.1.2, TN.8.21 of explanatory notes to this Category) **Fee:** $674.30 **Benefit:** 75% = $505.75 **Future End Date:**
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.) (See para GN.1.2, TN.8.21 of explanatory notes to this Category) **Fee:** $674.30 **Benefit:** 75% = $505.75 **Future End Date:**
38419	Bronchoscopy, as an independent procedure (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $213.05 **Benefit:** 75% = $159.80 **Future End Date:**

38420	Bronchoscopy with one or more endobronchial biopsies or other diagnostic or therapeutic procedures (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $281.40 **Benefit:** 75% = $211.05 **Future End Date:**
38422	Bronchus, removal of foreign body in (Anaes.) (Assist.) **Fee:** $440.10 **Benefit:** 75% = $330.10 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $307.60 **Benefit:** 75% = $230.70 **Future End Date:**
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.) **Fee:** $723.25 **Benefit:** 75% = $542.45 **Future End Date:**
38428	Bronchoscopy with treatment of tracheal stricture (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $295.10 **Benefit:** 75% = $221.35 **Future End Date:**
38429	Tracheal excision and repair of, without cardiopulmonary bypass (H) (Anaes.) (Assist.) **Fee:** $2,059.75 **Benefit:** 75% = $1544.85 **Future End Date:**
38431	Tracheal excision and repair of, with cardiopulmonary bypass (H) (Anaes.) (Assist.) **Fee:** $2,786.00 **Benefit:** 75% = $2089.50 **Future End Date:**
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.) **Fee:** $298.85 **Benefit:** 75% = $224.15 **Future End Date:**
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.) **Fee:** $1,147.10 **Benefit:** 75% = $860.35 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,803.30 **Benefit:** 75% = $1352.50 **Future End Date:**
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.) **Fee:** $1,147.10 **Benefit:** 75% = $860.35 **Future End Date:**
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.) **Fee:** $1,373.10 **Benefit:** 75% = $1029.85 **Future End Date:**
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.) **Fee:** $2,059.65 **Benefit:** 75% = $1544.75 **Future End Date:**
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.) **Fee:** $1,833.60 **Benefit:** 75% = $1375.20 **Future End Date:**
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.) **Fee:** $2,265.55 **Benefit:** 75% = $1699.20 **Future End Date:**
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.) **Fee:** $2,831.95 **Benefit:** 75% = $2124.00 **Future End Date:**
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.) **Fee:** $159.90 **Benefit:** 75% = $119.95 85% = $135.95 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $197.00 **Benefit:** 75% = $147.75 **Future End Date:**
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.) **Fee:** $478.00 **Benefit:** 75% = $358.50 **Future End Date:**
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.) **Fee:** $1,720.65 **Benefit:** 75% = $1290.50

	Future End Date:
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.) **Fee:** $1,833.60 **Benefit:** 75% = $1375.20 **Future End Date:**
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.) **Fee:** $1,147.10 **Benefit:** 75% = $860.35 **Future End Date:**
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.) **Fee:** $4,248.10 **Benefit:** 75% = $3186.10 **Future End Date:**
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.) **Fee:** $434.55 **Benefit:** 75% = $325.95 **Future End Date:**
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.) **Fee:** $1,416.50 **Benefit:** 75% = $1062.40 **Future End Date:**
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.) **Fee:** $686.70 **Benefit:** 75% = $515.05 **Future End Date:**
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.) **Fee:** $1,025.30 **Benefit:** 75% = $769.00 **Future End Date:**

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.) **Fee:** $1,833.60 **Benefit:** 75% = $1375.20 **Future End Date:**
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.) **Fee:** $2,565.20 **Benefit:** 75% = $1923.90 **Future End Date:**
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.) **Fee:** $329.65 **Benefit:** 75% = $247.25 **Future End Date:**
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.) (See para TN.8.259 of explanatory notes to this Category) **Fee:** $1,711.90 **Benefit:** 75% = $1283.95 **Future End Date:**
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.) **Fee:** $912.40 **Benefit:** 75% = $684.30 **Future End Date:**
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.) **Fee:** $1,369.50 **Benefit:** 75% = $1027.15 **Future End Date:**
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.) **Fee:** $684.70 **Benefit:** 75% = $513.55 **Future End Date:**

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.) **Fee:** $390.75 **Benefit:** 75% = $293.10 **Future End Date:**
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.) **Fee:** $424.65 **Benefit:** 75% = $318.50 **Future End Date:**
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.) **Fee:** $1,146.65 **Benefit:** 75% = $860.00 **Future End Date:**
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.) **Fee:** $1,797.60 **Benefit:** 75% = $1348.20 **Future End Date:**
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.) **Fee:** $2,172.65 **Benefit:** 75% = $1629.50 **Future End Date:**
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.) **Fee:** $2,831.95 **Benefit:** 75% = $2124.00 **Future End Date:**
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.) (See para TN.8.260 of explanatory notes to this Category) **Fee:** $1,147.10 **Benefit:** 75% = $860.35

	Future End Date:
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.) **Fee:** $1,833.60 **Benefit:** 75% = $1375.20 **Future End Date:**
	CARDIAC SURGERY PROCEDURES
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.) **Fee:** $1,147.10 **Benefit:** 75% = $860.35 **Future End Date:**
	VALVULAR PROCEDURES
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.) **Fee:** $1,714.25 **Benefit:** 75% = $1285.70 **Future End Date:**

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.) **Fee:** $1,714.25 **Benefit:** 75% = $1285.70 **Future End Date:**
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.) (See para TN.8.213, TN.8.67 of explanatory notes to this Category) **Fee:** $2,397.85 **Benefit:** 75% = $1798.40 **Future End Date:**
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.)

	Fee: $2,429.60 **Benefit:** 75% = $1822.20 **Future End Date:**
38485	MITRAL ANNULUS, reconstruction of, after decalcification, when performed in association with valve surgery (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $978.00 **Benefit:** 75% = $733.50 **Future End Date:**
38487	MITRAL VALVE, open valvotomy of (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,059.75 **Benefit:** 75% = $1544.85 **Future End Date:**
38490	Reconstruction and re-implantation of sub-valvular structures, if performed in conjunction with a service to which item 38499 applies (H) (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $663.70 **Benefit:** 75% = $497.80 **Future End Date:**
38493	OPERATIVE MANAGEMENT of acute infective endocarditis, in association with heart valve surgery (Anaes.) (Assist.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,342.95 **Benefit:** 75% = $1757.25 **Future End Date:**
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.) (See para AN.33.1, TN.8.135, TN.8.278 of explanatory notes to this Category) **Fee:** $1,714.25 **Benefit:** 75% = $1285.70 **Future End Date:**
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.) **Fee:** $2,429.60 **Benefit:** 75% = $1822.20 **Future End Date:**

38514	TAVI, for the treatment of symptomatic severe aortic stenosis, performed via transfemoral delivery, unless transfemoral delivery is contraindicated or not feasible, if: (a) the TAVI Patient is at intermediate risk for surgery; and (b) the service: i. is performed by a TAVI Practitioner in a TAVI Hospital; and ii. includes all intraoperative diagnostic imaging that the TAVI Practitioner performs upon the TAVI Patient; and iii. includes valvuloplasty, if required; and iv. is performed in a facility where cardiothoracic surgery is available and a thoracotomy can be performed immediately and without transfer; and v. 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.) (See para AN.33.1, TN.8.135, TN.8.214, TN.8.278 of explanatory notes to this Category) **Fee:** $1,714.25 **Benefit:** 75% = $1285.70 **Future End Date:**
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.) **Fee:** $2,990.75 **Benefit:** 75% = $2243.10 **Future End Date:**
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.)

	Fee: $3,681.00 **Benefit:** 75% = $2760.75 **Future End Date:**
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.) **Fee:** $1,265.35 **Benefit:** 75% = $949.05 **Future End Date:**
38522	TAVI, for the treatment of symptomatic severe native calcific aortic stenosis, performed via transfemoral delivery, unless transfemoral delivery is contraindicated or not feasible, if: (a) the TAVI Patient is at low risk for surgery; and (b) the service: i. is performed by a TAVI Practitioner in a TAVI Hospital; and ii. includes all intraoperative diagnostic imaging that the TAVI Practitioner performs upon the TAVI Patient; and iii. includes valvuloplasty, if required; and iv. is performed in a facility where cardiothoracic surgery is available and a thoracotomy can be performed immediately and without transfer; and v. 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.) (See para AN.33.1, TN.8.135, TN.8.214, TN.8.278 of explanatory notes to this Category) **Fee:** $1,714.25 **Benefit:** 75% = $1285.70 **Future End Date:**
38523	Percutaneous transcatheter delivery of dual-filter cerebral embolic protection system during a TAVI procedure, for the reduction of postoperative embolic ischaemic strokes, if: a. the service is performed upon a TAVI Patient in a TAVI Hospital; and b. 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.) **Fee:** $311.60 **Benefit:** 75% = $233.70 **Future End Date:**
	SURGERY FOR ISCHAEMIC HEART DISEASE
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.) **Fee:** $2,819.90 **Benefit:** 75% = $2114.95 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,296.20 **Benefit:** 75% = $1722.15 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,858.95 **Benefit:** 75% = $2144.25 **Future End Date:**
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.) **Fee:** $746.85 **Benefit:** 75% = $560.15 **Future End Date:**
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.) **Fee:** $718.15 **Benefit:** 75% = $538.65 **Future End Date:**
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.) **Fee:** $1,197.00 **Benefit:** 75% = $897.75 **Future End Date:**
	ARRHYTHMIA SURGERY

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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,511.75 **Benefit:** 75% = $1883.85 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $3,198.10 **Benefit:** 75% = $2398.60 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $3,432.75 **Benefit:** 75% = $2574.60 **Future End Date:**
	PROCEDURES ON THORACIC AORTA
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,688.80 **Benefit:** 75% = $2016.60 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category)

	Fee: $3,385.25 **Benefit:** 75% = $2538.95 **Future End Date:**
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.) **Fee:** $4,873.15 **Benefit:** 75% = $3654.90 **Future End Date:**
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.) **Fee:** $2,990.75 **Benefit:** 75% = $2243.10 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $3,716.00 **Benefit:** 75% = $2787.00 **Future End Date:**
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.) **Fee:** $5,176.30 **Benefit:** 75% = $3882.25 **Future End Date:**
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.) **Fee:** $5,847.75 **Benefit:** 75% = $4385.85 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,229.75 **Benefit:** 75% = $1672.35 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,541.70 **Benefit:** 75% = $1906.30 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,378.40 **Benefit:** 75% = $1783.80 **Future End Date:**
	CIRCULATORY SUPPORT PROCEDURES
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,833.60 **Benefit:** 75% = $1375.20

	Future End Date:
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,147.10 **Benefit:** 75% = $860.35 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $573.50 **Benefit:** 75% = $430.15 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $642.95 **Benefit:** 75% = $482.25 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,833.60 **Benefit:** 75% = $1375.20 **Future End Date:**

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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,285.50 **Benefit:** 75% = $1714.15 **Future End Date:**
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.) **Fee:** $1,833.60 **Benefit:** 75% = $1375.20 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $912.40 **Benefit:** 75% = $684.30 **Future End Date:**

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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,025.30 **Benefit:** 75% = $769.00 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $801.40 **Benefit:** 75% = $601.05 **Future End Date:**
	RE-OPERATION
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $663.70 **Benefit:** 75% = $497.80 **Future End Date:**
	MISCELLANEOUS CARDIOTHORACIC SURGICAL PROCEDURES
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,404.70 **Benefit:** 75% = $1803.55 **Future End Date:**
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.) **Fee:** $2,554.85 **Benefit:** 75% = $1916.15 **Future End Date:**
	CARDIAC TUMOURS
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,285.10 **Benefit:** 75% = $1713.85 **Future End Date:**

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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,572.05 **Benefit:** 75% = $1929.05 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,406.10 **Benefit:** 75% = $1804.60 **Future End Date:**
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.) **Fee:** $2,854.10 **Benefit:** 75% = $2140.60 **Future End Date:**
	CONGENITAL CARDIAC SURGERY
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.) **Fee:** $2,596.30 **Benefit:** 75% = $1947.25 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,277.50 **Benefit:** 75% = $958.15 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,310.80 **Benefit:** 75% = $1733.10 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,181.20 **Benefit:** 75% = $1635.90 **Future End Date:**

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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,571.35 **Benefit:** 75% = $1928.55 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,042.30 **Benefit:** 75% = $1531.75 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,583.20 **Benefit:** 75% = $1937.40 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,790.40 **Benefit:** 75% = $1342.80 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,604.90 **Benefit:** 75% = $1953.70 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,790.40 **Benefit:** 75% = $1342.80 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,554.85 **Benefit:** 75% = $1916.15 **Future End Date:**

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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $1,790.40 **Benefit:** 75% = $1342.80 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,554.85 **Benefit:** 75% = $1916.15 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,342.60 **Benefit:** 75% = $1756.95 **Future End Date:**
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.) (See para TN.8.210, TN.8.67 of explanatory notes to this Category) **Fee:** $2,303.00 **Benefit:** 75% = $1727.25 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,554.85 **Benefit:** 75% = $1916.15 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,554.85 **Benefit:** 75% = $1916.15 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,554.85 **Benefit:** 75% = $1916.15 **Future End Date:**

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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $3,198.10 **Benefit:** 75% = $2398.60 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,554.85 **Benefit:** 75% = $1916.15 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,554.85 **Benefit:** 75% = $1916.15 **Future End Date:**
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.) (See para TN.8.67 of explanatory notes to this Category) **Fee:** $2,554.85 **Benefit:** 75% = $1916.15 **Future End Date:**
	MISCELLANEOUS PROCEDURES ON THE CHEST
38800	THORACIC CAVITY, aspiration of, for diagnostic purposes, not being a service associated with a service to which item 38803 applies **Fee:** $46.05 **Benefit:** 75% = $34.55 85% = $39.15 **Future End Date:**
38803	THORACIC CAVITY, aspiration of, with therapeutic drainage (paracentesis), with or without diagnostic sample **Fee:** $92.05 **Benefit:** 75% = $69.05 85% = $78.25 **Future End Date:**
38812	PERCUTANEOUS NEEDLE BIOPSY of lung (Anaes.) **Fee:** $250.35 **Benefit:** 75% = $187.80 85% = $212.80 **Future End Date:**

	Group T8. Surgical Operations
	Subgroup 7. Neurosurgical

39014	Medial branch block of one or more primary posterior rami, injection of an anaesthetic agent under image guidance (Anaes.) (See para TN.7.6, TN.8.4 of explanatory notes to this Category) **Fee:** $149.45 **Benefit:** 75% = $112.10 85% = $127.05 **Future End Date:**
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.) (See para TN.8.4, TN.8.245 of explanatory notes to this Category) **Fee:** $320.80 **Benefit:** 75% = $240.60 85% = $272.70 **Future End Date:**
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.) (See para TN.8.4, TN.8.245 of explanatory notes to this Category) **Fee:** $320.80 **Benefit:** 75% = $240.60 85% = $272.70 **Future End Date:**
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.) (See para TN.8.4, TN.8.245 of explanatory notes to this Category) **Fee:** $356.50 **Benefit:** 75% = $267.40 85% = $303.05 **Future End Date:**
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.) (See para TN.8.4, TN.8.245 of explanatory notes to this Category) **Fee:** $356.50 **Benefit:** 75% = $267.40 85% = $303.05 **Future End Date:**
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.) (See para TN.8.4, TN.8.245 of explanatory notes to this Category) **Fee:** $392.10 **Benefit:** 75% = $294.10 85% = $333.30 **Future End Date:**
39129	Peripheral lead or leads, percutaneous placement of, including intraoperative test stimulation, for the management of chronic neuropathic pain (H) (Anaes.) (Assist.)

	(See para TN.8.241 of explanatory notes to this Category) **Fee:** $726.15 **Benefit:** 75% = $544.65 **Future End Date:**
	GENERAL
39000	LUMBAR PUNCTURE (Anaes.) **Fee:** $90.10 **Benefit:** 75% = $67.60 85% = $76.60 **Future End Date:**
39007	Procedure to obtain access to intracranial space (including subdural space, ventricle or basal cistern), percutaneously or by burr-hole (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $190.80 **Benefit:** 75% = $143.10 **Future End Date:**
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.) (See para TN.7.6, TN.7.5, TN.8.240, TN.8.4 of explanatory notes to this Category) **Fee:** $130.60 **Benefit:** 75% = $97.95 85% = $111.05 **Future End Date:**
39015	Intracranial parenchymal pressure monitoring device, insertion of—including burr hole (excluding after care) (Anaes.) (See para TN.8.166, TN.8.4 of explanatory notes to this Category) **Fee:** $450.05 **Benefit:** 75% = $337.55 **Future End Date:**
39018	Cerebrospinal reservoir, ventricular reservoir or external ventricular drain, insertion of, with or without stereotaxy (Anaes.) (Assist.) **Fee:** $989.40 **Benefit:** 75% = $742.05 **Future End Date:**
	PAIN RELIEF
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.) (See para TN.7.6, TN.8.4 of explanatory notes to this Category) **Fee:** $284.35 **Benefit:** 75% = $213.30 85% = $241.70 **Future End Date:**
39109	Trigeminal gangliotomy by radiofrequency, balloon or glycerol, including stereotaxy (H) (Anaes.) (Assist.) **Fee:** $1,696.70 **Benefit:** 75% = $1272.55 **Future End Date:**
39113	Cranial nerve, neurectomy or intracranial decompression of, using microsurgical techniques, including stereotaxy and cranioplasty (Anaes.) (Assist.) **Fee:** $2,846.30 **Benefit:** 75% = $2134.75 **Future End Date:**

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.) (See para TN.8.4, TN.8.245 of explanatory notes to this Category) **Fee:** $392.10 **Benefit:** 75% = $294.10 85% = $333.30 **Future End Date:**
39121	Percutaneous cordotomy (H) (Anaes.) (Assist.) (See para GN.1.2, TN.8.4 of explanatory notes to this Category) **Fee:** $756.10 **Benefit:** 75% = $567.10 **Future End Date:**
39124	CORDOTOMY OR MYELOTOMY, partial or total laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Anaes.) (Assist.) **Fee:** $1,935.15 **Benefit:** 75% = $1451.40 **Future End Date:**
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.) (See para TN.8.244 of explanatory notes to this Category) **Fee:** $356.75 **Benefit:** 75% = $267.60 **Future End Date:**
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.) (See para TN.8.244 of explanatory notes to this Category) **Fee:** $433.15 **Benefit:** 75% = $324.90 **Future End Date:**
39127	Subcutaneous reservoir and spinal catheter, insertion of, for the management of chronic pain, including cancer pain (H) (Anaes.) (See para TN.8.4, TN.8.244 of explanatory notes to this Category) **Fee:** $566.95 **Benefit:** 75% = $425.25 **Future End Date:**
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.) (See para TN.8.244 of explanatory notes to this Category) **Fee:** $789.80 **Benefit:** 75% = $592.35 **Future End Date:**
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.) (See para TN.8.4, TN.8.244 of explanatory notes to this Category) **Fee:** $806.85 **Benefit:** 75% = $605.15 **Future End Date:**
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 (See para TN.8.253, TN.8.244 of explanatory notes to this Category) **Fee:** $153.00 **Benefit:** 75% = $114.75 85% = $130.05 **Future End Date:**
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.) (See para TN.8.4, TN.8.244 of explanatory notes to this Category) **Fee:** $190.80 **Benefit:** 75% = $143.10 **Future End Date:**
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.) (See para TN.8.244 of explanatory notes to this Category) **Fee:** $407.60 **Benefit:** 75% = $305.70 **Future End Date:**
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.) (See para TN.8.244 of explanatory notes to this Category) **Fee:** $190.80 **Benefit:** 75% = $143.10 **Future End Date:**

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.) (See para TN.8.4, TN.8.244 of explanatory notes to this Category) **Fee:** $190.80 **Benefit:** 75% = $143.10 **Future End Date:**
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.) (See para TN.8.244 of explanatory notes to this Category) **Fee:** $724.55 **Benefit:** 75% = $543.45 **Future End Date:**
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.) (See para TN.8.241 of explanatory notes to this Category) **Fee:** $806.85 **Benefit:** 75% = $605.15 **Future End Date:**
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.) (See para TN.8.244 of explanatory notes to this Category) **Fee:** $1,083.30 **Benefit:** 75% = $812.50 **Future End Date:**
39140	Epidural catheter, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $350.55 **Benefit:** 75% = $262.95 **Future End Date:**
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 (See para TN.8.253, TN.8.244 of explanatory notes to this Category) **Fee:** $153.00 **Benefit:** 75% = $114.75 85% = $130.05 **Future End Date:**
	PERIPHERAL NERVES
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.) **Fee:** $422.95 **Benefit:** 75% = $317.25 **Future End Date:**
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.) (See para TN.8.283 of explanatory notes to this Category) **Fee:** $557.90 **Benefit:** 75% = $418.45 **Future End Date:**
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.) **Fee:** $810.05 **Benefit:** 75% = $607.55 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $986.40 **Benefit:** 75% = $739.80 **Future End Date:**
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.) (See para TN.8.283 of explanatory notes to this Category) **Fee:** $855.05 **Benefit:** 75% = $641.30 **Future End Date:**
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.) (See para TN.8.283 of explanatory notes to this Category) **Fee:** $477.05 **Benefit:** 75% = $357.80 **Future End Date:**
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.) (See para TN.8.283 of explanatory notes to this Category) **Fee:** $1,233.05 **Benefit:** 75% = $924.80 **Future End Date:**
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.) **Fee:** $765.20 **Benefit:** 75% = $573.90 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $557.90 **Benefit:** 75% = $418.45 **Future End Date:**
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.) (See para TN.8.189, TN.8.254 of explanatory notes to this Category) **Fee:** $566.95 **Benefit:** 75% = $425.25 **Future End Date:**
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.) (See para TN.8.245 of explanatory notes to this Category) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60 **Future End Date:**
39324	Neurectomy or removal of tumour or neuroma from superficial peripheral nerve (Anaes.) (Assist.) (See para TN.8.4, TN.8.254 of explanatory notes to this Category) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60 **Future End Date:**
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.)

	(See para TN.8.4, TN.8.254 of explanatory notes to this Category) **Fee:** $567.05 **Benefit:** 75% = $425.30 **Future End Date:**
39328	Neurectomy, neurotomy or removal of tumour from deep peripheral nerve, by open operation, for upper limb surgery (H) (Anaes.) (Assist.) **Fee:** $567.05 **Benefit:** 75% = $425.30 **Future End Date:**
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.) (See para GN.1.2, TN.8.186, TN.8.283 of explanatory notes to this Category) **Fee:** $422.95 **Benefit:** 75% = $317.25 **Future End Date:**
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.) (See para TN.8.196, TN.8.254, TN.8.200, TN.8.283 of explanatory notes to this Category) **Fee:** $331.25 **Benefit:** 75% = $248.45 **Future End Date:**
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.) (See para TN.8.283 of explanatory notes to this Category) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60 **Future End Date:**
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.) (See para TN.8.283 of explanatory notes to this Category) **Fee:** $496.95 **Benefit:** 75% = $372.75 **Future End Date:**
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.) (See para TN.8.283 of explanatory notes to this Category) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60 **Future End Date:**
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.) (See para GN.1.2, TN.8.283 of explanatory notes to this Category) **Fee:** $496.95 **Benefit:** 75% = $372.75 **Future End Date:**
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.) (See para GN.1.2, TN.8.283 of explanatory notes to this Category) **Fee:** $651.95 **Benefit:** 75% = $489.00 **Future End Date:**
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.) (See para GN.1.2, TN.8.186, TN.8.283 of explanatory notes to this Category) **Fee:** $331.25 **Benefit:** 75% = $248.45 **Future End Date:**
	CRANIAL NERVES

39503	Facio-hypoglossal nerve or facio-accessory nerve, anastomosis of (Anaes.) (Assist.) (See para TN.8.166 of explanatory notes to this Category) **Fee:** $1,143.05 **Benefit:** 75% = $857.30 **Future End Date:**
	CRANIO-CEREBRAL INJURIES
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.) **Fee:** $2,146.70 **Benefit:** 75% = $1610.05 **Future End Date:**
39610	Fractured skull, without brain laceration or dural penetration, repair of (Anaes.) (Assist.) **Fee:** $1,143.05 **Benefit:** 75% = $857.30 **Future End Date:**
39612	Fractured skull, with brain laceration or dural penetration but without cerebrospinal fluid, rhinorrhoea or otorrhoea, repair of (Anaes.) (Assist.) **Fee:** $1,341.15 **Benefit:** 75% = $1005.90 **Future End Date:**
39615	Fractured skull, after trauma, with cerebrospinal fluid rhinorrhoea or otorrhoea, repair of, including stereotaxy and dermofat graft (Anaes.) (Assist.) **Fee:** $2,288.50 **Benefit:** 75% = $1716.40 **Future End Date:**
	SKULL BASE SURGERY
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.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $5,095.30 **Benefit:** 75% = $3821.50 **Future End Date:**
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.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $4,071.75 **Benefit:** 75% = $3053.85 **Future End Date:**
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.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $5,374.35 **Benefit:** 75% = $4030.80 **Future End Date:**

39651	Petro-clival, clival or foramen magnum tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty - one surgeon (Anaes.) (Assist.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $6,630.60 **Benefit:** 75% = $4972.95 **Future End Date:**
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.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $5,095.30 **Benefit:** 75% = $3821.50 **Future End Date:**
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.) (See para TN.8.70 of explanatory notes to this Category) **Fee:** $4,071.75 **Benefit:** 75% = $3053.85 **Future End Date:**
	INTRA-CRANIAL NEOPLASMS
39700	Skull tumour, benign or malignant, excision of, including stereotaxy and cranioplasty (Anaes.) (Assist.) **Fee:** $2,169.10 **Benefit:** 75% = $1626.85 **Future End Date:**
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.) **Fee:** $1,741.80 **Benefit:** 75% = $1306.35 **Future End Date:**
39710	Intracranial tumour, one or more, biopsy, drainage, decompression or removal of, through a single craniotomy, including stereotaxy and cranioplasty (Anaes.) (Assist.) **Fee:** $2,900.55 **Benefit:** 75% = $2175.45 **Future End Date:**
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.) **Fee:** $4,430.50 **Benefit:** 75% = $3322.90 **Future End Date:**
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.)

	Fee: $3,233.55 **Benefit:** 75% = $2425.20 **Future End Date:**
39718	Arachnoidal cyst, craniotomy for, including stereotaxy and neuroendoscopy (Anaes.) (Assist.) **Fee:** $1,953.20 **Benefit:** 75% = $1464.90 **Future End Date:**
39720	Awake craniotomy for functional neurosurgery (Anaes.) (Assist.) **Fee:** $4,144.75 **Benefit:** 75% = $3108.60 **Future End Date:**
	CEREBROVASCULAR DISEASE
39801	Aneurysm, clipping, proximal ligation, or reinforcement of sac, including stereotaxy and cranioplasty (Anaes.) (Assist.) **Fee:** $6,630.60 **Benefit:** 75% = $4972.95 **Future End Date:**
39803	Intracranial arteriovenous malformation or fistula, treatment through a craniotomy, including stereotaxy, cranioplasty and all angiography (Anaes.) (Assist.) **Fee:** $6,630.60 **Benefit:** 75% = $4972.95 **Future End Date:**
39815	Carotid-cavernous fistula, obliteration of—combined cervical and intracranial procedure (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $2,187.00 **Benefit:** 75% = $1640.25 **Future End Date:**
39818	Intracranial vascular bypass using indirect techniques, including stereotaxy (Anaes.) (Assist.) **Fee:** $2,902.75 **Benefit:** 75% = $2177.10 **Future End Date:**
39821	Intracranial vascular bypass using direct anastomosis techniques, including stereotaxy (Anaes.) (Assist.) **Fee:** $4,135.70 **Benefit:** 75% = $3101.80 **Future End Date:**
40004	Ventricular, lumbar or cisternal shunt diversion, insertion or revision of, including stereotaxy (Anaes.) (Assist.) **Fee:** $1,980.25 **Benefit:** 75% = $1485.20 **Future End Date:**
	INFECTION
39900	Intracranial infection, treated by burr hole, including stereotaxy, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.) **Fee:** $1,741.80 **Benefit:** 75% = $1306.35 **Future End Date:**
39903	Intracranial infection, treated by craniotomy, including stereotaxy, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.) **Fee:** $2,614.80 **Benefit:** 75% = $1961.10

	Future End Date:
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.) (See para TN.8.166 of explanatory notes to this Category) **Fee:** $954.05 **Benefit:** 75% = $715.55 **Future End Date:**
	CEREBROSPINAL FLUID CIRCULATION DISORDERS
40012	Endoscopic ventriculostomy for treatment of cerebrospinal fluid circulation disorders, including stereotaxy (Anaes.) (Assist.) **Fee:** $2,047.75 **Benefit:** 75% = $1535.85 **Future End Date:**
40018	Lumbar cerebrospinal fluid drain, insertion of, other than a service associated with a service to which item 22053 applies (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $190.80 **Benefit:** 75% = $143.10 **Future End Date:**
	CONGENITAL DISORDERS
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.) (See para TN.8.166 of explanatory notes to this Category) **Fee:** $1,215.10 **Benefit:** 75% = $911.35 **Future End Date:**
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.) **Fee:** $2,884.65 **Benefit:** 75% = $2163.50 **Future End Date:**
40109	Encephalocoele or cranial meningocele, excision and closure of, including stereotaxy and dermofat graft (Anaes.) (Assist.) **Fee:** $2,238.95 **Benefit:** 75% = $1679.25 **Future End Date:**
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.) **Fee:** $2,860.10 **Benefit:** 75% = $2145.10 **Future End Date:**
40119	Craniostenosis, operation for, other than a service associated with a service to which item 40600 applies (Anaes.) (Assist.) **Fee:** $1,143.05 **Benefit:** 75% = $857.30 **Future End Date:**
	SKULL RECONSTRUCTION

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.) **Fee:** $1,143.05 **Benefit:** 75% = $857.30 **Future End Date:**
	EPILEPSY
40700	Corpus callosotomy, for epilepsy, including stereotaxy (Anaes.) (Assist.) **Fee:** $2,803.80 **Benefit:** 75% = $2102.85 **Future End Date:**
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.) **Fee:** $407.60 **Benefit:** 75% = $305.70 **Future End Date:**
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.) **Fee:** $190.80 **Benefit:** 75% = $143.10 **Future End Date:**
40703	Corticectomy, topectomy or partial lobectomy, for epilepsy, including stereotaxy and cranioplasty (Anaes.) (Assist.) **Fee:** $2,900.55 **Benefit:** 75% = $2175.45 **Future End Date:**
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.) **Fee:** $806.85 **Benefit:** 75% = $605.15 **Future End Date:**
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.) **Fee:** $724.55 **Benefit:** 75% = $543.45 **Future End Date:**

40706	Hemispherectomy or functional hemispherectomy, for intractable epilepsy, including stereotaxy (Anaes.) (Assist.) **Fee:** $4,144.80 **Benefit:** 75% = $3108.60 **Future End Date:**
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 **Fee:** $227.05 **Benefit:** 75% = $170.30 85% = $193.00 **Future End Date:**
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.) **Fee:** $407.60 **Benefit:** 75% = $305.70 **Future End Date:**
40709	Intracranial electrode placement by burr hole, including stereotaxy (Anaes.) (Assist.) **Fee:** $1,741.80 **Benefit:** 75% = $1306.35 **Future End Date:**
40712	Intracranial electrode placement by craniotomy, single or multiple, including stereotactic EEG, including stereotaxy (Anaes.) (Assist.) **Fee:** $4,144.80 **Benefit:** 75% = $3108.60 **Future End Date:**
	STEREOTACTIC PROCEDURES
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.) **Fee:** $2,089.55 **Benefit:** 75% = $1567.20 **Future End Date:**
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.) (See para GN.1.2, TN.8.166 of explanatory notes to this Category) **Fee:** $1,431.10 **Benefit:** 75% = $1073.35

	Future End Date:
40804	Magnetic resonance imaging—scan of head (including magnetic resonance angiography if performed) by a radiologist on request by a specialist or consultant physician, for the sole purpose of guiding focused ultrasound for the treatment of medically refractory essential tremor in association with the services described in items 40805 and 40806, including: (a) stereotactic scan of brain, with frame in place; and (b) assistance with computerised planning; and (c) interpretation of intraprocedural imaging Applicable once per patient per lifetime (H) (Anaes.) **Fee:** $1,126.05 **Benefit:** 75% = $844.55 **Future End Date:**
40805	Neurological assessment and evaluation during the treatment of medically refractory essential tremor with magnetic resonance imaging-guided focused ultrasound, performed by a neurologist in association with the services described in items 40804 and 40806, including: (a) assistance with target localisation incorporating anatomical and physiological techniques; and (b) continuous intraprocedural neurological assessment and evaluation Applicable once per patient per lifetime (H) (Anaes.) **Fee:** $2,326.70 **Benefit:** 75% = $1745.05 **Future End Date:**
40806	Treatment of medically refractory essential tremor with magnetic resonance imaging-guided focused ultrasound, performed by a neurosurgeon in association with the services described in items 40804 and 40805, including: (a) computer assisted anatomical localisation; and (b) frame placement; and (c) target verification using anatomical and physiological techniques; and (d) delivery of treatment with lesion production in the basal ganglia, brain stem, thalamus or deep white matter tracts Applicable once per patient per lifetime (H) (Anaes.) **Fee:** $3,583.85 **Benefit:** 75% = $2687.90 **Future End Date:**
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.) **Fee:** $2,710.35 **Benefit:** 75% = $2032.80 **Future End Date:**
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.) **Fee:** $4,743.40 **Benefit:** 75% = $3557.55 **Future End Date:**
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.) **Fee:** $407.60 **Benefit:** 75% = $305.70 **Future End Date:**
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.) **Fee:** $630.05 **Benefit:** 75% = $472.55 **Future End Date:**
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.)

	Fee: $305.75 **Benefit:** 75% = $229.35 **Future End Date:**
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.) **Fee:** $630.05 **Benefit:** 75% = $472.55 **Future End Date:**
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.) **Fee:** $2,420.95 **Benefit:** 75% = $1815.75 **Future End Date:**
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.) **Fee:** $227.05 **Benefit:** 75% = $170.30 85% = $193.00 **Future End Date:**
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 **Fee:** $227.05 **Benefit:** 75% = $170.30 85% = $193.00 **Future End Date:**
	MISCELLANEOUS
40905	Craniotomy, performed by a neurosurgeon in conjunction with the correction of craniofacial abnormalities (Anaes.) (Assist.) **Fee:** $720.20 **Benefit:** 75% = $540.15 **Future End Date:**

	Group T8. Surgical Operations
	Subgroup 8. Ear, Nose And Throat
41500	EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.) (See para TN.8.72 of explanatory notes to this Category) **Fee:** $98.70 **Benefit:** 75% = $74.05 85% = $83.90 **Future End Date:**
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: a. dysphonia where non stroboscopic techniques of the visualising the larynx have failed to identify any frank abnormality of the vocal folds; or b. benign or malignant vocal fold lesions; or c. premalignant or malignant laryngeal lesions; or d. vocal fold motion impairment or glottal insufficiency; or e. 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 (See para TN.8.76 of explanatory notes to this Category) **Fee:** $222.10 **Benefit:** 75% = $166.60 85% = $188.80 **Future End Date:**
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.) **Fee:** $285.85 **Benefit:** 75% = $214.40 85% = $243.00 **Future End Date:**
41506	AURAL POLYP, removal of (Anaes.) **Fee:** $172.40 **Benefit:** 75% = $129.30 85% = $146.55 **Future End Date:**
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.) **Fee:** $195.05 **Benefit:** 75% = $146.30 **Future End Date:**
41512	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, not being a service to which item 41515 applies (Anaes.) (Assist.) **Fee:** $701.20 **Benefit:** 75% = $525.90 **Future End Date:**

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.) (See para TN.8.73 of explanatory notes to this Category) **Fee:** $460.20 **Benefit:** 75% = $345.15 **Future End Date:**
41518	EXTERNAL AUDITORY MEATUS, removal of EXOSTOSES IN (Anaes.) (Assist.) **Fee:** $1,111.60 **Benefit:** 75% = $833.70 **Future End Date:**
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.) **Fee:** $1,183.55 **Benefit:** 75% = $887.70 **Future End Date:**
41524	Reconstruction of external auditory canal (H) (Anaes.) (Assist.) (See para TN.8.74 of explanatory notes to this Category) **Fee:** $341.85 **Benefit:** 75% = $256.40 **Future End Date:**
41539	Ossicular chain reconstruction, other than a service associated with a service to which item 41611 applies (H) (Anaes.) (Assist.) **Fee:** $1,304.50 **Benefit:** 75% = $978.40 **Future End Date:**
41542	Ossicular chain reconstruction and myringoplasty, other than a service associated with a service to which item 41611 applies (H) (Anaes.) (Assist.) **Fee:** $1,429.40 **Benefit:** 75% = $1072.05 **Future End Date:**
41548	OBLITERATION OF THE MASTOID CAVITY (Anaes.) (Assist.) **Fee:** $827.90 **Benefit:** 75% = $620.95 **Future End Date:**
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.) **Fee:** $1,429.40 **Benefit:** 75% = $1072.05 **Future End Date:**
41572	LABYRINTHOTOMY OR DESTRUCTION OF LABYRINTH (Anaes.) (Assist.) **Fee:** $1,236.65 **Benefit:** 75% = $927.50 **Future End Date:**
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.) **Fee:** $2,915.30 **Benefit:** 75% = $2186.50 **Future End Date:**

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.) **Fee:** $4,373.00 **Benefit:** 75% = $3279.75 **Future End Date:**
41578	CEREBELLO PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $2,915.30 **Benefit:** 75% = $2186.50 **Future End Date:**
41579	CEREBELLO-PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, co-surgeon (Assist.) **Fee:** $2,186.40 **Benefit:** 75% = $1639.80 **Future End Date:**
41581	TUMOUR INVOLVING INFRA-TEMPORAL FOSSA, removal of, involving craniotomy and radical excision of (Anaes.) (Assist.) **Fee:** $3,353.15 **Benefit:** 75% = $2514.90 **Future End Date:**
41584	PARTIAL TEMPORAL BONE RESECTION for removal of tumour involving mastoidectomy with or without decompression of facial nerve (Anaes.) (Assist.) **Fee:** $2,301.15 **Benefit:** 75% = $1725.90 **Future End Date:**
41587	TOTAL TEMPORAL BONE RESECTION for removal of tumour (Anaes.) (Assist.) **Fee:** $3,134.20 **Benefit:** 75% = $2350.65 **Future End Date:**
41590	ENDOLYMPHATIC SAC, TRANSMASTOID DECOMPRESSION with or without drainage of (Anaes.) (Assist.) **Fee:** $1,429.40 **Benefit:** 75% = $1072.05 **Future End Date:**
41593	TRANSLABYRINTHINE VESTIBULAR NERVE SECTION (Anaes.) (Assist.) **Fee:** $1,862.90 **Benefit:** 75% = $1397.20 **Future End Date:**
41596	RETROLABYRINTHINE VESTIBULAR NERVE SECTION or COCHLEAR NERVE SECTION, or BOTH (Anaes.) (Assist.) **Fee:** $2,082.00 **Benefit:** 75% = $1561.50 **Future End Date:**
41599	INTERNAL AUDITORY MEATUS, exploration by middle cranial fossa approach with cranial nerve decompression (Anaes.) (Assist.) **Fee:** $2,082.00 **Benefit:** 75% = $1561.50 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $714.75 **Benefit:** 75% = $536.10 **Future End Date:**
41608	STAPEDECTOMY (Anaes.) (Assist.) **Fee:** $1,304.50 **Benefit:** 75% = $978.40 **Future End Date:**
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.) **Fee:** $839.35 **Benefit:** 75% = $629.55 **Future End Date:**
41614	Round window surgery including repair of cochleotomy, other than a service associated with a service to which item 41617 applies (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,304.50 **Benefit:** 75% = $978.40 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,304.50 **Benefit:** 75% = $978.40 **Future End Date:**
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.) **Fee:** $2,268.40 **Benefit:** 75% = $1701.30 **Future End Date:**
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.) **Fee:** $2,246.55 **Benefit:** 75% = $1684.95 **Future End Date:**
41620	GLOMUS TUMOUR, transtympanic removal of (Anaes.) (Assist.) **Fee:** $986.90 **Benefit:** 75% = $740.20 **Future End Date:**
41623	GLOMUS TUMOUR, transmastoid removal of, including mastoidectomy (Anaes.) (Assist.) **Fee:** $1,429.40 **Benefit:** 75% = $1072.05 **Future End Date:**
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.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $172.40 **Benefit:** 75% = $129.30 85% = $146.55 **Future End Date:**
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.) **Fee:** $285.85 **Benefit:** 75% = $214.40 85% = $243.00 **Future End Date:**
41641	PERFORATION OF TYMPANUM, cauterisation or diathermy of (Anaes.) **Fee:** $56.80 **Benefit:** 75% = $42.60 85% = $48.30 **Future End Date:**
41644	EXCISION OF RIM OF EARDRUM PERFORATION, not being a service associated with myringoplasty (Anaes.) **Fee:** $171.05 **Benefit:** 75% = $128.30 85% = $145.40 **Future End Date:**
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.) (See para TN.8.255 of explanatory notes to this Category) **Fee:** $131.55 **Benefit:** 75% = $98.70 85% = $111.85 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $131.55 **Benefit:** 75% = $98.70 **Future End Date:**
41656	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $146.95 **Benefit:** 75% = $110.25 85% = $124.95 **Future End Date:**
41659	NOSE, removal of FOREIGN BODY IN, other than by simple probing (Anaes.) **Fee:** $92.80 **Benefit:** 75% = $69.60 85% = $78.90 **Future End Date:**
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 (See para TN.8.75 of explanatory notes to this Category) **Fee:** $98.70 **Benefit:** 75% = $74.05 85% = $83.90 **Future End Date:**
41668	Nasal polyp or polypi, removal of (Anaes.) (See para TN.8.75 of explanatory notes to this Category) **Fee:** $263.15 **Benefit:** 75% = $197.40 85% = $223.70 **Future End Date:**
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.) **Fee:** $120.25 **Benefit:** 75% = $90.20 85% = $102.25 **Future End Date:**
41677	NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.) **Fee:** $107.75 **Benefit:** 75% = $80.85 85% = $91.60 **Future End Date:**
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.) **Fee:** $140.30 **Benefit:** 75% = $105.25 85% = $119.30 **Future End Date:**

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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $86.10 **Benefit:** 75% = $64.60 **Future End Date:**
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.) **Fee:** $39.00 **Benefit:** 75% = $29.25 85% = $33.15 **Future End Date:**
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.) **Fee:** $110.00 **Benefit:** 75% = $82.50 **Future End Date:**
41704	MAXILLARY ANTRUM, LAVAGE OF each attendance at which the procedure is performed, including any associated consultation (Anaes.) **Fee:** $43.50 **Benefit:** 75% = $32.65 85% = $37.00 **Future End Date:**
41707	Maxillary or sphenopalatine artery, ligation of (H) (Anaes.) (Assist.) (See para TN.8.256 of explanatory notes to this Category) **Fee:** $536.85 **Benefit:** 75% = $402.65 **Future End Date:**
41713	Vidian neurectomy or exposure of vidian canal (H) (Anaes.) (Assist.) **Fee:** $725.95 **Benefit:** 75% = $544.50 **Future End Date:**
41719	Antrum, drainage of, through tooth socket, other than a service associated with a service to which item 41722 applies (Anaes.) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60 **Future End Date:**
41722	Oroantral fistula, plastic closure of, other than a service associated with a service to which item 41719 or 45009 applies (Anaes.) (Assist.) **Fee:** $703.25 **Benefit:** 75% = $527.45 85% = $597.80 **Future End Date:**
41725	Ligation of ethmoidal artery or arteries, anterior, posterior or both, by any approach (unilateral) (H) (Anaes.) (Assist.) (See para TN.8.256 of explanatory notes to this Category) **Fee:** $536.85 **Benefit:** 75% = $402.65 **Future End Date:**
41728	Removal of sinonasal or nasopharyngeal tumour, excluding inflammatory nasal polyps, by any approach (H) (Anaes.) (Assist.) **Fee:** $1,073.95 **Benefit:** 75% = $805.50 **Future End Date:**

41740	Frontal sinus, catheterisation of, other than a service associated with a service to which item 41749 applies on the same side (H) (Anaes.) **Fee:** $70.40 **Benefit:** 75% = $52.80 **Future End Date:**
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.) **Fee:** $403.95 **Benefit:** 75% = $303.00 **Future End Date:**
41746	Paranasal sinus, radical obliteration of, including any graft harvest (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $930.15 **Benefit:** 75% = $697.65 **Future End Date:**
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.) **Fee:** $725.95 **Benefit:** 75% = $544.50 **Future End Date:**
41755	EUSTACHIAN TUBE, catheterisation of (Anaes.) **Fee:** $55.60 **Benefit:** 75% = $41.70 85% = $47.30 **Future End Date:**
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.) (See para TN.8.257 of explanatory notes to this Category) **Fee:** $146.95 **Benefit:** 75% = $110.25 85% = $124.95 **Future End Date:**
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.) **Fee:** $216.35 **Benefit:** 75% = $162.30 85% = $183.90 **Future End Date:**
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.) **Fee:** $324.50 **Benefit:** 75% = $243.40 85% = $275.85 **Future End Date:**
41770	PHARYNGEAL POUCH, removal of, with or without cricopharyngeal myotomy (Anaes.) (Assist.) **Fee:** $839.35 **Benefit:** 75% = $629.55 **Future End Date:**
41776	Cricopharyngeal myotomy by any approach, including open inversion of pharyngeal pouch or endoscopic repair of pharyngeal pouch (H) (Anaes.) (Assist.) **Fee:** $702.25 **Benefit:** 75% = $526.70 **Future End Date:**
41779	PHARYNGOTOMY (lateral), with or without total excision of tongue (Anaes.) (Assist.) **Fee:** $839.35 **Benefit:** 75% = $629.55 **Future End Date:**
41785	Partial pharyngectomy, by any approach, with or without partial glossectomy (H) (Anaes.) (Assist.) **Fee:** $1,365.00 **Benefit:** 75% = $1023.75 **Future End Date:**
41786	UVULOPALATOPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes.) (Assist.) **Fee:** $882.15 **Benefit:** 75% = $661.65 **Future End Date:**
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.) **Fee:** $353.90 **Benefit:** 75% = $265.45 **Future End Date:**
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.) **Fee:** $444.65 **Benefit:** 75% = $333.50 **Future End Date:**

41797	TONSILS OR TONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general anaesthesia, following removal of (Anaes.) **Fee:** $172.40 **Benefit:** 75% = $129.30 **Future End Date:**
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.) **Fee:** $195.05 **Benefit:** 75% = $146.30 **Future End Date:**
41804	Removal of lingual tonsil (H) (Anaes.) **Fee:** $107.75 **Benefit:** 75% = $80.85 **Future End Date:**
41807	PERITONSILLAR ABSCESS (quinsy), incision of (Anaes.) **Fee:** $83.80 **Benefit:** 75% = $62.85 85% = $71.25 **Future End Date:**
41810	Uvulotomy or uvulectomy (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $42.60 **Benefit:** 75% = $31.95 **Future End Date:**
41813	VALLECULAR OR PHARYNGEAL CYSTS, removal of (Anaes.) (Assist.) **Fee:** $426.55 **Benefit:** 75% = $319.95 **Future End Date:**
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.) **Fee:** $230.05 **Benefit:** 75% = $172.55 **Future End Date:**
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.) **Fee:** $426.55 **Benefit:** 75% = $319.95 **Future End Date:**
41828	OESOPHAGEAL STRICTURE, dilatation of, without oesophagoscopy (Anaes.) **Fee:** $62.55 **Benefit:** 75% = $46.95 85% = $53.20 **Future End Date:**
41831	Oesophagus, endoscopic pneumatic dilatation of, for treatment of achalasia (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $427.30 **Benefit:** 75% = $320.50 **Future End Date:**
41832	Oesophagus, balloon dilatation of, using interventional imaging techniques (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $273.50 **Benefit:** 75% = $205.15 **Future End Date:**

41834	Total laryngectomy, including cricopharyngeal myotomy and tracheo oesophageal puncture (H) (Anaes.) (Assist.) **Fee:** $1,893.65 **Benefit:** 75% = $1420.25 **Future End Date:**
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.) (See para TN.8.258 of explanatory notes to this Category) **Fee:** $1,479.45 **Benefit:** 75% = $1109.60 **Future End Date:**
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.) (See para TN.8.258 of explanatory notes to this Category) **Fee:** $1,819.00 **Benefit:** 75% = $1364.25 **Future End Date:**
41843	LARYNGOPHARYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUITY after laryngopharyngectomy USING STOMACH OR BOWEL (Anaes.) (Assist.) **Fee:** $1,599.60 **Benefit:** 75% = $1199.70 **Future End Date:**
41855	Microlaryngoscopy, by any approach, with or without biopsy (H) (Anaes.) (Assist.) **Fee:** $344.95 **Benefit:** 75% = $258.75 **Future End Date:**
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.) **Fee:** $723.25 **Benefit:** 75% = $542.45 **Future End Date:**
41867	Microlaryngoscopy, with partial or complete arytenoidectomy or arytenoid repositioning (H) (Anaes.) (Assist.) **Fee:** $734.15 **Benefit:** 75% = $550.65 **Future End Date:**
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.) **Fee:** $544.40 **Benefit:** 75% = $408.30 85% = $462.75 **Future End Date:**
41873	Larynx, fractured, operation for (H) (Anaes.) (Assist.) **Fee:** $703.25 **Benefit:** 75% = $527.45 **Future End Date:**
41876	Larynx, external operation on, or laryngofissure, with or without cordectomy (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $703.25 **Benefit:** 75% = $527.45 **Future End Date:**

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.) **Fee:** $1,139.65 **Benefit:** 75% = $854.75 **Future End Date:**
41880	Tracheostomy by a percutaneous technique (H) (Anaes.) **Fee:** $304.15 **Benefit:** 75% = $228.15 **Future End Date:**
41881	Tracheostomy by open exposure of the trachea (H) (Anaes.) (Assist.) **Fee:** $480.95 **Benefit:** 75% = $360.75 **Future End Date:**
41884	Cricothyrostomy (H) (Anaes.) **Fee:** $108.95 **Benefit:** 75% = $81.75 **Future End Date:**
41885	Trache-oesophageal fistula, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $344.60 **Benefit:** 75% = $258.45 **Future End Date:**
41886	Trachea, removal of foreign body in (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $213.05 **Benefit:** 75% = $159.80 **Future End Date:**
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.) **Fee:** $3,233.55 **Benefit:** 75% = $2425.20 **Future End Date:**
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.) **Fee:** $2,288.50 **Benefit:** 75% = $1716.40 **Future End Date:**
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.) **Fee:** $1,530.05 **Benefit:** 75% = $1147.55 **Future End Date:**
41907	NASAL SEPTUM BUTTON, insertion of (Anaes.) **Fee:** $146.95 **Benefit:** 75% = $110.25 85% = $124.95 **Future End Date:**
41910	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.) **Fee:** $467.10 **Benefit:** 75% = $350.35

T8. SURGICAL OPERATIONS	8. EAR, NOSE AND THROAT
	Future End Date:

T8. SURGICAL OPERATIONS	9. OPHTHALMOLOGY
	Group T8. Surgical Operations
	Subgroup 9. Ophthalmology
42503	OPHTHALMOLOGICAL EXAMINATION under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $122.65 **Benefit:** 75% = $92.00 **Future End Date:**
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.) (See para TN.8.296 of explanatory notes to this Category) **Fee:** $359.95 **Benefit:** 75% = $270.00 **Future End Date:**
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.) **Fee:** $359.95 **Benefit:** 75% = $270.00 **Extended Medicare Safety Net Cap:** $54.00 **Future End Date:**
42506	Eye, enucleation of, without insertion of implant (H) (Anaes.) (Assist.) **Fee:** $576.00 **Benefit:** 75% = $432.00 **Future End Date:**
42509	Eye, enucleation of, with insertion of non-integrated implant, without muscle attachment (H) (Anaes.) (Assist.) **Fee:** $729.00 **Benefit:** 75% = $546.75 **Future End Date:**
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.) **Fee:** $840.30 **Benefit:** 75% = $630.25 **Future End Date:**
42512	Globe, evisceration of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $576.00 **Benefit:** 75% = $432.00 **Future End Date:**

42515	GLOBE, EVISCERATION OF, AND INSERTION OF INTRASCLERAL BALL OR CARTILAGE (Anaes.) (Assist.) **Fee:** $729.00 **Benefit:** 75% = $546.75 **Future End Date:**
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.) **Fee:** $422.95 **Benefit:** 75% = $317.25 **Future End Date:**
42521	ANOPHTHALMIC SOCKET, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (Anaes.) (Assist.) **Fee:** $1,440.15 **Benefit:** 75% = $1080.15 **Future End Date:**
42527	CONTRACTED SOCKET, RECONSTRUCTION INCLUDING MUCOUS MEMBRANE GRAFTING AND STENT MOULD (Anaes.) (Assist.) **Fee:** $485.95 **Benefit:** 75% = $364.50 **Future End Date:**
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.) **Fee:** $756.10 **Benefit:** 75% = $567.10 **Future End Date:**
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.) **Fee:** $485.95 **Benefit:** 75% = $364.50 **Future End Date:**
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.) **Fee:** $998.85 **Benefit:** 75% = $749.15 **Future End Date:**
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.) **Fee:** $1,422.15 **Benefit:** 75% = $1066.65 **Future End Date:**
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.) **Fee:** $603.15 **Benefit:** 75% = $452.40 **Future End Date:**
42543	ORBIT, exploration of retrobulbar aspect with removal of tumour or foreign body (Anaes.) (Assist.) **Fee:** $1,057.85 **Benefit:** 75% = $793.40 **Future End Date:**

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.) **Fee:** $1,530.05 **Benefit:** 75% = $1147.55 **Future End Date:**
42548	OPTIC NERVE MENINGES, incision of (Anaes.) (Assist.) **Fee:** $908.90 **Benefit:** 75% = $681.70 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $756.10 **Benefit:** 75% = $567.10 **Future End Date:**
42554	EYE, PENETRATING WOUND OR RUPTURE OF, with incarceration or prolapse of uveal tissue repair (Anaes.) (Assist.) **Fee:** $882.15 **Benefit:** 75% = $661.65 **Future End Date:**
42557	EYE, PENETRATING WOUND OR RUPTURE OF, with incarceration of lens or vitreous repair (Anaes.) (Assist.) **Fee:** $1,233.05 **Benefit:** 75% = $924.80 **Future End Date:**
42563	Intraocular foreign body, removal from anterior segment (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $621.20 **Benefit:** 75% = $465.90 **Future End Date:**
42569	INTRAOCULAR FOREIGN BODY, removal from posterior segment (Anaes.) (Assist.) **Fee:** $1,233.05 **Benefit:** 75% = $924.80 **Future End Date:**
42572	ORBITAL ABSCESS OR CYST, drainage of (Anaes.) **Fee:** $140.45 **Benefit:** 75% = $105.35 85% = $119.40 **Future End Date:**
42573	DERMOID, periorbital, excision of, on a patient 10 years of age or over (Anaes.) **Fee:** $272.20 **Benefit:** 75% = $204.15 85% = $231.40 **Future End Date:**
42574	Dermoid, orbital, excision of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $578.40 **Benefit:** 75% = $433.80 **Future End Date:**
42575	TARSAL CYST, extirpation of (Anaes.) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 **Future End Date:**

42576	Dermoid, periorbital, excision of, on a patient under 10 years of age (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $353.90 **Benefit:** 75% = $265.45 **Future End Date:**
42581	ECTROPION OR ENTROPION, tarsal cauterisation of (Anaes.) **Fee:** $140.45 **Benefit:** 75% = $105.35 85% = $119.40 **Future End Date:**
42584	TARSORRHAPHY (Anaes.) (Assist.) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60 **Future End Date:**
42587	TRICHIASIS (due to causes other than trachoma), treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes.) **Fee:** $62.25 **Benefit:** 75% = $46.70 85% = $52.95 **Future End Date:**
42588	TRICHIASIS (due to trachoma), treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes.) **Fee:** $62.25 **Benefit:** 75% = $46.70 85% = $52.95 **Future End Date:**
42590	Canthoplasty, medial or lateral, excluding when performed in conjunction with cosmetic blepharoplasty (Anaes.) (Assist.) **Fee:** $405.00 **Benefit:** 75% = $303.75 85% = $344.25 **Extended Medicare Safety Net Cap:** $324.00 **Future End Date:**
42596	Lacrimal sac, excision of, or operation on (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $603.15 **Benefit:** 75% = $452.40 **Future End Date:**
42599	Lacrimal canalicular system, establishment of patency by closed operation using silicone tubes or similar, one eye (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $756.10 **Benefit:** 75% = $567.10 **Future End Date:**
42602	Lacrimal canalicular system, establishment of patency by open operation, one eye (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $756.10 **Benefit:** 75% = $567.10 **Future End Date:**
42605	Lacrimal canaliculus, immediate repair of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $557.90 **Benefit:** 75% = $418.45 **Future End Date:**

42608	LACRIMAL DRAINAGE by insertion of glass tube, as an independent procedure (Anaes.) (Assist.) **Fee:** $359.95 **Benefit:** 75% = $270.00 85% = $306.00 **Future End Date:**
42610	Nasolacrimal tube (unilateral), removal or replacement of, or lacrimal passages, probing for obstruction, unilateral, with or without lavage—under general anaesthesia (H) (Anaes.) **Fee:** $115.20 **Benefit:** 75% = $86.40 **Future End Date:**
42611	Nasolacrimal tube (bilateral), removal or replacement of, or lacrimal passages, probing for obstruction, bilateral, with or without lavage—under general anaesthesia (H) (Anaes.) **Fee:** $172.80 **Benefit:** 75% = $129.60 **Future End Date:**
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) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $57.75 **Benefit:** 75% = $43.35 85% = $49.10 **Future End Date:**
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) **Fee:** $86.50 **Benefit:** 75% = $64.90 85% = $73.55 **Future End Date:**
42617	PUNCTUM SNIP operation (Anaes.) **Fee:** $163.95 **Benefit:** 75% = $123.00 85% = $139.40 **Future End Date:**
42620	PUNCTUM, occlusion of, by use of a plug (Anaes.) **Fee:** $63.10 **Benefit:** 75% = $47.35 85% = $53.65 **Future End Date:**
42622	PUNCTUM, permanent occlusion of, by use of electrical cautery (Anaes.) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 **Future End Date:**
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.) **Fee:** $837.15 **Benefit:** 75% = $627.90 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category)

	Fee: $1,350.20 **Benefit:** 75% = $1012.65 **Future End Date:**
42629	Dacryocystorhinostomy, with placement of a permanent bypass tube from the conjunctival sac to the nasal cavity (H) (Anaes.) (Assist.) **Fee:** $1,017.05 **Benefit:** 75% = $762.80 **Future End Date:**
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.) **Fee:** $140.45 **Benefit:** 75% = $105.35 85% = $119.40 **Future End Date:**
42635	CORNEAL PERFORATIONS, sealing of, with tissue adhesive (Anaes.) (Assist.) **Fee:** $359.95 **Benefit:** 75% = $270.00 85% = $306.00 **Future End Date:**
42638	CONJUNCTIVAL GRAFT OVER CORNEA (Anaes.) (Assist.) **Fee:** $450.05 **Benefit:** 75% = $337.55 85% = $382.55 **Future End Date:**
42641	AUTOCONJUNCTIVAL TRANSPLANT, or mucous membrane graft (Anaes.) (Assist.) **Fee:** $585.05 **Benefit:** 75% = $438.80 85% = $497.30 **Future End Date:**
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.) (See para TN.8.78, TN.8.4 of explanatory notes to this Category) **Fee:** $86.35 **Benefit:** 75% = $64.80 85% = $73.40 **Future End Date:**
42647	Corneal scars, removal of, by partial keratectomy, other than a service associated with a service to which item 42686 or 42650 applies (Anaes.) **Fee:** $244.85 **Benefit:** 75% = $183.65 85% = $208.15 **Future End Date:**
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.) (See para TN.8.4 of explanatory notes to this Category) **Fee:** $86.35 **Benefit:** 75% = $64.80 85% = $73.40 **Future End Date:**
42651	CORNEA, epithelial debridement for eliminating band keratopathy (Anaes.) **Fee:** $192.50 **Benefit:** 75% = $144.40 85% = $163.65 **Future End Date:**
42652	Corneal collagen cross linking, on a patient with a corneal ectatic disorder, with evidence of progression—per eye (Anaes.) (See para TN.8.136 of explanatory notes to this Category) **Fee:** $1,436.30 **Benefit:** 75% = $1077.25 85% = $1327.80 **Future End Date:**

42653	CORNEA transplantation of (Anaes.) (Assist.) **Fee:** $1,565.20 **Benefit:** 75% = $1173.90 **Future End Date:**
42656	CORNEA, transplantation of, second and subsequent procedures (Anaes.) (Assist.) **Fee:** $1,998.20 **Benefit:** 75% = $1498.65 **Future End Date:**
42662	SCLERA, transplantation of, full thickness, including collection of donor material (Anaes.) (Assist.) **Fee:** $1,079.90 **Benefit:** 75% = $809.95 **Future End Date:**
42665	Sclera, transplantation of, superficial or lamellar, including collection of donor material (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $720.15 **Benefit:** 75% = $540.15 **Future End Date:**
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 **Fee:** $169.85 **Benefit:** 75% = $127.40 85% = $144.40 **Future End Date:**
42668	CORNEAL SUTURES, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or operating microscope (Anaes.) **Fee:** $90.10 **Benefit:** 75% = $67.60 85% = $76.60 **Future End Date:**
42672	Corneal incisions, to correct corneal astigmatism of more than $1^{1/}_{2}$ dioptres following anterior segment surgery, including appropriate measurements and calculations, performed as an independent procedure (H) (Anaes.) (Assist.) (See para GN.1.2, TN.8.79 of explanatory notes to this Category) **Fee:** $1,079.90 **Benefit:** 75% = $809.95 **Future End Date:**
42673	Additional corneal incisions, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres, including appropriate measurements and calculations, performed in conjunction with other anterior segment surgery (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $539.90 **Benefit:** 75% = $404.95 **Future End Date:**
42676	CONJUNCTIVA, biopsy of, as an independent procedure **Fee:** $138.45 **Benefit:** 75% = $103.85 85% = $117.70 **Future End Date:**
42677	CONJUNCTIVA, CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at which treatment is given including any associated consultation (Anaes.) **Fee:** $72.95 **Benefit:** 75% = $54.75 85% = $62.05

	Future End Date:
42680	CONJUNCTIVA, cryotherapy to, for melanotic lesions or similar using CO^2 or N^20 (Anaes.) **Fee:** $359.95 **Benefit:** 75% = $270.00 85% = $306.00 **Future End Date:**
42683	CONJUNCTIVAL CYSTS, removal of, requiring admission to hospital or approved day-hospital facility (Anaes.) **Fee:** $144.10 **Benefit:** 75% = $108.10 **Future End Date:**
42686	Pterygium, removal of, other than a service associated with a service to which item 42632 or 42647 applies (Anaes.) **Fee:** $327.55 **Benefit:** 75% = $245.70 85% = $278.45 **Future End Date:**
42689	PINGUECULA, removal of, not being a service associated with the fitting of contact lenses (Anaes.) **Fee:** $140.45 **Benefit:** 75% = $105.35 85% = $119.40 **Future End Date:**
42692	LIMBIC TUMOUR, removal of, excluding Pterygium (Anaes.) (Assist.) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60 **Future End Date:**
42695	LIMBIC TUMOUR, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Anaes.) (Assist.) **Fee:** $539.90 **Benefit:** 75% = $404.95 85% = $458.95 **Future End Date:**
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.) (See para GN.1.2, TN.8.80 of explanatory notes to this Category) **Fee:** $711.80 **Benefit:** 75% = $533.85 **Future End Date:**
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.) (See para GN.1.2, TN.8.80 of explanatory notes to this Category) **Fee:** $396.95 **Benefit:** 75% = $297.75 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $910.35 **Benefit:** 75% = $682.80 **Future End Date:**
42703	Intraocular lens or iris prosthesis, insertion of, into the posterior chamber with fixation to the iris or sclera (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category)

	Fee: $684.65 **Benefit:** 75% = $513.50 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $557.90 **Benefit:** 75% = $418.45 **Future End Date:**
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.) (See para TN.8.296 of explanatory notes to this Category) **Fee:** $1,090.55 **Benefit:** 75% = $817.95 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $954.05 **Benefit:** 75% = $715.55 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,079.90 **Benefit:** 75% = $809.95 **Future End Date:**
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.) **Fee:** $450.05 **Benefit:** 75% = $337.55 **Future End Date:**
42716	Cataract, juvenile, removal of, including subsequent needlings (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,431.10 **Benefit:** 75% = $1073.35 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category)

	Fee: $621.20 **Benefit:** 75% = $465.90 **Future End Date:**
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.) **Fee:** $1,602.00 **Benefit:** 75% = $1201.50 **Future End Date:**
42731	LIMBAL OR PARS PLANA LENSECTOMY combined with vitrectomy, not being a service associated with items 42698, 42702, 42719, or 42725 (Anaes.) (Assist.) **Fee:** $1,818.05 **Benefit:** 75% = $1363.55 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $359.95 **Benefit:** 75% = $270.00 **Future End Date:**
42743	Anterior chamber, irrigation of blood from, as an independent procedure (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $756.10 **Benefit:** 75% = $567.10 **Future End Date:**
42744	Needle revision of glaucoma filtration bleb, following glaucoma filtering surgery (Anaes.) **Fee:** $359.75 **Benefit:** 75% = $269.85 85% = $305.80 **Future End Date:**
42746	Glaucoma filtering surgery, if conservative therapies have failed, are likely to fail, or are contraindicated (H) (Anaes.) (Assist.) **Fee:** $1,143.05 **Benefit:** 75% = $857.30 **Future End Date:**
42749	Glaucoma filtering surgery, if previous filtering surgery has been performed (H) (Anaes.) (Assist.) **Fee:** $1,431.10 **Benefit:** 75% = $1073.35 **Future End Date:**
42750	Subconjunctival injection of antifibrotic agent following glaucoma filtering surgery, as an independent procedure (Anaes.) **Fee:** $63.80 **Benefit:** 75% = $47.85 85% = $54.25 **Future End Date:**
42752	Insertion of glaucoma drainage device incorporating an extraocular reservoir (H) (Anaes.) (Assist.) (See para TN.8.83 of explanatory notes to this Category) **Fee:** $1,602.00 **Benefit:** 75% = $1201.50

	Future End Date:
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 lumen One eye (H) (Anaes.) (Assist.) **Fee:** $197.95 **Benefit:** 75% = $148.50 **Future End Date:**
42758	Goniotomy for the treatment of primary congenital glaucoma, excluding the minimally invasive implantation of glaucoma drainage devices (Anaes.) (Assist.) **Fee:** $837.15 **Benefit:** 75% = $627.90 **Future End Date:**
42761	Division of anterior or posterior synechiae, as an independent procedure, other than by laser (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $621.20 **Benefit:** 75% = $465.90 **Future End Date:**
42764	Iridectomy (including excision of tumour of iris) or iridotomy, as an independent procedure, other than by laser (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $621.20 **Benefit:** 75% = $465.90 **Future End Date:**
42767	TUMOUR, INVOLVING CILIARY BODY OR CILIARY BODY AND IRIS, excision of (Anaes.) (Assist.) **Fee:** $1,304.95 **Benefit:** 75% = $978.75 **Future End Date:**
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.) (See para TN.8.82 of explanatory notes to this Category) **Fee:** $352.80 **Benefit:** 75% = $264.60 85% = $299.90 **Future End Date:**
42773	Detached retina, pneumatic retinopexy for, as an independent procedure (Anaes.) (Assist.) **Fee:** $1,079.90 **Benefit:** 75% = $809.95 85% = $971.40 **Future End Date:**
42776	DETACHED RETINA, buckling or resection operation for (Anaes.) (Assist.) **Fee:** $1,602.00 **Benefit:** 75% = $1201.50 **Future End Date:**
42779	DETACHED RETINA, revision of scleral buckling operation for (Anaes.) (Assist.) **Fee:** $1,998.20 **Benefit:** 75% = $1498.65 **Future End Date:**
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.)

	(See para TN.8.84 of explanatory notes to this Category) **Fee:** $539.90 **Benefit:** 75% = $404.95 85% = $458.95 **Future End Date:**
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.) (See para TN.8.85 of explanatory notes to this Category) **Fee:** $422.95 **Benefit:** 75% = $317.25 85% = $359.55 **Future End Date:**
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.) (See para TN.8.86 of explanatory notes to this Category) **Fee:** $422.95 **Benefit:** 75% = $317.25 85% = $359.55 **Future End Date:**
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.) (See para TN.8.87 of explanatory notes to this Category) **Fee:** $422.95 **Benefit:** 75% = $317.25 85% = $359.55 **Future End Date:**
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.) (See para TN.8.88 of explanatory notes to this Category) **Fee:** $81.05 **Benefit:** 75% = $60.80 85% = $68.90 **Future End Date:**
42801	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, insertion of (Anaes.) (Assist.) **Fee:** $1,256.45 **Benefit:** 75% = $942.35 **Future End Date:**
42802	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, removal of (Anaes.) (Assist.) **Fee:** $627.95 **Benefit:** 75% = $471.00 **Future End Date:**
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.) **Fee:** $702.00 **Benefit:** 75% = $526.50 **Future End Date:**
42808	Laser iridoplasty **Fee:** $425.85 **Benefit:** 75% = $319.40 85% = $362.00 **Future End Date:**

42809	RETINA, photocoagulation of, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.) **Fee:** $539.90 **Benefit:** 75% = $404.95 85% = $458.95 **Future End Date:**
42810	PHOTOTHERAPEUTIC KERATECTOMY, by laser, for corneal scarring or disease, excluding surgery for refractive error (Anaes.) **Fee:** $679.40 **Benefit:** 75% = $509.55 85% = $577.50 **Future End Date:**
42811	TRANSPUPILLARY THERMOTHERAPY, for treatment of choroidal and retinal tumours or vascular malformations (Anaes.) **Fee:** $539.90 **Benefit:** 75% = $404.95 85% = $458.95 **Future End Date:**
42812	Removal of scleral buckling material, from an eye having undergone previous scleral buckling surgery (Anaes.) **Fee:** $197.95 **Benefit:** 75% = $148.50 85% = $168.30 **Future End Date:**
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.) **Fee:** $756.10 **Benefit:** 75% = $567.10 **Future End Date:**
42818	Retina or ciliary body, cryotherapy to, as an independent procedure, or when performed in conjunction with item 42809 (Anaes.) **Fee:** $702.00 **Benefit:** 75% = $526.50 85% = $596.70 **Future End Date:**
42821	OCULAR TRANSILLUMINATION, for the diagnosis and measurement of intraocular tumours (Anaes.) **Fee:** $108.20 **Benefit:** 75% = $81.15 85% = $92.00 **Future End Date:**
42824	RETROBULBAR INJECTION OF ALCOHOL OR OTHER DRUG, as an independent procedure **Fee:** $83.60 **Benefit:** 75% = $62.70 85% = $71.10 **Future End Date:**
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.) **Fee:** $702.00 **Benefit:** 75% = $526.50 **Future End Date:**
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.) **Fee:** $873.00 **Benefit:** 75% = $654.75 **Future End Date:**

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.) **Fee:** $837.15 **Benefit:** 75% = $627.90 **Future End Date:**
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.) **Fee:** $1,044.05 **Benefit:** 75% = $783.05 **Future End Date:**
42845	READJUSTMENT OF ADJUSTABLE SUTURES, 1 or both eyes, as an independent procedure following an operation for correction of squint (Anaes.) (See para TN.8.89 of explanatory notes to this Category) **Fee:** $226.75 **Benefit:** 75% = $170.10 85% = $192.75 **Future End Date:**
42848	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 15 years or over (Anaes.) (Assist.) **Fee:** $837.15 **Benefit:** 75% = $627.90 **Future End Date:**
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.) **Fee:** $1,044.05 **Benefit:** 75% = $783.05 **Future End Date:**
42854	Ruptured medial palpebral ligament or ruptured extra-ocular muscle, repair of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $485.95 **Benefit:** 75% = $364.50 **Future End Date:**
42857	Resuturing of wound following intraocular procedures with or without excision of prolapsed iris (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $485.95 **Benefit:** 75% = $364.50 **Future End Date:**
42860	Eyelid (upper or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid retractors (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,079.90 **Benefit:** 75% = $809.95 **Future End Date:**
42863	Eyelid (upper or lower), recession of, by open operation on and direct release of the lid retractors, one eye (Anaes.) (Assist.) **Fee:** $927.15 **Benefit:** 75% = $695.40 85% = $818.65 **Future End Date:**

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.) **Fee:** $899.85 **Benefit:** 75% = $674.90 85% = $791.35 **Future End Date:**
42869	EYELID closure in facial nerve paralysis, insertion of foreign implant for (Anaes.) (Assist.) **Fee:** $657.10 **Benefit:** 75% = $492.85 85% = $558.55 **Future End Date:**
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.) **Fee:** $288.05 **Benefit:** 75% = $216.05 85% = $244.85 **Future End Date:**
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. **Fee:** $544.70 **Benefit:** 75% = $408.55 85% = $463.00 **Future End Date:**
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. **Fee:** $653.70 **Benefit:** 75% = $490.30 85% = $555.65 **Future End Date:**
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 (See para TN.8.121 of explanatory notes to this Category) **Fee:** $359.95 **Benefit:** 75% = $270.00 85% = $306.00 **Extended Medicare Safety Net Cap:** $288.00 **Future End Date:**
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 (See para TN.8.121 of explanatory notes to this Category) **Fee:** $359.95 **Benefit:** 75% = $270.00 85% = $306.00 **Extended Medicare Safety Net Cap:** $288.00 **Future End Date:**
43034	Paracentesis of anterior chamber or vitreous cavity, or both, for either or both of the following: (a) the injection of therapeutic substances;

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	(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.) (See para TN.8.121 of explanatory notes to this Category) **Fee:** $359.95 **Benefit:** 75% = $270.00 85% = $306.00 **Extended Medicare Safety Net Cap:** $288.00 **Future End Date:**
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.) (See para TN.8.121 of explanatory notes to this Category) **Fee:** $359.95 **Benefit:** 75% = $270.00 85% = $306.00 **Extended Medicare Safety Net Cap:** $288.00 **Future End Date:**
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.) (See para TN.8.121 of explanatory notes to this Category) **Fee:** $359.95 **Benefit:** 75% = $270.00 85% = $306.00 **Extended Medicare Safety Net Cap:** $288.00 **Future End Date:**
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.) (See para TN.8.121 of explanatory notes to this Category) **Fee:** $359.95 **Benefit:** 75% = $270.00 85% = $306.00 **Extended Medicare Safety Net Cap:** $288.00 **Future End Date:**
43050	Choroidal detachment, repair by external drainage (H) (Anaes.) (Assist.) **Fee:** $806.95 **Benefit:** 75% = $605.25 **Future End Date:**

T8. SURGICAL OPERATIONS	10. OPERATIONS FOR OSTEOMYELITIS
	Group T8. Surgical Operations
	Subgroup 10. Operations For Osteomyelitis
	CHRONIC
43521	OPERATION ON SKULL (Anaes.) (Assist.) **Fee:** $556.05 **Benefit:** 75% = $417.05 **Future End Date:**

T8. SURGICAL OPERATIONS	10. OPERATIONS FOR OSTEOMYELITIS
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.) **Fee:** $426.55 **Benefit:** 75% = $319.95 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $426.55 **Benefit:** 75% = $319.95 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $703.25 **Benefit:** 75% = $527.45 **Future End Date:**

T8. SURGICAL OPERATIONS	11. PAEDIATRIC
	Group T8. Surgical Operations
	Subgroup 11. Paediatric
	SURGERY IN NEONATE OR YOUNG CHILD
43801	INTESTINAL MALROTATION with or without volvulus, laparotomy for, not involving bowel resection (Anaes.) (Assist.) **Fee:** $1,145.90 **Benefit:** 75% = $859.45 **Future End Date:**
43804	INTESTINAL MALROTATION with or without volvulus, laparotomy for, with bowel resection and anastomosis, with or without formation of stoma (Anaes.) (Assist.) **Fee:** $1,219.90 **Benefit:** 75% = $914.95 **Future End Date:**
43805	UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, on a patient under 10 years of age (Anaes.) **Fee:** $426.55 **Benefit:** 75% = $319.95 **Future End Date:**
43807	DUODENAL ATRESIA or STENOSIS, duodenoduodenostomy or duodenojejunostomy for (Anaes.) (Assist.) **Fee:** $1,330.95 **Benefit:** 75% = $998.25 **Future End Date:**
43810	JEJUNAL ATRESIA, bowel resection and anastomosis for, with or without tapering (Anaes.) (Assist.) **Fee:** $1,552.75 **Benefit:** 75% = $1164.60 **Future End Date:**

43813	MECONIUM ILEUS, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intesinal perforation with or without meconium peritonitis (Anaes.) (Assist.) **Fee:** $1,552.75 **Benefit:** 75% = $1164.60 **Future End Date:**
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.) **Fee:** $1,441.80 **Benefit:** 75% = $1081.35 **Future End Date:**
43819	Agangliosis Coli, laparotomy for, with or without frozen section biopsies and formation of stoma (Anaes.) (Assist.) **Fee:** $1,164.60 **Benefit:** 75% = $873.45 **Future End Date:**
43822	ANORECTAL MALFORMATION, laparotomy and colostomy for (Anaes.) (Assist.) **Fee:** $1,164.60 **Benefit:** 75% = $873.45 **Future End Date:**
43825	NEONATAL ALIMENTARY OBSTRUCTION, laparotomy for, not being a service to which any other item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $1,330.95 **Benefit:** 75% = $998.25 **Future End Date:**
43828	ACUTE NEONATAL NECROTISING ENTEROCOLITIS, laparotomy for, with resection, including any anastomoses or stoma formation (Anaes.) (Assist.) **Fee:** $1,470.45 **Benefit:** 75% = $1102.85 **Future End Date:**
43831	ACUTE NEONATAL NECROTISING ENTEROCOLITIS where no definitive procedure is possible, laparotomy for (Anaes.) (Assist.) **Fee:** $1,145.90 **Benefit:** 75% = $859.45 **Future End Date:**
43832	Branchial fistula, removal of, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $781.50 **Benefit:** 75% = $586.15 **Future End Date:**
43834	BOWEL RESECTION for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (Anaes.) (Assist.) **Fee:** $1,330.95 **Benefit:** 75% = $998.25 **Future End Date:**
43835	STRANGULATED, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel resection, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $811.15 **Benefit:** 75% = $608.40 **Future End Date:**
43837	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, with diagnosis confirmed in the first 24 hours of life (Anaes.) (Assist.)

	Fee: $1,663.60 **Benefit:** 75% = $1247.70 **Future End Date:**
43838	Diaphragmatic hernia, congential repair of, by thoracic or abdominal approach, not being a service to which any of items 31569 to 31581 apply, on a patient under 10 years of age (Anaes.) (Assist.) **Fee:** $1,489.45 **Benefit:** 75% = $1117.10 **Future End Date:**
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.) **Fee:** $1,441.80 **Benefit:** 75% = $1081.35 **Future End Date:**
43841	Femoral or inguinal hernia or infantile hydrocele, repair of, on a patient under 10 years of age, other than a service to which item 30651 or 43835 applies (H) (Anaes.) (Assist.) **Fee:** $722.70 **Benefit:** 75% = $542.05 **Future End Date:**
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.) **Fee:** $2,218.25 **Benefit:** 75% = $1663.70 **Future End Date:**
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.) **Fee:** $2,384.55 **Benefit:** 75% = $1788.45 **Future End Date:**
43849	OESOPHAGEAL ATRESIA, gastrostomy for (Anaes.) (Assist.) **Fee:** $610.05 **Benefit:** 75% = $457.55 **Future End Date:**
43852	OESOPHAGEAL ATRESIA, thoracotomy for, and division of tracheo-oesophageal fistula without anastomosis (Anaes.) (Assist.) **Fee:** $1,940.85 **Benefit:** 75% = $1455.65 **Future End Date:**
43855	OESOPHAGEAL ATRESIA, delayed primary anastomosis for (Anaes.) (Assist.) **Fee:** $2,051.95 **Benefit:** 75% = $1539.00 **Future End Date:**
43858	OESOPHAGEAL ATRESIA, cervical oesophagostomy for (Anaes.) (Assist.) **Fee:** $720.85 **Benefit:** 75% = $540.65 **Future End Date:**
43861	CONGENITAL CYSTADENOMATOID MALFORMATION OR CONGENITAL LOBAR EMPHYSEMA, thoracotomy and lung resection for (Anaes.) (Assist.) **Fee:** $1,996.50 **Benefit:** 75% = $1497.40 **Future End Date:**
43864	GASTROSCHISIS, operation for (Anaes.) (Assist.)

	Fee: $1,497.35 **Benefit:** 75% = $1123.05 **Future End Date:**
43867	GASTROSCHISIS or Exomphalos, secondary operation for, with removal of silo (Anaes.) (Assist.) **Fee:** $831.80 **Benefit:** 75% = $623.85 **Future End Date:**
43870	EXOMPHALOS containing small bowel only, operation for (Anaes.) (Assist.) **Fee:** $1,164.60 **Benefit:** 75% = $873.45 **Future End Date:**
43873	EXOMPHALOS containing small bowel and other viscera, operation for (Anaes.) (Assist.) **Fee:** $1,552.75 **Benefit:** 75% = $1164.60 **Future End Date:**
43876	SACROCOCCYGEAL TERATOMA, excision of, by posterior approach (Anaes.) (Assist.) **Fee:** $1,330.95 **Benefit:** 75% = $998.25 **Future End Date:**
43879	SACROCOCCYGEAL TERATOMA, excision of, by combined posterior and abdominal approach (Anaes.) (Assist.) **Fee:** $1,552.75 **Benefit:** 75% = $1164.60 **Future End Date:**
43882	Cloacal exstrophy, operation for (H) (Anaes.) (Assist.) **Fee:** $1,996.50 **Benefit:** 75% = $1497.40 **Future End Date:**
	THORACIC SURGERY
43900	TRACHEO-OESOPHAGEAL FISTULA without atresia, division and repair of (Anaes.) (Assist.) **Fee:** $1,330.95 **Benefit:** 75% = $998.25 **Future End Date:**
43903	OESOPHAGEAL ATRESIA or CORROSIVE OESOPHAGEAL STRICTURE, oesophageal replacement for, utilizing gastric tube, jejunum or colon (Anaes.) (Assist.) **Fee:** $2,218.25 **Benefit:** 75% = $1663.70 **Future End Date:**
43906	OESOPHAGUS, resection of congenital, anastomic or corrosive stricture and anastomosis, not being a service to which item 43903 applies (Anaes.) (Assist.) **Fee:** $1,940.85 **Benefit:** 75% = $1455.65 **Future End Date:**
43909	TRACHEOMALACIA, aortopexy for (Anaes.) (Assist.) **Fee:** $1,940.85 **Benefit:** 75% = $1455.65 **Future End Date:**
43912	THORACOTOMY and excision of 1 or more of bronchogenic or enterogenous cyst or mediastinal teratoma (Anaes.) (Assist.) **Fee:** $1,833.60 **Benefit:** 75% = $1375.20 **Future End Date:**

43915	EVENTRATION, plication of diaphragm for (Anaes.) (Assist.) **Fee:** $1,386.40 **Benefit:** 75% = $1039.80 **Future End Date:**
	ABDOMINAL SURGERY
43930	HYPERTROPHIC PYLORIC STENOSIS, pyloromyotomy for (Anaes.) (Assist.) **Fee:** $533.15 **Benefit:** 75% = $399.90 **Future End Date:**
43933	IDIOPATHIC INTUSSUSCEPTION, laparotomy and manipulative reduction of (Anaes.) (Assist.) **Fee:** $624.10 **Benefit:** 75% = $468.10 **Future End Date:**
43936	INTUSSUSCEPTION, laparotomy and resection with anastomosis (Anaes.) (Assist.) **Fee:** $1,164.60 **Benefit:** 75% = $873.45 **Future End Date:**
43939	VENTRAL HERNIA following neonatal closure of exomphalos or gastroschisis, repair of (Anaes.) (Assist.) **Fee:** $887.25 **Benefit:** 75% = $665.45 **Future End Date:**
43942	ABDOMINAL WALL VITELLO INTESTINAL REMNANT, excision of (Anaes.) **Fee:** $277.30 **Benefit:** 75% = $208.00 **Future End Date:**
43945	PATENT VITELLO INTESTINAL DUCT, excision of (Anaes.) (Assist.) **Fee:** $1,164.60 **Benefit:** 75% = $873.45 **Future End Date:**
43948	UMBILICAL GRANULOMA, excision of, under general anaesthesia (Anaes.) **Fee:** $166.45 **Benefit:** 75% = $124.85 **Future End Date:**
43951	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, without gastrostomy (Anaes.) (Assist.) **Fee:** $1,042.85 **Benefit:** 75% = $782.15 **Future End Date:**
43954	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (Anaes.) (Assist.) **Fee:** $1,275.65 **Benefit:** 75% = $956.75 **Future End Date:**
43957	GASTRO-OESOPHAGEAL REFLUX, LAPAROTOMY AND FUNDOPLICATION for, with or without hiatus hernia, in child with neurological disease, with gastrostomy (Anaes.) (Assist.) **Fee:** $1,386.40 **Benefit:** 75% = $1039.80 **Future End Date:**
43960	ANORECTAL MALFORMATION, perineal anoplasty of (Anaes.) (Assist.)

	Fee: $487.75 **Benefit:** 75% = $365.85 **Future End Date:**
43963	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of (Anaes.) (Assist.) **Fee:** $1,940.85 **Benefit:** 75% = $1455.65 **Future End Date:**
43966	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of, with laparotomy (Anaes.) (Assist.) **Fee:** $2,218.25 **Benefit:** 75% = $1663.70 **Future End Date:**
43969	PERSISTENT CLOACA, total correction of, with genital repair using posterior sagittal approach, with or without laparotomy (Anaes.) (Assist.) **Fee:** $3,050.15 **Benefit:** 75% = $2287.65 **Future End Date:**
43972	CHOLEDOCHAL CYST, resection of, with 1 duct anastomosis (Anaes.) (Assist.) **Fee:** $2,218.25 **Benefit:** 75% = $1663.70 **Future End Date:**
43975	CHOLEDOCHAL CYST, resection of, with 2 duct anastomoses (Anaes.) (Assist.) **Fee:** $2,606.55 **Benefit:** 75% = $1954.95 **Future End Date:**
43978	BILIARY ATRESIA, portoenterostomy for (Anaes.) (Assist.) **Fee:** $2,218.25 **Benefit:** 75% = $1663.70 **Future End Date:**
43981	NEPHROBLASTOMA, NEUROBLASTOMA OR OTHER MALIGNANT TUMOUR, laparotomy (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.) **Fee:** $610.05 **Benefit:** 75% = $457.55 **Future End Date:**
43984	NEPHROBLASTOMA, radical nephrectomy for (Anaes.) (Assist.) **Fee:** $1,552.75 **Benefit:** 75% = $1164.60 **Future End Date:**
43987	NEUROBLASTOMA, radical excision of (Anaes.) (Assist.) **Fee:** $1,719.20 **Benefit:** 75% = $1289.40 **Future End Date:**
43990	Aganglionosis Coli, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends to sigmoid colon (Anaes.) (Assist.) **Fee:** $2,107.45 **Benefit:** 75% = $1580.60 **Future End Date:**
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.)

	Fee: $2,273.75 **Benefit:** 75% = $1705.35 **Future End Date:**
43996	Aganglionosis Coli, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or without side to side ileocolic anastomosis (Anaes.) (Assist.) **Fee:** $2,551.00 **Benefit:** 75% = $1913.25 **Future End Date:**
43999	Aganglionosis Coli, anal sphincterotomy as an independent procedure for (Anaes.) (Assist.) **Fee:** $319.00 **Benefit:** 75% = $239.25 **Future End Date:**
44101	RECTUM, examination of, on a patient under 2 years of age, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.) **Fee:** $399.85 **Benefit:** 75% = $299.90 **Future End Date:**
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.) **Fee:** $307.60 **Benefit:** 75% = $230.70 **Future End Date:**
44104	Rectal prolapse, submucosal or perirectal injection for, under general anaesthesia, on a patient under 2 years of age (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $70.25 **Benefit:** 75% = $52.70 **Future End Date:**
44105	Rectal prolapse, submucosal or perirectal injection for, under general anaesthesia, on a patient 2 years of age or over (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $53.95 **Benefit:** 75% = $40.50 **Future End Date:**
44108	Inguinal hernia, laparoscopic or open repair of, at age less than 12 months (H) (Anaes.) (Assist.) **Fee:** $722.70 **Benefit:** 75% = $542.05 **Future End Date:**
44111	Obstructed or strangulated inguinal hernia, laparoscopic or open repair of, at age less than 12 months, including orchidopexy when performed (H) (Anaes.) (Assist.) **Fee:** $811.15 **Benefit:** 75% = $608.40 **Future End Date:**
44114	Inguinal hernia, laparoscopic or open repair of, at age less than 12 months when orchidopexy also required (H) (Anaes.) (Assist.) **Fee:** $811.15 **Benefit:** 75% = $608.40 **Future End Date:**
	MISCELLANEOUS SURGERY
44130	Lymphadenectomy, for atypical mycobacterial infection or other granulomatous disease (H) (Anaes.) (Assist.)

	(See para GN.1.2 of explanatory notes to this Category) **Fee:** $554.50 **Benefit:** 75% = $415.90 **Future End Date:**
44133	TORTICOLLIS, open division of sternomastoid muscle for (Anaes.) (Assist.) **Fee:** $440.10 **Benefit:** 75% = $330.10 **Future End Date:**
44136	Ingrown toe nail, operation for, under general anaesthesia (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $202.90 **Benefit:** 75% = $152.20 **Future End Date:**

	Group T8. Surgical Operations
	Subgroup 12. Amputations
44325	Amputation of hand, transcarpal (H) (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $353.90 **Benefit:** 75% = $265.45 **Future End Date:**
44328	Amputation of hand, proximal to wrist radiocarpal joint, through forearm (H) (Anaes.) (Assist.) **Fee:** $426.55 **Benefit:** 75% = $319.95 **Future End Date:**
44331	Amputation at shoulder (H) (Anaes.) (Assist.) **Fee:** $703.25 **Benefit:** 75% = $527.45 **Future End Date:**
44334	Interscapulothoracic amputation (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,429.40 **Benefit:** 75% = $1072.05 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $172.40 **Benefit:** 75% = $129.30 **Future End Date:**

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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $263.15 **Benefit:** 75% = $197.40 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $304.00 **Benefit:** 75% = $228.00 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $344.95 **Benefit:** 75% = $258.75 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $394.75 **Benefit:** 75% = $296.10 **Future End Date:**

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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $263.15 **Benefit:** 75% = $197.40 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $315.85 **Benefit:** 75% = $236.90 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $522.35 **Benefit:** 75% = $391.80 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $353.90 **Benefit:** 75% = $265.45 **Future End Date:**
44367	Amputation through thigh, at knee or below knee (H) (Anaes.) (Assist.) **Fee:** $624.70 **Benefit:** 75% = $468.55 **Future End Date:**
44370	Amputation at hip (H) (Anaes.) (Assist.) **Fee:** $862.05 **Benefit:** 75% = $646.55 **Future End Date:**
44373	Hindquarter, amputation of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,769.45 **Benefit:** 75% = $1327.10 **Future End Date:**
44376	Amputation stump, re-amputation of, to provide adequate skin and muscle cover (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Derived Fee:** 75% of the original amputation fee **Future End Date:**

	Group T8. Surgical Operations
	Subgroup 13. Plastic And Reconstructive Surgery
45070	Developmental breast abnormality, single stage correction of, involving surgery on one breast, if: (a) the correction involves either: (i) insertion of an implant with or without mastopexy; or (ii) reduction mammaplasty; and (b) there is a difference in breast volume with the other breast, 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 (c) photographic 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 (H) (Anaes.) (Assist.) **Fee:** $1,014.40 **Benefit:** 75% = $760.80 **Future End Date:**

45071	Developmental breast abnormality, 2 stage correction of, first stage, involving surgery on one breast with insertion of a tissue expander, if: (a) there is a difference in breast volume with the other breast, 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 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 (H) (Anaes.) (Assist.) **Fee:** $1,014.40 **Benefit:** 75% = $760.80 **Future End Date:**
45072	Developmental breast abnormality, 2 stage correction of, second stage, involving surgery on one breast with exchange of a tissue expander for an implant (which must have at least a 10% volume difference), if: (a) there is a difference in breast volume with the other breast, 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 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 (H) (Anaes.) (Assist.) **Fee:** $734.05 **Benefit:** 75% = $550.55 **Future End Date:**
45440	Split thickness skin graft to a small defect that is: (a) less than 40 mm in diameter: (i) on areas below the knee; or (ii) distal to the ulnar styloid; or (iii) on the genital area; or (iv) on areas above the clavicle; or (b) less than 80 mm in diameter on any other part of the body (Anaes.) (Assist.) (See para TN.8.266 of explanatory notes to this Category) **Fee:** $340.30 **Benefit:** 75% = $255.25 85% = $289.30 **Future End Date:**
45443	Split thickness skin graft to a large defect that is: (a) 40 mm or more in diameter: (i) on areas below the knee; or (ii) distal to the ulnar styloid; or

	(iii) on the genital area; or (iv) on areas above the clavicle; or (b) 80 mm or more in diameter on any other part of the body (Anaes.) (Assist.) (See para TN.8.266 of explanatory notes to this Category) **Fee:** $702.00 **Benefit:** 75% = $526.50 85% = $596.70 **Future End Date:**
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.) **Fee:** $1,957.50 **Benefit:** 75% = $1468.15 **Future End Date:**
45510	Scar, of face or neck, not more than 3 cm in length, revision of, if: (a) undertaken in the operating theatre of a hospital; or (b) performed by a specialist in the practice of the specialist's specialty (Anaes.) (See para TN.8.95 of explanatory notes to this Category) **Fee:** $263.15 **Benefit:** 75% = $197.40 85% = $223.70 **Future End Date:**
45529	Breast reconstruction (bilateral), following mastectomy, using permanent prostheses, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.) (See para TN.8.97 of explanatory notes to this Category) **Fee:** $2,243.65 **Benefit:** 75% = $1682.75 **Future End Date:**
45531	Post-mastectomy breast reconstruction, autologous (bilateral), 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.) (See para TN.8.8, TN.8.97 of explanatory notes to this Category) **Fee:** $2,302.75 **Benefit:** 75% = $1727.10 **Future End Date:**
45532	Revision of post-mastectomy breast reconstruction, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.) **Fee:** $324.20 **Benefit:** 75% = $243.15 **Future End Date:**
45537	Perforator flap, such as a thoracodorsal artery perforator (TDAP) flap or a lateral intercostal artery perforator (LICAP) flap, or similar, raising on a named source vessel, for reconstruction of a partial mastectomy defect, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.) **Fee:** $941.45 **Benefit:** 75% = $706.10 **Future End Date:**

45538	Perforator flap, such as a deep inferior epigastric perforator (DIEP) flap or similar, raising in preparation for microsurgical transfer of a free flap for post mastectomy breast reconstruction, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.) **Fee:** $1,077.20 **Benefit:** 75% = $807.90 **Future End Date:**
45540	Breast reconstruction (bilateral), 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.) **Fee:** $3,020.35 **Benefit:** 75% = $2265.30 **Future End Date:**
45541	Breast reconstruction (bilateral), 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.) **Fee:** $1,284.80 **Benefit:** 75% = $963.60 **Future End Date:**
45547	Revision of breast prosthesis pocket, if: (a) breast prosthesis or tissue expander has been placed for the purpose of breast reconstruction in the context of breast cancer or for developmental breast abnormality; and (b) the prosthesis or tissue expander has migrated or rotated from its intended position or orientation; and (c) the existing prosthesis is used (H) (Anaes.) (Assist.) (See para TN.8.262 of explanatory notes to this Category) **Fee:** $837.15 **Benefit:** 75% = $627.90 **Future End Date:**
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.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $3,515.20 **Benefit:** 75% = $2636.40 **Future End Date:**
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.) (See para TN.8.8, TN.8.97 of explanatory notes to this Category)

	Fee: $1,238.75 **Benefit:** 75% = $929.10 **Future End Date:**
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.) **Fee:** $1,018.75 **Benefit:** 75% = $764.10 **Future End Date:**
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.) **Fee:** $477.45 **Benefit:** 75% = $358.10 **Future End Date:**
45717	Alveolar cleft (congenital), unilateral, bone grafting of, including local flap closure of associated oro-nasal fistulae and ridge augmentation, other than a service associated with a service to which item 45718 applies (H) (Anaes.) (Assist.) **Fee:** $1,407.50 **Benefit:** 75% = $1055.65 **Future End Date:**
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.) (See para TN.8.105 of explanatory notes to this Category) **Fee:** $1,531.35 **Benefit:** 75% = $1148.55 **Future End Date:**
45874	Temporomandibular joint, including condylar head and glenoid fossa, total alloplastic replacement (H) (Anaes.) (Assist.) **Fee:** $1,577.30 **Benefit:** 75% = $1183.00 **Future End Date:**
46050	Perforator flap, raising on a named source vessel, for pedicled transfer for head or neck or other non-breast reconstruction (H) (Anaes.) (Assist.) (See para TN.8.268 of explanatory notes to this Category) **Fee:** $941.45 **Benefit:** 75% = $706.10 **Future End Date:**
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.) (See para TN.8.268 of explanatory notes to this Category) **Fee:** $297.15 **Benefit:** 75% = $222.90 **Future End Date:**
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 applies Single surgeon (H) (Anaes.) (Assist.) (See para TN.8.267 of explanatory notes to this Category) **Fee:** $3,186.20 **Benefit:** 75% = $2389.65 **Future End Date:**
46062	Free transfer of tissue with a vascularised bone component (including chimeric/composite flap), for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to): (a) anastomoses of all required vessels using microvascular techniques; and (b) harvesting of flap (including osteotomies); and (c) raising of tissue on a vascular pedicle; and (d) preparation of recipient vessels; and (e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed; other than the following: (g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base; (h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) (See para TN.8.267 of explanatory notes to this Category) **Fee:** $3,047.70 **Benefit:** 75% = $2285.80 **Future End Date:**
46064	Free transfer of tissue with a vascularised bone component (including chimeric/composite flap), for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to): (a) anastomoses of all required vessels using microvascular techniques; and (b) harvesting of flap (including osteotomies); and (c) raising of tissue on a vascular pedicle; and (d) preparation of recipient vessels; and (e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed; other than the following: (g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base; (h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.) (See para TN.8.267 of explanatory notes to this Category) **Fee:** $2,285.90 **Benefit:** 75% = $1714.45 **Future End Date:**

46066	Double free flap, including one free transfer of tissue with a vascularized bone component, for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to): (a) anastomoses of all required vessels using microvascular techniques; and (b) harvesting of flap (including osteotomies); and (c) raising of tissue on a vascular pedicle; and (d) preparation of recipient vessels; and (e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed; other than the following: (g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base; (h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) (See para TN.8.267 of explanatory notes to this Category) **Fee:** $4,571.50 **Benefit:** 75% = $3428.65 **Future End Date:**
46068	Double free flap, including one free transfer of tissue with a vascularized bone component, for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to): (a) anastomoses of all required vessels using microvascular techniques; and (b) harvesting of flap (including osteotomies); and (c) raising of tissue on a vascular pedicle; and (d) preparation of recipient vessels; and (e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed; other than the following: (g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base; (h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.) (See para TN.8.267 of explanatory notes to this Category) **Fee:** $3,428.85 **Benefit:** 75% = $2571.65 **Future End Date:**
46070	Double free flap, including 2 free transfers of tissue (reconstructive surgery) for the repair of major tissue defect, involving anastomoses of all required vessels using microvascular techniques, all necessary elements of the operation, including (but not limited to): (a) raising each flap of tissue on a separate vascular pedicle; and (b) preparation of recipient vessels; and (c) transfer of tissue; and (d) inset of tissue at recipient site; and (e) direct repair of secondary cutaneous defect, if performed; other than a service: (f) performed in the context of breast reconstruction; or (g) associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) **Fee:** $4,571.50 **Benefit:** 75% = $3428.65 **Future End Date:**

46072	Double free flap, including 2 free transfers of tissue (reconstructive surgery) for the repair of major tissue defect, involving anastomoses of all required vessels using microvascular techniques, all necessary elements of the operation including (but not limited to): (a) raising each flap of tissue on a separate vascular pedicle; and (b) preparation of recipient vessels; and (c) transfer of tissue; and (d) inset of tissue at recipient site; and (e) direct repair of secondary cutaneous defect, if performed; other than a service: (f) performed in the context of breast reconstruction; or (g) associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.) **Fee:** $3,428.85 **Benefit:** 75% = $2571.65 **Future End Date:**
46080	Post-mastectomy breast reconstruction, autologous, single surgeon (unilateral) using a myocutaneous or perforator flap, by microsurgical transfer: (a) including anastomosis of artery and one or more veins (including repair of secondary skin defect); but (b) excluding repair of muscular aponeurotic layer; other than a service associated with a service to which item 30166, 30169, 30175, 30177 or 30179 applies (H) (Anaes.) (Assist.) **Fee:** $3,515.20 **Benefit:** 75% = $2636.40 **Future End Date:**
46082	Post-mastectomy breast reconstruction, autologous, single surgeon (bilateral) using a myocutaneous or perforator flap, by microsurgical transfer: (a) including anastomoses of arteries and veins (including repair of secondary skin defect); but (b) excluding repair of muscular aponeurotic layer; other than a service associated with a service to which item 30166, 30169, 30175, 30177 or 30179 applies (H) (Anaes.) (Assist.) **Fee:** $6,151.55 **Benefit:** 75% = $4613.70 **Future End Date:**
46084	Post-mastectomy breast reconstruction, autologous, conjoint surgery (unilateral) using a myocutaneous or perforator flap, by microsurgical transfer: (a) including anastomosis of artery and one or more veins (including repair of secondary skin defect); but (b) excluding repair of muscular aponeurotic layer; other than a service associated with a service to which item 30166, 30169, 30175, 30177 or 30179 applies—conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) **Fee:** $3,047.70 **Benefit:** 75% = $2285.80 **Future End Date:**
46086	Post-mastectomy breast reconstruction, autologous, conjoint surgery (unilateral) using a myocutaneous or perforator flap, by microsurgical transfer: (a) including anastomosis of artery and one or more veins (including repair of secondary skin defect); but (b) excluding repair of muscular aponeurotic layer;

	other than a service associated with a service to which item 30166, 30169, 30175, 30177 or 30179 applies—conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.) **Fee:** $2,285.90 **Benefit:** 75% = $1714.45 **Future End Date:**
46088	Post-mastectomy breast reconstruction, autologous, conjoint surgery (bilateral) using a myocutaneous or perforator flap, by microsurgical transfer: (a) including anastomosis of artery and one or more veins (including repair of secondary skin defect); but (b) excluding repair of muscular aponeurotic layer; other than a service associated with a service to which item 30166, 30169, 30175, 30177 or 30179 applies—conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) **Fee:** $5,333.40 **Benefit:** 75% = $4000.05 **Future End Date:**
46090	Post-mastectomy breast reconstruction, autologous, conjoint surgery (bilateral) using a myocutaneous or perforator flap, by microsurgical transfer: (a) including anastomoses of arteries and veins (including repair of secondary skin defect); but (b) excluding repair of muscular aponeurotic layer; other than a service associated with a service to which item 30166, 30169, 30175, 30177 or 30179 applies—conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.) **Fee:** $4,000.20 **Benefit:** 75% = $3000.15 **Future End Date:**
46092	Lower pole coverage of reconstructive breast prosthesis, following mastectomy, using muscle or fascia turnover flap or autologous dermal flaps, if the service is performed in combination with a service to which item 31522, 31523, 31528, 31529, 45527, 45539 or 45542 applies (H) (Anaes.) (Assist.) **Fee:** $485.95 **Benefit:** 75% = $364.50 **Future End Date:**
46094	Lower pole coverage or complete implant coverage of reconstructive breast prosthesis, following mastectomy, using allograft or synthetic products (H) (Anaes.) (Assist.) **Fee:** $359.05 **Benefit:** 75% = $269.30 **Future End Date:**
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 46111, 46113 to 46123 and 46125 to 46135 apply; other than a service to which item 46112, 46124 or 46136 applies (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Derived Fee:** 40% of the fee for the co-claimed service **Future End Date:**
46101	Excision of burnt tissue, if the area of burn excised involves not more than 1% of the total body surface (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $404.00 **Benefit:** 75% = $303.00 85% = $343.40 **Future End Date:**

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.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $641.30 **Benefit:** 75% = $481.00 **Future End Date:**
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.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $703.35 **Benefit:** 75% = $527.55 **Future End Date:**
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.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $1,073.10 **Benefit:** 75% = $804.85 **Future End Date:**
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.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $1,443.15 **Benefit:** 75% = $1082.40 **Future End Date:**
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.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $1,813.90 **Benefit:** 75% = $1360.45 **Future End Date:**
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.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $2,184.00 **Benefit:** 75% = $1638.00 **Future End Date:**
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.) (See para TN.8.275, TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $2,553.45 **Benefit:** 75% = $1915.10 **Future End Date:**
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.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $2,923.60 **Benefit:** 75% = $2192.70 **Future End Date:**
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.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category)

	Fee: $3,331.00 **Benefit:** 75% = $2498.25 **Future End Date:**
46111	Excision of burnt tissue, if the area of burn excised involves 80% or more of total body surface, excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $3,730.50 **Benefit:** 75% = $2797.90 **Future End Date:**
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), excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $2,059.45 **Benefit:** 75% = $1544.60 **Future End Date:**
46113	Excised burn wound closure, or closure of skin defect secondary to burns contracture release, to an area of less than 1% of total body surface, 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) autologous skin cell suspension for definitive closure, or autologous skin cell suspension in conjunction with autologous skin grafting for definitive closure, if the total area being treated in the procedure is: (A) for a patient aged less than 15 years—at least 10% of total body surface; or (B) for a patient aged 15 years or over—at least 20% of total body surface; or (iii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound (H) (Anaes.) (Assist.) (See para GN.1.2, TN.8.301, TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $404.00 **Benefit:** 75% = $303.00 **Future End Date:**
46114	Excised burn wound closure, or closure of skin defect secondary to burns contracture release, to an area of at least 1% but less than 3% of total body surface, 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) autologous skin cell suspension for definitive closure, or autologous skin cell suspension in conjunction with autologous skin grafting for definitive closure, if the total area being treated in the procedure is: (A) for a patient aged less than 15 years—at least 10% of total body surface; or (B) for a patient aged 15 years or over—at least 20% of total body surface; or

	(iii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound (H) (Anaes.) (Assist.) (See para TN.8.301, TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $641.30 **Benefit:** 75% = $481.00 **Future End Date:**
46115	Excised burn wound closure or closure of skin defect secondary to burns contracture release, to an area of at least 3% but less than 10% of total body surface, 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) autologous skin cell suspension for definitive closure, or autologous skin cell suspension in conjunction with autologous skin grafting for definitive closure, if the total area being treated in the procedure is: (A) for a patient aged less than 15 years—at least 10% of total body surface; or (B) for a patient aged 15 years or over—at least 20% of total body surface; or (iii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound (H) (Anaes.) (Assist.) (See para TN.8.301, TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $703.35 **Benefit:** 75% = $527.55 **Future End Date:**
46116	Excised burn wound closure or closure of skin defect secondary to burns contracture release, to an area of at least 10% but less than 20% of total body surface, 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) for a patient aged less than 15 years—autologous skin cell suspension for definitive closure, or autologous skin cell suspension in conjunction with autologous skin grafting for definitive closure; or (iii) for a patient aged 15 years or over—autologous skin cell suspension for definitive closure, or autologous skin cell suspension in conjunction with autologous skin grafting for definitive closure, if the total area being treated in the procedure is at least 20% of total body surface; or (iv) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.301, TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $1,073.10 **Benefit:** 75% = $804.85 **Future End Date:**
46117	Excised burn wound closure, to an area of at least 20% but less than 30% of total body surface, 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) autologous skin cell suspension for definitive closure; or (iii) autologous skin cell suspension in conjunction with autologous skin grafting for definitive closure; or (iv) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.301, TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $1,443.15 **Benefit:** 75% = $1082.40 **Future End Date:**
46118	Excised burn wound closure, to an area of at least 30% but less than 40% of total body surface, 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) autologous skin cell suspension for definitive closure; or (iii) autologous skin cell suspension in conjunction with autologous skin grafting for definitive closure; or (iv) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.301, TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $1,813.90 **Benefit:** 75% = $1360.45 **Future End Date:**
46119	Excised burn wound closure, to an area of at least 40% but less than 50% of total body surface, 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) autologous skin cell suspension for definitive closure; or (iii) autologous skin cell suspension in conjunction with autologous skin grafting for definitive closure; or (iv) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.301, TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $2,184.00 **Benefit:** 75% = $1638.00 **Future End Date:**
46120	Excised burn wound closure, to an area of at least 50% but less than 60% of total body surface, 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) autologous skin cell suspension for definitive closure; or (iii) autologous skin cell suspension in conjunction with autologous skin grafting for definitive closure; or (iv) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.301, TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $2,553.45 **Benefit:** 75% = $1915.10 **Future End Date:**
46121	Excised burn wound closure, to an area of at least 60% but less than 70% of total body surface, 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) autologous skin cell suspension for definitive closure; or (iii) autologous skin cell suspension in conjunction with autologous skin grafting for definitive closure; or (iv) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.301, TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $2,923.60 **Benefit:** 75% = $2192.70 **Future End Date:**
46122	Excised burn wound closure, to an area of at least 70% but less than 80% of total body surface, 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) autologous skin cell suspension for definitive closure; or (iii) autologous skin cell suspension in conjunction with autologous skin grafting for definitive closure; or (iv) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.301, TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $3,331.00 **Benefit:** 75% = $2498.25 **Future End Date:**
46123	Excised burn wound closure, to an area of at least 80% of total body surface, 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) autologous skin cell suspension for definitive closure; or (iii) autologous skin cell suspension in conjunction with autologous skin grafting for definitive

	closure; or (iv) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.301, TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $3,730.50 **Benefit:** 75% = $2797.90 **Future End Date:**
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) autologous skin cell suspension for definitive closure; or (iii) autologous skin cell suspension in conjunction with autologous skin grafting for definitive closure; or (iv) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.) (See para TN.8.301, TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $2,059.45 **Benefit:** 75% = $1544.60 **Future End Date:**
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.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $404.00 **Benefit:** 75% = $303.00 85% = $343.40 **Future End Date:**
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.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $641.30 **Benefit:** 75% = $481.00 **Future End Date:**
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.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $888.35 **Benefit:** 75% = $666.30 **Future End Date:**
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.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $1,628.55 **Benefit:** 75% = $1221.45

	Future End Date:
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.) (See para TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $2,980.30 **Benefit:** 75% = $2235.25 **Future End Date:**
46130	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, to an area involving less than 1% of total body surface, if the service: (a) is provided following a previous procedure that used non-autologous temporary wound closure or simple dressings; and (b) involves: (i) autologous tissue (split skin graft or other); or (ii) autologous skin cell suspension, or autologous skin cell suspension in conjunction with autologous skin grafting, if the total area being treated in the procedure is: (A) for a patient aged less than 15 years—at least 10% of total body surface; or (B) for a patient aged 15 years or over—at least 20% of total body surface (H) (Anaes.) (Assist.) (See para TN.8.301, TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $404.00 **Benefit:** 75% = $303.00 **Future End Date:**
46131	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, to an area involving at least 1% but less than 3% of total body surface, if the service: (a) is provided following a previous procedure that used non-autologous temporary wound closure or simple dressings; and (b) involves: (i) autologous tissue (split skin graft or other); or (ii) autologous skin cell suspension, or autologous skin cell suspension in conjunction with autologous skin grafting, if the total area being treated in the procedure is: (A) for a patient aged less than 15 years—at least 10% of total body surface; or (B) for a patient aged 15 years or over—at least 20% of total body surface (H) (Anaes.) (Assist.) (See para TN.8.301, TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $641.30 **Benefit:** 75% = $481.00 **Future End Date:**
46132	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, to an area involving at least 3% but less than 10% of total body surface, if the service:

	(a) is provided following a previous procedure that used non-autologous temporary wound closure or simple dressings; and (b) involves: (i) autologous tissue (split skin graft or other); or (ii) autologous skin cell suspension, or autologous skin cell suspension in conjunction with autologous skin grafting, if the total area being treated in the procedure is: (A) for a patient aged less than 15 years—at least 10% of total body surface; or (B) for a patient aged 15 years or over—at least 20% of total body surface (H) (Anaes.) (Assist.) (See para TN.8.301, TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $703.35 **Benefit:** 75% = $527.55 **Future End Date:**
46133	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, to an area involving at least 10% but less than 20% of total body surface, if the service: (a) is provided following a previous procedure that used non-autologous temporary wound closure or simple dressings; and (b) involves: (i) autologous tissue (split skin graft or other); or (ii) for a patient aged less than 15 years—autologous skin cell suspension, or autologous skin cell suspension in conjunction with autologous skin grafting; or (iii) for a patient aged 15 years or over—autologous skin cell suspension, or autologous skin cell suspension in conjunction with autologous skin grafting, if the total area being treated in the procedure is at least 20% of total body surface; (excluding aftercare) (H) (Anaes.) (Assist.) (See para TN.8.301, TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $1,073.10 **Benefit:** 75% = $804.85 **Future End Date:**
46134	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis, to an area involving at least 20% but less than 30% of total body surface, if the service: (a) is provided following a previous procedure that used non-autologous temporary wound closure; and (b) involves: (i) autologous tissue (split skin graft or other); or (ii) autologous skin cell suspension; or (iii) autologous skin cell suspension in conjunction with autologous skin grafting; (excluding aftercare) (H) (Anaes.) (Assist.) (See para TN.8.301, TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $2,374.90 **Benefit:** 75% = $1781.20 **Future End Date:**
46135	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis, to an area involving at least 30% of total body surface, if the service:

	(a) is provided following a previous procedure that used non-autologous temporary wound closure; and (b) involves: (i) autologous tissue (split skin graft or other); or (ii) autologous skin cell suspension; or (iii) autologous skin cell suspension in conjunction with autologous skin grafting; (excluding aftercare) (H) (Anaes.) (Assist.) (See para TN.8.301, TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $3,730.50 **Benefit:** 75% = $2797.90 **Future End Date:**
46136	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis, of whole face, if the service: (a) is provided following a previous procedure that used non-autologous temporary wound closure; and (b) involves: (i) autologous tissue (split skin graft or other); or (ii) autologous skin cell suspension; or (iii) autologous skin cell suspension in conjunction with autologous skin grafting; (excluding aftercare) (H) (Anaes.) (Assist.) (See para TN.8.301, TN.8.273, TN.8.274 of explanatory notes to this Category) **Fee:** $2,059.45 **Benefit:** 75% = $1544.60 **Future End Date:**
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.) **Fee:** $308.10 **Benefit:** 75% = $231.10 85% = $261.90 **Future End Date:**
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.) **Fee:** $462.25 **Benefit:** 75% = $346.70 **Future End Date:**
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.) **Fee:** $554.55 **Benefit:** 75% = $415.95 **Future End Date:**
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.) **Fee:** $718.85 **Benefit:** 75% = $539.15 **Future End Date:**
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.) (See para TN.8.269, TN.8.107, CN.0.11 of explanatory notes to this Category)

	Fee: $1,591.65 **Benefit:** 75% = $1193.75 **Future End Date:**
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.) (See para TN.8.269, TN.8.107, CN.0.11 of explanatory notes to this Category) **Fee:** $1,735.45 **Benefit:** 75% = $1301.60 **Future End Date:**
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.) (See para TN.8.269, TN.8.107, CN.0.11 of explanatory notes to this Category) **Fee:** $1,301.60 **Benefit:** 75% = $976.20 **Future End Date:**
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.) (See para TN.8.269, TN.8.107, CN.0.11 of explanatory notes to this Category) **Fee:** $2,169.10 **Benefit:** 75% = $1626.85 **Future End Date:**
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.) (See para TN.8.107, CN.0.11 of explanatory notes to this Category) **Fee:** $1,816.50 **Benefit:** 75% = $1362.40 **Future End Date:**
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.) (See para TN.8.107, CN.0.11 of explanatory notes to this Category) **Fee:** $1,816.50 **Benefit:** 75% = $1362.40 **Future End Date:**
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.) (See para TN.8.107, CN.0.11 of explanatory notes to this Category) **Fee:** $2,073.75 **Benefit:** 75% = $1555.35 **Future End Date:**
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.) (See para TN.8.107, CN.0.11 of explanatory notes to this Category) **Fee:** $1,555.30 **Benefit:** 75% = $1166.50 **Future End Date:**
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.) (See para TN.8.107, CN.0.11 of explanatory notes to this Category) **Fee:** $2,592.15 **Benefit:** 75% = $1944.15 **Future End Date:**
46159	Midfacial osteotomies, Le Fort II or Le Fort III—conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.) (See para CN.0.11 of explanatory notes to this Category) **Fee:** $2,293.35 **Benefit:** 75% = $1720.05 **Future End Date:**
46160	Midfacial osteotomies, Le Fort II or Le Fort III—conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.) (See para CN.0.11 of explanatory notes to this Category) **Fee:** $1,720.00 **Benefit:** 75% = $1290.00 **Future End Date:**
46161	Midfacial osteotomies, Le Fort II or Le Fort III—single surgeon (H) (Anaes.) (Assist.) (See para CN.0.11 of explanatory notes to this Category) **Fee:** $2,866.65 **Benefit:** 75% = $2150.00 **Future End Date:**
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.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $1,197.00 **Benefit:** 75% = $897.75 **Future End Date:**
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.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $2,034.75 **Benefit:** 75% = $1526.10 **Future End Date:**
46172	Removal or debulking of brachial plexus tumour, involving intraneural dissection, either supraclavicular or infraclavicular dissection (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $2,992.25 **Benefit:** 75% = $2244.20 **Future End Date:**

46173	Removal or debulking of brachial plexus tumour, involving intraneural dissection, both supraclavicular and infraclavicular dissection (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $4,189.15 **Benefit:** 75% = $3141.90 **Future End Date:**
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.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $2,992.25 **Benefit:** 75% = $2244.20 **Future End Date:**
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.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $4,787.55 **Benefit:** 75% = $3590.70 **Future End Date:**
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.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $1,197.00 **Benefit:** 75% = $897.75 **Future End Date:**
46177	Reconstruction of deficit of the brachial plexus, single cord or trunk, by any appropriate method, single surgeon (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $2,034.75 **Benefit:** 75% = $1526.10 **Future End Date:**
46178	Reconstruction of deficit of the brachial plexus, single cord or trunk, by any appropriate method, conjoint surgery, principal surgeon (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $2,034.75 **Benefit:** 75% = $1526.10 **Future End Date:**
46179	Reconstruction of deficit of the brachial plexus, single cord or trunk, by any appropriate method, conjoint surgery, conjoint surgeon (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $1,693.60 **Benefit:** 75% = $1270.20 **Future End Date:**

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.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $2,992.25 **Benefit:** 75% = $2244.20 **Future End Date:**
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.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $2,992.25 **Benefit:** 75% = $2244.20 **Future End Date:**
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.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $2,495.50 **Benefit:** 75% = $1871.65 **Future End Date:**
46183	Reconstruction of deficit of the brachial plexus, whole plexus, by any appropriate method, single surgeon (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $3,590.65 **Benefit:** 75% = $2693.00 **Future End Date:**
46184	Reconstruction of deficit of the brachial plexus, whole plexus, by any appropriate method, conjoint surgery, principal surgeon (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $3,590.65 **Benefit:** 75% = $2693.00 **Future End Date:**
46185	Reconstruction of deficit of the brachial plexus, whole plexus, by any appropriate method, conjoint surgery, conjoint surgeon (H) (Anaes.) (Assist.) (See para TN.8.270 of explanatory notes to this Category) **Fee:** $2,992.25 **Benefit:** 75% = $2244.20 **Future End Date:**
	GENERAL
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.) **Fee:** $647.85 **Benefit:** 75% = $485.90 85% = $550.70 **Future End Date:**
45003	Single stage local myocutaneous flap repair to one defect, simple and small not in association with any of items 31356 to 31383 (Anaes.) **Fee:** $720.15 **Benefit:** 75% = $540.15 85% = $612.15 **Extended Medicare Safety Net Cap:** $576.15 **Future End Date:**

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.) **Fee:** $1,242.00 **Benefit:** 75% = $931.50 **Future End Date:**
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.) **Fee:** $453.70 **Benefit:** 75% = $340.30 **Future End Date:**
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.) **Fee:** $931.45 **Benefit:** 75% = $698.60 **Future End Date:**
45015	MUSCLE OR MYOCUTANEOUS FLAP, delay of (Anaes.) **Fee:** $359.95 **Benefit:** 75% = $270.00 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $566.95 **Benefit:** 75% = $425.25 **Future End Date:**
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.) **Fee:** $474.85 **Benefit:** 75% = $356.15 **Future End Date:**
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.) (See para TN.8.91 of explanatory notes to this Category) **Fee:** $212.30 **Benefit:** 75% = $159.25 85% = $180.50 **Future End Date:**
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.) (See para TN.8.91 of explanatory notes to this Category) **Fee:** $212.30 **Benefit:** 75% = $159.25 85% = $180.50 **Extended Medicare Safety Net Cap:** $169.85 **Future End Date:**
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.) (See para TN.8.91 of explanatory notes to this Category) **Fee:** $477.05 **Benefit:** 75% = $357.80 85% = $405.50 **Extended Medicare Safety Net Cap:** $381.65 **Future End Date:**
45027	Vascular anomaly, cauterisation of or injection into, if undertaken in the operating theatre of a hospital (H) (Anaes.) (See para TN.8.263 of explanatory notes to this Category) **Fee:** $144.10 **Benefit:** 75% = $108.10 **Future End Date:**
45030	Vascular anomaly, of skin, mucous membrane and/or subcutaneous tissue, small, excision and suture of (Anaes.) (See para TN.8.263 of explanatory notes to this Category) **Fee:** $162.45 **Benefit:** 75% = $121.85 85% = $138.10 **Future End Date:**
45033	Vascular anomaly, large or involving deeper tissue including facial muscle, excision and suture of (H) (Anaes.) (Assist.) (See para GN.1.2, TN.8.263 of explanatory notes to this Category) **Fee:** $294.30 **Benefit:** 75% = $220.75 **Future End Date:**

45035	Vascular anomaly, large, deep, and involving major neurovascular structures, excision of, including dissection of muscles, nerves or major vessels (H) (Anaes.) (Assist.) (See para TN.8.263 of explanatory notes to this Category) **Fee:** $840.30 **Benefit:** 75% = $630.25 **Future End Date:**
45036	Vascular anomaly, of neck, deep and involving major neurovascular structures, excision of, including dissection of cranial nerves and major vessels (H) (Anaes.) (Assist.) (See para TN.8.263 of explanatory notes to this Category) **Fee:** $1,350.20 **Benefit:** 75% = $1012.65 **Future End Date:**
45045	Vascular anomaly on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.) (See para TN.8.263 of explanatory notes to this Category) **Fee:** $369.20 **Benefit:** 75% = $276.90 85% = $313.85 **Future End Date:**
45048	LYMPHOEDEMATOUS tissue or lymphangiectasis, of lower leg and foot, or thigh, or upper arm, or forearm and hand, major excision of (Anaes.) (Assist.) **Fee:** $927.15 **Benefit:** 75% = $695.40 **Future End Date:**
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.) **Fee:** $567.05 **Benefit:** 75% = $425.30 **Future End Date:**
45054	Limb or chest, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (H) (Anaes.) (Assist.) (See para TN.8.92 of explanatory notes to this Category) **Fee:** $390.25 **Benefit:** 75% = $292.70 **Future End Date:**
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.) **Fee:** $1,521.60 **Benefit:** 75% = $1141.20 **Future End Date:**
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.) **Fee:** $1,521.60 **Benefit:** 75% = $1141.20 **Future End Date:**
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.) **Fee:** $1,101.10 **Benefit:** 75% = $825.85 **Future End Date:**
	SKIN FLAP SURGERY

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.) (See para TN.8.93 of explanatory notes to this Category) **Fee:** $340.30 **Benefit:** 75% = $255.25 85% = $289.30 **Extended Medicare Safety Net Cap:** $272.25 **Future End Date:**
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.) (See para TN.8.93 of explanatory notes to this Category) **Fee:** $495.40 **Benefit:** 75% = $371.55 85% = $421.10 **Future End Date:**
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.) (See para TN.8.126, TN.8.93 of explanatory notes to this Category) **Fee:** $495.40 **Benefit:** 75% = $371.55 85% = $421.10 **Future End Date:**
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.) (See para TN.8.93, TN.8.207 of explanatory notes to this Category) **Fee:** $485.95 **Benefit:** 75% = $364.50 85% = $413.10 **Extended Medicare Safety Net Cap:** $388.80 **Future End Date:**
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.) (See para TN.8.93 of explanatory notes to this Category) **Fee:** $459.15 **Benefit:** 75% = $344.40 85% = $390.30 **Extended Medicare Safety Net Cap:** $367.35 **Future End Date:**
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.) **Fee:** $459.15 **Benefit:** 75% = $344.40 85% = $390.30 **Future End Date:**

45209	Pedicled flap repair (forehead, cross arm, cross leg, abdominal or similar), first stage of a multistage procedure (H) (Anaes.) (Assist.) (See para TN.8.271 of explanatory notes to this Category) **Fee:** $567.05 **Benefit:** 75% = $425.30 **Future End Date:**
45212	Pedicled flap repair (forehead, cross arm, cross leg, abdominal or similar), subsequent stage of a multistage procedure (H) (Anaes.) (Assist.) (See para GN.1.2, TN.8.271 of explanatory notes to this Category) **Fee:** $281.40 **Benefit:** 75% = $211.05 **Future End Date:**
45221	DIRECT FLAP REPAIR, small (cross finger or similar), first stage (Anaes.) **Fee:** $313.15 **Benefit:** 75% = $234.90 85% = $266.20 **Future End Date:**
45224	DIRECT FLAP REPAIR, small (cross finger or similar), second stage (Anaes.) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60 **Future End Date:**
45227	Indirect flap or tubed pedicle, formation of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $533.15 **Benefit:** 75% = $399.90 **Future End Date:**
45230	DIRECT OR INDIRECT FLAP OR TUBED PEDICLE, delay of (Anaes.) **Fee:** $266.60 **Benefit:** 75% = $199.95 85% = $226.65 **Future End Date:**
45233	Indirect flap or tubed pedicle, preparation of intermediate or final site and attachment to the site (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $567.05 **Benefit:** 75% = $425.30 **Future End Date:**
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.) **Fee:** $313.15 **Benefit:** 75% = $234.90 85% = $266.20 **Future End Date:**
	FREE GRAFTS
45451	Full thickness skin graft to one defect, with an average diameter of 5 mm or more (Anaes.) (Assist.) (See para TN.8.266 of explanatory notes to this Category) **Fee:** $567.05 **Benefit:** 75% = $425.30 85% = $482.00 **Future End Date:**
	OTHER GRAFTS AND MISCELLANEOUS PROCEDURES
45496	FLAP, free tissue transfer using microvascular techniques - *revision of*, by open operation (Anaes.) **Fee:** $498.05 **Benefit:** 75% = $373.55 **Future End Date:**

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.) **Fee:** $379.40 **Benefit:** 75% = $284.55 **Future End Date:**
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.) **Fee:** $1,304.95 **Benefit:** 75% = $978.75 **Future End Date:**
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.) **Fee:** $2,124.10 **Benefit:** 75% = $1593.10 **Future End Date:**
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.) **Fee:** $3,186.20 **Benefit:** 75% = $2389.65 **Future End Date:**
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.) **Fee:** $2,430.10 **Benefit:** 75% = $1822.60 **Future End Date:**
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.) **Fee:** $2,124.10 **Benefit:** 75% = $1593.10 **Future End Date:**
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.) **Fee:** $3,216.75 **Benefit:** 75% = $2412.60

	Future End Date:
45512	SCAR, of face or neck, more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty (Anaes.) (See para TN.8.95 of explanatory notes to this Category) **Fee:** $353.90 **Benefit:** 75% = $265.45 85% = $300.85 **Future End Date:**
Amend 45515	Scar, other than on face or neck, not more than 7 cm in length, revision of, if: (a) the service is: (i) undertaken in the operating theatre of a hospital; or (ii) performed by a specialist in the practice of the specialist's specialty; and (b) the service is not performed in conjunction with the insertion of breast implants for cosmetic purposes; and (c) the incision made for revision of the scar is not used as an approach for another procedure (including a procedure which does not attract a medicare benefit); and (d) sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes (Anaes.) (See para TN.8.95 of explanatory notes to this Category) **Fee:** $223.25 **Benefit:** 75% = $167.45 85% = $189.80 **Future End Date:**
Amend 45518	Scar, other than on face or neck, more than 7 cm in length, revision of, if: (a) the service is: (i) undertaken in the operating theatre of a hospital; or (ii) performed by a specialist in the practice of the specialist's specialty; and (b) the service is not performed in conjunction with the insertion of breast implants for cosmetic purposes; and (c) the incision made for revision of the scar is not used as an approach for another procedure (including a procedure which does not attract a medicare benefit); and (d) sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes (Anaes.) (See para GN.1.2, TN.8.95 of explanatory notes to this Category) **Fee:** $270.15 **Benefit:** 75% = $202.65 85% = $229.65 **Future End Date:**

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.) **Fee:** $1,077.70 **Benefit:** 75% = $808.30 **Future End Date:**
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.) **Fee:** $756.10 **Benefit:** 75% = $567.10 **Future End Date:**
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.) **Fee:** $1,616.70 **Benefit:** 75% = $1212.55 **Future End Date:**
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.) (See para TN.8.96, TN.8.294 of explanatory notes to this Category) **Fee:** $887.70 **Benefit:** 75% = $665.80 **Future End Date:**
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.) (See para TN.8.97 of explanatory notes to this Category) **Fee:** $1,282.15 **Benefit:** 75% = $961.65 **Future End Date:**
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.) (See para TN.8.294 of explanatory notes to this Category) **Fee:** $1,331.35 **Benefit:** 75% = $998.55 **Future End Date:**
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.) (See para TN.8.8, TN.8.97 of explanatory notes to this Category) **Fee:** $1,315.85 **Benefit:** 75% = $986.90 **Future End Date:**
45534	Autologous fat grafting, unilateral service (harvesting, preparation and injection of adipocytes) if: (a) the autologous fat grafting is for one or more of the following purposes: (i) the correction of defects arising from treatment and prevention of breast cancer in patients with contour defects, greater than or equal to 20% volume asymmetry, post-treatment pain or poor prosthetic coverage; (ii) the preparation of post mastectomy thin or irradiated skin flaps in patients intending to have breast reconstruction; (iii) breast reconstruction in breast cancer patients; (iv) the correction of developmental disorders of the breast; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes Up to a total of 4 services per side (for total treatment of a single breast), other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (See para TN.8.294 of explanatory notes to this Category) **Fee:** $756.10 **Benefit:** 75% = $567.10 **Future End Date:**
45535	Autologous fat grafting, bilateral service (harvesting, preparation and injection of adipocytes) if: (a) the autologous fat grafting is for one or more of the following purposes:

	(i) the correction of defects arising from treatment and prevention of breast cancer in patients with contour defects, greater than or equal to 20% volume asymmetry, post-treatment pain or poor prosthetic coverage; (ii) the preparation of post mastectomy thin or irradiated skin flaps in patients intending to have breast reconstruction; (iii) breast reconstruction in breast cancer patients; (iv) the correction of developmental disorders of the breast; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes Up to a total of 4 services, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (See para TN.8.294 of explanatory notes to this Category) **Fee:** $1,323.35 **Benefit:** 75% = $992.55 **Future End Date:**
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.) **Fee:** $1,726.00 **Benefit:** 75% = $1294.50 **Future End Date:**
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.) **Fee:** $734.15 **Benefit:** 75% = $550.65 **Future End Date:**
45545	Nipple or areola or both, reconstruction of, by any surgical technique (Anaes.) (Assist.) (See para GN.1.2, TN.8.100 of explanatory notes to this Category) **Fee:** $745.15 **Benefit:** 75% = $558.90 85% = $636.65 **Extended Medicare Safety Net Cap:** $596.15 **Future End Date:**
45546	NIPPLE OR AREOLA or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple (See para TN.8.100 of explanatory notes to this Category) **Fee:** $236.80 **Benefit:** 75% = $177.60 85% = $201.30 **Future End Date:**
45548	Breast prosthesis, removal of, as an independent procedure (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $331.25 **Benefit:** 75% = $248.45 **Future End Date:**

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.) (See para TN.8.167 of explanatory notes to this Category) **Fee:** $531.10 **Benefit:** 75% = $398.35 **Future End Date:**
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.) (See para TN.8.98, TN.8.262 of explanatory notes to this Category) **Fee:** $684.15 **Benefit:** 75% = $513.15 **Future End Date:**
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.) (See para TN.8.98, TN.8.262 of explanatory notes to this Category) **Fee:** $837.15 **Benefit:** 75% = $627.90 **Future End Date:**
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.) (See para TN.8.99 of explanatory notes to this Category) **Fee:** $916.85 **Benefit:** 75% = $687.65

	Future End Date:
	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.) (See para TN.8.99 of explanatory notes to this Category) **Fee:** $1,375.20 **Benefit:** 75% = $1031.40
45558	**Future End Date:**
	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.) **Fee:** $566.95 **Benefit:** 75% = $425.25 85% = $481.95 **Extended Medicare Safety Net Cap:** $198.45
45560	**Future End Date:**
	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.) **Fee:** $2,124.10 **Benefit:** 75% = $1593.10
45561	**Future End Date:**
	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.) **Fee:** $1,315.85 **Benefit:** 75% = $986.90
45562	**Future End Date:**
	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.) **Fee:** $1,315.85 **Benefit:** 75% = $986.90
45563	**Future End Date:**
	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
45564	(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.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $3,047.70 **Benefit:** 75% = $2285.80 **Future End Date:**
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.) (See para TN.8.8 of explanatory notes to this Category) **Fee:** $2,285.90 **Benefit:** 75% = $1714.45 **Future End Date:**
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.) **Fee:** $1,282.15 **Benefit:** 75% = $961.65 **Future End Date:**
45568	Tissue expander, removal of, including complete excision of fibrous capsule if performed (H) (Anaes.) (Assist.) **Fee:** $531.10 **Benefit:** 75% = $398.35 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $349.15 **Benefit:** 75% = $261.90 **Future End Date:**
45575	Facial nerve paralysis, free fascia graft for (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $862.05 **Benefit:** 75% = $646.55 **Future End Date:**
45578	FACIAL NERVE PARALYSIS, muscle transfer for (Anaes.) (Assist.)

	Fee: $998.30 **Benefit:** 75% = $748.75 **Future End Date:**
45581	Facial nerve paralysis, excision of tissue for (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $331.25 **Benefit:** 75% = $248.45 **Future End Date:**
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.) (See para TN.8.101 of explanatory notes to this Category) **Fee:** $756.10 **Benefit:** 75% = $567.10 **Future End Date:**
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.) (See para TN.8.101 of explanatory notes to this Category) **Fee:** $756.10 **Benefit:** 75% = $567.10 **Future End Date:**
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.) (See para TN.8.102 of explanatory notes to this Category) **Fee:** $1,066.25 **Benefit:** 75% = $799.70 **Future End Date:**
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.) (See para TN.8.102 of explanatory notes to this Category)

	Fee: $1,599.55 **Benefit:** 75% = $1199.70 **Future End Date:**
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.) **Fee:** $756.10 **Benefit:** 75% = $567.10 **Future End Date:**
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.) **Fee:** $578.40 **Benefit:** 75% = $433.80 **Future End Date:**
45596	Hemimaxillectomy (H) (Anaes.) (Assist.) (See para TN.8.264 of explanatory notes to this Category) **Fee:** $1,077.70 **Benefit:** 75% = $808.30 **Future End Date:**
45597	Total maxillectomy (bilateral) (H) (Anaes.) (Assist.) (See para TN.8.264 of explanatory notes to this Category) **Fee:** $1,442.70 **Benefit:** 75% = $1082.05 **Future End Date:**
45599	Mandible, total resection of, other than a service associated with a service to which item 45608 applies (H) (Anaes.) (Assist.) **Fee:** $1,121.00 **Benefit:** 75% = $840.75

	Future End Date:
45602	MANDIBLE, including lower border, OR MAXILLA, sub-total resection of (Anaes.) (Assist.) **Fee:** $837.15 **Benefit:** 75% = $627.90 **Future End Date:**
45605	MANDIBLE OR MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.) **Fee:** $703.25 **Benefit:** 75% = $527.45 **Future End Date:**
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.) **Fee:** $990.20 **Benefit:** 75% = $742.65 **Future End Date:**
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.) (See para TN.8.267 of explanatory notes to this Category) **Fee:** $990.20 **Benefit:** 75% = $742.65 **Future End Date:**
45611	Mandible, condylectomy of (H) (Anaes.) (Assist.) **Fee:** $567.05 **Benefit:** 75% = $425.30 **Future End Date:**
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.) **Fee:** $998.30 **Benefit:** 75% = $748.75 85% = $889.80 **Extended Medicare Safety Net Cap:** $798.65 **Future End Date:**
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.)

	(See para TN.8.103 of explanatory notes to this Category) **Fee:** $281.40 **Benefit:** 75% = $211.05 85% = $239.20 **Extended Medicare Safety Net Cap:** $225.15 **Future End Date:**
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.) (See para TN.8.103 of explanatory notes to this Category) **Fee:** $390.25 **Benefit:** 75% = $292.70 85% = $331.75 **Extended Medicare Safety Net Cap:** $312.20 **Future End Date:**
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.) **Fee:** $865.35 **Benefit:** 75% = $649.05 85% = $756.85 **Extended Medicare Safety Net Cap:** $692.30 **Future End Date:**
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.) **Fee:** $1,122.05 **Benefit:** 75% = $841.55 85% = $1013.55 **Extended Medicare Safety Net Cap:** $897.65 **Future End Date:**
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.) **Fee:** $224.55 **Benefit:** 75% = $168.45 **Future End Date:**
45626	Ectropion or entropion, not caused by trachoma, correction of (unilateral) (Anaes.) **Fee:** $390.25 **Benefit:** 75% = $292.70 85% = $331.75

	Future End Date:
45627	Ectropion or entropion, caused by trachoma, correction of (unilateral) (Anaes.) **Fee:** $390.25 **Benefit:** 75% = $292.70 85% = $331.75 **Future End Date:**
45629	Symblepharon, grafting for (H) (Anaes.) (Assist.) **Fee:** $567.05 **Benefit:** 75% = $425.30 **Future End Date:**
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.) (See para GN.1.2, TN.8.104 of explanatory notes to this Category) **Fee:** $612.75 **Benefit:** 75% = $459.60 **Future End Date:**
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.) (See para GN.1.2, TN.8.104 of explanatory notes to this Category) **Fee:** $703.25 **Benefit:** 75% = $527.45 **Future End Date:**
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.) (See para TN.8.104 of explanatory notes to this Category) **Fee:** $1,275.90 **Benefit:** 75% = $956.95 **Future End Date:**
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.) (See para TN.8.104 of explanatory notes to this Category) **Fee:** $1,531.35 **Benefit:** 75% = $1148.55 **Future End Date:**
45645	CHOANAL ATRESIA, repair of by puncture and dilatation (Anaes.) **Fee:** $267.60 **Benefit:** 75% = $200.70 **Future End Date:**
45646	Choanal atresia, correction by open operation with bone removal (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,077.70 **Benefit:** 75% = $808.30 **Future End Date:**
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.) (See para TN.8.104 of explanatory notes to this Category) **Fee:** $176.85 **Benefit:** 75% = $132.65 **Future End Date:**

45652	Rhinophyma of a moderate or severe degree, carbon dioxide laser or erbium laser excision - ablation of (Anaes.) **Fee:** $426.55 **Benefit:** 75% = $319.95 85% = $362.60 **Extended Medicare Safety Net Cap:** $341.25 **Future End Date:**
45653	RHINOPHYMA, shaving of (Anaes.) **Fee:** $426.55 **Benefit:** 75% = $319.95 85% = $362.60 **Future End Date:**
45656	COMPOSITE GRAFT (Chondrocutaneous or chondromucosal) to nose, ear or eyelid (Anaes.) (Assist.) **Fee:** $601.15 **Benefit:** 75% = $450.90 85% = $511.00 **Future End Date:**
45658	Correction of a congenital deformity of the ear if: (a) the congenital deformity is not related to a prominent ear; and (b) the deformity has been clinically diagnosed as a constricted ear, Stahl's ear, or a similar congenital deformity; and (c) photographic evidence demonstrating the clinical need for this service is documented in the patient notes. (Anaes.) (Assist.) **Fee:** $623.95 **Benefit:** 75% = $468.00 **Future End Date:**
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.) **Fee:** $623.95 **Benefit:** 75% = $468.00 **Future End Date:**
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.) **Fee:** $3,445.50 **Benefit:** 75% = $2584.15 **Future End Date:**
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.) **Fee:** $1,531.35 **Benefit:** 75% = $1148.55 **Future End Date:**

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.) **Fee:** $390.25 **Benefit:** 75% = $292.70 85% = $331.75 **Future End Date:**
45668	VERMILIONECTOMY, by surgical excision (Anaes.) **Fee:** $390.25 **Benefit:** 75% = $292.70 85% = $331.75 **Future End Date:**
45669	Vermilionectomy for biopsy-confirmed cellular atypia, using carbon dioxide laser or erbium laser excision - ablation (Anaes.) (See para TN.8.106 of explanatory notes to this Category) **Fee:** $390.25 **Benefit:** 75% = $292.70 85% = $331.75 **Future End Date:**
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.) **Fee:** $998.30 **Benefit:** 75% = $748.75 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $290.40 **Benefit:** 75% = $217.80 **Future End Date:**
45675	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.) **Fee:** $578.40 **Benefit:** 75% = $433.80 **Future End Date:**
45676	MACROSTOMIA, operation for (Anaes.) (Assist.) **Fee:** $688.60 **Benefit:** 75% = $516.45 **Future End Date:**
45677	Cleft lip, unilateral—primary repair of nasolabial complex, one stage, without anterior palate repair (H) (Anaes.) (Assist.) **Fee:** $683.30 **Benefit:** 75% = $512.50 **Future End Date:**
45680	Cleft lip, unilateral—primary repair of nasolabial complex, one stage, with anterior palate repair (H) (Anaes.) (Assist.) **Fee:** $891.15 **Benefit:** 75% = $668.40 **Future End Date:**
45683	Cleft lip, bilateral—primary repair of nasolabial complex, one stage, without anterior palate repair (H) (Anaes.) (Assist.) **Fee:** $989.95 **Benefit:** 75% = $742.50 **Future End Date:**

45686	Cleft lip, bilateral—primary repair of nasolabial complex, one stage, with anterior palate repair (H) (Anaes.) (Assist.) **Fee:** $1,168.45 **Benefit:** 75% = $876.35 **Future End Date:**
45689	CLEFT LIP, lip adhesion procedure, unilateral or bilateral (Anaes.) (Assist.) **Fee:** $313.35 **Benefit:** 75% = $235.05 **Future End Date:**
45692	Cleft lip, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $359.95 **Benefit:** 75% = $270.00 **Future End Date:**
45695	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.) **Fee:** $585.05 **Benefit:** 75% = $438.80 **Future End Date:**
45698	CLEFT LIP, primary columella lengthening procedure, bilateral (Anaes.) **Fee:** $549.05 **Benefit:** 75% = $411.80 **Future End Date:**
45701	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) **Fee:** $990.20 **Benefit:** 75% = $742.65 **Future End Date:**
45704	Cleft lip reconstruction using full thickness flap (Abbe or similar), second stage (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $359.95 **Benefit:** 75% = $270.00 **Future End Date:**
45707	CLEFT PALATE, primary repair (Anaes.) (Assist.) **Fee:** $935.85 **Benefit:** 75% = $701.90 **Future End Date:**
45710	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.) **Fee:** $585.05 **Benefit:** 75% = $438.80 **Future End Date:**
45713	CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.) **Fee:** $666.20 **Benefit:** 75% = $499.65 **Future End Date:**
45714	Oro-nasal fistula, repair of, including a local flap for closure (H) (Anaes.) (Assist.) **Fee:** $935.85 **Benefit:** 75% = $701.90 **Future End Date:**

45716	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.) **Fee:** $935.85 **Benefit:** 75% = $701.90 **Future End Date:**
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) is the result of a diagnosed craniofacial disorder; or (iii) has arisen from trauma (other than from previous cosmetic surgery) or a diagnosed pathological process; and (b) for a craniofacial disorder—evidence of diagnosis of the disorder is documented in the patient notes; and (c) sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes (H) (Anaes.) (Assist.) (See para TN.8.108 of explanatory notes to this Category) **Fee:** $896.05 **Benefit:** 75% = $672.05 **Future End Date:**
45767	Hypertelorism, correction of, using intracranial approach (H) (Anaes.) (Assist.) **Fee:** $3,006.20 **Benefit:** 75% = $2254.65 **Future End Date:**
45773	Syndromic orbital dystopia, such as Treacher Collins Syndrome, bilateral facial or periorbital reconstruction, with bone grafts from a distant site (H) (Anaes.) (Assist.) **Fee:** $2,098.65 **Benefit:** 75% = $1574.00 **Future End Date:**
45776	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, intracranial (Anaes.) (Assist.) **Fee:** $2,098.65 **Benefit:** 75% = $1574.00 **Future End Date:**
45779	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, extracranial (Anaes.) (Assist.) **Fee:** $1,542.95 **Benefit:** 75% = $1157.25 **Future End Date:**
45782	Fronto-orbital advancement (H) (Anaes.) (Assist.) **Fee:** $1,179.70 **Benefit:** 75% = $884.80 **Future End Date:**
45785	Cranial vault reconstruction for single suture synostosis (H) (Anaes.) (Assist.) **Fee:** $1,996.55 **Benefit:** 75% = $1497.45 **Future End Date:**

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.) **Fee:** $1,973.85 **Benefit:** 75% = $1480.40 **Future End Date:**
45791	Absent condyle and ascending ramus in craniofacial microsomia, construction of, not including harvesting of graft material (H) (Anaes.) (Assist.) **Fee:** $1,066.25 **Benefit:** 75% = $799.70 **Future End Date:**
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.) **Fee:** $603.15 **Benefit:** 75% = $452.40 85% = $512.70 **Future End Date:**
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.) **Fee:** $223.25 **Benefit:** 75% = $167.45 85% = $189.80 **Future End Date:**
	ORAL AND MAXILLOFACIAL SURGERY
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.) (See para TN.8.109 of explanatory notes to this Category) **Fee:** $161.55 **Benefit:** 75% = $121.20 85% = $137.35 **Future End Date:**
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.) (See para TN.8.109 of explanatory notes to this Category) **Fee:** $295.10 **Benefit:** 75% = $221.35 85% = $250.85 **Future End Date:**
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.) (See para GN.1.2, TN.8.109 of explanatory notes to this Category) **Fee:** $444.65 **Benefit:** 75% = $333.50 **Future End Date:**

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.) (See para GN.1.2, TN.8.109 of explanatory notes to this Category) **Fee:** $601.15 **Benefit:** 75% = $450.90 **Future End Date:**
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.) (See para GN.1.2, TN.8.109 of explanatory notes to this Category) **Fee:** $703.25 **Benefit:** 75% = $527.45 **Future End Date:**
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.) **Fee:** $426.55 **Benefit:** 75% = $319.95 85% = $362.60 **Future End Date:**
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.) **Fee:** $130.35 **Benefit:** 75% = $97.80 **Future End Date:**
45825	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.) **Fee:** $405.00 **Benefit:** 75% = $303.75 85% = $344.25 **Future End Date:**
45827	Mylohyoid ridge, reduction of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $387.05 **Benefit:** 75% = $290.30 **Future End Date:**
45829	MAXILLARY TUBEROSITY, reduction of (Anaes.) **Fee:** $295.30 **Benefit:** 75% = $221.50 85% = $251.05 **Future End Date:**
45831	Papillary hyperplasia of the palate, surgical reduction of—cannot be claimed more than once per occasion of service (H) (Anaes.) (Assist.) **Fee:** $387.05 **Benefit:** 75% = $290.30 **Future End Date:**
45837	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.) **Fee:** $702.00 **Benefit:** 75% = $526.50 85% = $596.70 **Future End Date:**

45841	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.) **Fee:** $566.95 **Benefit:** 75% = $425.25 85% = $481.95 **Future End Date:**
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.) **Fee:** $603.15 **Benefit:** 75% = $452.40 85% = $512.70 **Future End Date:**
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.) **Fee:** $223.25 **Benefit:** 75% = $167.45 85% = $189.80 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $695.30 **Benefit:** 75% = $521.50 **Future End Date:**
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.) **Fee:** $171.20 **Benefit:** 75% = $128.40 **Future End Date:**
45855	Temporomandibular joint, arthroscopy of, with or without biopsy, other than a service associated with another arthroscopic procedure of that joint (H) (Anaes.) (Assist.) **Fee:** $347.75 **Benefit:** 75% = $260.85 **Future End Date:**
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.) **Fee:** $782.60 **Benefit:** 75% = $586.95 **Future End Date:**
45865	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.) **Fee:** $347.75 **Benefit:** 75% = $260.85 85% = $295.60

T8. SURGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	Future End Date:
45871	Temporomandibular joint, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,602.00 **Benefit:** 75% = $1201.50 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,800.15 **Benefit:** 75% = $1350.15 **Future End Date:**
45882	The treatment of a premalignant lesion of the oral mucosa by a treatment using cryotherapy, diathermy or carbon dioxide laser. **Fee:** $51.50 **Benefit:** 75% = $38.65 85% = $43.80 **Future End Date:**
45888	Removal of a deep foreign body using interventional imaging techniques (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $495.00 **Benefit:** 75% = $371.25 **Future End Date:**
45891	Repair to one defect using temporalis muscle by a single stage local flap (Anaes.) (Assist.) **Fee:** $721.10 **Benefit:** 75% = $540.85 85% = $612.95 **Future End Date:**
45894	Grafting (mucosa or split skin), in the oral cavity of a mucosal defect (Anaes.) **Fee:** $245.00 **Benefit:** 75% = $183.75 85% = $208.25 **Future End Date:**
45939	Cryosurgery of the peripheral branches of the trigeminal nerve for pain relief (H) (Anaes.) (Assist.) **Fee:** $535.05 **Benefit:** 75% = $401.30 **Future End Date:**

T8. SURGICAL OPERATIONS	14. HAND SURGERY
	Group T8. Surgical Operations
	Subgroup 14. 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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $486.00 **Benefit:** 75% = $364.50 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $630.20 **Benefit:** 75% = $472.65 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $630.15 **Benefit:** 75% = $472.65 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $630.15 **Benefit:** 75% = $472.65 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $810.25 **Benefit:** 75% = $607.70 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $1,080.35 **Benefit:** 75% = $810.30 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $1,350.40 **Benefit:** 75% = $1012.80 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $1,620.45 **Benefit:** 75% = $1215.35 **Future End Date:**

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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $945.30 **Benefit:** 75% = $709.00 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $1,102.65 **Benefit:** 75% = $827.00 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $1,102.65 **Benefit:** 75% = $827.00 **Future End Date:**
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.)

	(See para TN.8.190 of explanatory notes to this Category) **Fee:** $414.20 **Benefit:** 75% = $310.65 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $675.10 **Benefit:** 75% = $506.35 **Future End Date:**
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.) (See para GN.1.2, TN.8.184, TN.8.190, TN.8.283, TN.8.185 of explanatory notes to this Category) **Fee:** $558.00 **Benefit:** 75% = $418.50 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category)

	Fee: $315.15 **Benefit:** 75% = $236.40 **Future End Date:**
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.) (See para TN.8.190, TN.8.283, TN.8.185 of explanatory notes to this Category) **Fee:** $558.00 **Benefit:** 75% = $418.50 **Future End Date:**
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.) (See para TN.8.184, TN.8.190, TN.8.283, TN.8.185 of explanatory notes to this Category) **Fee:** $474.30 **Benefit:** 75% = $355.75 **Future End Date:**
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.) (See para TN.8.190, TN.8.283, TN.8.185 of explanatory notes to this Category) **Fee:** $304.20 **Benefit:** 75% = $228.15 **Future End Date:**
46342	Synovectomy of distal radioulnar or carpometacarpal joint of hand—one or more joints (H) (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $558.00 **Benefit:** 75% = $418.50 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $675.10 **Benefit:** 75% = $506.35 **Future End Date:**
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.) (See para TN.8.190, TN.8.283, TN.8.284 of explanatory notes to this Category) **Fee:** $292.55 **Benefit:** 75% = $219.45 **Future End Date:**

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.) (See para TN.8.190, TN.8.283, TN.8.284 of explanatory notes to this Category) **Fee:** $436.60 **Benefit:** 75% = $327.45 **Future End Date:**
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.) (See para TN.8.190, TN.8.283, TN.8.284 of explanatory notes to this Category) **Fee:** $585.15 **Benefit:** 75% = $438.90 **Future End Date:**
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.) (See para TN.8.190, TN.8.283, TN.8.284 of explanatory notes to this Category) **Fee:** $729.20 **Benefit:** 75% = $546.90 **Future End Date:**
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.) (See para TN.8.190, TN.8.283, TN.8.284 of explanatory notes to this Category) **Fee:** $877.75 **Benefit:** 75% = $658.35 **Future End Date:**
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.) (See para TN.8.190, TN.8.284 of explanatory notes to this Category) **Fee:** $252.00 **Benefit:** 75% = $189.00 85% = $214.20 **Future End Date:**
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.) (See para GN.1.2, TN.8.190, TN.8.283 of explanatory notes to this Category) **Fee:** $558.00 **Benefit:** 75% = $418.50 **Future End Date:**
46365	Excision of rheumatoid nodules of hand —one lesion (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $315.15 **Benefit:** 75% = $236.40 85% = $267.90 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $475.85 **Benefit:** 75% = $356.90 85% = $404.50 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $153.15 **Benefit:** 75% = $114.90 85% = $130.20 **Future End Date:**
46372	Fasciectomy for Dupuytren's contracture, including dissection of nerves (if performed)—one ray (H) (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $512.20 **Benefit:** 75% = $384.15 **Future End Date:**
46375	Fasciectomy for Dupuytren's contracture, including dissection of nerves (if performed)—2 rays (H) (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $607.65 **Benefit:** 75% = $455.75 **Future End Date:**
46378	Fasciectomy for Dupuytren's contracture, including dissection of nerves (if performed)—3 rays (H) (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $810.25 **Benefit:** 75% = $607.70 **Future End Date:**
46379	Fasciectomy for Dupuytren's contracture, including dissection of nerves (if performed)—4 rays (H) (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $1,020.70 **Benefit:** 75% = $765.55 **Future End Date:**
46380	Fasciectomy for Dupuytren's contracture, including dissection of nerves (if performed)—5 rays (H) (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $1,286.15 **Benefit:** 75% = $964.65 **Future End Date:**

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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $360.00 **Benefit:** 75% = $270.00 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $360.00 **Benefit:** 75% = $270.00 **Future End Date:**
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.) (See para TN.8.190, TN.8.283 of explanatory notes to this Category) **Fee:** $742.75 **Benefit:** 75% = $557.10 **Future End Date:**
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.) (See para TN.8.190, TN.8.283 of explanatory notes to this Category) **Fee:** $990.55 **Benefit:** 75% = $742.95 **Future End Date:**
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.) (See para TN.8.190, TN.8.283 of explanatory notes to this Category) **Fee:** $1,147.80 **Benefit:** 75% = $860.85 **Future End Date:**

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.) (See para TN.8.190, TN.8.283 of explanatory notes to this Category) **Fee:** $1,430.35 **Benefit:** 75% = $1072.80 **Future End Date:**
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.) (See para TN.8.190, TN.8.283 of explanatory notes to this Category) **Fee:** $1,782.40 **Benefit:** 75% = $1336.80 **Future End Date:**
46399	Osteotomy of phalanx or metacarpal of hand, with internal fixation—one bone (H) (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $619.75 **Benefit:** 75% = $464.85 **Future End Date:**
46401	Operative treatment of non-union of phalanx or metacarpal of hand, including internal fixation (if performed) (H) (Anaes.) (Assist.) (See para GN.1.2, TN.8.190, TN.8.282 of explanatory notes to this Category) **Fee:** $497.40 **Benefit:** 75% = $373.05 **Future End Date:**
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.) (See para TN.8.190, TN.8.283 of explanatory notes to this Category) **Fee:** $828.20 **Benefit:** 75% = $621.15 **Future End Date:**
46411	Reconstruction of complete flexor tendon pulley of hand or wrist, with graft, including harvest of graft (if performed)—one pulley (H) (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category)

	Fee: $486.05 **Benefit:** 75% = $364.55 **Future End Date:**
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.) (See para GN.1.2, TN.8.190, TN.8.283 of explanatory notes to this Category) **Fee:** $630.05 **Benefit:** 75% = $472.55 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $585.15 **Benefit:** 75% = $438.90 **Future End Date:**
46420	Primary repair of extensor tendon of hand or wrist—one tendon (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $244.85 **Benefit:** 75% = $183.65 85% = $208.15 **Future End Date:**
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.) (See para TN.8.190, TN.8.283 of explanatory notes to this Category) **Fee:** $391.60 **Benefit:** 75% = $293.70 **Future End Date:**
46426	Primary repair of flexor tendon of hand or wrist, proximal to A1 pulley—one tendon (H) (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $405.05 **Benefit:** 75% = $303.80 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $675.35 **Benefit:** 75% = $506.55 **Future End Date:**
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.) (See para GN.1.2, TN.8.190, TN.8.283 of explanatory notes to this Category) **Fee:** $581.85 **Benefit:** 75% = $436.40 **Future End Date:**
46438	Closed pin fixation of mallet finger (H) (Anaes.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $162.05 **Benefit:** 75% = $121.55 **Future End Date:**

46441	Open reduction of mallet finger, including any of the following (if performed): (a) joint release; (b) pin fixation; (c) tenolysis (H) (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $391.60 **Benefit:** 75% = $293.70 **Future End Date:**
46442	MALLET FINGER with intra articular fracture involving more than one third of base of terminal phalanx - open reduction (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $336.20 **Benefit:** 75% = $252.15 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $585.15 **Benefit:** 75% = $438.90 **Future End Date:**
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.) (See para TN.8.190, TN.8.283 of explanatory notes to this Category) **Fee:** $270.15 **Benefit:** 75% = $202.65 **Future End Date:**
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.) (See para TN.8.190, TN.8.283 of explanatory notes to this Category) **Fee:** $450.15 **Benefit:** 75% = $337.65 **Future End Date:**

46456	Percutaneous tenotomy of digit of hand (Anaes.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $117.00 **Benefit:** 75% = $87.75 85% = $99.45 **Future End Date:**
46464	Amputation of a supernumerary complete digit of hand (H) (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $270.15 **Benefit:** 75% = $202.65 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $270.15 **Benefit:** 75% = $202.65 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $472.60 **Benefit:** 75% = $354.45 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $675.10 **Benefit:** 75% = $506.35 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $877.75 **Benefit:** 75% = $658.35 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $1,080.35 **Benefit:** 75% = $810.30 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $450.15 **Benefit:** 75% = $337.65 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $360.00 **Benefit:** 75% = $270.00 **Future End Date:**
46486	Accurate reconstruction of acute nail bed laceration using magnification (H) (Anaes.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $270.15 **Benefit:** 75% = $202.65 **Future End Date:**

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.) (See para TN.8.188, TN.8.190 of explanatory notes to this Category) **Fee:** $315.15 **Benefit:** 75% = $236.40 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $432.15 **Benefit:** 75% = $324.15 **Future End Date:**
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.) (See para GN.1.2, TN.8.190 of explanatory notes to this Category) **Fee:** $394.45 **Benefit:** 75% = $295.85 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $243.20 **Benefit:** 75% = $182.40 **Future End Date:**
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.) (See para TN.8.190, TN.8.284 of explanatory notes to this Category) **Fee:** $263.15 **Benefit:** 75% = $197.40 85% = $223.70 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $315.15 **Benefit:** 75% = $236.40 85% = $267.90 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $394.05 **Benefit:** 75% = $295.55 85% = $334.95 **Future End Date:**
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.) (See para GN.1.2, TN.8.190 of explanatory notes to this Category) **Fee:** $472.65 **Benefit:** 75% = $354.50 **Future End Date:**
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.) (See para GN.1.2, TN.8.190 of explanatory notes to this Category) **Fee:** $452.90 **Benefit:** 75% = $339.70 **Future End Date:**
46504	Neurovascular island flap, heterodigital, for pulp re-innervation and soft tissue cover (H) (Anaes.) (Assist.) (See para GN.1.2, TN.8.187, TN.8.190 of explanatory notes to this Category) **Fee:** $1,323.25 **Benefit:** 75% = $992.45 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $1,795.30 **Benefit:** 75% = $1346.50 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $420.05 **Benefit:** 75% = $315.05 **Future End Date:**
46513	Removal of nail of finger or thumb—one nail (Anaes.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $67.60 **Benefit:** 75% = $50.70 85% = $57.50 **Future End Date:**
46519	Drainage of midpalmar, thenar or hypothenar spaces or dorsum of hand, excluding aftercare (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $169.00 **Benefit:** 75% = $126.75 85% = $143.65 **Future End Date:**

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.) (See para TN.8.190, TN.8.283 of explanatory notes to this Category) **Fee:** $504.15 **Benefit:** 75% = $378.15 **Future End Date:**
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.) (See para TN.8.190, TN.8.283 of explanatory notes to this Category) **Fee:** $67.60 **Benefit:** 75% = $50.70 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $202.90 **Benefit:** 75% = $152.20 85% = $172.50 **Future End Date:**
46531	Partial resection of ingrowing nail of finger or thumb, including phenolisation (Anaes.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $101.95 **Benefit:** 75% = $76.50 85% = $86.70 **Future End Date:**
46534	Complete ablation of nail germinal matrix (H) (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $281.85 **Benefit:** 75% = $211.40 **Future End Date:**

	Group T8. Surgical Operations
	Subgroup 15. Orthopaedic
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.) **Fee:** $719.35 **Benefit:** 75% = $539.55 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $907.55 **Benefit:** 75% = $680.70 **Future End Date:**
	TREATMENT OF DISLOCATIONS
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.) **Fee:** $84.65 **Benefit:** 75% = $63.50 **Future End Date:**
47003	Treatment of dislocation of clavicle, by closed reduction (Anaes.) **Fee:** $101.45 **Benefit:** 75% = $76.10 85% = $86.25 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $422.60 **Benefit:** 75% = $316.95 **Future End Date:**
47009	Treatment of dislocation of shoulder, requiring general anaesthesia, other than a service to which item 47012 applies (H) (Anaes.)

	(See para GN.1.2 of explanatory notes to this Category) **Fee:** $202.90 **Benefit:** 75% = $152.20 **Future End Date:**
47012	Treatment of dislocation of shoulder, requiring general anaesthesia, by open reduction (H) (Anaes.) (Assist.) **Fee:** $405.55 **Benefit:** 75% = $304.20 **Future End Date:**
47015	Treatment of dislocation of shoulder, not requiring general anaesthesia **Fee:** $101.45 **Benefit:** 75% = $76.10 85% = $86.25 **Future End Date:**
47018	Treatment of dislocation of elbow, by closed reduction (Anaes.) **Fee:** $236.50 **Benefit:** 75% = $177.40 85% = $201.05 **Future End Date:**
47021	Treatment of dislocation of elbow, by open reduction (H) (Anaes.) (Assist.) **Fee:** $315.50 **Benefit:** 75% = $236.65 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $236.50 **Benefit:** 75% = $177.40 85% = $201.05 **Future End Date:**
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.) (See para GN.1.2, TN.8.190 of explanatory notes to this Category) **Fee:** $777.65 **Benefit:** 75% = $583.25 **Future End Date:**
47030	Treatment of dislocation of carpus, carpus on radius and ulna or carpometacarpal joint, by closed reduction (Anaes.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $236.50 **Benefit:** 75% = $177.40 85% = $201.05 **Future End Date:**
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.) (See para GN.1.2, TN.8.190 of explanatory notes to this Category) **Fee:** $777.65 **Benefit:** 75% = $583.25 **Future End Date:**

47042	Treatment of dislocation of interphalangeal or metacarpophalangeal joint, by closed reduction (Anaes.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $135.05 **Benefit:** 75% = $101.30 85% = $114.80 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $504.45 **Benefit:** 75% = $378.35 **Future End Date:**
47047	Treatment of dislocation of prosthetic hip, by closed reduction (Anaes.) (Assist.) **Fee:** $388.75 **Benefit:** 75% = $291.60 85% = $330.45 **Future End Date:**
47049	Treatment of dislocation of prosthetic hip, by open reduction (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $518.25 **Benefit:** 75% = $388.70 **Future End Date:**
47052	Treatment of dislocation of native hip, by closed reduction (Anaes.) (Assist.) **Fee:** $505.35 **Benefit:** 75% = $379.05 85% = $429.55 **Future End Date:**
47053	Treatment of dislocation of native hip, by open reduction, with internal fixation (if performed) (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $673.65 **Benefit:** 75% = $505.25 **Future End Date:**
47054	Treatment of dislocation of knee, by closed reduction, including application of external fixator (if performed) (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $388.75 **Benefit:** 75% = $291.60 **Future End Date:**
47057	Treatment of dislocation of patella, by closed reduction (Anaes.) **Fee:** $152.05 **Benefit:** 75% = $114.05 85% = $129.25 **Future End Date:**
47060	Treatment of dislocation of patella, by open reduction (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category)

	Fee: $202.90 **Benefit:** 75% = $152.20 **Future End Date:**
47063	Treatment of dislocation of ankle or tarsus, by closed reduction (Anaes.) (Assist.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $304.20 **Benefit:** 75% = $228.15 85% = $258.60 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $405.55 **Benefit:** 75% = $304.20 **Future End Date:**
47069	Treatment of dislocation of toe, by closed reduction—one toe (Anaes.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $84.65 **Benefit:** 75% = $63.50 85% = $72.00 **Future End Date:**
	TREATMENT OF FRACTURES
47301	Treatment of fracture of middle or proximal phalanx, by closed reduction, requiring anaesthesia—one bone (Anaes.) (See para TN.8.124, TN.8.190 of explanatory notes to this Category) **Fee:** $103.90 **Benefit:** 75% = $77.95 85% = $88.35 **Future End Date:**
47304	Treatment of fracture of metacarpal, by closed reduction, requiring anaesthesia—one bone (H) (Anaes.) (See para TN.8.124, TN.8.190 of explanatory notes to this Category) **Fee:** $118.35 **Benefit:** 75% = $88.80 **Future End Date:**
47307	Treatment of fracture of phalanx or metacarpal, by closed reduction, including percutaneous K-wire fixation (if performed)—one bone (H) (Anaes.) (Assist.) (See para TN.8.124, TN.8.190 of explanatory notes to this Category) **Fee:** $239.35 **Benefit:** 75% = $179.55 **Future End Date:**
47310	Treatment of fracture of phalanx or metacarpal, by open reduction, with internal fixation (H) (Anaes.) (Assist.) (See para TN.8.124, TN.8.190 of explanatory notes to this Category) **Fee:** $394.95 **Benefit:** 75% = $296.25 **Future End Date:**

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.) (See para TN.8.124, TN.8.190 of explanatory notes to this Category) **Fee:** $383.05 **Benefit:** 75% = $287.30 **Future End Date:**
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.) (See para TN.8.124, TN.8.190 of explanatory notes to this Category) **Fee:** $760.00 **Benefit:** 75% = $570.00 **Future End Date:**
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.) (See para TN.8.124, TN.8.190 of explanatory notes to this Category) **Fee:** $777.95 **Benefit:** 75% = $583.50 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $112.45 **Benefit:** 75% = $84.35 85% = $95.60 **Future End Date:**
47351	Treatment of fracture of carpus (excluding scaphoid), by open reduction, with internal fixation (H) (Anaes.) (Assist.) (See para GN.1.2, TN.8.190 of explanatory notes to this Category) **Fee:** $281.85 **Benefit:** 75% = $211.40 **Future End Date:**
47354	Treatment of fracture of carpal scaphoid, by cast immobilisation, other than a service associated with a service to which item 47357 applies (Anaes.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $202.90 **Benefit:** 75% = $152.20 85% = $172.50 **Future End Date:**
47357	Treatment of fracture of carpal scaphoid, by reduction, with fixation by any means (H) (Anaes.) (Assist.) (See para GN.1.2, TN.8.190 of explanatory notes to this Category) **Fee:** $450.65 **Benefit:** 75% = $338.00 **Future End Date:**

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 (See para TN.8.124 of explanatory notes to this Category) **Fee:** $157.75 **Benefit:** 75% = $118.35 85% = $134.10 **Future End Date:**
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.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $236.50 **Benefit:** 75% = $177.40 85% = $201.05 **Future End Date:**
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.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $335.15 **Benefit:** 75% = $251.40 **Future End Date:**
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.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $267.60 **Benefit:** 75% = $200.70 **Future End Date:**
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.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $485.90 **Benefit:** 75% = $364.45 **Future End Date:**
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.) (See para TN.8.124 of explanatory notes to this Category) **Fee:** $347.15 **Benefit:** 75% = $260.40 **Future End Date:**
47381	Treatment of fracture of shaft of radius or ulna, by closed reduction (H) (Anaes.) **Fee:** $304.20 **Benefit:** 75% = $228.15 **Future End Date:**
47384	Treatment of fracture of shaft of radius or ulna, by open reduction with internal fixation (H) (Anaes.) (Assist.) **Fee:** $405.55 **Benefit:** 75% = $304.20 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $349.20 **Benefit:** 75% = $261.90 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $563.40 **Benefit:** 75% = $422.55 **Future End Date:**
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.) **Fee:** $326.70 **Benefit:** 75% = $245.05 85% = $277.70 **Future End Date:**
47390	Treatment of fracture of shafts of radius and ulna, by closed reduction (H) (Anaes.) **Fee:** $490.20 **Benefit:** 75% = $367.65 **Future End Date:**
47393	Treatment of fracture of shafts of radius and ulna, by open reduction, with internal fixation (H) (Anaes.) (Assist.) **Fee:** $653.55 **Benefit:** 75% = $490.20 **Future End Date:**
47396	Treatment of fracture of olecranon, by closed reduction (Anaes.) **Fee:** $225.25 **Benefit:** 75% = $168.95 85% = $191.50 **Future End Date:**
47399	Treatment of fracture of olecranon, by open reduction (H) (Anaes.) (Assist.) **Fee:** $450.65 **Benefit:** 75% = $338.00 **Future End Date:**
47402	Treatment of fracture of olecranon, with excision of olecranon fragment and reimplantation of tendon (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $337.90 **Benefit:** 75% = $253.45 **Future End Date:**
47405	Treatment of fracture of head or neck of radius, by closed reduction (Anaes.) **Fee:** $225.25 **Benefit:** 75% = $168.95 85% = $191.50 **Future End Date:**

47408	Treatment of fracture of head or neck of radius, by open reduction, including internal fixation and excision (if performed) (H) (Anaes.) (Assist.) **Fee:** $450.65 **Benefit:** 75% = $338.00 **Future End Date:**
47411	Treatment of fracture of tuberosity of humerus, other than a service to which item 47417 applies (Anaes.) **Fee:** $135.05 **Benefit:** 75% = $101.30 85% = $114.80 **Future End Date:**
47414	Treatment of fracture of tuberosity of humerus, by open reduction (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $270.50 **Benefit:** 75% = $202.90 **Future End Date:**
47417	Treatment of fracture of tuberosity of humerus and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) **Fee:** $315.50 **Benefit:** 75% = $236.65 85% = $268.20 **Future End Date:**
47420	Treatment of fracture of tuberosity of humerus and associated dislocation of shoulder, by open reduction (H) (Anaes.) (Assist.) **Fee:** $619.75 **Benefit:** 75% = $464.85 **Future End Date:**
47423	Humerus, proximal, treatment of fracture of, other than a service to which item 47426, 47429 or 47432 applies (Anaes.) **Fee:** $259.10 **Benefit:** 75% = $194.35 85% = $220.25 **Future End Date:**
47426	Humerus, proximal, treatment of fracture of, by closed reduction (H) (Anaes.) **Fee:** $388.75 **Benefit:** 75% = $291.60 **Future End Date:**
47429	Humerus, proximal, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.) **Fee:** $518.25 **Benefit:** 75% = $388.70 **Future End Date:**
47432	Humerus, proximal, treatment of intra-articular fracture of, by open reduction (H) (Anaes.) (Assist.) **Fee:** $647.80 **Benefit:** 75% = $485.85 **Future End Date:**
47435	Humerus, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $495.80 **Benefit:** 75% = $371.85 **Future End Date:**
47438	Humerus, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (H) (Anaes.) (Assist.) **Fee:** $788.90 **Benefit:** 75% = $591.70

	Future End Date:
47441	Humerus, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction (H) (Anaes.) (Assist.) **Fee:** $985.95 **Benefit:** 75% = $739.50 **Future End Date:**
47444	Humerus, shaft of, treatment of fracture of, other than a service to which item 47447 or 47450 applies (Anaes.) **Fee:** $270.50 **Benefit:** 75% = $202.90 85% = $229.95 **Future End Date:**
47447	Humerus, shaft of, treatment of fracture of, by closed reduction (H) (Anaes.) **Fee:** $405.55 **Benefit:** 75% = $304.20 **Future End Date:**
47450	Humerus, shaft of, treatment of fracture of, by internal or external fixation (H) (Anaes.) (Assist.) **Fee:** $540.90 **Benefit:** 75% = $405.70 **Future End Date:**
47451	Humerus, shaft of, treatment of fracture of, by intramedullary fixation (H) (Anaes.) (Assist.) **Fee:** $652.05 **Benefit:** 75% = $489.05 **Future End Date:**
47453	Humerus, distal, (supracondylar or condylar), treatment of fracture of, other than a service to which item 47456 or 47459 applies (Anaes.) (Assist.) **Fee:** $315.50 **Benefit:** 75% = $236.65 85% = $268.20 **Future End Date:**
47456	Humerus, distal (supracondylar or condylar), treatment of fracture of, by closed reduction (H) (Anaes.) (Assist.) **Fee:** $473.40 **Benefit:** 75% = $355.05 **Future End Date:**
47459	Humerus, distal (supracondylar or condylar), treatment of fracture of, by open reduction (H) (Anaes.) (Assist.) **Fee:** $631.10 **Benefit:** 75% = $473.35 **Future End Date:**
47462	Clavicle, treatment of fracture of, other than a service to which item 47465 applies (Anaes.) **Fee:** $135.05 **Benefit:** 75% = $101.30 85% = $114.80 **Future End Date:**
47465	Clavicle, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $619.75 **Benefit:** 75% = $464.85 **Future End Date:**
47466	Sternum, treatment of fracture of, other than a service to which item 47467 applies (Anaes.) **Fee:** $135.05 **Benefit:** 75% = $101.30 85% = $114.80 **Future End Date:**

47467	Sternum, treatment of fracture of, by open reduction (H) (Anaes.) **Fee:** $270.50 **Benefit:** 75% = $202.90 **Future End Date:**
47468	Scapula, neck or glenoid region of, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $518.25 **Benefit:** 75% = $388.70 **Future End Date:**
47471	RIBS (one or more), treatment of fracture of - each attendance **Fee:** $51.50 **Benefit:** 75% = $38.65 85% = $43.80 **Future End Date:**
47474	PELVIC RING, treatment of fracture of, not involving disruption of pelvic ring or acetabulum **Fee:** $225.25 **Benefit:** 75% = $168.95 85% = $191.50 **Future End Date:**
47477	Pelvic ring, treatment of fracture of, with disruption of pelvic ring or acetabulum (H) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $281.85 **Benefit:** 75% = $211.40 **Future End Date:**
47480	PELVIC RING, treatment of fracture of, requiring traction (H) (Anaes.) (Assist.) **Fee:** $563.40 **Benefit:** 75% = $422.55 **Future End Date:**
47483	PELVIC RING, treatment of fracture of, requiring control by external fixation (H) (Anaes.) (Assist.) **Fee:** $676.10 **Benefit:** 75% = $507.10 **Future End Date:**
47486	Treatment of fracture of anterior pelvic ring or sacroiliac joint disruption (or both), by open reduction, with internal fixation (H) (Anaes.) (Assist.) **Fee:** $1,126.80 **Benefit:** 75% = $845.10 **Future End Date:**
47489	Treatment of fracture of posterior pelvic ring or sacroiliac joint disruption (or both), by open reduction, with internal fixation (H) (Anaes.) (Assist.) **Fee:** $1,690.25 **Benefit:** 75% = $1267.70 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $563.40 **Benefit:** 75% = $422.55 **Future End Date:**
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.) **Fee:** $845.00 **Benefit:** 75% = $633.75 **Future End Date:**

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.) (See para TN.8.168 of explanatory notes to this Category) **Fee:** $1,126.80 **Benefit:** 75% = $845.10 **Future End Date:**
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.) **Fee:** $1,690.25 **Benefit:** 75% = $1267.70 **Future End Date:**
47514	Treatment of posterior wall fracture of acetabulum and associated femoral head fracture, by open reduction, with internal fixation (H) (Anaes.) (Assist.) **Fee:** $985.95 **Benefit:** 75% = $739.50 **Future End Date:**
47516	FEMUR, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.) **Fee:** $518.25 **Benefit:** 75% = $388.70 85% = $440.55 **Future End Date:**
47519	FEMUR, treatment of trochanteric or subcapital fracture of, by internal fixation (H) (Anaes.) (Assist.) **Fee:** $1,036.70 **Benefit:** 75% = $777.55 **Future End Date:**
47528	FEMUR, treatment of fracture of, by internal fixation or external fixation (H) (Anaes.) (Assist.) **Fee:** $901.55 **Benefit:** 75% = $676.20 **Future End Date:**
47531	FEMUR, treatment of fracture of shaft, by intramedullary fixation and cross fixation (H) (Anaes.) (Assist.) **Fee:** $1,149.35 **Benefit:** 75% = $862.05 **Future End Date:**

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.) **Fee:** $1,295.85 **Benefit:** 75% = $971.90 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $518.25 **Benefit:** 75% = $388.70 **Future End Date:**
47540	Hip spica or shoulder spica, application of, as an independent procedure (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $259.10 **Benefit:** 75% = $194.35 **Future End Date:**
47543	Tibia, plateau of, treatment of medial or lateral fracture of, other than a service to which item 47546 or 47549 applies (Anaes.) **Fee:** $270.50 **Benefit:** 75% = $202.90 85% = $229.95 **Future End Date:**
47546	Tibia, plateau of, treatment of medial or lateral fracture of, by closed reduction (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $405.55 **Benefit:** 75% = $304.20 **Future End Date:**
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.) **Fee:** $644.25 **Benefit:** 75% = $483.20 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $450.65 **Benefit:** 75% = $338.00 **Future End Date:**
47555	Tibia, plateau of, treatment of both medial and lateral fractures of, by closed reduction (H) (Anaes.) **Fee:** $676.10 **Benefit:** 75% = $507.10 **Future End Date:**

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.) **Fee:** $1,194.45 **Benefit:** 75% = $895.85 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $914.80 **Benefit:** 75% = $686.10 **Future End Date:**
47561	Treatment of fracture of shaft of tibia, by cast immobilisation, other than a service to which item 47570 or 47573 applies (Anaes.) **Fee:** $326.70 **Benefit:** 75% = $245.05 85% = $277.70 **Future End Date:**
47565	Tibia, shaft of, treatment of fracture of, by internal fixation or external fixation (H) (Anaes.) (Assist.) **Fee:** $852.65 **Benefit:** 75% = $639.50 **Future End Date:**
47566	Tibia, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (H) (Anaes.) (Assist.) **Fee:** $1,086.90 **Benefit:** 75% = $815.20 **Future End Date:**
47568	Closed reduction of proximal tibia, distal tibia or shaft of tibia, with or without treatment of fibular fracture (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $490.20 **Benefit:** 75% = $367.65 **Future End Date:**
47570	Tibia, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $653.55 **Benefit:** 75% = $490.20 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $816.95 **Benefit:** 75% = $612.75 **Future End Date:**
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.) **Fee:** $676.10 **Benefit:** 75% = $507.10 **Future End Date:**
47579	Treatment of fracture of patella, other than a service to which item 47582 or 47585 applies (Anaes.) **Fee:** $191.60 **Benefit:** 75% = $143.70 85% = $162.90 **Future End Date:**
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.) **Fee:** $507.25 **Benefit:** 75% = $380.45 **Future End Date:**
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.) **Fee:** $524.40 **Benefit:** 75% = $393.30 **Future End Date:**
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.) **Fee:** $1,577.30 **Benefit:** 75% = $1183.00 **Future End Date:**
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.) **Fee:** $1,915.75 **Benefit:** 75% = $1436.85 **Future End Date:**
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.) **Fee:** $955.05 **Benefit:** 75% = $716.30 **Future End Date:**
47595	Treatment of fracture of ankle joint, hindfoot, midfoot, metatarsals or toes, by non-surgical management—one leg (Anaes.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $192.85 **Benefit:** 75% = $144.65 85% = $163.95 **Future End Date:**
47597	Treatment of fracture of ankle joint, by closed reduction (Anaes.) (Assist.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $388.75 **Benefit:** 75% = $291.60 85% = $330.45 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $676.10 **Benefit:** 75% = $507.10 **Future End Date:**

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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $852.65 **Benefit:** 75% = $639.50 **Future End Date:**
47612	Treatment of intra-articular fracture of hindfoot, by closed reduction, with or without dislocation—one foot (H) (Anaes.) (Assist.) (See para GN.1.2, TN.8.199 of explanatory notes to this Category) **Fee:** $490.20 **Benefit:** 75% = $367.65 **Future End Date:**
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.) (See para GN.1.2, TN.8.199 of explanatory notes to this Category) **Fee:** $563.40 **Benefit:** 75% = $422.55 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category)

	Fee: $704.25 **Benefit:** 75% = $528.20 **Future End Date:**
47621	Treatment of intra-articular fracture of midfoot, by closed reduction, with or without dislocation—one foot (H) (Anaes.) (Assist.) (See para GN.1.2, TN.8.199 of explanatory notes to this Category) **Fee:** $490.20 **Benefit:** 75% = $367.65 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $676.10 **Benefit:** 75% = $507.10 **Future End Date:**
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.) (See para GN.1.2, TN.8.199 of explanatory notes to this Category) **Fee:** $405.55 **Benefit:** 75% = $304.20 **Future End Date:**
47637	Treatment of fractures of metatarsal, by closed reduction—one or more metatarsals of one foot (Anaes.) (Assist.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $229.60 **Benefit:** 75% = $172.20 85% = $195.20 **Future End Date:**
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.) (See para GN.1.2, TN.8.199 of explanatory notes to this Category) **Fee:** $270.50 **Benefit:** 75% = $202.90 **Future End Date:**

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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $360.35 **Benefit:** 75% = $270.30 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $563.40 **Benefit:** 75% = $422.55 **Future End Date:**
47663	Treatment of fracture of phalanx of toe, by closed reduction—one toe (Anaes.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $169.00 **Benefit:** 75% = $126.75 85% = $143.65 **Future End Date:**
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.) (See para GN.1.2, TN.8.199 of explanatory notes to this Category) **Fee:** $281.85 **Benefit:** 75% = $211.40 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $135.05 **Benefit:** 75% = $101.30 **Future End Date:**

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.) (See para GN.1.2, TN.8.199 of explanatory notes to this Category) **Fee:** $202.90 **Benefit:** 75% = $152.20 **Future End Date:**
47735	Nasal bones, treatment of fracture of, other than a service to which item 47738 or 47741 applies—each attendance **Fee:** $51.55 **Benefit:** 75% = $38.70 85% = $43.85 **Future End Date:**
47738	Nasal bones, treatment of fracture of, by reduction (Anaes.) **Fee:** $281.85 **Benefit:** 75% = $211.40 85% = $239.60 **Future End Date:**
47741	Nasal bones, treatment of fracture of, by open reduction involving osteotomies (H) (Anaes.) (Assist.) **Fee:** $574.95 **Benefit:** 75% = $431.25 **Future End Date:**
47753	Maxilla or mandible, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (H) (Anaes.) (Assist.) **Fee:** $486.65 **Benefit:** 75% = $365.00 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $285.85 **Benefit:** 75% = $214.40 **Future End Date:**
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.) **Fee:** $537.80 **Benefit:** 75% = $403.35 **Future End Date:**
47786	Maxilla, treatment of fracture of, requiring open reduction and internal fixation involving one or more plates (H) (Anaes.) (Assist.) **Fee:** $860.25 **Benefit:** 75% = $645.20 **Future End Date:**

47789	Mandible, treatment of fracture of, requiring open reduction and internal fixation involving one or more plates (H) (Anaes.) (Assist.) **Fee:** $860.25 **Benefit:** 75% = $645.20 **Future End Date:**
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.) (See para TN.8.281 of explanatory notes to this Category) **Fee:** $1,444.30 **Benefit:** 75% = $1083.25 **Future End Date:**
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.) (See para TN.8.281 of explanatory notes to this Category) **Fee:** $1,444.30 **Benefit:** 75% = $1083.25 **Future End Date:**
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.) (See para TN.8.281 of explanatory notes to this Category) **Fee:** $1,309.00 **Benefit:** 75% = $981.75 **Future End Date:**
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.) (See para TN.8.281 of explanatory notes to this Category) **Fee:** $1,309.00 **Benefit:** 75% = $981.75 **Future End Date:**
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.) (See para TN.8.281 of explanatory notes to this Category) **Fee:** $970.95 **Benefit:** 75% = $728.25 **Future End Date:**

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.) (See para TN.8.282 of explanatory notes to this Category) **Fee:** $970.95 **Benefit:** 75% = $728.25 **Future End Date:**
	GENERAL OPERATIONS
47790	Tendon, large, lengthening of, as an independent procedure (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $337.90 **Benefit:** 75% = $253.45 **Future End Date:**
47791	Tenosynovectomy, not being a service associated with a service to which another item in this Group applies (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $315.50 **Benefit:** 75% = $236.65 **Future End Date:**
47900	Injection into, or aspiration of, unicameral bone cyst (Anaes.) (See para TN.8.169 of explanatory notes to this Category) **Fee:** $202.90 **Benefit:** 75% = $152.20 85% = $172.50 **Future End Date:**
47903	Epicondylitis, open operation for (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $281.85 **Benefit:** 75% = $211.40 **Future End Date:**
47904	Digital nail of toe, removal of, not being a service to which item 47906 applies (Anaes.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $67.60 **Benefit:** 75% = $50.70 85% = $57.50 **Future End Date:**
47906	Digital nail of toe, removal of, in the operating theatre of a hospital (H) (Anaes.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $135.05 **Benefit:** 75% = $101.30 **Future End Date:**

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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $202.90 **Benefit:** 75% = $152.20 85% = $172.50 **Future End Date:**
47916	Partial resection for ingrowing nail of toe, including phenolisation (Anaes.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $101.95 **Benefit:** 75% = $76.50 85% = $86.70 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $281.85 **Benefit:** 75% = $211.40 85% = $239.60 **Future End Date:**
47921	Orthopaedic pin or wire, insertion of, as an independent procedure (Anaes.) **Fee:** $135.05 **Benefit:** 75% = $101.30 85% = $114.80 **Future End Date:**
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.) (See para TN.8.179 of explanatory notes to this Category) **Fee:** $45.10 **Benefit:** 75% = $33.85 85% = $38.35 **Future End Date:**
47927	Removal of one or more buried wires, pins or screws (inserted for internal fixation purposes)—one bone (H) (Anaes.) (See para TN.8.179 of explanatory notes to this Category) **Fee:** $169.00 **Benefit:** 75% = $126.75

	Future End Date:
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.) (See para TN.8.179 of explanatory notes to this Category) **Fee:** $450.65 **Benefit:** 75% = $338.00 **Future End Date:**
47953	Repair of distal biceps brachii tendon, by any method, performed as an independent procedure (H) (Anaes.) (Assist.) (See para GN.1.2, GN.10.26 of explanatory notes to this Category) **Fee:** $518.25 **Benefit:** 75% = $388.70 **Future End Date:**
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.) (See para TN.8.180 of explanatory notes to this Category) **Fee:** $450.65 **Benefit:** 75% = $338.00 85% = $383.10 **Future End Date:**
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.) **Fee:** $779.90 **Benefit:** 75% = $584.95 **Future End Date:**
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.) **Fee:** $1,169.85 **Benefit:** 75% = $877.40 **Future End Date:**
47960	TENOTOMY, SUBCUTANEOUS, not being a service to which another item in this Group applies (Anaes.) (See para TN.8.290 of explanatory notes to this Category) **Fee:** $157.75 **Benefit:** 75% = $118.35 85% = $134.10 **Future End Date:**
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.) **Fee:** $259.10 **Benefit:** 75% = $194.35 **Future End Date:**
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.) **Fee:** $518.25 **Benefit:** 75% = $388.70 **Future End Date:**
47975	Forearm or calf, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (H) (Anaes.) (Assist.) **Fee:** $441.85 **Benefit:** 75% = $331.40 **Future End Date:**
47978	Forearm or calf, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue (H) (Anaes.) **Fee:** $268.45 **Benefit:** 75% = $201.35 **Future End Date:**
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.) **Fee:** $180.15 **Benefit:** 75% = $135.15 85% = $153.15 **Future End Date:**
47982	Forage (Drill decompression), of neck or head of femur, or both (H) (Anaes.) (Assist.) **Fee:** $436.80 **Benefit:** 75% = $327.60 **Future End Date:**
47983	Stabilisation of slipped capital femoral epiphysis, by internal fixation (H) (Anaes.) (Assist.) **Fee:** $1,036.70 **Benefit:** 75% = $777.55 **Future End Date:**
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.) **Fee:** $1,036.70 **Benefit:** 75% = $777.55 **Future End Date:**
	BONE GRAFTS
48245	Harvesting and insertion of bone graft (autograft) via separate incisions and at separate surgical fields (H) (Anaes.) (Assist.) (See para TN.8.177 of explanatory notes to this Category) **Fee:** $374.35 **Benefit:** 75% = $280.80 **Future End Date:**
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.) (See para TN.8.282, TN.8.177 of explanatory notes to this Category) **Fee:** $579.75 **Benefit:** 75% = $434.85 **Future End Date:**

48251	Harvesting and insertion of osteochondral graft (autograft) via separate incisions at the same joint or joint complex (H) (Anaes.) (Assist.) (See para TN.8.282, TN.8.177 of explanatory notes to this Category) **Fee:** $477.10 **Benefit:** 75% = $357.85 **Future End Date:**
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.) (See para TN.8.282, TN.8.177 of explanatory notes to this Category) **Fee:** $1,093.05 **Benefit:** 75% = $819.80 **Future End Date:**
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.) (See para TN.8.282, TN.8.177, TN.8.178 of explanatory notes to this Category) **Fee:** $477.10 **Benefit:** 75% = $357.85 **Future End Date:**
	OSTEOTOMY AND OSTEECTOMY
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.) (See para TN.8.196, TN.8.168, TN.8.200, TN.8.223, TN.8.199 of explanatory notes to this Category) **Fee:** $394.45 **Benefit:** 75% = $295.85 **Future End Date:**
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.) (See para TN.8.196, TN.8.168, TN.8.200, TN.8.223, TN.8.199 of explanatory notes to this Category) **Fee:** $619.75 **Benefit:** 75% = $464.85 **Future End Date:**
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.) (See para TN.8.196, TN.8.168, TN.8.200, TN.8.190 of explanatory notes to this Category) **Fee:** $394.45 **Benefit:** 75% = $295.85 **Future End Date:**
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.) (See para TN.8.196, TN.8.168, TN.8.200, TN.8.190 of explanatory notes to this Category) **Fee:** $619.75 **Benefit:** 75% = $464.85 **Future End Date:**
48412	Osteotomy of humerus, without internal fixation (H) (Anaes.) (Assist.) (See para TN.8.168 of explanatory notes to this Category) **Fee:** $754.85 **Benefit:** 75% = $566.15 **Future End Date:**
48415	Osteotomy of humerus, with internal fixation (H) (Anaes.) (Assist.) (See para TN.8.168 of explanatory notes to this Category) **Fee:** $957.80 **Benefit:** 75% = $718.35 **Future End Date:**
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.) (See para TN.8.200 of explanatory notes to this Category) **Fee:** $754.85 **Benefit:** 75% = $566.15 **Future End Date:**
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.) (See para TN.8.200 of explanatory notes to this Category) **Fee:** $957.80 **Benefit:** 75% = $718.35 **Future End Date:**
48421	Osteotomy of proximal tibia, to alter lower limb alignment or rotation (or both), with internal or external fixation (or both) (H) (Anaes.) (Assist.) (See para TN.8.196, TN.8.168 of explanatory notes to this Category) **Fee:** $1,100.10 **Benefit:** 75% = $825.10 **Future End Date:**
48422	Osteotomy of distal femur, to alter lower limb alignment or rotation (or both), with internal or external fixation (or both) (H) (Anaes.) (Assist.) (See para TN.8.168 of explanatory notes to this Category) **Fee:** $1,093.05 **Benefit:** 75% = $819.80 **Future End Date:**
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.) (See para TN.8.168 of explanatory notes to this Category) **Fee:** $901.55 **Benefit:** 75% = $676.20 **Future End Date:**

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.) (See para TN.8.168 of explanatory notes to this Category) **Fee:** $901.55 **Benefit:** 75% = $676.20 **Future End Date:**
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.) (See para TN.8.168 of explanatory notes to this Category) **Fee:** $1,093.05 **Benefit:** 75% = $819.80 **Future End Date:**
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.) (See para TN.8.168 of explanatory notes to this Category) **Fee:** $1,093.05 **Benefit:** 75% = $819.80 **Future End Date:**
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.) (See para TN.8.196, TN.8.200, TN.8.201, TN.8.199, TN.8.292 of explanatory notes to this Category) **Fee:** $321.15 **Benefit:** 75% = $240.90 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $1,278.95 **Benefit:** 75% = $959.25 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $676.10 **Benefit:** 75% = $507.10 **Future End Date:**
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.) (See para TN.8.291 of explanatory notes to this Category) **Fee:** $321.15 **Benefit:** 75% = $240.90 **Future End Date:**
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.) (See para TN.8.291 of explanatory notes to this Category) **Fee:** $321.15 **Benefit:** 75% = $240.90 **Future End Date:**
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.) (See para TN.8.291 of explanatory notes to this Category) **Fee:** $321.15 **Benefit:** 75% = $240.90 **Future End Date:**
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.) (See para TN.8.292 of explanatory notes to this Category) **Fee:** $321.15 **Benefit:** 75% = $240.90 **Future End Date:**
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.) (See para TN.8.292 of explanatory notes to this Category) **Fee:** $321.15 **Benefit:** 75% = $240.90 **Future End Date:**
50395	Osteotomy and distillation of greater trochanter, with internal fixation (H) (Anaes.) (Assist.) **Fee:** $1,093.05 **Benefit:** 75% = $819.80 **Future End Date:**
	GROWTH PLATE PROCEDURES
48507	Epiphysiodesis of a long bone, in a patient less than 18 years of age (H) (Anaes.) (Assist.) **Fee:** $438.30 **Benefit:** 75% = $328.75 **Future End Date:**
48509	Hemiepiphysiodesis, partial growth plate arrest using internal fixation, in a patient less than 18 years of age (H) (Anaes.) (Assist.) **Fee:** $394.45 **Benefit:** 75% = $295.85 **Future End Date:**
48512	Epiphysiolysis, release of focal growth plate closure, in a patient less than 18 years of age (H) (Anaes.) (Assist.) **Fee:** $1,070.55 **Benefit:** 75% = $802.95 **Future End Date:**
	SHOULDER
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.) **Fee:** $563.40 **Benefit:** 75% = $422.55 **Future End Date:**
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.) **Fee:** $563.40 **Benefit:** 75% = $422.55 **Future End Date:**
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.) (See para TN.8.290 of explanatory notes to this Category) **Fee:** $259.10 **Benefit:** 75% = $194.35 85% = $220.25 **Future End Date:**
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.) (See para TN.8.290 of explanatory notes to this Category) **Fee:** $259.10 **Benefit:** 75% = $194.35 **Future End Date:**
48900	Shoulder, excision of coraco-acromial ligament or removal of calcium deposit from cuff or both (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $337.90 **Benefit:** 75% = $253.45 **Future End Date:**
48903	Shoulder, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination (H) (Anaes.) (Assist.) **Fee:** $676.10 **Benefit:** 75% = $507.10 **Future End Date:**
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.) **Fee:** $676.10 **Benefit:** 75% = $507.10 **Future End Date:**
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.) **Fee:** $901.55 **Benefit:** 75% = $676.20 **Future End Date:**

48915	Shoulder, hemi-arthroplasty of (H) (Anaes.) (Assist.) **Fee:** $901.55 **Benefit:** 75% = $676.20 **Future End Date:**
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.) (See para TN.8.287 of explanatory notes to this Category) **Fee:** $1,803.15 **Benefit:** 75% = $1352.40 **Future End Date:**
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.) (See para TN.8.287 of explanatory notes to this Category) **Fee:** $2,041.70 **Benefit:** 75% = $1531.30 **Future End Date:**
48921	Shoulder, total replacement arthroplasty, revision of (H) (Anaes.) (Assist.) **Fee:** $1,859.15 **Benefit:** 75% = $1394.40 **Future End Date:**
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.) **Fee:** $2,141.05 **Benefit:** 75% = $1605.80 **Future End Date:**

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.) (See para TN.8.289 of explanatory notes to this Category) **Fee:** $840.80 **Benefit:** 75% = $630.60 **Future End Date:**
48927	Shoulder prosthesis, removal of (H) (Anaes.) (Assist.) **Fee:** $439.30 **Benefit:** 75% = $329.50 **Future End Date:**
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.) (See para TN.8.289 of explanatory notes to this Category) **Fee:** $840.80 **Benefit:** 75% = $630.60 **Future End Date:**
48939	Shoulder, arthrodesis of, with synovectomy if performed (H) (Anaes.) (Assist.) **Fee:** $1,295.85 **Benefit:** 75% = $971.90 **Future End Date:**
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.) **Fee:** $1,690.25 **Benefit:** 75% = $1267.70 **Future End Date:**
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.) **Fee:** $563.40 **Benefit:** 75% = $422.55

	Future End Date:
48944	Arthrodesis of scapulothoracic joint, including either or both of the following (if performed): (a) joint debridement; (b) synovectomy; —one joint (H) (Anaes.) (Assist.) **Fee:** $563.40 **Benefit:** 75% = $422.55 **Future End Date:**
48945	SHOULDER, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region (H) (Anaes.) (Assist.) **Fee:** $326.70 **Benefit:** 75% = $245.05 **Future End Date:**
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.) **Fee:** $732.50 **Benefit:** 75% = $549.40 **Future End Date:**
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.) **Fee:** $1,070.55 **Benefit:** 75% = $802.95 **Future End Date:**
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.) **Fee:** $732.50 **Benefit:** 75% = $549.40 **Future End Date:**
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.) **Fee:** $732.50 **Benefit:** 75% = $549.40 **Future End Date:**
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.) **Fee:** $1,126.80 **Benefit:** 75% = $845.10 **Future End Date:**
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.) **Fee:** $1,295.85 **Benefit:** 75% = $971.90 **Future End Date:**
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.) **Fee:** $1,809.60 **Benefit:** 75% = $1357.20 **Future End Date:**
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.) **Fee:** $1,126.80 **Benefit:** 75% = $845.10 **Future End Date:**
48972	Tenodesis of biceps, by open or arthroscopic means, performed as an independent procedure (H) (Anaes.) (Assist.) **Fee:** $518.25 **Benefit:** 75% = $388.70 **Future End Date:**
48980	Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the shoulder girdle (H) (Anaes.) (Assist.) **Fee:** $957.80 **Benefit:** 75% = $718.35 **Future End Date:**
	ELBOW

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.) (See para TN.8.290 of explanatory notes to this Category) **Fee:** $259.10 **Benefit:** 75% = $194.35 **Future End Date:**
48983	Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the elbow (H) (Anaes.) (Assist.) **Fee:** $702.40 **Benefit:** 75% = $526.80 **Future End Date:**
48986	Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the forearm (H) (Anaes.) (Assist.) **Fee:** $957.80 **Benefit:** 75% = $718.35 **Future End Date:**
49100	ELBOW, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture (H) (Anaes.) (Assist.) **Fee:** $394.45 **Benefit:** 75% = $295.85 **Future End Date:**
49104	Repair of one or more ligaments of the elbow, for acute instability—within 6 weeks after the time of injury (H) (Anaes.) (Assist.) **Fee:** $633.80 **Benefit:** 75% = $475.35 **Future End Date:**
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.) **Fee:** $929.60 **Benefit:** 75% = $697.20 **Future End Date:**
49106	Elbow, arthrodesis of, with synovectomy if performed (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,126.80 **Benefit:** 75% = $845.10 **Future End Date:**
49109	ELBOW, total synovectomy of (H) (Anaes.) (Assist.) **Fee:** $845.00 **Benefit:** 75% = $633.75 **Future End Date:**
49112	Radial head replacement of elbow, other than a service associated with a service to which item 49115 applies (H) (Anaes.) (Assist.) **Fee:** $845.00 **Benefit:** 75% = $633.75 **Future End Date:**
49113	Removal of radial head prosthesis (H) (Anaes.) (Assist.) (See para TN.8.288 of explanatory notes to this Category) **Fee:** $840.80 **Benefit:** 75% = $630.60 **Future End Date:**

49114	Revision of radial head replacement (H) (Anaes.) (Assist.) (See para TN.8.288 of explanatory notes to this Category) **Fee:** $840.80 **Benefit:** 75% = $630.60 **Future End Date:**
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.) (See para TN.8.288 of explanatory notes to this Category) **Fee:** $1,352.05 **Benefit:** 75% = $1014.05 **Future End Date:**
49116	ELBOW, total replacement arthroplasty of, revision procedure, including removal of prosthesis (H) (Anaes.) (Assist.) (See para TN.8.288 of explanatory notes to this Category) **Fee:** $1,784.70 **Benefit:** 75% = $1338.55 **Future End Date:**
49117	Revision of total replacement arthroplasty of elbow, including bone grafting and removal of prosthesis (H) (Anaes.) (Assist.) (See para TN.8.288 of explanatory notes to this Category) **Fee:** $2,141.65 **Benefit:** 75% = $1606.25 **Future End Date:**
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.) **Fee:** $326.70 **Benefit:** 75% = $245.05 **Future End Date:**
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.) **Fee:** $732.50 **Benefit:** 75% = $549.40 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category)

	Fee: $444.65 **Benefit:** 75% = $333.50 **Future End Date:**
49127	Elbow joint, arthroplasty of, other than a service to which another item applies (H) (Anaes.) (Assist.) (See para TN.8.289 of explanatory notes to this Category) **Fee:** $840.80 **Benefit:** 75% = $630.60 **Future End Date:**
	WRIST
49200	Wrist, arthrodesis of, with synovectomy if performed, with or without internal fixation of the radiocarpal joint (H) (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $980.25 **Benefit:** 75% = $735.20 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $928.50 **Benefit:** 75% = $696.40 **Future End Date:**
49206	Proximal row carpectomy of wrist, including either or both of the following (if performed): (a) styloidectomy; (b) synovectomy (H) (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $676.10 **Benefit:** 75% = $507.10 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $901.55 **Benefit:** 75% = $676.20 **Future End Date:**

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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $1,190.10 **Benefit:** 75% = $892.60 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $281.85 **Benefit:** 75% = $211.40 **Future End Date:**
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.) (See para GN.1.2, TN.8.190 of explanatory notes to this Category) **Fee:** $1,008.40 **Benefit:** 75% = $756.30 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $777.65 **Benefit:** 75% = $583.25 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $326.70 **Benefit:** 75% = $245.05 **Future End Date:**
49219	Diagnosis of carpometacarpal joint of thumb or joint of digit, by arthroscopic means, including biopsy (if performed) (H) (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $326.70 **Benefit:** 75% = $245.05 **Future End Date:**
49220	Treatment of carpometacarpal joint of thumb or joint of digit, by arthroscopic means—one joint (H) (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $732.50 **Benefit:** 75% = $549.40 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $732.50 **Benefit:** 75% = $549.40 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $845.00 **Benefit:** 75% = $633.75 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $845.00 **Benefit:** 75% = $633.75 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $1,102.65 **Benefit:** 75% = $827.00 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category)

	Fee: $464.20 **Benefit:** 75% = $348.15 **Future End Date:**
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.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $699.95 **Benefit:** 75% = $525.00 **Future End Date:**
49239	Excision of pisiform or hook of hamate or sesamoid bone of hand, including release of ulnar nerve (if performed) (H) (Anaes.) (Assist.) (See para TN.8.190 of explanatory notes to this Category) **Fee:** $348.15 **Benefit:** 75% = $261.15 **Future End Date:**
	HIP
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.) **Fee:** $1,859.15 **Benefit:** 75% = $1394.40 **Future End Date:**
49300	Sacro-iliac joint—arthrodesis of (H) (Anaes.) (Assist.) **Fee:** $623.95 **Benefit:** 75% = $468.00 **Future End Date:**
49303	Arthrotomy of hip, by open procedure, including any of the following (if performed): (a) lavage; (b) drainage; (c) biopsy (H) (Anaes.) (Assist.) **Fee:** $653.55 **Benefit:** 75% = $490.20 **Future End Date:**
49306	Hip, arthrodesis of, with synovectomy if performed (H) (Anaes.) (Assist.) **Fee:** $1,295.85 **Benefit:** 75% = $971.90 **Future End Date:**
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.) **Fee:** $901.55 **Benefit:** 75% = $676.20 **Future End Date:**
49315	Hip, arthroplasty of, unipolar or bipolar (H) (Anaes.) (Assist.) **Fee:** $1,014.15 **Benefit:** 75% = $760.65 **Future End Date:**
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.) (See para TN.8.286, TN.8.191 of explanatory notes to this Category) **Fee:** $1,577.30 **Benefit:** 75% = $1183.00 **Future End Date:**
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.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $2,771.25 **Benefit:** 75% = $2078.45 **Future End Date:**
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.) (See para TN.8.286 of explanatory notes to this Category) **Fee:** $1,915.75 **Benefit:** 75% = $1436.85 **Future End Date:**
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.) **Fee:** $411.75 **Benefit:** 75% = $308.85 **Future End Date:**
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.) **Fee:** $495.70 **Benefit:** 75% = $371.80 **Future End Date:**
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.) (See para TN.8.127 of explanatory notes to this Category) **Fee:** $732.50 **Benefit:** 75% = $549.40 **Future End Date:**
49372	Revision arthroplasty of hip, with exchange of head or liner (or both) (H) (Anaes.) (Assist.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $1,104.05 **Benefit:** 75% = $828.05 **Future End Date:**
49374	Revision arthroplasty of hip, with exchange of head and acetabular shell or cup, including minor bone grafting (if performed) (H) (Anaes.) (Assist.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $2,050.45 **Benefit:** 75% = $1537.85 **Future End Date:**
49376	Revision arthroplasty of hip, with exchange of head and acetabular shell or cup, including major bone grafting (if performed) (H) (Anaes.) (Assist.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $2,523.70 **Benefit:** 75% = $1892.80 **Future End Date:**
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.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $2,208.05 **Benefit:** 75% = $1656.05 **Future End Date:**
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.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $2,681.35 **Benefit:** 75% = $2011.05 **Future End Date:**
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.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $3,470.05 **Benefit:** 75% = $2602.55 **Future End Date:**
49384	Revision arthroplasty of hip, for pelvic discontinuity, with revision of acetabular component (H) (Anaes.) (Assist.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $4,100.90 **Benefit:** 75% = $3075.70 **Future End Date:**
49386	Revision arthroplasty of hip, with revision of femoral component with femoral osteotomy, including minor bone grafting (if performed) (H) (Anaes.) (Assist.)

	(See para TN.8.191 of explanatory notes to this Category) **Fee:** $2,839.15 **Benefit:** 75% = $2129.40 **Future End Date:**
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.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $3,312.30 **Benefit:** 75% = $2484.25 **Future End Date:**
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.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $3,943.25 **Benefit:** 75% = $2957.45 **Future End Date:**
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.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $5,520.50 **Benefit:** 75% = $4140.40 **Future End Date:**
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.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $4,731.80 **Benefit:** 75% = $3548.85 **Future End Date:**
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.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $3,154.55 **Benefit:** 75% = $2365.95 **Future End Date:**
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.) (See para TN.8.191 of explanatory notes to this Category) **Fee:** $2,365.95 **Benefit:** 75% = $1774.50 **Future End Date:**
49592	Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the hip, including pelvis and proximal femur (H) (Anaes.) (Assist.) **Fee:** $1,366.30 **Benefit:** 75% = $1024.75 **Future End Date:**
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.) **Fee:** $563.40 **Benefit:** 75% = $422.55 **Future End Date:**
	KNEE

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.) **Fee:** $390.20 **Benefit:** 75% = $292.65 **Future End Date:**
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.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $450.65 **Benefit:** 75% = $338.00 **Future End Date:**
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.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $586.00 **Benefit:** 75% = $439.50 **Future End Date:**
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.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $879.05 **Benefit:** 75% = $659.30 **Future End Date:**
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.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $901.55 **Benefit:** 75% = $676.20 **Future End Date:**

49512	Primary or revision arthrodesis of knee, including arthrodesis (H) (Anaes.) (Assist.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $1,577.30 **Benefit:** 75% = $1183.00 **Future End Date:**
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.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $1,014.15 **Benefit:** 75% = $760.65 **Future End Date:**
49516	Bilateral unicompartmental arthroplasty of femur and proximal tibia of knee (H) (Anaes.) (Assist.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $2,526.80 **Benefit:** 75% = $1895.10 **Future End Date:**
49517	Unicompartmental arthroplasty of femur and proximal tibia of knee (H) (Anaes.) (Assist.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $1,443.90 **Benefit:** 75% = $1082.95 **Future End Date:**
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.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $1,577.30 **Benefit:** 75% = $1183.00 **Future End Date:**
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.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $2,771.25 **Benefit:** 75% = $2078.45 **Future End Date:**
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.) (See para TN.8.285, TN.8.117 of explanatory notes to this Category) **Fee:** $1,915.75 **Benefit:** 75% = $1436.85 **Future End Date:**
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.) (See para TN.8.285, TN.8.117 of explanatory notes to this Category) **Fee:** $2,253.75 **Benefit:** 75% = $1690.35 **Future End Date:**
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.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $1,915.75 **Benefit:** 75% = $1436.85 **Future End Date:**
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.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $1,577.30 **Benefit:** 75% = $1183.00 **Future End Date:**
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.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $2,366.50 **Benefit:** 75% = $1774.90 **Future End Date:**
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.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $3,043.10 **Benefit:** 75% = $2282.35 **Future End Date:**
49534	Arthroplasty of patella and trochlea of patello-femoral joint of knee, performed as a primary procedure (H) (Anaes.) (Assist.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $870.50 **Benefit:** 75% = $652.90 **Future End Date:**
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.) (See para TN.8.182, TN.8.117 of explanatory notes to this Category) **Fee:** $1,126.80 **Benefit:** 75% = $845.10 **Future End Date:**
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.) (See para TN.8.182, TN.8.117 of explanatory notes to this Category) **Fee:** $1,577.30 **Benefit:** 75% = $1183.00 **Future End Date:**
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.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $1,836.40 **Benefit:** 75% = $1377.30 **Future End Date:**
49548	Knee, revision of patello-femoral stabilisation (H) (Anaes.) (Assist.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $1,126.80 **Benefit:** 75% = $845.10 **Future End Date:**
49551	Knee, revision of procedures to which item 49536 or 49542 applies (H) (Anaes.) (Assist.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $1,577.30 **Benefit:** 75% = $1183.00 **Future End Date:**
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.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $2,253.75 **Benefit:** 75% = $1690.35 **Future End Date:**
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.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $1,100.10 **Benefit:** 75% = $825.10

	Future End Date:
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.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $1,578.80 **Benefit:** 75% = $1184.10 **Future End Date:**
49569	Knee, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (H) (Anaes.) (Assist.) (See para TN.8.117 of explanatory notes to this Category) **Fee:** $901.55 **Benefit:** 75% = $676.20 **Future End Date:**
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.) (See para TN.8.183, TN.8.117 of explanatory notes to this Category) **Fee:** $326.70 **Benefit:** 75% = $245.05 **Future End Date:**
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.) (See para TN.8.183, TN.8.117 of explanatory notes to this Category) **Fee:** $795.05 **Benefit:** 75% = $596.30 **Future End Date:**
49574	Removal of loose bodies of knee, by arthroscopic means—one or more bodies (H) (Anaes.) (Assist.) (See para TN.8.183, TN.8.117 of explanatory notes to this Category) **Fee:** $795.05 **Benefit:** 75% = $596.30 **Future End Date:**

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.) (See para TN.8.183, TN.8.117 of explanatory notes to this Category) **Fee:** $795.05 **Benefit:** 75% = $596.30 **Future End Date:**
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.) (See para TN.8.183, TN.8.117 of explanatory notes to this Category) **Fee:** $795.05 **Benefit:** 75% = $596.30 **Future End Date:**
49580	Partial meniscectomy of knee, by arthroscopic means, for traumatic meniscus tear (H) (Anaes.) (Assist.) (See para TN.8.183, TN.8.117 of explanatory notes to this Category) **Fee:** $795.05 **Benefit:** 75% = $596.30 **Future End Date:**
49582	Meniscal repair of knee, by arthroscopic means (H) (Anaes.) (Assist.) (See para TN.8.183, TN.8.117 of explanatory notes to this Category) **Fee:** $928.30 **Benefit:** 75% = $696.25 **Future End Date:**
49584	Chondral, osteochondral or meniscal graft of knee, by arthroscopic means (H) (Anaes.) (Assist.) (See para TN.8.183, TN.8.117 of explanatory notes to this Category) **Fee:** $928.30 **Benefit:** 75% = $696.25 **Future End Date:**
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.) (See para GN.1.2, TN.8.183, TN.8.117 of explanatory notes to this Category) **Fee:** $928.30 **Benefit:** 75% = $696.25 **Future End Date:**
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.) (See para GN.1.2, TN.8.183, TN.8.117 of explanatory notes to this Category) **Fee:** $444.65 **Benefit:** 75% = $333.50 **Future End Date:**

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.) **Fee:** $1,093.05 **Benefit:** 75% = $819.80 **Future End Date:**
	ANKLE
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.) **Fee:** $819.85 **Benefit:** 75% = $614.90 **Future End Date:**
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.) (See para TN.8.196, TN.8.202, TN.8.199 of explanatory notes to this Category) **Fee:** $732.50 **Benefit:** 75% = $549.40 **Future End Date:**
49706	Arthrotomy of joint of ankle, including removal of loose bodies and joint debridement, including release of joint contracture (if performed) (H) (Anaes.) (Assist.) (See para TN.8.223, TN.8.199 of explanatory notes to this Category) **Fee:** $394.45 **Benefit:** 75% = $295.85 **Future End Date:**
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.) (See para TN.8.223, TN.8.199, TN.8.195 of explanatory notes to this Category) **Fee:** $845.00 **Benefit:** 75% = $633.75 **Future End Date:**
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.) (See para TN.8.200, TN.8.199 of explanatory notes to this Category) **Fee:** $1,126.80 **Benefit:** 75% = $845.10 **Future End Date:**
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.) (See para TN.8.201, TN.8.199 of explanatory notes to this Category) **Fee:** $1,352.05 **Benefit:** 75% = $1014.05 **Future End Date:**
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.) (See para TN.8.201, TN.8.199 of explanatory notes to this Category)

	Fee: $1,784.70 **Benefit:** 75% = $1338.55 **Future End Date:**
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.) (See para TN.8.201, TN.8.199, TN.8.283 of explanatory notes to this Category) **Fee:** $2,141.65 **Benefit:** 75% = $1606.25 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $450.65 **Benefit:** 75% = $338.00 **Future End Date:**
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.) (See para TN.8.204, TN.8.199 of explanatory notes to this Category) **Fee:** $788.90 **Benefit:** 75% = $591.70 **Future End Date:**
49727	Lengthening of major tendon of ankle, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy (H) (Anaes.) (Assist.) (See para TN.8.204, TN.8.199 of explanatory notes to this Category) **Fee:** $337.90 **Benefit:** 75% = $253.45 **Future End Date:**
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.) (See para TN.8.204, TN.8.199 of explanatory notes to this Category) **Fee:** $675.95 **Benefit:** 75% = $507.00 **Future End Date:**
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.) (See para TN.8.200, TN.8.199, TN.8.283 of explanatory notes to this Category) **Fee:** $1,690.35 **Benefit:** 75% = $1267.80 **Future End Date:**

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.) (See para TN.8.200, TN.8.199 of explanatory notes to this Category) **Fee:** $1,595.70 **Benefit:** 75% = $1196.80 **Future End Date:**
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.) (See para TN.8.200, TN.8.199, TN.8.283 of explanatory notes to this Category) **Fee:** $2,393.60 **Benefit:** 75% = $1795.20 **Future End Date:**
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.) (See para TN.8.199, TN.8.283 of explanatory notes to this Category) **Fee:** $444.65 **Benefit:** 75% = $333.50 **Future End Date:**
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.) (See para TN.8.199, TN.8.283 of explanatory notes to this Category) **Fee:** $676.75 **Benefit:** 75% = $507.60 **Future End Date:**
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.) (See para TN.8.204, TN.8.200 of explanatory notes to this Category) **Fee:** $1,183.35 **Benefit:** 75% = $887.55 **Future End Date:**
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.) (See para TN.8.199, TN.8.283 of explanatory notes to this Category) **Fee:** $444.65 **Benefit:** 75% = $333.50 **Future End Date:**
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.) (See para TN.8.199, TN.8.283 of explanatory notes to this Category) **Fee:** $600.20 **Benefit:** 75% = $450.15 **Future End Date:**
	FOOT

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.) (See para TN.8.201, TN.8.202, TN.8.199 of explanatory notes to this Category) **Fee:** $732.50 **Benefit:** 75% = $549.40 **Future End Date:**
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.) (See para TN.8.201, TN.8.202, TN.8.199 of explanatory notes to this Category) **Fee:** $732.50 **Benefit:** 75% = $549.40 **Future End Date:**
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.) (See para TN.8.201, TN.8.223, TN.8.199 of explanatory notes to this Category) **Fee:** $394.45 **Benefit:** 75% = $295.85 **Future End Date:**
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.) (See para TN.8.204, TN.8.199 of explanatory notes to this Category) **Fee:** $788.90 **Benefit:** 75% = $591.70 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $563.40 **Benefit:** 75% = $422.55 **Future End Date:**
49760	Arthroereisis of subtalar joint, including any of the following (if performed): (a) capsulotomy; (b) synovectomy; (c) joint debridement (H) (Anaes.) (Assist.) (See para TN.8.200, TN.8.199 of explanatory notes to this Category) **Fee:** $422.60 **Benefit:** 75% = $316.95 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $619.75 **Benefit:** 75% = $464.85 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $929.60 **Benefit:** 75% = $697.20 **Future End Date:**
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.)

	(See para TN.8.199 of explanatory notes to this Category) **Fee:** $1,084.60 **Benefit:** 75% = $813.45 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $1,239.45 **Benefit:** 75% = $929.60 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $1,394.50 **Benefit:** 75% = $1045.90 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $1,549.35 **Benefit:** 75% = $1162.05 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $1,704.35 **Benefit:** 75% = $1278.30 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $1,859.20 **Benefit:** 75% = $1394.40 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $1,084.60 **Benefit:** 75% = $813.45 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $1,802.75 **Benefit:** 75% = $1352.10 **Future End Date:**
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.)

	(See para TN.8.199 of explanatory notes to this Category) **Fee:** $392.45 **Benefit:** 75% = $294.35 **Future End Date:**
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.) (See para TN.8.199, TN.8.283 of explanatory notes to this Category) **Fee:** $486.40 **Benefit:** 75% = $364.80 **Future End Date:**
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.) (See para TN.8.199, TN.8.283 of explanatory notes to this Category) **Fee:** $331.25 **Benefit:** 75% = $248.45 **Future End Date:**
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.) (See para TN.8.199, TN.8.283 of explanatory notes to this Category) **Fee:** $447.25 **Benefit:** 75% = $335.45 **Future End Date:**
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.) (See para TN.8.200, TN.8.224, TN.8.199, TN.8.283 of explanatory notes to this Category) **Fee:** $1,406.85 **Benefit:** 75% = $1055.15 **Future End Date:**
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.) (See para TN.8.200, TN.8.199 of explanatory notes to this Category) **Fee:** $833.00 **Benefit:** 75% = $624.75 **Future End Date:**
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.) (See para TN.8.200, TN.8.199 of explanatory notes to this Category) **Fee:** $1,249.50 **Benefit:** 75% = $937.15 **Future End Date:**
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.) (See para TN.8.200, TN.8.199 of explanatory notes to this Category) **Fee:** $1,457.70 **Benefit:** 75% = $1093.30 **Future End Date:**
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.) (See para TN.8.200, TN.8.199 of explanatory notes to this Category) **Fee:** $1,665.85 **Benefit:** 75% = $1249.40 **Future End Date:**
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.) (See para TN.8.200, TN.8.199 of explanatory notes to this Category) **Fee:** $1,249.50 **Benefit:** 75% = $937.15 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $1,037.20 **Benefit:** 75% = $777.90 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $1,166.70 **Benefit:** 75% = $875.05 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $1,296.25 **Benefit:** 75% = $972.20 **Future End Date:**
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.)

	(See para TN.8.199 of explanatory notes to this Category) **Fee:** $1,425.80 **Benefit:** 75% = $1069.35 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $1,555.35 **Benefit:** 75% = $1166.55 **Future End Date:**
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.) (See para TN.8.200, TN.8.199 of explanatory notes to this Category) **Fee:** $1,337.80 **Benefit:** 75% = $1003.35 **Future End Date:**
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.) (See para TN.8.200, TN.8.199 of explanatory notes to this Category) **Fee:** $1,162.00 **Benefit:** 75% = $871.50

	Future End Date:
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.) (See para TN.8.200, TN.8.199 of explanatory notes to this Category) **Fee:** $526.85 **Benefit:** 75% = $395.15 **Future End Date:**
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.) (See para TN.8.200, TN.8.199 of explanatory notes to this Category) **Fee:** $591.75 **Benefit:** 75% = $443.85 **Future End Date:**
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.) (See para TN.8.200, TN.8.199 of explanatory notes to this Category) **Fee:** $690.35 **Benefit:** 75% = $517.80 **Future End Date:**

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.) (See para TN.8.200, TN.8.199 of explanatory notes to this Category) **Fee:** $788.95 **Benefit:** 75% = $591.75 **Future End Date:**
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.) (See para TN.8.200, TN.8.199 of explanatory notes to this Category) **Fee:** $887.60 **Benefit:** 75% = $665.70 **Future End Date:**
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.) (See para TN.8.200, TN.8.199 of explanatory notes to this Category) **Fee:** $986.25 **Benefit:** 75% = $739.70 **Future End Date:**

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.) (See para TN.8.200, TN.8.199 of explanatory notes to this Category) **Fee:** $1,084.85 **Benefit:** 75% = $813.65 **Future End Date:**
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.) (See para TN.8.200, TN.8.199 of explanatory notes to this Category) **Fee:** $1,183.50 **Benefit:** 75% = $887.65 **Future End Date:**
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.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $157.75 **Benefit:** 75% = $118.35 **Future End Date:**
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.) (See para GN.1.2, TN.8.204, TN.8.199 of explanatory notes to this Category) **Fee:** $202.90 **Benefit:** 75% = $152.20 **Future End Date:**
49806	Subcutaneous tenotomy of foot, by small percutaneous incisions—one or more tendons (Anaes.) (See para TN.8.204, TN.8.199 of explanatory notes to this Category) **Fee:** $157.75 **Benefit:** 75% = $118.35 85% = $134.10 **Future End Date:**
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.) (See para GN.1.2, TN.8.204, TN.8.223, TN.8.199 of explanatory notes to this Category) **Fee:** $259.10 **Benefit:** 75% = $194.35 **Future End Date:**
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.) (See para TN.8.204, TN.8.201, TN.8.223, TN.8.199 of explanatory notes to this Category) **Fee:** $518.25 **Benefit:** 75% = $388.70 **Future End Date:**
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.) (See para TN.8.200, TN.8.199 of explanatory notes to this Category) **Fee:** $1,641.35 **Benefit:** 75% = $1231.05 **Future End Date:**
49818	Release of plantar fascia, including excision of calcaneal spur (if performed) (H) (Anaes.) (Assist.)

	(See para TN.8.197, TN.8.223, TN.8.199 of explanatory notes to this Category) **Fee:** $326.70 **Benefit:** 75% = $245.05 **Future End Date:**
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.) (See para TN.8.194, TN.8.201, TN.8.199 of explanatory notes to this Category) **Fee:** $518.25 **Benefit:** 75% = $388.70 **Future End Date:**
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.) (See para TN.8.194, TN.8.199 of explanatory notes to this Category) **Fee:** $907.20 **Benefit:** 75% = $680.40 **Future End Date:**
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.) (See para TN.8.194, TN.8.196, TN.8.201, TN.8.223, TN.8.199 of explanatory notes to this Category) **Fee:** $563.40 **Benefit:** 75% = $422.55

	Future End Date:
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.) (See para TN.8.194, TN.8.201, TN.8.223, TN.8.223, TN.8.199 of explanatory notes to this Category) **Fee:** $985.95 **Benefit:** 75% = $739.50 **Future End Date:**
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.) (See para TN.8.194, TN.8.196, TN.8.201, TN.8.223, TN.8.199 of explanatory notes to this Category) **Fee:** $619.75 **Benefit:** 75% = $464.85 **Future End Date:**
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.) (See para TN.8.194, TN.8.196, TN.8.201, TN.8.223, TN.8.199 of explanatory notes to this Category) **Fee:** $1,070.55 **Benefit:** 75% = $802.95 **Future End Date:**

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.) (See para TN.8.194, TN.8.196, TN.8.201, TN.8.223, TN.8.199 of explanatory notes to this Category) **Fee:** $774.75 **Benefit:** 75% = $581.10 **Future End Date:**
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.) (See para TN.8.194, TN.8.196, TN.8.201, TN.8.223, TN.8.199 of explanatory notes to this Category) **Fee:** $1,337.80 **Benefit:** 75% = $1003.35 **Future End Date:**
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.) (See para TN.8.201, TN.8.199 of explanatory notes to this Category) **Fee:** $619.75 **Benefit:** 75% = $464.85 **Future End Date:**
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.) (See para TN.8.200, TN.8.223, TN.8.199 of explanatory notes to this Category) **Fee:** $774.75 **Benefit:** 75% = $581.10 **Future End Date:**
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.) (See para TN.8.200, TN.8.199 of explanatory notes to this Category) **Fee:** $518.25 **Benefit:** 75% = $388.70 **Future End Date:**
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.) (See para TN.8.197, TN.8.223, TN.8.199 of explanatory notes to this Category) **Fee:** $450.65 **Benefit:** 75% = $338.00 **Future End Date:**
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.) (See para TN.8.201, TN.8.199 of explanatory notes to this Category) **Fee:** $416.85 **Benefit:** 75% = $312.65 **Future End Date:**
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.) (See para TN.8.201, TN.8.199 of explanatory notes to this Category) **Fee:** $389.35 **Benefit:** 75% = $292.05 **Future End Date:**
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.) (See para TN.8.199, TN.8.283 of explanatory notes to this Category) **Fee:** $360.35 **Benefit:** 75% = $270.30 **Future End Date:**
49878	Talipes equinovarus, calcaneo valgus or metatarsus varus, treatment by cast, splint or manipulation—each attendance (Anaes.) (See para TN.8.199 of explanatory notes to this Category) **Fee:** $67.60 **Benefit:** 75% = $50.70 85% = $57.50 **Future End Date:**
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.) (See para TN.8.199, TN.8.283 of explanatory notes to this Category) **Fee:** $263.15 **Benefit:** 75% = $197.40 **Future End Date:**

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.) (See para TN.8.199, TN.8.283 of explanatory notes to this Category) **Fee:** $355.45 **Benefit:** 75% = $266.60 **Future End Date:**
	OTHER JOINTS
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.) **Fee:** $432.15 **Benefit:** 75% = $324.15 **Future End Date:**
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.) **Fee:** $171.20 **Benefit:** 75% = $128.40 **Future End Date:**
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.) (See para TN.8.200 of explanatory notes to this Category) **Fee:** $937.80 **Benefit:** 75% = $703.35

	Future End Date:
50130	Joint or joints, application of external fixator to, other than for treatment of fractures (H) (Anaes.) (Assist.) **Fee:** $373.80 **Benefit:** 75% = $280.35 **Future End Date:**
	MALIGNANT DISEASE
50200	Core needle biopsy of aggressive or potentially malignant bone or soft tissue tumour, excluding aftercare, if the service has not already applied to the patient twice in the preceding 12 months for a service provided by the same provider (Anaes.) (See para TN.8.209 of explanatory notes to this Category) **Fee:** $225.25 **Benefit:** 75% = $168.95 85% = $191.50 **Future End Date:**
50201	Incisional biopsy of aggressive or potentially malignant bone or soft tissue tumour, excluding aftercare, if the service has not already applied to the patient twice in the preceding 12 months for a service provided by the same provider (Anaes.) (Assist.) (See para TN.8.209 of explanatory notes to this Category) **Fee:** $394.35 **Benefit:** 75% = $295.80 85% = $335.20 **Future End Date:**
50203	Intralesional or marginal excision of bone or soft tissue tumour (H) (Anaes.) (Assist.) (See para GN.1.2, TN.8.209, TN.8.171 of explanatory notes to this Category) **Fee:** $495.80 **Benefit:** 75% = $371.85 **Future End Date:**
50206	Intralesional or marginal excision of bone tumour, with at least one of the following: (a) autograft; (b) allograft; (c) cementation (H) (Anaes.) (Assist.) (See para TN.8.209, TN.8.171 of explanatory notes to this Category) **Fee:** $732.50 **Benefit:** 75% = $549.40 **Future End Date:**
50209	Intralesional or marginal excision of bone tumour, with at least 2 of the following: (a) autograft; (b) allograft; (c) cementation (H) (Anaes.) (Assist.) (See para TN.8.209, TN.8.171 of explanatory notes to this Category) **Fee:** $901.55 **Benefit:** 75% = $676.20 **Future End Date:**

50212	Wide excision of malignant or aggressive bone or soft tissue tumour (or both), affecting a limb, trunk or scapula (H) (Anaes.) (Assist.) (See para TN.8.173, TN.8.174 of explanatory notes to this Category) **Fee:** $1,971.90 **Benefit:** 75% = $1478.95 **Future End Date:**
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.) (See para TN.8.173, TN.8.175 of explanatory notes to this Category) **Fee:** $2,479.05 **Benefit:** 75% = $1859.30 **Future End Date:**
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.) (See para TN.8.173, TN.8.175 of explanatory notes to this Category) **Fee:** $3,267.90 **Benefit:** 75% = $2450.95 **Future End Date:**
50221	Wide excision of malignant or aggressive bone or soft tissue tumour (or both) of pelvis, sacrum or spine, without reconstruction (H) (Anaes.) (Assist.) (See para TN.8.173, TN.8.175 of explanatory notes to this Category) **Fee:** $3,042.30 **Benefit:** 75% = $2281.75 **Future End Date:**
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.) (See para GN.1.2, TN.8.173, TN.8.175 of explanatory notes to this Category) **Fee:** $3,380.40 **Benefit:** 75% = $2535.30 **Future End Date:**
50233	Treatment of malignant or aggressive bone or soft tissue tumour (or both) by hindquarter or forequarter amputation (H) (Anaes.) (Assist.) (See para TN.8.176 of explanatory notes to this Category) **Fee:** $2,591.70 **Benefit:** 75% = $1943.80 **Future End Date:**
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.) (See para TN.8.176 of explanatory notes to this Category) **Fee:** $2,028.35 **Benefit:** 75% = $1521.30 **Future End Date:**
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.) (See para TN.8.176 of explanatory notes to this Category) **Fee:** $1,352.05 **Benefit:** 75% = $1014.05 **Future End Date:**
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.) **Fee:** $1,014.15 **Benefit:** 75% = $760.65 **Future End Date:**
	LIMB LENGTHENING AND DEFORMITY CORRECTION
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.) **Fee:** $3,042.55 **Benefit:** 75% = $2281.95 **Future End Date:**
50300	Gradual correction of joint deformity, with application of external fixator (H) (Anaes.) (Assist.) (See para TN.8.193 of explanatory notes to this Category) **Fee:** $1,385.60 **Benefit:** 75% = $1039.20 **Future End Date:**
50303	Limb lengthening, by gradual distraction, with application of external fixator or intra-medullary device (H) (Anaes.) (Assist.) (See para TN.8.193 of explanatory notes to this Category) **Fee:** $1,891.80 **Benefit:** 75% = $1418.85 **Future End Date:**
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.) (See para TN.8.193 of explanatory notes to this Category) **Fee:** $2,953.75 **Benefit:** 75% = $2215.35 **Future End Date:**
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.) (See para TN.8.193 of explanatory notes to this Category)

	Fee: $365.15 **Benefit:** 75% = $273.90 **Future End Date:**
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 (See para TN.8.192 of explanatory notes to this Category) **Fee:** $52.25 **Benefit:** 75% = $39.20 85% = $44.45 **Future End Date:**
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.) (See para TN.8.202 of explanatory notes to this Category) **Fee:** $900.30 **Benefit:** 75% = $675.25 **Future End Date:**
50321	Release of soft tissue of talipes equinovarus, by open means (H) (Anaes.) (Assist.) **Fee:** $1,111.70 **Benefit:** 75% = $833.80 **Future End Date:**
50324	Revision of release of soft tissue of talipes equinovarus, by open means (H) (Anaes.) (Assist.) **Fee:** $1,584.90 **Benefit:** 75% = $1188.70 **Future End Date:**
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.) **Fee:** $273.70 **Benefit:** 75% = $205.30 **Future End Date:**
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.) **Fee:** $738.20 **Benefit:** 75% = $553.65

	Future End Date:
50335	Treatment of vertical, congenital talus, by percutaneous or open stabilisation of talonavicular joint and Achilles' tenotomy (H) (Anaes.) (Assist.) **Fee:** $738.20 **Benefit:** 75% = $553.65 **Future End Date:**
50336	Talus, vertical, congenital, combined anterior and posterior reconstruction (H) (Anaes.) (Assist.) **Fee:** $1,103.55 **Benefit:** 75% = $827.70 **Future End Date:**
50339	Tibialis anterior or tibialis posterior tendon transfer (split or whole) (H) (Anaes.) (Assist.) **Fee:** $706.75 **Benefit:** 75% = $530.10 **Future End Date:**
50345	Hyperextension deformity of toe, release incorporating V-Y plasty of skin, lengthening of extensor tendons and release of capsule contracture (H) (Anaes.) (Assist.) **Fee:** $414.90 **Benefit:** 75% = $311.20 **Future End Date:**
50348	Knee, deformity of, post-operative manipulation and change of plaster, performed under general anaesthesia (H) (Anaes.) **Fee:** $273.70 **Benefit:** 75% = $205.30 **Future End Date:**
50351	Treatment of developmental dislocation of hip, by open reduction, including application of hip spica (H) (Anaes.) (Assist.) **Fee:** $1,911.75 **Benefit:** 75% = $1433.85 **Future End Date:**
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.) **Fee:** $67.60 **Benefit:** 75% = $50.70 85% = $57.50 **Future End Date:**
50354	Resection and fixation of congenital pseudarthrosis of tibia (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,568.00 **Benefit:** 75% = $1176.00 **Future End Date:**
50357	Transfer of tendon of rectus femoris or medial or lateral hamstring (H) (Anaes.) (Assist.) **Fee:** $672.10 **Benefit:** 75% = $504.10 **Future End Date:**
50360	Combined medial and lateral hamstring tendon transfer (H) (Anaes.) (Assist.) **Fee:** $779.90 **Benefit:** 75% = $584.95 **Future End Date:**
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.) **Fee:** $779.90 **Benefit:** 75% = $584.95 **Future End Date:**
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.) **Fee:** $1,369.00 **Benefit:** 75% = $1026.75 **Future End Date:**
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.) **Fee:** $597.40 **Benefit:** 75% = $448.05 **Future End Date:**
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.) **Fee:** $1,045.50 **Benefit:** 75% = $784.15 **Future End Date:**
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.) **Fee:** $779.90 **Benefit:** 75% = $584.95 **Future End Date:**
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.) **Fee:** $1,369.00 **Benefit:** 75% = $1026.75 **Future End Date:**
50390	Application of cast under general anaesthesia, for patient with perthes, cerebral palsy, or other neuromuscular conditions, affecting hips or knees (H) (Anaes.) **Fee:** $273.70 **Benefit:** 75% = $205.30 **Future End Date:**
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.) **Fee:** $1,012.20 **Benefit:** 75% = $759.15 **Future End Date:**
50394	Multiple peri-acetabular osteotomy, including internal fixation (if performed) (H) (Anaes.) (Assist.) **Fee:** $3,324.25 **Benefit:** 75% = $2493.20 **Future End Date:**
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.) **Fee:** $556.10 **Benefit:** 75% = $417.10 **Future End Date:**
50399	Forearm, radial aplasia or dysplasia (radial club hand), centralisation or radialisation of (H) (Anaes.) (Assist.) **Fee:** $1,103.55 **Benefit:** 75% = $827.70 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,568.00 **Benefit:** 75% = $1176.00 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $2,115.70 **Benefit:** 75% = $1586.80 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,568.00 **Benefit:** 75% = $1176.00 **Future End Date:**
50420	Patella, congenital dislocation of, reconstruction of the quadriceps (H) (Anaes.) (Assist.) **Fee:** $1,294.25 **Benefit:** 75% = $970.70 **Future End Date:**
50423	Tibia, fibula or both, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,194.75 **Benefit:** 75% = $896.10 **Future End Date:**
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.) **Fee:** $556.10 **Benefit:** 75% = $417.10 **Future End Date:**
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.) **Fee:** $928.30 **Benefit:** 75% = $696.25 **Future End Date:**
	SINGLE EVEN MULTILEVEL SURGERY FOR CHILDREN WITH CEREBRAL PALSY
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $1,468.50 **Benefit:** 75% = $1101.40 **Future End Date:**
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $1,468.50 **Benefit:** 75% = $1101.40 **Future End Date:**
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $1,663.05 **Benefit:** 75% = $1247.30 **Future End Date:**
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $1,663.05 **Benefit:** 75% = $1247.30 **Future End Date:**
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $2,482.85 **Benefit:** 75% = $1862.15 **Future End Date:**
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $2,482.85 **Benefit:** 75% = $1862.15 **Future End Date:**
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,497.10 **Benefit:** 75% = $2622.85 **Future End Date:**
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $3,497.10 **Benefit:** 75% = $2622.85 **Future End Date:**
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,435.20 **Benefit:** 75% = $3326.40 **Future End Date:**

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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,435.20 **Benefit:** 75% = $3326.40 **Future End Date:**
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $5,117.80 **Benefit:** 75% = $3838.35 **Future End Date:**
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $5,117.80 **Benefit:** 75% = $3838.35 **Future End Date:**
	TREATMENT OF FRACTURES IN PAEDIATRIC PATIENTS
50508	Treatment of fracture of distal end of radius or ulna (or both), by closed reduction, for a patient with open growth plates (Anaes.) (See para TN.8.118, TN.8.119 of explanatory notes to this Category) **Fee:** $473.00 **Benefit:** 75% = $354.75 85% = $402.05 **Future End Date:**
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.) (See para TN.8.118, TN.8.119 of explanatory notes to this Category) **Fee:** $631.15 **Benefit:** 75% = $473.40 **Future End Date:**
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.) (See para TN.8.118, TN.8.119, TN.8.190 of explanatory notes to this Category) **Fee:** $489.00 **Benefit:** 75% = $366.75 **Future End Date:**
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.) (See para TN.8.118, TN.8.119, TN.8.190 of explanatory notes to this Category) **Fee:** $788.75 **Benefit:** 75% = $591.60 **Future End Date:**
50532	Treatment of fracture of shafts of radius or ulna (or both), by closed reduction, for a patient with open growth plate (H) (Anaes.) (See para TN.8.118, TN.8.119 of explanatory notes to this Category) **Fee:** $686.30 **Benefit:** 75% = $514.75 **Future End Date:**
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.) (See para TN.8.118, TN.8.119 of explanatory notes to this Category) **Fee:** $915.00 **Benefit:** 75% = $686.25 **Future End Date:**

50540	Olecranon, with open growth plate, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.) (See para TN.8.118, TN.8.119 of explanatory notes to this Category) **Fee:** $631.15 **Benefit:** 75% = $473.40 **Future End Date:**
50544	Radius, with open growth plate, treatment of fracture of head or neck of, by closed reduction of (H) (Anaes.) (See para GN.1.2, TN.8.118, TN.8.119 of explanatory notes to this Category) **Fee:** $315.50 **Benefit:** 75% = $236.65 **Future End Date:**
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.) (See para TN.8.118, TN.8.119 of explanatory notes to this Category) **Fee:** $631.15 **Benefit:** 75% = $473.40 **Future End Date:**
50552	Humerus, proximal, with open growth plate, treatment of fracture of, by closed reduction (H) (Anaes.) (See para TN.8.118, TN.8.119 of explanatory notes to this Category) **Fee:** $544.30 **Benefit:** 75% = $408.25 **Future End Date:**
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.) (See para TN.8.118, TN.8.119 of explanatory notes to this Category) **Fee:** $725.55 **Benefit:** 75% = $544.20 **Future End Date:**
50560	Humerus, shaft of, with open growth plate, treatment of fracture of, by closed reduction (H) (Anaes.) (See para TN.8.118, TN.8.119 of explanatory notes to this Category) **Fee:** $567.85 **Benefit:** 75% = $425.90 **Future End Date:**
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.) (See para TN.8.118, TN.8.119 of explanatory notes to this Category) **Fee:** $757.20 **Benefit:** 75% = $567.90 **Future End Date:**
50568	Humerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by closed reduction (H) (Anaes.) (See para TN.8.118, TN.8.119 of explanatory notes to this Category) **Fee:** $662.65 **Benefit:** 75% = $497.00 **Future End Date:**
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.) (See para TN.8.118, TN.8.119 of explanatory notes to this Category) **Fee:** $883.50 **Benefit:** 75% = $662.65 **Future End Date:**

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.) (See para GN.1.2, TN.8.118, TN.8.119 of explanatory notes to this Category) **Fee:** $725.55 **Benefit:** 75% = $544.20 **Future End Date:**
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.) (See para TN.8.118, TN.8.119 of explanatory notes to this Category) **Fee:** $757.20 **Benefit:** 75% = $567.90 **Future End Date:**
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.) (See para TN.8.118, TN.8.119 of explanatory notes to this Category) **Fee:** $725.55 **Benefit:** 75% = $544.20 **Future End Date:**
50588	Tibia and fibula, with open growth plates, treatment of fracture of, by internal fixation (H) (Anaes.) (Assist.) (See para TN.8.118, TN.8.119 of explanatory notes to this Category) **Fee:** $946.40 **Benefit:** 75% = $709.80 **Future End Date:**
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.) **Fee:** $1,149.35 **Benefit:** 75% = $862.05 **Future End Date:**
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.) **Fee:** $359.25 **Benefit:** 75% = $269.45 **Future End Date:**
	SPINE SURGERY FOR SCOLIOSIS AND KYPHOSIS IN PAEDIATRIC PATIENTS
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $520.35 **Benefit:** 75% = $390.30 **Future End Date:**
50604	Scoliosis or kyphosis, in a child or adolescent, spinal fusion for (without instrumentation) (H) (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $2,208.25 **Benefit:** 75% = $1656.20 **Future End Date:**
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,101.70 **Benefit:** 75% = $3076.30

	Future End Date:
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $5,834.35 **Benefit:** 75% = $4375.80 **Future End Date:**
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $741.30 **Benefit:** 75% = $556.00 **Future End Date:**
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,101.70 **Benefit:** 75% = $3076.30 **Future End Date:**
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,101.70 **Benefit:** 75% = $3076.30 **Future End Date:**
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $5,066.80 **Benefit:** 75% = $3800.10 **Future End Date:**
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,259.45 **Benefit:** 75% = $3194.60 **Future End Date:**
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $4,732.70 **Benefit:** 75% = $3549.55 **Future End Date:**
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $2,616.15 **Benefit:** 75% = $1962.15

	Future End Date:
50644	Spine, bone graft to, for a child or adolescent, associated with surgery for correction of scoliosis or kyphosis or both (H) (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $2,524.15 **Benefit:** 75% = $1893.15 **Future End Date:**
	TREATMENT OF HIP DYSPLASIA OR DISLOCATION IN PAEDIATRIC PATIENTS
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.) (See para TN.8.118 of explanatory notes to this Category) **Fee:** $594.40 **Benefit:** 75% = $445.80 **Future End Date:**

	Group T8. Surgical Operations
	Subgroup 16. Tissue 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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $978.00 **Benefit:** 75% = $733.50 **Future End Date:**
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)

T8. SURGICAL OPERATIONS	16. TISSUE ABLATION
	(Anaes.) (See para GN.1.2, TN.8.120 of explanatory notes to this Category) **Fee:** $978.00 **Benefit:** 75% = $733.50 **Future End Date:**

T8. SURGICAL OPERATIONS	17. SPINAL SURGERY
	Group T8. Surgical Operations
	Subgroup 17. 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.) (See para TN.8.142, TN.8.141 of explanatory notes to this Category) **Fee:** $1,718.15 **Benefit:** 75% = $1288.65 **Future End Date:**
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.) (See para TN.8.142, TN.8.141 of explanatory notes to this Category) **Fee:** $2,290.65 **Benefit:** 75% = $1718.00 **Future End Date:**
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.) (See para TN.8.142, TN.8.141 of explanatory notes to this Category) **Fee:** $2,863.30 **Benefit:** 75% = $2147.50 **Future End Date:**
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.) (See para TN.8.142, TN.8.141 of explanatory notes to this Category) **Fee:** $3,435.95 **Benefit:** 75% = $2577.00 **Future End Date:**
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.) (See para TN.8.142, TN.8.141 of explanatory notes to this Category) **Fee:** $4,008.65 **Benefit:** 75% = $3006.50 **Future End Date:**
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.) (See para TN.8.143, TN.8.141 of explanatory notes to this Category) **Fee:** $916.20 **Benefit:** 75% = $687.15 **Future End Date:**
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.) (See para TN.8.143, TN.8.141 of explanatory notes to this Category) **Fee:** $1,533.50 **Benefit:** 75% = $1150.15 **Future End Date:**
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.) (See para TN.8.143, TN.8.141 of explanatory notes to this Category) **Fee:** $1,907.60 **Benefit:** 75% = $1430.70 **Future End Date:**
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.) (See para TN.8.143, TN.8.141 of explanatory notes to this Category) **Fee:** $2,270.10 **Benefit:** 75% = $1702.60 **Future End Date:**
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.) (See para TN.8.143, TN.8.141 of explanatory notes to this Category) **Fee:** $2,620.70 **Benefit:** 75% = $1965.55 **Future End Date:**
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.) (See para TN.8.143, TN.8.141 of explanatory notes to this Category) **Fee:** $3,063.05 **Benefit:** 75% = $2297.30 **Future End Date:**
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.) (See para TN.8.143, TN.8.141 of explanatory notes to this Category) **Fee:** $3,353.65 **Benefit:** 75% = $2515.25 **Future End Date:**

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.) (See para TN.8.144, TN.8.141 of explanatory notes to this Category) **Fee:** $1,126.80 **Benefit:** 75% = $845.10 **Future End Date:**
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.) (See para TN.8.144, TN.8.141 of explanatory notes to this Category) **Fee:** $1,352.20 **Benefit:** 75% = $1014.15 **Future End Date:**
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.) (See para TN.8.144, TN.8.141 of explanatory notes to this Category) **Fee:** $1,577.65 **Benefit:** 75% = $1183.25 **Future End Date:**
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.) (See para TN.8.144, TN.8.141 of explanatory notes to this Category) **Fee:** $1,690.25 **Benefit:** 75% = $1267.70 **Future End Date:**
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.) (See para TN.8.144, TN.8.141 of explanatory notes to this Category) **Fee:** $1,803.00 **Benefit:** 75% = $1352.25 **Future End Date:**
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.) (See para TN.8.144, TN.8.141 of explanatory notes to this Category) **Fee:** $1,915.60 **Benefit:** 75% = $1436.70 **Future End Date:**
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.) (See para TN.8.145, TN.8.141 of explanatory notes to this Category) **Fee:** $1,295.85 **Benefit:** 75% = $971.90 **Future End Date:**
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.) (See para TN.8.145, TN.8.141 of explanatory notes to this Category) **Fee:** $1,814.30 **Benefit:** 75% = $1360.75 **Future End Date:**

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.) (See para TN.8.145, TN.8.141 of explanatory notes to this Category) **Fee:** $2,267.85 **Benefit:** 75% = $1700.90 **Future End Date:**
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.) (See para TN.8.145, TN.8.141 of explanatory notes to this Category) **Fee:** $2,462.20 **Benefit:** 75% = $1846.65 **Future End Date:**
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.) (See para TN.8.145, TN.8.141 of explanatory notes to this Category) **Fee:** $2,591.75 **Benefit:** 75% = $1943.85 **Future End Date:**
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.) (See para TN.8.146, TN.8.141 of explanatory notes to this Category) **Fee:** $2,214.25 **Benefit:** 75% = $1660.70 **Future End Date:**
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.) (See para TN.8.146, TN.8.141 of explanatory notes to this Category) **Fee:** $2,693.05 **Benefit:** 75% = $2019.80 **Future End Date:**
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.) (See para TN.8.146, TN.8.141 of explanatory notes to this Category) **Fee:** $3,064.00 **Benefit:** 75% = $2298.00 **Future End Date:**
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.) (See para TN.8.146, TN.8.141 of explanatory notes to this Category) **Fee:** $1,633.70 **Benefit:** 75% = $1225.30 **Future End Date:**

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.) (See para TN.8.146, TN.8.141 of explanatory notes to this Category) **Fee:** $2,450.65 **Benefit:** 75% = $1838.00 **Future End Date:**
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.) (See para TN.8.146, TN.8.141 of explanatory notes to this Category) **Fee:** $2,859.00 **Benefit:** 75% = $2144.25 **Future End Date:**
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.) (See para TN.8.146, TN.8.141 of explanatory notes to this Category) **Fee:** $2,872.55 **Benefit:** 75% = $2154.45 **Future End Date:**
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.) (See para TN.8.146, TN.8.141 of explanatory notes to this Category) **Fee:** $3,232.20 **Benefit:** 75% = $2424.15 **Future End Date:**
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.) (See para TN.8.146, TN.8.141 of explanatory notes to this Category) **Fee:** $3,949.85 **Benefit:** 75% = $2962.40

	Future End Date:
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.) (See para TN.8.147, TN.8.141 of explanatory notes to this Category) **Fee:** $3,392.80 **Benefit:** 75% = $2544.60 **Future End Date:**
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.) (See para TN.8.147, TN.8.141 of explanatory notes to this Category) **Fee:** $4,397.80 **Benefit:** 75% = $3298.35 **Future End Date:**
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.) (See para TN.8.147, TN.8.141 of explanatory notes to this Category) **Fee:** $5,326.60 **Benefit:** 75% = $3994.95 **Future End Date:**
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.) (See para TN.8.147, TN.8.141 of explanatory notes to this Category) **Fee:** $5,928.00 **Benefit:** 75% = $4446.00 **Future End Date:**
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.) (See para TN.8.147, TN.8.141 of explanatory notes to this Category) **Fee:** $6,556.45 **Benefit:** 75% = $4917.35 **Future End Date:**
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.) (See para TN.8.147, TN.8.141 of explanatory notes to this Category) **Fee:** $6,903.20 **Benefit:** 75% = $5177.40 **Future End Date:**
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.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $2,992.25 **Benefit:** 75% = $2244.20 **Future End Date:**

51072	Craniocervical junction lesion, transoral approach for, not being a service associated with a service to which item 51071 or 51073 applies (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $3,111.95 **Benefit:** 75% = $2334.00 **Future End Date:**
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.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $3,949.85 **Benefit:** 75% = $2962.40 **Future End Date:**
51102	Thoracoplasty in combination with thoracic scoliosis correction—3 or more ribs (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $1,416.50 **Benefit:** 75% = $1062.40 **Future End Date:**
51103	Odontoid screw fixation (Anaes.) (Assist.) (See para TN.8.148, TN.8.141 of explanatory notes to this Category) **Fee:** $2,489.25 **Benefit:** 75% = $1866.95 **Future End Date:**
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.) (See para GN.1.2, TN.8.141 of explanatory notes to this Category) **Fee:** $901.55 **Benefit:** 75% = $676.20 **Future End Date:**
51111	Skull calipers or halo, insertion of, as an independent procedure (Anaes.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $383.20 **Benefit:** 75% = $287.40 **Future End Date:**
51112	Plaster jacket, application of, as an independent procedure (Anaes.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $259.10 **Benefit:** 75% = $194.35 85% = $220.25 **Future End Date:**
51113	Halo, application of, in addition to spinal fusion for scoliosis, or other conditions (Anaes.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $287.35 **Benefit:** 75% = $215.55 **Future End Date:**
51114	Halo thoracic orthosis—application of both halo and thoracic jacket (Anaes.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $507.25 **Benefit:** 75% = $380.45 **Future End Date:**
51115	Halo-femoral traction, as an independent procedure (H) (Anaes.) (See para GN.1.2, TN.8.141 of explanatory notes to this Category) **Fee:** $507.25 **Benefit:** 75% = $380.45 **Future End Date:**

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.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $281.85 **Benefit:** 75% = $211.40 **Future End Date:**
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.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $2,146.80 **Benefit:** 75% = $1610.10 **Future End Date:**
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.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $1,295.85 **Benefit:** 75% = $971.90 **Future End Date:**
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.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $529.55 **Benefit:** 75% = $397.20 **Future End Date:**
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.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $979.80 **Benefit:** 75% = $734.85 **Future End Date:**

T8. SURGICAL OPERATIONS	17. SPINAL SURGERY
51145	Wound debridement or excision for post operative infection or haematoma following spinal surgery (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $529.55 **Benefit:** 75% = $397.20 **Future End Date:**
51150	Coccyx, excision of (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $533.15 **Benefit:** 75% = $399.90 **Future End Date:**
51160	Anterior exposure of thoracic or lumbar spine, one motion segment, not being a service to which item 51165 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.149 of explanatory notes to this Category) **Fee:** $1,376.45 **Benefit:** 75% = $1032.35 **Future End Date:**
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.) (See para TN.8.141, TN.8.149 of explanatory notes to this Category) **Fee:** $1,735.55 **Benefit:** 75% = $1301.70 **Future End Date:**
51170	Syringomyelia or hydromyelia, craniotomy for, with or without duraplasty, intradural dissection, plugging of obex or local cerebrospinal fluid shunt (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $2,614.75 **Benefit:** 75% = $1961.10 **Future End Date:**
51171	Syringomyelia or hydromyelia, treatment by direct cerebrospinal fluid shunt (for example, syringosubarachnoid shunt, syringopleural shunt or syringoperitoneal shunt) (Anaes.) (Assist.) (See para TN.8.141 of explanatory notes to this Category) **Fee:** $1,098.05 **Benefit:** 75% = $823.55 **Future End Date:**

T8. SURGICAL OPERATIONS	18. MYRINGOPLASTY AND TYMPANOMASTOID PROCEDURES
	Group T8. Surgical Operations
	Subgroup 18. Myringoplasty and Tympanomastoid Procedures
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.) **Fee:** $703.25 **Benefit:** 75% = $527.45 **Future End Date:**
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.)

	Fee: $1,145.90 **Benefit:** 75% = $859.45 **Future End Date:**
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.) **Fee:** $1,369.60 **Benefit:** 75% = $1027.20 **Future End Date:**
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.) **Fee:** $1,534.15 **Benefit:** 75% = $1150.65 **Future End Date:**
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.) **Fee:** $623.95 **Benefit:** 75% = $468.00 **Future End Date:**
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.) **Fee:** $1,906.70 **Benefit:** 75% = $1430.05 **Future End Date:**
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.) **Fee:** $2,246.55 **Benefit:** 75% = $1684.95 **Future End Date:**
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.) **Fee:** $1,304.50 **Benefit:** 75% = $978.40 **Future End Date:**
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.) **Fee:** $1,429.40 **Benefit:** 75% = $1072.05 **Future End Date:**
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.) **Fee:** $1,769.45 **Benefit:** 75% = $1327.10 **Future End Date:**
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.)

T8. SURGICAL OPERATIONS	18. MYRINGOPLASTY AND TYMPANOMASTOID PROCEDURES
	Fee: $2,288.25 **Benefit:** 75% = $1716.20 **Future End Date:**
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.) **Fee:** $1,304.50 **Benefit:** 75% = $978.40 **Future End Date:**
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.) **Fee:** $623.95 **Benefit:** 75% = $468.00 **Future End Date:**
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.) **Fee:** $1,369.60 **Benefit:** 75% = $1027.20 **Future End Date:**
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.) **Fee:** $1,709.55 **Benefit:** 75% = $1282.20 **Future End Date:**

T8. SURGICAL OPERATIONS	19. FUNCTIONAL SINUS SURGERY
	Group T8. Surgical Operations
	Subgroup 19. Functional Sinus Surgery
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.) **Fee:** $816.75 **Benefit:** 75% = $612.60 **Future End Date:**
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.) **Fee:** $1,207.45 **Benefit:** 75% = $905.60 **Future End Date:**
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.) **Fee:** $1,964.70 **Benefit:** 75% = $1473.55 **Future End Date:**

T8. SURGICAL OPERATIONS	20. SINUS PROCEDURES
	Group T8. Surgical Operations
	Subgroup 20. Sinus Procedures
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.) **Fee:** $423.50 **Benefit:** 75% = $317.65 **Future End Date:**
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.) **Fee:** $1,213.65 **Benefit:** 75% = $910.25 **Future End Date:**
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.) **Fee:** $578.40 **Benefit:** 75% = $433.80 **Future End Date:**
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.) **Fee:** $353.90 **Benefit:** 75% = $265.45 **Future End Date:**

T8. SURGICAL OPERATIONS	21. AIRWAY PROCEDURES
	Group T8. Surgical Operations
	Subgroup 21. Airway Procedures
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.) (See para TN.8.104 of explanatory notes to this Category) **Fee:** $627.75 **Benefit:** 75% = $470.85 **Future End Date:**
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.) **Fee:** $245.10 **Benefit:** 75% = $183.85 85% = $208.35 **Future End Date:**
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.) **Fee:** $319.65 **Benefit:** 75% = $239.75 **Future End Date:**

T8. SURGICAL OPERATIONS	21. AIRWAY PROCEDURES
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.) **Fee:** $918.05 **Benefit:** 75% = $688.55 **Future End Date:**

T9. ASSISTANCE AT OPERATIONS	
	Group T9. Assistance At Operations
51300	Assistance at any operation mentioned in an item in Group T8 that includes "(Assist.)" for which the fee does not exceed $668.25 or at a series or combination of operations mentioned in an item in Group T8 that include "(Assist.)" for which the aggregate fee does not exceed $668.25 (See para TN.9.2, TN.9.1 of explanatory notes to this Category) **Fee:** $103.25 **Benefit:** 75% = $77.45 85% = $87.80 **Future End Date:**
51303	Assistance at any operation mentioned in an item in Group T8 that includes "(Assist.)" for which the fee exceeds $668.25 or at a series or combination of operations mentioned in an item in Group T8 that include "(Assist.)" for which the aggregate fee exceeds $668.25 (See para TN.9.3, TN.9.1 of explanatory notes to this Category) **Derived Fee:** one fifth of the established fee for the operation or combination of operations **Future End Date:**
51306	Assistance at a birth involving Caesarean section (H) (See para GN.1.2, TN.9.1 of explanatory notes to this Category) **Fee:** $149.25 **Benefit:** 75% = $111.95 **Future End Date:**
51309	Assistance at a series or combination of operations that include "(Assist.)" and assistance at a birth involving Caesarean section (H) (See para GN.1.2, TN.9.4, TN.9.1 of explanatory notes to this Category) **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) **Future End Date:**
51312	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615 and 16627 (H) (See para GN.1.2, TN.4.11, TN.9.1 of explanatory notes to this Category) **Derived Fee:** One fifth of the established fee for the procedure or combination of procedures **Future End Date:**
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) (See para GN.1.2, TN.9.1 of explanatory notes to this Category) **Fee:** $326.05 **Benefit:** 75% = $244.55 **Future End Date:**
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

T9. ASSISTANCE AT OPERATIONS	
	(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) (See para GN.1.2, TN.9.5, TN.9.1 of explanatory notes to this Category) **Fee:** $215.20 **Benefit:** 75% = $161.40 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	1. HEAD
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 1. 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) **Fee:** $118.50 **Benefit:** 75% = $88.90 85% = $100.75 **Future End Date:**
20102	Initiation of the management of anaesthesia for plastic repair of cleft lip (H) (6 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
20104	Initiation of the management of anaesthesia for electroconvulsive therapy (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	1. HEAD
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) **Fee:** $118.50 **Benefit:** 75% = $88.90 85% = $100.75 **Future End Date:**
20124	Initiation of the management of anaesthesia for otoscopy (H) (4 basic units) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
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) **Fee:** $118.50 **Benefit:** 75% = $88.90 85% = $100.75 **Future End Date:**
20142	Initiation of the management of anaesthesia for lens surgery (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
20143	Initiation of the management of anaesthesia for retinal surgery (H) (6 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
20144	Initiation of the management of anaesthesia for corneal transplant (H) (7 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45 **Future End Date:**
20145	Initiation of the management of anaesthesia for vitrectomy (H) (7 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45 **Future End Date:**
20146	Initiation of the management of anaesthesia for biopsy of conjunctiva (H) (5 basic units) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
20147	Initiation of the management of anaesthesia for squint repair (H) (6 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**

20148	INITIATION OF MANAGEMENT OF ANAESTHESIA for ophthalmoscopy (4 basic units) **Fee:** $94.80 **Benefit:** 75% = $71.10 85% = $80.60 **Future End Date:**
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) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
20162	Initiation of the management of anaesthesia for intranasal surgery for malignancy or for intranasal ablation (H) (7 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45 **Future End Date:**
20164	Initiation of the management of anaesthesia for biopsy of soft tissue of the nose and accessory sinuses (H) (4 basic units) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
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) **Fee:** $142.20 **Benefit:** 75% = $106.65 85% = $120.90 **Future End Date:**
20172	Initiation of the management of anaesthesia for repair of cleft palate (H) (7 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45 **Future End Date:**
20174	Initiation of the management of anaesthesia for excision of retropharyngeal tumour (H) (9 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $213.30 **Benefit:** 75% = $160.00 **Future End Date:**
20176	Initiation of the management of anaesthesia for radical intraoral surgery (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90

	Future End Date:
20192	Initiation of the management of anaesthesia for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction) (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $355.50 **Benefit:** 75% = $266.65 **Future End Date:**
20212	Initiation of the management of anaesthesia for subdural taps (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
20214	Initiation of the management of anaesthesia for burr holes of the cranium (H) (9 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $213.30 **Benefit:** 75% = $160.00 **Future End Date:**
20216	Initiation of the management of anaesthesia for intracranial vascular procedures, including those for aneurysms or arterio-venous abnormalities (H) (20 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $474.00 **Benefit:** 75% = $355.50 **Future End Date:**
20220	Initiation of the management of anaesthesia for spinal fluid shunt procedures (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
20222	Initiation of the management of anaesthesia for ablation of an intracranial nerve (H) (6 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
20225	Initiation of the management of anaesthesia for all cranial bone procedures (H) (12 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $284.40 **Benefit:** 75% = $213.30 **Future End Date:**
20230	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the head or face (H) (12 basic units) (See para GN.1.2, TN.10.28 of explanatory notes to this Category)

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	1. HEAD
	Fee: $284.40 **Benefit:** 75% = $213.30 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	2. NECK
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 2. 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) **Fee:** $118.50 **Benefit:** 75% = $88.90 85% = $100.75 **Future End Date:**
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) **Fee:** $355.50 **Benefit:** 75% = $266.65 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
20321	Initiation of the management of anaesthesia for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
20330	Initiation of the management of anaesthesia for laser surgery to the airway (excluding nose and mouth) (H) (8 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $189.60 **Benefit:** 75% = $142.20 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category)

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	2. NECK
	Fee: $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
20352	Initiation of the management of anaesthesia for simple ligation of major vessels of neck (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
20355	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the neck (H) (12 basic units) (See para GN.1.2, TN.10.28 of explanatory notes to this Category) **Fee:** $284.40 **Benefit:** 75% = $213.30 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	3. THORAX
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 3. 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) **Fee:** $71.10 **Benefit:** 75% = $53.35 85% = $60.45 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
20402	Initiation of management of anaesthesia for reconstructive procedures on breast, including implant reconstruction and exchange (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
20403	Initiation of management of anaesthesia for axillary dissection or sentinel node biopsy (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90

	Future End Date:
20404	Initiation of the management of anaesthesia for mastectomy (H) (6 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
20405	Initiation of the management of anaesthesia for reconstructive procedures on the breast using myocutaneous flaps (H) (8 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $189.60 **Benefit:** 75% = $142.20 **Future End Date:**
20406	Initiation of the management of anaesthesia for radical or modified radical procedures on breast with internal mammary node dissection (H) (13 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $308.10 **Benefit:** 75% = $231.10 **Future End Date:**
20410	Initiation of the management of anaesthesia for electrical conversion of arrhythmias (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
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) **Fee:** $118.50 **Benefit:** 75% = $88.90 85% = $100.75 **Future End Date:**
20440	Initiation of the management of anaesthesia for percutaneous bone marrow biopsy of the sternum (H) (4 basic units) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
20452	Initiation of the management of anaesthesia for radical surgery on clavicle, scapula or sternum (H) (6 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	3. THORAX
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
20472	Initiation of the management of anaesthesia for thoracoplasty (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
20474	Initiation of the management of anaesthesia for radical procedures on chest wall (H) (13 basic units) (See para GN.1.2, TN.10.22 of explanatory notes to this Category) **Fee:** $308.10 **Benefit:** 75% = $231.10 **Future End Date:**
20475	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior thorax (H) (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	4. INTRATHORACIC
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 4. Intrathoracic
20500	Initiation of the management of anaesthesia for open procedures on the oesophagus (H) (15 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $355.50 **Benefit:** 75% = $266.65 **Future End Date:**
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) **Fee:** $142.20 **Benefit:** 75% = $106.65 85% = $120.90 **Future End Date:**
20522	Initiation of the management of anaesthesia for needle biopsy of pleura (H) (4 basic units)

	(See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
20524	Initiation of the management of anaesthesia for pneumocentesis (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
20526	Initiation of the management of anaesthesia for thoracoscopy (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
20528	Initiation of the management of anaesthesia for mediastinoscopy (H) (8 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $189.60 **Benefit:** 75% = $142.20 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $308.10 **Benefit:** 75% = $231.10 **Future End Date:**
20542	Initiation of the management of anaesthesia for pulmonary decortication (H) (15 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $355.50 **Benefit:** 75% = $266.65 **Future End Date:**
20546	Initiation of the management of anaesthesia for pulmonary resection with thoracoplasty (H) (15 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $355.50 **Benefit:** 75% = $266.65 **Future End Date:**
20548	Initiation of the management of anaesthesia for intrathoracic repair of trauma to trachea and bronchi (H) (15 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $355.50 **Benefit:** 75% = $266.65 **Future End Date:**
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

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	4. INTRATHORACIC
	(H) (20 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $474.00 **Benefit:** 75% = $355.50 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	5. SPINE AND SPINAL CORD
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 5. 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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
20604	Initiation of the management of anaesthesia for posterior cervical laminectomy with the patient in the sitting position (H) (13 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $308.10 **Benefit:** 75% = $231.10 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
20622	Initiation of the management of anaesthesia for thoracolumbar sympathectomy (H) (13 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $308.10 **Benefit:** 75% = $231.10 **Future End Date:**
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) **Fee:** $189.60 **Benefit:** 75% = $142.20 **Future End Date:**
20632	Initiation of the management of anaesthesia for lumbar sympathectomy (H) (7 basic units)

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	5. SPINE AND SPINAL CORD
	(See para GN.1.2 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45 **Future End Date:**
20634	Initiation of the management of anaesthesia for chemonucleolysis (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
20670	Initiation of the management of anaesthesia for extensive spine or spinal cord procedures, or both (H) (13 basic units) (See para GN.1.2, TN.10.23 of explanatory notes to this Category) **Fee:** $308.10 **Benefit:** 75% = $231.10 **Future End Date:**
20680	Initiation of the management of anaesthesia for manipulation of spine when performed in the operating theatre of a hospital (H) (3 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $71.10 **Benefit:** 75% = $53.35 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	6. UPPER ABDOMEN
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 6. 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) **Fee:** $71.10 **Benefit:** 75% = $53.35 85% = $60.45 **Future End Date:**
20702	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units) **Fee:** $94.80 **Benefit:** 75% = $71.10 85% = $80.60 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	6. UPPER ABDOMEN
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) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
20704	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior upper abdomen (H) (10 basic units) (See para GN.1.2, TN.10.28 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
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) (See para GN.1.2, TN.10.27 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45 **Future End Date:**
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) **Fee:** $118.50 **Benefit:** 75% = $88.90 85% = $100.75 **Future End Date:**
20740	Initiation of the management of anaesthesia for upper gastrointestinal endoscopic procedures (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	6. UPPER ABDOMEN
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) (See para TN.10.27 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
20752	Initiation of the management of anaesthesia for repair of incisional hernia or wound dehiscence, or both (H) (6 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
20754	Initiation of the management of anaesthesia for procedures on an omphalocele (H) (7 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45 **Future End Date:**
20756	Initiation of the management of anaesthesia for transabdominal repair of diaphragmatic hernia (H) (9 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $213.30 **Benefit:** 75% = $160.00 **Future End Date:**
20770	Initiation of the management of anaesthesia for procedures on major upper abdominal blood vessels (H) (15 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $355.50 **Benefit:** 75% = $266.65 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $189.60 **Benefit:** 75% = $142.20 **Future End Date:**
20791	Initiation of the management of anaesthesia for bariatric surgery in a patient with clinically severe obesity (H) (10 basic units) (See para GN.1.2, TN.8.29 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	6. UPPER ABDOMEN
	Future End Date:
20792	Initiation of the management of anaesthesia for partial hepatectomy (excluding liver biopsy) (H) (13 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $308.10 **Benefit:** 75% = $231.10 **Future End Date:**
20793	Initiation of the management of anaesthesia for extended or trisegmental hepatectomy (H) (15 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $355.50 **Benefit:** 75% = $266.65 **Future End Date:**
20794	Initiation of the management of anaesthesia for pancreatectomy, partial or total (H) (12 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $284.40 **Benefit:** 75% = $213.30 **Future End Date:**
20798	Initiation of the management of anaesthesia for neuro endocrine tumour removal in the upper abdomen (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
20799	Initiation of the management of anaesthesia for percutaneous procedures on an intra-abdominal organ in the upper abdomen (H) (6 basic units) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	7. LOWER ABDOMEN
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 7. 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) **Fee:** $71.10 **Benefit:** 75% = $53.35 85% = $60.45 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	7. LOWER ABDOMEN
20802	INITIATION OF MANAGEMENT OF ANAESTHESIA for lipectomy of the lower abdomen (5 basic units) **Fee:** $118.50 **Benefit:** 75% = $88.90 85% = $100.75 **Future End Date:**
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) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
20804	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior lower abdomen (H) (10 basic units) (See para TN.10.28 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
20806	Initiation of the management of anaesthesia for laparoscopic procedures in the lower abdomen (H) (7 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45 **Future End Date:**
20810	Initiation of the management of anaesthesia for lower intestinal endoscopic procedures (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
20815	Initiation of the management of anaesthesia for extracorporeal shock wave lithotripsy to urinary tract (H) (6 basic units) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
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) **Fee:** $118.50 **Benefit:** 75% = $88.90 85% = $100.75 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10

	Future End Date:
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) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
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) (See para GN.1.2, TN.10.27 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $189.60 **Benefit:** 75% = $142.20 **Future End Date:**
20842	Initiation of the management of anaesthesia for amniocentesis (H) (4 basic units) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
20845	Initiation of the management of anaesthesia for radical prostatectomy (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
20846	Initiation of the management of anaesthesia for radical hysterectomy (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
20847	Initiation of the management of anaesthesia for ovarian malignancy (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**

20848	Initiation of the management of anaesthesia for pelvic exenteration (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
20850	Initiation of the management of anaesthesia for caesarean section (H) (12 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $284.40 **Benefit:** 75% = $213.30 **Future End Date:**
20855	Initiation of the management of anaesthesia for caesarean hysterectomy or hysterectomy within 24 hours of birth (H) (15 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $355.50 **Benefit:** 75% = $266.65 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
20862	Initiation of the management of anaesthesia for renal procedures, including upper one-third of ureter (H) (7 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45 **Future End Date:**
20863	Initiation of the management of anaesthesia for nephrectomy (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
20864	Initiation of the management of anaesthesia for total cystectomy (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
20866	Initiation of the management of anaesthesia for adrenalectomy (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
20867	Initiation of the management of anaesthesia for neuro endocrine tumour removal in the lower abdomen (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	7. LOWER ABDOMEN
	Future End Date:
20868	Initiation of the management of anaesthesia for renal transplantation (donor or recipient) (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $355.50 **Benefit:** 75% = $266.65 **Future End Date:**
20882	Initiation of the management of anaesthesia for inferior vena cava ligation (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
20884	Initiation of the management of anaesthesia for percutaneous umbrella insertion (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
20886	Initiation of the management of anaesthesia for percutaneous procedures on an intra-abdominal organ in the lower abdomen (H) (6 basic units) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	8. PERINEUM
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 8. 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) **Fee:** $71.10 **Benefit:** 75% = $53.35 85% = $60.45 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	8. PERINEUM
20902	Initiation of the management of anaesthesia for anorectal procedures (including surgical haemorrhoidectomy, but not banding of haemorrhoids) (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
20904	Initiation of the management of anaesthesia for radical perineal procedures, including radical perineal prostatectomy or radical vulvectomy (H) (7 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45 **Future End Date:**
20905	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the perineum (H) (10 basic units) (See para GN.1.2, TN.10.28 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
20906	Initiation of the management of anaesthesia for vulvectomy (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
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) **Fee:** $94.80 **Benefit:** 75% = $71.10 85% = $80.60 **Future End Date:**
20911	Initiation of the management of anaesthesia for endoscopic ureteroscopic surgery including laser procedures (H) (5 basic units) (See para GN.1.2, TN.10.29 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
20912	Initiation of the management of anaesthesia for transurethral resection of bladder tumour or tumours (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
20914	Initiation of the management of anaesthesia for transurethral resection of prostate (H) (7 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45 **Future End Date:**
20916	Initiation of the management of anaesthesia for bleeding post-transurethral resection (H) (7 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45

	Future End Date:
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) **Fee:** $94.80 **Benefit:** 75% = $71.10 85% = $80.60 **Future End Date:**
20924	Initiation of the management of anaesthesia for procedures on undescended testis, unilateral or bilateral (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
20926	Initiation of the management of anaesthesia for radical orchidectomy, inguinal approach (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
20928	Initiation of the management of anaesthesia for radical orchidectomy, abdominal approach (H) (6 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
20930	Initiation of the management of anaesthesia for orchiopexy, unilateral or bilateral (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
20932	Initiation of the management of anaesthesia for complete amputation of penis (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
20934	Initiation of the management of anaesthesia for complete amputation of penis with bilateral inguinal lymphadenectomy (H) (6 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
20936	Initiation of the management of anaesthesia for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy (H) (8 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $189.60 **Benefit:** 75% = $142.20 **Future End Date:**
20938	Initiation of the management of anaesthesia for insertion of penile prosthesis (H) (4 basic units)

	(See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
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) **Fee:** $94.80 **Benefit:** 75% = $71.10 85% = $80.60 **Future End Date:**
20942	Initiation of the management of anaesthesia for vaginal procedures (including repair operations and urinary incontinence procedures) (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
20943	INITIATION OF MANAGEMENT OF ANAESTHESIA for transvaginal assisted reproductive services (4 basic units) **Fee:** $94.80 **Benefit:** 75% = $71.10 85% = $80.60 **Future End Date:**
20944	Initiation of the management of anaesthesia for vaginal hysterectomy (H) (6 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
20946	Initiation of the management of anaesthesia for vaginal birth (H) (8 basic units) **Fee:** $189.60 **Benefit:** 75% = $142.20 **Future End Date:**
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) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
20950	Initiation of the management of anaesthesia for culdoscopy (H) (5 basic units) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
20952	Initiation of the management of anaesthesia for hysteroscopy (H) (4 basic units) **Fee:** $94.80 **Benefit:** 75% = $71.10

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	8. PERINEUM
	Future End Date:
20954	Initiation of the management of anaesthesia for correction of inverted uterus (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
20956	INITIATION OF MANAGEMENT OF ANAESTHESIA for evacuation of retained products of conception, as a complication of confinement (4 basic units) **Fee:** $94.80 **Benefit:** 75% = $71.10 85% = $80.60 **Future End Date:**
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) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
20960	Initiation of the management of anaesthesia for vaginal procedures in the management of post-partum haemorrhage, if the blood loss is greater than 500 ml (H) (7 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	9. PELVIS (EXCEPT HIP)
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 9. 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) **Fee:** $71.10 **Benefit:** 75% = $53.35 85% = $60.45 **Future End Date:**
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) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**

21112	Initiation of the management of anaesthesia for percutaneous bone marrow biopsy of the anterior iliac crest (H) (4 basic units) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
21114	Initiation of the management of anaesthesia for percutaneous bone marrow biopsy of the posterior iliac crest (H) (5 basic units) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21116	Initiation of the management of anaesthesia for percutaneous bone marrow harvesting from the pelvis (H) (6 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
21120	Initiation of the management of anaesthesia for procedures on the bony pelvis (H) (6 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $71.10 **Benefit:** 75% = $53.35 **Future End Date:**
21140	Initiation of the management of anaesthesia for interpelviabdominal (hindquarter) amputation (H) (15 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $355.50 **Benefit:** 75% = $266.65 **Future End Date:**
21150	Initiation of the management of anaesthesia for radical procedures for tumour of the pelvis, except hindquarter amputation (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
21155	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior pelvis (H) (10 basic units) (See para GN.1.2, TN.10.28 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	9. PELVIS (EXCEPT HIP)
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
21170	Initiation of the management of anaesthesia for open procedures involving symphysis pubis or sacroiliac joint (H) (8 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $189.60 **Benefit:** 75% = $142.20 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	10. UPPER LEG (EXCEPT KNEE)
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 10. 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) **Fee:** $71.10 **Benefit:** 75% = $53.35 85% = $60.45 **Future End Date:**
21199	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg (4 basic units) **Fee:** $94.80 **Benefit:** 75% = $71.10 85% = $80.60 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
21202	Initiation of the management of anaesthesia for arthroscopic procedures of the hip joint (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
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)

	(See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
21212	Initiation of the management of anaesthesia for hip disarticulation (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
21214	Initiation of management of anaesthesia for primary total hip replacement. (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
21215	Initiation of management of anaesthesia for revision total hip replacement (H) (15 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $355.50 **Benefit:** 75% = $266.65 **Future End Date:**
21216	Initiation of the management of anaesthesia for bilateral total hip replacement (H) (14 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $331.80 **Benefit:** 75% = $248.85 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
21232	Initiation of the management of anaesthesia for above knee amputation (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21234	Initiation of the management of anaesthesia for radical resection of the upper two-thirds of femur (H) (8 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $189.60 **Benefit:** 75% = $142.20 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	10. UPPER LEG (EXCEPT KNEE)
21260	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures involving veins of upper leg, including exploration (4 basic units) **Fee:** $94.80 **Benefit:** 75% = $71.10 85% = $80.60 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $189.60 **Benefit:** 75% = $142.20 **Future End Date:**
21272	Initiation of the management of anaesthesia for femoral artery ligation (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
21274	Initiation of the management of anaesthesia for femoral artery embolectomy (H) (6 basic units) (See para GN.1.2, TN.10.24 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
21275	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the upper leg (H) (10 basic units) (See para GN.1.2, TN.10.28 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
21280	Initiation of the management of anaesthesia for microsurgical reimplantation of upper leg (H) (15 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $355.50 **Benefit:** 75% = $266.65 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	11. KNEE AND POPLITEAL AREA
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 11. 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) **Fee:** $71.10 **Benefit:** 75% = $53.35 **Future End Date:**
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) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
21360	Initiation of the management of anaesthesia for open procedures on lower one-third of femur (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $71.10 **Benefit:** 75% = $53.35 **Future End Date:**
21382	Initiation of the management of anaesthesia for arthroscopic procedures of knee joint (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $71.10 **Benefit:** 75% = $53.35 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
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)

	(See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
21402	Initiation of the management of anaesthesia for knee replacement (H) (7 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45 **Future End Date:**
21403	Initiation of the management of anaesthesia for bilateral knee replacement (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
21404	Initiation of the management of anaesthesia for disarticulation of knee (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21420	Initiation of the management of anaesthesia for cast application, removal or repair, involving knee joint, undertaken in a hospital (H) (3 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $71.10 **Benefit:** 75% = $53.35 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
21432	Initiation of the management of anaesthesia for repair of arteriovenous fistula of knee or popliteal area (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $189.60 **Benefit:** 75% = $142.20 **Future End Date:**
21445	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the knee or popliteal area (H) (10 basic units) (See para GN.1.2, TN.10.28 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 12. 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) **Fee:** $71.10 **Benefit:** 75% = $53.35 85% = $60.45 **Future End Date:**
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) **Fee:** $94.80 **Benefit:** 75% = $71.10 85% = $80.60 **Future End Date:**
21462	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on lower leg, ankle, or foot (3 basic units) **Fee:** $71.10 **Benefit:** 75% = $53.35 85% = $60.45 **Future End Date:**
21464	Initiation of the management of anaesthesia for arthroscopic procedure of ankle joint (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
21472	Initiation of the management of anaesthesia for repair of Achilles tendon (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21474	Initiation of the management of anaesthesia for gastrocnemius recession (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
21482	Initiation of the management of anaesthesia for radical resection of bone involving lower leg, ankle or foot (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**

21484	Initiation of the management of anaesthesia for osteotomy or osteoplasty of tibia or fibula (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21486	Initiation of the management of anaesthesia for total ankle replacement (H) (7 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45 **Future End Date:**
21490	Initiation of the management of anaesthesia for lower leg cast application, removal or repair, undertaken in a hospital (H) (3 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $71.10 **Benefit:** 75% = $53.35 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $189.60 **Benefit:** 75% = $142.20 **Future End Date:**
21502	Initiation of the management of anaesthesia for embolectomy of the lower leg (H) (6 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
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) **Fee:** $94.80 **Benefit:** 75% = $71.10 85% = $80.60 **Future End Date:**
21522	Initiation of the management of anaesthesia for venous thrombectomy of the lower leg (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21530	Initiation of the management of anaesthesia for microsurgical reimplantation of lower leg, ankle or foot (H) (15 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $355.50 **Benefit:** 75% = $266.65 **Future End Date:**
21532	Initiation of the management of anaesthesia for microsurgical reimplantation of toe (H) (8 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $189.60 **Benefit:** 75% = $142.20

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	12. LOWER LEG (BELOW KNEE)
	Future End Date:
	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the lower leg (H) (10 basic units) (See para GN.1.2, TN.10.28 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75
21535	**Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	13. SHOULDER AND AXILLA
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 13. Shoulder And Axilla
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the shoulder or axilla (3 basic units) **Fee:** $71.10 **Benefit:** 75% = $53.35 85% = $60.45
21600	**Future End Date:**
	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) **Fee:** $118.50 **Benefit:** 75% = $88.90
21610	**Future End Date:**
	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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10
21620	**Future End Date:**
	Initiation of the management of anaesthesia for arthroscopic procedures of shoulder joint (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90
21622	**Future End Date:**
	Initiation of the management of anaesthesia for open procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint, other than a service to which another item in this Subgroup applies (H) (5 basic units)
21630	(See para GN.1.2 of explanatory notes to this Category)

	Fee: $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
21634	Initiation of the management of anaesthesia for shoulder disarticulation (H) (9 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $213.30 **Benefit:** 75% = $160.00 **Future End Date:**
21636	Initiation of the management of anaesthesia for interthoracoscapular (forequarter) amputation (H) (15 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $355.50 **Benefit:** 75% = $266.65 **Future End Date:**
21638	Initiation of the management of anaesthesia for total shoulder replacement (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $189.60 **Benefit:** 75% = $142.20 **Future End Date:**
21652	Initiation of the management of anaesthesia for procedures for axillary-brachial aneurysm (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
21654	Initiation of the management of anaesthesia for bypass graft of arteries of shoulder or axilla (H) (8 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $189.60 **Benefit:** 75% = $142.20 **Future End Date:**
21656	Initiation of the management of anaesthesia for axillary-femoral bypass graft (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	13. SHOULDER AND AXILLA
21670	Initiation of the management of anaesthesia for procedures on veins of shoulder or axilla (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $71.10 **Benefit:** 75% = $53.35 **Future End Date:**
21682	Initiation of the management of anaesthesia for shoulder spica application, when undertaken in a hospital (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
21685	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the shoulder or the axilla (H) (10 basic units) (See para GN.1.2, TN.10.28 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	14. UPPER ARM AND ELBOW
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 14. 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) **Fee:** $71.10 **Benefit:** 75% = $53.35 85% = $60.45 **Future End Date:**
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) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**

21712	Initiation of the management of anaesthesia for open tenotomy of the upper arm or elbow (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21714	Initiation of the management of anaesthesia for tenoplasty of the upper arm or elbow (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21716	Initiation of the management of anaesthesia for tenodesis for rupture of long tendon of biceps (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $71.10 **Benefit:** 75% = $53.35 **Future End Date:**
21732	Initiation of the management of anaesthesia for arthroscopic procedures of elbow joint (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
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) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21756	Initiation of the management of anaesthesia for radical procedures on the upper arm or elbow (H) (6 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
21760	Initiation of the management of anaesthesia for total elbow replacement (H) (7 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	14. UPPER ARM AND ELBOW
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) **Fee:** $189.60 **Benefit:** 75% = $142.20 **Future End Date:**
21772	Initiation of the management of anaesthesia for embolectomy of arteries of the upper arm (H) (6 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
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) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
21785	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the upper arm or elbow (H) (10 basic units) (See para GN.1.2, TN.10.28 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
21790	Initiation of the management of anaesthesia for microsurgical reimplantation of upper arm (H) (15 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $355.50 **Benefit:** 75% = $266.65 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	15. FOREARM WRIST AND HAND
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 15. 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) **Fee:** $71.10 **Benefit:** 75% = $53.35 85% = $60.45

	Future End Date:
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) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $71.10 **Benefit:** 75% = $53.35 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
21832	Initiation of the management of anaesthesia for total wrist replacement (H) (7 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45 **Future End Date:**
21834	Initiation of the management of anaesthesia for arthroscopic procedures of the wrist joint (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $189.60 **Benefit:** 75% = $142.20 **Future End Date:**
21842	Initiation of the management of anaesthesia for embolectomy of artery of forearm, wrist or hand (H) (6 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
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) **Fee:** $94.80 **Benefit:** 75% = $71.10

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	15. FOREARM WRIST AND HAND
	Future End Date:
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $71.10 **Benefit:** 75% = $53.35 **Future End Date:**
21865	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the forearm, wrist or hand (H) (10 basic units) (See para GN.1.2, TN.10.28 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
21870	Initiation of the management of anaesthesia for microsurgical reimplantation of forearm, wrist or hand (H) (15 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $355.50 **Benefit:** 75% = $266.65 **Future End Date:**
21872	Initiation of the management of anaesthesia for microsurgical reimplantation of a finger (H) (8 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $189.60 **Benefit:** 75% = $142.20 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	16. ANAESTHESIA FOR BURNS
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 16. 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) **Fee:** $71.10 **Benefit:** 75% = $53.35 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category)

	Fee: $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $213.30 **Benefit:** 75% = $160.00 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $260.70 **Benefit:** 75% = $195.55 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $308.10 **Benefit:** 75% = $231.10 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $355.50 **Benefit:** 75% = $266.65 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $402.90 **Benefit:** 75% = $302.20 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category)

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	16. ANAESTHESIA FOR BURNS
	Fee: $450.30 **Benefit:** 75% = $337.75 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $497.70 **Benefit:** 75% = $373.30 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 17. 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) **Fee:** $71.10 **Benefit:** 75% = $53.35 **Future End Date:**
21906	Initiation of the management of anaesthesia for injection procedure for myelography—lumbar or thoracic (H) (5 basic units) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21908	Initiation of the management of anaesthesia for injection procedure for myelography—cervical (H) (6 basic units) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
21910	Initiation of the management of anaesthesia for injection procedure for myelography—posterior fossa (H) (9 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $213.30 **Benefit:** 75% = $160.00 **Future End Date:**
21912	Initiation of the management of anaesthesia for injection procedure for discography—lumbar or thoracic (H)

	(5 basic units) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21914	Initiation of the management of anaesthesia for injection procedure for discography—cervical (H) (6 basic units) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
21915	Initiation of the management of anaesthesia for peripheral arteriogram (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21916	Initiation of the management of anaesthesia for arteriograms—cerebral, carotid or vertebral (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21918	INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde arteriogram: brachial or femoral (5 basic units) **Fee:** $118.50 **Benefit:** 75% = $88.90 85% = $100.75 **Future End Date:**
21922	INITIATION OF MANAGEMENT OF ANAESTHESIA for computerised axial tomography scanning, magnetic resonance scanning, digital subtraction angiography scanning (6 basic units) **Fee:** $142.20 **Benefit:** 75% = $106.65 85% = $120.90 **Future End Date:**
21925	Initiation of the management of anaesthesia for retrograde cystography, retrograde urethrography or retrograde cystourethrography (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
21926	Initiation of the management of anaesthesia for fluoroscopy (H) (4 basic units) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
21930	Initiation of the management of anaesthesia for bronchography (H) (6 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**

21935	Initiation of the management of anaesthesia for phlebography (H) (5 basic units) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21936	Initiation of the management of anaesthesia for heart—2 dimensional real time transoesophageal examination (H) (5 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21939	Initiation of the management of anaesthesia for peripheral venous cannulation (H) (3 basic units) **Fee:** $71.10 **Benefit:** 75% = $53.35 **Future End Date:**
21941	Initiation of the management of anaesthesia for cardiac catheterisation (including coronary arteriography, ventriculography, cardiac mapping or insertion of automatic defibrillator or transvenous pacemaker) (H) (7 basic units) (See para GN.1.2, TN.10.25 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45 **Future End Date:**
21942	Initiation of the management of anaesthesia for cardiac electrophysiological procedures including radio frequency ablation (H) (10 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21945	Initiation of the management of anaesthesia for lumbar puncture, cisternal puncture or epidural injection (H) (5 basic units) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21949	Initiation of the management of anaesthesia for harvesting of bone marrow for the purpose of transplantation (H)

	(5 basic units) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21952	Initiation of the management of anaesthesia for diagnostic muscle biopsy to assess for malignant hyperpyrexia (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
21955	Initiation of the management of anaesthesia for electroencephalography (H) (5 basic units) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21959	Initiation of the management of anaesthesia for brain stem evoked response audiometry (H) (5 basic units) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21962	Initiation of the management of anaesthesia for electrocochleography by extratympanic method or transtympanic membrane insertion method (H) (5 basic units) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
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) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
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) **Fee:** $189.60 **Benefit:** 75% = $142.20 85% = $161.20 **Future End Date:**
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) **Fee:** $355.50 **Benefit:** 75% = $266.65 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES
21973	Initiation of the management of anaesthesia for brachytherapy using radioactive sealed sources (H) (5 basic units) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21976	Initiation of the management of anaesthesia for therapeutic nuclear medicine (H) (5 basic units) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
21980	Initiation of the management of anaesthesia for radiotherapy (H) (5 basic units) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	18. MISCELLANEOUS
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 18. Miscellaneous
21990	INITIATION OF MANAGEMENT OF ANAESTHESIA when no procedure ensues (3 basic units) (See para TN.10.12 of explanatory notes to this Category) **Fee:** $71.10 **Benefit:** 75% = $53.35 85% = $60.45 **Future End Date:**
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) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
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) (See para TN.10.13 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 85% = $80.60 **Future End Date:**

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 19. Therapeutic And Diagnostic Services
22002	Administration of blood or bone marrow, when performed in association with the management of anaesthesia (H) (4 basic units) (See para TN.10.8 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
22007	Endotracheal intubation with flexible fibreoptic scope associated with difficult airway, when performed in association with the management of anaesthesia (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
22008	Double lumen endobronchial tube or bronchial blocker, insertion of, when performed in association with the management of anaesthesia (H) (4 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
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)

	(See para GN.1.2, TN.10.8 of explanatory notes to this Category) **Fee:** $71.10 **Benefit:** 75% = $53.35 **Future End Date:**
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) (See para GN.1.2, TN.10.8 of explanatory notes to this Category) **Fee:** $71.10 **Benefit:** 75% = $53.35 **Future End Date:**
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) (See para GN.1.2, TN.10.8 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
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) (See para GN.1.2, TN.1.6, TN.10.8 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**

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) (See para GN.1.2, TN.10.8 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
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) (See para GN.1.2, TN.10.17 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
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) (See para TN.10.8, TN.10.17 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 **Future End Date:**
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) (See para GN.1.2, TN.10.17 of explanatory notes to this Category) **Fee:** $71.10 **Benefit:** 75% = $53.35 **Future End Date:**
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) (See para GN.1.2, TN.10.17 of explanatory notes to this Category) **Fee:** $47.40 **Benefit:** 75% = $35.55 **Future End Date:**
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) (See para TN.10.8 of explanatory notes to this Category) **Fee:** $23.70 **Benefit:** 75% = $17.80 85% = $20.15 **Future End Date:**
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) (See para GN.1.2, TN.10.30 of explanatory notes to this Category) **Fee:** $213.30 **Benefit:** 75% = $160.00 **Future End Date:**
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) (See para TN.10.8 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
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) (See para TN.10.8 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 **Future End Date:**
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) (See para TN.10.8 of explanatory notes to this Category) **Fee:** $426.60 **Benefit:** 75% = $319.95 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	19. THERAPEUTIC AND DIAGNOSTIC SERVICES
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) (See para GN.1.2, TN.10.10 of explanatory notes to this Category) **Fee:** $284.40 **Benefit:** 75% = $213.30 **Future End Date:**
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) (See para GN.1.2, TN.10.10 of explanatory notes to this Category) **Fee:** $711.00 **Benefit:** 75% = $533.25 **Future End Date:**
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) (See para GN.1.2, TN.10.10 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 **Future End Date:**
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) (See para GN.1.2, TN.10.10 of explanatory notes to this Category) **Fee:** $355.50 **Benefit:** 75% = $266.65 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	20. ADMINISTRATION OF ANAESTHESIA IN CONNECTION WITH A DENTAL SERVICE
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 20. 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) (See para TN.10.14 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 85% = $120.90 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	20. ADMINISTRATION OF ANAESTHESIA IN CONNECTION WITH A DENTAL SERVICE
22905	INITIATION OF MANAGEMENT OF ANAESTHESIA for restorative dental work (6 basic units) (See para TN.10.14 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 85% = $120.90 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	21. ANAESTHESIA/PERFUSION TIME UNITS
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 21. Anaesthesia/Perfusion Time Units
23010	Anaesthesia, perfusion or assistance, if the service time is not more than 15 minutes (1 basic units) (See para GN.1.2, TN.10.3 of explanatory notes to this Category) **Fee:** $23.70 **Benefit:** 75% = $17.80 85% = $20.15 **Future End Date:**
23025	16 MINUTES TO 30 MINUTES (2 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $47.40 **Benefit:** 75% = $35.55 85% = $40.30 **Future End Date:**
23035	31 MINUTES to 45 MINUTES (3 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $71.10 **Benefit:** 75% = $53.35 85% = $60.45 **Future End Date:**
23045	46 MINUTES to 1:00 HOUR (4 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $94.80 **Benefit:** 75% = $71.10 85% = $80.60 **Future End Date:**
23055	1:01 HOURS to 1:15 HOURS (5 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $118.50 **Benefit:** 75% = $88.90 85% = $100.75 **Future End Date:**
23065	1:16 HOURS to 1:30 HOURS (6 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $142.20 **Benefit:** 75% = $106.65 85% = $120.90 **Future End Date:**
23075	1:31 HOURS to 1:45 HOURS (7 basic units)

	(See para TN.10.3 of explanatory notes to this Category) **Fee:** $165.90 **Benefit:** 75% = $124.45 85% = $141.05 **Future End Date:**
23085	1:46 HOURS to 2:00 HOURS (8 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $189.60 **Benefit:** 75% = $142.20 85% = $161.20 **Future End Date:**
23091	2:01 HOURS TO 2:10 HOURS (9 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $213.30 **Benefit:** 75% = $160.00 85% = $181.35 **Future End Date:**
23101	2:11 HOURS TO 2:20 HOURS (10 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $237.00 **Benefit:** 75% = $177.75 85% = $201.45 **Future End Date:**
23111	2:21 HOURS TO 2:30 HOURS (11 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $260.70 **Benefit:** 75% = $195.55 85% = $221.60 **Future End Date:**
23112	2:31 HOURS TO 2:40 HOURS (12 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $284.40 **Benefit:** 75% = $213.30 85% = $241.75 **Future End Date:**
23113	2:41 HOURS TO 2:50 HOURS (13 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $308.10 **Benefit:** 75% = $231.10 85% = $261.90 **Future End Date:**
23114	2:51 HOURS TO 3:00 HOURS (14 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $331.80 **Benefit:** 75% = $248.85 85% = $282.05 **Future End Date:**
23115	3:01 HOURS TO 3:10 HOURS (15 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $355.50 **Benefit:** 75% = $266.65 85% = $302.20 **Future End Date:**
23116	3:11 HOURS TO 3:20 HOURS (16 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $379.20 **Benefit:** 75% = $284.40 85% = $322.35 **Future End Date:**

23117	3:21 HOURS TO 3:30 HOURS (17 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $402.90 **Benefit:** 75% = $302.20 85% = $342.50 **Future End Date:**
23118	3:31 HOURS TO 3:40 HOURS (18 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $426.60 **Benefit:** 75% = $319.95 85% = $362.65 **Future End Date:**
23119	3:41 HOURS TO 3:50 HOURS (19 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $450.30 **Benefit:** 75% = $337.75 85% = $382.80 **Future End Date:**
23121	3:51 HOURS TO 4:00 HOURS (20 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $474.00 **Benefit:** 75% = $355.50 85% = $402.90 **Future End Date:**
23170	4:01 HOURS TO 4:10 HOURS (21 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $497.70 **Benefit:** 75% = $373.30 85% = $423.05 **Future End Date:**
23180	4:11 HOURS TO 4:20 HOURS (22 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $521.40 **Benefit:** 75% = $391.05 85% = $443.20 **Future End Date:**
23190	4:21 HOURS TO 4:30 HOURS (23 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $545.10 **Benefit:** 75% = $408.85 85% = $463.35 **Future End Date:**
23200	4:31 HOURS TO 4:40 HOURS (24 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $568.80 **Benefit:** 75% = $426.60 85% = $483.50 **Future End Date:**
23210	4:41 HOURS TO 4:50 HOURS (25 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $592.50 **Benefit:** 75% = $444.40 85% = $503.65 **Future End Date:**
23220	4:51 HOURS TO 5:00 HOURS (26 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $616.20 **Benefit:** 75% = $462.15 85% = $523.80

	Future End Date:
23230	5:01 HOURS TO 5:10 HOURS (27 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $639.90 **Benefit:** 75% = $479.95 85% = $543.95 **Future End Date:**
23240	5:11 HOURS TO 5:20 HOURS (28 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $663.60 **Benefit:** 75% = $497.70 85% = $564.10 **Future End Date:**
23250	5:21 HOURS TO 5:30 HOURS (29 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $687.30 **Benefit:** 75% = $515.50 85% = $584.25 **Future End Date:**
23260	5:31 HOURS TO 5:40 HOURS (30 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $711.00 **Benefit:** 75% = $533.25 85% = $604.35 **Future End Date:**
23270	5:41 HOURS TO 5:50 HOURS (31 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $734.70 **Benefit:** 75% = $551.05 85% = $626.20 **Future End Date:**
23280	(5:51 HOURS TO 6:00 HOURS (32 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $758.40 **Benefit:** 75% = $568.80 85% = $649.90 **Future End Date:**
23290	6:01 HOURS TO 6:10 HOURS (33 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $782.10 **Benefit:** 75% = $586.60 85% = $673.60 **Future End Date:**
23300	6:11 HOURS TO 6:20 HOURS (34 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $805.80 **Benefit:** 75% = $604.35 85% = $697.30 **Future End Date:**
23310	6:21 HOURS TO 6:30 HOURS (35 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $829.50 **Benefit:** 75% = $622.15 85% = $721.00 **Future End Date:**
23320	6:31 HOURS TO 6:40 HOURS (36 basic units)

	(See para TN.10.3 of explanatory notes to this Category) **Fee:** $853.20 **Benefit:** 75% = $639.90 85% = $744.70 **Future End Date:**
23330	6:41 HOURS TO 6:50 HOURS (37 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $876.90 **Benefit:** 75% = $657.70 85% = $768.40 **Future End Date:**
23340	6:51 HOURS TO 7:00 HOURS (38 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $900.60 **Benefit:** 75% = $675.45 85% = $792.10 **Future End Date:**
23350	7:01 HOURS TO 7:10 HOURS (39 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $924.30 **Benefit:** 75% = $693.25 85% = $815.80 **Future End Date:**
23360	7:11 HOURS TO 7:20 HOURS (40 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $948.00 **Benefit:** 75% = $711.00 85% = $839.50 **Future End Date:**
23370	7:21 HOURS TO 7:30 HOURS (41 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $971.70 **Benefit:** 75% = $728.80 85% = $863.20 **Future End Date:**
23380	7:31 HOURS TO 7:40 HOURS (42 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $995.40 **Benefit:** 75% = $746.55 85% = $886.90 **Future End Date:**
23390	7:41 HOURS TO 7:50 HOURS (43 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,019.10 **Benefit:** 75% = $764.35 85% = $910.60 **Future End Date:**
23400	7:51 HOURS TO 8:00 HOURS (44 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,042.80 **Benefit:** 75% = $782.10 85% = $934.30 **Future End Date:**
23410	8:01 HOURS TO 8:10 HOURS (45 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,066.50 **Benefit:** 75% = $799.90 85% = $958.00 **Future End Date:**

23420	8:11 HOURS TO 8:20 HOURS (46 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,090.20 **Benefit:** 75% = $817.65 85% = $981.70 **Future End Date:**
23430	8:21 HOURS TO 8:30 HOURS (47 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,113.90 **Benefit:** 75% = $835.45 85% = $1005.40 **Future End Date:**
23440	8:31 HOURS TO 8:40 HOURS (48 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,137.60 **Benefit:** 75% = $853.20 85% = $1029.10 **Future End Date:**
23450	8:41 HOURS TO 8:50 HOURS (49 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,161.30 **Benefit:** 75% = $871.00 85% = $1052.80 **Future End Date:**
23460	8:51 HOURS TO 9:00 HOURS (50 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,185.00 **Benefit:** 75% = $888.75 85% = $1076.50 **Future End Date:**
23470	9:01 HOURS TO 9:10 HOURS (51 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,208.70 **Benefit:** 75% = $906.55 85% = $1100.20 **Future End Date:**
23480	9:11 HOURS TO 9:20 HOURS (52 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,232.40 **Benefit:** 75% = $924.30 85% = $1123.90 **Future End Date:**
23490	9:21 HOURS TO 9:30 HOURS (53 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,256.10 **Benefit:** 75% = $942.10 85% = $1147.60 **Future End Date:**
23500	9:31 HOURS TO 9:40 HOURS (54 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,279.80 **Benefit:** 75% = $959.85 85% = $1171.30 **Future End Date:**
23510	9:41 HOURS TO 9:50 HOURS (55 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,303.50 **Benefit:** 75% = $977.65 85% = $1195.00

	Future End Date:
23520	9:51 HOURS TO 10:00 HOURS (56 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,327.20 **Benefit:** 75% = $995.40 85% = $1218.70 **Future End Date:**
23530	10:01 HOURS TO 10:10 HOURS (57 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,350.90 **Benefit:** 75% = $1013.20 85% = $1242.40 **Future End Date:**
23540	10:11 HOURS TO 10:20 HOURS (58 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,374.60 **Benefit:** 75% = $1030.95 85% = $1266.10 **Future End Date:**
23550	10:21 HOURS TO 10:30 HOURS (59 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,398.30 **Benefit:** 75% = $1048.75 85% = $1289.80 **Future End Date:**
23560	10:31 HOURS TO 10:40 HOURS (60 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,422.00 **Benefit:** 75% = $1066.50 85% = $1313.50 **Future End Date:**
23570	10:41 HOURS TO 10:50 HOURS (61 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,445.70 **Benefit:** 75% = $1084.30 85% = $1337.20 **Future End Date:**
23580	10:51 HOURS TO 11:00 HOURS (62 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,469.40 **Benefit:** 75% = $1102.05 85% = $1360.90 **Future End Date:**
23590	11:01 HOURS TO 11:10 HOURS (63 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,493.10 **Benefit:** 75% = $1119.85 85% = $1384.60 **Future End Date:**
23600	11:11 HOURS TO 11:20 HOURS (64 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,516.80 **Benefit:** 75% = $1137.60 85% = $1408.30 **Future End Date:**
23610	11:21 HOURS TO 11:30 HOURS (65 basic units)

	(See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,540.50 **Benefit:** 75% = $1155.40 85% = $1432.00 **Future End Date:**
23620	11:31 HOURS TO 11:40 HOURS (66 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,564.20 **Benefit:** 75% = $1173.15 85% = $1455.70 **Future End Date:**
23630	11:41 HOURS TO 11:50 HOURS (67 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,587.90 **Benefit:** 75% = $1190.95 85% = $1479.40 **Future End Date:**
23640	11:51 HOURS TO 12:00 HOURS (68 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,611.60 **Benefit:** 75% = $1208.70 85% = $1503.10 **Future End Date:**
23650	12:01 HOURS TO 12:10 HOURS (69 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,635.30 **Benefit:** 75% = $1226.50 85% = $1526.80 **Future End Date:**
23660	12:11 HOURS TO 12:20 HOURS (70 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,659.00 **Benefit:** 75% = $1244.25 85% = $1550.50 **Future End Date:**
23670	12:21 HOURS TO 12:30 HOURS (71 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,682.70 **Benefit:** 75% = $1262.05 85% = $1574.20 **Future End Date:**
23680	12:31 HOURS TO 12:40 HOURS (72 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,706.40 **Benefit:** 75% = $1279.80 85% = $1597.90 **Future End Date:**
23690	12:41 HOURS TO 12:50 HOURS (73 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,730.10 **Benefit:** 75% = $1297.60 85% = $1621.60 **Future End Date:**
23700	12:51 HOURS TO 13:00 HOURS (74 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,753.80 **Benefit:** 75% = $1315.35 85% = $1645.30 **Future End Date:**

23710	13:01 HOURS TO 13:10 HOURS (75 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,777.50 **Benefit:** 75% = $1333.15 85% = $1669.00 **Future End Date:**
23720	13:11 HOURS TO 13:20 HOURS (76 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,801.20 **Benefit:** 75% = $1350.90 85% = $1692.70 **Future End Date:**
23730	13:21 HOURS TO 13:30 HOURS (77 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,824.90 **Benefit:** 75% = $1368.70 85% = $1716.40 **Future End Date:**
23740	13:31 HOURS TO 13:40 HOURS (78 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,848.60 **Benefit:** 75% = $1386.45 85% = $1740.10 **Future End Date:**
23750	13:41 HOURS TO 13:50 HOURS (79 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,872.30 **Benefit:** 75% = $1404.25 85% = $1763.80 **Future End Date:**
23760	13:51 HOURS TO 14:00 HOURS (80 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,896.00 **Benefit:** 75% = $1422.00 85% = $1787.50 **Future End Date:**
23770	14:01 HOURS TO 14:10 HOURS (81 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,919.70 **Benefit:** 75% = $1439.80 85% = $1811.20 **Future End Date:**
23780	14:11 HOURS TO 14:20 HOURS (82 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,943.40 **Benefit:** 75% = $1457.55 85% = $1834.90 **Future End Date:**
23790	14:21 HOURS TO 14:30 HOURS (83 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,967.10 **Benefit:** 75% = $1475.35 85% = $1858.60 **Future End Date:**
23800	14:31 HOURS TO 14:40 HOURS (84 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $1,990.80 **Benefit:** 75% = $1493.10 85% = $1882.30

	Future End Date:
23810	14:41 HOURS TO 14:50 HOURS (85 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,014.50 **Benefit:** 75% = $1510.90 85% = $1906.00 **Future End Date:**
23820	14:51 HOURS TO 15:00 HOURS (86 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,038.20 **Benefit:** 75% = $1528.65 85% = $1929.70 **Future End Date:**
23830	15:01 HOURS TO 15:10 HOURS (87 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,061.90 **Benefit:** 75% = $1546.45 85% = $1953.40 **Future End Date:**
23840	15:11 HOURS TO 15:20 HOURS (88 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,085.60 **Benefit:** 75% = $1564.20 85% = $1977.10 **Future End Date:**
23850	15:21 HOURS TO 15:30 HOURS (89 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,109.30 **Benefit:** 75% = $1582.00 85% = $2000.80 **Future End Date:**
23860	15:31 HOURS TO 15:40 HOURS (90 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,133.00 **Benefit:** 75% = $1599.75 85% = $2024.50 **Future End Date:**
23870	15:41 HOURS TO 15:50 HOURS (91 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,156.70 **Benefit:** 75% = $1617.55 85% = $2048.20 **Future End Date:**
23880	15:51 HOURS TO 16:00 HOURS (92 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,180.40 **Benefit:** 75% = $1635.30 85% = $2071.90 **Future End Date:**
23890	16:01 HOURS TO 16:10 HOURS (93 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,204.10 **Benefit:** 75% = $1653.10 85% = $2095.60 **Future End Date:**
23900	16:11 HOURS TO 16:20 HOURS (94 basic units)

	(See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,227.80 **Benefit:** 75% = $1670.85 85% = $2119.30 **Future End Date:**
23910	16:21 HOURS TO 16:30 HOURS (95 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,251.50 **Benefit:** 75% = $1688.65 85% = $2143.00 **Future End Date:**
23920	16:31 HOURS TO 16:40 HOURS (96 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,275.20 **Benefit:** 75% = $1706.40 85% = $2166.70 **Future End Date:**
23930	16:41 HOURS TO 16:50 HOURS (97 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,298.90 **Benefit:** 75% = $1724.20 85% = $2190.40 **Future End Date:**
23940	16:51 HOURS TO 17:00 HOURS (98 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,322.60 **Benefit:** 75% = $1741.95 85% = $2214.10 **Future End Date:**
23950	17:01 HOURS TO 17:10 HOURS (99 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,346.30 **Benefit:** 75% = $1759.75 85% = $2237.80 **Future End Date:**
23960	17:11 HOURS TO 17:20 HOURS (100 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,370.00 **Benefit:** 75% = $1777.50 85% = $2261.50 **Future End Date:**
23970	17:21 HOURS TO 17:30 HOURS (101 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,393.70 **Benefit:** 75% = $1795.30 85% = $2285.20 **Future End Date:**
23980	17:31 HOURS TO 17:40 HOURS (102 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,417.40 **Benefit:** 75% = $1813.05 85% = $2308.90 **Future End Date:**
23990	17:41 HOURS TO 17:50 HOURS (103 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,441.10 **Benefit:** 75% = $1830.85 85% = $2332.60 **Future End Date:**

24100	17:51 HOURS TO 18:00 HOURS (104 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,464.80 **Benefit:** 75% = $1848.60 85% = $2356.30 **Future End Date:**
24101	18:01 HOURS TO 18:10 HOURS (105 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,488.50 **Benefit:** 75% = $1866.40 85% = $2380.00 **Future End Date:**
24102	18:11 HOURS TO 18:20 HOURS (106 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,512.20 **Benefit:** 75% = $1884.15 85% = $2403.70 **Future End Date:**
24103	18:21 HOURS TO 18:30 HOURS (107 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,535.90 **Benefit:** 75% = $1901.95 85% = $2427.40 **Future End Date:**
24104	18:31 HOURS TO 18:40 HOURS (108 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,559.60 **Benefit:** 75% = $1919.70 85% = $2451.10 **Future End Date:**
24105	18:41 HOURS TO 18:50 HOURS (109 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,583.30 **Benefit:** 75% = $1937.50 85% = $2474.80 **Future End Date:**
24106	18:51 HOURS TO 19:00 HOURS (110 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,607.00 **Benefit:** 75% = $1955.25 85% = $2498.50 **Future End Date:**
24107	19:01 HOURS TO 19:10 HOURS (111 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,630.70 **Benefit:** 75% = $1973.05 85% = $2522.20 **Future End Date:**
24108	19:11 HOURS TO 19:20 HOURS (112 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,654.40 **Benefit:** 75% = $1990.80 85% = $2545.90 **Future End Date:**
24109	19:21 HOURS TO 19:30 HOURS (113 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,678.10 **Benefit:** 75% = $2008.60 85% = $2569.60

	Future End Date:
24110	19:31 HOURS TO 19:40 HOURS (114 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,701.80 **Benefit:** 75% = $2026.35 85% = $2593.30 **Future End Date:**
24111	19:41 HOURS TO 19:50 HOURS (115 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,725.50 **Benefit:** 75% = $2044.15 85% = $2617.00 **Future End Date:**
24112	19:51 HOURS TO 20:00 HOURS (116 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,749.20 **Benefit:** 75% = $2061.90 85% = $2640.70 **Future End Date:**
24113	20:01 HOURS TO 20:10 HOURS (117 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,772.90 **Benefit:** 75% = $2079.70 85% = $2664.40 **Future End Date:**
24114	20:11 HOURS TO 20:20 HOURS (118 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,796.60 **Benefit:** 75% = $2097.45 85% = $2688.10 **Future End Date:**
24115	20:21 HOURS TO 20:30 HOURS (119 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,820.30 **Benefit:** 75% = $2115.25 85% = $2711.80 **Future End Date:**
24116	20:31 HOURS TO 20:40 HOURS (120 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,844.00 **Benefit:** 75% = $2133.00 85% = $2735.50 **Future End Date:**
24117	20:41 HOURS TO 20:50 HOURS (121 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,867.70 **Benefit:** 75% = $2150.80 85% = $2759.20 **Future End Date:**
24118	20:51 HOURS TO 21:00 HOURS (122 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,891.40 **Benefit:** 75% = $2168.55 85% = $2782.90 **Future End Date:**
24119	21:01 HOURS TO 21:10 HOURS (123 basic units)

	(See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,915.10 **Benefit:** 75% = $2186.35 85% = $2806.60 **Future End Date:**
24120	21:11 HOURS TO 21:20 HOURS (124 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,938.80 **Benefit:** 75% = $2204.10 85% = $2830.30 **Future End Date:**
24121	21:21 HOURS TO 21:30 HOURS (125 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,962.50 **Benefit:** 75% = $2221.90 85% = $2854.00 **Future End Date:**
24122	21:31 HOURS TO 21:40 HOURS (126 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $2,986.20 **Benefit:** 75% = $2239.65 85% = $2877.70 **Future End Date:**
24123	21:41 HOURS TO 21:50 HOURS (127 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $3,009.90 **Benefit:** 75% = $2257.45 85% = $2901.40 **Future End Date:**
24124	21:51 HOURS TO 22:00 HOURS (128 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $3,033.60 **Benefit:** 75% = $2275.20 85% = $2925.10 **Future End Date:**
24125	22:01 HOURS TO 22:10 HOURS (129 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $3,057.30 **Benefit:** 75% = $2293.00 85% = $2948.80 **Future End Date:**
24126	22:11 HOURS TO 22:20 HOURS (130 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $3,081.00 **Benefit:** 75% = $2310.75 85% = $2972.50 **Future End Date:**
24127	22:21 HOURS TO 22:30 HOURS (131 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $3,104.70 **Benefit:** 75% = $2328.55 85% = $2996.20 **Future End Date:**
24128	22:31 HOURS TO 22:40 HOURS (132 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $3,128.40 **Benefit:** 75% = $2346.30 85% = $3019.90 **Future End Date:**

24129	22:41 HOURS TO 22:50 HOURS (133 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $3,152.10 **Benefit:** 75% = $2364.10 85% = $3043.60 **Future End Date:**
24130	22:51 HOURS TO 23:00 HOURS (134 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $3,175.80 **Benefit:** 75% = $2381.85 85% = $3067.30 **Future End Date:**
24131	23:01 HOURS TO 23:10 HOURS (135 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $3,199.50 **Benefit:** 75% = $2399.65 85% = $3091.00 **Future End Date:**
24132	23:11 HOURS TO 23:20 HOURS (136 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $3,223.20 **Benefit:** 75% = $2417.40 85% = $3114.70 **Future End Date:**
24133	23:21 HOURS TO 23:30 HOURS (137 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $3,246.90 **Benefit:** 75% = $2435.20 85% = $3138.40 **Future End Date:**
24134	23:31 HOURS TO 23:40 HOURS (138 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $3,270.60 **Benefit:** 75% = $2452.95 85% = $3162.10 **Future End Date:**
24135	23:41 HOURS TO 23:50 HOURS (139 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $3,294.30 **Benefit:** 75% = $2470.75 85% = $3185.80 **Future End Date:**
24136	23:51 HOURS TO 24:00 HOURS (140 basic units) (See para TN.10.3 of explanatory notes to this Category) **Fee:** $3,318.00 **Benefit:** 75% = $2488.50 85% = $3209.50 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	22. ANAESTHESIA/PERFUSION MODIFYING UNITS - PHYSICAL STATUS
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 22. 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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $23.70 **Benefit:** 75% = $17.80 85% = $20.15 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $47.40 **Benefit:** 75% = $35.55 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $71.10 **Benefit:** 75% = $53.35 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	23. ANAESTHESIA/PERFUSION MODIFYING UNITS - OTHER
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 23. Anaesthesia/Perfusion Modifying Units - Other
25013	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is aged under 4 years (H) (1 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $23.70 **Benefit:** 75% = $17.80 **Future End Date:**
25014	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is aged 75 years or more (1 basic units) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $23.70 **Benefit:** 75% = $17.80 85% = $20.15 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	23. ANAESTHESIA/PERFUSION MODIFYING UNITS - OTHER
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $47.40 **Benefit:** 75% = $35.55 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	24. ANAESTHESIA AFTER HOURS EMERGENCY MODIFIER
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 24. 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) (See para GN.1.2 of explanatory notes to this Category) **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 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **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 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	25. PERFUSION AFTER HOURS EMERGENCY MODIFIER
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 25. Perfusion After Hours Emergency Modifier

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	25. 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) (See para GN.1.2 of explanatory notes to this Category) **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 **Future End Date:**

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE	26. ASSISTANCE AT ANAESTHESIA
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 26. 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) (See para GN.1.2, TN.10.9 of explanatory notes to this Category) **Derived Fee:** An amount of 5 base 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 **Future End Date:**
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) (See para GN.1.2, TN.10.9 of explanatory notes to this Category) **Derived Fee:** An amount of 5 base 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 22002 - 22051 **Future End Date:**

T11. BOTULINUM TOXIN INJECTIONS

	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 (See para TN.11.1 of explanatory notes to this Category) **Fee:** $149.45 **Benefit:** 75% = $112.10 85% = $127.05 **Future End Date:**
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 (See para TN.11.1 of explanatory notes to this Category) **Fee:** $149.45 **Benefit:** 75% = $112.10 85% = $127.05 **Future End Date:**
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 (See para TN.11.1 of explanatory notes to this Category) **Fee:** $298.85 **Benefit:** 75% = $224.15 85% = $254.05 **Future End Date:**
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.) (See para TN.7.5, TN.11.1 of explanatory notes to this Category)

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	Fee: $149.45 **Benefit:** 75% = $112.10 85% = $127.05 **Future End Date:**
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.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $149.45 **Benefit:** 75% = $112.10 85% = $127.05 **Future End Date:**
Amend 18360	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 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) the 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 (See para TN.11.1 of explanatory notes to this Category) **Fee:** $149.45 **Benefit:** 75% = $112.10 85% = $127.05 **Future End Date:**
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.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $149.45 **Benefit:** 75% = $112.10 85% = $127.05 **Future End Date:**
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

T11. BOTULINUM TOXIN INJECTIONS	
	(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.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $295.30 **Benefit:** 75% = $221.50 85% = $251.05 **Future End Date:**
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 (See para TN.11.1 of explanatory notes to this Category) **Fee:** $149.45 **Benefit:** 75% = $112.10 85% = $127.05 **Future End Date:**
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.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $187.25 **Benefit:** 75% = $140.45 85% = $159.20 **Future End Date:**
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 (See para TN.11.1 of explanatory notes to this Category) **Fee:** $319.60 **Benefit:** 75% = $239.70 85% = $271.70 **Future End Date:**
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.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $53.90 **Benefit:** 75% = $40.45 85% = $45.85 **Future End Date:**

T11. BOTULINUM TOXIN INJECTIONS	
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.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $53.90 **Benefit:** 75% = $40.45 85% = $45.85 **Future End Date:**
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.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $149.45 **Benefit:** 75% = $112.10 85% = $127.05 **Future End Date:**
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.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $149.45 **Benefit:** 75% = $112.10 85% = $127.05 **Future End Date:**
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

T11. BOTULINUM TOXIN INJECTIONS	
	(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.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $275.15 **Benefit:** 75% = $206.40 **Future End Date:**
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) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $149.45 **Benefit:** 75% = $112.10 85% = $127.05 **Future End Date:**
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

T11. BOTULINUM TOXIN INJECTIONS	
	(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.) (See para TN.11.1 of explanatory notes to this Category) **Fee:** $275.15 **Benefit:** 75% = $206.40 **Future End Date:**

CATEGORY 4: ORAL AND MAXILLOFACIAL SERVICES

SUMMARY OF CHANGES FROM 01/11/2026

The 01/11/2026 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

Description Amended
51700 51703

Changes to general medical services

From 1 November 2026, changes will be made relating to general medical services. These changes include:

- Administrative amendments to replace references to the term “residential aged care facility” with “residential care home” to align with terminology in the *Aged Care Act 2024*.

ORAL AND MAXILLOFACIAL SERVICES NOTES

ON.1.1 Benefits for Medical Services Performed by Approved Dental Practitioners

Under the provisions of the *Health Insurance Act 1973* (the Act), Medicare benefits are payable where an eligible person incurs medical expenses in respect of certain professional services rendered by a approved dental practitioner approved before 1 November 2004.

Category 4 is restricted to those dental practitioners who were approved by the Minister prior to 1November2004 for the provision of oral and maxillofacial surgery services and relevant attendances.

Approved dental practitioners may also request certain diagnostic imaging services - refer to Category 5 - Diagnostic Imaging Services for more information.

ON.1.2 Changes to the Scheme Effective from 1 November 2004

From 1 November 2004, access to Category 4 is restricted to those dental practitioners who were approved by the Minister prior to 1 November 2004. No new approvals will be granted after that date.

Background

Since 2000, practitioners performing oral and maxillofacial surgery in Australia are required to have both dental and medical qualifications in order to sit for their FRACDS(OMS) exam. This effectively means that since then, any practitioner who has obtained an FRACDS(OMS) or equivalent can access Category 3 of the MBS because they are medically qualified. The Government, in consultation with the Australian and New Zealand Association of Oral and Maxillofacial Surgeons, the Australian Dental Association, the Royal Australian College of Surgeons, the Royal Australian College of Dental Surgeons and the Australian Medical Association, has agreed that access by new practitioners to Category 4 will be withdrawn from 1November2004. Practitioners who were approved prior to that date will continue to have access to Category 4. The long-term proposal is that once all practitioners who currently access Category 4 have left the workforce, Category 4 will be removed from the Medicare Benefits Schedule.

Details of the services attracting Medicare benefits are set out in the Medicare Benefits Schedule.

ON.2.1 Definition of Oral and Maxillofacial Surgery

Oral and Maxillofacial Surgery is defined as the surgical specialty which deals with the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects of the oral and maxillofacial region.

ON.2.2 Services that can be provided by Eligible Dental Practitioners

Dental practitioners holding the FRACDS (OMS) or equivalent who were approved by the Minister prior to 1 November 2004 may perform prescribed oral and maxillofacial services listed under Category 4 - Oral and Maxillofacial Services of the MBS. All dental practitioners approved for the purposes of subsection 3(1) of the Act are also recognised to perform items of oral and maxillofacial surgery under Category 7 - Cleft and Craniofacial Services of the MBS.

The sole purpose of granting approval to dental practitioners is to enable payment of Medicare benefits.

The services set out under Category 4 - Oral and Maxillofacial Services and Category 7 - Cleft and Craniofacial Services are the only ones for which Medicare benefits are payable when the services are performed by an eligible dental practitioner.

ON.3.1 Principles of Interpretation

Each professional service listed in the Schedule is a complete medical service in itself. Where a service is rendered partly by one practitioner and partly by another, only the one amount of benefit is payable.

ON.3.2 Multiple Operation Rule

The Schedule fees for two or more operations performed on a patient on the one occasion are calculated by the following rule:-

100% for the item with the greatest Schedule fee, plus 50% for the item with the next greatest Schedule fee, plus 25% for each other item.

NOTE:

1. Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents

2. Where two or more operations performed on the one occasion have fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.

3. The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

The above rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient by different dental practitioners unless either practitioner assists the other. In this case, the fees and benefits specified in the Schedule apply. For these purposes the term "operation" includes all services in Groups O3 to O9.

If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

ON.3.3 After Care (Post-operative Treatment)

The fee specified for each of the operations listed in the Schedule contains a component for the consequential after-care customarily provided unless otherwise indicated. After-care is deemed to include all post-operative treatment rendered by practitioners and need not necessarily be limited to treatment given by the approved dental practitioner or to treatment given by any one practitioner. This does not preclude, however, the payment of benefit for professional services for the treatment by a dental practitioner of an intercurrent condition or an unusual complication arising from the operation.

Some minor operations are merely stages in the treatment of a particular condition. Professional services by dental practitioners subsequent to such operations should not be regarded as after-care but rather as continuation of the treatment of the original condition and should attract benefit. Item 52057 is a service to which this policy applies.

ON.3.4 Administration of Anaesthetics by Medical Practitioners

When a medical practitioner administers an anaesthetic in connection with a procedure prescribed for the payment of Medicare benefits (and the procedure has been performed by an approved dental practitioner), Medicare benefits are payable for the administration of the anaesthetic on the same basis as if the procedure had been rendered by a medical practitioner.

The Schedule fee for anaesthesia is established using the RVG schedule at Category 3 - Group T10.

Before the payment of benefits for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of additional details are required on the anaesthetist's account:

- The anaesthetist's account must show the name/s of the medical practitioner/s who performed the associated operation/s. Also, where the after hours emergency modifier applies to the anaesthesia service, the account must include the start time, the end time and the total time of the anaesthesia;

- The assistant anaesthetist's account must show the name/s of the medical practitioners who performed the associated operation/s, as well as the name of the principle anaesthetist. In addition, where the after hours emergency modifier applies, the assistant anaesthetist's account must record the start time, the end time and the total time for which he or she was providing professional attention to the patient during the anaesthesia.

ON.4.1 Consultations - (Items 51700 and 51703)

The consultation item numbers (51700 and 51703) are to be used by approved dental practitioners in the practice of oral and maxillofacial surgery.

The referral must be from a registered dental practitioner or a medical practitioner.

ON.4.2 Assistance at Operations - (Items 51800 and 51803)

Items covering operations which are eligible for benefits for assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery or surgical assistance have been identified by the inclusion of the word "Assist" in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

The assistance must be rendered by a practitioner other than the surgeon, the anaesthetist or the assistant anaesthetist.

Where more than one practitioner provides assistance to an approved dental practitioner no additional benefits are payable. The assistance benefit is the same irrespective of the number of practitioners providing assistance.

Benefits payable under item 51800

Medicare benefits are payable under Item 51800 for assistance rendered at the following procedures:

51900, 51904, 52010, 52018, 52039, 52048, 52051, 52062, 52063, 52066, 52078, 52090, 52092, 52095, 52105, 52108, 52111, 52130, 52138, 52141, 52144, 52147, 52182, 52300, 52303, 52312, 52315, 52321, 52324, 52336, 52339, 52424, 52440, 52452, 52480, 52482, 52600, 52603, 52609, 52612, 52615, 52624, 52626, 52627, 52800, 52803, 52806, 52809, 52818, 52824, 52828, 52830, 53006, 53009, 53016, 53215, 53220, 53225, 53226, 53236, 53239, 53242, 53406, 53409, 53412, 53413, 53415, 53416, 53453, 53460.

Where assistance with any of the above procedures is provided by a medical practitioner, benefits are payable under item 51300.

Benefits payable under Item 51803

Medicare benefits are payable under Item 51803 for assistance rendered at the following procedures:

51906, 52054, 52094, 52114, 52117, 52120, 52122, 52123, 52126, 52129, 52131, 52148, 52158, 52184, 52186, 52306, 52330, 52333, 52337, 52342, 52345, 52348, 52351, 52354, 52357, 52360, 52363, 52366, 52369, 52372, 52375, 52378, 52379, 52380, 52382, 52430, 52442, 52444, 52446, 52456, 52484, 52618, 52621, 52812, 52815, 52821, 52832, 53015, 53017, 53019, 53209, 53212, 53218, 53221, 53224, 53227, 53230, 53233, 53414, 53418, 53419, 53422, 53423, 53424, 53425, 53427, 53429, 53455.

or at a combination of procedures (including those identified as payable under item 51800 above) for which the aggregate fee exceeds the amount specified in the item.

Where assistance with any of the above procedures is provided by a medical practitioner, benefits are payable under Item 51303.

Assistance at multiple operations

Where assistance is provided at two or more operations performed on a patient on the one occasion the multi operation formula is applied to all the operations to determine the surgical fee payable to each approved dental

practitioner. The multi-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Items 51800/51300 or 51803/51303).

The derived fee applicable to Item 51803/51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery.

ON.4.3 Repair of Wound - (Item 51900)

Item 51900 covers debridement of "deep and extensively contaminated" wound. Benefits are not payable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures.

ON.4.4 Lipectomy, Wedge Excision - Two or More Excisions - (Item 51906)

Multiple lipectomies attract benefits under Item 51906 once only, i.e. the multiple operation rule does not apply.

Medicare benefits are not payable in respect of liposuction.

ON.4.5 Upper Aerodigestive Tract Endoscopic Procedure - (Item 52035)

The following are guidelines of appropriate minimum standards for the performance of GI endoscopy in relation to (a) cleaning, disinfection and sterilisation procedures, and (b) anaesthetic and resuscitation equipment. These guidelines are based on the advice of the Gastroenterological Society of Australia, the Sections of HPB and Upper GI and of Colon and Rectal Surgery of the Royal Australasian College of Surgeons, and the Colorectal Surgical Society of Australia.

Cleaning, disinfection and sterilisation procedures

Endoscopic procedures should be performed in facilities where endoscope and accessory reprocessing protocols follow procedures outlined in:-

(i) 'Infection and Endoscopy' (3rd edition), Gastroenterological Society of Australia;

(ii) 'Infection control in the health care setting - Guidelines for the prevention of transmission of infectious diseases', National Health and Medical Research Council; and

(iii) Australian Standard AS 4187-1994 (and Amendments), Standards Association of Australia.

Anaesthetic and resuscitation equipment

Where the patient is anaesthetised, anaesthetic equipment, administration and monitoring, and post operative and resuscitation facilities should conform to the standards outlined in 'Sedation for Endoscopy', Australian & New Zealand College of Anaesthetists, Gastroenterological Society of Australia and Royal Australasian College of Surgeons. These guidelines will be taken into account in determining appropriate practice in the context of the Professional Services Review process.

ON.4.6 Tumour, cyst, Ulcer or Scar - (Items 52036 to 52054)

It is recognised that odontogenic keratocysts, although not neoplastic, often require the surgical management of benign tumours.

ON.4.7 Aspiration of Haematoma - (Item 52056)

Aspiration of haematoma is indicated in clinical situations where incision may leave an unsightly scar or where access is difficult for conventional drainage.

ON.4.8 Osteotomy of Jaw - (Items 52342 to 52375)

The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site.

Bone grafts taken from a separate site, e.g. iliac crest, would attract additional benefit under Item 52318 or 52319 for the harvesting, plus item 52130 or 52131 for the grafting.

Where the site of grafting under item 52131 requires closure by single stage local flap, item 52300 may be claimed where clinically appropriate. Clinically appropriate in this instance means that the flap is required to close defects because the defect cannot be closed directly.

A local skin flap is an area of skin or subcutaneous tissue designed to be elevated from the skin adjoining a defect requiring closure. The flap remains partially attached by pedicle and is moved to the defect by rotation, advancement or transposition, or a combination of these manoeuvres.

Benefits are only payable where the flap is required for adequate wound closure. A secondary defect will be created which may be closed by direct suture, skin grafting or sometimes a further local skin flap. This latter procedure will also attract benefit if closed by graft or flap repair but not been closed by direct suture.

By definition, direct wound closure (e.g. by suture) does not constitute skin flap. Similarly, angled, curved or trapdoor incisions which are used for exposure and which are sutured back into the same position relative to the adjacent tissues are not skin flap repairs. Undermining of the edges of the wound prior to suturing is considered a normal part of wound closure and is not considered to skin flap repair.

For the purposes of these items, a reference to maxilla includes the zygoma.

ON.4.9 Genioplasty - (Item 52378)

Genioplasty attracts benefit once only although a section is made on both sides of the symphysis of the mandible.

ON.4.10 Fracture of Mandible or Maxilla - (Items 53400 to 53439)

There are two maxillae in the skull and for the purpose of these items the mandible is regarded as comprising two bones.

Hence a bilateral fracture of the mandible would be assessed as:

· Item 53409 x 1½;

· two maxillae and one side of the mandible as Item 53406 x 1½ + 53409 x ¼.

Splinting in Item 53406 or 53409 refers to cap splints, arch bars, silver (cast metal) or acrylic splints.

ON.4.12 Destruction of Nerve Branch by Neurolytic Agent - (Item 53706)

Item 53706 includes the use of botulinum toxin as a neurolytic agent.

ORAL AND MAXILLOFACIAL SERVICES ITEMS

O1. CONSULTATIONS	
	Group O1. Consultations
Amend 51700	APPROVED DENTAL PRACTITIONER, REFERRED CONSULTATION - SURGERY, HOSPITAL OR RESIDENTIAL CARE HOME 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 care home where the patient is referred to him or her (See para ON.4.1 of explanatory notes to this Category) **Fee:** $102.35 **Benefit:** 75% = $76.80 85% = $87.00 **Extended Medicare Safety Net Cap:** $307.05 **Future End Date:**
Amend 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 care home where the patient is referred to him or her (See para ON.4.1 of explanatory notes to this Category) **Fee:** $51.50 **Benefit:** 75% = $38.65 85% = $43.80 **Extended Medicare Safety Net Cap:** $154.50 **Future End Date:**

O1. CONSULTATIONS	1. DENTAL PRACTITIONER VIDEO SERVICES
	Group O1. Consultations
	Subgroup 1. dental practitioner video services
54001	Video attendance (other than a second or subsequent attendance in a single course of treatment) by an approved dental practitioner in the practice of oral and maxillofacial surgery, if the patient is referred to the approved dental practitioner **Fee:** $102.35 **Benefit:** 85% = $87.00 **Extended Medicare Safety Net Cap:** $307.05 **Future End Date:**
54002	Video attendance by an approved dental practitioner in the practice of oral and maxillofacial surgery, each attendance after the first in a single course of treatment, if the patient is referred to the approved dental practitioner **Fee:** $51.50 **Benefit:** 85% = $43.80 **Extended Medicare Safety Net Cap:** $154.50 **Future End Date:**

O1. CONSULTATIONS	2. DENTAL PRACTITIONER PHONE SERVICES
	Group O1. Consultations
	Subgroup 2. dental practitioner phone services
54004	Phone attendance by an approved dental practitioner in the practice of oral and maxillofacial surgery, each attendance after the first in a single course of treatment, if the patient is referred to the approved dental practitioner **Fee:** $51.50 **Benefit:** 85% = $43.80 **Extended Medicare Safety Net Cap:** $154.50

O1. CONSULTATIONS	2. DENTAL PRACTITIONER PHONE SERVICES
	Future End Date:

O2. ASSISTANCE AT OPERATION	
	Group O2. Assistance At Operation
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 $668.25 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 $668.25 (H) (See para GN.1.2, ON.4.2 of explanatory notes to this Category) **Fee:** $103.25 **Benefit:** 75% = $77.45 **Future End Date:**
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 $668.25 or at a series or combination of operations mentioned in an item that include "(Assist.)" if the aggregate fee exceeds $668.25 (See para ON.4.2 of explanatory notes to this Category) **Derived Fee:** one fifth of the established fee for the operation or combination of operations **Future End Date:**

O3. GENERAL SURGERY	
	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.) (See para ON.4.3 of explanatory notes to this Category) **Fee:** $390.25 **Benefit:** 75% = $292.70 85% = $331.75 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $88.50 **Benefit:** 75% = $66.40 **Future End Date:**
51904	Lipectomy—wedge excision of skin or fat—one excision (H) (Anaes.) (Assist.) **Fee:** $544.40 **Benefit:** 75% = $408.30 **Future End Date:**
51906	Lipectomy—wedge excision of skin or fat—2 or more excisions (H) (Anaes.) (Assist.) (See para ON.4.4 of explanatory notes to this Category) **Fee:** $827.90 **Benefit:** 75% = $620.95 **Future End Date:**
52000	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes.) **Fee:** $98.70 **Benefit:** 75% = $74.05 85% = $83.90 **Future End Date:**

O3. GENERAL SURGERY	
52003	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60 **Future End Date:**
52006	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes.) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60 **Future End Date:**
52009	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) **Fee:** $222.10 **Benefit:** 75% = $166.60 85% = $188.80 **Future End Date:**
52010	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.) **Fee:** $304.00 **Benefit:** 75% = $228.00 85% = $258.40 **Future End Date:**
52012	SUPERFICIAL FOREIGN BODY, removal of, as an independent procedure (Anaes.) **Fee:** $28.15 **Benefit:** 75% = $21.15 85% = $23.95 **Future End Date:**
52015	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and suture, as an independent procedure (Anaes.) **Fee:** $131.55 **Benefit:** 75% = $98.70 85% = $111.85 **Future End Date:**
52018	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60 **Future End Date:**
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.) **Fee:** $35.20 **Benefit:** 75% = $26.40 85% = $29.95 **Future End Date:**
52024	BIOPSY OF SKIN OR MUCOUS MEMBRANE, as an independent procedure (Anaes.) **Fee:** $62.55 **Benefit:** 75% = $46.95 85% = $53.20 **Future End Date:**
52025	LYMPH NODE OF NECK, biopsy of (Anaes.) **Fee:** $220.15 **Benefit:** 75% = $165.15 85% = $187.15 **Future End Date:**
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.) **Fee:** $179.25 **Benefit:** 75% = $134.45 85% = $152.40 **Future End Date:**
52030	SINUS, excision of, involving superficial tissue only (Anaes.)

O3. GENERAL SURGERY	
	Fee: $107.75 **Benefit:** 75% = $80.85 85% = $91.60 **Future End Date:**
52033	SINUS, excision of, involving muscle and deep tissue (Anaes.) **Fee:** $220.15 **Benefit:** 75% = $165.15 85% = $187.15 **Future End Date:**
52034	PREMALIGNANT LESIONS of the oral mucous, treatment by cryotherapy, diathermy or carbon dioxide laser **Fee:** $51.50 **Benefit:** 75% = $38.65 85% = $43.80 **Future End Date:**
52035	ENDOSCOPIC LASER THERAPY for neoplasia and benign vascular lesions of the oral cavity (Anaes.) (See para ON.4.5 of explanatory notes to this Category) **Fee:** $569.80 **Benefit:** 75% = $427.35 85% = $484.35 **Future End Date:**
52036	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 52039 applies (Anaes.) (See para ON.4.6 of explanatory notes to this Category) **Fee:** $151.95 **Benefit:** 75% = $114.00 85% = $129.20 **Future End Date:**
52039	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Anaes.) (Assist.) (See para ON.4.6 of explanatory notes to this Category) **Fee:** $390.25 **Benefit:** 75% = $292.70 85% = $331.75 **Future End Date:**
52042	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.) (See para ON.4.6 of explanatory notes to this Category) **Fee:** $206.45 **Benefit:** 75% = $154.85 85% = $175.50 **Future End Date:**
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.) (See para ON.4.6 of explanatory notes to this Category) **Fee:** $295.10 **Benefit:** 75% = $221.35 85% = $250.85 **Future End Date:**
52048	Tumour or deep cyst (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5 mm separation between the cyst lining and tooth structure or if a tumour or cyst has been proven by positive histopathology), removal of, requiring wide excision, other than a service to which another item in Groups O3 to O9 applies (H) (Anaes.) (Assist.)

O3. GENERAL SURGERY	
	(See para GN.1.2, ON.4.6 of explanatory notes to this Category) **Fee:** $444.65 **Benefit:** 75% = $333.50 **Future End Date:**
52051	Tumour, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (H) (Anaes.) (Assist.) (See para GN.1.2, ON.4.6 of explanatory notes to this Category) **Fee:** $601.15 **Benefit:** 75% = $450.90 **Future End Date:**
52054	Tumour, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (H) (Anaes.) (Assist.) (See para GN.1.2, ON.4.6 of explanatory notes to this Category) **Fee:** $703.25 **Benefit:** 75% = $527.45 **Future End Date:**
52055	HAEMATOMA, SMALL ABSCESS OR CELLULITIS, not requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding after care) **Fee:** $32.75 **Benefit:** 75% = $24.60 85% = $27.85 **Future End Date:**
52056	HAEMATOMA, aspiration of (Anaes.) (See para ON.4.7 of explanatory notes to this Category) **Fee:** $32.75 **Benefit:** 75% = $24.60 85% = $27.85 **Future End Date:**
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.) (See para GN.1.2, ON.3.3 of explanatory notes to this Category) **Fee:** $195.05 **Benefit:** 75% = $146.30 **Future End Date:**
52058	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS, using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $284.35 **Benefit:** 75% = $213.30 85% = $241.70 **Future End Date:**
52059	ABSCESS, DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $320.35 **Benefit:** 75% = $240.30 85% = $272.30 **Future End Date:**
52060	Muscle in the oral and maxillofacial region, excision of (H) (Anaes.) **Fee:** $226.75 **Benefit:** 75% = $170.10 **Future End Date:**
52061	Muscle, in the oral and maxillofacial region, ruptured, repair of (limited), not associated with external wound (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $267.60 **Benefit:** 75% = $200.70 **Future End Date:**
52062	Muscle, in the oral and maxillofacial region, ruptured, repair of (extensive), not associated with external wound (H) (Anaes.) (Assist.)

O3. GENERAL SURGERY	
	(See para GN.1.2 of explanatory notes to this Category) **Fee:** $353.90 **Benefit:** 75% = $265.45 **Future End Date:**
52063	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) **Fee:** $426.55 **Benefit:** 75% = $319.95 85% = $362.60 **Future End Date:**
52064	BONE CYST, injection into or aspiration of (Anaes.) **Fee:** $202.90 **Benefit:** 75% = $152.20 85% = $172.50 **Future End Date:**
52066	Submandibular gland, extirpation of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $533.15 **Benefit:** 75% = $399.90 **Future End Date:**
52069	Sublingual gland, extirpation of (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $237.65 **Benefit:** 75% = $178.25 **Future End Date:**
52072	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes.) **Fee:** $70.40 **Benefit:** 75% = $52.80 85% = $59.85 **Future End Date:**
52073	Salivary gland, repair of cutaneous fistula of (H) (Anaes.) **Fee:** $179.25 **Benefit:** 75% = $134.45 **Future End Date:**
52075	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures (Anaes.) **Fee:** $179.25 **Benefit:** 75% = $134.45 85% = $152.40 **Future End Date:**
52078	Tongue, partial excision of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $353.90 **Benefit:** 75% = $265.45 **Future End Date:**
52081	TONGUE TIE, division or excision of frenulum (Anaes.) **Fee:** $55.60 **Benefit:** 75% = $41.70 85% = $47.30 **Future End Date:**
52084	TONGUE TIE, MANDIBULAR FRENULUM OR MAXILLARY FRENULUM, division or excision of frenulum, in a patient aged not less than 2 years (Anaes.) **Fee:** $142.95 **Benefit:** 75% = $107.25 85% = $121.55 **Future End Date:**
52087	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.) **Fee:** $245.00 **Benefit:** 75% = $183.75 85% = $208.25 **Future End Date:**

O3. GENERAL SURGERY	
52090	OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes.) (Assist.) **Fee:** $426.55 **Benefit:** 75% = $319.95 85% = $362.60 **Future End Date:**
52092	Operation on skull for osteomyelitis (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $556.05 **Benefit:** 75% = $417.05 **Future End Date:**
52094	Operation on any combination of adjoining bones in the oral and maxillofacial region, being bones referred to in item 52092 (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $703.20 **Benefit:** 75% = $527.40 **Future End Date:**
52095	Bone growth stimulator in the oral and maxillofacial region, insertion of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $455.80 **Benefit:** 75% = $341.85 **Future End Date:**
52096	ORTHOPAEDIC PIN OR WIRE, insertion of, into maxilla or mandible or zygoma, as an independent procedure (Anaes.) **Fee:** $135.05 **Benefit:** 75% = $101.30 85% = $114.80 **Future End Date:**
52097	EXTERNAL FIXATION, removal of, in the operating theatre of a hospital (Anaes.) **Fee:** $191.60 **Benefit:** 75% = $143.70 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $225.25 **Benefit:** 75% = $168.95 **Future End Date:**
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.) **Fee:** $169.00 **Benefit:** 75% = $126.75 85% = $143.65 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $169.00 **Benefit:** 75% = $126.75 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $315.50 **Benefit:** 75% = $236.65

O3. GENERAL SURGERY	
	Future End Date:
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.) **Fee:** $130.35 **Benefit:** 75% = $97.80 **Future End Date:**
52108	LIP, full thickness wedge excision of, with repair by direct sutures (Anaes.) (Assist.) **Fee:** $390.25 **Benefit:** 75% = $292.70 85% = $331.75 **Future End Date:**
52111	VERMILIONECTOMY (Anaes.) (Assist.) **Fee:** $390.25 **Benefit:** 75% = $292.70 85% = $331.75 **Future End Date:**
52114	Mandible or maxilla, segmental resection of, for tumours or cysts (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $703.25 **Benefit:** 75% = $527.45 **Future End Date:**
52117	Mandible, including lower border, or maxilla, sub-total resection of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $837.15 **Benefit:** 75% = $627.90 **Future End Date:**
52120	Mandible, hemimandiblectomy of, including condylectomy, if performed (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $990.20 **Benefit:** 75% = $742.65 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $990.20 **Benefit:** 75% = $742.65 **Future End Date:**
52123	Mandible, total resection of both sides, including condylectomies if performed (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,121.00 **Benefit:** 75% = $840.75 **Future End Date:**
52126	Maxilla, total resection of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,077.70 **Benefit:** 75% = $808.30 **Future End Date:**
52129	Maxilla, total resection of both maxillae (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,442.70 **Benefit:** 75% = $1082.05 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category)

O3. GENERAL SURGERY	
	Fee: $529.55 **Benefit:** 75% = $397.20 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $732.50 **Benefit:** 75% = $549.40 **Future End Date:**
52132	TRACHEOSTOMY (Anaes.) **Fee:** $298.00 **Benefit:** 75% = $223.50 85% = $253.30 **Future End Date:**
52133	CRICOTHYROSTOMY by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.) **Fee:** $108.95 **Benefit:** 75% = $81.75 85% = $92.65 **Future End Date:**
52135	POST-OPERATIVE or POST-NASAL HAEMORRHAGE, or both, control of, where undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $172.80 **Benefit:** 75% = $129.60 **Future End Date:**
52138	Maxillary artery, ligation of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $536.85 **Benefit:** 75% = $402.65 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $531.10 **Benefit:** 75% = $398.35 **Future End Date:**
52144	Foreign body, deep, removal of using interventional imaging techniques (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $495.00 **Benefit:** 75% = $371.25 **Future End Date:**
52147	Duct of major salivary gland, transposition of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $467.10 **Benefit:** 75% = $350.35 **Future End Date:**
52148	Parotid duct, repair of, using micro-surgical techniques (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $825.65 **Benefit:** 75% = $619.25 **Future End Date:**
52158	Submandibular ducts, relocation of, for surgical control of drooling (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,329.35 **Benefit:** 75% = $997.05 **Future End Date:**
52180	MALIGNANT DISEASE

O3. GENERAL SURGERY	
	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, biopsy of (not including aftercare) (Anaes.) **Fee:** $225.25 **Benefit:** 75% = $168.95 85% = $191.50 **Future End Date:**
52182	Bone or malignant deep soft tissue tumour in the oral and maxillofacial region, lesional or marginal excision of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $495.80 **Benefit:** 75% = $371.85 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $732.50 **Benefit:** 75% = $549.40 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $901.55 **Benefit:** 75% = $676.20 **Future End Date:**

O4. PLASTIC & RECONSTRUCTIVE	
	Group O4. Plastic & Reconstructive
52300	SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, with skin or mucosa (Anaes.) (Assist.) **Fee:** $340.30 **Benefit:** 75% = $255.25 85% = $289.30 **Future End Date:**
52303	Single-stage local flap, if indicated, repair to one defect, with buccal pad of fat (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $485.95 **Benefit:** 75% = $364.50 **Future End Date:**
52306	Single-stage local flap, if indicated, repair to one defect, using temporalis muscle (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $721.10 **Benefit:** 75% = $540.85 **Future End Date:**
52309	FREE GRAFTING (mucosa or split skin) of a granulating area (Anaes.) **Fee:** $245.00 **Benefit:** 75% = $183.75 85% = $208.25 **Future End Date:**
52312	FREE GRAFTING (mucosa, split skin or connective tissue) to 1 defect, including elective dissection (Anaes.) (Assist.) **Fee:** $340.30 **Benefit:** 75% = $255.25 85% = $289.30 **Future End Date:**
52315	FREE GRAFTING, FULL THICKNESS, to 1 defect (mucosa or skin) (Anaes.) (Assist.) **Fee:** $567.05 **Benefit:** 75% = $425.30 85% = $482.00 **Future End Date:**

O4. PLASTIC & RECONSTRUCTIVE	
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $169.00 **Benefit:** 75% = $126.75 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $281.85 **Benefit:** 75% = $211.40 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $567.05 **Benefit:** 75% = $425.30 **Future End Date:**
52324	Direct flap repair, using tongue, first stage (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $567.05 **Benefit:** 75% = $425.30 **Future End Date:**
52327	Direct flap repair, using tongue, second stage (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $281.40 **Benefit:** 75% = $211.05 **Future End Date:**
52330	Palatal defect (oro-nasal fistula), plastic closure of, including services to which item 52300, 52303, 52306 or 52324 applies (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $935.85 **Benefit:** 75% = $701.90 **Future End Date:**
52333	Cleft palate, primary repair (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $935.85 **Benefit:** 75% = $701.90 **Future End Date:**
52336	Cleft palate, secondary repair, closure of fistula using local flaps (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $585.05 **Benefit:** 75% = $438.80 **Future End Date:**
52337	Alveolar cleft (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,279.65 **Benefit:** 75% = $959.75 **Future End Date:**
52339	Cleft palate, secondary repair, lengthening procedure (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $666.20 **Benefit:** 75% = $499.65 **Future End Date:**

O4. PLASTIC & RECONSTRUCTIVE	
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.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,157.15 **Benefit:** 75% = $867.90 **Future End Date:**
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.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,304.95 **Benefit:** 75% = $978.75 **Future End Date:**
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.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,474.65 **Benefit:** 75% = $1106.00 **Future End Date:**
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.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,656.15 **Benefit:** 75% = $1242.15 **Future End Date:**
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.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,678.95 **Benefit:** 75% = $1259.25 **Future End Date:**
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.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,890.15 **Benefit:** 75% = $1417.65 **Future End Date:**
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.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,928.20 **Benefit:** 75% = $1446.15 **Future End Date:**
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.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $2,169.10 **Benefit:** 75% = $1626.85 **Future End Date:**

O4. PLASTIC & RECONSTRUCTIVE	
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.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $2,121.25 **Benefit:** 75% = $1590.95 **Future End Date:**
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.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $2,385.10 **Benefit:** 75% = $1788.85 **Future End Date:**
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.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $2,314.30 **Benefit:** 75% = $1735.75 **Future End Date:**
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.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $2,592.15 **Benefit:** 75% = $1944.15 **Future End Date:**
52378	Genioplasty including transposition of nerves and vessels and bone grafts taken from the same site (H) (Anaes.) (Assist.) (See para GN.1.2, ON.4.9 of explanatory notes to this Category) **Fee:** $896.05 **Benefit:** 75% = $672.05 **Future End Date:**
52379	Face, contour reconstruction of one region, using autogenous bone or cartilage graft (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,531.35 **Benefit:** 75% = $1148.55 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $2,607.55 **Benefit:** 75% = $1955.70 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $3,125.85 **Benefit:** 75% = $2344.40

O4. PLASTIC & RECONSTRUCTIVE	
	Future End Date:
52420	Mandible, fixation by intermaxillary wiring, excluding wiring for obesity (H) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $288.60 **Benefit:** 75% = $216.45 **Future End Date:**
52424	Dermis, dermofat or fascia graft (excluding transfer of fat by injection) in the oral and maxillofacial region (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $566.95 **Benefit:** 75% = $425.25 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,304.95 **Benefit:** 75% = $978.75 **Future End Date:**
52440	Cleft lip, unilateral—primary repair, one stage, without anterior palate repair (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $647.85 **Benefit:** 75% = $485.90 **Future End Date:**
52442	Cleft lip, unilateral—primary repair, one stage, with anterior palate repair (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $810.05 **Benefit:** 75% = $607.55 **Future End Date:**
52444	Cleft lip, bilateral—primary repair, one stage, without anterior palate repair (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $899.85 **Benefit:** 75% = $674.90 **Future End Date:**
52446	Cleft lip, bilateral—primary repair, one stage, with anterior palate repair (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,062.30 **Benefit:** 75% = $796.75 **Future End Date:**
52450	Cleft lip, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $359.95 **Benefit:** 75% = $270.00 **Future End Date:**
52452	Cleft lip, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $585.05 **Benefit:** 75% = $438.80 **Future End Date:**
52456	Cleft lip reconstruction using full thickness flap (Abbe or similar), first stage (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $990.20 **Benefit:** 75% = $742.65 **Future End Date:**
52458	Cleft lip reconstruction using full thickness flap (Abbe or similar), second stage (H) (Anaes.)

O4. PLASTIC & RECONSTRUCTIVE	
	(See para GN.1.2 of explanatory notes to this Category) **Fee:** $359.95 **Benefit:** 75% = $270.00 **Future End Date:**
52460	Velo-pharyngeal incompetence, pharyngeal flap for, or pharyngoplasty for (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $935.85 **Benefit:** 75% = $701.90 **Future End Date:**
52480	Composite graft (chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $601.15 **Benefit:** 75% = $450.90 **Future End Date:**
52482	Macrocheilia or macroglossia, operation for (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $578.40 **Benefit:** 75% = $433.80 **Future End Date:**
52484	Macrostomia, operation for (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $688.60 **Benefit:** 75% = $516.45 **Future End Date:**

O5. PREPROSTHETIC	
	Group O5. Preprosthetic
52600	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.) **Fee:** $405.00 **Benefit:** 75% = $303.75 85% = $344.25 **Future End Date:**
52603	Mylohyoid ridge, reduction of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $387.05 **Benefit:** 75% = $290.30 **Future End Date:**
52606	MAXILLARY TUBEROSITY, reduction of (Anaes.) **Fee:** $295.30 **Benefit:** 75% = $221.50 85% = $251.05 **Future End Date:**
52609	Papillary hyperplasia of the palate, removal of—less than 5 lesions (H) (Anaes.) (Assist.) **Fee:** $387.05 **Benefit:** 75% = $290.30 **Future End Date:**
52612	Papillary hyperplasia of the palate, removal of—5 to 20 lesions (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $485.95 **Benefit:** 75% = $364.50 **Future End Date:**
52615	Papillary hyperplasia of the palate, removal of—more than 20 lesions (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $603.15 **Benefit:** 75% = $452.40 **Future End Date:**

O5. PREPROSTHETIC	
52618	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.) **Fee:** $702.00 **Benefit:** 75% = $526.50 85% = $596.70 **Future End Date:**
52621	Floor of mouth lowering (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed—unilateral (H) (Anaes.) (Assist.) **Fee:** $702.00 **Benefit:** 75% = $526.50 **Future End Date:**
52624	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.) **Fee:** $566.95 **Benefit:** 75% = $425.25 85% = $481.95 **Future End Date:**
52626	Alveolar ridge augmentation—unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $347.75 **Benefit:** 75% = $260.85 **Future End Date:**
52627	OSSEO-INTEGRATION PROCEDURE - in the practice of oral and maxillofacial surgery, extra oral implantation of titanium fixture (Anaes.) (Assist.) **Fee:** $603.15 **Benefit:** 75% = $452.40 85% = $512.70 **Future End Date:**
52630	OSSEO-INTEGRATION PROCEDURE - in the practice of oral and maxillofacial surgery, fixation of transcutaneous abutment (Anaes.) **Fee:** $223.25 **Benefit:** 75% = $167.45 85% = $189.80 **Future End Date:**
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.) **Fee:** $603.15 **Benefit:** 75% = $452.40 85% = $512.70 **Future End Date:**
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.) **Fee:** $223.25 **Benefit:** 75% = $167.45 85% = $189.80 **Future End Date:**

O6. NEUROSURGICAL	
	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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $331.25 **Benefit:** 75% = $248.45 **Future End Date:**
52803	Nerve trunk, internal (interfascicular), neurolysis of, using microsurgical techniques (H) (Anaes.) (Assist.)

O6. NEUROSURGICAL	
	(See para GN.1.2 of explanatory notes to this Category) **Fee:** $477.05 **Benefit:** 75% = $357.80 **Future End Date:**
52806	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from superficial peripheral nerve (Anaes.) (Assist.) **Fee:** $331.25 **Benefit:** 75% = $248.45 85% = $281.60 **Future End Date:**
52809	Neurectomy, neurotomy or removal of tumour from deep peripheral nerve (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $567.05 **Benefit:** 75% = $425.30 **Future End Date:**
52812	Nerve trunk, primary repair of, using microsurgical techniques (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $810.05 **Benefit:** 75% = $607.55 **Future End Date:**
52815	Nerve trunk, secondary repair of, using microsurgical techniques (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $855.05 **Benefit:** 75% = $641.30 **Future End Date:**
52818	Nerve, transposition of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $567.05 **Benefit:** 75% = $425.30 **Future End Date:**
52821	Nerve graft to nerve trunk (cable graft) including harvesting of nerve graft using microsurgical techniques (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,233.05 **Benefit:** 75% = $924.80 **Future End Date:**
52824	Peripheral branches of the trigeminal nerve, cryosurgery of, for pain relief (H) (Anaes.) (Assist.) **Fee:** $531.10 **Benefit:** 75% = $398.35 **Future End Date:**
52826	Injection of primary branch of trigeminal nerve with alcohol, cortisone, phenol, or similar substance (H) (Anaes.) **Fee:** $284.35 **Benefit:** 75% = $213.30 **Future End Date:**
52828	Cutaneous nerve, primary repair of, using microsurgical techniques (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $422.95 **Benefit:** 75% = $317.25 **Future End Date:**
52830	Cutaneous nerve, secondary repair of, using microsurgical techniques (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $557.90 **Benefit:** 75% = $418.45 **Future End Date:**

O6. NEUROSURGICAL	
52832	CUTANEOUS NERVE, nerve graft to, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $765.20 **Benefit:** 75% = $573.90 85% = $656.70 **Future End Date:**

O7. EAR, NOSE & THROAT	
	Group O7. Ear, Nose & Throat
53000	MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.) **Fee:** $39.00 **Benefit:** 75% = $29.25 85% = $33.15 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $110.00 **Benefit:** 75% = $82.50 **Future End Date:**
53004	MAXILLARY ANTRUM, LAVAGE OF - each attendance at which the procedure is performed, including any associated consultation (Anaes.) **Fee:** $42.60 **Benefit:** 75% = $31.95 85% = $36.25 **Future End Date:**
53006	Antrostomy (radical) (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $623.95 **Benefit:** 75% = $468.00 **Future End Date:**
53009	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.) **Fee:** $353.90 **Benefit:** 75% = $265.45 85% = $300.85 **Future End Date:**
53012	ANTRUM, drainage of, through tooth socket (Anaes.) **Fee:** $140.70 **Benefit:** 75% = $105.55 85% = $119.60 **Future End Date:**
53015	Oro-antral fistula, plastic closure of (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $703.25 **Benefit:** 75% = $527.45 85% = $597.80 **Future End Date:**
53016	Nasal septum, septoplasty, submucous resection or closure of septal perforation (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $578.40 **Benefit:** 75% = $433.80 **Future End Date:**
53017	Nasal septum, reconstruction of (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $721.65 **Benefit:** 75% = $541.25 **Future End Date:**
53019	Maxillary sinus, bone graft to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), unilateral (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $695.30 **Benefit:** 75% = $521.50

O7. EAR, NOSE & THROAT	
	Future End Date:
53052	POST-NASAL SPACE, direct examination of, with or without biopsy (Anaes.) **Fee:** $146.95 **Benefit:** 75% = $110.25 85% = $124.95 **Future End Date:**
53054	NASENDOSCOPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX one or more of these procedures (Anaes.) **Fee:** $146.95 **Benefit:** 75% = $110.25 85% = $124.95 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $86.10 **Benefit:** 75% = $64.60 **Future End Date:**
53058	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.) **Fee:** $146.95 **Benefit:** 75% = $110.25 85% = $124.95 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $120.25 **Benefit:** 75% = $90.20 **Future End Date:**
53062	POST SURGICAL NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.) **Fee:** $107.75 **Benefit:** 75% = $80.85 85% = $91.60 **Future End Date:**
53064	CRYOTHERAPY TO NOSE in the treatment of nasal haemorrhage (Anaes.) **Fee:** $195.05 **Benefit:** 75% = $146.30 85% = $165.80 **Future End Date:**
53068	Turbinectomy or turbinectomies, partial or total, unilateral (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $163.40 **Benefit:** 75% = $122.55 **Future End Date:**
53070	Turbinates, submucous resection of, unilateral (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $213.05 **Benefit:** 75% = $159.80 **Future End Date:**

O8. TEMPOROMANDIBULAR JOINT	
	Group O8. Temporomandibular Joint
53200	MANDIBLE, treatment of a dislocation of, not requiring open reduction (Anaes.) **Fee:** $84.65 **Benefit:** 75% = $63.50 85% = $72.00

O8. TEMPOROMANDIBULAR JOINT	
	Future End Date:
	Mandible, treatment of a dislocation of, requiring open reduction (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $142.05 **Benefit:** 75% = $106.55
53203	**Future End Date:**
	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.) **Fee:** $171.20 **Benefit:** 75% = $128.40
53206	**Future End Date:**
	Glenoid fossa, zygomatic arch and temporal bone, reconstruction of (Obwegeser technique) (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,973.85 **Benefit:** 75% = $1480.40
53209	**Future End Date:**
	Absent condyle and ascending ramus in hemifacial microsomia, construction of, not including harvesting of graft material (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,066.25 **Benefit:** 75% = $799.70
53212	**Future End Date:**
	Temporomandibular joint, arthroscopy of, with or without biopsy, other than a service associated with another arthroscopic procedure of that joint (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $489.25 **Benefit:** 75% = $366.95
53215	**Future End Date:**
	Temporomandibular joint, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions—one or more of such procedures (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $782.60 **Benefit:** 75% = $586.95
53218	**Future End Date:**
	Temporomandibular joint, arthrotomy of, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $394.45 **Benefit:** 75% = $295.85
53220	**Future End Date:**
	Temporomandibular joint, open surgical exploration of, with or without microsurgical techniques (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,044.05 **Benefit:** 75% = $783.05
53221	**Future End Date:**
	Temporomandibular joint, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,157.40 **Benefit:** 75% = $868.05
53224	**Future End Date:**
	Arthrocentesis, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space (Anaes.) (Assist.)
53225	

O8. TEMPOROMANDIBULAR JOINT	
	(See para GN.1.2 of explanatory notes to this Category) **Fee:** $347.75 **Benefit:** 75% = $260.85 85% = $295.60 **Future End Date:**
53226	Temporomandibular joint, synovectomy of, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $373.80 **Benefit:** 75% = $280.35 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,422.15 **Benefit:** 75% = $1066.65 **Future End Date:**
53230	Temporomandibular joint, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,602.00 **Benefit:** 75% = $1201.50 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,800.15 **Benefit:** 75% = $1350.15 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $563.40 **Benefit:** 75% = $422.55 **Future End Date:**
53239	Temporomandibular joint, arthrodesis of, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $563.40 **Benefit:** 75% = $422.55 **Future End Date:**
53242	Temporomandibular joint or joints, application of external fixator to, other than for treatment of fractures (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $373.80 **Benefit:** 75% = $280.35 **Future End Date:**

O9. TREATMENT OF FRACTURES	
	Group O9. Treatment Of Fractures
53400	MAXILLA, unilateral or bilateral, treatment of fracture of, not requiring splinting (See para ON.4.10 of explanatory notes to this Category) **Fee:** $154.60 **Benefit:** 75% = $115.95 85% = $131.45

O9. TREATMENT OF FRACTURES	
	Future End Date:
53403	MANDIBLE, treatment of fracture of, not requiring splinting (See para ON.4.10 of explanatory notes to this Category) **Fee:** $188.95 **Benefit:** 75% = $141.75 85% = $160.65 **Future End Date:**
53406	Maxilla, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (H) (Anaes.) (Assist.) (See para GN.1.2, ON.4.10 of explanatory notes to this Category) **Fee:** $486.65 **Benefit:** 75% = $365.00 **Future End Date:**
53409	Mandible, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (H) (Anaes.) (Assist.) (See para GN.1.2, ON.4.10 of explanatory notes to this Category) **Fee:** $486.65 **Benefit:** 75% = $365.00 **Future End Date:**
53410	ZYGOMATIC BONE, treatment of fracture of, not requiring surgical reduction (See para ON.4.10 of explanatory notes to this Category) **Fee:** $102.50 **Benefit:** 75% = $76.90 85% = $87.15 **Future End Date:**
53411	Zygomatic bone, treatment of fracture of, requiring surgical reduction, by temporal, intra-oral or other approach (H) (Anaes.) (See para GN.1.2, ON.4.10 of explanatory notes to this Category) **Fee:** $285.85 **Benefit:** 75% = $214.40 **Future End Date:**
53412	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at one site (H) (Anaes.) (Assist.) (See para GN.1.2, ON.4.10 of explanatory notes to this Category) **Fee:** $469.30 **Benefit:** 75% = $352.00 **Future End Date:**
53413	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (H) (Anaes.) (Assist.) (See para GN.1.2, ON.4.10 of explanatory notes to this Category) **Fee:** $574.95 **Benefit:** 75% = $431.25 **Future End Date:**
53414	Zygomatic bone, treatment of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (H) (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $660.50 **Benefit:** 75% = $495.40 **Future End Date:**
53415	Maxilla, treatment of fracture of, requiring open reduction (H) (Anaes.) (Assist.) (See para GN.1.2, ON.4.10 of explanatory notes to this Category) **Fee:** $521.45 **Benefit:** 75% = $391.10 **Future End Date:**
53416	Mandible, treatment of fracture of, requiring open reduction (H) (Anaes.) (Assist.) (See para GN.1.2, ON.4.10 of explanatory notes to this Category) **Fee:** $521.45 **Benefit:** 75% = $391.10 **Future End Date:**

O9. TREATMENT OF FRACTURES	
53418	Maxilla, treatment of fracture of, requiring open reduction and internal fixation not involving a plate (H) (Anaes.) (Assist.) (See para GN.1.2, ON.4.10 of explanatory notes to this Category) **Fee:** $677.90 **Benefit:** 75% = $508.45 **Future End Date:**
53419	Mandible, treatment of fracture of, requiring open reduction and internal fixation not involving a plate (H) (Anaes.) (Assist.) (See para GN.1.2, ON.4.10 of explanatory notes to this Category) **Fee:** $677.90 **Benefit:** 75% = $508.45 **Future End Date:**
53422	Maxilla, treatment of fracture of, requiring open reduction and internal fixation involving a plate (H) (Anaes.) (Assist.) (See para GN.1.2, ON.4.10 of explanatory notes to this Category) **Fee:** $860.25 **Benefit:** 75% = $645.20 **Future End Date:**
53423	Mandible, treatment of fracture of, requiring open reduction and internal fixation involving a plate (H) (Anaes.) (Assist.) (See para GN.1.2, ON.4.10 of explanatory notes to this Category) **Fee:** $860.25 **Benefit:** 75% = $645.20 **Future End Date:**
53424	Maxilla, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving a plate (H) (Anaes.) (Assist.) (See para GN.1.2, ON.4.10 of explanatory notes to this Category) **Fee:** $738.00 **Benefit:** 75% = $553.50 **Future End Date:**
53425	Mandible, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving a plate (H) (Anaes.) (Assist.) (See para GN.1.2, ON.4.10 of explanatory notes to this Category) **Fee:** $738.00 **Benefit:** 75% = $553.50 **Future End Date:**
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.) (See para GN.1.2, ON.4.10 of explanatory notes to this Category) **Fee:** $1,008.10 **Benefit:** 75% = $756.10 **Future End Date:**
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.) (See para GN.1.2, ON.4.10 of explanatory notes to this Category) **Fee:** $1,008.10 **Benefit:** 75% = $756.10 **Future End Date:**
53439	MANDIBLE, treatment of a closed fracture of, involving a joint surface (Anaes.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $285.85 **Benefit:** 75% = $214.40 85% = $243.00 **Future End Date:**
53453	Orbital cavity, reconstruction of a wall or floor with or without foreign implant (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $578.40 **Benefit:** 75% = $433.80

O9. TREATMENT OF FRACTURES	
	Future End Date:
53455	Orbital cavity, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $679.35 **Benefit:** 75% = $509.55 **Future End Date:**
53458	NASAL BONES, treatment of fracture of, not being a service to which item 53459 or 53460 applies **Fee:** $51.55 **Benefit:** 75% = $38.70 85% = $43.85 **Future End Date:**
53459	NASAL BONES, treatment of fracture of, by reduction (Anaes.) **Fee:** $281.85 **Benefit:** 75% = $211.40 85% = $239.60 **Future End Date:**
53460	Nasal bones, treatment of fractures of, by open reduction involving osteotomies (H) (Anaes.) (Assist.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $574.95 **Benefit:** 75% = $431.25 **Future End Date:**

O11. REGIONAL OR FIELD NERVE BLOCKS	
	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 **Fee:** $149.45 **Benefit:** 75% = $112.10 85% = $127.05 **Future End Date:**
53702	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent **Fee:** $74.85 **Benefit:** 75% = $56.15 85% = $63.65 **Future End Date:**
53704	FACIAL NERVE, injection of an anaesthetic agent **Fee:** $45.10 **Benefit:** 75% = $33.85 85% = $38.35 **Future End Date:**
53706	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies (See para ON.4.12 of explanatory notes to this Category) **Fee:** $149.45 **Benefit:** 75% = $112.10 85% = $127.05 **Future End Date:**

CATEGORY 5: DIAGNOSTIC IMAGING SERVICES

SUMMARY OF CHANGES FROM 01/11/2026

The 01/11/2026 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

Description Amended

57541 61564

Changes relating to diagnostic imaging services

From 1 November 2026, changes will be made relating to diagnostic imaging services. This includes:

- Enabling the maximum benefit payable for item 61438 for patients accessing this nuclear medicine imaging service;
- Amending the frequency restriction for item 61564 for prostate-specific membrane antigen positron emission tomography studies for the restaging of recurrent prostate adenocarcinoma to allow the service to apply once in a 12-month period;
- Administrative amendments to replace references to the term “residential aged care facility” with “residential care home” to align with terminology in the *Aged Care Act 2024*;
- Administrative amendments to align Modified Monash (MM) location classifications with the most recent 2023 MM location categories.

DIAGNOSTIC IMAGING SERVICES NOTES

IN.0.1 Diagnostic Imaging Services – Overview

Section 4AA of the *Health Insurance Act 1973* (the Act) enables the *Health Insurance (Diagnostic Imaging Services Table) Regulations* to prescribe a table of diagnostic imaging services that sets out rules for interpretation of the table, items of diagnostic imaging services and the amount of fees applicable to each item. For further information on diagnostic imaging, visit the Department of Health, Disability and Ageing's website.

IN.0.2 What is a Diagnostic Imaging Service and who may provide a service

What is a diagnostic imaging service

A diagnostic imaging service is defined in the Act as "an R-type diagnostic imaging service or an NR-type diagnostic imaging service to which an item in the DIST applies".

A diagnostic imaging service includes the diagnostic imaging procedure, which is defined in the Act as 'a procedure for the production of images (for example x-rays, computerised tomography scans, ultrasound scans, magnetic resonance imaging scans and nuclear scans) for use in the rendering of diagnostic imaging services as well as the report'.

The Schedule fee for each diagnostic imaging service described in the DIST covers both the diagnostic imaging procedure and the reading and report on that procedure by the diagnostic imaging service provider. Exceptions to the reporting requirement are as follows:

- where the service is provided in conjunction with a surgical procedure, the findings may be noted on the operation record (items 55054, 55130, 55135, 55848, 57341, 59312, 59314, 60506, 60509 and 61109);

- where a service is provided in preparation of a radiological procedure (items 60918 and 60927).

As for all Medicare services, diagnostic imaging services have to be clinically relevant before they are eligible for Medicare benefits. A clinically relevant service is a service that is generally accepted by the profession as being necessary for the appropriate treatment of the patient.

For R-type services rendered at the request of another practitioner, responsibility for determining the clinical relevance of the service lies with the requesting practitioner. For NR-type services (and R-type services provided without a request under the exemption provisions - see IN.0.6 - 'Exemptions from the written request requirements for R-type diagnostic imaging services'), the clinical relevance of the service is determined by the providing practitioner.

Who may provide a diagnostic imaging service

Unless otherwise stated, a diagnostic imaging service specified in the DIST may be provided by:

a) a medical practitioner; or

b) a person, other than a medical practitioner, who provides the service under the supervision of a medical practitioner in accordance with accepted medical practice.

For the purposes of Medicare, however, the rendering practitioner is the medical practitioner who provides the report.

Medicare benefits are not payable, for example, when a medical practitioner refers patients to self-employed paramedical personnel, such as radiographers or other persons, who either bill the patient or the practitioner requesting the service.

Reports provided by practitioners located outside Australia

Under the Act, Medicare benefits are only payable for services rendered in Australia. Where a service consists of a number of components, such as a diagnostic imaging service, all components need to be rendered in Australia in order to qualify for Medicare benefits. For diagnostic imaging services, this means that all elements of the service, including the preparation of report on the procedure, would need to be rendered in Australia.

IN.0.3 Registration of Sites Undertaking Diagnostic Imaging Procedures

All sites (including hospitals) and bases for mobile equipment at or from which diagnostic imaging procedures are performed need to be registered with Services Australia in order for Medicare benefits to be payable for diagnostic imaging procedures provided at the site, or in the case of procedures reported remotely, for procedures reported for the site.

Registered sites and bases for mobile equipment are allocated a Location Specific Practice Number (LSPN). The LSPN is a unique identifier comprising a six digit numeric and is required on all accounts, receipts and Medicare assignment of benefits agreement for diagnostic imaging services before patients can receive Medicare benefits. In addition, benefits are not payable unless there is equipment of appropriate type listed on the register for the practice.

Sites or bases for mobile equipment need only register once. To maintain registration, sites are required to advise of any changes to their primary information within 28 days of the change occurring. Primary information is:

- proprietor details;
- ACN (for companies);
- business name and ABN;
- address of practice site or base for mobile equipment;
- type of equipment located at the site;
- information about any health care provider not employed at, or contracted to provide services for the site or base, who has an interest in any of the equipment listed on the register.

Suspension or Cancellation

Registration will be suspended if a proprietor fails to respond to notices from Services Australia about registration details. The suspension will be lifted as soon as the notices are responded to and Medicare benefits will be backdated for the period of suspension.

Registration will be cancelled after a continuous period of three months suspension. Cancellation under these circumstances is taken to have commenced from the date of suspension.

The proprietor may, at any time, request cancellation of the registration of a practice site or base for mobile equipment. Otherwise, registration may be cancelled by Service Australia if the registration was obtained improperly (false information supplied) or if the proprietor fails to notify Services Australia of changes to primary information. A decision to cancel a registration will only be made following due consideration of a submission by the site or base. The proprietor may apply to the Administrative Appeals Tribunal for a review of this decision. If registration is cancelled involuntarily, the proprietor may not apply to re-register the site or base for a period of 12 months unless permitted to do so.

Proprietors of unregistered practices (including where the registration is under suspension or has been cancelled) need to either advise patients in writing or display a notice that no Medicare benefits will be payable for the diagnostic imaging services.

From 1 July 2010 practices applying for an LSPN will also need to apply for and be accredited under the Diagnostic Imaging Accreditation Scheme (DIAS) in order to be eligible to provide diagnostic imaging services under Medicare. Information about DIAS is available here: Diagnostic Imaging Accreditation Scheme (the DIAS).

For full details about LSPNs including how to register a practice site are available at Services Australia' website at https://www.servicesaustralia.gov.au/search/LSPN.

IN.0.4 Accreditation of Practices

Background

All practices providing diagnostic imaging services needed to be accredited under the Diagnostic Imaging Accreditation Scheme (DIAS) in order for Medicare benefits to be payable for those services.

First time accreditation

New practices entering the Scheme may choose to be accredited against either three entry-level Standards or the full suite of Standards. Practices initially choosing to be accredited against the entry level Standards have a further period of two years to become accredited against the full suite of Standards.

Re-accreditation of Practices

Practices previously accredited must seek re-accreditation against the full suite of Standards and cannot apply for re-accreditation against the entry level Standards. Accreditation against the full suite of Standards is for a four year period.

Non-Accredited Practices

Practices may choose not to be accredited and still provide diagnostic imaging services, but these services do not attract a Medicare benefit.

Practices which are not accredited under the DIAS must inform patients prior to carrying out the service that the practice is not accredited and as such the service does not attract a Medicare benefit. It is an offence under the *Health Insurance Act 1973* not to do so.

The Medical Imaging Accreditation Program (MIAP)

The Royal Australian and New Zealand College of Radiologist (RANZCR) offers a voluntary accreditation program jointly with the National Association of Testing Authorities (NATA).

Practices participating in MIAP can seek recognition of their MIAP accreditation under the DIAS. This recognition will grant MIAP Practices accreditation against the full suite of Standards until the date of the expiration of the recognised MIAP accreditation. By this date Practices will need to either provide their Approved Accreditor with evidence of renewal of MIAP accreditation or have been granted accreditation against the full suite of Standard.

The Standards

The current Standards are made up of three entry level Standards and the full suite of Practice Accreditation Standards. If a practice is applying for accreditation against the entry level Standards, an accreditation decision will be made by an Approved Accreditor within 15 business days of the lodgement of an application for accreditation. If a practice is applying for accreditation against the full suite of Standards, an accreditation decision will be made by an Approved Accreditor within 30 business days of the lodgement of an application for accreditation.

From the date of being granted accreditation, the practice site can provide diagnostic imaging services under Medicare.

Entry Level Standards

- Registration and Licensing Standard (Standard 1.2)
- Radiation Safety Standard (Standard 1.3)

- Equipment Inventory Standard (Standard 1.4)

Full Suite Standards

- Part 1 - Organisational Standards
- Part 2 - Pre-procedure Standards
- Part 3 - Procedure Standards
- Part 4 - Post Procedure Standards

Applying for accreditation

Whether a practice is applying for accreditation against entry-level Standards or the full suite Standards, the application process is the same. A practice is required to submit to an Approved Accreditor either:

- an application for accreditation providing written documentary evidence of compliance with the entry level Standards or the full suite Standards; or
- written evidence of accreditation under the Medical Imaging Accreditation Program (MIAP) jointly administered by RANZCR and NATA.

Renewal of Accreditation

Practices awarded accreditation against the full suite of Standards enter the maintenance program which requires them to be re-accredited every 4 years.

Approved Accreditors

There are three Accreditation agencies approved by the Minister for Health to provide Accreditation services:

HDAA Australia	(HDAA)	Ph: 1800 601 696
National Association of Testing Authorities	(NATA)	Ph: 1800 621 666
Quality Innovation Performance	(QIP)	Ph: 1300 888 329

Further information can be obtained from:

Website: www.safetyandquality.gov.au

Email: AdviceCentre@safetyandquality.gov.au

Phone: 1800 304 056

IN.0.5 Capital Sensitivity Diagnostic Imaging Equipment

Except where there is an exemption in force, Medicare benefits are not payable for diagnostic imaging services rendered using equipment, other than positron emission tomography (PET), that has exceeded its 'effective life age' for new equipment or 'maximum extended life age' for upgraded equipment as shown in the table below.

This is known as capital sensitivity and is intended to ensure that patients have access to quality diagnostic imaging services by encouraging providers to upgrade and replace aged equipment as appropriate.

Life ages of diagnostic imaging equipment

Type of Equipment	Definition of type of equipment	Effective life age for new equipment (years)	Maximum extended life age (years)
Ultrasound	Equipment primarily used in carrying out a diagnostic imaging procedure used in rendering a service to which an item in Group I1 applies	10	15
CT	Equipment primarily used in carrying out a diagnostic imaging procedure used in rendering a service to which an item in Group I2 applies	10	15
Mammography	Equipment primarily used in carrying out a diagnostic imaging procedure used in rendering a service to which an item in Subgroup 10 of Group I3 applies	10	15
Angiography	Equipment primarily used in carrying out a diagnostic imaging procedure used in rendering a service to which an item in Subgroup 13 of Group I3 applies	10	15
Other diagnostic radiology	Equipment primarily used in carrying out a diagnostic imaging procedure used in rendering a service to which an item in Subgroups 1 to 9, 12, 14, 15 or 17 of Group I3 applies	15	20
Nuclear medicine imaging (other than for PET)	Equipment primarily used in carrying out a diagnostic imaging procedure used in rendering a service to which an item in Group I4 applies (other than items 61523 to 61647)	10	15
MRI	Equipment primarily used in carrying out a diagnostic imaging procedure used in rendering a service to which an item in Group I5 applies	10	20

Capital sensitivity exemptions

An exemption is available for practices where they have not been able to replace or upgrade equipment due to delays beyond the control of the practice.

For full details about the rules for capital sensitivity, how to apply for an exemption and the definition of upgrade, providers should access the Department of Health, Disability and Ageing's website at www.health.gov.au/capitalsensitivity or send an email enquiry to capsens@health.gov.au.

IN.0.6 Requests for R-type Diagnostic Imaging Services

Request requirements

Medicare benefits are not payable for diagnostic imaging services that are classified as R-type (requested) services unless, prior to commencing the relevant service, the practitioner receives a request from a requesting practitioner who determined the service was necessary.

There are exemptions to the request requirements in specified circumstances. These circumstances are detailed below under 'Exemptions from the written request requirements for R-type diagnostic imaging services'.

Expiry of a diagnostic imaging request

Requests for diagnostic imaging do not expire and are valid until the required test has been performed.

Form of a diagnostic imaging request

Responsibility for the adequacy of requesting details rests with the requesting practitioner. A request for a diagnostic imaging service does not have to be in a particular form, however, the legislation provides that a request must be in writing and contain sufficient information, in terms that are generally understood by the profession, to clearly identify the item/s of service requested.

The *Electronic Transactions Act 1999* allows for documents required by law to be in writing, to instead be provided electronically in a range of circumstances. Diagnostic imaging requests may be made by email or other electronic medium, either directly to the imaging practice (with the patient's consent), or via the patient, as long as:

- the recipient agrees to the request being made in that form;
- it would be accessible for subsequent reference; and
- it contains the information prescribed as for requests made in writing.

There is no requirement for a diagnostic imaging request to be signed.

A written request must contain the name and address or name and provider number in respect of the place of practice of the requesting practitioner.

A request to a medical imaging specialist for a diagnostic imaging service should include sufficient clinical information to assist the service provider to accurately provide the diagnostic imaging service requested and:

- ensure compliance with the MBS item descriptors, and
- where the requested service involves ionising radiation (x-ray, CT etc.), make a decision whether to expose the patient to radiation, consistent with the diagnostic imaging providers' obligations under the International Commission on Radiological Protection's doctrine of radiation protection.

Unless sufficient clinical information is provided, the requesting practitioner may be asked to provide additional information to the diagnostic imaging provider, which could result in delays for the patient.

The following should be provided on a request for a diagnostic imaging service:

- ***A clear and legible request*** - a request must be in writing, dated and be legible so that all information contained is transferred between requestor and provider without loss of content or meaning, or risk of misinterpretation. The use of abbreviations should be avoided. Where permitted, verbal referrals should ensure clear communication between the requestor and provider.

Under the *Electronic Transactions Act 1999*, this information can be provided in electronic form.

Identity of the patient – a request should include details which confirm the identity of the patient, including their contact details.

Identity of the requestor – a request should include the identity and contact details of the requesting practitioner, including their Medicare provider number, to ensure effective and timely communication.

Clinical detail - a request should include a clinical justification for each examination requested and performed to support the performance of the diagnostic imaging examination.

- Requests should contain information to enable the provider to confirm that the requested diagnostic imaging modality and examination are appropriate to that individual patient's presentation and circumstances, to answer the referrer's diagnostic question with the least number of diagnostic steps (with due regard for patient safety, radiation dose, local expertise and cost).
- Where the request is for diagnostic imaging involving ionising radiation (e.g. x-ray, CT) the request should include clinical information for the provider to determine whether the expected clinical benefit to the patient of being exposed to diagnostic radiation outweighs the risk of radiation exposure ('justification for medical radiation exposure').
- The provider must have sufficient information to justify and approve a medical radiation procedure. Where known, this information should include pregnancy status for women of child-bearing age.

Before requesting a diagnostic imaging service, the requesting practitioner must turn their mind to the clinical relevance of the request and determine that the service is necessary. For example, an ultrasound to determine the sex of a foetus is generally not a clinically relevant service, unless there is an indication this service may determine further courses of treatment (e.g. where there is a genetic risk of a sex-related disease or condition).

The requestor should consider whether:

- they are duplicating recent tests.
- the results would change the diagnosis, affect patient management or do more harm than good.
- Royal Australian and New Zealand College of Radiologist (RANZCR)'s Education Modules for appropriate Imaging Referrals contains decision support tools for select clinical scenarios.
- the Australian Radiation Protection and Nuclear Safety Agency's Radiation Protection of the Patient Module provides information about diagnostic imaging for medical practitioners, to ensure radiation use is justified, and may aid in communicating benefits and risks of diagnostic imaging modalities to patients.
- the benefits and risks to the patient or carer have been communicated, including any alternatives available, and
- there is information available to the patient about the tests requested. Consumer resources available include the:

    - NPS Medicine Wise Choosing Wisely program

    - Consumers Health Forum's Why do I even need this test? A Diagnostic Imaging and Informed Consent Consumer Resource

    - RANZCR's Inside Radiology website.

MBS requirements - a request should meet any specific MBS item requirements. Failure to provide this information may mean that a Medicare benefit is not paid for the service.

Who may request a diagnostic imaging service?

The following practitioners may request a diagnostic imaging service:

Medical practitioners, specialists and consultant physicians

Specialists and consultant physicians can request any diagnostic imaging service (some exceptions apply, for example, obstetric ultrasound item 55712 where the requester needs to have obstetric qualifications).

Other medical practitioners can request any service and specific MRI Services – including on behalf of the treating practitioner, for example, by a resident medical officer at a hospital on behalf of the patient's treating practitioner.

Dentists

All dental practitioners who are registered under the National Law may request the following items:

57509, 57515, 57521, 57523, 57527, 57901 to 57969, 58100, 58300, 58503, 58903, 59733, 59739, 59751, 60500 and 60503.

Dental specialists are able to request the items listed above, as well as specific additional items depending on their specialty as set out below.

Approved dental practitioners

55028, 55030, 55032, 56001 to 56220, 56224, 56301 to 56507, 56801 to 57007, 57341, 57362, 57703, 57709, 57712, 57715, 58103 to 58115, 58306, 58506, 58521 to 58527, 58909, 59103, 59703, 60000 to 60009, 60506, 60509, 61109, 61372, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 63007 and 63334.

Note: Approved dental practitioners are dentists who were approved by the Minister before 1 November 2004 for the definition of professional service in subsection 3(1) of the *Health Insurance Act 1973*. Practitioners should contact Services Australia to determine their eligibility for requesting these services.

Oral and maxillofacial surgeons (with medical specialist registration)

Oral and maxillofacial surgeons who also have a medical qualification and are registered as medical specialist can request items in the Diagnostic Imaging Services Table, subject to any clauses or requirements relevant to the individual item.

Prosthodontists

55028, 56013, 56016, 56022, 56028, 57362, 58306, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462 and 63334.

Periodontists, endodontists, paediatric dentistry specialists and orthodontists

56022, 57362, 58306, 61421, 61454, 61457 and 63334.

Specialists in oral medicine, oral and maxillofacial pathology, oral surgery and special needs dentistry

55028, 55030, 55032, 56001, 56007, 56010, 56013, 56016, 56022, 56028, 56101, 56107, 56301, 56307, 56401, 56407, 57341, 57362, 58306, 58506, 58909, 59103, 59703, 60000 to 60009, 60506, 60509, 61109, 61372, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 63007 and 63334.

Chiropractors

57712, 57715, 58100 to 58106, 58109 and 58112.

Physiotherapists and Osteopaths

57712, 57715, 58100 to 58106, 58109, 58112, 58120 and 58121.

Podiatrists

55844, 55888, 55890, 55892, 55894, 57521, 57523 and 57527.

Participating Nurse Practitioners

55036, 55065, 55066, 55070, 55071, 55076, 55080, 55600, 55700, 55704, 55768, 55812, 55844, 55848, 55850, 55852, 55856, 55858, 55860, 55862, 55864, 55866, 55868, 55870, 55872, 55874, 55876, 55878, 55880, 55882, 55884, 55886, 55888, 55890, 55892, 55894, 57410, 57413, 57509, 57515, 57521, 57523, 57527, 57703, 57709, 57712, 57715, 57721, 58503 to 58527 and 58903.

Participating Midwives

55065, 55080, 55700, 55704, 55706, 55707, 55718.

Request to specified provider not required

It is not necessary that a written request for a diagnostic imaging service be addressed to a particular provider or that, if the request is addressed to a particular provider, the service must be rendered by that provider. Request forms containing relevant information about a diagnostic imaging provider supplied, or made available to, a requesting practitioner by a diagnostic imaging provider must include a statement that informs the patient that the request may be taken to a diagnostic imaging provider of the patient's choice.

Request for more than one service and limit on time to render services

The requesting practitioner may use a single request to order a number of diagnostic imaging services. However, all services provided under this request must be rendered within fourteen days after the rendering of the first service.

Contravention of request requirements

A practitioner who, without reasonable excuse makes a request for a diagnostic imaging service that does not include the required information in their request or in a request made on their behalf is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine of up to 10 penalty units.

A practitioner who renders "R-type" diagnostic imaging services and who, without reasonable excuse, provides either directly or indirectly, to a requesting practitioner a document to be used in the making of a request which would contravene the request information requirements is guilty of an offence under the *Health Insurance Act 1973*. The offence is punishable, upon conviction, by a fine of up to 10 penalty units.

Exemptions from the written request requirements for R-type diagnostic imaging services

There are exemptions from the general written request requirements (R-type) diagnostic imaging services and these are outlined as follows:

Consultant physician or specialist

A consultant physician or specialist is a medical practitioner recognised for the purposes of the *Health Insurance Act 1973* as a specialist or consultant physician, in a particular specialty.

A written request is not required for the payment of Medicare benefits when the diagnostic imaging service is provided by or on behalf of a consultant physician or a specialist (other than a specialist in diagnostic radiology) in their specialty and after clinical assessment determines that the service was necessary.

However, if in the referral to the consultant physician or specialist, the referring practitioner specifically requests a diagnostic imaging service (eg to a cardiologist to perform an echocardiogram) the service provided is a requested, not self-determined service. If further services are subsequently provided, these further services are self-determined - see "Additional services".

Additional services

A written request is not required for a diagnostic imaging service if that service was provided after one which has been formally requested and the providing practitioner determines that, on the basis of the results obtained from the requested service, that an additional service was necessary. However, the following services cannot be self-determined as "additional services":

- MRI services;
- PET services; and
- services not otherwise able to be requested by the original requesting practitioner.

For details required for accounts/receipts see Note IN.0.8.

Substituted services

A provider may substitute a service for the service originally requested when:

- the provider determines, from the clinical information provided on the request, that the substituted service would be more appropriate for the diagnosis of the patient's condition; and
- the provider has consulted with the requesting practitioner or taken all reasonable steps to do so before providing the substituted service; and
- the substituted service was one that would be accepted as a more appropriate service in the circumstances by the practitioner's speciality group.

However, the following services cannot be substituted:

- MRI services;
- PET services; and
- services not otherwise able to be requested by the original requesting practitioner.

For details required for accounts/receipts see Note IN.0.8.

Remote areas

A written request is not required for the payment of Medicare benefits for a R-type diagnostic imaging service rendered by a medical practitioner in a remote area provided:

- the R-type service is not one for which there is a corresponding NR-type service; and
- the medical practitioner rendering the service has been granted a remote area exemption for that service.

For details required for accounts/receipts see Note IN.0.8.

Definition of remote area

The definition of a remote area is one that is more than 30 kilometres by road from:

a) a hospital which provides a radiology service under the direction of a specialist in the specialty of diagnostic radiology; and

b) a free-standing radiology facility under the direction of a specialist in the specialty of diagnostic radiology.

Application for remote area exemption

A medical practitioner, other than a consultant physician or specialist, who believes that they qualify for exemption under the remote area definition, should obtain an application form from Services Australia website https://www.servicesaustralia.gov.au or by contacting Services Australia' Provider Eligibility Section, by email at sa.prov.elig@servicesaustralia.gov.au or via phone on 1800 032 259 Monday to Friday, between 8.30 am and 5.00 pm, Australian Eastern Standard Time.

Quality assurance requirement for remote area exemption

Application for, or continuation of, a remote area exemption will be contingent on practitioners being enrolled in an approved continuing medical education and quality assurance program. For further information, please visit the Australian College of Rural and Remote Medicine (ACRRM) website at www.acrrm.org.au, or call the ACRRM on 1800 223 226.

Emergencies

The written request requirement does not apply if the providing practitioner determines that, because the need for the service arose in an emergency, the service should be performed as quickly as possible.

For details required for accounts/receipts see Note IN.0.8.

Lost requests

The written request requirement does not apply where:

- the person who received the diagnostic imaging service, or someone acting on that person's behalf, claimed that a written request had been made for such a service but that the request had been lost; and
- the provider of the diagnostic imaging service or that provider's agent or employee obtained confirmation from the requesting practitioner that the request had been made.

The lost request exemption is applicable only to services that the practitioner could originally request.

For details required for accounts/receipts see Note IN.0.8.

Pre-existing diagnostic imaging practices

The legislation provides for exemption from the written request requirement for services provided by practitioners who have operated pre-existing diagnostic imaging practices. The exemption applies to the services covered by the following items: 57712, 57715, 57901, 57902, 57907, 57915, 57921, 58100 to 58115, 58521, 58524, 58527, 58700 and 59103.

To qualify for this pre-existing exemption the providing practitioner must:

- be treating their own patient;
- have determined that the service was necessary;
- have rendered between 17 October 1988 and 16 October 1990 at least 50 services (which resulted in the payment of Medicare benefits) of the kind which have been designated "R-type" services from 1 May 1991;
- provide the exempted services at the practice location where the services which enabled the practitioner to qualify for this exemption were rendered; and
- be enrolled in an approved continuing medical education and quality assurance program from 1 January 2001. For further information, please contact the Royal Australian College of General Practitioners (RACGP), at www.racgp.org.au, on 1800 472 247 or via email to racgp@racgp.org.au, or the Australian College of Rural and Remote Medicine (ACRRM), at www.acrrm.org.au or by calling 1800 223 226.

Benefits are only payable for services exempted under these provisions where the service was provided by the exempted medical practitioner at the exempted location. Exemptions are not transferable.

For details required for accounts/receipts see Note IN.0.8.

Retention of requests

A medical practitioner who has rendered an R-type diagnostic imaging service in response to a written request must retain that request for a period of two years commencing on the day on which the service was rendered.

A medical practitioner must, if requested by Services Australia, produce written requests retained by that practitioner for an R-type diagnostic imaging service as soon as practicable and in any case by the end of the day after the day on which Services Australia's request was made. An employee of Services Australia is authorised to make and retain copies of or take and retain extracts from written requests or written confirmations of lost requests.

A medical practitioner who, without reasonable excuse, fails to comply with the above requirements is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine of up to 10 penalty units.

The Department of Health, Disability and Ageing has developed a Health Practitioner Guideline to substantiate that a valid request existed (pathology or diagnostic imaging), which is located online at www.health.gov.au.

IN.0.7 Maintaining Records of Diagnostic Imaging Services

Providers of diagnostic imaging services must keep records of diagnostic imaging services in a manner that facilitates retrieval on the basis of the patient's name and date of service. Records of R-type diagnostic imaging services must be retained for a period of 2 years commencing on the day on which the service was rendered.

The records must include the report by the providing practitioner on the diagnostic imaging service. For ultrasound services, where the service is performed on behalf of a medical practitioner the report must record the name of the sonographer.

- Where the provider substitutes a service for the service originally requested, the provider's records must include:

  · words indicating that the providing practitioner has consulted with the requesting practitioner and the date of consultation; or

· if the providing practitioner has not consulted with the requesting practitioner, sufficient information to demonstrate that he or she has taken all reasonable steps to do so.

o For services rendered after a lost request, the records must include words to the effect that the request was lost but confirmed by the requesting practitioner and the manner of confirmation, e.g. how and when.

o For emergency services, the records must indicate the nature of the emergency.

If requested by Services Australia, records retained by a providing practitioner must be produced to an officer of Services Australia as soon as practicable but in any event within seven days after the request. Service Australia officers may make and retain copies, or take and retain extracts, of such records. A medical practitioner who, without reasonable excuse, contravenes any of the above provisions is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine of $1000.

IN.0.8 Details Required on Accounts, Receipts and Medicare Assignment of Benefit Agreement

In addition to the normal particulars of the patient, date of service, the services performed and the fees charged, the details which must be entered on accounts or receipts, and Medicare assignment of benefits agreement in respect of diagnostic imaging services are as follows:

- the LSPN of the diagnostic imaging premises or mobile facility where the diagnostic imaging procedure was undertaken;

- if the professional service is provided by a specialist in diagnostic radiology the name and either the address of the place of practice, or the provider number, of that specialist;

- if the medical practitioner is not a specialist in diagnostic radiology the name and either the practice address or provider number of the practitioner who is claiming or receiving fees;

- for R-type (requested) services and services rendered subsequent to lost requests, the account or receipt or the Medicare assignment agreement must indicate the date of the request and the name and provider number, or the name and address, of the requesting practitioner.

- services that are self-determined must be endorsed with the letters 'SD' to indicate that the service was self-determined. Services are classified as self-determined when rendered:

- by a consultant physician or specialist, in the course of that consultant physician or specialist practicing his or her specialty (other than a specialist in diagnostic radiology), or - to provide additional services to those specified in the original request and the additional services are of the type that would have otherwise required a referral from a specialist or consultant physician in a remote area, or

- under a pre-existing diagnostic imaging practice exemption.

- substituted services the account etc. must be endorsed 'SS'.

- emergencies, the account etc. must be endorsed ‘emergency’.

- lost requests the account etc. must be endorsed ‘lost request’.

IN.0.9 Contravention of State and Territory Laws and Disqualified Practitioners

Medicare benefits are not payable where a diagnostic imaging service is provided by, or on behalf of, a medical practitioner, and the provision of that service by that practitioner or any other person contravenes a state or territory law which, directly or indirectly, relates to the use of diagnostic imaging procedures or equipment. The Managing Director of Services Australia may notify the relevant state or territory authorities if he/she believes that a person may have contravened a law of a state or territory relating directly or indirectly to the use of diagnostic imaging procedures or equipment.

IN.0.10 Prohibited Practices

Part IIBA of the *Health Insurance Act 1973* (the Act) contains a number of provisions prohibiting inducements to request diagnostic imaging (and pathology) services.

Who might be affected?

Anyone who can provide or request a Medicare-funded diagnostic imaging service.

Anyone who has a relevant connection to a provider or a requester, including relatives, bodies corporate, trusts, partnerships and employees may also be affected.

What is prohibited?

- it is unlawful to ask for, accept, offer or provide a benefit, or make a threat, that is reasonably likely to induce a requester to make diagnostic imaging requests, or is related to the business of providing diagnostic imaging services.

- it is a criminal offence to ask for, accept, offer, or provide a benefit, or make a threat that is intended to induce requests to a particular provider.

- the prohibitions apply to the provision of benefits, or the making of threats, that are directed to a requester by a provider, whether directly or through another person.

A requester of diagnostic imaging services means:

- a medical practitioner;

- a dental practitioner, a chiropractor, a physiotherapist, a podiatrist or an osteopath (in relation to certain types of services prescribed in Regulations);

- a person who employs, or engages under a contract for services, one of the people mentioned above; or

- a person who exercises control or direction over one of the people mentioned above (in his or her professional capacity).

A provider of a diagnostic imaging service means:

- a person who renders that kind of service;

- a person who carries on a business of rendering that kind of service;

- a person who employs, or engages under a contract for services, one of the people detailed above; or

- a person who exercises control or direction over a person who renders that kind of service or a person who carries on a business of rendering that kind of service.

What is permitted?

Under the Act it is permitted to:

- share the profits of a diagnostic imaging business, provided the dividend is in proportion to the beneficiary's interest in the business;

- accept or pay remuneration, including salary, wages, commission, provided the remuneration is not substantially different from the usual remuneration paid to people engaged in similar employment;

- make or accept payments for property, goods or services, provided the amount paid is not substantially different from the market value of the property, goods or services;

- make or accept payments for shared property, goods or services, provided the amount paid is proportionate to the person's share of the cost of the property, goods or services and shared staff and/or equipment are not used to provide diagnostic imaging services;

- provide or accept property, goods or services, provided the benefit exchanged is not substantially different from the market value of the property, goods or services;

- provide benefits of a type determined by the Minister. These include items to support a requester to view diagnostic imaging reports, such as specially designed computer monitors. Modest gifts and hospitality may also be permitted, under certain circumstances. A full list of the Ministerial determined permitted benefits are contained in the *Health Insurance (Permitted benefits — diagnostic imaging services) Determination 2018*.

What are the penalties for those not complying with the provisions?

If the provisions are breached, a range of penalties would apply, depending on the kind of breach, including: civil penalties; criminal offences; referral to a Medicare Participation Review Committee (MPRC), possibly resulting in loss of access to Medicare. For further information on prohibited practices visit the Department of Health, Disability and Ageing's publication 'Guidance on Laws Relating to Pathology and Diagnostic Imaging - Prohibited Practices'.

IN.0.11 Multiple Services Rules

Multiple Services Rules

Background

There are several rules that may apply when calculating Medicare benefits payable when multiple diagnostic imaging services are provided to a patient at the same attendance (same day). These rules were developed in association with the diagnostic imaging profession representative organisations and reflect that there are efficiencies to the provider when these services are performed on the same occasion. Unless there are clinical reasons for doing so, they should be provided to the patient at the one attendance and the efficiencies from doing this reflected in the overall fee charged.

General diagnostic imaging - multiples services

The diagnostic imaging multiple services rules apply to all diagnostic imaging services. There are three rules, and more than one rule may apply in a patient episode. The rules do not apply to diagnostic imaging services rendered in a remote area by a medical practitioner who has a remote area exemption for that area - see IN.0.6.

Rule A. When a medical practitioner renders two or more diagnostic imaging services to a patient on the same day, then:

- the diagnostic imaging service with the highest Schedule fee has an unchanged Schedule fee; and
- the Schedule fee for each additional diagnostic imaging service is reduced by $5.

Rule B. When a medical practitioner renders at least one R-type diagnostic imaging service and at least one consultation to a patient on the same day, there is a deduction to the Schedule fee for the diagnostic imaging service with the highest Schedule fee as follows:

- if the Schedule fee for the consultation is $40 or more - by $35; or
- if the Schedule fee for the consultation is less than $40 but more than $15 - by $15; or
- if the Schedule fee for the consultation is less than $15 - by the amount of that fee.

The deduction under Rule B is made once only. If there is more than one consultation, the consultation with the highest Schedule fee determines the deduction amount. There is no further deduction for additional consultations.

A 'consultation' is a service rendered under an item from Category 1 of the MBS, that is, items 1 to 10816 and 90020 to 90096.

Rule C. When a medical practitioner renders an R-type diagnostic imaging service and at least one non-consultation service to the same patient on the same day, the Schedule fee for the diagnostic imaging service with the highest Schedule fee is reduced by $5.

A deduction under Rule C is made once only. There is no further deduction for any additional medical services.

For Rule C, a 'non-consultation' is defined as any following item from the MBS:

- Category 2, items 11000 to 12533;
- Category 3, items 13020 to 51318;
- Category 4, items 51700 to 53460;
- Category 7, items 75002 to 75854.

Pathology services are not included in Rule C.

When both Rules B and C apply, the sum of the deductions in the Schedule fee for the diagnostic imaging service with the highest Schedule fee is not to exceed that Schedule fee.

Ultrasound - Vascular

This rule applies to all vascular ultrasound items claimed on the same day of service ie whether performed at the same attendance by the same practitioner or at different attendances.

Where more than one vascular ultrasound service is provided to the same patient by the same practitioner on the same date of service, the following formula applies to the Schedule fee for each service:

- 100% for the item with the greatest Schedule fee
- plus 60% for the item with the next greatest Schedule fee
- plus 50% for each other item.

When the Schedule fee for some of the items are the same, the reduction is calculated in the following order:

- 100% for the item with the greatest Schedule fee and the lowest item number
- plus 60% for the item with the greatest Schedule fee and the second lowest item number
- plus 50% for each other item.

Note: If 2 or more Schedule fees are equally the highest, the one with the lowest item number is taken to have the higher fee e.g. item 55238 and 55280, item 55238 would be considered the highest.

When calculating the benefit, it should be noted that despite the reduction, the collective items are treated as one service for the application of Rule A of the General Diagnostic Imaging Multiple Services rules and the patient gap. Examples can be found on the Services Australia website.

Cardiac - transthoracic and stress echocardiograms

This rule applies to all transthoracic and stress echo items claimed on the same day of service, whether performed at the same attendance by the same practitioner or at different attendances.

Where more than one transthoracic and stress echo service is provided to the same patient by the same practitioner on the same date of service, the following formula applies to the Schedule fee for each service:

- 100% for the item with the greatest Schedule fee
- plus 60% for the item with the next greatest Schedule fee

If 2 or more Schedule fees are equally the highest, the one with the lowest item number is taken to have the higher fee.

As for the vascular multiple services rules, the collective items are treated as one service for the application of Rule A of the General Diagnostic Imaging Multiple Services rules and the patient gap.

Magnetic Resonance Imaging (MRI) - Musculoskeletal

If a medical practitioner performs 2 or more scans from subgroup 12 and 13 for the same patient on the same day, the fees specified for items that apply to the service are affected as follows:

- the item with the highest schedule fee retains 100% of the schedule fee; and
- any other fee, except the highest is reduced by 50%.

Note: If 2 or more Schedule fees are equally the highest, the one with the lowest item number is taken to have the higher fee eg. item 63322 and 63331, item 63322 would be considered the highest.

If the reduced fee is not a multiple of 5 cents, the reduced fee is taken to be the nearest amount that is a multiple of 5 cents.

In addition, the modifying item for contrast may only be claimed once for a group of services subject to this rule.

If a medical practitioner provides:

- 2 or more MRI services from subgroups 12 and 13 for the same patient on the same day; and
- 1 or more other diagnostic imaging services for that patient on that day

the amount of the fees payable for the MRI services is taken, for the purposes of this rule, to be an amount payable for 1 diagnostic imaging service in applying Rule A of the General Diagnostic Imaging Multiple Services rules.

Breast Imaging

If 2 or more of the following breast imaging services are performed for the same patient on the same day, the fees for those services are not affected by the Multiple Services rules:

- Breast ultrasound items 55066, 55070, 55071, 55073, 55076 or 55079;
- Mammography items 59300 or 59303;
- Radiographic examination items 59312, 59314 or 59318;
- Three dimensional tomosynthesis items 59302 or 59305; or
- MRI item 63464

IN.0.12 Co-claiming consultations with DIST items

Specialist radiologists - services other than MRI

Benefits are not payable for consultations rendered by specialist radiologists in conjunction with one of the following diagnostic imaging services:

· All musculoskeletal ultrasound – Group I1, Subgroup 6 (items 55812 – 55895)

· Diagnostic radiology items as follows:

- Group I3, Subgroup 1 – Radiographic Examination of the Extremities - items 57506 to 57527
- Group I3, Subgroup 2 – Radiographic Examination of Shoulder and Pelvis - items 57700 to 57721

- Group I3, Subgroup 3 – Radiographic Examination of the Head - items 57901 to 57969
- Group I3, Subgroup 4 – Radiographic Examination of the Spine - items 58100 to 58121
- Group I3, Subgroup 5 – Bone Age Study and Skeletal Survey - items 58300 and 58306
- Group I3, Subgroup 6 – Radiographic Examination of Thoracic Region - items 58500 to 58527
- Group I3, Subgroup 7 – Radiographic Examination of Urinary Tract - items 58700 to 58721
- Group I3, Subgroup 8 – Radiographic Examination of Alimentary Tract and Biliary System - items 58900 and 58903
- Group I3, Subgroup 9 – Radiographic Examination of Localisation of Foreign Bodies - item 59103

Radiologists may claim consultation items when they attend the patient before, during or after the rendering of other diagnostic imaging services. However, consultation items should only be claimed where the attendance on the patient is meaningful. That is:

- the radiologist utilises their medical knowledge, clinical acumen, technical skills and personal experience in clinical radiology to consult with a patient so as to alter, or potentially alter, the course of the patient's management in the best interests of the patient.
- the radiologist takes primary clinical responsibility for the management decisions made during the consultation (even if the decision is to proceed with the planned course of management).
- the consultation itself includes components of history taking; physical examination; discussion with the patient; formulation of management plans; and referral for additional opinion or tests.

Not all the components need be present in any one consultation, but presence of at least some indicates that a meaningful consultation occurred.

To claim a specialist referred consultation (item 104 or 105), the specialist radiologist must have received a valid referral (not simply a request for a diagnostic imaging service) from a medical practitioner for the investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s). The requesting practitioner must have undertaken a professional attendance with the patient and turned their mind to the patient's need for referral and have communicated relevant information about the patient to the specialist or consultant physician (this need not mean an attendance on the occasion of the referral) – see note GN.6.16.

A request for the undertaking of a diagnostic imaging service in the absence of the other elements of a referral as noted above does not constitute a valid referral for a specialist referred consultation.

The new consultation co-claiming rules do not apply to consultant physicians, other specialists and specialist radiologists who are also specialists in other medical disciplines. However, where a specialist radiologist has more than one qualification, co-claiming is only permitted where the patient has been referred to the provider in their non-radiologist capacity.

Where a specialist or consultant physician receives a request for diagnostic imaging service only, for example, a request to a cardiologist to do an echocardiogram, a consultation should not be claimed.

In addition, consultations must not be claimed in place of claiming a diagnostic imaging service.

Consultations with MRI services

Benefits are not payable for consultations rendered by any credentialled MRI provider in conjunction with MRI services unless the providing practitioner determines that a consultation is necessary for the treatment or management of the patient’s condition. A consultation has to be meaningful. The definition of a meaningful consultation is the same as shown under the heading 'Specialist radiologists - services other than MRI' and the valid referral requirements for specialist referred consultations as noted under that heading also apply.

IN.0.13 Ultrasound

Professional supervision for ultrasound services - R-type eligible services

Ultrasound services (items 55028 to 55895) marked with the symbol (R), except items 55600 and 55603, are not eligible for a Medicare benefit unless the diagnostic imaging procedure is performed under the professional supervision of a:

(a) specialist or a consultant physician in the practice of his or her specialty who is available to monitor and influence the conduct and diagnostic quality of the examination, and if necessary to personally attend the patient; or

(b) practitioner who is not a specialist or consultant physician, and who is available to monitor and influence the conduct and diagnostic quality of the examination and, if necessary, to personally attend the patient, and meets either of the following requirements:

(i) Between 1 September 1997 and 31 August 1999, at least 50 services were rendered by or on behalf of the practitioner at the location where the service was rendered and the rendering of those services entitled the payment of Medicare benefits.

(ii) Between 1 September 1997 and 31 August 1999, at least 50 services were rendered by or on behalf of the practitioner in nursing homes or patients' residences and the rendering of those services entitled payment of Medicare benefits.

If paragraph (a) or (b) cannot be complied with, ultrasound services are eligible for a Medicare benefit:

- in an emergency; or
- in a location that is not less than 30 kilometres by the most direct road route from another practice where services that comply with paragraph (a) or (b) are available.

Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

The rules regarding items 55600 and 55603 are set out under the heading ‘Subgroup 4: Urological ultrasound – Items 55600 and 55603’.

Sonographer accreditation

Sonographers performing medical ultrasound examinations (either R or NR type items) on behalf of a medical practitioner must be suitably qualified, involved in a relevant and appropriate Continuing Professional Development program and be Registered on the Register of Accredited Sonographers held by Services Australia.

Eligibility for registration

To be eligible for registration on the Register of Accredited Sonographers held by Services Australia, the person must be accredited with the Australian Sonographer Accreditation Registry. For accreditation with the Australian Sonographer Accreditation Registry the person must hold an accredited postgraduate qualification in medical ultrasound or be studying ultrasound.

For further information, please contact Services Australia, Provider Liaison Section, on 132 150 for the cost of a local call or the Australian Sonographer Accreditation Registry through its website at www.asar.com.au

Report requirements

The sonographer's initial and surname are to be written on the report. They are not required on billing documents or on the copy of the report given to the patient.

Benefits payable

In most instances, a benefit is payable once only for ultrasonic examination at the one attendance, irrespective of the areas involved.

Attendance means that there is a clear separation between one service and the next. For example, where there is a short time between one ultrasound and the next, benefits will be payable for one service only. As a guide, Services Australia will look to a separation of three hours between services and this must be stated on accounts issued for more than one service on the one day.

Where more than one ultrasound service is rendered on the same occasion and the service relates to a non-contiguous body area, and they are "clinically relevant", (i.e. the service is generally accepted in the medical profession as being necessary for the appropriate treatment or management of the patient to whom it is rendered), benefits greater than the single rate may be payable. Accounts should be marked "non-contiguous body areas".

Benefits for two contiguous areas may be payable where it is generally accepted that there are different preparation requirements for the patient and a clear difference in set-up time and scanning. Accounts should be endorsed "contiguous body area with different set-up requirements".

Subgroup 1: General Ultrasound

Abdominal Ultrasound Items 55036 and 55037

Medicare benefits are not payable for ultrasound items 55036 and 55037 unless a morphological assessment of the abdomen has been performed. That is, the items should be used for imaging purposes, not for non-imaging procedures such as transient elastography.

Urinary ultrasound Items 55084 and 55085

When a post-void residual is the only service clinically indicated and/or rendered, it is inappropriate to report a pelvic, urinary or abdominal ultrasound, instead of or in addition to this service (55084 or 55085).Similarly, if a complete pelvic, urinary or abdominal ultrasound is billed, it is inappropriate to bill separately for a post-void residual determination, since payment of this has already been included in the payment for the complete scans.

The report must contain an entry denoting the post-void residual amount and/or bladder capacity as calculated/estimated from the ultrasound device. In addition, the medical record must contain documentation of the indication for the service and the number of times performed to ensure an empty bladder has been reached.

Subgroup 2: Transoesophageal echocardiography

This subgroup now only contains transoesophageal echocardiography - items 55118, 55130 and 55135. Transthoracic and stress echocardiography are now in subgroup 7, the notes for which are covered in notes IN.1.3 to IN.1.10. and IR.0.1 to IR.1.3.

Subgroup 3: Vascular Ultrasound

General

Medicare benefits are only payable for:

- a maximum of two vascular ultrasound studies in a seven-day period. A vascular ultrasound study may include one or more items. Additionally, where a patient is referred for a bilateral study of both arms or both legs, the account should indicate 'bilateral' or 'left' and 'right' to enable a benefit to be paid.

- clinically relevant services, that is, the service is generally accepted in the medical profession as being necessary for the appropriate treatment or management of the patient to whom it is rendered. Any decision to have a patient return on a different day to complete a multi-area diagnostic imaging service should only be made based on clinical necessity.

Deep vein thrombosis (DVT) – Items 55244 and 55246

Medical practitioners referring patients for duplex ultrasound for suspected lower limb DVT (items 55244 and 55246) should read and consider the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCR) 2015 Choosing Wisely recommendations or RANZCR Choosing Wisely recommendations that succeed it.

Examination of peripheral vessels

Vascular ultrasound services can be claimed in conjunction with item 11612 (Exercise study for the evaluation of lower extremity arterial disease).

Subgroup 4: Urological ultrasound - Items 55600 and 55603

Benefits for these items are payable where the service is rendered in the following circumstances:

- a digital rectal examination of the prostate was personally performed by the medical practitioner who also personally rendered the ultrasound service; and
- the transducer probe or probes used can obtain both axial and sagittal scans in 2 planes at right angles; and
- the patient was assessed prior to the service by a medical practitioner recognised in one or more of the specialties specified, not more than 60 days prior to the ultrasound service. Item 55600 applies where the service is rendered by a medical practitioner who did not assess the patient, whereas item 55603 applies where the service was rendered by a medical practitioner who did assess the patient.

Subgroup 5: Obstetric and Gynaecological ultrasound

NR Services

Except for item 55758, Medicare benefits are not payable for more than three NR-type ultrasound services in Subgroup 5 of Group I1 (ultrasound) that are performed on the same patient in any one pregnancy.

Pre-requisite services

A patient must have previously had either a 55706 or 55709 ultrasound in the same pregnancy to be eligible to claim for either a 55712 or 55715 obstetric service. To be eligible to claim for either a 55721 or 55725 obstetric service, a patient must have previously had either a 55718 or 55723 ultrasound in the same pregnancy.

Frequency of services

Medicare benefits are only payable once per item per pregnancy for items 55706, 55707, 55708, 55709, 55718, 55723, 55742, 55743, 55759, 55762, 55768 and 55770.

Dating of pregnancy

When dating a pregnancy for the purpose of items 55700 to 55774, a patient is:

- "less than 12 weeks of gestation" means up to 11 weeks and 6 days of pregnancy;
- "12 to 16 weeks of gestation" means from 12 weeks 0 days of pregnancy up to 16 weeks plus 6 days of pregnancy (inclusive);
- "17 to 22 weeks of gestation" means from 17 weeks 0 days of pregnancy up to 22 weeks plus 6 days of pregnancy (inclusive);
- "after 22 weeks of gestation" means from 23 weeks 0 days of pregnancy onwards;

- "after 24 weeks of gestation" means from 25 weeks 0 days of pregnancy onwards;
- "between 14 and 30 weeks of gestation" means from 14 weeks 0 days of pregnancy to 30 weeks plus 6 days of pregnancy (inclusive); and
- "before 28 weeks gestation" means up to 27 weeks plus 6 days of pregnancy (inclusive).

Singleton pregnancies

Obstetric ultrasound items 55700 to 55725 (except for items 55736 and 55739 which are performed pre-pregnancy) cover scanning of a patient who is experiencing a singleton pregnancy, with the items including requested and non-requested services. Item 55729 covers both single and multiple pregnancies.

Except for items 55700 (R) and 55703 (NR) all singleton items restrict the claiming of cervical length items 55757 and 55758 within 24 hours. Items 55700 and 55703 advise that the ultrasound service cannot be performed on the same patient within 24 hours of a service mentioned in item 55704, 55705, 55707, 55708, 55740, 55741, 55742 or 55743. This accords with clinical practice guidelines which do not recommend repeat scanning at intervals less than 24 hours.

For all other singleton items, the ultrasound cannot be performed on the same patient within 24 hours of a service mentioned in another item in Subgroup 5 of Group I1. The most appropriate item to be claimed should be chosen based on clinical need, with each ultrasound scan representing a completed medical service.

Nuchal Translucency Testing

A nuchal translucency measurement ultrasound is performed to assess the patient's risk of fetal abnormality when the pregnancy is dated by a crown rump length of 45 to 84mm. If a nuchal translucency measurement is performed for a singleton pregnancy, items 55707 (R) or 55708 (NR) should be claimed. If a nuchal translucency measurement is performed for a multiple pregnancy, items 55742 (R) or 55743 (NR) should be claimed.

The nuchal translucency measurement ultrasound service should not be performed on the same patient within 24 hours of a service mentioned in another item in Subgroup 5 of Group I1. If nuchal translucency measurement for risk of foetal abnormality is performed (items 55707, 55708, 55742 or 55743) within 24 hours of any other additional items in Subgroup 5 of Group I1, only one fee is payable. It is the treating practitioner's responsibility to consider the clinical circumstances of any services rendered and to determine the appropriate MBS item(s) to claim, if any.

The RANZCR provides a credentialling program for providers of nuchal translucency scans.

Cervical length items 55757 and 55758

Items 55757 (R) and 55758 (NR) are to assess the cervical length of the patient to determine risk of preterm labour and can be claimed for any pregnancy. These items cannot be co-claimed within 24 hours of another item in Subgroup 5 of Group I1. There are no clinical grounds for repeat scanning within 24 hours.

Multiple pregnancies

Obstetric ultrasound items 55740 to 55774 (except for items 55757 and 55758) cover scanning of a patient who is experiencing a multiple pregnancy. Based on the recommendations of the profession, the items apply only to patients where a multiple pregnancy has been confirmed by ultrasound. The items include identical restrictions and provisions as the second and third trimester items (55706-55725) and include items for requested and non-requested services. Due to the ongoing risks and complications associated with multiple pregnancies regardless of pregnancy outcomes, any pregnancy identified as multiple at the commencement of the second trimester (13+0 weeks) should continue to utilise the multiple pregnancy items for the duration of that pregnancy.

With the exception of items 55740 (R) and 55741 (NR), the multiple pregnancy items cannot be co-claimed within 24 hours of cervical length items 55757 (R) or 55758 (NR). Items 55740 and 55741 cannot be co-claimed within 24 hours of another item in Subgroup 5 of Group I1. There are no clinical grounds for repeat scanning within 24 hours.

Obstetric and gynaecological services—Requests and clinical notes

For R-type obstetric and gynaecological ultrasound services, the request form must state the relevant condition or clinical indication for the service.

For NR type obstetric and gynaecological ultrasound services, the clinical notes of the services must state the relevant condition or clinical indication for the service.

Obstetric ultrasound and non-metropolitan providers (items 55712, 55721, 55764 and 55772)

In addition to the requirement that the request form and clinical notes must state the relevant condition or clinical indication for the service, where a practitioner has obstetric privileges at a non-metropolitan hospital and requests items 55712, 55721, 55764 and 55772, the practitioner must confirm his/her eligibility by stating 'non-metropolitan obstetric privileges' on the request form.

In relation to items 55712, 55721, 55764 and 55772, a non-metropolitan area includes any location outside of the Sydney, Melbourne, Brisbane, Adelaide, Perth, Greater Hobart, Darwin or Canberra major statistical divisions, as defined in the Australian Standard Geographical Classification 2010 published by the Australian Bureau of Statistics.

Subgroup 6: Musculoskeletal (MSK)

Multiple Musculoskeletal Ultrasound Scans

Generally, Medicare benefits are payable for more than one musculoskeletal ultrasound scan performed on the same day, however the scans are subject to Rule A of the general diagnostic imaging multiple services rules.

It is not permitted to split a bilateral scan. Where bilateral ultrasound scans are performed, the relevant item should be itemised once only on accounts and receipts or Medicare assignment of benefits agreements. For example, if both shoulders are scanned, item 55866 or 55867, as the case may be, should be claimed once only. This is because the item descriptor for these items covers both sides. A patient should not be asked to make a second appointment in order to attract a benefit for multiple scans.

Shoulder and knee (items 55864 to 55867 and 55880 to 55883)

Benefits for shoulder and knee ultrasound items are only payable when the request is based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific shoulder or knee pain alone or other specific conditions such as meniscal and cruciate ligament tears and assessment of chondral surfaces.

Items in association with a surgical procedure (55848 and 55850)

Item 55848 is a musculoskeletal (MSK) ultrasound service for use in association with a surgical procedure, such as a joint injection.

Item 55850 is a musculoskeletal ultrasound service for use in association with a surgical procedure, such as a joint injection, which is inclusive of a diagnostic ultrasound. This item cannot be claimed if diagnostic ultrasound was not conducted during the examination.

Subgroup 7 - Transthoracic and stress echocardiography

The notes for these items are shown in notes IN.1.3 to IN.1.10. and IR.0.1 to IR.1.3.

IN.0.14 Restriction anaesthetic items in conjunction with item 55054

An item in Group T10 (Relative Value Guide) cannot be claimed in association with item 55054 (ultrasound when used in conjunction with procedures). Medicare benefits will continue to be available for the procedures alone and whether individual anaesthetists choose to use ultrasound to assist with those procedures is a matter of clinical judgement for those providers.

IN.0.15 Group I2 - Computed Tomography (CT)

Professional supervision

CT services (items 56001 to 57362) are not eligible for a Medicare benefit unless the service is performed, for an eligible person:

(a) under the professional supervision of a specialist in diagnostic radiology who is available:

- to monitor and influence the conduct and diagnostic quality of the examination; and
- if necessary, to personally attend the patient;

(b) reported by a specialist in diagnostic radiology (who may or may not be the supervising specialist); or

(c) if the above criteria cannot be complied with

- in an emergency, or
- because of medical necessity in a remote location.

The definition of a remote location is one that is more than 30 kilometres by road from:

(a) a hospital which provides a radiology service under the direction of a specialist in the specialty of diagnostic radiology; or

(b) a free-standing radiology facility under the direction of a specialist in the specialty of diagnostic radiology.

Note: Practitioners do not have to apply for a remote location exemption in these circumstances.

Restriction on items—attenuation correction and anatomical correlation

Items in this Division do not apply to a CT service that is performed for the purpose of attenuation correction or anatomical correlation of another diagnostic imaging procedure.

Use of PET/CT or SPECT/CT machines

CT scans rendered on Positron Emission Tomography (PET)/CT or Single Photon Emission Computed Tomography (SPECT)/CT units are eligible for a Medicare benefit provided the CT scan is rendered under the same conditions as those applying to services rendered on stand-alone CT equipment.

Scan of more than one area/region

Where multiple regions are scanned on one occasion and a combination item exists that covers those regions, the combination item must be claimed. Items covering individual contiguous regions must not be used when scans of multiple regions are performed and a combination item exists that covers those regions.

More than one attendance of the patient to complete a scan

Items 56219 to 56238 (CT of the spine) and 56620 to 56630 (CT of the extremities) apply once only for a service described in any of those items, regardless of the number of patient attendances (ie patient visits) required to complete the service. For example, where a request relates to two or more regions of the spine and only one region is scanned on one occasion with the balance of regions being scanned on a subsequent occasion, benefits are payable for one service only.

Pre-contrast scans

Pre-contrast scans are included in an item of service with contrast medium only when the pre-contrast scans are of the same region.

Inclusive of intrathecal contrast medium – item 56219

The fee for item 56219 incorporates the cost of contrast medium for intrathecal injection and associated x-rays. Benefits are not payable for this item when rendered in association with myelogram item 59724. Where a myelogram is rendered under item 59724 and a CT is necessary, the relevant item would be scan of spine without intravenous contrast (items 56220, 56221 or 56223).

Computed tomography of the head

Exclusion of acoustic neuroma

If an axial scan is performed for the exclusion of acoustic neuroma, Medicare benefits are payable under item 56001 or 56007.

Assessment of headache

If item 56007 or 56036 is used for the assessment of headache of a patient, the fee mentioned in the item applies only if:

(a) a scan without intravenous contrast medium has been undertaken on the patient; and

(b) the service is required because the result of the scan is abnormal.

This rule applies to a patient who:

- is under 50 years; and
- is (apart from the headache) otherwise well; and
- has no localising symptoms or signs; and
- has no history of malignancy or immunosuppression.

Computed tomography of the spine

Multiple regions

CT items exist which separate the examination of the spine into the cervical, thoracic and lumbosacral regions.

These items are 56220 to 56238 inclusive. They include items for CT scans of two regions of the spine (56233 and 56234) and for all three regions of the spine (56237 and 56238). Restrictions apply to the following items:

- item 56233 should be claimed where two examinations of the kind referred to in items 56220, 56221 and 56223 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment agreement completed.
- item 56234 should be claimed where two examinations of the kind referred to in items 56224, 56225 and 56226 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment agreement completed.

Example: for a CT examination of the spine where the cervical and thoracic regions are to be studied (item 56233), item numbers 56220 and 56221 must be specified.

Computed tomography of the upper abdomen and pelvis

Items 56501 and 56507 are not eligible for benefits if performed for the purpose of performing a virtual colonoscopy (otherwise known as CT colonography and CT colography). Item 56553 is to be used for a CT colonography.

Computed tomography angiography

If items 57352, 57353, 57354 or 57357 are requested by a medical practitioner (other than a specialist or consultant physician) the patient's case must be discussed with a specialist or consultant physician (not the radiologist likely to perform the service) and noted as such on the request.

Item 57357 (angiography of the pulmonary arteries and their branches) may be requested by a medical practitioner (other than a specialist or consultant physician), without the patient's case being discussed with a specialist or consultant physician if the service is performed for the exclusion of pulmonary embolism as stated on the request.

Computed Tomography Coronary Angiography (CTCA) for coronary artery disease

Items 57360 and 57364 apply only to a CT service that is:

(a) performed under the professional supervision of a specialist or consultant physician recognised by the Conjoint Committee for the Recognition of Training in CT Coronary Angiography who is available:

- to monitor and influence the conduct and diagnostic quality of the examination; and
- if necessary, to personally attend the patient; and

(b) reported by a specialist or consultant physician (who may or may not be the supervising specialist) recognised by the Conjoint Committee for the Recognition of Training in CT Coronary Angiography; or

(c) if paragraphs a and b cannot be complied with

- in an emergency, or
- because of medical necessity in a remote location.

The definition of a remote location is one that is more than 30 kilometres by road from:

(a) a hospital which provides a radiology service under the direction of a specialist in the specialty of diagnostic radiology; or

(b) a free-standing radiology facility under the direction of a specialist in the specialty of diagnostic radiology.

Note: Practitioners do not have to apply for a remote location exemption in these circumstances.

IN.0.16 Group I3 - Diagnostic Radiology

Examination and report

As for all diagnostic imaging services, the benefits allocated to each item from 57506 to 60509 inclusive cover the total service, i.e. the image, reading and report. Separate benefits are not payable for individual components of the service, e.g. preliminary reading. Benefits are not separately payable for associated plain films involved with these items.

Exposure of more than one film

Where the radiographic examination of a specific area involves the exposure of more than one film, benefits are payable once only, except where special provision is made in the description of the item for the inclusion of all films taken for the purpose of the examination. This means that if an x-ray of the foot is requested, regardless of the number of exposures from different angles, the completed service comprises x-ray of the foot by one or more exposures and the report. The exception to this would be the plain x-ray of the spine items (58100 to 58121) where

the item number differs dependent upon the regions of the spine that are examined at the same occasion, ie. 58112 applies where two regions are examined.

Comparison X-rays

Where it is necessary for one or more films of the opposite limb to be taken for comparison purposes, benefits are payable for radiographic examination and reporting of one limb only. Comparison views are considered to be part of the examination requested.

Images produced using Dual Energy X-ray Absorptiometry (DEXA) equipment

X-ray items of the spine 58100 to 58121 and hip 57712 cannot be claimed when images are produced using Dual Energy X-ray Absorptiometry (DEXA) equipment. DEXA should be claimed under General Medical Services Table items 12306 to 12322.

Subgroup 1 – Radiographic examination of the extremities

Hand and wrist combination X-ray

An examination of the hand and the wrist on the same side should be claimed as item 57512 (NR) or 57515 (R). If items 57506 (NR) or 57509 (R) are claimed for multiple non-adjacent areas on the same side, or areas on different sides, the account should include annotation on this e.g. L and R hand, or hand and humerus.

Subgroup 4: Radiographic examination of the spine

Multiple regions

Multiple region items require that the regions of the spine to be studied must be specified on any account issued or patient assignment agreement completed.

Item 58112 - spine, two regions

Where item 58112 is rendered (spine, two regions), the item numbers for the regions of the spine being studied must be specified (i.e. from items 58100, 58103, 58106 and 58109).

Example: for a radiographic examination of the spine where the cervical and thoracic regions are to be studied, item numbers 58100 and 58103 must be specified on any account issued or patient assignment agreement completed.

Item 58115 - spine, three region

Where item 58115 is rendered (spine, three regions), the item numbers for the regions of the spine being studied must be specified (items 58100, 58103, 58106 and 58109).

Example: for a radiographic examination of the spine where the cervical, the thoracic and the lumbosacral regions are to be studied, item numbers 58100, 58103 and 58106 must be specified on any accounts issued or patient assignment agreement completed.

Item 58115 and 58108 - spine, three and four regions – request by medical practitioner

Three and four region radiographic examinations items 58115 and 58108 only apply when requested by a medical practitioner.

Items 58120 and 58121 - spine, three and four regions – request by non-medical practitioner

Items 58120 and 58121 apply to physiotherapists and osteopaths who request a three or four region x-ray. Benefits are payable for one of these items only per patient per calendar year.

Subgroup 8: Radiographic examination of alimentary tract and biliary system

Plain abdominal film - items 58900 and 58903

Benefits are not payable for items 58900 and 58903 in association with barium meal examinations or cholecystograms whether provided on the same day or previous day. Preliminary plain films are covered in each study.

Subgroup 10: Radiographic examination of the breasts

Request requirements - items 59300 and 59303

Benefits under items 59300 and 59303 are payable only where the patient has been referred in specific circumstances as indicated in the description of the items. To facilitate these provisions, the requesting medical practitioner is required to include in the request the clinical indication for the procedure.

Professional supervision

Mammography services (items 59300 to 59318) are not eligible for a Medicare benefit unless the diagnostic imaging procedure is performed under the professional supervision of a:

- specialist in the specialty of diagnostic radiology who is available to monitor and influence the conduct and diagnostic quality of the examination, and, if necessary, to personally attend on the patient; or
- if paragraph (a) cannot be complied with:
- in an emergency; or
- because of medical necessity in a remote location.

Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

Subgroup 12: Radiographic examination with opaque or contrast media

Myelogram- item 59724

Benefits are not payable where a myelogram is rendered in association with a CT myelogram (item 56219 – see IN.0.16). Where it is necessary to render a CT and a myelogram, CT items 56220, 56221 and 56223 would apply.

Subgroup 13: Angiography

Digital subtraction angiography (DSA) - items 60000-60078

Benefits are payable only where these services are rendered in an angiography suite (a room that contains only equipment designed for angiography that is able to perform digital subtraction or rapid-sequence film angiography). Benefits are not payable when these services are rendered using mobile DSA imaging equipment as these services are covered by item 59970.

Each item includes all preparation and contrast injections other than for selective catheterisation. For DSA, benefits are payable for a maximum of one DSA item (from Items 60000 to 60069). For selective DSA - one DSA item (from 60000 to 60069) and one item covering selective catheterisation (from 60072, 60075 or 60078).

If a DSA examination covers more than one of the specified regions/combinations, then the region/combination forming the major part of the examination should be selected, with itemisation to cover the total number of film runs obtained. A run is the injection of contrast, data acquisition, and the generation of a hard copy record.

Subgroup 16: Preparation for radiological procedure

Preparation items - 60918 and 60927

Items 60918 and 60927 apply only to the preparation of a patient for a radiological procedure for a service to which item 59970 applies. A report is not required for these services.

IN.0.17 Group I4 - Nuclear Medicine Imaging

Nuclear medicine imaging services other than PET

Benefits for a nuclear scanning service (other than PET) are only payable when the service is performed:

- by a nuclear medicine credentialled specialist or consultant physician, or by a person acting on behalf of the specialist; and
- the final report of the service is compiled by a nuclear medicine credentialled specialist.
- Additional benefits will only be attracted for a nuclear medicine credentialled specialist or consultant physician attendance under Category 1 of the Schedule where there is also a referral letter from the patient's treating medical practitioner for a full medical examination of the patient. The referral letter needs to be distinct from the request for the nuclear medicine scan.

Credentialling for nuclear medicine imaging services

Payment of Medicare benefits for nuclear medicine imaging services is limited to specialists or consultant physicians who are credentialled by the Joint Nuclear Medicine Credentialling and Accreditation Committee (JNMCAC) of the Royal Australian College of Physicians (RACP) and the Royal Australian and New Zealand College of Radiologists (RANZCR).

The scheme was developed by the profession in consultation with Government to ensure that specialists in nuclear medicine are appropriately trained and licensed, provide appropriate supervision of procedures and are involved in ongoing continuing medical education.

For information regarding the Scheme and for application forms, please go to RANZCR's website at www.ranzcr.com or RACP's website at www.racp.edu.au.

Radiopharmaceuticals

The schedule fees for nuclear medicine imaging services incorporate the costs of radiopharmaceuticals.

Myocardial perfusion studies - various items

See notes IN.1.10, IN.4.1, IN.4.2, IN.4.3 and IR.0.1 to IR.4.2.

Pulmonary Embolism (PE) – items 61328, 61340 and 61348

Medical practitioners requesting imaging for suspected PE should read and consider the RANZCR 2015 Choosing Wisely recommendations, or such clinical RANZCR Choosing Wisely recommendations that succeed it.

Hepatobiliary study (pre-treatment) - item 61360

Item 61360 - the standard hepatobiliary item - also includes allowance of the pre-procedural cholagogue administration for preparatory emptying of the gall bladder and also morphine augmentation.

Hepatobiliary study (infusion) - item 61361

Item 61361 applies specifically to a standard hepatobiliary study to which has been added an infusion of cholagogue following which acquisition is continued and quantification of gallbladder ejection fraction and/or common bile duct activity time curves are performed.

Whole body studies

"Whole body" studies should include the trunk, head and upper and lower limbs down to the elbow and knee joints respectively, whether acquired as multiple overlapping camera views or whole body sweeps (runs) with additional camera views as required. Any study that does not fulfil these criteria is a localised study.

Repeat studies - item 61462

Item 61462 covers repeat planar (whole body or localised) and/or SPECT imaging performed on a separate occasion using the same administration of radiopharmaceutical. The repeat planar and SPECT imaging when performed on a separate occasion using the same administration of radiopharmaceutical should be itemised as item 61462 and the original item and date of service should be indicated for reference purposes.

This item does not apply to bone scans, adrenal studies or gastro-oesophageal reflux studies, myocardial perfusion studies, colonic transit or CFS transport studies, where allowance for performance of the delayed study is incorporated into the baseline benefit fee.

Thyroid study - item 61473

Item 61473 incorporates the measurement of thyroid uptake on a gamma camera using a proven technique, where clinically indicated.

Positron Emission Tomography (PET) - items in Subgroup 2 of Group I4

General

PET services must be:

- performed under the supervision of a PET credentialled specialist. The service does not need to be performed by a PET credentialled specialist. For example, the service may be performed by a medical imaging technician when supervised by a PET credentialled specialist. If personal attendance is required, the person attending must be either a PET credentialled specialist, a nuclear medicine credentialled specialist, or a specialist in diagnostic radiology.

- reported by a PET credentialled specialist.

- provided in a comprehensive practice. The *Health Insurance (Diagnostic Imaging Services Table) Regulations (No.2) 2020* defines a comprehensive practice as a medical practice or hospital radiology department that provides x-ray, ultrasound and computed tomography (CT) services.

- provided using equipment that meets the Requirements for PET Accreditation (Instrumentation & Radiation Safety) 3rd Edition (2017) issued by the Australian and New Zealand Society of Nuclear Medicine Inc.

- only provided following a request from a specialist or consultant physician.

- Additional benefits will only be attracted for a nuclear medicine credentialled specialist or consultant physician attendance under Category 1 of the Schedule where there is also a referral letter from the patient's treating medical practitioner for a full medical examination of the patient. The referral letter needs to be distinct from the request for the nuclear medicine scan.

PET credentialled specialist means:

- a specialist or consultant physician who is credentialled under the Joint Nuclear Medicine Specialist Credentialling Program for the Recognition of the Credentials of Nuclear Medicine Specialists for Positron Emission Tomography overseen by the JNMCAC; or
- a specialist or consultant physician who:
    - is a Fellow of the RACP or RANZCR; and

- has reported 400 or more studies forming part of PET services for which a Medicare benefit was payable; and
- is authorised under State or Territory law to prescribe and administer to humans the PET radiopharmaceuticals that are to be administered to a person; and
- met these requirements before 1 November 2011.

Whole body FDG PET

In patients with Hodgkin and non- Hodgkin lymphoma (excluding indolent non- Hodgkin lymphoma), whole body FDG PET studies should not be used for surveillance nor for assessment of patients with suspected (as opposed to confirmed) disease recurrence.

PET for Alzheimer's disease

For item 61560:

- the study must include a quantitative comparison of the results with the results obtained from a PET study in a reference library of a normal brain.
- benefits are not payable for the item if the patient has a previous PET scan for Alzheimer's disease claimed in the previous 12 months.
- benefits are not payable for the item if a cerebral perfusion study (item 61402) for the diagnosis or management of Alzheimer's disease has been claimed in the previous 12 months.
- benefits are only payable for a maximum of three services in the patient's lifetime.

Prostate-specific membrane antigen (PSMA) PET study for Prostate Cancer

Item 61563 - Whole body PSMA PET study for the initial staging of the patient

- The requesting specialist or consultant physician is to record in the clinical notes and the imaging request that the patient:
    - has intermediate to high-risk prostate adenocarcinoma, as defined below;
    - has previously been untreated; and
    - is considered suitable for locoregional therapy with curative intent.
- Patients with intermediate risk prostate adenocarcinoma can be defined as having at least one of the following risk factors in the absence of any high-risk features: PSA of 10-20 ng/ml, or Gleason score of 7 or International Society of Urological Pathology (ISUP) grade group 2 or 3, or Stage T2b.
- Patients with high-risk prostate adenocarcinoma can be defined as having at least one of the following risk factors: PSA >20 ng/ml, or Gleason score >7 or ISUP grade group 4 or 5, or Stage T2c or ≥T3.
- Benefits are only payable for a maximum of one service in the patient's lifetime.

Item 61564 - Whole body PSMA PET study for the restaging of the patient

- The requesting specialist or consultant physician is to record in the clinical notes and the imaging request that the patient has undergone prior locoregional therapy for prostatic adenocarcinoma and is considered potentially suitable for further locoregional therapy for recurrent disease.
- This item can be claimed by patients with:
    - a prostate specific antigen (PSA) increase of 2ng/ml above the nadir after radiation therapy; or
    - failure of PSA levels to fall to undetectable levels; or
    - rising serum PSA after a radical prostatectomy.

- Benefits are only payable for a maximum of two services in the patient's lifetime.

Whole body PSMA PET study items 61563 and 61564 are not to be used for surveillance nor for assessment of patients with suspected (as opposed to confirmed) prostate adenocarcinoma or disease recurrence.

Claiming of diagnostic CT with PET scans

Diagnostic CT items should not be co-claimed with a whole body PET scan unless the service is clinically relevant and appropriately requested. Under the *Health Insurance (Diagnostic Imaging Services Table) Regulations (No. 2) 2020*, diagnostic CT items cannot be claimed with a PET item where the purpose of the CT is for attenuation correction or anatomical correlation. CT attenuation item 61505 is the correct item to be claimed in these circumstances.

IN.0.18 Group I5 - Magnetic Resonance Imaging

Meaning of the term 'scan' in MRI items

In items 63001 to 63563 and 63740 to 63746, scan means a minimum of 3 sequences.

Eligible services

Items in Subgroups 1 to 21 (other than items 63541 and 63543) apply to an MRI or MRA service performed:

(a) on request by a recognised specialist or consultant physician, where the request made in writing identifies the clinical indication for the service;

(b) under the professional supervision of an eligible provider; and

(c) with eligible equipment.

For information on what constitutes eligible equipment, please refer to '**MRI equipment eligibility**' below.

Items in Subgroups 22 and 32 apply to an MRI or MRA service performed:

(a) on request by a medical practitioner, where the request made in writing identifies the clinical indication for the service;

(b) under the professional supervision of an eligible provider; and

(c) with eligible equipment.

Items in Subgroups 33 and 34 of Group I5 apply to an MRI service performed:

(a) on request by a medical practitioner other than a specialist or consultant physician, where the request made in writing identifies the clinical indication for the service;

(b) under the professional supervision of an eligible provider; and

(c) with eligible equipment.

Prostate Multiparametric MRI items 63541 and 63543 apply to a service performed:

(a) at the request of a specialist in the speciality of urology, radiation oncology, or medical oncology; and

(b) under the professional supervision of an eligible provider; and

(c) using eligible equipment.

See also note IN.5.2 for specific conditions relating to items 63541 and 63543.

Requests

A request must identify the clinical indications for the service.

MRI services can only be requested by a recognised specialist medical practitioner or consultant physician for the purposes of the *Health Insurance Act 1973*. However, there are exceptions to this provision for a limited number of MRI services:

- all dental specialists, prosthodontists, oral and maxillofacial surgeons, oral medicine specialists and oral pathology specialists may request item 63334 - scan of musculoskeletal system for derangement of the temporomandibular joint(s); and
- oral and maxillofacial surgeons and oral medicine and oral pathology specialists can also request item 63007 - scan of the head for skull base or orbital tumour; and
- items in subgroup 33 and 34 may only be requested by a medical practitioner other than a specialist or a consultant physician.

For cardiac MRI items 63395 and 63397 (scan for diagnosis of arrhythmogenic right ventricular cardiomyopathy (ARVC)), the request must specify that ARVC is suspected on the basis of diagnostic criteria endorsed by the Cardiac Society of Australia and New Zealand (CSANZ), in force at the time the service is requested.

Permissible circumstances for performance of service

Benefits are only payable for MRI when performed as follows:

(a) both

- under the professional supervision of an eligible provider who is available to monitor and influence the conduct and diagnostic quality of the examination, including, if necessary, by personal attendance on the patient; and

- reported by an eligible provider; or

(b) if paragraph (a) is not complied with

- in an emergency; or

- because of medical necessity, in a remote location (refer to IN.0.6).

Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

Eligible providers

For items in Group I5 (excluding cardiac MRI items 63395 to 63397), an eligible provider is a specialist in diagnostic radiology.

For cardiac MRI items 63390 and 63395 to 63397, an eligible provider is a specialist in diagnostic radiology or a consultant physician, who is recognised by the Conjoint Committee for Certification in Cardiac MRI. The conjoint committee is comprised of specialists from RANZCR and the Cardiac Society of Australia and New Zealand (CSANZ).

MRI equipment eligibility

Eligible equipment is equipment which:

(a) is located at premises of a comprehensive practice in Modified Monash Areas 2 to 7; OR

(b) is located at premises:
(i) of a comprehensive practice in Modified Monash Areas 1; and

(ii) is made available to the practice by a person:
- who is subject to a deed with the Commonwealth that relates to the equipment.

A comprehensive practice for MRI services

The *Health Insurance* (*Diagnostic Imaging Services Table) Regulations* defines a comprehensive practice as a medical practice, or a radiology department of a hospital, that provides X-ray, ultrasound and computed tomography services (whether or not it provides other services).

The location of Medicare-eligible MRI machines is available at the Department of Health, Disability and Ageing's website at www.health.gov.au by searching for "MRI Unit Locations".

Limitation period for certain Medicare eligible MRI services

Item	MRI or MRA items	Limitation Period	Maximum number of services
1	63040 to 63073	12 months	3
2	63101	12 months	3
3	63125 to 63131	12 months	3
4	63161 to 63185	12 months	3
5	63219 to 63243	12 months	3
6	63271 to 63280	12 months	3
7	63322 to 63340	12 months	3
8	63361	12 months	2
9	63385 to 63391	12 months	2
10	63395	12 months	1
11	63397	36 months	1
12	63401 to 63404	12 months	3
13	63416	12 months	1
14	63425 to 63428	12 months	2
15	63461 to 63467	12 months	1
15A	63541	12 months	1
*	63545 and 63546	12 months	1
16	63547	patient's lifetime	1
17	63482	12 months	3
18	63507 to 63522 and 63551 to 63560	12 months	3
19	63563	24 months	1

Please note the * indicates restriction is included in the item descriptor.

The frequency restrictions are considered to be rolling restrictions and not based on calendar or financial years.

MRI items for the staging of histologically diagnosed cervical cancer at FIGO stage 1B or greater (63470 or 63473)

Items 63470 or 63473 in subgroup 20 may be claimed only once ever. After either 63470 or 63473 is claimed the patient is no longer eligible for Medicare benefits under either item.

MRI items for Crohn's disease (63740 to 63743)

Medicare benefits are only payable once in a 12 month period for item 63740, where it is provided for assessment of change to therapy in a patient with small bowel Crohn's disease. The 12 month limitation does not apply to this item otherwise.

Medicare benefits are only payable once in a 12 month period for item 63743, where it is provided for assessment of change to therapy of pelvis sepsis and fistulas from Crohn's disease. The 12 month limitation does not apply to this item otherwise.

MRI Subgroup 22 Modifying Items and eligible MRI and MRA service

Items in subgroup 22 (modifying items) may only be claimed in conjunction with an eligible MRI/MRA service.

Restrictions when applied to bilateral anatomical sites

Restrictions on the number of services of the kind described in subgroup 12 apply to specific anatomical sites. Where an item description applies to more than one anatomical site the restriction on the number of services applies to each site.

For example, item 63328 provides for an MRI scan for derangement of the knee or its supporting structures and applies to two specific anatomical sites, ie, right knee and left knee. Each anatomical site may be scanned up to 3 times in any 12-month period as clinically required.

Co-claiming head and spine MRI scans – items 63001-63131 and 63151 to 63280

Benefits are payable for only one head MRI scan at the same attendance. The items that will restrict with each other are in the range 63001 to 63131.

Benefits are payable for only one spine MRI scan at the same attendance. The items that will restrict with each other are in the range 63151 to 63280.

The head or spine item with the highest schedule fee can be claimed where indications spanning two or more service have been requested.

More than one item can be claimed where the clinical need for the additional service is:

- stated in the request for the service; and
- appropriately documented in the record of the service.

These rules clarify the policy intent for the items, that is, only one item should be claimable for a scan irrespective of the:

- number of clinical conditions being investigated; and
- the number of sequences required to complete the scan.

Where a request form seeks an investigation of more than one clinical condition, the item to claim is the item with the highest schedule fee. If the items have the same schedule fee, the item to be claimed is the item applicable to the first mentioned indication on the request form.

More than one item can be claimed where the request for the scan states that there is a clinical need for the additional service, and this is appropriately documented in the diagnostic imaging record for the patient. This does not mean different clinical indications listed in a request, rather it means that the requester is seeking separate and distinct scans.

Providers will need to indicate on the claim that separate and distinct scans have been requested.

MRI scan of the pelvis for pregnancy - 18 weeks gestation – suspected fetal abnormality (MBS item 63454)

Clinical Notes and Diagnostic Imaging Request

For item 63454 the requesting specialist practising in the specialty of obstetrics is to record in their clinical notes and the imaging request:

· the pregnancy is at, or after, 18 weeks gestation; and

· fetal abnormality is suspected; and

· an ultrasound has been previously performed and the diagnosis of fetal abnormality is indeterminate or requires further examination of the patient.

Providers

The service can only be requested by a specialist practising in the specialty of obstetrics.

Gestation period

For item 63454, "at or after 18 weeks gestation" means from 18 weeks 0 days of pregnancy onwards as confirmed by an ultrasound.

MRI scan of both breast for detection of cancer – younger than 60 years (MBS Item 63464)

Clinical Notes

For item 63464 the requesting specialist or consultant physician is to record in their clinical notes:

- the patient is asymptomatic; and
- the patient is younger than 60 years of age; and
- the patient is at a high risk of developing breast cancer due to one or more of the clinical indicators contained in the item descriptor. Reference the relevant clinical indicator/s in the clinical notes and request.

Clinically Relevant Evaluation Algorithm

A clinically relevant evaluation algorithm referenced in item 63464(c)(v) is considered to be the Tyrer-Cuzick (IBIS Risk Evaluator) algorithm version 8 (or later version). The lifetime risk estimation is one of a number of clinical indicators contained in the item descriptor which can support a patient being eligible to claim item 63464.

Restrictions

For item 63464, the service is not to be performed with items 55076 or 55079.

The service can only be claimed once in any 12-month period.

Age requirements

The age references in item 63464 are as follows:

- younger than 60 years of age refers to a patient who has not yet turned 60 years of age.
- before the age of 50 years refers to the patient being up to and including 49 years of age.
- at age 45 years or younger refers to the patient being up to and including 45 years of age.

MRI scan of the pelvis for multiple pregnancy - 18 weeks gestation – suspected fetal abnormality (MBS Item 63549)

Clinical Notes and Diagnostic Imaging Request

For item 63549 the requesting specialist practising in the specialty of obstetrics is to record in their clinical notes and the imaging request:

- the patient has a multiple pregnancy; and
- the pregnancy is at, or after, 18 weeks gestation; and
- fetal abnormality is suspected; and
- an ultrasound has been previously performed and diagnosis of fetal abnormality is indeterminate or requires further examination of the patient.

Providers

The service can only be requested by a specialist practising in the specialty of obstetrics.

Gestation period

For item 63549, "at or after 18 weeks gestation" means from 18 weeks 0 days of pregnancy onwards as confirmed by an ultrasound.

MRI scan of the liver (MBS Item 63545)

Clinical Notes

For item 63545 the requesting specialist or consultant physician is to record in their clinical notes:

- the patient has a confirmed extra hepatic primary malignancy (other than hepatocellular carcinoma);
- computed tomography is negative or inconclusive for hepatic metastatic disease; and
- the identification of liver metastases would change the patient's treatment planning.

Restrictions

The service can only be claimed once in any 12 month period.

MRI scan of the pelvis for sub-fertility and deep endometriosis (MBS Item 63563)

Clinical Notes and Diagnostic Imaging Request

For item 63563 the requesting specialist or consultant physician is to record in their clinical notes and the imaging request that the scan is for the investigation of

- sub-fertility requiring one or more of the following:
    - o an investigation of suspected Mullerian duct anomaly seen in pelvic ultrasound or hysterosalpingogram;
    - o an assessment of uterine mass identified on pelvic ultrasound before consideration of surgery;
    - o an investigation of recurrent implantation failure in IVF (2 or more embryo transfer cycles without viable pregnancy); or
- surgical planning of a patient with known or suspected deep endometriosis involving either the bowel, bladder or ureter, where the results of pelvic ultrasound are inconclusive.

The item includes scanning of the pelvic or abdomen regions, or both, depending on clinical requirements.

Restrictions

The service can only be claimed once in any 2 year period.

Definitions

"Recurrent implantation failure" is defined as failure to establish clinical pregnancy following two or more embryo transfer cycles. The number of embryos per cycle can be one or more.

"Viable pregnancy" is defined as any pregnancy that results in a live birth.

MRI scan of the pelvis for the initial staging, restaging and follow up of rectal cancer (MBS Item 63476)

Clinical Notes

Item 63476 is for an MRI scan of the pelvis for the evaluation of rectal cancer.

Where available, MRI scanning should be requested by the patient's specialist or consultant physician following consideration of their management at a properly constituted oncological multidisciplinary team meeting.

Medicare benefits are not payable for surveillance of clinically well patients following completion of therapy, noting this does not exclude patients participating in active surveillance following complete clinical response.

MRI scan of the cardiovascular system for suspected myocarditis (MBS Item 63390)

Clinical Notes

For Item 63390, the term 'drug' includes pharmaceutical preparations such as mRNA vaccinations.

IN.0.19 Bulk Billing Incentive

Out-of-hospital services attract higher benefits when they are bulk billed by the provider.

For all diagnostic imaging items (except those in Group 6 – Management of Bulk Billed Services and items 61369, 61466, 61485) benefits for bulk billed services are payable at 95% of the schedule fee for the item.

IN.0.20 Management of bulk-billed services

Additional bulk billing payment for diagnostic imaging services (items 64990 to 64995)

The items cannot be claimed where the associated diagnostic imaging service:

- has been requested by another practitioner;
- has been self determined by a specialist or consultant physician in the course of practicing as a specialist or consultant physician;
- is an additional service rendered because the providing practitioner formed the opinion that the results obtained following a requested diagnostic imaging service necessitated an additional service; or
- is a service that has been substituted for the originally requested service.

For more information about the provision of self determined, additional or substituted services see note IN.0.6 under the heading 'Exemptions from the written request requirements for R-type diagnostic imaging services'.

IN.1.3 Echocardiography - Initial study

Indications

Examples of other rare but acceptable indications include (but are not limited to): sudden death of an immediate relative, prior to the commencement of specific drugs which require cardiac monitoring, and for patients scheduled for cardiac surgery who have not previously had an echocardiogram.

Providers

Providers of this item number should meet the Level 1 requirements described in the Cardiac Society of Australia & New Zealand Guidelines for Training and Performance in Adult Echocardiography or equivalent. https://wwwhttps://www.csanz.edu.au/resource?resource=101.csanz.edu.au/resource?resource=101

Results

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

IN.1.4 Echocardiography - Primary valvular

Recommended intervals adapted from the 2014 American Heart Association/American College of Cardiology Guideline for the Management of Patients with Valvular Heart Disease.

The guidelines are available here.

Mild to moderate disease:

i. Aortic stenosis should have a repeat every 3–5 years for mild disease and 1–2 years for moderate disease.
ii. Other valvular disease should NOT have repeat imaging more frequently than every 3 years for mild disease and every 1–2 years for moderate disease.

Severe disease:

i. should be monitored in line with the guidelines.

Provider

Providers of this item number should meet the Level 1 requirements described in the CSANZ Guidelines for Training and Performance in Adult Echocardiography or equivalent.

Training and Performance in Adult Echocardiography

Results

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

IN.1.5 Echocardiography - Structural Heart Disease and Heart failure

Indications

When requesting this service the provider should adhere to the National Heart Foundation/Cardiac Society of Australia & New Zealand guidelines which state "An echocardiogram is usually repeated 3–6 months after commencing medical therapy in patients with heart failure and reduced ejection fraction (HFrEF) or if there is a

change in clinical status, or to determine eligibility for other pharmacological treatments (e.g. switching an ACE inhibitor or angiotensin receptor blocker to an angiotensin receptor neprilysin inhibitor [ARNI], adding ivabradine) or to determine eligibility for device therapy (ICD and CRT)"

Providers

Providers of this item number should meet the Level 1 requirements described in the CSANZ Guidelines for Training and Performance in Adult Echocardiography or equivalent. https://www.csanz.edu.au/wp-content/uploads/2015/04/Adult-Echo_2015-February.pdf

Results

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

IN.1.6 Echocardiography - Paediatric and Adult Congenital Heart Disease

Providers

i. For patients under 17 years it is expected that this service will be conducted by a paediatric cardiologist or appropriately qualified sonographer under the paediatric cardiologist's supervision.
ii. For patients 17 years and over with complex congenital heart disease it is expected that this service will be provided by a specialist practicing in the area of congenital heart disease or appropriately qualified sonographer under the specialist's supervision.

Providers of this service for patients under 17 years should meet the requirements described in the Cardiac Society of Australia & New Zealand guidelines for paediatric echocardiography, and should be competent to perform paediatric echocardiography.

https://www.csanz.edu.au/wp-content/uploads/2016/09/Paeds-Echo-Standards-of-Practice_2015_ratified_11-March-2016.pdf

Providers of this item number for patients 17 years and over with complex congenital heart disease should meet the Level 2 requirements described in the Cardiac Society of Australia & New Zealand Guidelines for Training and Performance in Adult Echocardiography.

https://www.csanz.edu.au/wp-content/uploads/2015/04/Adult-Echo_2015-February.pdf

Indications

Complex congenital heart disease does not include single lesions which are haemodynamically insignificant and uncomplicated.

Examples of non-complex congenital lesions include but are not limited to:

i) isolated atrial septal defect, ii) ventricular septal defect, iii) patent ductus arteriosus, iv) mitral valve prolapse, v) bicuspid aortic valve, vi) other isolated congenital valvular disease including congenital aortic stenosis or vii) aortic root dilation

Accepted for use in those persons under 17 years with significant genetic syndromes or dysrhythmias that are likely to lead to substantial structural or functional abnormalities.

Results

Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

Paediatric Investigations and Consultations

For investigations performed by a specialist paediatric or fetal cardiologist, co-claiming of a consultation with the investigation is permitted even when a consultation was not specifically requested when:

• the paediatric patient was referred for an investigation; and
• the paediatric patient was not known to the provider; and
• the paediatric patient was not under the care of another paediatric cardiologist; and
• the findings on the investigation appropriately warranted a consultation.

The paediatric co-claiming exception should not be applied to adult cardiologists treating or investigating adult congenital heart disease, unless the consultation service is provided after the echocardiographic examination where clinical management decisions are made, or the decision to perform the echocardiographic examination on the same day was made during the consultation service subject to clinical assessment.

IN.1.7 Echocardiography - Frequent repetition (Item 55133)

Providers

Providers of this item number should meet the Level 1 requirements described in the Cardiac Society of Australia & New Zealand Guidelines for Training and Performance in Adult Echocardiography or equivalent.

https://www.csanz.edu.au/wp-content/uploads/2015/04/Adult-Echo_2015-February.pdf

Results

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

IN.1.8 Repeat Echocardiogram (Item 55134)

Providers

It is expected that on average, a limited percentage of a provider’s services would be claimed under this item. However, it is acknowledged that some providers in specific areas of clinical practice may have higher rates that are clinically appropriate, and substantiation of this appropriateness (such as compliance with guidelines or best practice) may be requested by the Department of Health, Disability and Ageing's compliance area and will be considered during any clinical audit activities.

Providers of this item number should meet the Level 1 requirements described in the Cardiac Society of Australia & New Zealand Guidelines for Training and Performance in Adult Echocardiography or equivalent at

https://www.csanz.edu.au/

Results

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult

IN.1.9 Echocardiogram fetal item (55137)
Providers

This item may be claimed for fetal cardiac evaluation (claimed against the mother). It is expected that this service will be conducted by a paediatric cardiologist trained in fetal echocardiography or appropriately qualified sonographer under the paediatric cardiologist's supervision.

Providers of this item number should meet the:

- the Cardiac Society of Australia & New Zealand Guidelines for Paediatric Echocardiography for paediatric patients; and
- be competent to perform fetal echocardiography.

The Cardiac Society of Australia & New Zealand Guidelines for Paediatric Echocardiography are available at

https://www.csanz.edu.au/wp-content/uploads/2016/09/Paeds-Echo-Standards-of-Practice_2015_ratified_11-March-2016.pdf

Indications

For use when there is suspected or confirmed congenital structural or functional abnormality, fetal cardiac rhythm abnormalities, or where co-pathology, maternal illness or family history creates an increased risk of congenital cardiac abnormality requiring review by a paediatric cardiologist with specialist training and ongoing involvement in fetal cardiology.

Results

Discussion of these findings with a patient (mother) does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

For investigations performed by a specialist paediatric cardiologist (with fetal cardiology training), co-claiming of a consultation with the investigation is permitted even when a consultation was not specifically requested when:

- the patient was referred for an investigation; and
- the patient was not known to the provider; and
- the findings on the investigation appropriately warranted a consultation.

IN.1.10 Functional studies include stress echocardiograms and myocardial perfusion studies
Functional studies include stress echocardiograms and nuclear myocardial perfusion studies

Indications

Assessment before cardiac surgery or catheter-based interventions to ensure the criteria for intervention are met could include assessment of the severity of aortic stenosis in patients with impaired left ventricular function or obtaining objective evidence of the correlation between functional capacity and ischaemic threshold.

A calcium score of zero is normal in adults and clinician judgement should be applied for scores of 0–10 (does not apply to persons under 17 years).

Providers

Appropriately trained means a provider that meets the level 2 requirements for stress echocardiography as described in the Cardiac Society of Australia & New Zealand Guidelines for Training and Performance in Adult Echocardiography or CSANZ Guidelines for Training and Performance in Paediatric Echocardiography, or an equivalent training standard.

This available at: https://www.csanz.edu.au/wp-content/uploads/2015/04/Adult-Echo_2015-February.pdf

A complete echocardiogram refers to services performed under items 55126, 55127, 55128, 55129, 55132, 55134 and 55137.

In most cases, stress echocardiography and myocardial perfusion studies provide equivalent information. Consideration should be given to the radiation burden of any test that is requested when determining the appropriate modality for a patient, and the patient should be fully informed and involved in this decision.

Results

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

IN.1.11 Item 55080: Complex gynaecological ultrasound

This item (55080) covers the use of ultrasound scans for the assessment, management or planning, of a patient suspected of or diagnosed with a complex gynaecological condition which includes, but is not limited to, a range of complex gynaecological conditions such as endometriosis, adenomyosis, pelvic congestion syndrome, chronic pelvic inflammatory disease, and pelvic floor dysfunction.

The requesting practitioner must have identified that the patient is suspected of having, or is known to have a complex gynaecological condition. The requesting practitioner can be a medical practitioner (GP, specialist or consultant physician), nurse practitioner, or midwife.

The service is classified as a complex investigation due to the detailed imaging and thorough evaluation required to accurately diagnose and assess for each condition. A minimum expected scanning time of 30 minutes ensures that sufficient time is allocated for a comprehensive patient assessment and examination of the pelvic structures.

The scan must include detailed imaging and documentation of any identified pathology. Particular attention should be given to conditions such as severe endometriosis, which may necessitate a thorough evaluation of the pelvic structures.

The ultrasound scan may be performed using any or all approaches, including transabdominal and transvaginal techniques. This flexibility allows the practitioner to choose the most appropriate method(s) based on the patient's specific condition and clinical presentation.

It is recommended that the service be performed by a qualified practitioner with expertise in advanced pelvic ultrasound techniques to ensure comprehensive assessment and accurate diagnosis.

To avoid duplication of services, this item cannot be billed if a service mentioned in item 55038, 55065, 55700, 55704, 55736, or 55739 is performed on the same patient within 24 hours. This ensures that each service is distinct and necessary, preventing unnecessary repetition of diagnostic procedures.

IN.2.1 Indications for Computed Tomography Coronary Angiography (CTCA) Non-Coronary Artery Indication

Heart rate during CTCA should be less than 65 beats per minute wherever possible, and sublingual glyceryl trinitrate (GTN) should be administered immediately prior to scanning where clinically appropriate.

The presence of coronary calcium alone does not preclude CTCA.

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a separate consultation. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a separate consultation.

Indication (b)(iv) of the item recognises the increasing role of CTCA as an alternative to selective coronary angiography (invasive) in the assessment of the coronary arteries (including bypass grafts).

The service only applies if the patient meets the requirements of Notes: TR.8.3 (item 38247), TR.8.2 (item 38249) or item 38252 if subclause (iv) of the item applies.

IN.2.2 Computed Tomography Coronary Angiography (CTCA) for Coronary Artery Disease

Time restriction and claiming guidance for item 57360

Benefits are not payable for item 57360 more than once in a 5 year period following a service to which itself or 57364 applies that detected no obstructive coronary artery disease unless the patient meets the eligibility criteria for selective invasive coronary angiography (items 38244, 38247, 38248 or 38249). The criteria for these items are set out in explanatory notes TR8.2 and TR8.3.

The 5 year frequency restriction on the claiming of this item does not apply if obstructive coronary artery disease was detected as part of the previous service.

The 5 year frequency restriction does not apply if no obstructive coronary disease was detected at the previous service AND the patient meets the criteria for item 38244, 38247, 38248 or 38249.

Item 57360 can be claimed if the patient has known obstructive coronary disease.

IN.2.3 Lung Cancer Screening Program

Patient eligibility for the National Lung Cancer Screening Program (NLCSP)

As per the Medical Services Advisory Committee's (MSAC) recommendation, the patient:

- is aged 50 to 70 years and 364 days; and
- is asymptomatic (no signs or symptoms of lung cancer); and
- currently smoke or have quit smoking in the past 10 years; and
- have a history of cigarette tobacco smoking of at least 30 pack-years.

Patient eligibility is assessed and confirmed by the requesting healthcare provider in line with clinical judgement.

CT dose

Refer to current Royal Australian and New Zealand College of Radiologists (RANZCR) guidelines for appropriate low-dose CT dosage – www.ranzcr.com/college/document-library/nlcsp-low-dose-chest-ct-acquisition-guidelines.

Screening low-dose CT scan (MBS item 57410)

The Screening low-dose CT scan is the test individuals undertake approximately every 2 years when they participate in the NLCSP, i.e. it is the service performed at the beginning of a 2-yearly lung cancer screening round. Noting that not all screening rounds remain on a consistent 2-year cycle as this is dependent on findings and the nodule management protocol.

Screening low-dose CT scan is restricted to one scan within a 2-year screening round.

The National Cancer Screening Register will send screening reminders 3 months prior to the commencement of a new screening round. This is particularly relevant in rural and remote regions where access to GP services and radiology services might take longer. The individual may see a healthcare practitioner and present earlier following receipt of the screening reminder. This item may be claimed for services rendered within the 3-month period prior to commencement of the 2 year screening round. There is no time limit on when an individual can present for their Screening low-dose CT scan after 2 years, pending all other eligibility criteria is satisfied.

Interval low-dose CT scans (MBS item 57413)

This item allows for follow-up management of a patient who requires it following a Screening low-dose CT scan (item 57410).

Following the screening low-dose CT scan, some individuals will require clinical follow-up based on the nodule management guidelines. This item enables individuals to access subsequent low dose CT scans, noting there is no time restriction for when individuals must present for clinical follow-up within their screening round.

The Interval low-dose CT scan must either be linked to an initial Screening low-dose CT scan within the past two years OR linked to a previous Interval low-dose CT scan which occurred within the 2-year time period of a Screening low-dose CT scan.

Lung nodule identification, classification, and reporting system for low-dose CT scan

The lung nodule management protocols were developed based on the MSAC recommended nodule management guidelines, which are:

- PanCan for the first Screening low-dose CT scan
- LungRADS for subsequent Screening low-dose CT scans and Interval low-dose CT scans.

Reporting of low-dose CT scan results

Results of the Screening low-dose CT scan and Interval low-dose CT scans are required to be reported to the National Cancer Screening Register in line with the *National Cancer Screening Register Rules 2017*. The report on the service is submitted using a standardised reporting form and communicated back to the requesting healthcare provider per usual practice.

Exemption to supervision requirements for low-dose CT services performed as part of mobile screening services for the NLCSP

Mobile screening services will be used in remote areas, more than 30km from fixed radiology infrastructure. Mobile screening will be used to support eligible participants who do not have access to fixed radiology infrastructure. In these circumstances low-dose CT scans for the NLCSP can be performed without the supervision of a radiologist. The low-dose CT scan can be conducted by a radiographer in these circumstances.

IN.3.1 Appropriate usage of Fluoroscopy items 60506 and 60509

Overview

MBS items 60506 and 60509 pertain to the use of fluoroscopy with a mobile image intensifier during surgical procedures.

Appropriate Usage

Duration of Fluoroscopy:

- Item 60506 should be used when the fluoroscopy service lasts less than one hour.
- Item 60509 should be used when the fluoroscopy service lasts one hour or more.
- The duration refers specifically to the time the fluoroscopy is in use, not the total duration of the surgical operation.

Service Association:

- Both items should not be claimed in conjunction with other services within the same Diagnostic Radiology group. This ensures that the fluoroscopy service is billed appropriately and avoids duplication of claims.

Eligible Providers:

- These items can be claimed by medical practitioners, provided they meet the necessary requirements for performing fluoroscopy during surgical procedures.

Hospital Treatment:

- These procedures must be performed or provided in a hospital, as a part of hospital treatment. Only the 75% benefit is applicable for these items, meaning that the patient will receive 75% of the scheduled fee as the benefit. This requirement ensures that the procedures are performed in a controlled and regulated hospital environment, which is essential for patient safety and accurate billing.

Consistency across Surgical Procedures:

- A surgical operation can involve one or more surgical procedures. It is important to note that where more than one surgical procedure is involved, not all surgical procedures may be relevant for the fluoroscopy. However, the requirement that these procedures must be part of hospital treatment and that only the 75% benefit is applicable should be consistent across all procedures used as part of the surgical operation. This ensures uniformity in billing and compliance with MBS guidelines.

Timing Clarifications

- Fluoroscopy Procedure: The timing for the fluoroscopy procedure refers to the actual duration of the fluoroscopy service. For item 60506, this duration should be less than one hour, while for item 60509, it should be one hour or more.

- Surgical Operation: This encompasses the entire duration of the surgery from start to finish. A surgical operation can involve one or more surgical procedures. The total duration of the surgical operation is not directly relevant to the selection of MBS items 60506 or 60509, which are based solely on the duration of the fluoroscopy service.

IN.4.1 Single Rest Myocardial Perfusion Study - Item 61321

Item interpretation

A service provided under item 61321 is for a single rest myocardial perfusion study (MPS) for the assessment of extent and severity of viable and non-viable heart tissue (myocardium), when performed on a patient with left ventricular systolic dysfunction, using a single rest technetium-99m (Tc-99m) protocol for item 61321.

Results

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

IN.4.2 Single Rest Myocardial Perfusion Study Item 61325

Item indication

A service provided under new item 61325 is for a single rest myocardial perfusion study (MPS) for the assessment of extent and severity of viable and non-viable heart tissue (myocardium), when performed on a patient with left ventricular systolic dysfunction. This item allows the use of an initial rest study followed by redistribution study, later the same day, with or without 24 hour imaging, with thallous chloride-201 (Tl-201).

Claiming

This item can be claimed twice in a 24 month period, however it would be expected that the item would be claimed twice in a 24 hour period to reflect the requirements of the study.

Results

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

IN.4.3 Myocardial Perfusion Study Items

Stress Myocardial Perfusion Study Items (61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 and 61414)

Functional studies include stress echocardiograms and nuclear myocardial perfusion studies.

In most cases, stress echocardiography and myocardial perfusion studies provide equivalent information. Consideration should be given to the radiation burden of any test that is requested when determining the appropriate modality for a patient, the patient should be fully informed and involved in this decision.

A calcium score of zero is normal in adults and clinician judgement should be applied for scores of 0–10 (does not apply to persons under 17 years).

Results

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

IN.4.4 Substitute PET items for use in radiopharmaceutical supply disruptions

Substitute PET items are available for use in radiopharmaceutical supply disruptions. The following items are available:

Technetium-99m: items 61333, 61336 and 61341 can be used following a valid request for a service to which items 61348, 61402, 61421 or 61425 would apply.

Gallium-67: item 61527 can be used following a valid request for a service to which items 61429, 61430, 61442, 61450 or 61453 would apply.

Thallium-201: Item 61644 can be used following a valid request for a service to which item 61325 would apply.

For substitute PET items listed above, the following conditions must also be met:

a. the requested service is not available due to a supply disruption of the relevant radioisotope; and
b. the patient's clinical condition requires the service to be performed before the resumption of normal radioisotope supply is anticipated by the practitioner who provides the service; and
c. the report of the service performed includes a justification for the substitute service and the unavailability of the original item.

IN.5.1 Item 63541 - meaning of clause 2.5.9

Clause 2.5.9 mentioned in item 63541 is a clause in Schedule 1 of the DIST. The clause covers the patient categories to which the items apply.

In summary, the clause means that before the item applies:

- for a person 70 years or older, at least two PSA tests performed within an interval of 1- 3 months have a PSA concentration of greater than 5.5 µg/L and the free/total PSA ratio is less than 25%.
- for a person under 70 years, at least two prostate specific antigen (PSA) tests performed within an interval of 1- 3 months have PSA concentration of greater than 3.0 ng/ml, and the free/total PSA ratio is less than 25%, or the repeat PSA exceeds 5.5 µg/L; or
- for a person under 70 years with a relevant family history, at least two PSA tests performed within an interval of 1- 3 months have a PSA concentration greater than 2.0 ng/ml, and the free/total PSA ratio is less than 25%, or the repeat PSA exceeds 5.5 µg/L. Relevant family history is a first degree relative with or has had prostate cancer, or suspected of carrying a BRCA 1 or BRCA 2 mutation.

Benefits for this item are payable once only in a 12 month period.

IN.5.2 Item 63543 - claiming restrictions

A period of at least 12 months needs to have elapsed before benefits for a second service under 63543 are payable. Benefits are then only payable after a period of three years has elapsed from the date of the second scan and at least each three years thereafter.

Item 63543 is also applicable to a service described in that item if the clinical need for the service is stated in the request and documented in the record of the service.

Benefits are not payable where the service is provided for the purposes of treatment planning or monitoring after treatment for prostate cancer.

IN.5.4 Requirements for imaging under Item 63564

A service described under item 63564 applies only if the same patient has not received a service to which the same item applies within the preceding 12 months.

The use of this item is limited to individuals carrying a heritable germline or mosaic pathogenic or likely pathogenic mutation in the TP53 gene, ascertained by a clinical report from an accredited pathology laboratory.

IN.5.5 Explanatory Note for Items 63539 and 63540

For Items 63539 and 63540, access to these items is for patients with a confirmed clinical and/or molecular diagnosis of a rare genetic disorder associated with an increased risk of developing renal tumours.

The following list is intended to support providers in determining who may be eligible for the service. If a disorder is not included in the list but does meet all the eligibility criteria as described in the item descriptor, the service can still be provided.

Examples of eligible disorders could include:

- Tuberous sclerosis complex
- Von Hippel Lindau syndrome
- Birt-Hogg-Dube syndrome
- Hereditary papillary renal carcinoma syndrome
- Hereditary leiomyomatosis and renal cell carcinoma (HLRCC)
- Cowden syndrome (PTEN Hamartoma Tumour Syndrome spectrum)
- BAP1-associated cancer syndrome
- SDH associated renal cancer (risk for phaeochromocytoma and paraganglioma)
- Familial clear renal cell carcinoma with chromosome 3 translocation, or
- other rare genetic disorders associated with an increased risk of developing renal tumours.

IN.7.1 Time exclusion clarification for item 55126

Item 55126 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 55127, 55128, 55129, 55132, 55133 or 55134 applies has been provided to the patient.

IR.0.1 Stress echocardiography indications and requirements of use

1. For any particular patient, item 55141, 55143, 55145 or 55146 applies if one or more of the following is applicable:

a. the patient displays one or more of the following symptoms of typical or atypical angina:
    i. constricting discomfort in the:
        a. front of the chest; or
        b. neck; or
        c. shoulders; or
        d. jaw; or
        e. arms; or
    ii. the patient's symptoms, as described in subparagraph (1)(a)(i) above, are precipitated by physical exertion; or
    iii. the patient's symptoms, as described in subparagraph (1)(a)(i) above, are relieved by rest or glyceryl trinitrate within 5 minutes or less.
b. the patient has known coronary artery disease and displays one or more symptoms that are suggestive of ischaemia which:
    i. are not adequately controlled with medical therapy; or
    ii. have evolved since the last functional study.
c. the patient qualifies for one or more of the following indications:
    i. assessment of myocardial ischaemia with exercise is required because a patient with congenital heart lesions has undergone surgery and reversal of ischemia is considered possible; or
    ii. assessment indicates that resting 12 lead electrocardiogram changes are consistent with coronary artery disease or ischaemia in a patient that is without known coronary artery disease; or

iii. coronary artery disease related lesions, of uncertain functional significance, have previously been identified on computed tomography coronary angiography or invasive coronary angiography; or
iv. assessment by a specialist or consultant physician indicates that the patient has potential non-coronary artery disease, where a stress echocardiography study is likely to assist the diagnosis; or
v. assessment indicates that the patient has undue exertional dyspnoea of uncertain aetiology; or
vi. a pre-operative assessment of a patient with functional capacity of less than 4 metabolic equivalents confirms that surgery is intermediate to high risk, and the patient has at least one of following conditions:
    a. ischaemic heart disease;
    b. previous myocardial infarction;
    c. heart failure;
    d. stroke;
    e. transient ischaemic attack;
    f. renal dysfunction (serum creatinine greater than 170umol/L or 2 mg/dL or a creatinine clearance of less than 60 mL/min);
    g. diabetes mellitus requiring insulin therapy; or
vii. assessment before cardiac surgery or catheter-based interventions is required to:
    a. increase the cardiac output to assess the severity of aortic stenosis; or
    b. determine whether valve regurgitation worsens with exercise and/or correlates with functional capacity; or
    c. correlate functional capacity with the ischaemic threshold; or
viii. for patients where silent myocardial ischaemia is suspected, or due to the patient's cognitive capacity or expressive language impairment, it is not possible to accurately assess symptom frequency based on medical history.

2. For any particular patient, the request for a service to be provided under item 55141, 55143, 55145 or 55146 must identify the symptoms or clinical indications that apply to the patient, as outlined above in paragraph 1.

3. For any particular patient, item 55141, 55143, 55145 or 55146 applies to a service if:

a. the diagnostic imaging procedure is performed on premises equipped with resuscitation equipment, which includes a defibrillator; and
b. the diagnostic imaging procedure is performed by a person trained in exercise testing and cardiopulmonary resuscitation who is in personal attendance during the procedure; and
c. a second person trained in safely performing exercise or pharmacological stress monitoring and recording, recognising the symptoms and signs of cardiac disease, and cardiopulmonary resuscitation is located at the diagnostic imaging premises where the procedure is performed and is immediately available to respond at the time the exercise test is performed on the patient, if required; and
d. one of the persons mentioned in paragraphs 3 (b) and (c) must be a medical practitioner.

4. Limitation of ultrasound items 55141, 55143, 55145 and 55146

1. For any particular patient, a service under items 55141, 55143, 55145 and 55146 does not apply if:
    a. the patient has body habitus or other physical condition/s (including heart rhythm disturbance) to the extent where a stress echocardiography would not provide adequate information; or
    b. the patient is unable to exercise to the extent where a stress echocardiography would not provide adequate information; or
    c. results of a previous imaging service indicate that a stress echocardiography service would not provide adequate information.

IR.1.1 Repeat Stress echo requirements 55143

1. For any particular patient, item 55143 applies to a service if:

a. the service is for an exercise stress echocardiography and includes all of the following:
    i. two-dimensional recordings before exercise (baseline) from at least 2 acoustic windows; and
    ii. matching recordings at or immediately after peak exercise, which include at least parasternal short and long axis views, and apical 4-chamber and 2 chamber views; and
    iii. recordings on digital media with equipment permitting display of baseline and matching peak images on the same screen; and
    iv. resting electrocardiogram and continuous multi-channel electrocardiogram monitoring and recording during stress; and
    v. blood pressure monitoring and the recording of other parameters (including heart rate); or
b. the service is for a pharmacological stress echocardiography and includes all of the following:
    i. two-dimensional recordings before drug infusion (baseline) from at least 2 acoustic windows; and
    ii. matching recordings at least twice during drug infusion, including a recording at the peak drug dose, which include at least parasternal short and long axis views, and apical 4-chamber and 2 chamber views; and
    iii. recordings on digital media with equipment permitting display of baseline and matching peak images on the same screen; and
    iv. resting electrocardiogram and continuous multi-channel electrocardiogram monitoring and recording during stress; and
    v. blood pressure monitoring and the recording of other parameters (including heart rate).

IR.1.2 Echocardiography and attendance requirements

1. For any particular patient, a service associated with an attendance item listed in Part 2 of the general medical services table does not apply if a service to which item 55126, 55127, 55128, 55129, 55132, 55133, 55134, 55137, 55141, 55143, 55145 or 55146 applies is provided on the same day; unless:

a. the attendance service is provided after the service where clinical management decisions are made; or
b. the decision to perform the service on the same day was made during the attendance service subject to clinical assessment.

IR.1.3 Echocardiography Multiple Services Rule (EMSR)

1. If one or more services in paragraph (a) is rendered with one or more services in paragraph (b) for the same patient on the same day by the same medical practitioner, then the item with the lesser fee will be reduced by 40% of the fee.

2. The items applicable to the echocardiography multiple services fee reduction rule are:

a. a service to which one or more of items 55126, 55127, 55128, 55129, 55132, 55133, 55134 or 55137 apply; and
b. a service to which one or more of items 55141, 55143, 55145 or 55146 apply.

IR.4.1 Stress myocardial perfusion studies - Indications and requirements of use

1. For any particular patient, item 61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 or 61414 applies if one or more of the following is applicable:

a. if the patient displays one or more of the following symptoms of typical or atypical angina:
    i. constricting discomfort in the:
        a. front of the chest; or
        b. neck; or
        c. shoulders; or
        d. jaw; or
        e. arms; or
    ii. the patient's symptoms, as described in subparagraph (3)(a)(i), are precipitated by physical exertion; or

iii. the patient's symptoms, as described in subparagraph (3)(a)(i), are relieved by rest or glyceryl trinitrate within 5 minutes or less; or

b. if the patient has known coronary artery disease, and displays one or more symptoms that are suggestive of ischaemia:
    i. which are not adequately controlled with medical therapy; or
    ii. which have evolved since the last functional study; or
c. if the patient qualifies for one or more of the following indications:
    i. assessment indicates that resting 12 lead electrocardiogram changes are consistent with coronary artery disease or ischaemia, in a patient that is without known coronary artery disease; or
    ii. coronary artery disease related lesions, of uncertain functional significance, which have previously been identified on computed tomography coronary angiography or invasive coronary angiography; or
    iii. an assessment by a specialist or consultant physician indicates that the patient has possible painless myocardial ischaemia, which includes undue exertional dyspnoea of uncertain aetiology; or
    iv. a pre-operative assessment of a patient with functional capacity of less than 4 metabolic equivalents, confirming that surgery is intermediate to high risk, and the patient has at least one of following conditions:
        a. ischaemic heart disease or previous myocardial infarction; or
        b. heart failure; or
        c. stroke or transient ischaemic attack; or
        d. renal dysfunction (serum creatinine greater than 70umol/L or 2 mg/dL or a creatinine clearance of less than 60 mL/min); or
        e. diabetes mellitus requiring insulin therapy: or
    v. quantification of extent and severity of myocardial ischaemia, before either percutaneous coronary intervention or coronary bypass surgery, to ensure the criteria for intervention are met; or
    vi. assessment of relative amounts of ischaemic viable myocardium and non-viable (infarcted) myocardium, in patients with previous myocardial infarction; or
    vii. assessment of myocardial ischaemia with exercise is required, if a patient with congenital heart lesions has undergone surgery and ischemia is considered possible; or
    viii. assessment of myocardial perfusion in a person who is under 17 years old with coronary anomalies, before and after cardiac surgery for congenital heart disease, or where there is a probable or confirmed coronary artery abnormality; or
    ix. for patients where myocardial perfusion abnormality is suspected but due to the patient's cognitive capacity or expressive language impairment, it is not possible to accurately assess symptom frequency based on medical history.

2. For any particular patient, the request for a service to be provided under item 61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 or 61414 must identify the symptom/s or clinical indications/s, as outlined in subclause 1.2.1(1).

3. For any particular patient, item 61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 or 61414 applies to a service if:

a. the diagnostic imaging procedure is performed on premises equipped with resuscitation equipment, which includes a defibrillator; and
b. the diagnostic imaging procedure is performed by a person trained in cardiopulmonary resuscitation who is in personal attendance during the procedure; and
c. a second person trained in exercise testing and cardiopulmonary resuscitation is located at the diagnostic imaging premise where the procedure is performed and is immediately available to respond at the time the exercise test is performed on the patient, if required; and
d. one of the persons mentioned in paragraphs (b) and (c) must be a medical practitioner.

4. For any particular patient, a service associated with an attendance item listed in Part 2 of the general medical services table does not apply if a service to which item 61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 or 61414 applies is provided in the same day; unless:

a. the attendance service is provided after the service where clinical management decisions are made; or
b. the decision to perform the service on the same day was made during the attendance service subject to clinical assessment.

5. Limitations of items 61321, 61324, 61329, 61345, 61357, 61394, 61398, 61406 or 61414

a. items 61321, 61324, 61329, 61345, 61357, 61394, 61398, 61406 or 61414 are applicable not more than once in any 24-month period if the patient is 17 years old or older.

IR.4.2 Single rest myocardial perfusion studies - requirements for use

1. For any particular patient, a service associated with an attendance item listed in Part 2 of the general medical services table does not apply if a service to which item 61321 or 61325 or 61644 applies is provided in the same day; unless:

a. the attendance service is provided after the service where clinical management decisions are made; or
b. the decision to perform the service on the same day was made during the attendance service subject to clinical assessment.

2. Limitations of items 61321 and 61325

a. Item 61321 is applicable not more than once in any 24 month period if the patient is 17 years old or older.
b. Item 61325 is applicable not more than twice in any 24 month period if the patient is 17 years old or older.

Item 61644 has been introduced as a direct substitute for MBS item 61325. See IN.4.4 of explanatory notes to this Category for further information.

I1. ULTRASOUND	1. GENERAL
	Group I1. Ultrasound
	Subgroup 1. General
55028	Head, ultrasound scan of (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.60 **Benefit:** 75% = $96.45 85% = $109.35 **Future End Date:**
55029	Head, ultrasound scan of (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.55 **Benefit:** 75% = $33.45 85% = $37.90 **Future End Date:**
55030	Orbital contents, ultrasound scan of (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.60 **Benefit:** 75% = $96.45 85% = $109.35 **Future End Date:**
55031	Orbital contents, ultrasound scan of (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.55 **Benefit:** 75% = $33.45 85% = $37.90 **Future End Date:**
55032	Neck, one or more structures of, ultrasound scan of (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.60 **Benefit:** 75% = $96.45 85% = $109.35 **Future End Date:**
55033	Neck, one or more structures of, ultrasound scan of (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.55 **Benefit:** 75% = $33.45 85% = $37.90 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $131.00 **Benefit:** 75% = $98.25 85% = $111.35 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.55 **Benefit:** 75% = $33.45 85% = $37.90 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.60 **Benefit:** 75% = $96.45 85% = $109.35 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.55 **Benefit:** 75% = $33.45 85% = $37.90 **Future End Date:**
55048	Scrotum, ultrasound scan of (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $129.00 **Benefit:** 75% = $96.75 85% = $109.65 **Future End Date:**
55049	Scrotum, ultrasound scan of (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.55 **Benefit:** 75% = $33.45 85% = $37.90 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.60 **Benefit:** 75% = $96.45 85% = $109.35 **Extended Medicare Safety Net Cap:** $102.90 **Future End Date:**

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: 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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $115.80 **Benefit:** 75% = $86.85 85% = $98.45 **Future End Date:**
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 a service to which any other item in this Group applies (other than item 55070, 55071, 55073, 55076, 55079 or 55812) (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $257.00 **Benefit:** 75% = $192.75 85% = $218.45 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $41.15 **Benefit:** 75% = $30.90 85% = $35.00 **Future End Date:**
55070	Breast, one, ultrasound scan of (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $115.80 **Benefit:** 75% = $86.85 85% = $98.45 **Future End Date:**
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 a service to which any other item in this Group applies (other than item 55066, 55070, 55073, 55076, 55079 or 55812) (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $244.25 **Benefit:** 75% = $183.20 85% = $207.65 **Future End Date:**
55073	Breast, one, ultrasound scan of (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $40.05 **Benefit:** 75% = $30.05 85% = $34.05 **Future End Date:**
55076	Breasts, both, ultrasound scan of, including an ultrasound scan for post mastectomy surveillance (R) (See para IN.0.19 of explanatory notes to this Category)

I1. ULTRASOUND	1. GENERAL
	Fee: $128.60 **Benefit:** 75% = $96.45 85% = $109.35 **Future End Date:**
55079	Breasts, both, ultrasound scan of, including an ultrasound scan for post mastectomy surveillance (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.55 **Benefit:** 75% = $33.45 85% = $37.90 **Future End Date:**
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) (See para IN.1.11 of explanatory notes to this Category) **Fee:** $261.65 **Benefit:** 75% = $196.25 85% = $222.45 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $115.80 **Benefit:** 75% = $86.85 85% = $98.45 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $40.05 **Benefit:** 75% = $30.05 85% = $34.05 **Future End Date:**

I1. ULTRASOUND	2. CARDIAC
	Group I1. Ultrasound
	Subgroup 2. 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

I1. ULTRASOUND	2. CARDIAC
	(ii) a service associated with a service to which an item in Subgroup 3 of this Group applies (R) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $324.50 **Benefit:** 75% = $243.40 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $200.20 **Benefit:** 75% = $150.15 **Future End Date:**
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.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $416.55 **Benefit:** 75% = $312.45 **Future End Date:**

I1. ULTRASOUND	3. VASCULAR
	Group I1. Ultrasound
	Subgroup 3. 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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $199.70 **Benefit:** 75% = $149.80 85% = $169.75 **Extended Medicare Safety Net Cap:** $159.80 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $199.70 **Benefit:** 75% = $149.80 85% = $169.75 **Extended Medicare Safety Net Cap:** $159.80 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $199.70 **Benefit:** 75% = $149.80 85% = $169.75 **Extended Medicare Safety Net Cap:** $159.80 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $199.70 **Benefit:** 75% = $149.80 85% = $169.75 **Future End Date:**
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). (See para IN.0.19 of explanatory notes to this Category) **Fee:** $199.70 **Benefit:** 75% = $149.80 85% = $169.75 **Extended Medicare Safety Net Cap:** $159.80 **Future End Date:**
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). (See para IN.0.19 of explanatory notes to this Category)

	Fee: $199.70 **Benefit:** 75% = $149.80 85% = $169.75 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $199.70 **Benefit:** 75% = $149.80 85% = $169.75 **Extended Medicare Safety Net Cap:** $159.80 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $199.70 **Benefit:** 75% = $149.80 85% = $169.75 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $199.70 **Benefit:** 75% = $149.80 85% = $169.75 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $199.70 **Benefit:** 75% = $149.80 85% = $169.75 **Future End Date:**
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

I1. ULTRASOUND	3. VASCULAR
	(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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $199.70 **Benefit:** 75% = $149.80 85% = $169.75 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $199.70 **Benefit:** 75% = $149.80 85% = $169.75 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $199.70 **Benefit:** 75% = $149.80 85% = $169.75 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $130.75 **Benefit:** 75% = $98.10 85% = $111.15 **Extended Medicare Safety Net Cap:** $104.60 **Future End Date:**

I1. ULTRASOUND	4. UROLOGICAL
	Group I1. Ultrasound
	Subgroup 4. 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

I1. ULTRASOUND	4. UROLOGICAL
	(iv) recommended the scan for the management of the patient's current prostatic disease (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.60 **Benefit:** 75% = $96.45 85% = $109.35 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.60 **Benefit:** 75% = $96.45 85% = $109.35 **Future End Date:**

I1. ULTRASOUND	5. OBSTETRIC AND GYNAECOLOGICAL
	Group I1. Ultrasound
	Subgroup 5. 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) (See para IN.0.19, IN.0.13 of explanatory notes to this Category) **Fee:** $70.65 **Benefit:** 75% = $53.00 85% = $60.10 **Extended Medicare Safety Net Cap:** $40.70 **Future End Date:**
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) (See para IN.0.19, IN.0.13 of explanatory notes to this Category) **Fee:** $41.15 **Benefit:** 75% = $30.90 85% = $35.00 **Extended Medicare Safety Net Cap:** $20.40 **Future End Date:**
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) (See para IN.0.19, IN.0.13 of explanatory notes to this Category) **Fee:** $82.50 **Benefit:** 75% = $61.90 85% = $70.15 **Extended Medicare Safety Net Cap:** $47.70 **Future End Date:**
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) (See para IN.0.19, IN.0.13 of explanatory notes to this Category) **Fee:** $41.15 **Benefit:** 75% = $30.90 85% = $35.00 **Extended Medicare Safety Net Cap:** $20.40 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $117.85 **Benefit:** 75% = $88.40 85% = $100.20 **Extended Medicare Safety Net Cap:** $68.20

	Future End Date:
55707	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound (the ***current ultrasound***) scan of, by any or all approaches, if: (a) the pregnancy (as confirmed by the current ultrasound) is dated by a fetal crown rump length of 45 to 84 mm; and (b) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (c) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $82.50 **Benefit:** 75% = $61.90 85% = $70.15 **Extended Medicare Safety Net Cap:** $47.70 **Future End Date:**
55708	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 crown rump length of 45 to 84 mm; and (b) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (c) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $41.15 **Benefit:** 75% = $30.90 85% = $35.00 **Extended Medicare Safety Net Cap:** $20.40 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.70 **Benefit:** 75% = $33.55 85% = $38.00 **Extended Medicare Safety Net Cap:** $27.20 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $135.45 **Benefit:** 75% = $101.60 85% = $115.15 **Extended Medicare Safety Net Cap:** $81.80 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.10 **Benefit:** 75% = $35.35 85% = $40.05 **Extended Medicare Safety Net Cap:** $27.20 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $117.85 **Benefit:** 75% = $88.40 85% = $100.20

	Extended Medicare Safety Net Cap: $68.20 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $135.45 **Benefit:** 75% = $101.60 85% = $115.15 **Extended Medicare Safety Net Cap:** $81.80 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.70 **Benefit:** 75% = $33.55 85% = $38.00 **Extended Medicare Safety Net Cap:** $27.20 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.10 **Benefit:** 75% = $35.35 85% = $40.05 **Extended Medicare Safety Net Cap:** $27.20 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $32.10 **Benefit:** 75% = $24.10 85% = $27.30 **Extended Medicare Safety Net Cap:** $20.40 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $149.60 **Benefit:** 75% = $112.20 85% = $127.20 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $67.15 **Benefit:** 75% = $50.40 85% = $57.10 **Future End Date:**
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) (See para IN.0.19, IN.0.13 of explanatory notes to this Category) **Fee:** $122.60 **Benefit:** 75% = $91.95 85% = $104.25 **Extended Medicare Safety Net Cap:** $71.00 **Future End Date:**

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) (See para IN.0.19, IN.0.13 of explanatory notes to this Category) **Fee:** $61.25 **Benefit:** 75% = $45.95 85% = $52.10 **Extended Medicare Safety Net Cap:** $30.50 **Future End Date:**
55742	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound (the ***current ultrasound***) scan of, by any or all approaches, if: (a) an ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the pregnancy (as confirmed by the current ultrasound) is dated by a fetal crown rump length of 45 to 84 mm; and (c) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (d) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (R) (See para IN.0.19, IN.0.13 of explanatory notes to this Category) **Fee:** $122.60 **Benefit:** 75% = $91.95 85% = $104.25 **Extended Medicare Safety Net Cap:** $71.00 **Future End Date:**
55743	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound (the ***current ultrasound***) scan of, by any or all approaches, if: (a) an ultrasound of the same pregnancy confirms a multiple pregnancy; and (b) the pregnancy (as confirmed by the current ultrasound) is dated by a fetal crown rump length of 45 to 84 mm; and (c) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (d) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (NR) (See para IN.0.19, IN.0.13 of explanatory notes to this Category) **Fee:** $61.25 **Benefit:** 75% = $45.95 85% = $52.10 **Extended Medicare Safety Net Cap:** $30.50 **Future End Date:**
55757	Pelvis or abdomen, ultrasound (the ***current ultrasound***) scan of, for cervical length assessment for risk of preterm labour, by any or all approaches, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is between 14 and 30 weeks of gestation; and

	(b) any of the following apply: (i) the patient has a history indicating high risk of preterm labour or birth or second trimester fetal loss; (ii) the patient has symptoms suggestive of threatened preterm labour or second trimester fetal loss; (iii) the patient's cervical length is less than 25 mm on an ultrasound before 28 weeks gestation; and (c) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (R) (See para IN.0.19, IN.0.13 of explanatory notes to this Category) **Fee:** $58.40 **Benefit:** 75% = $43.80 85% = $49.65 **Extended Medicare Safety Net Cap:** $33.70 **Future End Date:**
55758	Pelvis or abdomen, ultrasound (the ***current ultrasound***) scan of, for cervical length assessment for risk of preterm labour, by any or all approaches, if: (a) the dating of the pregnancy (as confirmed by the current ultrasound) is between 14 and 30 weeks of gestation; and (b) any of the following apply: (i) the patient has a history indicating high risk of preterm labour or birth or second trimester fetal loss; (ii) the patient has symptoms suggestive of threatened preterm labour or second trimester fetal loss; (iii) the patient's cervical length is less than 25 mm on an ultrasound before 28 weeks gestation; and (c) the current ultrasound is not performed on the same patient within 24 hours of a service mentioned in another item in this Subgroup (NR) (See para IN.0.19, IN.0.13 of explanatory notes to this Category) **Fee:** $22.15 **Benefit:** 75% = $16.65 85% = $18.85 **Extended Medicare Safety Net Cap:** $10.90 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $176.70 **Benefit:** 75% = $132.55 85% = $150.20 **Future End Date:**

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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $70.65 **Benefit:** 75% = $53.00 85% = $60.10 **Extended Medicare Safety Net Cap:** $40.70 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $188.40 **Benefit:** 75% = $141.30 85% = $160.15 **Extended Medicare Safety Net Cap:** $109.00 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $76.55 **Benefit:** 75% = $57.45 85% = $65.10 **Extended Medicare Safety Net Cap:** $40.70 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $176.70 **Benefit:** 75% = $132.55 85% = $150.20 **Extended Medicare Safety Net Cap:** $102.40 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $70.65 **Benefit:** 75% = $53.00 85% = $60.10 **Extended Medicare Safety Net Cap:** $40.70 **Future End Date:**

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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $188.40 **Benefit:** 75% = $141.30 85% = $160.15 **Extended Medicare Safety Net Cap:** $109.00 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $76.55 **Benefit:** 75% = $57.45 85% = $65.10 **Extended Medicare Safety Net Cap:** $47.70 **Future End Date:**

	Group I1. Ultrasound
	Subgroup 6. Musculoskeletal
55812	Chest or abdominal wall, one or more areas, ultrasound scan of (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.60 **Benefit:** 75% = $96.45 85% = $109.35 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.55 **Benefit:** 75% = $33.45 85% = $37.90 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $102.85 **Benefit:** 75% = $77.15 85% = $87.45 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.55 **Benefit:** 75% = $33.45 85% = $37.90 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $161.00 **Benefit:** 75% = $120.75 85% = $136.85 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $212.45 **Benefit:** 75% = $159.35 85% = $180.60 **Future End Date:**
55852	Paediatric spine, spinal cord and overlying subcutaneous tissues, ultrasound scan of (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.60 **Benefit:** 75% = $96.45 85% = $109.35 **Future End Date:**
55854	Paediatric spine, spinal cord and overlying subcutaneous tissues, ultrasound scan of (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.55 **Benefit:** 75% = $33.45 85% = $37.90 **Future End Date:**

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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.60 **Benefit:** 75% = $96.45 85% = $109.35 **Future End Date:**
55857	Hand or wrist, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55859 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.55 **Benefit:** 75% = $33.45 85% = $37.90 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $142.65 **Benefit:** 75% = $107.00 85% = $121.30 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $49.55 **Benefit:** 75% = $37.20 85% = $42.15 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.60 **Benefit:** 75% = $96.45 85% = $109.35 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.55 **Benefit:** 75% = $33.45 85% = $37.90 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $142.65 **Benefit:** 75% = $107.00 85% = $121.30 **Future End Date:**
55863	Forearm or elbow, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55861 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $49.55 **Benefit:** 75% = $37.20 85% = $42.15

	Future End Date:
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.60 **Benefit:** 75% = $96.45 85% = $109.35 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.55 **Benefit:** 75% = $33.45 85% = $37.90 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $142.65 **Benefit:** 75% = $107.00 85% = $121.30 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $49.55 **Benefit:** 75% = $37.20 85% = $42.15 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.60 **Benefit:** 75% = $96.45 85% = $109.35 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.55 **Benefit:** 75% = $33.45 85% = $37.90 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $142.65 **Benefit:** 75% = $107.00 85% = $121.30 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $49.55 **Benefit:** 75% = $37.20 85% = $42.15 **Future End Date:**
55872	Paediatric hip examination for dysplasia, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55874 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.60 **Benefit:** 75% = $96.45 85% = $109.35 **Future End Date:**
55873	Paediatric hip examination for dysplasia, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55875 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.55 **Benefit:** 75% = $33.45 85% = $37.90 **Future End Date:**

55874	Paediatric hip examination for dysplasia, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55872 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $142.65 **Benefit:** 75% = $107.00 85% = $121.30 **Future End Date:**
55875	Paediatric hip examination for dysplasia, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55873 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $49.55 **Benefit:** 75% = $37.20 85% = $42.15 **Future End Date:**
55876	Buttock or thigh, or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55878 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.60 **Benefit:** 75% = $96.45 85% = $109.35 **Future End Date:**
55877	Buttock or thigh or both, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55879 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.55 **Benefit:** 75% = $33.45 85% = $37.90 **Future End Date:**
55878	Buttock or thigh, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55876 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $142.65 **Benefit:** 75% = $107.00 85% = $121.30 **Future End Date:**
55879	Buttock or thigh, or both, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55877 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $49.55 **Benefit:** 75% = $37.20 85% = $42.15 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.60 **Benefit:** 75% = $96.45 85% = $109.35 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.55 **Benefit:** 75% = $33.45 85% = $37.90 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $142.65 **Benefit:** 75% = $107.00 85% = $121.30 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $49.55 **Benefit:** 75% = $37.20 85% = $42.15 **Future End Date:**
55884	Lower leg, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55886 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.60 **Benefit:** 75% = $96.45 85% = $109.35 **Future End Date:**
55885	Lower leg, left or right, ultrasound scan of, if the service is not performed in conjunction with item 55887 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.55 **Benefit:** 75% = $33.45 85% = $37.90 **Future End Date:**
55886	Lower leg, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55884 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $142.65 **Benefit:** 75% = $107.00 85% = $121.30

	Future End Date:
55887	Lower leg, left and right, ultrasound scan of, if the service is not performed in conjunction with item 55885 (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $49.55 **Benefit:** 75% = $37.20 85% = $42.15 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.60 **Benefit:** 75% = $96.45 85% = $109.35 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.55 **Benefit:** 75% = $33.45 85% = $37.90 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $142.65 **Benefit:** 75% = $107.00 85% = $121.30 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $49.55 **Benefit:** 75% = $37.20 85% = $42.15 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $128.60 **Benefit:** 75% = $96.45 85% = $109.35 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.55 **Benefit:** 75% = $33.45 85% = $37.90 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $142.65 **Benefit:** 75% = $107.00 85% = $121.30 **Future End Date:**

I1. ULTRASOUND	6. MUSCULOSKELETAL
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $49.55 **Benefit:** 75% = $37.20 85% = $42.15 **Future End Date:**

I1. ULTRASOUND	7. TRANSTHORACIC ECHOCARDIOGRAM AND STRESS ECHOCARDIOGRAM.
	Group I1. Ultrasound
	Subgroup 7. Transthoracic Echocardiogram and Stress Echocardiogram.
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) (See para IN.7.1, IR.1.2, IR.1.3, IN.1.3, IN.0.19 of explanatory notes to this Category) **Fee:** $271.80 **Benefit:** 75% = $203.85 85% = $231.05 **Future End Date:**
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) (See para IN.7.1, IR.1.2, IR.1.3, IN.1.4, IN.0.19 of explanatory notes to this Category) **Fee:** $271.80 **Benefit:** 75% = $203.85 85% = $231.05 **Future End Date:**
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) (See para IN.7.1, IR.1.2, IR.1.3, IN.1.4, IN.0.19 of explanatory notes to this Category) **Fee:** $271.80 **Benefit:** 75% = $203.85 85% = $231.05 **Future End Date:**
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

I1. ULTRASOUND	7. TRANSTHORACIC ECHOCARDIOGRAM AND STRESS ECHOCARDIOGRAM.
	(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) (See para IN.7.1, IR.1.2, IR.1.3, IN.1.5, IN.0.19 of explanatory notes to this Category) **Fee:** $271.80 **Benefit:** 75% = $203.85 85% = $231.05 **Future End Date:**
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)

	(See para IN.7.1, IR.1.2, IR.1.3, IN.1.6, IN.0.19 of explanatory notes to this Category) **Fee:** $271.80 **Benefit:** 75% = $203.85 85% = $231.05 **Future End Date:**
55133	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 commenced medication 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) (See para IN.7.1, IR.1.2, IR.1.3, IN.1.7, IN.0.19 of explanatory notes to this Category) **Fee:** $244.60 **Benefit:** 75% = $183.45 85% = $207.95 **Future End Date:**
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) (See para IN.7.1, IR.1.2, IR.1.3, IN.1.8, IN.0.19 of explanatory notes to this Category) **Fee:** $271.80 **Benefit:** 75% = $203.85 85% = $231.05 **Future End Date:**
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) (See para IR.1.2, IR.1.3, IN.1.9, IN.0.19 of explanatory notes to this Category) **Fee:** $271.80 **Benefit:** 75% = $203.85 85% = $231.05 **Future End Date:**
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) (See para IR.1.2, IR.1.3, IN.1.10, IR.0.1, IN.0.19 of explanatory notes to this Category) **Fee:** $484.50 **Benefit:** 75% = $363.40 85% = $411.85 **Future End Date:**
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) (See para IR.1.1, IR.1.2, IR.1.3, IN.1.10, IR.0.1, IN.0.19 of explanatory notes to this Category) **Fee:** $484.50 **Benefit:** 75% = $363.40 85% = $411.85 **Future End Date:**
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. (See para IR.1.2, IR.1.3, IN.1.10, IR.0.1, IN.0.19 of explanatory notes to this Category) **Fee:** $561.55 **Benefit:** 75% = $421.20 85% = $477.35 **Future End Date:**
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.

I1. ULTRASOUND	7. TRANSTHORACIC ECHOCARDIOGRAM AND STRESS ECHOCARDIOGRAM.
	(See para IR.1.2, IR.1.3, IN.1.10, IR.0.1, IN.0.19 of explanatory notes to this Category) **Fee:** $561.55 **Benefit:** 75% = $421.20 85% = $477.35 **Future End Date:**

I2. COMPUTED TOMOGRAPHY	1. HEAD
	Group I2. Computed Tomography
	Subgroup 1. Head
56001	Computed tomography—scan of brain without intravenous contrast medium, not being a service to which item 57001 applies (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $225.20 **Benefit:** 75% = $168.90 85% = $191.45 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $288.65 **Benefit:** 75% = $216.50 85% = $245.40 **Future End Date:**
56010	Computed tomography—scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when performed (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $291.10 **Benefit:** 75% = $218.35 85% = $247.45 **Future End Date:**
56013	COMPUTED TOMOGRAPHY - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $288.65 **Benefit:** 75% = $216.50 85% = $245.40 **Future End Date:**
56016	Computed tomography—scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $334.80 **Benefit:** 75% = $251.10 85% = $284.60 **Future End Date:**
56022	Computed tomography—scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $259.80 **Benefit:** 75% = $194.85 85% = $220.85 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $388.80 **Benefit:** 75% = $291.60 85% = $330.50 **Future End Date:**

I2. COMPUTED TOMOGRAPHY	1. HEAD
56030	Computed tomography—scan of facial bones, para nasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $259.80 **Benefit:** 75% = $194.85 85% = $220.85 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $388.80 **Benefit:** 75% = $291.60 85% = $330.50 **Future End Date:**

I2. COMPUTED TOMOGRAPHY	2. NECK
	Group I2. Computed Tomography
	Subgroup 2. Neck
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $265.50 **Benefit:** 75% = $199.15 85% = $225.70 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $392.50 **Benefit:** 75% = $294.40 85% = $333.65 **Future End Date:**

I2. COMPUTED TOMOGRAPHY	3. SPINE
	Group I2. Computed Tomography
	Subgroup 3. Spine
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $376.60 **Benefit:** 75% = $282.45 85% = $320.15 **Future End Date:**
56220	Computed tomography—scan of spine, cervical region, without intravenous contrast medium (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)

	Fee: $277.10 **Benefit:** 75% = $207.85 85% = $235.55 **Future End Date:**
56221	Computed tomography—scan of spine, thoracic region, without intravenous contrast medium (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $277.10 **Benefit:** 75% = $207.85 85% = $235.55 **Future End Date:**
56223	Computed tomography—scan of spine, lumbosacral region, without intravenous contrast medium (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $277.10 **Benefit:** 75% = $207.85 85% = $235.55 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $405.60 **Benefit:** 75% = $304.20 85% = $344.80 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $405.60 **Benefit:** 75% = $304.20 85% = $344.80 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $405.60 **Benefit:** 75% = $304.20 85% = $344.80 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $277.10 **Benefit:** 75% = $207.85 85% = $235.55 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $405.60 **Benefit:** 75% = $304.20 85% = $344.80 **Future End Date:**
56237	Computed tomography—scan of spine, 3 regions cervical, thoracic and lumbosacral, without intravenous contrast medium (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $277.10 **Benefit:** 75% = $207.85 85% = $235.55 **Future End Date:**

I2. COMPUTED TOMOGRAPHY	3. SPINE
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $405.60 **Benefit:** 75% = $304.20 85% = $344.80 **Future End Date:**

I2. COMPUTED TOMOGRAPHY	4. CHEST AND UPPER ABDOMEN
	Group I2. Computed Tomography
	Subgroup 4. Chest and upper abdomen
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $340.65 **Benefit:** 75% = $255.50 85% = $289.60 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $461.80 **Benefit:** 75% = $346.35 85% = $392.55 **Future End Date:**

I2. COMPUTED TOMOGRAPHY	5. UPPER ABDOMEN ONLY
	Group I2. Computed Tomography
	Subgroup 5. Upper abdomen only
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $288.65 **Benefit:** 75% = $216.50 85% = $245.40 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $415.70 **Benefit:** 75% = $311.80 85% = $353.35 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category)

I2. COMPUTED TOMOGRAPHY	5. UPPER ABDOMEN ONLY
	Fee: $288.65 **Benefit:** 75% = $216.50 85% = $245.40 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $415.70 **Benefit:** 75% = $311.80 85% = $353.35 **Future End Date:**

I2. COMPUTED TOMOGRAPHY	6. UPPER ABDOMEN AND PELVIS
	Group I2. Computed Tomography
	Subgroup 6. Upper abdomen and pelvis
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $444.35 **Benefit:** 75% = $333.30 85% = $377.70 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $554.25 **Benefit:** 75% = $415.70 85% = $471.15 **Future End Date:**
56553	Computed tomography—scan of colon for exclusion or diagnosis of colorectal neoplasia in a symptomatic or high risk patient if: (a) one or more of the following applies: (i) the patient has had an incomplete colonoscopy in the 3 months before the scan; (ii) there is a high grade colonic obstruction; (iii) the service is requested by a specialist or consultant physician who performs colonoscopies in the practice of the specialist's or consultant physician's speciality; and (b) the service is not a service to which item 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $600.30 **Benefit:** 75% = $450.25 85% = $510.30 **Future End Date:**

I2. COMPUTED TOMOGRAPHY	7. EXTREMITIES
	Group I2. Computed Tomography
	Subgroup 7. Extremities

56620	Computed tomography—scan of knee, without intravenous contrast medium, not being a service to which item 56622 or 56629 applies (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $254.00 **Benefit:** 75% = $190.50 85% = $215.90 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $254.00 **Benefit:** 75% = $190.50 85% = $215.90 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $386.40 **Benefit:** 75% = $289.80 85% = $328.45 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $386.40 **Benefit:** 75% = $289.80 85% = $328.45 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $254.00 **Benefit:** 75% = $190.50 85% = $215.90 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $386.40 **Benefit:** 75% = $289.80 85% = $328.45 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $254.00 **Benefit:** 75% = $190.50 85% = $215.90 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category)

I2. COMPUTED TOMOGRAPHY	7. EXTREMITIES
	Fee: $386.40 **Benefit:** 75% = $289.80 85% = $328.45 **Future End Date:**

I2. COMPUTED TOMOGRAPHY	8. CHEST, ABDOMEN, PELVIS AND NECK
	Group I2. Computed Tomography
	Subgroup 8. Chest, abdomen, pelvis and neck
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $538.65 **Benefit:** 75% = $404.00 85% = $457.90 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $646.55 **Benefit:** 75% = $484.95 85% = $549.60 **Future End Date:**

I2. COMPUTED TOMOGRAPHY	9. BRAIN, CHEST AND UPPER ABDOMEN
	Group I2. Computed Tomography
	Subgroup 9. Brain, chest and upper abdomen
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $538.75 **Benefit:** 75% = $404.10 85% = $457.95 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $655.40 **Benefit:** 75% = $491.55 85% = $557.10 **Future End Date:**

I2. COMPUTED TOMOGRAPHY	10. PELVIMETRY
	Group I2. Computed Tomography
	Subgroup 10. Pelvimetry
57201	Computed tomography—pelvimetry (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category)

I2. COMPUTED TOMOGRAPHY	10. PELVIMETRY
	Fee: $179.20 **Benefit:** 75% = $134.40 85% = $152.35 **Future End Date:**

I2. COMPUTED TOMOGRAPHY	11. INTERVENTIONAL TECHNIQUES
	Group I2. Computed Tomography
	Subgroup 11. Interventional techniques
57341	Computed tomography, in conjunction with a surgical procedure using interventional techniques (R) (Anaes.) (See para IN.0.19, IN.0.2 of explanatory notes to this Category) **Fee:** $542.60 **Benefit:** 75% = $406.95 85% = $461.25 **Future End Date:**

I2. COMPUTED TOMOGRAPHY	12. SPIRAL ANGIOGRAPHY
	Group I2. Computed Tomography
	Subgroup 12. Spiral angiography
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $588.75 **Benefit:** 75% = $441.60 85% = $500.45 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $588.75 **Benefit:** 75% = $441.60 85% = $500.45 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $588.75 **Benefit:** 75% = $441.60 85% = $500.45 **Future End Date:**
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: a. the service is not a service to which another item in this group applies; and b. the service is not a study performed to image the coronary arteries; and

	c. 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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $588.75 **Benefit:** 75% = $441.60 85% = $500.45 **Future End Date:**
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.) (See para IN.2.2, IN.0.19 of explanatory notes to this Category) **Fee:** $808.10 **Benefit:** 75% = $606.10 85% = $699.60 **Future End Date:**
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.) (See para TR.8.6, TR.8.2, TR.8.3, IN.2.1, IN.0.19 of explanatory notes to this Category) **Fee:** $808.10 **Benefit:** 75% = $606.10 85% = $699.60

I2. COMPUTED TOMOGRAPHY	12. SPIRAL ANGIOGRAPHY
	Future End Date:

I2. COMPUTED TOMOGRAPHY	13. CONE BEAM COMPUTED TOMOGRAPHY
	Group I2. Computed Tomography
	Subgroup 13. Cone beam computed tomography
57362	Cone beam computed tomography—dental and temporo mandibular joint imaging (without contrast medium) for diagnosis and management of any of the following: (a) mandibular and dento alveolar fractures; (b) dental implant planning; (c) orthodontics; (d) endodontic conditions; (e) periodontal conditions; (f) temporo mandibular joint conditions Applicable once per patient per day, not being for a service to which any of items 57960 to 57969 apply, and not being a service associated with another service in Group I2 (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $130.65 **Benefit:** 75% = $98.00 85% = $111.10 **Future End Date:**

I2. COMPUTED TOMOGRAPHY	14. LOW DOSE COMPUTED TOMOGRAPHY
	Group I2. Computed Tomography
	Subgroup 14. Low dose computed tomography
57410	Low-dose computed tomography (low-dose CT) scan of chest for the National Lung Cancer Screening Program, without intravenous contrast medium, where: (a) the request states that the patient's eligibility to participate in the National Lung Cancer Screening Program has been assessed and confirmed; and (b) the service utilises the agreed nodule management protocol for standardised lung nodule identification, classification and reporting; and (c) the service is bulk-billed (R) (Anaes.) (See para IN.2.3 of explanatory notes to this Category) **Fee:** $347.55 **Benefit:** 75% = $260.70 85% = $295.45 **Future End Date:**
57413	Low-dose computed tomography (low-dose CT) scan of chest for the National Lung Cancer Screening Program, without intravenous contrast medium, where: (a) the service is:

I2. COMPUTED TOMOGRAPHY	14. LOW DOSE COMPUTED TOMOGRAPHY
	(i) performed as a clinical follow-up within 2 years of a screening low-dose CT scan of MBS item 57410; or (ii) performed as a clinical follow-up to a previous interval low-dose CT scan of MBS item 57413 linked to MBS item 57410; and (b) the service utilises the agreed nodule management protocol for standardised lung nodule identification, classification and reporting; and (c) the service is bulk-billed (R) (Anaes.) (See para IN.2.3 of explanatory notes to this Category) **Fee:** $347.55 **Benefit:** 75% = $260.70 85% = $295.45 **Future End Date:**

I3. DIAGNOSTIC RADIOLOGY	1. RADIOGRAPHIC EXAMINATION OF EXTREMITIES
	Group I3. Diagnostic Radiology
	Subgroup 1. Radiographic Examination Of Extremities
57506	Hand, wrist, forearm, elbow or humerus (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $35.05 **Benefit:** 75% = $26.30 85% = $29.80 **Future End Date:**
57509	Hand, wrist, forearm, elbow or humerus (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $46.80 **Benefit:** 75% = $35.10 85% = $39.80 **Future End Date:**
57512	Hand and wrist, or hand, wrist and forearm, or wrist and forearm, or forearm and elbow, or elbow and humerus (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.65 **Benefit:** 75% = $35.75 85% = $40.55 **Future End Date:**
57515	Hand and wrist, or hand, wrist and forearm, or wrist and forearm, or forearm and elbow, or elbow and humerus (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $63.60 **Benefit:** 75% = $47.70 85% = $54.10 **Future End Date:**
57518	Foot, ankle, leg or femur (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.35 **Benefit:** 75% = $28.80 85% = $32.60 **Future End Date:**
57521	Foot, ankle, leg or femur (R) (See para IN.0.19 of explanatory notes to this Category)

I3. DIAGNOSTIC RADIOLOGY	1. RADIOGRAPHIC EXAMINATION OF EXTREMITIES
	Fee: $51.15 **Benefit:** 75% = $38.40 85% = $43.50 **Future End Date:**
57522	Knee (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.35 **Benefit:** 75% = $28.80 85% = $32.60 **Future End Date:**
57523	Knee (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $51.15 **Benefit:** 75% = $38.40 85% = $43.50 **Future End Date:**
57524	Foot and ankle, or ankle and leg, or leg and knee, or knee and femur (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $58.15 **Benefit:** 75% = $43.65 85% = $49.45 **Future End Date:**
57527	Foot and ankle, or ankle and leg, or leg and knee, or knee and femur (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $77.45 **Benefit:** 75% = $58.10 85% = $65.85 **Future End Date:**

I3. DIAGNOSTIC RADIOLOGY	2. RADIOGRAPHIC EXAMINATION OF SHOULDER OR PELVIS
	Group I3. Diagnostic Radiology
	Subgroup 2. Radiographic Examination Of Shoulder Or Pelvis
57700	Shoulder or scapula (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.65 **Benefit:** 75% = $35.75 85% = $40.55 **Future End Date:**
57703	Shoulder or scapula (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $63.60 **Benefit:** 75% = $47.70 85% = $54.10 **Future End Date:**
57706	Clavicle (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.35 **Benefit:** 75% = $28.80 85% = $32.60 **Future End Date:**
57709	Clavicle (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $51.15 **Benefit:** 75% = $38.40 85% = $43.50 **Future End Date:**
57712	Hip joint (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.50 **Benefit:** 75% = $41.65 85% = $47.20

I3. DIAGNOSTIC RADIOLOGY	2. RADIOGRAPHIC EXAMINATION OF SHOULDER OR PELVIS
	Future End Date:
57715	Pelvic girdle (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $71.75 **Benefit:** 75% = $53.85 85% = $61.00 **Future End Date:**
57721	Femur, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $116.90 **Benefit:** 75% = $87.70 85% = $99.40 **Future End Date:**

I3. DIAGNOSTIC RADIOLOGY	3. RADIOGRAPHIC EXAMINATION OF HEAD
	Group I3. Diagnostic Radiology
	Subgroup 3. Radiographic Examination Of Head
57901	Skull, not in association with item 57902 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $76.00 **Benefit:** 75% = $57.00 85% = $64.60 **Future End Date:**
57902	Cephalometry, not in association with item 57901 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $76.00 **Benefit:** 75% = $57.00 85% = $64.60 **Future End Date:**
57905	Mastoids or petrous temporal bones (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $76.00 **Benefit:** 75% = $57.00 85% = $64.60 **Future End Date:**
57907	Sinuses or facial bones – orbit, maxilla or malar, any or all (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.70 **Benefit:** 75% = $41.80 85% = $47.35 **Future End Date:**
57915	Mandible, not by orthopantomography technique (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.50 **Benefit:** 75% = $41.65 85% = $47.20 **Future End Date:**
57918	Salivary calculus (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.50 **Benefit:** 75% = $41.65 85% = $47.20 **Future End Date:**

57921	Nose (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.50 **Benefit:** 75% = $41.65 85% = $47.20 **Future End Date:**
57924	Eye (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.50 **Benefit:** 75% = $41.65 85% = $47.20 **Future End Date:**
57927	Temporo mandibular joints (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $58.50 **Benefit:** 75% = $43.90 85% = $49.75 **Future End Date:**
57930	Teeth—single area (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $38.85 **Benefit:** 75% = $29.15 85% = $33.05 **Future End Date:**
57933	Teeth - full mouth (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $92.15 **Benefit:** 75% = $69.15 85% = $78.35 **Future End Date:**
57939	Palato pharyngeal studies with fluoroscopic screening (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $76.00 **Benefit:** 75% = $57.00 85% = $64.60 **Future End Date:**
57942	Palato pharyngeal studies without fluoroscopic screening (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $58.50 **Benefit:** 75% = $43.90 85% = $49.75 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $51.15 **Benefit:** 75% = $38.40 85% = $43.50 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.90 **Benefit:** 75% = $41.95 85% = $47.55 **Future End Date:**
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;

I3. DIAGNOSTIC RADIOLOGY	3. RADIOGRAPHIC EXAMINATION OF HEAD
	(d) periapical pathology (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.90 **Benefit:** 75% = $41.95 85% = $47.55 **Future End Date:**
57966	Orthopantomography for diagnosis or management (or both) of missing or crowded teeth, or developmental anomalies of the teeth or jaws (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.90 **Benefit:** 75% = $41.95 85% = $47.55 **Future End Date:**
57969	Orthopantomography for diagnosis or management (or both) of temporo mandibular joint arthroses or dysfunction (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.90 **Benefit:** 75% = $41.95 85% = $47.55 **Future End Date:**

I3. DIAGNOSTIC RADIOLOGY	4. RADIOGRAPHIC EXAMINATION OF SPINE
	Group I3. Diagnostic Radiology
	Subgroup 4. Radiographic Examination Of Spine
58100	Spine—cervical (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $79.05 **Benefit:** 75% = $59.30 85% = $67.20 **Future End Date:**
58103	Spine—thoracic (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $64.95 **Benefit:** 75% = $48.75 85% = $55.25 **Future End Date:**
58106	Spine—lumbosacral (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $90.65 **Benefit:** 75% = $68.00 85% = $77.10 **Future End Date:**
58108	Spine—4 regions, cervical, thoracic, lumbosacral and sacrococcygeal (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $129.55 **Benefit:** 75% = $97.20 85% = $110.15 **Future End Date:**
58109	Spine—sacrococcygeal (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.35 **Benefit:** 75% = $41.55 85% = $47.05 **Future End Date:**
58112	Spine—2 examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $114.55 **Benefit:** 75% = $85.95 85% = $97.40 **Future End Date:**

I3. DIAGNOSTIC RADIOLOGY	4. RADIOGRAPHIC EXAMINATION OF SPINE
58115	Spine—3 examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $129.55 **Benefit:** 75% = $97.20 85% = $110.15 **Future End Date:**
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) **Fee:** $129.55 **Benefit:** 75% = $97.20 85% = $110.15 **Future End Date:**
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) **Fee:** $129.55 **Benefit:** 75% = $97.20 85% = $110.15 **Future End Date:**

I3. DIAGNOSTIC RADIOLOGY	5. BONE AGE STUDY AND SKELETAL SURVEYS
	Group I3. Diagnostic Radiology
	Subgroup 5. Bone Age Study And Skeletal Surveys
58300	Bone age study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $47.20 **Benefit:** 75% = $35.40 85% = $40.15 **Future End Date:**
58306	Skeletal survey (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $105.30 **Benefit:** 75% = $79.00 85% = $89.55 **Future End Date:**

I3. DIAGNOSTIC RADIOLOGY	6. RADIOGRAPHIC EXAMINATION OF THORACIC REGION
	Group I3. Diagnostic Radiology
	Subgroup 6. Radiographic Examination Of Thoracic Region
58500	Chest (lung fields) by direct radiography (NR) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $41.65 **Benefit:** 75% = $31.25 85% = $35.45 **Future End Date:**
58503	Chest (lung fields) by direct radiography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.50 **Benefit:** 75% = $41.65 85% = $47.20 **Future End Date:**
58506	Chest (lung fields) by direct radiography with fluoroscopic screening (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $71.60 **Benefit:** 75% = $53.70 85% = $60.90 **Future End Date:**

I3. DIAGNOSTIC RADIOLOGY	6. RADIOGRAPHIC EXAMINATION OF THORACIC REGION
58509	Thoracic inlet or trachea (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $46.80 **Benefit:** 75% = $35.10 85% = $39.80 **Future End Date:**
58521	Left ribs, right ribs or sternum (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $51.15 **Benefit:** 75% = $38.40 85% = $43.50 **Future End Date:**
58524	Left and right ribs, left ribs and sternum, or right ribs and sternum (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $66.55 **Benefit:** 75% = $49.95 85% = $56.60 **Future End Date:**
58527	Left ribs, right ribs and sternum (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $81.75 **Benefit:** 75% = $61.35 85% = $69.50 **Future End Date:**

I3. DIAGNOSTIC RADIOLOGY	7. RADIOGRAPHIC EXAMINATION OF URINARY TRACT
	Group I3. Diagnostic Radiology
	Subgroup 7. Radiographic Examination Of Urinary Tract
58700	Plain renal only (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $54.20 **Benefit:** 75% = $40.65 85% = $46.10 **Future End Date:**
58706	Intravenous pyelography, with or without preliminary plain films and with or without tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $186.00 **Benefit:** 75% = $139.50 85% = $158.10 **Future End Date:**
58715	Antegrade or retrograde pyelography with or without preliminary plain films and with preparation and contrast injection, one side (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $178.60 **Benefit:** 75% = $133.95 85% = $151.85 **Future End Date:**
58718	Retrograde cystography or retrograde urethrography with or without preliminary plain films and with preparation and contrast injection (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $148.55 **Benefit:** 75% = $111.45 85% = $126.30 **Future End Date:**
58721	Retrograde micturating cysto urethrography, with preparation and contrast injection (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $162.85 **Benefit:** 75% = $122.15 85% = $138.45

I3. DIAGNOSTIC RADIOLOGY	7. RADIOGRAPHIC EXAMINATION OF URINARY TRACT
	Future End Date:

I3. DIAGNOSTIC RADIOLOGY	8. RADIOGRAPHIC EXAMINATION OF ALIMENTARY TRACT AND BILIARY SYSTEM
	Group I3. Diagnostic Radiology
	Subgroup 8. 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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $42.10 **Benefit:** 75% = $31.60 85% = $35.80 **Future End Date:**
58903	Plain abdominal only, not being a service associated with a service to which item 58909, 58912 or 58915 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $56.10 **Benefit:** 75% = $42.10 85% = $47.70 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $105.90 **Benefit:** 75% = $79.45 85% = $90.05 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $129.90 **Benefit:** 75% = $97.45 85% = $110.45 **Future End Date:**
58915	Barium or other opaque meal, small bowel series only, with or without preliminary plain film (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $93.05 **Benefit:** 75% = $69.80 85% = $79.10 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $163.20 **Benefit:** 75% = $122.40 85% = $138.75 **Future End Date:**
58921	Opaque enema, with or without air contrast study and with or without preliminary plain films (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $159.40 **Benefit:** 75% = $119.55 85% = $135.50 **Future End Date:**
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)

I3. DIAGNOSTIC RADIOLOGY	8. RADIOGRAPHIC EXAMINATION OF ALIMENTARY TRACT AND BILIARY SYSTEM
	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $90.05 **Benefit:** 75% = $67.55 85% = $76.55 **Future End Date:**
58933	Cholegraphy, percutaneous transhepatic, with or without preliminary plain films and with preparation and contrast injection (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $242.25 **Benefit:** 75% = $181.70 85% = $205.95 **Future End Date:**
58936	Cholegraphy, drip infusion, with or without preliminary plain films, with preparation and contrast injection and with or without tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $230.85 **Benefit:** 75% = $173.15 85% = $196.25 **Future End Date:**
58939	Defaecogram (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $164.10 **Benefit:** 75% = $123.10 85% = $139.50 **Future End Date:**

I3. DIAGNOSTIC RADIOLOGY	9. RADIOGRAPHIC EXAMINATION FOR LOCALISATION OF FOREIGN BODIES
	Group I3. Diagnostic Radiology
	Subgroup 9. 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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $25.05 **Benefit:** 75% = $18.80 85% = $21.30 **Future End Date:**

I3. DIAGNOSTIC RADIOLOGY	10. RADIOGRAPHIC EXAMINATION OF BREASTS
	Group I3. Diagnostic Radiology
	Subgroup 10. 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)

	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $105.40 **Benefit:** 75% = $79.05 85% = $89.60 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $238.00 **Benefit:** 75% = $178.50 85% = $202.30 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $63.55 **Benefit:** 75% = $47.70 85% = $54.05 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $134.20 **Benefit:** 75% = $100.65 85% = $114.10 **Future End Date:**
59312	Radiographic examination of both breasts, in conjunction with a surgical procedure on each breast, using interventional techniques (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $102.50 **Benefit:** 75% = $76.90 85% = $87.15 **Future End Date:**

I3. DIAGNOSTIC RADIOLOGY	10. RADIOGRAPHIC EXAMINATION OF BREASTS
59314	Radiographic examination of one breast, in conjunction with a surgical procedure using interventional techniques (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $61.85 **Benefit:** 75% = $46.40 85% = $52.60 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.40 **Benefit:** 75% = $41.55 85% = $47.10 **Future End Date:**

I3. DIAGNOSTIC RADIOLOGY	12. RADIOGRAPHIC EXAMINATION WITH OPAQUE OR CONTRAST MEDIA
	Group I3. Diagnostic Radiology
	Subgroup 12. 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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $113.75 **Benefit:** 75% = $85.35 85% = $96.70 **Future End Date:**
59703	Dacryocystography, one side, with or without preliminary plain film and with preparation and contrast injection (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $89.45 **Benefit:** 75% = $67.10 85% = $76.05 **Future End Date:**
59712	Hysterosalpingography, with or without preliminary plain films and with preparation and contrast injection (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $133.90 **Benefit:** 75% = $100.45 85% = $113.85 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $169.10 **Benefit:** 75% = $126.85 85% = $143.75 **Future End Date:**
59718	Phlebography, one side, with or without preliminary plain films and with preparation and contrast injection (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $158.60 **Benefit:** 75% = $118.95 85% = $134.85 **Future End Date:**

I3. DIAGNOSTIC RADIOLOGY	12. RADIOGRAPHIC EXAMINATION WITH OPAQUE OR CONTRAST MEDIA
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $266.75 **Benefit:** 75% = $200.10 85% = $226.75 **Future End Date:**
59733	Sialography, one side, with preparation and contrast injection, not being a service associated with a service to which item 57918 applies (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $126.90 **Benefit:** 75% = $95.20 85% = $107.90 **Future End Date:**
59739	Sinogram or fistulogram, one or more regions, with or without preliminary plain films and with preparation and contrast injection (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $86.85 **Benefit:** 75% = $65.15 85% = $73.85 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $163.95 **Benefit:** 75% = $123.00 85% = $139.40 **Future End Date:**
59754	Lymphangiography, one or both sides, with preliminary plain films and follow-up radiography and with preparation and contrast injection (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $258.40 **Benefit:** 75% = $193.80 85% = $219.65 **Future End Date:**
59763	Air insufflation during video—fluoroscopic imaging including associated consultation (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $157.65 **Benefit:** 75% = $118.25 85% = $134.05 **Future End Date:**

I3. DIAGNOSTIC RADIOLOGY	13. ANGIOGRAPHY
	Group I3. Diagnostic Radiology
	Subgroup 13. 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.) **Fee:** $198.25 **Benefit:** 75% = $148.70 **Future End Date:**
60000	Digital subtraction angiography, examination of head and neck with or without arch aortography—1 to 3 data acquisition runs (R) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $664.50 **Benefit:** 75% = $498.40

	Future End Date:
60003	Digital subtraction angiography, examination of head and neck with or without arch aortography—4 to 6 data acquisition runs (R) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $974.35 **Benefit:** 75% = $730.80 **Future End Date:**
60006	Digital subtraction angiography, examination of head and neck with or without arch aortography—7 to 9 data acquisition runs (R) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,385.50 **Benefit:** 75% = $1039.15 **Future End Date:**
60009	Digital subtraction angiography, examination of head and neck with or without arch aortography—10 or more data acquisition runs (R) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,621.35 **Benefit:** 75% = $1216.05 **Future End Date:**
60012	Digital subtraction angiography, examination of thorax—1 to 3 data acquisition runs (R) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $664.50 **Benefit:** 75% = $498.40 **Future End Date:**
60015	Digital subtraction angiography, examination of thorax—4 to 6 data acquisition runs (R) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $974.35 **Benefit:** 75% = $730.80 **Future End Date:**
60018	Digital subtraction angiography, examination of thorax—7 to 9 data acquisition runs (R) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,385.50 **Benefit:** 75% = $1039.15 **Future End Date:**
60021	Digital subtraction angiography, examination of thorax—10 or more data acquisition runs (R) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,621.35 **Benefit:** 75% = $1216.05 **Future End Date:**
60024	Digital subtraction angiography, examination of abdomen—1 to 3 data acquisition runs (R) (H) (Anaes.) **Fee:** $664.50 **Benefit:** 75% = $498.40 **Future End Date:**
60027	Digital subtraction angiography, examination of abdomen—4 to 6 data acquisition runs (R) (H) (Anaes.) **Fee:** $974.35 **Benefit:** 75% = $730.80 **Future End Date:**
60030	Digital subtraction angiography, examination of abdomen—7 to 9 data acquisition runs (R) (H) (Anaes.) **Fee:** $1,385.50 **Benefit:** 75% = $1039.15

	Future End Date:
60033	Digital subtraction angiography, examination of abdomen—10 or more data acquisition runs (R) (H) (Anaes.) **Fee:** $1,621.35 **Benefit:** 75% = $1216.05 **Future End Date:**
60036	Digital subtraction angiography, examination of upper limb or limbs—1 to 3 data acquisition runs (R) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $664.50 **Benefit:** 75% = $498.40 **Future End Date:**
60039	Digital subtraction angiography, examination of upper limb or limbs—4 to 6 data acquisition runs (R) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $974.35 **Benefit:** 75% = $730.80 **Future End Date:**
60042	Digital subtraction angiography, examination of upper limb or limbs—7 to 9 data acquisition runs (R) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,385.50 **Benefit:** 75% = $1039.15 **Future End Date:**
60045	Digital subtraction angiography, examination of upper limb or limbs—10 or more data acquisition runs (R) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,621.35 **Benefit:** 75% = $1216.05 **Future End Date:**
60048	Digital subtraction angiography, examination of lower limb or limbs—1 to 3 data acquisition runs (R) (H) (Anaes.) **Fee:** $664.50 **Benefit:** 75% = $498.40 **Future End Date:**
60051	Digital subtraction angiography, examination of lower limb or limbs—4 to 6 data acquisition runs (R) (H) (Anaes.) **Fee:** $974.35 **Benefit:** 75% = $730.80 **Future End Date:**
60054	Digital subtraction angiography, examination of lower limb or limbs—7 to 9 data acquisition runs (R) (H) (Anaes.) **Fee:** $1,385.50 **Benefit:** 75% = $1039.15 **Future End Date:**
60057	Digital subtraction angiography, examination of lower limb or limbs—10 or more data acquisition runs (R) (H) (Anaes.) **Fee:** $1,621.35 **Benefit:** 75% = $1216.05 **Future End Date:**
60060	Digital subtraction angiography, examination of aorta and lower limb or limbs—1 to 3 data acquisition runs (R) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category)

I3. DIAGNOSTIC RADIOLOGY	13. ANGIOGRAPHY
	Fee: $664.50 **Benefit:** 75% = $498.40 **Future End Date:**
60063	Digital subtraction angiography, examination of aorta and lower limb or limbs—4 to 6 data acquisition runs (R) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $974.35 **Benefit:** 75% = $730.80 **Future End Date:**
60066	Digital subtraction angiography, examination of aorta and lower limb or limbs—7 to 9 data acquisition runs (R) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,385.50 **Benefit:** 75% = $1039.15 **Future End Date:**
60069	Digital subtraction angiography, examination of aorta and lower limb or limbs—10 or more data acquisition runs (R) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $1,621.35 **Benefit:** 75% = $1216.05 **Future End Date:**
60072	Selective arteriography or selective venography by digital subtraction angiography technique—one vessel (NR) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $56.65 **Benefit:** 75% = $42.50 **Future End Date:**
60075	Selective arteriography or selective venography by digital subtraction angiography technique—2 vessels (NR) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $113.25 **Benefit:** 75% = $84.95 **Future End Date:**
60078	Selective arteriography or selective venography by digital subtraction angiography technique—3 or more vessels (NR) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $169.90 **Benefit:** 75% = $127.45 **Future End Date:**

I3. DIAGNOSTIC RADIOLOGY	15. FLUOROSCOPIC EXAMINATION
	Group I3. Diagnostic Radiology
	Subgroup 15. Fluoroscopic Examination
60500	Fluoroscopy, with general anaesthesia (not being a service associated with a radiographic examination) (R) (H) (Anaes.) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $51.15 **Benefit:** 75% = $38.40 **Future End Date:**
60503	Fluoroscopy, without general anaesthesia (not being a service associated with a radiographic examination) (R) (See para IN.0.19 of explanatory notes to this Category)

I3. DIAGNOSTIC RADIOLOGY	15. FLUOROSCOPIC EXAMINATION
	Fee: $35.05 **Benefit:** 75% = $26.30 85% = $29.80 **Future End Date:**
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) (See para GN.1.2, IN.3.1 of explanatory notes to this Category) **Fee:** $75.10 **Benefit:** 75% = $56.35 **Future End Date:**
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) (See para GN.1.2, IN.3.1 of explanatory notes to this Category) **Fee:** $116.50 **Benefit:** 75% = $87.40 **Future End Date:**

I3. DIAGNOSTIC RADIOLOGY	16. PREPARATION FOR RADIOLOGICAL PROCEDURE
	Group I3. Diagnostic Radiology
	Subgroup 16. 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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $55.50 **Benefit:** 75% = $41.65 85% = $47.20 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $44.75 **Benefit:** 75% = $33.60 85% = $38.05 **Future End Date:**

I3. DIAGNOSTIC RADIOLOGY	17. INTERVENTIONAL TECHNIQUES
	Group I3. Diagnostic Radiology
	Subgroup 17. Interventional Techniques

I3. DIAGNOSTIC RADIOLOGY	17. 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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $305.00 **Benefit:** 75% = $228.75 **Future End Date:**

I3. DIAGNOSTIC RADIOLOGY	18. MISCELLANEOUS
	Group I3. Diagnostic Radiology
	Subgroup 18. Miscellaneous
Amend 57541	Fee for a service rendered using first eligible x-ray procedure carried out during attendance at a residential care home, where the service has been requested by a medical practitioner or a participating nurse practitioner who has attended the patient in person and the request identifies one or more of the following indications: a. the patient has experienced a fall and one or more of the following items apply to the service 57509, 57515, 57521, 57527, 57703, 57709, 57712, 57715, 58521, 58524, 58527; or b. pneumonia or heart failure is suspected and item 58503 applies to the service; or c. acute abdomen or bowel obstruction is suspected and item 58903 applies to the service. This call-out fee can be claimed once only per visit at a residential care home irrespective of the number of patients attended. NOTE: If the service is bulked billed 95% of the fee is payable. The multiple services rule does not apply to this item. (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $86.75 **Benefit:** 85% = $73.75 **Future End Date:**

I4. NUCLEAR MEDICINE IMAGING	1. NUCLEAR MEDICINE - NON PET
	Group I4. Nuclear Medicine Imaging
	Subgroup 1. Nuclear medicine - non PET
61310	Myocardial infarct avid study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $399.35 **Benefit:** 75% = $299.55 85% = $339.45 **Future End Date:**
61313	Gated cardiac blood pool study, (equilibrium) (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $329.85 **Benefit:** 75% = $247.40 85% = $280.40 **Future End Date:**
61314	Gated cardiac blood pool study, with or without intervention, and first pass blood flow or cardiac shunt study (R)

	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $456.70 **Benefit:** 75% = $342.55 85% = $388.20 **Future End Date:**
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) (See para IR.4.1, IR.4.2, IN.4.1, IN.0.19 of explanatory notes to this Category) **Fee:** $357.70 **Benefit:** 75% = $268.30 85% = $304.05 **Future End Date:**
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)

	(See para IR.4.1, IN.4.3, IN.0.19 of explanatory notes to this Category) **Fee:** $710.10 **Benefit:** 75% = $532.60 85% = $603.60 **Future End Date:**
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) (See para IR.4.2, IN.4.2, IN.0.19 of explanatory notes to this Category) **Fee:** $1,949.45 **Benefit:** 75% = $1462.10 85% = $1840.95 **Future End Date:**
61328	Lung perfusion study (R) (See para IN.0.19, IN.0.17 of explanatory notes to this Category) **Fee:** $247.50 **Benefit:** 75% = $185.65 85% = $210.40 **Future End Date:**
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) (See para IR.4.1, IN.4.3, IN.0.19 of explanatory notes to this Category) **Fee:** $1,067.85 **Benefit:** 75% = $800.90 85% = $959.35 **Future End Date:**
61340	Lung ventilation study using aerosol, technegas or xenon gas (R) (See para IN.0.19, IN.0.17 of explanatory notes to this Category) **Fee:** $275.10 **Benefit:** 75% = $206.35 85% = $233.85 **Future End Date:**
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)

	(See para IR.4.1, IN.4.3, IN.0.19 of explanatory notes to this Category) **Fee:** $1,067.85 **Benefit:** 75% = $800.90 85% = $959.35 **Future End Date:**
61348	Lung perfusion study and lung ventilation study using aerosol, technegas or xenon gas (R) (See para IN.0.19, IN.0.17 of explanatory notes to this Category) **Fee:** $482.05 **Benefit:** 75% = $361.55 85% = $409.75 **Future End Date:**
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) (See para IR.4.1, IN.4.3, IN.0.19 of explanatory notes to this Category) **Fee:** $1,067.85 **Benefit:** 75% = $800.90 85% = $959.35 **Future End Date:**
61353	Liver and spleen study (colloid) (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $420.40 **Benefit:** 75% = $315.30 85% = $357.35

	Future End Date:
61356	Red blood cell spleen or liver study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $427.10 **Benefit:** 75% = $320.35 85% = $363.05 **Future End Date:**
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) (See para IR.4.1, IN.4.3, IN.0.19 of explanatory notes to this Category) **Fee:** $710.10 **Benefit:** 75% = $532.60 85% = $603.60 **Future End Date:**
61360	Hepatobiliary study, including morphine administration or pre-treatment with a cholagogue when performed (R) (See para IN.0.19, IN.0.17 of explanatory notes to this Category) **Fee:** $438.55 **Benefit:** 75% = $328.95 85% = $372.80 **Future End Date:**
61361	Hepatobiliary study with formal quantification following baseline imaging, using a cholagogue (R) (See para IN.0.19, IN.0.17 of explanatory notes to this Category) **Fee:** $501.70 **Benefit:** 75% = $376.30 85% = $426.45 **Future End Date:**

61364	Bowel haemorrhage study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $540.40 **Benefit:** 75% = $405.30 85% = $459.35 **Future End Date:**
61368	Meckel's diverticulum study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $242.60 **Benefit:** 75% = $181.95 85% = $206.25 **Future End Date:**
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) **Fee:** $2,191.90 **Benefit:** 75% = $1643.95 85% = $2083.40 **Future End Date:**
61372	Salivary study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $242.60 **Benefit:** 75% = $181.95 85% = $206.25 **Future End Date:**
61373	Gastro-oesophageal reflux study, including delayed imaging on a separate occasion when performed (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $532.50 **Benefit:** 75% = $399.40 85% = $452.65 **Future End Date:**
61376	Oesophageal clearance study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $155.85 **Benefit:** 75% = $116.90 85% = $132.50 **Future End Date:**
61381	Gastric emptying study, using single tracer (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $624.55 **Benefit:** 75% = $468.45 85% = $530.90 **Future End Date:**
61383	Combined solid and liquid gastric emptying study using dual isotope technique or the same isotope on separate days (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $679.50 **Benefit:** 75% = $509.65 85% = $577.60 **Future End Date:**
61384	Radionuclide colonic transit study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $747.80 **Benefit:** 75% = $560.85 85% = $639.30 **Future End Date:**

61386	Renal study, including perfusion and renogram images and computer analysis or cortical study with planar imaging (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $361.55 **Benefit:** 75% = $271.20 85% = $307.35 **Future End Date:**
61387	Renal cortical study, with single photon emission tomography and planar quantification (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $468.40 **Benefit:** 75% = $351.30 85% = $398.15 **Future End Date:**
61389	Single renal study with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $402.90 **Benefit:** 75% = $302.20 85% = $342.50 **Future End Date:**
61390	Renal study with diuretic administration after a baseline study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $445.80 **Benefit:** 75% = $334.35 85% = $378.95 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $658.45 **Benefit:** 75% = $493.85 85% = $559.70 **Future End Date:**
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) (See para IR.4.1, IN.4.3, IN.0.19 of explanatory notes to this Category)

	Fee: $710.10 **Benefit:** 75% = $532.60 85% = $603.60 **Future End Date:**
61397	Cystoureterogram (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $268.45 **Benefit:** 75% = $201.35 85% = $228.20 **Future End Date:**
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) (See para IR.4.1, IN.4.3, IN.0.19 of explanatory notes to this Category) **Fee:** $1,067.85 **Benefit:** 75% = $800.90 85% = $959.35 **Future End Date:**
61402	Cerebral perfusion study, with single photon emission tomography and with planar imaging when performed (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $657.95 **Benefit:** 75% = $493.50 85% = $559.30 **Future End Date:**
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) (See para IR.4.1, IN.4.3, IN.0.19 of explanatory notes to this Category) **Fee:** $1,067.85 **Benefit:** 75% = $800.90 85% = $959.35 **Future End Date:**
61409	Cerebro-spinal fluid transport study using technetium 99m, with imaging on 2 or more separate occasions (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $949.80 **Benefit:** 75% = $712.35 85% = $841.30 **Future End Date:**
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 (See para IR.4.1, IN.4.3, IN.0.19 of explanatory notes to this Category)

	Fee: $1,067.85 **Benefit:** 75% = $800.90 85% = $959.35 **Future End Date:**
61413	Cerebro spinal fluid shunt patency study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $245.70 **Benefit:** 75% = $184.30 85% = $208.85 **Future End Date:**
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) (See para IR.4.1, IN.4.3, IN.0.19 of explanatory notes to this Category) **Fee:** $710.10 **Benefit:** 75% = $532.60 85% = $603.60 **Future End Date:**
61421	Bone study—whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $521.70 **Benefit:** 75% = $391.30 85% = $443.45 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $653.15 **Benefit:** 75% = $489.90 85% = $555.20 **Future End Date:**
61426	Whole body study using iodine (R) (See para IN.0.19, IN.0.17 of explanatory notes to this Category) **Fee:** $603.30 **Benefit:** 75% = $452.50 85% = $512.85 **Future End Date:**

61429	Whole body study using gallium (R) (See para IN.0.19, IN.0.17 of explanatory notes to this Category) **Fee:** $1,636.50 **Benefit:** 75% = $1227.40 85% = $1528.00 **Future End Date:**
61430	Whole body study using gallium, with single photon emission tomography (R) (See para IN.0.19, IN.0.17 of explanatory notes to this Category) **Fee:** $1,763.20 **Benefit:** 75% = $1322.40 85% = $1654.70 **Future End Date:**
61433	Whole body study using cells labelled with technetium (R) (See para IN.0.19, IN.0.17 of explanatory notes to this Category) **Fee:** $540.40 **Benefit:** 75% = $405.30 85% = $459.35 **Future End Date:**
61434	Whole body study using cells labelled with technetium, with single photon emission tomography (R) (See para IN.0.19, IN.0.17 of explanatory notes to this Category) **Fee:** $669.20 **Benefit:** 75% = $501.90 85% = $568.85 **Future End Date:**
61438	Whole body study using thallium (R) (See para IN.0.19, IN.0.17 of explanatory notes to this Category) **Fee:** $2,323.50 **Benefit:** 75% = $1742.65 85% = $2215.00 **Future End Date:**
61441	Bone marrow study—whole body using technetium labelled bone marrow agents (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $532.50 **Benefit:** 75% = $399.40 85% = $452.65 **Future End Date:**
61442	Whole body study, using gallium—with single photon emission tomography of 2 or more body regions acquired separately (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,864.20 **Benefit:** 75% = $1398.15 85% = $1755.70 **Future End Date:**
61445	Bone marrow study—localised using technetium labelled agent (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $311.85 **Benefit:** 75% = $233.90 85% = $265.10 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $362.70 **Benefit:** 75% = $272.05 85% = $308.30 **Future End Date:**
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)

	(See para IN.0.19 of explanatory notes to this Category) **Fee:** $496.05 **Benefit:** 75% = $372.05 85% = $421.65 **Future End Date:**
61450	Localised study using gallium (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,478.30 **Benefit:** 75% = $1108.75 85% = $1369.80 **Future End Date:**
61453	Localised study using gallium, with single photon emission tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,605.75 **Benefit:** 75% = $1204.35 85% = $1497.25 **Future End Date:**
61454	Localised study using cells labelled with technetium (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $378.55 **Benefit:** 75% = $283.95 85% = $321.80 **Future End Date:**
61457	Localised study using cells labelled with technetium, with single photon emission tomography (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $511.55 **Benefit:** 75% = $383.70 85% = $434.85 **Future End Date:**
61461	Localised study using thallium (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $2,165.70 **Benefit:** 75% = $1624.30 85% = $2057.20 **Future End Date:**
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) (See para IN.0.19, IN.0.17 of explanatory notes to this Category) **Fee:** $140.25 **Benefit:** 75% = $105.20 85% = $119.25 **Future End Date:**
61466	Cerebro-spinal fluid transport study using indium-111, with imaging on 2 or more separate occasions (R) **Fee:** $5,100.85 **Benefit:** 75% = $3825.65 85% = $4992.35 **Future End Date:**
61469	Lymphoscintigraphy (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $378.55 **Benefit:** 75% = $283.95 85% = $321.80 **Future End Date:**

I4. NUCLEAR MEDICINE IMAGING	1. NUCLEAR MEDICINE - NON PET
61473	Thyroid study (R) (See para IN.0.19, IN.0.17 of explanatory notes to this Category) **Fee:** $190.75 **Benefit:** 75% = $143.10 85% = $162.15 **Future End Date:**
61480	Parathyroid study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $420.65 **Benefit:** 75% = $315.50 85% = $357.60 **Future End Date:**
61485	Adrenal study, with single photon emission tomography (R) **Fee:** $3,658.00 **Benefit:** 75% = $2743.50 85% = $3549.50 **Future End Date:**
61495	Tear duct study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $242.60 **Benefit:** 75% = $181.95 85% = $206.25 **Future End Date:**
61499	Particle perfusion study (infra arterial) or Le Veen shunt study (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $275.10 **Benefit:** 75% = $206.35 85% = $233.85 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $955.50 **Benefit:** 75% = $716.65 85% = $847.00 **Future End Date:**

I4. NUCLEAR MEDICINE IMAGING	2. PET
	Group I4. Nuclear Medicine Imaging
	Subgroup 2. PET
61333	Lung ventilation study using Galligas and lung perfusion study using gallium-68 macro aggregated albumin (^{68}Ga-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) (See para IN.4.4 of explanatory notes to this Category) **Fee:** $443.35 **Benefit:** 75% = $332.55 85% = $376.85 **Future End Date:**
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) (See para IN.4.4 of explanatory notes to this Category) **Fee:** $605.05 **Benefit:** 75% = $453.80 85% = $514.30

	Future End Date:
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) (See para IN.4.4 of explanatory notes to this Category) **Fee:** $600.70 **Benefit:** 75% = $450.55 85% = $510.60 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $844.50 **Future End Date:**
61524	Whole body FDG PET study, performed for the staging of locally advanced (Stage III) breast cancer, for a patient who is considered suitable for active therapy (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $844.50 **Future End Date:**
61525	Whole body FDG PET study, performed for the evaluation of suspected metastatic or suspected locally or regionally recurrent breast carcinoma, for a patient who is considered suitable for active therapy (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $844.50 **Future End Date:**
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) (See para IN.4.4 of explanatory notes to this Category) **Fee:** $752.35 **Benefit:** 75% = $564.30 85% = $643.85 **Future End Date:**
61528	Whole body PSMA PET study, performed for the assessment of suitability for Lutetium 177 PSMA therapy in a patient with metastatic castrate resistant prostate cancer, after progressive disease has developed while undergoing prior treatment with at least one taxane chemotherapy and at least one androgen receptor signalling inhibitor. (R) (Anaes.) **Fee:** $1,300.00 **Benefit:** 75% = $975.00 85% = $1191.50 **Future End Date:**

I4. NUCLEAR MEDICINE IMAGING	2. PET
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $844.50 **Future End Date:**
61530	Whole body 68Ga-DOTA-somatostatin receptor agonist PET study for: a) staging of histologically confirmed neuroendocrine neoplasm (NEN) considered surgically incurable on conventional imaging, or b) evaluation of somatostatin receptor expression of histologically confirmed and inoperable NEN, either locally advanced or metastatic, under consideration for peptide receptor radionuclide therapy (PRRT); or c) evaluation of response to PRRT therapy; or d) evaluation of suspected recurrent or metastatic disease in known somatostatin receptor positive NEN. (R) (Anaes.) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $844.50 **Future End Date:**
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) **Fee:** $901.00 **Benefit:** 75% = $675.75 85% = $792.50 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $844.50 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $999.00 **Benefit:** 75% = $749.25 85% = $890.50 **Future End Date:**
61559	FDG PET study of the brain, performed for the evaluation of refractory epilepsy which is being evaluated for surgery (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $918.00 **Benefit:** 75% = $688.50 85% = $809.50 **Future End Date:**
61560	FDG PET study of the brain, performed for the diagnosis of Alzheimer's disease, if: a. clinical evaluation of the patient by a specialist, or in consultation with a specialist, is equivocal; and b. the service includes a quantitative comparison of the results of the study with the results of an FDG PET study of a normal brain from a reference database; and c. a service to which this item applies has not been performed on the patient in the previous 12 months; and d. a service to which item 61402 applies has not been performed on the patient in the previous 12 months for the diagnosis or management of Alzheimer's disease

	Applicable not more than 3 times per lifetime (R) **Fee:** $605.05 **Benefit:** 75% = $453.80 85% = $514.30 **Future End Date:**
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) (See para IN.0.19, IN.0.17 of explanatory notes to this Category) **Fee:** $1,300.00 **Benefit:** 75% = $975.00 85% = $1191.50 **Future End Date:**
Amend 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 once in any 12 month period (R) (See para IN.0.17, IN.0.19 of explanatory notes to this Category) **Fee:** $1,300.00 **Benefit:** 75% = $975.00 85% = $1191.50 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $844.50 **Future End Date:**
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) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $844.50 **Future End Date:**
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) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $844.50 **Future End Date:**
61577	Whole body FDG PET study, performed for the staging of proven oesophageal or GEJ carcinoma, in patients considered suitable for active therapy (R). **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $844.50 **Future End Date:**
61598	Whole body FDG PET study performed for the staging of biopsy-proven newly diagnosed or recurrent head and neck cancer (R). **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $844.50 **Future End Date:**

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). **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $844.50 **Future End Date:**
61610	Whole body FDG PET study performed for the evaluation of metastatic squamous cell carcinoma of unknown primary site involving cervical nodes (R). **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $844.50 **Future End Date:**
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 patient Applicable once per cancer diagnosis (R) (See para IN.0.19, IN.0.17 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $844.50 **Future End Date:**
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) (See para IN.0.19, IN.0.17 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $844.50 **Future End Date:**
61620	Whole body FDG PET study for the initial staging of newly diagnosed or previously untreated Hodgkin or non-Hodgkin lymphoma (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $844.50 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $844.50 **Future End Date:**
61628	Whole body FDG PET study for restaging following confirmation of recurrence of Hodgkin or non-Hodgkin lymphoma (R) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $844.50 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $844.50 **Future End Date:**

I4. NUCLEAR MEDICINE IMAGING	2. PET
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) **Fee:** $999.00 **Benefit:** 75% = $749.25 85% = $890.50 **Future End Date:**
61644	Single rest myocardial perfusion study for the assessment of the extent and severity of non-viable myocardium, with PET, if: (a) the service is performed because the service to which item 61325 applies cannot be performed due to unavailability of thallous chloride 201 (Tl-201); and (b) the patient has left ventricular systolic dysfunction and probable or confirmed coronary artery disease; and (c) the service is performed in conjunction with a rest myocardial perfusion study using technetium-99m; 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 or 11730 applies; and (f) this service and item 61325 are applicable only twice each 24 months (R) (See para IR.4.2 of explanatory notes to this Category) **Fee:** $329.00 **Benefit:** 75% = $246.75 85% = $279.65 **Future End Date:**
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) **Fee:** $999.00 **Benefit:** 75% = $749.25 85% = $890.50 **Future End Date:**
61647	Whole body ^{68}Ga 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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $844.50 **Future End Date:**

I4. NUCLEAR MEDICINE IMAGING	3. ADJUNCTIVE SERVICES
	Group I4. Nuclear Medicine Imaging
	Subgroup 3. Adjunctive services
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING — 1. SCAN OF HEAD - FOR SPECIFIED CONDITIONS

	Group I5. Magnetic Resonance Imaging
	Subgroup 1. 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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
63004	MRI—scan of head (including MRA, if performed) for inflammation of brain or meninges (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
63007	MRI—scan of head (including MRA, if performed) for skull base or orbital tumour (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $386.55 **Benefit:** 75% = $289.95 85% = $328.60 **Future End Date:**
63019	MRI—scan of head (including MRA if performed) for the assessment of suitability for the treatment of medically refractory essential tremor with magnetic resonance imaging-guided focused ultrasound Applicable once per patient per lifetime (R) (Contrast) (Anaes.) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
63020	MRI—scan of head (including MRA if performed) for the post-procedure assessment of the patient following magnetic resonance imaging-guided focused ultrasound for the treatment of medically refractory essential tremor Applicable once per patient per lifetime (R) (Contrast) (Anaes.) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**

	Group I5. Magnetic Resonance Imaging
	Subgroup 2. Scan Of Head - For Specified Conditions
63040	MRI—scan of head (including MRA, if performed) for acoustic neuroma (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $386.55 **Benefit:** 75% = $289.95 85% = $328.60 **Future End Date:**
63043	MRI—scan of head (including MRA, if performed) for pituitary tumour (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $412.25 **Benefit:** 75% = $309.20 85% = $350.45 **Future End Date:**
63046	MRI—scan of head (including MRA, if performed) for toxic or metabolic or ischaemic encephalopathy (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
63049	MRI—scan of head (including MRA, if performed) for demyelinating disease of the brain (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
63052	MRI—scan of head (including MRA, if performed) for congenital malformation of the brain or meninges (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
63055	MRI—scan of head (including MRA, if performed) for venous sinus thrombosis (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
63058	MRI—scan of head (including MRA, if performed) for head trauma (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
63061	MRI—scan of head (including MRA, if performed) for epilepsy (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
63064	MRI—scan of head (including MRA, if performed) for stroke (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	2. SCAN OF HEAD - FOR SPECIFIED CONDITIONS
63067	MRI—scan of head (including MRA, if performed) for carotid or vertebral artery dissection (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
63070	MRI—scan of head (including MRA, if performed) for intracranial aneurysm (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
63073	MRI—scan of head (including MRA, if performed) for intracranial arteriovenous malformation (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	3. SCAN OF HEAD AND NECK VESSELS - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 3. 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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $566.90 **Benefit:** 75% = $425.20 85% = $481.90 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	4. SCAN OF HEAD AND CERVICAL SPINE - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 4. 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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $566.90 **Benefit:** 75% = $425.20 85% = $481.90 **Future End Date:**
63114	MRI—scan of head and cervical spine (including MRA, if performed) for inflammation of the central nervous system or meninges (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $566.90 **Benefit:** 75% = $425.20 85% = $481.90 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	5. SCAN OF HEAD AND CERVICAL SPINE - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 5. Scan Of Head And Cervical Spine - For Specified Conditions
63125	MRI—scan of head and cervical spine (including MRA, if performed) for demyelinating disease of the central nervous system (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $566.90 **Benefit:** 75% = $425.20 85% = $481.90 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $566.90 **Benefit:** 75% = $425.20 85% = $481.90 **Future End Date:**
63131	MRI—scan of head and cervical spine (including MRA, if performed) for syrinx (congenital or acquired) (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $566.90 **Benefit:** 75% = $425.20 85% = $481.90 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	6. SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR INFECTION OR TUMOUR
	Group I5. Magnetic Resonance Imaging
	Subgroup 6. 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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $412.25 **Benefit:** 75% = $309.20 85% = $350.45 **Future End Date:**
63154	MRI—scan of one region or 2 contiguous regions of the spine for tumour (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $412.25 **Benefit:** 75% = $309.20 85% = $350.45 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	7. SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR OTHER CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 7. 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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $412.25 **Benefit:** 75% = $309.20 85% = $350.45

I5. MAGNETIC RESONANCE IMAGING	7. SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR OTHER CONDITIONS
	Future End Date:
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $412.25 **Benefit:** 75% = $309.20 85% = $350.45 **Future End Date:**
63167	MRI—scan of one region or 2 contiguous regions of the spine for myelopathy (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $412.25 **Benefit:** 75% = $309.20 85% = $350.45 **Future End Date:**
63170	MRI—scan of one region or 2 contiguous regions of the spine for syrinx (congenital or acquired) (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $412.25 **Benefit:** 75% = $309.20 85% = $350.45 **Future End Date:**
63173	MRI—scan of one region or 2 contiguous regions of the spine for cervical radiculopathy (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $412.25 **Benefit:** 75% = $309.20 85% = $350.45 **Future End Date:**
63176	MRI—scan of one region or 2 contiguous regions of the spine for sciatica (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $412.25 **Benefit:** 75% = $309.20 85% = $350.45 **Future End Date:**
63179	MRI—scan of one region or 2 contiguous regions of the spine for spinal canal stenosis (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $412.25 **Benefit:** 75% = $309.20 85% = $350.45 **Future End Date:**
63182	MRI—scan of one region or 2 contiguous regions of the spine for previous spinal surgery (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $412.25 **Benefit:** 75% = $309.20 85% = $350.45 **Future End Date:**
63185	MRI—scan of one region or 2 contiguous regions of the spine for trauma (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $412.25 **Benefit:** 75% = $309.20 85% = $350.45 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	8. SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR INFECTION OR TUMOUR
	Group I5. Magnetic Resonance Imaging

I5. MAGNETIC RESONANCE IMAGING	8. SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR INFECTION OR TUMOUR
	Subgroup 8. 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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $515.30 **Benefit:** 75% = $386.50 85% = $438.05 **Future End Date:**
63204	MRI—scan of 3 contiguous or 2 non contiguous regions of the spine for tumour (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $515.30 **Benefit:** 75% = $386.50 85% = $438.05 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	9. SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR OTHER CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 9. 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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $515.30 **Benefit:** 75% = $386.50 85% = $438.05 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $515.30 **Benefit:** 75% = $386.50 85% = $438.05 **Future End Date:**
63225	MRI—scan of 3 contiguous or 2 non contiguous regions of the spine for myelopathy (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $515.30 **Benefit:** 75% = $386.50 85% = $438.05 **Future End Date:**
63228	MRI—scan of 3 contiguous or 2 non contiguous regions of the spine for syrinx (congenital or acquired) (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $515.30 **Benefit:** 75% = $386.50 85% = $438.05 **Future End Date:**
63231	MRI—scan of 3 contiguous or 2 non contiguous regions of the spine for cervical radiculopathy (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $515.30 **Benefit:** 75% = $386.50 85% = $438.05

I5. MAGNETIC RESONANCE IMAGING	9. SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR OTHER CONDITIONS
	Future End Date:
63234	MRI—scan of 3 contiguous or 2 non contiguous regions of the spine for sciatica (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $515.30 **Benefit:** 75% = $386.50 85% = $438.05 **Future End Date:**
63237	MRI—scan of 3 contiguous or 2 non contiguous regions of the spine for spinal canal stenosis (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $515.30 **Benefit:** 75% = $386.50 85% = $438.05 **Future End Date:**
63240	MRI—scan of 3 contiguous or 2 non contiguous regions of the spine for previous spinal surgery (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $515.30 **Benefit:** 75% = $386.50 85% = $438.05 **Future End Date:**
63243	MRI—scan of 3 contiguous or 2 non contiguous regions of the spine for trauma (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $515.30 **Benefit:** 75% = $386.50 85% = $438.05 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	10. SCAN OF CERVICAL SPINE AND BRACHIAL PLEXUS - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 10. Scan Of Cervical Spine And Brachial Plexus - For Specified Conditions
63271	MRI—scan of cervical spine and brachial plexus for tumour (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $566.90 **Benefit:** 75% = $425.20 85% = $481.90 **Future End Date:**
63274	MRI—scan of cervical spine and brachial plexus for trauma (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $566.90 **Benefit:** 75% = $425.20 85% = $481.90 **Future End Date:**
63277	MRI—scan of cervical spine and brachial plexus for cervical radiculopathy (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $566.90 **Benefit:** 75% = $425.20 85% = $481.90 **Future End Date:**
63280	MRI—scan of cervical spine and brachial plexus for previous surgery (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $566.90 **Benefit:** 75% = $425.20 85% = $481.90 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	11. SCAN OF MUSCULOSKELETAL SYSTEM - FOR TUMOUR, INFECTION OR OSTEONECROSIS
	Group I5. Magnetic Resonance Imaging
	Subgroup 11. 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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $438.05 **Benefit:** 75% = $328.55 85% = $372.35 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $438.05 **Benefit:** 75% = $328.55 85% = $372.35 **Future End Date:**
63307	MRI—scan of musculoskeletal system for osteonecrosis (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $438.05 **Benefit:** 75% = $328.55 85% = $372.35 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	12. SCAN OF MUSCULOSKELETAL SYSTEM - FOR JOINT DERANGEMENT
	Group I5. Magnetic Resonance Imaging
	Subgroup 12. Scan Of Musculoskeletal System - For Joint Derangement
63322	MRI—scan of musculoskeletal system for derangement of hip or its supporting structures (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
63325	MRI—scan of musculoskeletal system for derangement of shoulder or its supporting structures (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
63328	MRI—scan of musculoskeletal system for derangement of knee or its supporting structures (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
63331	MRI—scan of musculoskeletal system for derangement of ankle or foot (or both) or its supporting structures (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	12. SCAN OF MUSCULOSKELETAL SYSTEM - FOR JOINT DERANGEMENT
63334	MRI—scan of musculoskeletal system for derangement of one or both temporomandibular joints or their supporting structures (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $386.55 **Benefit:** 75% = $289.95 85% = $328.60 **Future End Date:**
63337	MRI—scan of musculoskeletal system for derangement of wrist or hand (or both) or its supporting structures (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $515.30 **Benefit:** 75% = $386.50 85% = $438.05 **Future End Date:**
63340	MRI—scan of musculoskeletal system for derangement of elbow or its supporting structures (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	13. SCAN OF MUSCULOSKELETAL SYSTEM - FOR GAUCHER DISEASE
	Group I5. Magnetic Resonance Imaging
	Subgroup 13. Scan Of Musculoskeletal System - For Gaucher Disease
63361	MRI—scan of musculoskeletal system for Gaucher disease (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	14. SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 14. 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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $515.30 **Benefit:** 75% = $386.50 85% = $438.05 **Future End Date:**
63388	MRI—scan of cardiovascular system for tumour of the heart or a great vessel (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $515.30 **Benefit:** 75% = $386.50 85% = $438.05 **Future End Date:**
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.) **Fee:** $632.65 **Benefit:** 75% = $474.50 85% = $537.80 **Future End Date:**
63391	MRI—scan of cardiovascular system for abnormality of thoracic aorta (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $983.75 **Benefit:** 75% = $737.85 85% = $875.25 **Future End Date:**
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

I5. MAGNETIC RESONANCE IMAGING	14. SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS
	cardiomyopathy (ARVC) (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $983.75 **Benefit:** 75% = $737.85 85% = $875.25 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	15. MAGNETIC RESONANCE ANGIOGRAPHY - SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 15. 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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	16. MAGNETIC RESONANCE ANGIOGRAPHY - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
	Group I5. Magnetic Resonance Imaging
	Subgroup 16. 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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	17. MAGNETIC RESONANCE IMAGING - PERSON UNDER THE AGE OF 16 YEARS - FOR PHYSEAL FUSION OR GAUCHER DISEASE
	Group I5. Magnetic Resonance Imaging
	Subgroup 17. Magnetic Resonance Imaging - Person Under the Age of 16 Years - For Physeal Fusion or Gaucher Disease

I5. MAGNETIC RESONANCE IMAGING	17. 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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
63428	MRI—scan of person under the age of 16 for Gaucher disease (R) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	18. MAGNETIC RESONANCE IMAGING - PERSON UNDER THE AGE OF 16 YEARS - FOR OTHER CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 18. 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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
63443	MRI—scan of person under the age of 16 for mediastinal mass (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
63446	MRI—scan of person under the age of 16 for congenital uterine or anorectal abnormality (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	19. SCAN OF BODY - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 19. 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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $412.25 **Benefit:** 75% = $309.20 85% = $350.45 **Future End Date:**

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 Applicable not more than once in a 12 month period (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $793.75 **Benefit:** 75% = $595.35 85% = $685.25 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $793.75 **Benefit:** 75% = $595.35 85% = $685.25 **Future End Date:**
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.) **Fee:** $793.75 **Benefit:** 75% = $595.35 85% = $685.25 **Future End Date:**

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.) **Fee:** $1,159.50 **Benefit:** 75% = $869.65 85% = $1051.00 **Future End Date:**
63531	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 a breast lesion; and (ii) the results of conventional imaging are inconclusive for the presence of breast cancer; and (iii) biopsy has not been possible (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $793.75 **Benefit:** 75% = $595.35 85% = $685.25 **Future End Date:**
63533	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 a breast cancer; and (ii) there is a discrepancy between the clinical assessment and the conventional imaging assessment of the extent of the malignancy; and (c) the results of breast MRI imaging may alter treatment planning (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $793.75 **Benefit:** 75% = $595.35 85% = $685.25 **Future End Date:**
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.) (See para IN.5.1, IN.0.19 of explanatory notes to this Category) **Fee:** $517.55 **Benefit:** 75% = $388.20 85% = $439.95 **Future End Date:**
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.) (See para IN.5.2, IN.0.19 of explanatory notes to this Category) **Fee:** $517.55 **Benefit:** 75% = $388.20 85% = $439.95 **Future End Date:**
63547	MRI—scan of both breasts for the detection of cancer, if:

I5. MAGNETIC RESONANCE IMAGING	19. SCAN OF BODY - FOR SPECIFIED CONDITIONS
	(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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $793.75 **Benefit:** 75% = $595.35 85% = $685.25 **Future End Date:**
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.) (See para IN.5.4 of explanatory notes to this Category) **Fee:** $1,698.25 **Benefit:** 75% = $1273.70 85% = $1589.75 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	20. SCANS OF PELVIS AND UPPER ABDOMEN - FOR SPECIFIED CONDITIONS
	Group I5. Magnetic Resonance Imaging
	Subgroup 20. Scans 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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $1,380.40 **Benefit:** 75% = $1035.30 85% = $1271.90 **Future End Date:**

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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $721.50 **Benefit:** 75% = $541.15 85% = $613.30 **Future End Date:**
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.) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
63539	MRI—scan of the abdomen, requested by a specialist or consultant physician, to assess the development or growth of renal tumours in a patient with a confirmed clinical or molecular diagnosis of a genetic disorder associated with an increased risk of developing renal tumours, other than a service to which item 63540 applies Applicable once in any 12 month period (R) (Contrast) (Anaes.) **Fee:** $721.50 **Benefit:** 75% = $541.15 85% = $613.30 **Future End Date:**

63540	MRI—scan of the abdomen, requested by a specialist or consultant physician, to assess a patient with one or more known renal tumours and with a confirmed clinical or molecular diagnosis of a genetic disorder associated with an increased risk of developing renal tumours, if the service is performed: (a) to evaluate changes in clinical condition or suspected complications of the known renal tumours; or (b) where a disease specific line of treatment has been initiated and an assessment of patient responsiveness to the treatment is required Applicable once in any 3 month period (R) (Contrast) (Anaes.) **Fee:** $721.50 **Benefit:** 75% = $541.15 85% = $613.30 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $2,070.50 **Benefit:** 75% = $1552.90 85% = $1962.00 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	20. SCANS OF PELVIS AND UPPER ABDOMEN - FOR SPECIFIED CONDITIONS
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) **Fee:** $525.90 **Benefit:** 75% = $394.45 85% = $447.05 **Future End Date:**
63741	MRI—scan with enteroclysis for Crohn's disease if the service is related to item 63740 (R) **Fee:** $305.10 **Benefit:** 75% = $228.85 85% = $259.35 **Future End Date:**
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) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	21. SCAN OF BODY - FOR SUSPECTED HEPATO-BILIARY OR PANCREATIC PATHOLOGY
	Group I5. Magnetic Resonance Imaging
	Subgroup 21. 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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
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

I5. MAGNETIC RESONANCE IMAGING	21. SCAN OF BODY - FOR SUSPECTED HEPATO-BILIARY OR PANCREATIC PATHOLOGY
	(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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $632.65 **Benefit:** 75% = $474.50 85% = $537.80 **Future End Date:**
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 class A or B; and (c) the patient has an identified hepatic lesion over 10 mm in diameter. For any particular patient—applicable not more than once in a 12 month period (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $632.65 **Benefit:** 75% = $474.50 85% = $537.80 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	22. MODIFYING ITEMS
	Group I5. Magnetic Resonance Imaging
	Subgroup 22. Modifying Items
	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 (See para IN.0.19 of explanatory notes to this Category) **Fee:** $51.55 **Benefit:** 75% = $38.70 85% = $43.85
63491	**Future End Date:**
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 (See para IN.0.19 of explanatory notes to this Category)

I5. MAGNETIC RESONANCE IMAGING	22. MODIFYING ITEMS
	Fee: $51.55 **Benefit:** 75% = $38.70 85% = $43.85 **Future End Date:**
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 (See para IN.0.19 of explanatory notes to this Category) **Fee:** $287.55 **Benefit:** 75% = $215.70 85% = $244.45 **Future End Date:**
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 (See para IN.0.19 of explanatory notes to this Category) **Fee:** $180.35 **Benefit:** 75% = $135.30 85% = $153.30 **Future End Date:**
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 (See para IN.0.19 of explanatory notes to this Category) **Fee:** $51.55 **Benefit:** 75% = $38.70 85% = $43.85 **Future End Date:**
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) (See para GN.1.2 of explanatory notes to this Category) **Fee:** $180.35 **Benefit:** 75% = $135.30 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	32. MAGNETIC RESONANCE IMAGING - PIP BREAST IMPLANT
	Group I5. Magnetic Resonance Imaging
	Subgroup 32. 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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $575.20 **Benefit:** 75% = $431.40 85% = $488.95 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $575.20 **Benefit:** 75% = $431.40 85% = $488.95 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $575.20 **Benefit:** 75% = $431.40 85% = $488.95 **Future End Date:**
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) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $575.20 **Benefit:** 75% = $431.40 85% = $488.95 **Future End Date:**

	Group I5. Magnetic Resonance Imaging
	Subgroup 33. 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.) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
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.) **Fee:** $515.30 **Benefit:** 75% = $386.50 85% = $438.05 **Future End Date:**
63513	MRI—scan of knee for internal joint derangement for a patient under 16 years (R) (Contrast) (Anaes.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
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.) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
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.) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
63522	MRI—scan of wrist following radiographic examination for a patient under 16 years if a scaphoid fracture is suspected (R) (Contrast) (Anaes.)

I5. MAGNETIC RESONANCE IMAGING	33. SCAN OF BODY - PERSON UNDER THE AGE OF 16 YEARS - GENERAL PRACTICE REQUESTS
	Fee: $515.30 **Benefit:** 75% = $386.50 85% = $438.05 **Future End Date:**

I5. MAGNETIC RESONANCE IMAGING	34. SCAN OF BODY - PERSON OVER THE AGE OF 16 YEARS - GENERAL PRACTICE REQUESTS
	Group I5. Magnetic Resonance Imaging
	Subgroup 34. 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.) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**
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.) **Fee:** $412.25 **Benefit:** 75% = $309.20 85% = $350.45 **Future End Date:**
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.) **Fee:** $566.90 **Benefit:** 75% = $425.20 85% = $481.90 **Future End Date:**
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.) (See para IN.0.19 of explanatory notes to this Category) **Fee:** $463.80 **Benefit:** 75% = $347.85 85% = $394.25 **Future End Date:**

I6. MANAGEMENT OF BULK-BILLED SERVICES	
	Group I6. Management Of Bulk-Billed Services
64990	A diagnostic imaging service to which an item in this table (other than this item or item 64991, 64992, 64993, 64994 or 64995) applies if: (a) the service is an unreferred service; and

I6. MANAGEMENT OF BULK-BILLED SERVICES	
	(b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in respect of the fees for: (i) this item; and (ii) the other item in this table applying to the service (See para IN.0.19, IN.0.20 of explanatory notes to this Category) **Fee:** $8.25 **Benefit:** 85% = $7.05 **Future End Date:**
64991	A diagnostic imaging service to which an item in this table (other than this item or item 64990, 64992, 64993, 64994 or 64995) applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in respect of the fees for: (i) this item; and (ii) the other item in this table applying to the service; and (e) the service is provided at, or from, a practice location in a Modified Monash 2 area (See para IN.0.19, IN.0.20 of explanatory notes to this Category) **Fee:** $12.50 **Benefit:** 85% = $10.65 **Future End Date:**
64992	A diagnostic imaging service to which an item in this table (other than this item or item 64990, 64991, 64993, 64994 or 64995) applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in respect of the fees for: (i) this item; and (ii) the other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in: (i) a Modified Monash 3 are; or

	(ii) a Modified Monash 4 area (See para IN.0.20 of explanatory notes to this Category) **Fee:** $13.30 **Benefit:** 85% = $11.35 **Future End Date:**
64993	A diagnostic imaging service to which an item in this table (other than this item or item 64990, 64991, 64992, 64994 or 64995) applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in respect of the fees for: (i) this item; and (ii) the other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in a Modified Monash 5 area (See para IN.0.20 of explanatory notes to this Category) **Fee:** $14.05 **Benefit:** 85% = $11.95 **Future End Date:**
64994	A diagnostic imaging service to which an item in this table (other than this item or item 64990, 64991, 64992, 64993 or 64995) applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in respect of the fees for: (i) this item; and (ii) the other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in a Modified Monash 6 area (See para IN.0.20 of explanatory notes to this Category) **Fee:** $15.00 **Benefit:** 85% = $12.75 **Future End Date:**
64995	A diagnostic imaging service to which an item in this table (other than this item or item 64990, 64991, 64992, 64993 or 64994) applies if: (a) the service is an unreferred service; and

I6. MANAGEMENT OF BULK-BILLED SERVICES	
	(b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in respect of the fees for: (i) this item; and (ii) the other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in a Modified Monash 7 area (See para IN.0.20 of explanatory notes to this Category) **Fee:** $16.35 **Benefit:** 85% = $13.90 **Future End Date:**

CATEGORY 6: PATHOLOGY SERVICES

SUMMARY OF CHANGES FROM 01/11/2026

The 01/11/2026 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

Description Amended

71099 73358 73359 73360 73433 73932 73933 73934 73935

Changes relating to pathology services

From 1 November 2026, changes will be made relating to pathology services. This includes:

- Administrative amendments to replace references to the term “residential aged care facility” with “residential care home” to align with terminology in the *Aged Care Act 2024*;
- Amendments to remove the requirement for specialist paediatricians to consult a clinical geneticist before requesting genetic testing for childhood syndromes under items 73358, 73359 and 73360;
- Amending item 71099 to enable the use of the Crithidia method as a choice of testing for double-stranded DNA antibody assessment under this item;
- Amending item 73433 to expand *NTRK1-3* testing to adult patients with locally advanced or metastatic glioma, glioneuronal tumour or glioblastoma;
- Expanding the definitions of the terms "eligible Aboriginal and Torres Strait Islander health worker" and "health professional" in relation to services to which item 73813 applies for detection of infection with chlamydia trachomatis, neisseria gonorrhoeae or trichomonas vaginalis; and
- Administrative amendments to replace references to the term “residential aged care facility” with “residential care home” to align with terminology in the *Aged Care Act 2024*.

PATHOLOGY SERVICES NOTES

PN.0.1 Changes to the Pathology Services Table
Health Insurance Regulations

The *Health Insurance Act 1973* allows the Minister for Health to determine an appropriate Pathology Services Table which is then prescribed by Regulation.

Pathology submissions relating to new medical services and technologies should be submitted to the Medical Services Advisory Committee (MSAC). MSAC has been established to advise the Minister on the strength of evidence pertaining to new and emerging medical technologies and procedures in relation to their safety, effectiveness and cost effectiveness, and under what circumstances public funding should be supported. Details of how to submit an application to MSAC and guidelines for applying can be found on MSAC's website - www.msac.gov.au.

PN.0.2 Explanatory Notes - Definitions
Excessive Pathology Service

This means a pathology service for which a Medicare benefit has become or may become payable and which is not reasonably necessary for the adequate medical or dental care of the patient concerned.

PN.0.3 Group of Practitioners
This means:

(i) a practitioner conducting a medical practice or a dental practice, or a participating nurse practitioner practice, or a participating midwife practice together with another practitioner, or other practitioners, participating (whether as employees or otherwise) in the provision of professional services as part of that practice; or

(ii) two or more practitioners conducting a medical practice or a dental practice, or a participating nurse practitioner practice, or a participating midwife practice as partners; or

(iii) those partners together with any other practitioner who participates (whether as an employee or otherwise) in the provision of professional services as part of that practice.

PN.0.4 Initiate
In relation to a pathology service this means to request the provision of pathology services for a patient.

PN.0.5 Patient Episode
A patient episode comprises a pathology service or services specified in one or more items which are provided for a single patient, the need for which was determined under subsection 16A(1) of the Act on the same day, whether they were provided by one or more approved pathology practitioners on one day or over several days and whether they are requested by one or more treating practitioners. Even if a treating practitioner writes separate request forms to cover the collection of specimens at different times, where the decision to collect the multiple specimens was made at the same time, the multiple tests are deemed to belong to the same patient episode. In addition, if more than one request is made, on the same or different days, for tests on the same specimen within 14 days, they are part of the same patient episode.

Rule 4 of the Pathology Services Table provides an exemption to the above and enables services requested on one day which are performed under strictly limited circumstances for seriously or chronically ill patients with certain specified conditions to each be classified as a patient episode. See PN.0.33 and PN.1.2 for further information on exemptions.

Rule 14.(8) also provides that only a single patient episode initiation fee will be payable for all the specimens collected on one day from one patient in or by one Approved Pathology Authority.

PN.0.7 Personal Supervision
This means that an Approved Pathology Practitioner will, to the fullest extent possible, be responsible for exercising an acceptable level of control over the rendering of pathology services. See PN.13.1, PN.13.2 and PN.13.3 for a full description of the responsibilities involved in personal supervision.

PN.0.8 Prescribed Pathology Service
These are simple basic pathology services which are included in Group P9 and may be performed by a medical practitioner in the practitioner's surgery without the need to obtain Approved Pathology Authority, Approved Pathology Practitioner or Accredited Pathology Laboratory status.

PN.0.9 Proprietor of a Laboratory
This means in relation to a pathology laboratory the person, authority or body of persons having effective control of:

(i) the laboratory premises, whether or not the holder of an estate or interest in the premises;

(ii) the use of equipment used in the laboratory; and

(iii) the employment of staff in the laboratory.

PN.0.10 Specialist Pathologist
This means a medical practitioner recognised for the purposes of the *Health Insurance Act 1973* as a specialist in pathology (see GN.5.14). The principal specialty of pathology includes a number of sectional specialties. Accordingly, a medical practitioner who is recognised as a specialist in a sectional specialty of pathology is recognised as a specialist pathologist for this purpose.

PN.0.11 Designated Pathology Service
This means a pathology service specified in items 65150, 65175 66650, 66695, 66711, 66722, 66785, 66800, 66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165. Where one Approved Pathology Practitioner in an Approved Pathology Authority has performed some but not all the estimations in a coned item and has requested another Approved Pathology Practitioner in another Approved Pathology Authority to do the rest, the service provided by the second practitioner is deemed to be the "designated pathology service". Thus the first practitioner claims under the appropriate item for the services which he/she provides while the second practitioner claims one of items 65150, 65175, 66650, 66695, 66711, 66722, 66785, 66800, 66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165. Where one Approved Pathology Practitioner in an Approved Pathology Authority has performed some, but not all estimations and has requested another Approved Pathology Practitioner in another Approved Pathology Authority to do the remainder, the first Approved Pathology Practitioner can raise a "patient episode initiation fee". The second Approved Pathology Practitioner who receives the specimen can raise a "specimen referred fee".

PN.0.12 Interpretation of The Schedule - Items Referring to 'The Detection Of'
Items that contain the term 'detection of' should be taken to mean 'testing for the presence of'.

PN.0.13 Blood Grouping - (Item 65096)
Where a request includes 'Group and Hold' or 'Group and Save', the appropriate item is 65096.

PN.0.14 Glycosylated Haemoglobin - (Item 66551)
The requirement of "established diabetes" in this item may be satisfied by:

(a) a statement of the diagnosis by the ordering practitioner on the current request form or on a previous request form held in the database of the Approved Pathology Authority; or

(b) two or more blood glucose levels that are in the diabetic range and is contained in the database of the Approved Pathology Authority; or

(c) an oral glucose tolerance test result that is in the diabetic range and is contained in the database of the Approved Pathology Authority.

PN.0.15 Iron Studies - (Item 66596)

Where a request includes 'Iron Studies', 'IS', 'Fe', '% saturation' or 'Iron', the relevant item is 66596.

PN.0.17 Antibiotics/Antimicrobial Chemotherapeutic Agents

A test for the quantitation of antibiotics/antimicrobial chemotherapeutic agents is claimable under item 66800 or 66812 - 'quantitation of a drug being used therapeutically'.

PN.0.18 Human Immunodeficiency Virus (HIV) Diagnostic Tests - (included in Items 69384, 69387, 69390, 69393, 69396, 69405, 69408, 69411, 69413 and 69415)

Prior to ordering an HIV diagnostics tests (included in items 69384, 69387, 69390, 69393, 69396, 69405, 69408, 69411, 69413, 69415) the ordering practitioner should ensure that the patient has given informed consent. Appropriate discussion should be provided to the patient. Further discussion may be necessary upon receipt of the test results.

PN.0.19 Hepatitis - (Item 69481)

Benefits for item 69481 are payable only if the request from the ordering practitioner indicates in writing that the patient is suspected of suffering from acute or chronic hepatitis; either by the use of the provisional diagnosis of hepatitis or by relevant clinical or laboratory information eg "hepatomegaly", "jaundice" or "abnormal liver function tests".

PN.0.20 Eosinophil Cationic Protein - (Item 71095)

Item 71095 applies to children aged less than 12 years who cannot be reliably monitored by spirometry or flowmeter readings.

PN.0.21 Tissue Pathology and Cytology - (Items 72813 to 73061)

When services described in Group P5 need to be performed upon material which is submitted for cytology items listed in Group P6 only the fee for the P6 item can be claimed.

PN.0.22 Cervical and Vaginal Screening - (Items 73070 to 73076)

It is the responsibility of the treating healthcare practitioner to determine if the sample is being collected as part of the routine screening program under 73070 or 73071 or represents a sample falling under 73072 or 73074 or 73075 or 73076, and to indicate this on the request form. Unless a co-test is specifically requested, requiring the pathology laboratory to perform both a human papillomavirus (HPV) test and a liquid-based cytology (LBC) test on the same specimen, for a clinician-collected sample, the pathology laboratory will by default perform a HPV test and then only undertake reflex LBC testing if oncogenic HPV (any type) is detected. The pathology laboratory will issue the HPV test result, the LBC test result and overall screening risk rating as a combined report as prescribed by the National Pathology Accreditation Advisory Council (NPAAC) Requirements for Laboratories reporting tests for the National Cervical Screening Program (NPAAC Requirements).

The test used for detecting oncogenic HPV must allow partial HPV genotyping to identify HPV16, HPV18 with or without HPV45 as well as meet the criteria for a population-based screening test as prescribed by the NPAAC Requirements.

When used together, the self-collection device and the HPV test must meet the NPAAC Requirements, including the HPV test must be a polymerase chain reaction (PCR) test.

73070 applies to a HPV test on a cervical specimen for primary screening purposes and collected by a healthcare practitioner (or an accredited test provider under the supervision of a healthcare practitioner).

73071 applies to HPV tests for primary screening purposes requested by a healthcare practitioner (or an accredited test provider under the supervision of a healthcare practitioner) on a self-collected vaginal specimen.

Tests for both 73070 and 73071 must be from an asymptomatic patient as part of routine five yearly screening recommended by the National Cervical Screening Program. The *Health Insurance Act 1973* excludes payment of Medicare Benefits for health screening services except where Ministerial directions have been issued to enable benefits to be paid, this includes HPV testing that is performed in accordance with the policy of the National Cervical Screening Program (available at https://www.health.gov.au/initiatives-and-programs/national-cervical-screening-program). This policy provides for a screening interval of five years for an asymptomatic patient commencing at 24 years and 9 months of age and for a patient aged between 70 to 74 years of age to cease cervical screening if the last test result is normal (i.e. low risk). A patient aged 75 years of age or older who has never had a cervical screening test or has not had one in the previous five years, may request a cervical screening test and be screened.

In accordance with the national policy for the National Cervical Screening Program, where oncogenic HPV (any type) is detected from a sample collected by a healthcare practitioner (73070), the pathology laboratory will conduct reflex LBC automatically under 73076 (a) without requiring an additional request by the treating healthcare professional.

Where oncogenic HPV (non 16/18) is detected from a self-collected vaginal sample (73071), the participant will need to return to their healthcare practitioner for the collection of a cervical sample for LBC. The healthcare practitioner collected liquid based sample from the cervix that follows, can be claimed under 73076 (a) with a further request by the treating healthcare practitioner.

73072 applies to HPV tests where the specimen has been collected in accordance with the National Cervical Screening Program: Guidelines for the Management of Screen Detected Abnormalities, Screening in Specific Populations and Investigation of Abnormal Vaginal Bleeding (NCSP Clinical Guidelines) which provides for:

(a) a HPV test performed on a patient within a specific population suggestive of a higher risk of pre-cancerous or cancerous cervical changes. HPV tests carried out in specific populations under Item 73072 should be in accordance with the NCSP Clinical Guidelines including:

(i) screening with a primary HPV test every 3 years for an immune-deficient patient; or

(ii) a single HPV test between 20 and 24 years of age could be considered by healthcare practitioners on a case-by-case basis for a patient who experienced first sexual activity at a young age (less than 14 years of age) and who has not received the HPV vaccine before sexual debut; or

(b) a HPV test performed for the follow up management of previously detected oncogenic HPV infection; or

(c) a co-test (HPV+LBC) for the investigation of symptoms of cervical cancer, most commonly abnormal vaginal bleeding; or

(d) annual HPV tests for the management of a patient following treatment of high grade squamous intraepithelial lesions (HSIL) of the cervix as part of a 'test of cure' process performed at 12 months after treatment and annually thereafter, until HPV tests are negative on two separate consecutive occasions, at which point the patient can return to routine five yearly screening; or

(e) a co-test (HPV+LBC) for the follow up management of glandular abnormalities; or

(f) a co-test (HPV+LBC) for screening a patient exposed to diethylstilbestrol (DES) in utero and daughters of patients exposed to DES in utero, if requested; or

(g) a co-test (HPV+LBC) for a patient previously treated for a genital tract malignancy.

A co-test requires both HPV and LBC tests to be performed irrespective of the HPV test result and so must be performed on a clinician collected cervical sample. In cases where a co-test is indicated but a self-collected sample has been received, a HPV test may be performed and may be claimed under 73072 (but the lab report will indicate that LBC is required). In other HPV tests, LBC is only required if oncogenic HPV (any type) is detected; where oncogenic HPV (any type) has been detected in a liquid based sample from the cervix by a healthcare professional, the pathology laboratory will conduct LBC automatically without requiring an additional request. It is the intention of the National Cervical Screening Program where a co-test is requested or oncogenic HPV has previously been detected under this item, the LBC can be claimed under 73076 without requiring an additional request by the treating healthcare professional.

73074 applies to a HPV test on a vaginal vault specimen from a patient with past history of total hysterectomy, in accordance with the NCSP Clinical Guidelines which provides for:

(a) a HPV test for a patient who has no evidence of cervical pathology but the patient has never been screened or their screening history is not available, performed at 12 months following a total hysterectomy and annually thereafter until a patient has two negative HPV tests (i.e. oncogenic HPV is not detected on two separate consecutive occasions at which point they can be advised that no further testing is required; or

(b) a HPV test for a patient who has had a total hysterectomy, performed at 12 months following a total hysterectomy and annually thereafter if LSIL or HSIL is identified in the cervix at the time of total hysterectomy, regardless of screening history. Once the person has tested negative for oncogenic HPV on 2 consecutive occasions they can be advised that no further testing is required.

(c) Co-testing (HPV+LBC) for a patient who has had a total hysterectomy, performed at 12 months after treatment and annually thereafter if the total hysterectomy was after adenocarcinoma in situ (AIS) or if adenocarcinoma in situ is identified in the hysterectomy sample. Once the person has tested negative on both tests (HPV and LBC) for 2 consecutive occasions, they do not need further testing.

73075 applies to HPV tests repeated due to an unsatisfactory HPV test under 73070 or 73071 or 73072 or 73074.

73076 applies to a liquid-based cytology (LBC) test on a cervical or vaginal vault specimen:

(a) as part of a reflex test following detection of oncogenic HPV described in the national policy and NCSP Clinical Guidelines associated with items 73070 or 73071 or 73072 (a) or (b) or (d) or 73074 or 73075; or

(b) as part of a co-test described in the national policy and NCSP Clinical Guidelines under 73072 (c) or (d) or (e) or (f) or 73074; or

(c) where the previous specimen collected is unsatisfactory; or

(d) for the follow up management of a patient with a past history of total hysterectomy for endometrial adenocarcinoma.

PN.0.23 Informed consent and genetic counselling for genetic tests

Items 73297, 73300, 73305, 73334, 73339, 73340, 73393, 73394, 73417, 73418, 73440, 73441, 73442, 73443, and 73444

Prior to ordering these tests the ordering practitioner should ensure the patient (or approximate proxy) has given written informed consent. Testing should only be performed after genetic counselling. Appropriate genetic counselling should be provided to the patient either by the specialist treating practitioner, a genetic counselling service or a clinical geneticist on referral. Further counselling may be necessary upon receipt of the test results.

Items 73295, 73296, 73304, 73333, 73392, 73395, 73416 and 73419

Patients who are found to have any form of affected allele should be referred for post-test genetic counselling as there may be implications for other family members. Appropriate genetic counselling should be provided to the patient either by the specialist treating practitioner, a genetic counselling service or a clinical geneticist on referral.

PN.0.24 Additional Bulk Billing Payment for Pathology Services

Additional Bulk Billing Payment for Pathology Services - (Item 74990, 74991, 75861, 75862, 75863 and 75864)

The Additional Bulk Billing Payment for Pathology Services operates in the same way as the equivalent items for unreferred medical services (see note MN.1.1), apart from the following differences:

- Item 74990 and 74991 can only be used in conjunction with items in the Pathology Services Table of the MBS
- Item 74990 and 74991 applies to unreferred pathology services performed by a medical practitioner which are included in Group P9 of the Pathology Services Table, and unreferred pathology services provided by category M laboratories
- Item 74990 and item 74991 applies to pathology services self determined by general practitioners and specialists with dual qualifications acting in their capacity as general practitioners.

Specialists and consultant physicians who provide pathology services are not able to claim the Additional Bulk Billing Payment unless, for the purposes of the *Health Insurance Act 1973*, the medical practitioner is also a general practitioner and the service provided by the medical practitioner has not been referred to that practitioner by another medical practitioner or person with referring rights.

The pathology rules (see note PN.0.33) have been amended to exclude the Additional Bulk Billing Payment items from the Multiple Services Rule and the Coning Rule.

Item 74991 can only be used where the service is provided at, or from, a practice location that is in a MMM 2 area under the Modified Monash Model classification system

Item 75861 can only be used where the service is provided at, or from, a practice location that is in a MMM 3 or 4 area under the Modified Monash Model classification system

Item 75862 can only be used where the service is provided at, or from, a practice location that is in a MMM 5 area under the Modified Monash Model classification system

Item 75863 can only be used where the service is provided at, or from, a practice location that is in a MMM 6 area under the Modified Monash Model classification system

Item 75864 can only be used where the service is provided at, or from, a practice location that is in an MMM 7 area under the Modified Monash Model classification system.

PN.0.25 Transfer of Existing Items from Group P1 (Haematology) to Group P7 Genetics Effective 1 May 2006.

PN.0.25 has been created to note the transfer of existing items from Group P1 (Haematology) items 65168, 65174, 65200 and item 66794 from Group P2 (Chemistry) to Group P7 (Genetics) as items 73308, 73311, 73314, 73317 and the introduction of the new item in Group P7 (Genetics) item 73320 HLA-B27 typing by nucleic acid amplification (NAA) which was effective as of 1 May 2006.

PN.0.26 RAS gene mutation status (Item 73338)

Item 73338 provides for testing of RAS mutations to limit subsidy of anti-EGFR antibodies to only those patients demonstrated to have no RAS mutations.

For a Medicare benefit to be payable, the test must be conducted for all clinically relevant mutations on KRAS exons 2, 3 and 4 and NRAS exons 2, 3 and 4, or until a RAS mutation is found.

Enabling the requirements of the item descriptor to be met once any RAS mutation is found means that once the test indicates that the patient is not RAS wild-type and therefore not suitable for access to cetuximab and panitumumab under the PBS, a pathologist is not required to continue testing for other clinically relevant mutations.

PN.0.27 Germline gene mutation tests (Items 73416 and 73392)
Genomic testing methods for future re-analysis

Items 73416 and 73392

The rapidly expanding field of genomic medicine has resulted in recognition of an increasing number of genetic causes of cardiac diseases. Use of genomic testing methods that permit reanalysis of existing data for variants in newly described clinically relevant genes are recommended/encouraged.

PN.0.28 Abbreviations, Groups of Tests
As stated at PN.3.2, details that must be recorded on accounts, receipts or assignment agreement of an Approved Pathology Practitioner/Authority include a description of the pathology service that is of sufficient detail to identify the specific service rendered. The lists of abbreviations for group tests are contained in PN.0.31. The abbreviations are provided to allow users to identify and refer to particular pathology services, or particular groups of pathology services, more accurately and conveniently.

The above requirements may be used for billing purposes but treating practitioners requesting pathology services are encouraged to use the approved abbreviations. In this regard treating practitioners should note that:

- pathology services cannot be self determined by a rendering pathologist responding to a request. This places the onus for medical necessity on the treating practitioner who, in normal circumstances would, if he or she was unclear in deciding the appropriate test for a clinical situation, consult a pathologist for assistance; and

- Approved Pathology Practitioners/Authorities undertake not to issue accounts etc unless the pathology service was rendered in response to an unambiguous request.

PN.0.29 Tests not Listed
Tests which are not listed in the Pathology Services Table do not attract Medicare benefits. As explained in PN.0.1, changes to the Pathology Services Table can only be made by the Minister for Health and Aged Care.

PN.0.30 Audit of Claims
Services Australia is undertaking routine audits of claims for pathology benefits against requested services to ensure compliance with the provisions of the *Health Insurance Act 1973*.

PN.0.31 Groups of Tests
For the purposes of recording a description of the pathology service on accounts etc, an Approved Pathology Practitioner /Authority may use group abbreviations or group descriptions for the following specified groups of tests. These groups consist of two or more tests within the same item. These groups exclude abbreviations such as MBA and TORCH.

Treating practitioners are encouraged to use these group abbreviations or group descriptions where appropriate.

For ease of identification of group tests, it is recommended that practitioners use the following abbreviations. Tests requested individually may attract Medicare benefits.

Group	Estimations included in Group	Group Abbreviation	Item Numbers
Cardiac enzymes or cardiac markers	Creatine kinase isoemzymes, Myoglobin, Troponin	CE / CM	66518, 66519

Group	Estimations included in Group	Group Abbreviation	Item Numbers
Coagulation studies	Full blood count, Prothrombin time, Activated partial thromboplastin time and two or more of the following tests - Fibrinogen, Thrombin, Clotting time, Fibrinogen degradation products, Fibrin monomer, D-dimer factor XIII screening tests	COAG	65129, 65070
Electrolytes	Sodium (NA), Potassium (K), Chloride (CL) and Bicarbonate (HCO3)	E	66509
Full Blood Examination	Erythrocyte count, Haematocrit, Haemoglobin, Platelet count, Red cell count, Leucocyte count, Manual or instrument generated differential, Morphological assessment of blood film where appropriate	FBE, FBC, CBC	65070
Lipid studies	Cholesterol (CHOL) and Triglycerides (TRIG)	FATS	66503
Liver function tests	Alkaline phosphatase (ALP), Alanine aminotransferase (ALT), Aspartate aminotransferase (AST), Albumin (ALB), Bilirubin (BIL), Gamma glutamyl transpeptidase (GGT), Lactate dehydrogenase (LDH), and Protein (PROT)	LFT	66512
Syphilis serology	Rapid plasma regain test (RPR), or Venereal disease research laboratory test (VDRL), and Treponema pallidum haemagglutination test (TPHA), or Fluorescent treponemal antibody-absorption test (FTA)	STS	69387
Urea, Electrolytes, Creatinine	Urea, Electrolytes, Creatinine	U&E	66512

PN.0.32 Complexity Levels for Histopathology Items

Only one of these histopathology examination items (72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838) can be claimed in a patient episode.

The remaining items (72844, 72846, 72847, 72848, 72849, 72850, 72851, 72852, 72855, 72856 and 72857) are add-on items, covering enzyme histochemistry and immunohistochemistry, electron microscopy and frozen sections, which can be claimed in addition to the main item.

The list of complexity levels by type of specimen are contained in Part 3 of Schedule 1 of the *Health Insurance (Pathology Services Table) Regulations 2020*, which is available at www.legislation.gov.au

PN.0.33 Pathology Services Table

Rules for the Interpretation of the Pathology Services Table

Please note that in the *Health Insurance (Pathology Services Table) Regulations 2020* rules and sub-rules are referred to as clauses and sub-clauses. In addition in the Regulations a rule that refers to specific items within a pathology group, for example Group P1 Haemotology, is listed directly above the Schedule of Services for that group. A table cross referencing the following rules with the clauses in the Regulations is at the end of this section.

1. (1) In this table

patient episode means:

(a) a pathology service or pathology services (other than a pathology service to which paragraph 1 (1) (b) refers) provided for a single patient whose need for the service or services was determined under section 16A of the Act:

(i) on the same day; or

(ii) if more than 1 test is performed on the 1 specimen within 14 days - on the same or different days;

whether the services:

(iii) are requested by 1 or more practitioners; or

(iv) are described in a single item or in more than 1 item; or

(v) are rendered by 1 approved pathology practitioner or more than 1 approved pathology practitioner; or

(vi) are rendered on the same or different days; or

(b) a pathology service to which rule 4 refers that is provided in the circumstances set out in that rule that relates to the service.

receiving APP means an approved pathology practitioner in an approved pathology authority who performs one or more pathology services in respect of a single patient episode following receipt of a request for those services from a referring APP.

recognised pathologist means a medical practitioner recognised as a specialist in pathology by a determination under section 3D, 3DB or 3E of the Act.

referring APP means an approved pathology practitioner in an approved pathology authority who:

(i) has been requested to render 1 or more pathology services, all of which are requested in a single patient episode; and

(ii) is unable, because of the lack of facilities in, or expertise or experience of the staff of, the laboratory of the authority, to render 1 or more of the pathology services; and

(iii) requests an approved pathology practitioner (the ***receiving APP***) in another approved pathology authority to render the pathology service or services that the referring APP is unable to render; and

(iv) renders each pathology service (if any) included in that patient episode, other than the pathology service or services in respect of which the request mentioned in subparagraph (iii) is made.

serial examinations means a series of examinations requested on 1 occasion whether or not:

(a) the materials are received on different days by the approved pathology practitioner; or

(b) the examinations or cultures were requested on 1 or more request forms by the treating practitioner.

***the* Act** means the *Health Insurance Act 1973.*

1. (2) In these rules, a reference to a request to an approved pathology practitioner includes a reference to a request for a pathologist-determinable service to which subsection 16A (6) of the Act applies.

1. (3) A reference in this table by number to an item that is not included in this table is a reference to the item that has that number in the general medical services table or the diagnostic imaging services table, as the case requires.

1. (4) A reference to a **Group** in the table includes every item in the Group and a reference to a **Subgroup** in the table includes every item in the Subgroup.

Precedence of items

2. (1) If a service is described:

(a) in an item in general terms; and

(b) in another item in specific terms;

only the item that describes the service in specific terms applies to the service.

2. (2) Subject to subrule (3), if:

(a) subrule (1) does not apply; and

(b) a service is described in 2 or more items;

only the item that provides the lower or lowest fee for the service applies to the service.

2. (3) If an item is expressed to include a pathology service that is described in another item, the other item does not apply to the service in addition to the first-mentioned item, whether or not the services described in the 2 items are requested separately.

Application of Additional Bulk Billing Payment for Pathology Services (items 74990, 74991, 75861, 75862, 75863 and 75864)

2. (4) Despite subrules (1), (2) and (3):

(a) if an Additional Bulk Billing Payment item applies to a pathology service, the fee specified in that item applies in addition to the fee specified in any other item in the table that applies to the service.

2. (5) For the Additional Bulk Billing Payment for Pathology Services:

bulk-billed, in relation to a pathology service, means:

(a) a medicare benefit is payable to a person in respect of the service; and

(b) under an agreement entered into under section 20A of the Act:

(i) the person assigns to the practitioner by whom, or on whose behalf, the service is provided, his or her right to the payment of the medicare benefit; and

(ii) the practitioner accepts the assignment in full payment of his or her fee for the service provided.

Concessional beneficiary means a person who is a concessional beneficiary within the meaning given by subsection 84(1) of the *National Health Act 1953*.

unreferred service means a pathology service that:

(a) is provided to a person by, or on behalf of, a medical practitioner, being a medical practitioner who is not a consultant physician, or specialist, in any speciality (other than a medical practitioner who is, for the purposes of the Act, both a general practitioner and a consultant physician, or specialist, in a particular speciality); and

(b) has not been referred to the medical practitioner by another medical practitioner or person with referring rights.

2. (6) For items 74991, 75861, 75862, 75863 and 75864:

practice location, in relation to the provision of a pathology service, means the place of practice in respect of which the practitioner by whom, or on whose behalf, the service is provided, has been allocated a provider number by the Commission.

Circumstances in which services rendered following 2 requests to be taken to have been rendered following 1 request

3. (1) In subrule 3(2), ***service*** includes assay, estimation and test.

3. (2) Two or more pathology services (other than services to which, under rule 4, this rule does not apply) rendered for a patient following 2 or more requests are taken to have been rendered following a single request if:

(a) the services are listed in the same item; and

(ab) that item is not item 74990, 74991, 75861, 75862, 75863 or 75864; and

(b) the patient's need for the services was determined under subsection 16A (1) of the Act on the same day even if the services are rendered by an approved pathology practitioner on more than one day.

Services to which rule 3 does not apply

4. (1) Rule 3 does not apply to a pathology service described in item 65060, 65070, 65120, 65123, 65126, 65129, 65150, 65153, 65156, 66500, 66503, 66506, 66509, 66512, 66584 or 66800, if:

(a) the service is rendered in relation to one or more specimens taken on each of not more than 6 separate occasions in a period of 24 hours; and

(b) the service is rendered to an inpatient in a hospital; and

(c) each service must be rendered as soon as possible after collection and after authorization of the result of the previous specimen; and

(d) the account for the service is endorsed 'Rule 3 Exemption'.

4. (2) Rule 3 does not apply to any of the following pathology services:

(a) estimation of prothrombin time (INR) in respect of a patient undergoing anticoagulant therapy;

(b) quantitative estimation of lithium in respect of a patient undergoing lithium therapy;

(c) a service described in item 65070 in relation to a patient undergoing chemotherapy for neoplastic disease or immunosuppressant therapy;

(d) a service described in item 65070 in relation to clozapine, ticlopidine hydrochloride, methotrexate, gold, sulfasalazine or penicillamine therapy of a patient;

(e) a service described in item 66500 - 66512 in relation to methotrexate or leflunomide therapy of a patient;

(f) quantitative estimation of urea, creatinine and electrolytes in relation to:

(i) cisplatin or ciclosporin therapy of a patient; or

(ii) chronic renal failure of a patient being treated in a dialysis program conducted by a recognised hospital;

(g) quantitative estimation of albumin and calcium in relation to therapy of a patient with vitamin D, its metabolites or analogues;

(h) quantitative estimation of calcium, phosphate, magnesium, urea, creatinine and electrolytes in cancer patients receiving bisphosphonate infusions.

if:

(i) under a request for a service, other than a request for a service described in paragraph (a), no more than 6 tests are requested; and

(ii) the tests are performed within 6 months of the request; and

(iii) the account for the service is endorsed "Rule 3 Exemption".

4. (3) Rule 3 does not apply to a pathology service described in items 65109 or 65110 if:

(a) The service is rendered on not more than 5 separate occasions in the case of item 65109 and 2 separate occasions in the case of item 65110 in a period of 24 hours; and

(b) The service is rendered in response to a written request separated in time from the previous request; and

(c) The account for the service is endorsed "Rule 3 Exemption".

Item taken to refer only to the first service of a particular kind

5. (1) For an item in Group P1 (Haematology):

(a) if pathology services of a kind referred to in item 65090 or 65093 are rendered for a patient during a period when the patient is in hospital, the item applies only to the first pathology service of that kind rendered for the patient during the period; and

(b) if:

(i) tests (except tests mentioned in item 65099, 65102, 65105 and 65108) are carried out in relation to a patient episode; and

(ii) specimen material from the patient episode is stored; and

(iii) in response to a request made within 14 days of the patient episode, further tests (except tests mentioned in item 65099, 65102, 65105 and 65108) are carried out on the stored material; the later tests and the earlier tests are taken to be part of one patient episode.

5. (2) Benefits for items 65102 and 65108 are payable only if a minimum of 6 units are issued for the patient's care in any 1 day.

5.(3) For items 65099 and 65102:

compatibility tests by crossmatch means that, in addition to all the tests described in paragraphs (a) and (b) of the item, donor red cells from each unit must have been tested directly against the serum of the patient by 1 or more accepted crossmatching techniques.

Certain items not to apply to a service referred by one pathology practitioner to another

6. (1) In this rule:

designated pathology service means a pathology service in respect of tests relating to a single patient episode that are tests of the kind described in item 65150, 65175, 66650, 66695, 66711, 66722, 66785, 66800, 66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165.

6. (2) This rule applies in respect of a designated pathology service where:

(a) an approved pathology practitioner ***(practitioner A)*** in an approved pathology authority:

(i) has been requested to render the designated pathology service; and

(ii) is unable, because of the lack of facilities in, or expertise or experience of the staff of, the laboratory of the authority, to render 1 or more of the tests included in the service; and

(iii) requests an approved pathology practitioner ***(practitioner B)*** in another approved pathology authority to render the test or tests that practitioner A is unable to render; and

(iv) renders each test (if any) included in the service, other than the test or tests in respect of which the request mentioned in subparagraph (iii) is made; and

(b) the tests mentioned in subparagraph (a) (iv) that practitioner A renders are not tests constituting a service described in item 65156, 65179, 66653, 66712, 66734, 66788, 66806, 66815, 66822, 66828, 69496, 71093, 71159 or 71168.

6. (3) If this rule applies in respect of a designated pathology service:

(a) item 65150, 65153, 65175, 65176, 65177, 65178, 66650, 66695, 66698, 66701, 66704, 66707, 66711, 66722, 66725, 66728, 66731, 66785, 66800, 66803, 66812, 66819, 66825, 69384, 69387, 69390, 69393, 69396, 69494, 69495, 71089, 71091, 71153, 71155, 71157, 71165, 71166 or 71167 (as the case requires) applies in respect of the test or tests rendered by practitioner A; and

(b) where practitioner B renders a service under a request referred to in subparagraph (2) (a) (iii) and:

(i) practitioner A has rendered one or more of the tests that the service comprises - subject to subrule (4), the amount specified in item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 (as the case requires) shall be taken to be the fee for each test that the service comprises; or

(ii) practitioner A has not rendered any of the tests that the service comprises -

(A) the amount specified in item 65157, 65180, 66651, 66696, 66714, 66723, 66789, 66804, 66816, 66820, 66826, 69400, 69497, 71090, 71154 or 71169 (as the case requires) shall be taken to be the fee for the first test that the service comprises; and

(B) subject to subrule (4), the amount specified in item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 (as the case requires) shall be taken to be the fee for each subsequent test that the service comprises.

6. (4) For paragraph (3) (b), the maximum number of tests to which item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 applies is:

(a) for item 66652, 66715, 66790, 66817, 66821 or 66827:

2 - X; and

(b) for item 65158, 66805, 69498 or 71092:

3 - X; and

(c) for item 71156 or 71170:

4 - X; and

(d) for item 65181 or 66724:

5 - X; and

where X is the number of tests rendered by practitioner A in relation to the designated pathology service in respect of which the request mentioned in that paragraph is made.

6. (5) Items in Group P10 (Patient episode initiation) do not apply to the second mentioned approved pathology practitioner in subrule (2).

Items not to be split

7. Except as stated in rule 6, the amount specified in an item is payable only to one approved pathology practitioner in respect of a single patient episode.

Creatinine ratios - Group P2 (chemical)

8. A pathology service mentioned in an item (except item 66500) in Group P2 (chemical) that:

(a) involves the measurement of a substance in urine; and

(b) requires calculation of a substance/creatinine ratio;

is taken to include the measurement of creatinine necessary for the calculation.

Thyroid function testing

9. (1) For item 66719:

abnormal level of TSH means a level of TSH that is outside the normal reference range in respect of the particular method of assay used to determine the level.

9. (2) Except where paragraph (a) of item 66719 is satisfied, the amount specified in the item is not payable in respect of a pathology service described in the item unless the pathologist who renders the service has a written statement from the medical practitioner who requested the service that satisfies subrule (3).

9. (3) The written statement from the medical practitioner must indicate:

(a) that the tests are required for a particular purpose, being a purpose specified in paragraph (b) of item 66719; or

(b) that the medical practitioner who requested the tests suspects the patient has pituitary dysfunction; or

(c) that the patient is on drugs that interfere with thyroid hormone metabolism or function.

Meaning of "serial examinations or cultures"

10. For an item in Group P3 (Microbiology):

(a) ***serial examinations or cultures*** means a series of examinations or cultures requested on 1 occasion whether or not:

(i) the materials are received on different days by the approved pathology practitioner; or

(ii) the examinations or cultures were requested on 1 or more request forms by the treating practitioner; and

(b) if:

(i) tests are carried out in relation to a patient episode; and

(ii) specimen material from the patient episode is stored; and

(iii)in response to a request made within 14 days of the patient episode, further tests are carried out on the stored material;

the later tests and the earlier tests are taken to be part of one patient episode.

Investigation for hepatitis serology

11. A medicare benefit is not payable in respect of more than one of items 69475, 69478 and 69481 in a patient episode.

Tests in Group P4 (Immunology) relating to antibodies

12. For items in Group P4 (Immunology), in items 71119, 71121, 71123 and 71125, if:

(a) tests are carried out in relation to a patient episode; and

(b) specimen material from the patient episode is stored; and

(c) in response to a request made within 14 days of the patient episode, further tests are carried out on the stored material;

the later tests and the earlier tests are taken to be part of one patient episode.

Tests on biopsy material - Group P5 (Tissue pathology) and Group P6 (Cytology)

13. (1) For items in Group P5 (Tissue pathology):

(a) ***biopsy material*** means all tissue received by the Approved Pathology Practitioner:

(i) from a medical procedure or group of medical procedures performed on a patient at the same time; or

(ii) after being expelled spontaneously from a patient.

(b) ***cytology*** means microscopic examination of 1 or more stained preparations of cells separated naturally or artificially from their normal environment by methods recognised as adequate to demonstrate their structure to a degree sufficient to enable an opinion to be formed about whether they are likely to be normal, abnormal but benign, or abnormal and malignant but, in accordance with customary laboratory practice, does not include examination of a blood film and a bone marrow aspirate; and

(c) ***separately identified specimen*** means an individual specimen collected, identified so that it is clearly distinguished from any other specimen, and sent for testing by or on behalf of the treating practitioner responsible for the procedure in which the specimen was taken.

13. (2) For Groups P5 and P6 of the pathology services table, services in Group P6 include any services described in Group P5 on the material submitted for a test in Group P6.

13. (3) For subrule (2), any sample submitted for cytology from which a cell block is prepared does not qualify for a Group P5 item.

13.(4) If more than 1 of the services mentioned in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 are performed in a single patient episode, only the fee for the item performed having the highest specified fee is applicable to the services.

13.(5) If more than 1 histopathological examinations are performed on separate specimens, of different complexity levels, from a single patient episode, a medicare benefit is payable only for the examination that has the highest schedule fee.

13.(6) In items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 a reference to a ***complexity level*** is a reference to the level given to a specimen type mentioned in Part 4 of this Table.

13.(7) If more than 1 of the services mentioned in items 72846, 72847, 72848; 72849 and 72850 or 73059, 73060, 73061, 73064 and 73065 are performed in a single patient episode, a medicare benefit is payable only for the item performed that has the highest scheduled fee.

13.(8) If more than 1 of the services mentioned in items 73049, 73051, 73062, 73063, 73066 and 73067 are performed in a single patient episode, only the fee for the item performed having the higher or highest specified fee applies to the services.

Items in Groups P10 (Patient episode initiation) and P11 (Specimen referred) not to apply in certain circumstances

14. (1) For this rule and items in Groups P10 (Patient episode initiation) and P11 (Specimen referred):

approved collection centre has the same meaning as in Part IIA of the Act.

institution means a place at which residential accommodation or day care is, or both residential accommodation and day care are, made available to:

(a) disadvantaged children; or

(b) juvenile offenders; or

(c) aged persons; or

(d) chronically ill psychiatric patients; or

(e) homeless persons; or

(f) unemployed persons; or

(g) persons suffering from alcoholism; or

(h) persons addicted to drugs; or

(i) physically or mentally handicapped persons;

but does not include:

(j) a hospital; or

(k) a residential aged care home; or

(l) accommodation for aged persons that is attached to a residential aged care home or situated within a residential aged care home.

prescribed laboratory means a laboratory operated by:

(a) the Australian Government; or

(b) an authority of the Commonwealth; or

(c) a State or internal Territory; or

(d) an authority of a State or internal Territory; or

(e) an Australian tertiary education institution.

specimen collection centre has the same meaning as in Part IIA of the Act.

treating practitioner has the same meaning as in paragraph 16A(1)(a) of the Act.

14. (2) If a service described in an item in Group P10 is rendered by, or on behalf of, an approved pathology practitioner who is a recognised pathologist, the relevant one of those items does not apply to the service if:

(a) the service is rendered upon a request made in the course of a service provided to a public patient in a recognised hospital or when attending an outpatient service of a recognised hospital.

14. (3) An item in Group P10 or P11 does not apply to a pathology service to which subsection 16A(7) of the Act applies.

14. (4) An item in Group P10 or P11 does not apply to a pathology service unless at least 1 item in Groups P1 to P8 also applies to the service.

14. (5) Subject to subrule (7), if one item in Group P10 applies to a patient episode, no other item in the Group applies to the patient episode.

14. (6) An item in Group P11 applies only to the approved pathology practitioner or approved pathology authority to whom the specimen mentioned in the item was referred.

14. (7) If, in respect of the same patient episode:

(a) services referred to in 1 or more items in Group P5 and 1 or more of Groups P1, P2, P3, P4, P6, P7 and P8 are rendered by an approved pathology practitioner in the laboratory of another approved pathology authority; or

(b) services referred to in 1 or more items in Group P6 and 1 or more of Groups P1, P2, P3, P4, P5, P7 and P8 are rendered by another approved pathology practitioner in the laboratory of another approved pathology authority;

the fee specified in the applicable item in Group P10 is payable to both approved pathology practitioners.

14. (8) If more than one specimen is collected from a person on the same day for the provision of pathology services:

(a) in accordance with more than 1 request; and

(b) in or by a single approved pathology authority;

the fee specified in the applicable item in Group P10 applies once only to the services unless an exemption listed in Rule 4 applies or an exemption has been granted under Rule 3 "S4B(3)".

14. (9) The amount specified in item 73940 is payable only once in respect of a single patient episode.

Application of an item in Group P11 (Specimen referred) to a service excludes certain other items

15. If item 73940 applies to a patient episode, none of the items in Group P10 applies to any pathology service rendered by the approved pathology authority or approved pathology practitioner who claimed item 73940 in respect of the patient episode.

Circumstances in which an item in Group P11 (Specimen referred) does not apply

16. (1) An item in Group P11 does not apply to a referral if:

(a) a service in respect of the same patient episode has been carried out by the referring approved pathology authority; and

(b) the approved pathology authority to which the referral is made is related to the referring approved pathology authority.

16. (2) An approved pathology authority is ***related to*** another approved pathology authority for subrule (1) if:

(a) both approved pathology authorities are employed (including employed under contract) by the same person, whether or not the person is also an approved pathology authority; or

(b) either of the approved pathology authorities is employed (including employed under contract) by the other; or

(c) both approved pathology authorities are corporations and are related corporations within the meaning of the Corporations Act; or

(d) the approved pathology authorities are partners (whether or not either or both of the approved pathology authorities are individuals and whether or not other persons are in partnership with either or both of the approved pathology authorities; or

(e) both approved pathology authorities are operated by the Commonwealth or an authority of the Commonwealth; or

(f) both approved pathology authorities are operated by the same State or internal Territory or an authority of the same State or internal Territory.

16. (3) An item in Group P11 does not apply to a referral if the following common tests are referred either singly or in combination (except if the following items are referred in combination with other items not similarly specified): 65060, 65070, 65120, 66500, 66503, 66506, 66509, 66512, 66536, 66596, 69300, 69303, 69333 or 73527.

Abbreviations

17. (1) The abbreviations in Part 4 of this table may be used to identify particular pathology services or groups of pathology services.

17. (2) The names of services or drugs not listed in Part 4 of this table must be written in full.

Certain pathology services to be treated as 1 service

18. (1) In this rule:

general practitioner means a medical practitioner who:

(a) is not a consultant physician in any specialty; and

(b) is not a specialist in any specialty.

set of pathology services means a group of pathology services:

(a) that consists of services that are described in at least 4 different items; and

(b) all of which are requested in a single patient episode; and

(c) each of which relates to a patient who is not an admitted patient of a hospital; and

(d) excludes services referred to in an item in Group P10, Group P11, Group P12 or

Group P13, items 66900, 69484, 73070, 73071, 73072, 73074, 73075 or 73076; and

(e) excludes services described in the following items:

65079, 65082, 65157, 65158, 65166, 65180, 65181, 66606, 66610, 66639, 66642, 66651, 66652, 66663, 66666, 66696, 66697, 66714, 66715, 66723, 66724, 66780, 66783, 66789, 66790, 66792, 66804, 66805, 66816, 66817, 66820, 66821, 66826, 66827, 66832, 66834, 66837, 69325, 69328, 69331, 69379, 69383, 69400, 69401, 69451, 69500, 69484, 69489, 69492, 69497, 69498, 71076, 71090, 71092, 71096, 71148, 71154, 71156, 71169, 71170, 73309, 73312, 73315, 73318, 73321 and 73324;

where those services are performed by an approved pathology practitioner in an accredited pathology laboratory of an approved pathology authority following referral by another approved pathology practitioner in an accredited pathology laboratory of an approved pathology authority which is not **related to** the first mentioned approved pathology authority.

(1A) An approved pathology authority is **related to** another approved pathology authority for the purposes of paragraph 18(1)(e) if that approved pathology authority would be related to the other approved pathology authority for the purposes of rule 16(2).

18. (2) If a general practitioner requests a set of pathology services, the pathology services in the set are to be treated as individual pathology services in accordance with this rule.

18. (3) If the fee specified in 1 item that describes any of the services in the set of pathology services is higher than the fees specified in the other items that describe the services in the set:

(a) the pathology service described in the first-mentioned item is to be treated as 1 pathology service; and

(b) either:

(i) the pathology service in the set that is described in the item that specifies the second-highest fee is to be treated as 1 pathology service; or

(ii) if 2 or more items that describe any of those services specify the second-highest fee¿ the pathology service described in the item that specifies the second-highest fee, and has the lowest item number, is to be treated as 1 pathology service; and

(c) the pathology services in the set, other than the services that are to be treated as 1 pathology service under paragraphs (a) and (b), are to be treated as 1 pathology service.

18. (4) If the fees specified in 2 or more items that describe any of the services in the set of pathology services are the same, and higher than the fees specified in the other items that describe the services in the set:

(a) the pathology service in the set that is described in the item that specifies the highest fee, and has the lowest item number, is to be treated as 1 pathology service; and

(b) the pathology service in the set that is described in the item that specifies the highest fee, and has the second-lowest item number, is to be treated as 1 pathology service; and

(c) the pathology services in the set, other than the services that are to be treated as 1 pathology service under paragraphs (a) and (b), are to be treated as 1 pathology service.

18. (5) If pathology services are to be treated as 1 pathology service under paragraph (3)(c) or (4)(c), the fee for the 1 pathology service is the highest fee specified in any of the items that describe the pathology services that are to be treated as the 1pathology service.

Haemochromatosis testing

20. For items 73317 and 73318:

elevated serum ferritin for a patient, means a level of ferritin above the normal reference range in respect of the particular method of assay used to determine the level.

Nutritional and toxicity metals testing

22. (1) For this rule:

nutritional metals testing group means items 66819, 66820, 66821 and 66822.

metal toxicity testing group means items 66825, 66826, 66827, 66828, 66831 and 66832.

22. (2) An item in the nutritional metals testing group or the metal toxicity testing group does not apply in relation to a service performed if medicare benefits are paid or payable for tests that are performed for the same patient in 3 patient episodes requested within 6 months before the request for that service, under any of:

(a) that item; or

(b) the other item in the same group; or

(c) an item in the other group.

Antineutrophil Cytoplasmic Antibody

23. A request for Antineutrophil Cytoplasmic Antibody immunofluorescence test (ANCA) shall be deemed to include requests for antineutrophil proteinase 3 antibody test (PR-3 ANCA) and antimyeloperoxidase antibody test (MPO ANCA) where the immunofluorescence test for ANCA is abnormal, or has been abnormal, or those specific antibodies have been previously detected.

Satisfying Requirements Described in Items

24. Unless stated elsewhere in these rules, where an item contains a requirement, this requirement is satisfied if:

(a) The requirement/s as stipulated in the item descriptor are contained in the request form; or

(b) The requirement/s as stipulated in the item descriptor were supplied previously in writing to the APA and this documentation is retained by the APA; or

(c) The results of other laboratory tests performed in the same episode meet the requirement/s as stipulated in the item descriptor; or

(d) The results of laboratory tests that meet the requirement/s as stipulated in the item descriptor are supplied on the request form; or

The results of laboratory tests that meet the requirement/s as stipulated in the item descriptor are contained in the APA's records.

Limitation on certain items

25. (a) For any particular patient, items 66539, 66605, 66606, 66607, 66610, 69380, 69488, 69489, 71075, 71127, 71135 or 71137 is applicable not more than twice in a 12 month period.

(b) For any particular patient, item 66626 is applicable not more than 36 times in a 12 month period.

(c) For any particular patient, items 66655, 66659, 66838, 66841, 69482 or 69491 are applicable not more than once in a 12 month period.

(d) For any particular patient, item 66750 or 66751 is applicable not more than once in a pregnancy.

(e) For any particular patient, item 69336 is applicable not more than once in each period of 7 days.

(f) For any particular patient, items 66660, 69445, 69451, 69483, 71079 or 73523 are applicable not more than 4 times in a 12 month period.

(g) For any particular patient, items 66554, 66830 and 71077 are applicable not more than 6 times in a 12 month period.

(h) For any particular patient, item 66819, 66820, 66821, 66822, 66825, 66826, 66827 or 66828 is applicable not more than 3 times in a 6 month period.

(i) For any particular patient, items 73339 and 73340 are applicable not more than once.

(j) For any particular patient, items 69499 and 69500 are applicable not more than once (in total for both items) in 12 months.

Antigen Detection - Group P3 (Microbiology)

26. If the service listed in 69316, 69317, 69319, 69494, 69495, 69496, 69497 or 69498 is a pathologist determinable service the specialist pathologist is required to record the reasons for determining the need for this service.

27. If the service rendered in 71148, 73320 or 73321 is a pathologist determinable service, the specialist pathologist is required to record the reason for determining the need for this service including the result of the service in 71147.

Second Opinion morphology, limitations on items 72858 and 72859

28.1 Items 72858 and 72859 apply:

(a) only to a service that is covered by:

(i) item 65084 or 65087; or

(ii) item 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 or 72838; or

(iii) an item in Group P6 (other than item 73070, 73071, 73072, 73074, 73075 or 73076); and

(b) only if the treating practitioner and the approved pathology practitioner who provided the original opinion on the patient specimen agree that a second opinion is reasonably necessary for diagnostic purposes.

28.2 Items72858 and 72859 do not apply if the accredited pathology laboratory in which the second opinion is provided is the same laboratory in which the original opinion was provided.

Table for Cross Referencing Rules and Clauses appearing in Regulations

1 Nov 2010 MBS Book Rules	***Health Insurance (Pathology Services Table) Regulations 2010* Clauses**					
1	Dictionary					
2	1.2.1	2.12.1				
3	1.2.2					
4	1.2.3	2.1.1	2.2.2			
5	2.1.2					
6	1.2.4					
7	1.2.5					
8	2.2.1					

9	2.2.5					
10	2.3.1					
11	2.3.3					
12	2.4.2					
13	2.5.1	2.6.1				
14	2.10.1	2.11.1				
15	2.11.2					
16	2.11.3					
17	1.1.1					
18	1.2.6					
18A	1.2.7					
19	2.3.5					
20	2.7.1					
21	2.2.4					
22	2.2.7					
23	2.4.4					
24	1.2.8	2.4.5				
25	2.2.3	2.2.6	2.2.7	2.3.4	2.4.1	2.8.1
26	2.3.2					
27	2.4.3	2.7.2				

PN.0.35 Detection of measurable residual disease in patients with acute lymphoblastic leukaemia (MBS items 71202 and 73310)

The number of measurable residual disease (MRD) tests per patient, per episode of disease or per relapse is not expected to exceed 12, inclusive of a baseline assessment.

PN.1.1 Pathology Services in Relation to Medicare Benefits - Outline of Arrangements

Basic Requirements

Determination of Necessity of Service

The treating practitioner must determine that the pathology service is necessary.

Request for Service

The service may only be provided:

(i) in response to a request from the treating practitioner, including a participating midwife or a participating nurse practitioner, or from another Approved Pathology Practitioner and the request must be in writing (or, if oral, confirmed in writing within fourteen days); or

(ii) if determined to be necessary by an Approved Pathology Practitioner who is treating the patient.

Services requested by participating midwives and participating nurse practitioners:

(i) A participating midwife can request the following services:

Items 65060, 65070, 65090 to 65099 (inclusive), 65114, 66500 to 66512 (inclusive), 66545, 66548, 66566, 66743, 66750, 66751, 69303 to 69317 (inclusive), 69324, 69384 to 69415 (inclusive), 73070, 73071, 73075, 73076, 73420, 73421 and 73529.

(ii) A participating nurse practitioner can request items in the range 65060 to 73529 (inclusive), and 73825 to 73837 (inclusive).

Provision of Service

The following conditions relate to provision of services:

(i) the service has to be provided by or on behalf of an Approved Pathology Practitioner;

(ii) the service has to be provided in a pathology laboratory accredited for that kind of service;

(iii) the proprietor of the laboratory where the service is performed must be an Approved Pathology Authority;

(iv) the Approved Pathology Practitioner providing the service must either be the proprietor of the laboratory or party to an agreement, either by way of contract of employment or otherwise, with the proprietor of the laboratory in which the service is provided; and

(v) no benefit will be payable for services provided by an Approved Pathology Practitioner on behalf of an Approved Pathology Authority if they are not performed in the laboratories of that particular Approved Pathology Authority.

Therapeutic Goods Act 1989

For any service listed in the MBS to be eligible for a Medicare benefit, the service must be rendered in accordance with the provisions of the relevant Commonwealth and State and Territory laws. Approved Pathology Practitioners have the responsibility to ensure that the supply of medicines or medical devices used in the provision of pathology services is strictly in accordance with the provisions of the *Therapeutic Goods Act 1989*.

PN.1.2 Exemptions to Basic Requirements

Satisfying requirements described in pathology service

Unless the contrary intention appears, a requirement contained in the description of a pathology service in Part 2 is satisfied if:

(a) for a requirement for information - the information:

(i) is included in the request for the service; or

(ii) was supplied in writing on an earlier occasion to the approved pathology authority that rendered the service, and has been kept by the approved pathology authority; or

(b) for a requirement for laboratory test results - the results are:

(i) included in the request for the service; or

(ii) obtained from another laboratory test performed in the same patient episode; or

(iii) included in results from an earlier laboratory test that have been kept by the approved pathology authority.

Services Where Request Not Required

A pathologist-determinable service is a pathology service:

(a) that is rendered by or on behalf of an approved pathology practitioner for a person who is a patient of that approved pathology practitioner who has determined that the service is necessary.

(b) that is specified in item 73319, 73329, 73332, 73336, 73337, 73389, 73341, 73342, 73344, 73436, 73429 or only one immunohistochemistry items 72846, 72847, 72848, 72849, 72850 and 72860 or electronmicroscopy items 72851 and 72852 or immunocytochemistry items 73059, 73060 or 73061, and 73364 to 73383 or biomarker testing items 73437 to 73439 and is considered necessary by the approved pathology practitioner as a consequence of information resulting from a pathology service contained in tissue examination items 72813 to 72838 or cytology items 73045 to 73051 respectively.

Please note: a written request is required for a service contained in items 72813 to 72838 and items 73045 to 73051.

(c) that is specified in one of the antigen detection items 69494, 69495 or 69496 is considered necessary by the approved pathology practitioner as a consequence of information provided by the requesting practitioner or by the nature or appearance of the specimen or as a consequence of information resulting from a pathology service contained in items 69303, 69306, 69312, 69318, 69321 and 69345.

Please note: a written request is required for a service contained in items 69303, 69306, 69312, 69318, 69321 and 69345.

(d) that is specified in item 73320, HLA-B27 typing by nucleic acid amplification, and is considered necessary by the approved pathology practitioner because the results of HLA-B27 typing described in item 71147 are unsatisfactory.

(e) that is specified in item 73305, detection of mutation of the FMRI gene by Southern Blot analysis where the results in item 73300 are inconclusive.

(f) that is specified in alpha thalassaemia genetic testing items 73411, 73412 or 73413 and is considered necessary by the approved pathology practitioner because the results of testing described in item 73410 were inconclusive.

(g) that is specified in item 66839, rendered in the same patient episode as a service to which item 66838 applies if the result of that service is inconclusive or abnormal

(h) that is specified in item 66842, where the patient obtained inconclusive results from a service described in item 66839

(i) that is specified in item 69499 or 69500, where either a positive or inconclusive HCV serology test result is obtained from a service described in either item 69475, 69478, 69481, 69484, 69405, 69408, 69411, 69413 or 69415

PN.1.3 Circumstances Where Medicare Benefits Not Attracted

Services Rendered by Disqualified Practitioner

Medicare benefits are not payable for pathology services if at the time the service is rendered, the person, by or on whose behalf the service is rendered, is a person in relation to whom a determination is in force in relation to that class of services. That is, where an Approved Pathology Practitioner has breached an undertaking, and a determination has been made that Medicare benefits should not be paid during a specified period (of up to five years) in respect of specified pathology services rendered by the practitioner.

Note: An Approved Pathology Practitioner may be disqualified for reasons other than a breach of undertaking.

Certain Pathology Tests Do Not Attract Medicare Benefits

Certain tests of public health significance do not qualify for payment of Medicare benefits. Examples of services in this category are:

- examination by animal inoculation;

- Guthrie test for phenylketonuria;

- neonatal screening for hypothyroidism (T4/TSH estimation);

- neonatal screening for Cystic Fibrosis;

- neonatal screening for Galactosemia;

- pathology services used with the intention of monitoring the performance enhancing effects of any substance;

- pathology tests carried out on specimens collected from persons occupationally exposed to sexual transmission of disease where the purpose of the collection of specimens is for testing in accordance with conditions determined by the health authority of the State or Territory in which the service is performed.

In addition to the above, certain other tests do not qualify for payment of Medicare benefits. These include:

- cytotoxic food testing;

- pathology services performed for the purposes of control estimation, repeat tests (eg. for confirmation of earlier tests on the same specimen, etc);

- preparation of autogenous vaccines;

- tissue banking and preparation procedures;

- pathology services performed on stillborn babies or cadavers;

- pathology services which are performed routinely in association with the termination of pregnancy without there being any indication for the necessity of the services.

However, benefits will be paid for the following pathology tests:

- item 65060 - haemoglobin estimation;

- item 65090 - blood grouping ABO and Rh (D antigen);

- item 65096 - examination of serum for Rh and other blood group antibodies.

PN.2.1 Responsibilities of Treating/Requesting Practitioners

Form of Request

A treating practitioner may request a pathology service either orally or in writing but oral requests must be confirmed in writing within fourteen days from the day when the oral request was made.

Pathology request agreement and combined pathology request/offer to assign agreement which are prepared by the pathologists and distributed to requesting practitioners on or after 1 August 2012 must include the minimum information detailed under PN.2.2.

All written requests for pathology services should contain the following particulars:

(i) a description of the individual pathology services, or recognised groups of pathology tests to be rendered (see PN.0.28 and PN.0.31). The description must be sufficient to enable the item in which the service is specified to be identified;

(ii) the date of request;

(iii) the name of the requesting practitioner and their practice address or provider number;

(iv) the patient's name and address;

(v) details of the hospital status of the patient, as follows (for benefit rate assessment). That is, whether the patient was or will be, at the time of the service and when the specimen is obtained:

(a) a private patient in a private hospital, or approved day hospital facility;

(b) a private patient in a recognised hospital;

(c) a public patient in a recognised hospital;

(d) an outpatient of a recognised hospital;

Offence Not to Confirm an Oral Request

A requesting practitioner who, without reasonable excuse, does not confirm in writing an oral request within fourteen days of making the oral request is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine not exceeding $1,100 (10 Penalty Units in accordance with the *Crimes Act 1914*), and the request is deemed never to have been made.

Services Australia, in consultation with the Department of Health, Disability and Ageing, has developed a Health Practitioner Guideline to substantiate that a valid request existed (pathology or diagnostic imaging) which is located on the Department of Health, Disability and Ageing's website.

PN.2.2 Responsibilities of Approved Pathology Practitioners

Combined Request/Assignment Form Only

A combined request and assignment of benefit forms must include:

(i) the name of the individual for whom the service was provided;

(ii) the date on which the assignment agreement was made;

(iii) indication the assignment of benefit agreement was completed prior to (pre-assignment) the provision of the professional service;

(iv) confirmation if the assignor is the patient (yes or no);

(v) the date on which the specimen was obtained;

(vi) a statement confirming the assignor's consent;

(vii) a description of the service delivered.

(viii) be signed by the patient (or their assignor)

Specifications for bulk billed assignment of benefit agreements are outlined in Part 65C of the *Health Insurance Regulations 2018*.

Recordkeeping Obligations

From 1 July 2026, a copy of the assignment of benefit will only be provided to the patient upon request. Approved Pathology Practitioners must retain all Medicare claim documentation for a minimum of two years from the date of claim submission.

Referral From An Approved Pathology Practitioner To Another Approved Pathology Practitioner

Where an Approved Pathology Practitioner refers some or all services requested to another Approved Pathology Practitioner not associated with the same Approved Pathology Authority the following apply:

- Where all the services are referred, the first Approved Pathology Practitioner should forward the original request to the second Approved Pathology Practitioner, and the document bearing the patient's assignment agreement so that the second Approved Pathology Authority can direct-bill Services Australia;
- Where some of the services which are listed in different items in the Schedule are referred, the first Approved Pathology Practitioner must issue his/her own request in writing listing the tests to be performed, and when necessary, forward a photocopy of the patient's assignment voucher so that the second Approved Pathology Authority can direct-bill Medicare in addition to the details of the first Approved Pathology Practitioner, the second Approved Pathology Practitioner must show on the account/receipt/assignment agreement:

    (i) name and provider number of the original requesting practitioner; and

    (ii) date of original request.

PN.2.3 Pathology Tests not Covered by Request

An Approved Pathology Practitioner, who has been requested to perform one or more pathology services, may consider it necessary, in the interest of the patient, that additional tests to those requested be carried out. The Approved Pathology Practitioner must discuss this need with the requesting practitioner, and if the requesting practitioner determines that additional tests are necessary, the Approved Pathology Practitioner must arrange with the requesting practitioner to forward an amended or second request for those services. The account will then be issued in the ordinary way and the additional services will attract benefits providing the Approved Pathology Practitioner is a recognised specialist pathologist.

PN.2.4 Faecal Calprotectin Testing (Items 66522 & 66523)

A patient previously diagnosed with inflammatory bowel disease is not eligible for this item.

Clinical alarms:

Unexplained weight loss (> 3 kg or 5% bodyweight), iron deficiency ± anaemia, melaena, overt rectal bleeding, positive faecal human haemoglobin, abdominal pain awaking patient from sleep, diarrhoea, disturbing sleep or faecal incontinence, documented unexplained fever, family history of colon cancer, family history of inflammatory bowel disease (IBD) in symptomatic patients, or a family history of coeliac disease in symptomatic patients

PN.2.5 NT-proBNP testing in patients with systemic sclerosis and pulmonary arterial hypertension - MBS items 66585 and 66586

MBS item 66585

NT-proBNP testing under MBS item 66585 should be performed along with a pulmonary function test (PFT) measuring diffusing capacity for carbon monoxide in accordance with the 2012 Australian Scleroderma Interest Group (ASIG) pulmonary arterial hypertension (PAH) screening algorithm.

Repeat testing within a 12 month period should only be performed for a patient presenting with new symptoms suggestive of PAH since last assessment or a patient that has a borderline NT-proBNP level between 168-209 pg/mL.

MBS items 66585 and 66586

Where MBS items 66585 or 66586 are requested by a medical practitioner (other than a specialist or consultant physician), the request should be made in consultation with a specialist or consultant physician who manages the treatment of the patient.

PN.2.6 Brain Natriuretic Peptide (BNP) or N-Terminal-pro Brain Natriuretic Peptide (NT-proBNP) testing under MBS item 66829 is intended as a decision aid regarding the clinical necessity of an echocardiogram

BNP or NT-proBNP testing under MBS item 66829 is intended as a decision aid regarding the clinical necessity of an echocardiogram. Where a patient presents with symptoms of suspected but uncertain heart failure, a BNP or NT-proBNP test under MBS item 66829 can be requested where clinically appropriate, in line with guidelines from the National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand.

PN.2.7 Urine microscopy and culture - MBS item 69333

Urine microscopy and culture using item 69333 should only be undertaken for patients with symptoms of a urinary tract infection and/or kidney disease, or when clinically indicated as per the groups specified in the item descriptor.

Common symptoms of urinary tract infection or kidney disease may include but are not limited to:

- burning sensation during urination
- haematuria
- frequent or infrequent urination
- urine that is dark, cloudy, frothy or strong smelling
- pain or pressure in the lower abdomen and/or pelvic region
- nausea and/or vomiting
- chills and/or fever
- signs of sepsis or delirium

The following situations (without symptoms or risk factors listed in the description) do not make item 69333 applicable:

- undergoing non-urological surgery
- spinal cord injuries
- diabetes
- indwelling urinary catheters
- advanced age or aged care residency

Additionally, urine microscopy and culture should not be performed to check clearance of infection in the absence of continuing symptoms, except where a patient suffers from recurrent urinary tract infections.

PN.2.8 Vitamin B12 testing items - MBS items 66838, 66839, 66842

Please note that pathology providers who bill item 66839 must claim this within the same episode as item 66838 where initial vitamin B12 result is inconclusive or abnormal.

Lethargy/tiredness alone is not an appropriate indication for vitamin B12 testing. Presence of other symptoms of, or risk factors for, vitamin B12 deficiency along with lethargy/tiredness may indicate vitamin B12 testing is appropriate. Other symptoms may include (but are not limited to):

- abnormal findings on a blood count, such as anaemia or macrocytosis
- cognitive difficulties such as difficulty concentrating or short-term memory loss (sometimes described as 'brain fog'), which can also be symptoms of delirium or dementia
- eyesight problems related to optic nerve dysfunction:
    - blurred vision
    - optic atrophy
    - visual field loss (scotoma)
- glossitis
- neurological or mobility problems related to peripheral neuropathy, or to central nervous system disease including myelopathy (spinal cord disease):
    - balance issues and falls caused by impaired proprioception (the ability to sense movement, action and location) and linked to sensory ataxia (which may have been caused by spinal cord damage)
    - impaired gait
    - pins and needles or numbness (paraesthesia)

- symptoms or signs of anaemia that suggest iron treatment is not working properly during pregnancy or breastfeeding

Clinical conditions with a recognised risk of vitamin B12 deficiency include but are not limited to:

- Malabsorption disorders, including coeliac disease
- Gastrointestinal disorders, including atrophic gastritis
- Autoimmune conditions, including type 1 diabetes.

PN.3.1 Details Required on Accounts, Receipts or Assignment Agreements
General

Medicare benefit is not payable in respect of a pathology service unless specified details are provided, by the practitioner rendering the service, on his or her account, receipt or assignment agreement.

PN.3.2 Approved Pathology Practitioners
In addition to holding a request in writing from the treating medical or dental practitioner or from another Approved Pathology Practitioner, the following additional details must be recorded as an assignment agreement of the Approved Pathology Practitioner providing the service:

(i) the full name of the individual for whom the service was provided;

(ii) the date on which the assignment agreement was initiated;

(iii) indication as to whether the assignment of benefit agreement was completed prior to (pre-assignment) or following (post-assignment) the provision of the professional service;

(iv) confirmation if the assignor is the patient (yes or no);

(v) the date on which the specimen was obtained;

(vi) a statement confirming the assignor’s consent;

(vii) a description of the service delivered.

A statement of assignor’s agreement must indicate that entering into a pre-episodic agreement for a pathology service (except for group P9 services) also serves as the assignor’s consent to assign their right to the Medicare benefit payment to the professional for a pathologist-determinable service. A determinable service is one performed by, or on behalf of, an Approved Pathology Practitioner and is clinically indicated.

Where some services are referred from one Approved Pathology Practitioner to another Approved Pathology Practitioner, the request details to be shown on the second Approved Pathology Practitioner's account, receipt or assignment agreement must be identical to those of the original requesting practitioner including the date of request.

PN.3.3 Prescribed Pathology Services
For Prescribed Pathology Services (that is, pathology items in Group P9) the medical practitioner who renders the service must ensure his or her account, receipt or assignment agreement includes his or her name, address or provider number, the date of the service, and a description to clearly identify the service in the Schedule that was rendered.

If the service was determined necessary by another medical practitioner who is a member of the same group practice as the practitioner who rendered the service, the name of the requesting practitioner, sufficient to identify the practitioner from other practitioners in the same group practice with the same surname, must also be included together with the date on which the request was made.

PN.3.4 Interferon Gamma Release Assay (IGRA) for detection of latent tuberculosis - (Item 69471)

Before undertaking testing it is advisable to consult with a medical practitioner experienced in the management of tuberculosis. Neither IGRA tests or the tuberculin skin test (Mantoux) can absolutely exclude latent tuberculosis and following close contact exposure preventative therapy should always be considered in young children and immunosuppressed patients.

IGRA testing for the diagnosis of latent tuberculosis should be requested in compliance with recommendations made by the National Tuberculosis Advisory Committee in 2016 or later.
http://www.health.gov.au/internet/main/publishing.nsf/Content/cdna-ntac-pubs.htm including:

- IGRAs have no place in the initial investigation of active TB disease and cannot and should not be used to exclude suspected TB disease.
- IGRA should not be used for the purpose of screening prior to BCG vaccination.
- While IGRA tests can be used in children less than 5 years of age, there may be a higher proportion of indeterminate test results and tuberculin skin testing is preferred, unless there is a history of BCG.

At least eight weeks should elapse following last possible TB exposure before testing of a contact of a confirmed case of active tuberculosis – testing of contacts should be performed only after discussion with appropriate State or Territory public health authorities.

PN.4.1 Inbuilt Multiple Services Rule

The term "Multiple Services Rule" (Rule 3 of the Pathology Services Table) describes an arrangement which places limits on the benefits payable for items in the Pathology Services Table depending on the range of services performed during a single patient episode. A patient episode is defined in PN.0.5.

PN.4.2 Exemptions

Under Rule 4 of the Pathology Services Table, exemptions to the multiple services rule have been granted for certain specified tests. In some circumstances tests which are repeated up to 6 times over a 24 hour period, or tests which are requested up to 6 times on a single request form and are performed within 6 months of the date of request may be eligible for separate Medicare benefits. The services to which the exemptions apply are listed under Rule 4.(1 and 2) and cover seriously or chronically ill patients who require particular tests under specified circumstances. In order to claim the exemptions, accounts should be endorsed "Rule 3 Exemption".

Where a practitioner seeks an exemption to the multiple services rule for a patient whose condition requires a series of pathology investigations at various times throughout any one day or over a longer period of time, and the services required are not exempted under Rule 4, an application for exemption can be made which is endorsed "S4B(3)". Some factors that the delegate of the Minister may take into consideration in approving an exemption are: the patient is seriously ill; there are distinct and separate collections and performances of tests; and the services involve substantial additional expenses for the Approved Pathology Practitioner. These, and other clinical details, should be supplied by the practitioner when seeking an S4B(3) exemption.

If Rule 3 exemptions are endorsed "S4B(3)", claim assessment could take longer as all S4B(3) claims are passed to the delegate for assessment. S4B(3) covers all exemptions to the multiple services rule but, where applicable, specific "Rule 3 exemption" endorsements will speed up the payment of claims. Rule 3 and S4B(3) exemptions cannot be used to overcome time based restrictions within items e.g. "-. each test to a maximum of 4 tests in a 12 month period".

PN.5.1 Episode Cone

Description of Rule 18

The term "Episode Cone" describes an arrangement under which Medicare benefits payable in a patient episode for a set of pathology services, containing more than three items, ordered by a general practitioner for a non-hospitalised

patient, will be equivalent to the sum of the benefits for the three items with the highest Schedule fees. Further information on the episode coning arrangements is provided in PR.6.1.

PN.5.2 Exemptions

Some items are not included in the count of the items performed when applying episode coning. The items which have been exempted from the cone include all the items identified in Rule 18.(1)(d) and (e).

PN.6.1 Bulk Billing Incentives for Episodes Consisting of a P10 Service

The Fees for items in Group P13 are additional payments for bulk billing a patient episode consisting of a pathology service to which a Group P10 item (Pathology Episode Initiation fee) applies.

PN.6.2 Patient Episode Initiation Fees (PEIs)

Items in Groups P10 of the Pathology Services Table are only applicable to services performed:

(i) by or on behalf of an Approved Pathology Practitioner who is a recognised specialist pathologist; and

(ii) in private practice.

Accordingly, these fees are not payable for pathology services rendered by an Approved Pathology Practitioner, being a specialist pathologist when requested for a privately referred out-patient of a recognised hospital.

The patient episode initiation fees (PEIs) will be applicable on an episodic basis i.e. a claim may be made for the provision of pathology services requested by a practitioner in respect of one individual on the same day. For example, if a practitioner orders three pathology tests for a person on the one day, Medicare benefits will be payable for each of those tests but only one PEI will be applicable.

This Rule applies even when the treating practitioner has requested pathology tests from two or more Approved Pathology Practitioners. Thus a PEI will only be paid for the first account submitted unless an exemption listed in Rule 4 or 14.(7) applies or an exemption has been granted under "S4B(3)".

Under Rule 14.(7) two PEIs are payable in relation to the same patient episode where a referring practitioner refers two different specimens to two different Approved Pathology Authorities in the following circumstances:

- a tissue pathology specimen and any other non-tissue pathology specimen; or

- a cytopathology specimen and any other non-cytopathology specimen.

Rule 14.(8) also provides that only one PEI will be paid for the collection of specimens from a patient on one day in or by a single Approved Pathology Authority.

The patient episode initiation benefits are two-tiered. Higher benefits are paid for the collection of specimens from patients who are not private inpatients or private outpatients of a recognised hospital where the specimens are tested in a private laboratory.

A lower and uniform PEI benefit is paid where patients are private patients associated with a recognised hospital and the specimens are tested in a private laboratory or where the testing is performed by a prescribed laboratory on specimen collected from a patient eligible to claim Medicare benefits.

PN.6.3 Patient Episode Initiation Fees for Certain Tissue Pathology and Screening Items

Tissue Pathology items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72830 and 72836 and Cervical screening items 73070, 73071, 73072, 73074, 73075, 73076 will be subject to a different patient episode initiation fee structure - items 73922 to 73939 refer.

PN.6.4 Hospital, Government etc Laboratories

The following laboratories have been prescribed for the purposes of payment of Medicare benefits:

(i) laboratories operated by the Australian Government (these include health laboratories operated by the Australian Government Department of Health, Disability and Ageing as well as the laboratories operated by other Departments, e.g. the Departments of Defence and Veterans' Affairs operate laboratories from which pathology services are provided);

(ii) laboratories operated by a State Government or authority of a State (laboratories operated or associated with recognised hospitals are also included);

(iii) laboratories operated by the Northern Territory and the Australian Capital Territory; and

(iv) laboratories operated by Australian tertiary education institutions eg Universities.

PN.7.1 Assignment of Medicare Benefits - Patient Assignment

In addition to the general arrangements relating to the assignment of benefits, as outlined at paragraph 7 of the "General Explanatory Notes" in Section 1 of this book, it should be noted that, where the treating practitioner requests pathology services but the patient does not physically attend the Approved Pathology Practitioner, the patient may complete an assignment voucher at the time of the visit to the requesting doctor offering to assign benefits for the Approved Pathology Practitioner's services.

If an Approved Pathology Practitioner refers some of the tests requested by the treating practitioner to another Approved Pathology Authority, he/she should provide the second Approved Pathology Authority with a photocopy of the patient's assignment voucher so that the second Approved Pathology Authority can also direct-bill Medicare.

PN.7.2 Approved Pathology Practitioner Eligibility

If a practitioner requests an Approved Pathology Practitioner to perform a necessary pathology service, that Approved Pathology Practitioner must personally perform the service or have it performed on his/her behalf in order to be eligible to receive benefits by way of assignment. If, however, the first Approved Pathology Practitioner arranges for the service to be rendered by a second Approved Pathology Practitioner with the same Approved Pathology Authority, the second Approved Pathology Practitioner and not the first, is eligible to receive an assignment of the Medicare benefit for the service in question.

PN.7.3 Cystic fibrosis gene testing

(1) For any particular patient, item 73345, 73347, 73348 and 73349 is applicable not more than once in a lifetime.

(2) For any particular patient, item 73346 and 73350 is applicable not more than once in a pregnancy.

(3) The testing laboratory used to undertake tests for items 73345, 73346, 73347, 73348, 73349 and 73350 must use a cystic fibrosis transmembrane conductance regulator methodology appropriate to the clinical setting with:

(a) sufficient diagnostic range and sensitivity to detect at least 95% of pathogenic cystic fibrosis transmembrane conductance regulator variants likely to be present in the patient; and

(b) with at least 25 of the most frequently encountered cystic fibrosis transmembrane conductance regulator variants in the Australian population.

PN.7.4 Intellectual disability or global developmental delay

Intellectual disability or global developmental delay of at least moderate severity, to be determined by a specialist paediatrician according to Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria.

PN.7.5 'Abnormal red cell indices' for the purpose of genetic testing for thalassaemia and item 73410

'Abnormal red cell indices' refers to a mean corpuscular volume <80 fL and/or mean corpuscular haemoglobin <28 pg and haematological studies suggestive of thalassaemia.

PN.7.6 Genetic testing for the diagnosis of neuromuscular disorders (NMDs)

Where a neuromuscular disorder (NMD) is clinically suspected that is tested for using a single gene test described under items 73434 or 73435, the single gene test should be conducted prior to gene panel testing items on the Medicare Benefits Schedule (MBS).

PN.7.7 Genetic testing for the diagnosis of neuromuscular disorders (NMDs) - data reanalysis

Variants may be previously unreported because the relevant gene was not included in the original virtual panel, or because the pathogenicity of the variant has been re-classified in the interim.

PN.7.10 Somatic gene testing for the diagnosis and characterisation of gliomas - Item 73429

Testing should include, but not be restricted to, genes described in the current World Health Organization Classification of Tumours.

PN.7.11 Single gene testing for the diagnosis of heritable neuromuscular disorders - item 73434

Where a recessive variant has been identified using item 73434, reproductive partners should first be tested using item 73434, prior to gene sequencing under item 73427 where no relevant variant was detected by item 73434 and if considered appropriate, after genetic counselling.

PN.7.12 Item 73434 minimum gene list

Testing for pathogenic or likely pathogenic gene variants associated with neuromuscular disorders (item 73434) should include, but is not limited to, any one of the following genes: DMPK, CNBP, HTT, PABPN1, C9orf72, AR, SMN1, PRNP, MTND1, MT-ND4, MT-ND4L, MT-ND6, MT-TK, MT-L1, MT-ATP6, FXN, ATN1; or all five of the following genes: ATXN1, ATXN2, ATXN3, CACNA1A, ATXN7.

PN.7.13 Genetic testing for childhood hearing loss - MBS items 73440, 73441, 73443, 73444

MBS Items 73440 and 73441

When determining the genes to be assessed on the virtual panel, the list of phenotypically driven genes should be based on a recognised test directory.

MBS Items 73443 and 73444

Prior to requesting or performing these tests, the requesting practitioner or pathologist should consider if the patient has previously received equivalent testing. Testing should not be required more than:

- once per variant per lifetime, for item 73443
- once per gene per lifetime, for item 73444

Additional testing should only be performed if it is clinically relevant.

PN.7.14 Note for haematological malignancy gene panel tests

Testing should include, but not be restricted to, genes described in the current World Health Organization Classification of Haematolymphoid Tumours: Lymphoid Neoplasms or other appropriate international guidelines.

PN.7.15 Repeat testing for non-small cell lung cancer (NSCLC) by multiple methodologies

Prior to requesting or performing these tests, the requesting practitioner or pathologist should consider if the patient has already received equivalent testing under the same or another methodology in the same new diagnosis of non-small cell lung cancer (NSCLC).
Repeat testing by multiple methods in the same new diagnosis of NSCLC should only be performed if it is clinically relevant.

Items 73337, 73341, 73344 and 73436 support sequential single-gene testing for biomarkers in patients with NSCLC.

Item 73437 supports use of one next generation sequencing (NGS) panel for testing of all biomarkers supported under items 73337, 73341, 73344 and 73436.

Items 73438 and 73439 support sequential use of two NGS panels for testing of all biomarkers supported under 73337 and 73436, and 73341 and 73344 respectively.

PN.7.16 Reproductive carrier testing for cystic fibrosis, spinal muscular atrophy, and fragile X syndrome - MBS items 73451 and 73452

MBS items 73451 and 73452

Fragile X syndrome (FXS) is inherited in an X-linked dominant fashion.

The sex chromosomal pattern of a patient determines the likelihood of being a genetic carrier of FXS and the risk of FXS carriers passing on a variant(s) in the FMR1 gene that would cause their child to be born with the condition. Patients with certain sex chromosomal patterns have no risk of influencing whether their child is born with FXS, regardless of whether they are a carrier of the condition.

The intent of MBS item 73451 is to test a patient who:

(a) is either planning a pregnancy or is already pregnant; and
(b) if found to be a genetic carrier of fragile X syndrome, is at risk of passing on a variant(s) in the FMR1 gene that would cause their child to be born with the condition

The intent of MBS item 73452 is to test a patient who:

(a) is the reproductive partner of the patient planning pregnancy or already pregnant tested under item 73451.
(b) is not at risk of passing on a variant(s) in the FMR1 gene that would cause their child to be born with fragile X syndrome, regardless of whether they are a genetic carrier of the condition

The patient who is planning pregnancy or already pregnant must be tested first under MBS item 73451 prior to testing the reproductive partner patient under MBS item 73452, to ensure an informative and clinically relevant test result is obtained in the FMR1 gene.

MBS item 73451

The laboratory used to undertake reproductive carrier testing under item 73451 should use a methodology appropriate to the clinical setting with:

(a) sufficient diagnostic range and sensitivity to detect at least 95% of pathogenic variants likely to be present in the patient; and
(b) at least 50 of the most frequently encountered cystic fibrosis transmembrane conductance regulator variants in the Australian population.

PN.7.18 Targeted carrier testing for severe monogenic conditions - MBS item 73453

Where the couple is already pregnant and both patients are of Ashkenazi Jewish descent, concurrent testing of any partner(s) not already tested is recommended.

PN.7.19 Practice note for item 73307

PBS restrictions for PARP inhibitors for a patient with homologous recombination deficiency (HRD) may include:

HRD positivity is considered to be a score of 42 or greater using the Myriad MyChoice HRD assay or a validated equivalent.

PN.7.20 PN.7.20

The number of measurable residual disease (MRD) tests per patient, per episode of disease or per relapse is not expected to exceed 12, inclusive of a baseline assessment.

PN.7.21 Note for RhD testing of alloimmunised patients

An alternative test methodology to that used for Item 73420 is recommended to minimise the risk of false negative results in alloimmunised patients, such as using a more sensitive method, confirming the presence of cell-free fetal DNA, or repeat testing of negative results on a second sample. When repeat testing is used to reduce the risk of false negative results, item 73421 should only be billed once.

PN.7.22 DPYD genotyping to diagnose or predict fluoropyrimidine-induced toxicity

The list of gene variants analysed should be selected in line with current clinical guidelines, such as the eviQ guidelines, and should include direct detection of at least the following variants:
• NM_000110.4(DPYD):c.1905+1G>A
• NM_000110.4(DPYD):c.1679T>G
• NM_000110.4(DPYD):c.2846A>T
• NM_000110.4(DPYD):c.1129-5923C>G

PN.7.23 Genetic testing for HLA variants to predict severe drug hypersensitivity reactions to carbamazepine or oxcarbazepine – Item 73400

Item 73400 Genetic testing:

- should be in line with contemporaneous clinical guidelines
- should at a minimum include the following alleles: HLA-B*15:02, HLA-A*31:01
- should be conducted prior to initiation of treatment with carbamazepine or oxcarbazepine, unless the patient requires urgent treatment before the test result is available.

Requesting physicians should note:

- Not all drug hypersensitivity reactions to carbamazepine or oxcarbazepine are linked to HLA-B*15:02, HLA-A*31:01. Thus, genetic testing cannot definitively exclude the possibility of a drug hypersensitivity event. Clinical vigilance remains necessary, even after negative results from the relevant HLA alleles testing.

- HLA-B*15:02 is of higher prevalence in patients with East Asian ancestry. An individual's self-reported ancestry should not be used solely to predict whether the individual has the HLA-B*15:02 or HLA-A*31:01 alleles.

PN.8.1 Accredited Pathology Laboratories - Need for Accreditation

A pathology service will not attract Medicare benefits unless that service is provided in a pathology laboratory which is accredited for that kind of service. Details of the administration of the pathology laboratory accreditation arrangements are set out below.

PN.8.2 Applying for Accreditation

To become an Accredited Pathology Laboratory it is necessary to lodge a completed application form with the Manager, Pathology Section, Services Australia, PO Box 1001, TUGGERANONG ACT 2901. The prescribed fees for Approved Pathology Laboratories are:

- $2500 for Category GX labs
- $2000 for Category GY labs
- $1500 for Category B labs
- $ 750 for Category M & S labs.

It is necessary for an application for inspection be made to the National Association of Testing Authorities (NATA) NATA is the independent body chosen to act on the Australian Government's behalf as the primary inspection agency. The Royal Australian College of General Practitioners (RACGP) has also been appointed to inspect laboratories in Category M (general practitioner) in Victoria only.

Details of laboratory categories and associated supervisory requirements can be found on the Department of Health, Disability and Ageing's internet site (www.health.gov.au/topics/pathology).

PN.8.3 Effective Period of Accreditation

Accreditation takes effect from the date of approval by the Minister for Health and Ageing. The Minister has no power to backdate an approval. Transitional accreditation may be given pending full accreditation. An application and fee are required annually.

PN.8.4 Assessment of Applications for Accreditation

The principles of accreditation for pathology laboratories as determined by the Minister are used to assess applications for accreditation. These principles also require pathology laboratories to address National Pathology Accreditation Advisory Council standards. Copies of the principles and standards are available from the Secretariat, National Pathology Accreditation Advisory Council (see PH.6) on (02) 6289 4017 or email npaac@health.gov.au.

PN.8.5 Refusal of Accreditation and Right of Review

An applicant who has been notified of the intention to refuse accreditation may, within 28 days of being notified, provide further information to the Minister which may be taken into consideration prior to a final decision being made.

Applicants refused accreditation or any person affected by the decision have the right to appeal to the Administrative Appeals Tribunal.

PN.8.6 National Pathology Accreditation Advisory Council (NPAAC)

NPAAC was established in 1979. Its functions are to develop policy for accreditation of pathology laboratories, introduce and maintain uniform standards of practice in pathology services throughout Australia and initiate and

coordinate educational programs in relation to pathology practice. The agencies used to inspect laboratories on the Australian Government's behalf are required to conduct inspections using the standards set down by NPAAC. For further information the NPAAC Secretariat can be contacted on (02) 6289 4017 or email npaac@health.gov.au.

PN.8.7 Change of Address/Location

Laboratories are accredited for the particular premises given on the application form. Where a laboratory is relocated to other premises, any previously issued approvals for that Accredited Pathology Laboratory lapse. Medicare benefits are not payable for any pathology services performed at the new location until a new application has been approved by the Minister for Health and Ageing. Paragraph PH.2 sets out the method for applying for accreditation.

PN.8.8 Change of Ownership of a Laboratory

Part of the assessment of an application for an Accredited Pathology Laboratory relates to the Approved Pathology Authority status. Where the ownership, or some other material change occurs affecting the laboratory, the Minister for Health and Ageing must be provided with those changed details. Medicare benefits will not be payable for any pathology services performed on any premises other than those premises for which approval has been given.

PN.8.9 Approved Collection Centres (ACC)

New arrangements for specimen collection centres commenced on 1 December 2001 and replaced the Licensed Collection Centre (LCC) Scheme.

To enable the payment of Medicare benefits for pathology services performed on pathology specimens collected in a collection centre, the centre must first be approved. The exception to this rule is collection centres on the premises of recognised hospitals (recognised hospital in this context means the same as "recognized hospital" in Part 1 Section 3 of the *Health Insurance Act 1973*) as they do not need approval.

In order for a collection centre to be approved, a public or private Approved Pathology Authority must submit a completed application form to Services Australia including details of the type of application (renewal, new or cancellation of collection centre), the location of the premises, the owner, and any leasing arrangements.

Application forms can be accessed by going to the Services Australia website. Completed application forms and any enquiries should be forwarded to Pathology Registration, PO Box 9822 MELBOURNE VIC 3001.

PN.9.1 Approved Pathology Practitioners

Introduction

A pathology service will not attract Medicare benefits unless that service is provided by or on behalf of an Approved Pathology Practitioner. (Approved Pathology Practitioners must be registered medical practitioners.) Set out below is information which relates to Approved Pathology Practitioner requirements.

PN.9.2 Applying for Acceptance of the Approved Pathology Practitioner Undertaking

To apply for acceptance of an Approved Pathology Practitioner Undertaking, it is necessary to send:

(i) a completed application for acceptance of an Approved Pathology Practitioner Undertaking; and

(ii) a signed Approved Pathology Practitioner Undertaking to the Pathology Registration, Services Australia,

PO Box 9822, Melbourne Victoria 3001.

An application form, undertaking and associated literature can be obtained from the Pathology Registration Coordinator.

Payment of Acceptance Fee

On receipt of advice that the Minister has accepted an undertaking, a cheque for $500 should be sent to the Pathology Registration Coordinator. Applicants are required to pay this fee within 14 days of the notice being given. As there is no discretion under the *Health Insurance Act 1973* to accept late payments, failure to pay the fee within the required time means that:

(i) acceptance of the undertaking will be revoked;

(ii) a new application must be completed;

(iii) acceptance of the new undertaking cannot be backdated; and

(iv) there will therefore be a period during which Medicare benefits cannot be paid.

PN.9.3 Undertakings - Approved Pathology Practitioner

Consideration of Undertakings

The Minister is unable to accept an undertaking from a person in respect of whom there is a determination in force that the person has breached the undertaking, or from a person who, if the undertaking were accepted, would be likely to carry on the business of a prescribed person or would enable a person to avoid the financial consequences of the disqualification (or likely disqualification) of that prescribed person. A 'prescribed person' includes, amongst other things, fully or partially disqualified persons (or persons likely to be so disqualified).

Similarly an undertaking cannot be accepted unless the Minister is satisfied that the person giving such undertaking is a fit and proper person to be an Approved Pathology Practitioner.

When an undertaking has been given, the Minister may require the person giving the undertaking to provide additional information within a fixed period of time and if the person does not comply the Minister may refuse to accept the undertaking.

Refusal of Undertaking and Rights of Review

Where the Minister refuses to accept an undertaking, for any of the reasons shown above, the Minister must notify the person of the decision. The notification must include advice of a right of internal review of the decision and a right of further appeal to the Administrative Appeals Tribunal if the internal review upholds the original decision to refuse the undertaking.

Effective Period of Undertaking

The following applies:

(i) Date of Effect the earliest day from which the Minister or delegate can accept an undertaking is the day of the decision in respect of the undertaking. The day the undertaking is signed is to be the day it is actually signed and must not be backdated;

(ii) Period of Effect in determining the period of effect of the undertaking the Minister shall, unless the Minister considers that special circumstances exist, determine that the period of effect shall be twelve months from the day on which the undertaking comes into force. There is a requirement for the Minister to notify persons giving undertakings of the period of time for which the undertaking is to have effect, and the notice is to advise persons whose interests are affected by the decision of their rights of appeal to the Administrative Appeals Tribunal against the Minister's decision;

(iii) Renewals when an undertaking is given and accepted by the Minister while a former undertaking is current, the new undertaking does not take effect until the former undertaking ceases to be in force. When an undertaking is given while a former undertaking is current and the date on which the former undertaking is to expire passes without the Minister giving notice to accept or reject the new undertaking, the former undertaking remains in force until the Minister gives such notification. This provision does not apply when the renewal application is not received by Services Australia until after the expiry of the existing undertaking. Under these circumstances there

will be a period during which Medicare benefits cannot be paid unless the new application can be backdated to the expiry of the previous undertaking. This is a limited discretion for periods up to one month and special conditions apply; and

(iv) Cessation of Undertaking the undertaking ceases to be in force if it is terminated, if the Minister revokes acceptance of the undertaking, or if the period of effect for the undertaking expires whichever event first occurs.

An Approved Pathology Practitioner may terminate an undertaking at any time providing that the practitioner gives at least 30 days notice of his/her intention to do so.

PN.9.4 Obligations and Responsibilities of Approved Pathology Practitioners

The requirements of the legislation and the undertaking impose a number of obligations and responsibilities on Approved Pathology Practitioners and the Minister. The more complex of these not already dealt with are considered in PK, PL and PM dealing with Breaches of Undertakings, Excessive Pathology Services and Personal Supervision.

PN.10.1 Approved Pathology Authorities

Introduction

A pathology service will not attract Medicare benefits unless the proprietor of the laboratory in which the pathology service is performed is an Approved Pathology Authority. Following is information which relates to Approved Pathology Authority requirements.

PN.10.2 Applying for Acceptance of an Approved Pathology Authority Undertaking

To apply for acceptance of an Approved Pathology Authority Undertaking, it is necessary to send:

(i) a completed application for acceptance of an Approved Pathology Authority Undertaking; and

(ii) a signed Approved Pathology Authority Undertaking to the Pathology Registration, Services Australia,

PO Box 9822, Melbourne Victoria 3001.

An application form, undertaking and associated literature can be obtained from the Pathology Registration Coordinator.

Payment of Acceptance Fee

On receipt of advice that the Minister has accepted an undertaking, a cheque for $1,500 should be sent to the Pathology Registration Coordinator. Applicants are required to pay this fee within 14 days of the notice being given. As there is no discretion under the *Health Insurance Act 1973* to accept late payments, failure to pay the fee within the required time means that:

(i) acceptance of the undertaking will be revoked;

(ii) a new application must be completed;

(iii) acceptance of the new undertaking cannot be backdated; and

(iv) there will therefore be a period during which Medicare benefits cannot be paid.

PN.10.3 Undertakings - Approved Pathology Authority

Consideration of Undertakings

The Minister is unable to accept undertakings from a person in respect of whom there is a determination in force that the person has breached the undertaking, or from a person who, if the undertaking were accepted, would be likely to

carry on the business of a prescribed person or would enable a person to avoid the financial consequences of the disqualification (or likely disqualification) of that prescribed person. A 'prescribed person' includes, inter alia, fully or partially disqualified persons (or persons likely to be so disqualified).

Similarly an undertaking cannot be accepted unless the Minister is satisfied that the person giving such undertaking is a fit and proper person to be an Approved Pathology Authority.

When an undertaking has been given the Minister may require the person giving the undertaking to provide additional information within a specified period of time and if the person does not comply the Minister may refuse to accept the undertaking.

Refusal of Undertaking and Rights of Review

Where the Minister refuses to accept an undertaking, the Minister must notify the person of the decision. The notification must include advice of a right of internal review of the decision and a right of further appeal to the Administrative Appeals Tribunal if the internal review upholds the original decision to refuse the undertaking.

Effective Period of Undertaking

The following applies:

(i) Date of Effect the earliest day from which the Minister or delegate can accept an undertaking is the day of the decision in respect of the undertaking. The day the undertaking is signed is to be the day it is actually signed and must not be backdated;

(ii) Period of Effect in determining the period of effect of the undertaking the Minister shall, unless the Minister considers that special circumstances exist, determine that the period of effect shall be twelve months from the day on which the undertaking comes into force. There is a requirement for the Minister to notify persons giving an undertaking of the period of time for which the undertaking is to have effect, and the notice is to advise persons whose interests are affected by the decision of their rights of appeal to the Administrative Appeals Tribunal against the Minister's decision;

(iii) Renewals when an undertaking is given and accepted by the Minister while a former undertaking is current, the new undertaking does not take effect until the former undertaking ceases to be in force. When an undertaking is given while a former undertaking is current and the date on which the former undertaking is to expire passes without the Minister giving notice to accept or reject the new undertaking, the former undertaking remains in force until the Minister gives such notification. This provision does not apply when the renewal application is not received by Services Australia until after the expiry of the existing undertaking. Under these circumstances there will be a period during which Medicare benefits cannot be paid unless the new application can be backdated to the expiry of the previous undertaking. This is a limited discretion for periods up to one month and special conditions apply; and

(iv) Cessation of Undertaking the undertaking ceases to be in force if it is terminated, if the Minister revokes acceptance of the undertaking, or if the period of effect for the undertaking expires whichever event first occurs.

An Approved Pathology Authority may terminate an undertaking at any time providing that at least 30 days notice of the intention to terminate the undertaking is given.

PN.10.4 Obligations and Responsibilities of Approved Pathology Authorities

The requirements of the legislation and the undertaking impose a number of obligations and responsibilities on Approved Pathology Authorities and the Minister. The more complex of these which have not already been covered are considered in paragraphs PK and PL dealing with Breaches of Undertakings and Excessive Pathology Services.

PN.11.1 Breaches of Undertakings

Notice Required

Where the Minister has reasonable grounds for believing that an Approved Pathology Practitioner or an Approved Pathology Authority has breached the undertaking, the Minister is required to give notice in writing to the person explaining the grounds for that belief and inviting the person to put a submission to the Minister to show cause why no further action should be taken in the matter.

PN.11.2 Decisions by Minister

Where a person provides a submission, the Minister may decide to take no further action against the person. Alternatively the Minister may refer the matter to a Medicare Participation Review Committee, notifying the grounds for believing that the undertaking has been breached. If after 28 days no submission has been received from the person, the Minister must refer that matter to the Committee.

PN.11.3 Appeals

The Minister is empowered to suspend an undertaking where notice has been given to a Medicare Participation Review Committee of its possible breach, pending the outcome of the Committee's proceedings. The Minister must give notice in writing to the person who provided the undertaking of the determination to suspend it, and the notice shall inform the person of a right of appeal against the determination to the Administrative Appeals Tribunal. The Minister may also publish a notice of a determination in the Public Service Gazette. Rights of appeal to the Administrative Appeals Tribunal also exist in respect of any determination made by a Medicare Participation Review Committee.

PN.12.1 Initiation of Excessive Pathology Services

Notice Required

Where the Minister has reasonable grounds for believing that a person, of a specified class of persons, has initiated, or caused or permitted the initiation of excessive pathology services the Minister is required to give notice in writing to the person explaining the grounds for the belief and inviting the person to put a submission to the Minister to show cause why no further action should be taken in the matter.

PN.12.2 Classes of Persons

The classes of persons are:

(i) the practitioner who initiated the services;

(ii) the employer of the practitioner who caused or permitted the practitioner to initiate the services; or

(iii) an officer of the body corporate employing the practitioner who caused or permitted the practitioner to initiate the services.

PN.12.3 Decisions by Minister for Health and Ageing

Where a person provides a submission, the Minister may decide to take no further action against the person. Alternatively, the Minister may refer the matter to a Professional Services Review (PSR) Committee, notifying the grounds for believing that excessive pathology services have been initiated. If after 28 days no submission has been received from the person, the Minister must refer the matter to the Committee. The Minister must give to the person notice in writing of the decision.

PN.12.4 Appeals

Unlike the procedures relating to breaches of undertaking there is no power given to the Minister to determine a penalty. The Minister's role is either deciding to take no further action or referring the matter to a PSR Committee. Accordingly, there are no rights of appeal to the Administrative Appeals Tribunal applicable to the above procedures. However, rights of appeal to the Administrative Appeals Tribunal exist in respect of any determination made by a Medicare Participation Review Committee.

PN.13.1 Personal Supervision

Introduction

The *Health Insurance Act 1973* provides that the form of undertaking to be given by an Approved Pathology Practitioner may make provision for pathology services carried out under the personal supervision of the Approved Pathology Practitioner.

PN.13.2 Extract from Undertaking

The following is an extract from the Approved Pathology Practitioner (APP) undertaking:

Part 2 - Personal supervision

2.1 I acknowledge that it is my obligation, subject to Parts 2.2 and 2.4, personally to supervise any person who renders any service on my behalf and I undertake to accept personal responsibility for the rendering of that service under the following conditions of personal supervision:

(i) Subject to the following conditions, I will usually be physically available in the laboratory while services are being provided at the laboratory;

(ii) I may, subject to paragraph (vi) below, be physically absent from the laboratory while services are being rendered outside its normal hours of operation but in that event I will leave with the person rendering the service particulars of the manner in which I may be contacted while the service is being rendered and I must be able to personally attend at the laboratory while the service is being rendered or formally designate another APP present while I am absent;

(iii) I may, subject to paragraph (vi) below, be absent from the laboratory for brief periods due to illness or other personal necessity, or to take part in activities which, in accordance with normal and accepted practice, relate to the provision of services by that laboratory;

(iv) I will personally keep a written log of my absences from the laboratory that extend beyond one workday in respect of that laboratory and will retain that log in the laboratory for 18 months from date of last entry;

(v) If I am to be absent from the laboratory for more than 7 consecutive workdays, I will arrange for another APP to personally supervise the rendering of services in the laboratory. That arrangement shall be recorded in writing and retained in the laboratory for 18 months from date of last entry. Until such person is appointed, and his or her appointment is recorded in writing, I will remain personally responsible to comply with this undertaking;

(vi) If a service is being rendered on my behalf by a person who is not:

(a) a medical practitioner;

(b) a scientist; or

(c) a person having special qualifications or skills relevant to the service being rendered;

and no person in the above groups is physically present in the laboratory, then I must be physically present in the laboratory and closely supervise the rendering of the service;

(vii) I accept responsibility for taking all reasonable steps to ensure that in regard to services rendered by me or on my behalf:

(a) all persons who render services are adequately trained;

(b) all services which are to be rendered in the laboratory are allocated to persons employed by the APA and, these persons shall have appropriate qualifications and experience to render the services;

(c) the methods and procedures in operation in the laboratory for the purpose of rendering services are in accordance with proper and correct practices;

(d) for services rendered, proper quality control methods are established and reviewed to ensure their reliability and effectiveness; and

(e) results of services and tests rendered are accurately recorded and sent to the treating practitioner and, where applicable, a referring practitioner;

(viii) If I perform, or there is performed on my behalf, a service which consists of the analysis of a specimen which I know, or have reason to believe, has been taken other than in accordance with the provisions of section 16A(5AA) of the Act I will endorse, or cause to be endorsed, on the assignment agreement or the account for that service, as the case may be, particulars of the circumstances in which I believe, or have reason to believe, the specimen was taken.

2.2 Where services are to be rendered on my behalf in a Category B laboratory as defined in the *Health Insurance (Accredited Pathology Laboratories - Approval) Principles 2002*, I undertake to take all reasonable measures to ensure that the service is rendered under the supervision of an appropriate person as required by those Principles as in force from time to time.

2.3 I acknowledge to the best of my ability that any act or omission by a person, when acting with my authority, whether express or implied, that would, had it been done by me, have resulted in a breach of this undertaking, constitutes a breach of this undertaking by me.

2.4 Parts 2.1(i) to 2.1(vi) and 2.2 of this undertaking do not apply where a laboratory is limited to services (and associated equipment for those services) as detailed in Schedule 3.

PN.13.3 Notes on the Above

Part 2 of the APP Undertaking outlines the requirements for the personal supervision by an Approved Pathology Practitioner where a pathology service is rendered by another person on behalf of the APP. It should be noted that "on behalf of" does not relieve an Approved Pathology Practitioner of professional responsibility for the service or from being personally involved in the supervision of services in the laboratory.

PR.2.2 Restriction on items 66551, 73812 and 73826—timing

For any particular patient, item 66551 is applicable not more than 4 times in 12 months, either individually or in combination with a service to which item 73812 or 73826 applies.

PR.5.1 Limitation of item 72860

Item 72860 applies to a service (the relevant service) for a patient if:

(a) the relevant service is subsequent to one or more earlier patient episodes involving:

(i) the rendering of services to which one or more items in Groups P5, P6 or P7 apply (other than item 72860); and

(ii) the collection of tissue material (either biopsy material or samples submitted for cytology) from which a tissue block was prepared; and

(iii) the archiving of the tissue material in formalin fixed paraffin embedded blocks; and

(b) following the earlier patient episode or episodes, the treating practitioner determines that a service to which an item in Group P7 (which deal with genetic testing) applies is clinically necessary for the patient; and

(c) the relevant service is rendered in a patient episode with services to which one or more items in Group P7 apply, but is not rendered in the same accredited pathology laboratory as those services.

PR.6.1 Episode Cone

The episode cone is an arrangement, described in Rule 18, which effectively places an upper limit on the number of items for which Medicare benefits are payable in a patient episode. This cone only applies to services requested by general practitioners for their non-hospitalised patients. Pathology services requested for hospital in-patients, or ordered by specialists, are not subject to these coning arrangements.

When more than 3 items are requested by a general practitioner in a patient episode, the benefits payable will be equivalent to the sum of the benefits for the three items with the highest Schedule fees. Rule 18 provides that for the two items with the highest Schedule fees, Medicare benefits will be payable for each item. The remaining items are regarded as one service for which the benefit payable will be equivalent to that for the item with the third highest Schedule fee. Where items have the same Schedule fee, their item numbers are used as an artificial means to rank them.

The episode cone will apply even when the pathology services in a patient episode are performed by 2 or more Approved Pathology Authorities, with the exception of the services listed below.

The following items are not included in the count of the items performed when applying the episode cone:

(i) all the items in Groups P10, P11, P12 and P13;

(ii) Cervical Screening (items 73070, 73071, 73072, 73074, 73075, 73076);

(iii) all the items detailed at Rule 18 (e) (items 65079, 65082, 65157, 65158, 65166, 65180, 65181, 66606, 66609, 66639, 66642, 66651, 66652, 66663, 66666, 66696, 66697, 66714, 66715, 66723, 66724, 66780, 66783, 66789, 66790, 66792, 66804, 66805, 66816, 66817, 66820, 66821, 66826, 66827, 69325, 69328, 69331, 69379, 69383, 69400, 69401, 69451, 69500, 69489, 69492, 69497, 69498, 71076, 71090, 71092, 71096, 71148, 71154, 71156, 71169, 71170, 73309, 73312, 73315, 73318);

(iv) supplementary test for Hepatitis B and Hepatitis C (item 69484); and

(v) the carbon-labelled urea breath test to confirm or monitor Helicobacter pylori (item 66900).

PR.7.1 Items 73384 to 73387 (relating to pre implantation genetic testing under clause 2.7.3A of the pathology services table)—patient eligibility

A patient is eligible for a service described in any of items 73384 to 73387 only if:

(a) the patient or the patient's reproductive partner:

i. has an identified gene variant which places the patient at risk of having a pregnancy affected by a Mendelian or mitochondrial disorder; or
ii. is at risk of an autosomal dominant disorder which places the patient at risk of having a child who develops the autosomal dominant disorder; or
iii. has a chromosome re-arrangement or copy number variant which places the patient at risk of having a pregnancy affected by a chromosome disorder; and

(b) there is no curative treatment for the disorder and there is severe limitation of quality of life despite contemporary management of the disorder; and

(c) the patient has previously had a consultation, with a specialist or consultant physician practising as a clinical geneticist, that included a discussion about the disorder.

PR.7.2 Restriction on item 73290—conjunction with item 73391

2.7.1B Restriction on item 73290—conjunction with item 73391

Item 73290 applies to a service described in that item only if the service is not performed in conjunction with a service described in item 73391.

PR.7.3 Restriction on item 73287—conjunction with item 73388

2.7.1A Restriction on item 73287—conjunction with item 73388

Item 73287 applies to a service described in that item only if the service is not performed in conjunction with a service described in item 73388.

PR.9.1 Quality Assurance in Aboriginal Medical Services (QAAMS) Program items

Item numbers 73839, 73840 and 73844 can only be performed in the following circumstances:

a) the service is rendered by or on behalf of a medical practitioner;
b) the practitioner referred to in paragraph (a), or the organisation for which the practitioner works, is participating in the Quality Assurance in Aboriginal Medical Services Program; and
c) the service is provided in accordance with that Program; and
d) the practitioner referred to in paragraph (a) has determined the service to be necessary for his or her patient.

PR.9.3 Limitation of item 73826

Item 73826 does not apply to a service provided to a patient who has already been provided, in the last 12 months, 4 other services to which any of the following apply:

a. item 73826;
b. item 66551;
c. item 73812.

PR.9.4 Limitation of item 73812

Item 73812 does not apply to a service provided to a patient who has already been provided, in the last 12 months, 4 other services to which any of the following apply:

a. item 73812;
b. item 66551;
c. item 73826.

PR.9.5 Practice Rule for 73813

Item 73813 applies to a service only if:

(a) the service is rendered at, or from, a practice location in:

(i) a Modified Monash 6 area; or

(ii) a Modified Monash 7 area;

(b) the medical practitioner providing the service, or the health professional providing the service on behalf of a medical practitioner, is employed by an organisation that:

(i) delivers health services; and

(ii) is participating in the First Nations Molecular Point-of-Care (PoC) Testing Program;

(c) the service is provided in accordance with the Program referred to in subparagraph (b)(ii);

(d) the service is conducted by a medical practitioner, or on behalf of a medical practitioner by a health professional, who has achieved competency as a PoC operator by the First Nations Molecular PoC Testing Program for the test(s) performed;

(e) the PoC test(s) gives valid patient result(s).

PR.9.6 Practice Rule for 73825

Item 73825 applies to a service only if:

(a) the service is rendered at, or from, a practice location in:

(i) a Modified Monash 6 area; or

(ii) a Modified Monash 7 area;

(b) the nurse practitioner providing the service:

(i) is employed by an organisation that:

(A) delivers health services; and

(B) is participating in the First Nations Molecular Point-of-Care (PoC) Testing Program;

(c) the service is provided in accordance with the Program referred to in subparagraph (b)(i)(B);

(d) the service is conducted by a nurse practitioner who has achieved competency as a PoC operator by the First Nations Molecular PoC Testing Program for the test(s) performed; and

(e) the PoC test(s) gives valid patient result(s).

PATHOLOGY SERVICES ITEMS

P1. HAEMATOLOGY	
	Group P1. Haematology
65060	Haemoglobin, erythrocyte sedimentation rate, blood viscosity - 1 or more tests (See para PN.1.1, PN.0.33 of explanatory notes to this Category) **Fee:** $8.25 **Benefit:** 75% = $6.20 85% = $7.05 **Future End Date:**
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 **Fee:** $10.95 **Benefit:** 75% = $8.25 85% = $9.35 **Future End Date:**
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 (See para PN.1.1 of explanatory notes to this Category) **Fee:** $17.80 **Benefit:** 75% = $13.35 85% = $15.15 **Future End Date:**
65072	Examination for reticulocytes including a reticulocyte count by any method - 1 or more tests **Fee:** $10.70 **Benefit:** 75% = $8.05 85% = $9.10 **Future End Date:**
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

P1. HAEMATOLOGY	
	(h) Donath Landsteiner antibody test; or (i) other erythrocyte metabolic enzyme tests 1 or more tests **Fee:** $54.60 **Benefit:** 75% = $40.95 85% = $46.45 **Future End Date:**
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 **Fee:** $94.75 **Benefit:** 75% = $71.10 85% = $80.55 **Future End Date:**
65079	Tests described in item 65078 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $94.75 **Benefit:** 75% = $71.10 85% = $80.55 **Future End Date:**
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 **Fee:** $101.45 **Benefit:** 75% = $76.10 85% = $86.25 **Future End Date:**
65082	Tests described in item 65081 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $101.45 **Benefit:** 75% = $76.10 85% = $86.25 **Future End Date:**
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 **Fee:** $174.25 **Benefit:** 75% = $130.70 85% = $148.15 **Future End Date:**
65087	Bone marrow - examination of aspirated material (including clot sections where necessary), including (if performed):

P1. HAEMATOLOGY	
	any test described in item 65060, 65066 or 65070 **Fee:** $87.30 **Benefit:** 75% = $65.50 85% = $74.25 **Future End Date:**
65090	Blood grouping (including back-grouping if performed) - ABO and Rh (D antigen) (See para PN.1.1, PN.0.33 of explanatory notes to this Category) **Fee:** $11.70 **Benefit:** 75% = $8.80 85% = $9.95 **Future End Date:**
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) (See para PN.1.1 of explanatory notes to this Category) **Fee:** $23.15 **Benefit:** 75% = $17.40 85% = $19.70 **Future End Date:**
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 (See para PN.1.1 of explanatory notes to this Category) **Fee:** $43.10 **Benefit:** 75% = $32.35 85% = $36.65 **Future End Date:**
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) (See para PN.1.1 of explanatory notes to this Category) **Fee:** $114.40 **Benefit:** 75% = $85.80 85% = $97.25 **Future End Date:**
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) **Fee:** $172.95 **Benefit:** 75% = $129.75 85% = $147.05 **Future End Date:**

P1. HAEMATOLOGY	
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) **Fee:** $114.40 **Benefit:** 75% = $85.80 85% = $97.25 **Future End Date:**
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) **Fee:** $172.95 **Benefit:** 75% = $129.75 85% = $147.05 **Future End Date:**
65109	Release of fresh frozen plasma or cryoprecipitate for the use in a patient for the correction of a coagulopathy - 1 release. **Fee:** $13.55 **Benefit:** 75% = $10.20 85% = $11.55 **Future End Date:**
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. **Fee:** $13.55 **Benefit:** 75% = $10.20 85% = $11.55 **Future End Date:**
65111	Examination of serum for blood group antibodies (including identification and, if necessary, quantitation of any antibodies detected) **Fee:** $24.35 **Benefit:** 75% = $18.30 85% = $20.70 **Future End Date:**
65114	1 or more of the following tests: (a) direct Coombs (antiglobulin) test; (b) qualitative or quantitative test for cold agglutinins or heterophil antibodies (See para PN.1.1 of explanatory notes to this Category) **Fee:** $9.55 **Benefit:** 75% = $7.20 85% = $8.15 **Future End Date:**
65117	1 or more of the following tests: (a) Spectroscopic examination of blood for chemically altered haemoglobins; (b) detection of methaemalbumin (Schumm's test) **Fee:** $21.30 **Benefit:** 75% = $16.00 85% = $18.15

P1. HAEMATOLOGY	
	Future End Date:
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 **Fee:** $14.40 **Benefit:** 75% = $10.80 85% = $12.25 **Future End Date:**
65123	2 tests described in item 65120 **Fee:** $21.40 **Benefit:** 75% = $16.05 85% = $18.20 **Future End Date:**
65126	3 tests described in item 65120 **Fee:** $29.25 **Benefit:** 75% = $21.95 85% = $24.90 **Future End Date:**
65129	4 or more tests described in item 65120 (See para PN.0.28 of explanatory notes to this Category) **Fee:** $37.30 **Benefit:** 75% = $28.00 85% = $31.75 **Future End Date:**
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 **Fee:** $26.60 **Benefit:** 75% = $19.95 85% = $22.65 **Future End Date:**
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 **Fee:** $26.60 **Benefit:** 75% = $19.95 85% = $22.65 **Future End Date:**
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 **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 **Future End Date:**
65147	Quantitation of anti-Xa activity when monitoring is required for a patient receiving a low molecular weight heparin or heparinoid - 1 test **Fee:** $39.80 **Benefit:** 75% = $29.85 85% = $33.85 **Future End Date:**
65150	Assessment of von Willebrand factor, factor II, factor V, factor VII, factor VIII, factor IX, factor X, factor XI, factor XII, factor XIII, prekallikrein, high-molecular-weight kininogen, circulating coagulation factor inhibitors other than by Bethesda assay—one test **Fee:** $74.50 **Benefit:** 75% = $55.90 85% = $63.35 **Future End Date:**
65153	2 tests described in item 65150 (Item is subject to rule 6)

P1. HAEMATOLOGY	
	Fee: $149.05 **Benefit:** 75% = $111.80 85% = $126.70 **Future End Date:**
65156	3 or more tests described in item 65150 (Item is subject to rule 6) **Fee:** $223.50 **Benefit:** 75% = $167.65 85% = $190.00 **Future End Date:**
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) **Fee:** $74.50 **Benefit:** 75% = $55.90 85% = $63.35 **Future End Date:**
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) **Fee:** $74.50 **Benefit:** 75% = $55.90 85% = $63.35 **Future End Date:**
65159	Quantitation of circulating coagulation factor inhibitors by Bethesda assay - 1 test **Fee:** $74.50 **Benefit:** 75% = $55.90 85% = $63.35 **Future End Date:**
65162	Examination of a maternal blood film for the presence of fetal red blood cells (Kleihauer test) **Fee:** $11.00 **Benefit:** 75% = $8.25 85% = $9.35 **Future End Date:**
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 **Fee:** $36.20 **Benefit:** 75% = $27.15 85% = $30.80 **Future End Date:**
65166	A test described in item 65165 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $36.20 **Benefit:** 75% = $27.15 85% = $30.80 **Future End Date:**
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 **Fee:** $26.60 **Benefit:** 75% = $19.95 85% = $22.65 **Future End Date:**
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) **Fee:** $26.60 **Benefit:** 75% = $19.95 85% = $22.65 **Future End Date:**

P1. HAEMATOLOGY	
65176	2 tests described in item 65175 (Item is subject to rule 6) **Fee:** $51.10 **Benefit:** 75% = $38.35 85% = $43.45 **Future End Date:**
65177	3 tests described in item 65175 (Item is subject to rule 6) **Fee:** $75.60 **Benefit:** 75% = $56.70 85% = $64.30 **Future End Date:**
65178	4 tests described in item 65175 (Item is subject to rule 6) **Fee:** $100.05 **Benefit:** 75% = $75.05 85% = $85.05 **Future End Date:**
65179	5 tests described in item 65175 (Item is subject to rule 6) **Fee:** $124.50 **Benefit:** 75% = $93.40 85% = $105.85 **Future End Date:**
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) **Fee:** $26.60 **Benefit:** 75% = $19.95 85% = $22.65 **Future End Date:**
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) **Fee:** $24.45 **Benefit:** 75% = $18.35 85% = $20.80 **Future End Date:**

P2. CHEMICAL	
	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 (See para PN.1.1 of explanatory notes to this Category) **Fee:** $9.70 **Benefit:** 75% = $7.30 85% = $8.25 **Future End Date:**
66503	2 tests described in item 66500 (See para PN.1.1 of explanatory notes to this Category)

P2. CHEMICAL	
	Fee: $11.65 **Benefit:** 75% = $8.75 85% = $9.95 **Future End Date:**
66506	3 tests described in item 66500 (See para PN.1.1 of explanatory notes to this Category) **Fee:** $13.65 **Benefit:** 75% = $10.25 85% = $11.65 **Future End Date:**
66509	4 tests described in item 66500 (See para PN.1.1 of explanatory notes to this Category) **Fee:** $15.65 **Benefit:** 75% = $11.75 85% = $13.35 **Future End Date:**
66512	5 or more tests described in item 66500 (See para PN.1.1 of explanatory notes to this Category) **Fee:** $17.70 **Benefit:** 75% = $13.30 85% = $15.05 **Future End Date:**
66517	Quantitation of bile acids in blood in pregnancy. Applicable not more than 3 times in a pregnancy. **Fee:** $19.65 **Benefit:** 75% = $14.75 85% = $16.75 **Future End Date:**
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 **Fee:** $20.05 **Benefit:** 75% = $15.05 85% = $17.05 **Future End Date:**
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 **Fee:** $40.15 **Benefit:** 75% = $30.15 85% = $34.15 **Future End Date:**
66520	Fibroblast growth factor 23 quantification in serum or plasma, requested by a specialist or consultant physician to determine eligibility for a relevant treatment listed on the Pharmaceutical Benefits Scheme **Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50 **Future End Date:**
66522	Faecal calprotectin test for the diagnosis of inflammatory bowel disease, if all the following apply: a. the patient is under 50 years of age; b. the patient has gastrointestinal symptoms suggestive of inflammatory or functional bowel disease of more than 6 weeks' duration; c. infectious causes have been excluded; d. the likelihood of malignancy has been assessed as low; e. no relevant clinical alarms are present **Fee:** $75.00 **Benefit:** 75% = $56.25 85% = $63.75 **Future End Date:**
66523	Faecal calprotectin test for the diagnosis of inflammatory bowel disease, if all the following apply: a. 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 µg/g but not more than 100 µg/g); b. the patient has ongoing gastrointestinal symptoms suggestive of inflammatory or functional bowel disease;

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	c. the service is requested by a specialist or consultant physician practising as a specialist gastroenterologist; d. the request indicates that an endoscopic examination is not initially required; e. no relevant clinical alarms are present **Fee:** $75.00 **Benefit:** 75% = $56.25 85% = $63.75 **Future End Date:**
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 **Fee:** $75.00 **Benefit:** 75% = $56.25 85% = $63.75 **Future End Date:**
66536	Quantitation of HDL cholesterol **Fee:** $11.05 **Benefit:** 75% = $8.30 85% = $9.40 **Future End Date:**
66539	Electrophoresis of serum for demonstration of lipoprotein subclasses, if the cholesterol is >6.5 mmol/L and triglyceride >4.0 mmol/L or in the diagnosis of types III and IV hyperlipidaemia - (Item is subject to rule 25) **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05 **Future End Date:**
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 **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15 **Future End Date:**
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 (See para PN.1.1 of explanatory notes to this Category) **Fee:** $15.80 **Benefit:** 75% = $11.85 85% = $13.45 **Future End Date:**
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) (See para PN.1.1 of explanatory notes to this Category) **Fee:** $19.90 **Benefit:** 75% = $14.95 85% = $16.95 **Future End Date:**
66551	Quantitation of glycated haemoglobin performed in the management of established diabetes

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	(See para PR.2.2 of explanatory notes to this Category) (See para PR.2.2 of explanatory notes to this Category) **Fee:** $16.80 **Benefit:** 75% = $12.60 85% = $14.30 **Future End Date:**
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) **Fee:** $16.80 **Benefit:** 75% = $12.60 85% = $14.30 **Future End Date:**
66557	Quantitation of fructosamine performed in the management of established diabetes - each test to a maximum of 4 tests in a 12 month period **Fee:** $9.70 **Benefit:** 75% = $7.30 85% = $8.25 **Future End Date:**
66560	Microalbumin - quantitation in urine **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10 **Future End Date:**
66563	Osmolality, estimation by osmometer, in serum or in urine - 1 or more tests **Fee:** $24.70 **Benefit:** 75% = $18.55 85% = $21.00 **Future End Date:**
66566	Quantitation of: (a) blood gases (including pO_2, oxygen saturation and pCO_2) ; 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 (See para PN.1.1 of explanatory notes to this Category) **Fee:** $33.70 **Benefit:** 75% = $25.30 85% = $28.65 **Future End Date:**
66569	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 2 specimens performed within any 1 day **Fee:** $42.60 **Benefit:** 75% = $31.95 85% = $36.25 **Future End Date:**
66572	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 3 specimens performed within any 1 day **Fee:** $51.55 **Benefit:** 75% = $38.70 85% = $43.85 **Future End Date:**
66575	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 4 specimens performed within any 1 day **Fee:** $60.45 **Benefit:** 75% = $45.35 85% = $51.40 **Future End Date:**
66578	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 5 specimens performed within any 1 day **Fee:** $69.35 **Benefit:** 75% = $52.05 85% = $58.95 **Future End Date:**

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66581	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 6 or more specimens performed within any 1 day **Fee:** $78.25 **Benefit:** 75% = $58.70 85% = $66.55 **Future End Date:**
66584	Quantitation of ionised calcium (except if performed as part of item 66566) - 1 test **Fee:** $9.70 **Benefit:** 75% = $7.30 85% = $8.25 **Future End Date:**
66585	Quantification of laboratory-based BNP or NT-proBNP testing in a patient with systemic sclerosis (scleroderma) to assess risk of pulmonary arterial hypertension Maximum of 2 tests in a 12 month period (See para PN.2.5 of explanatory notes to this Category) **Fee:** $58.50 **Benefit:** 75% = $43.90 85% = $49.75 **Future End Date:**
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 (See para PN.2.5 of explanatory notes to this Category) **Fee:** $58.50 **Benefit:** 75% = $43.90 85% = $49.75 **Future End Date:**
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 **Fee:** $47.55 **Benefit:** 75% = $35.70 85% = $40.45 **Future End Date:**
66590	Calculus, analysis of 1 or more **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05 **Future End Date:**
66593	Ferritin - quantitation, except if requested as part of iron studies **Fee:** $18.00 **Benefit:** 75% = $13.50 85% = $15.30 **Future End Date:**
66596	Iron studies, consisting of quantitation of: (a) serum iron; and (b) transferrin or iron binding capacity; and (c) ferritin **Fee:** $32.55 **Benefit:** 75% = $24.45 85% = $27.70 **Future End Date:**
66605	Vitamins - quantitation of vitamins B1, B2, B3, B6 or C in blood, urine or other body fluid - 1 or more tests **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05 **Future End Date:**

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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) **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05 **Future End Date:**
66607	Vitamins - quantitation of vitamins A or E in blood, urine or other body fluid - 1 or more tests within a 6 month period **Fee:** $75.75 **Benefit:** 75% = $56.85 85% = $64.40 **Future End Date:**
66610	A test described in item 66607 if rendered by a receiving APP - 1 or more tests **Fee:** $75.75 **Benefit:** 75% = $56.85 85% = $64.40 **Future End Date:**
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 **Fee:** $41.50 **Benefit:** 75% = $31.15 85% = $35.30 **Future End Date:**
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) **Fee:** $24.10 **Benefit:** 75% = $18.10 85% = $20.50 **Future End Date:**
66629	Beta-2-microglobulin - quantitation in serum, urine or other body fluids - 1 or more tests **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10 **Future End Date:**
66632	Caeruloplasmin, haptoglobins, or prealbumin - quantitation in serum, urine or other body fluids - 1 or more tests **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10 **Future End Date:**
66635	Alpha-1-antitrypsin - quantitation in serum, urine or other body fluid - 1 or more tests **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10 **Future End Date:**

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66638	Isoelectric focussing or similar methods for determination of alpha-1-antitrypsin phenotype in serum - 1 or more tests **Fee:** $49.05 **Benefit:** 75% = $36.80 85% = $41.70 **Future End Date:**
66639	A test described in item 66638 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $29.20 **Benefit:** 75% = $21.90 85% = $24.85 **Future End Date:**
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 **Fee:** $29.20 **Benefit:** 75% = $21.90 85% = $24.85 **Future End Date:**
66642	A test described in item 66641 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $29.20 **Benefit:** 75% = $21.90 85% = $24.85 **Future End Date:**
66644	C-1 esterase inhibitor - quantitation **Fee:** $20.15 **Benefit:** 75% = $15.15 85% = $17.15 **Future End Date:**
66647	C-1 esterase inhibitor - functional assay **Fee:** $45.10 **Benefit:** 75% = $33.85 85% = $38.35 **Future End Date:**
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) **Fee:** $24.35 **Benefit:** 75% = $18.30 85% = $20.70 **Future End Date:**
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) **Fee:** $24.35 **Benefit:** 75% = $18.30 85% = $20.70 **Future End Date:**
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

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	(Item is subject to rule 6 and 18) **Fee:** $20.30 **Benefit:** 75% = $15.25 85% = $17.30 **Future End Date:**
66653	2 or more tests described in item 66650 (Item is subject to rule 6) **Fee:** $44.60 **Benefit:** 75% = $33.45 85% = $37.95 **Future End Date:**
66654	Prostate specific antigen – quantitation in the monitoring of high-risk patients For any particular patient, applicable not more than once in 11 months **Fee:** $20.15 **Benefit:** 75% = $15.15 85% = $17.15 **Future End Date:**
66655	Prostate specific antigen—quantitation For any particular patient, applicable not more than once in 23 months **Fee:** $20.15 **Benefit:** 75% = $15.15 85% = $17.15 **Future End Date:**
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) **Fee:** $20.15 **Benefit:** 75% = $15.15 85% = $17.15 **Future End Date:**
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 **Fee:** $37.30 **Benefit:** 75% = $28.00 85% = $31.75 **Future End Date:**
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

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	For any particular patient, applicable not more than 4 times in 11 months **Fee:** $37.30 **Benefit:** 75% = $28.00 85% = $31.75 **Future End Date:**
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 **Fee:** $79.95 **Benefit:** 75% = $60.00 85% = $68.00 **Future End Date:**
66663	A test described in item 66662 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $79.95 **Benefit:** 75% = $60.00 85% = $68.00 **Future End Date:**
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 **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05 **Future End Date:**
66666	A test described in item 66665 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05 **Future End Date:**
66667	Quantitation of serum zinc in a patient receiving intravenous alimentation - each test **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05 **Future End Date:**
66671	Quantitation of serum aluminium in a patient in a renal dialysis program - each test **Fee:** $36.90 **Benefit:** 75% = $27.70 85% = $31.40 **Future End Date:**
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 **Fee:** $39.95 **Benefit:** 75% = $30.00 85% = $34.00 **Future End Date:**
66677	Test for tryptic activity in faeces in the investigation of diarrhoea of longer than 4 weeks duration in children under 6 years old **Fee:** $11.15 **Benefit:** 75% = $8.40 85% = $9.50 **Future End Date:**
66680	Quantitation of disaccharidases and other enzymes in intestinal tissue - 1 or more tests **Fee:** $74.45 **Benefit:** 75% = $55.85 85% = $63.30 **Future End Date:**
66683	Enzymes - quantitation in solid tissue or tissues other than blood elements or intestinal tissue - 1 or more tests

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	Fee: $74.45 **Benefit:** 75% = $55.85 85% = $63.30 **Future End Date:**
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 **Fee:** $50.65 **Benefit:** 75% = $38.00 85% = $43.10 **Future End Date:**
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) (See para TN.1.4 of explanatory notes to this Category) **Fee:** $30.50 **Benefit:** 75% = $22.90 85% = $25.95 **Future End Date:**
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) **Fee:** $30.50 **Benefit:** 75% = $22.90 85% = $25.95 **Future End Date:**
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) **Fee:** $13.20 **Benefit:** 75% = $9.90 85% = $11.25 **Future End Date:**
66698	2 tests described in item 66695 (Item is subject to rule 6) (See para TN.1.4 of explanatory notes to this Category) **Fee:** $43.70 **Benefit:** 75% = $32.80 85% = $37.15 **Future End Date:**
66701	3 tests described in item 66695 (Item is subject to rule 6)

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	(See para TN.1.4 of explanatory notes to this Category) **Fee:** $56.90 **Benefit:** 75% = $42.70 85% = $48.40 **Future End Date:**
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) (See para TN.1.4 of explanatory notes to this Category) **Fee:** $70.15 **Benefit:** 75% = $52.65 85% = $59.65 **Future End Date:**
66707	5 or more tests described in item 66695 (Item is subject to rule 6) (See para TN.1.4 of explanatory notes to this Category) **Fee:** $83.35 **Benefit:** 75% = $62.55 85% = $70.85 **Future End Date:**
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) **Fee:** $30.15 **Benefit:** 75% = $22.65 85% = $25.65 **Future End Date:**
66712	Two tests described in item 66711 (Item is subject to rule 6) **Fee:** $43.05 **Benefit:** 75% = $32.30 85% = $36.60 **Future End Date:**
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) **Fee:** $30.15 **Benefit:** 75% = $22.65 85% = $25.65 **Future End Date:**
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) **Fee:** $12.85 **Benefit:** 75% = $9.65 85% = $10.95 **Future End Date:**

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66716	TSH quantitation **Fee:** $25.05 **Benefit:** 75% = $18.80 85% = $21.30 **Future End Date:**
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 **Fee:** $34.80 **Benefit:** 75% = $26.10 85% = $29.60 **Future End Date:**
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) **Fee:** $37.90 **Benefit:** 75% = $28.45 85% = $32.25 **Future End Date:**
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) **Fee:** $37.90 **Benefit:** 75% = $28.45 85% = $32.25 **Future End Date:**
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) **Fee:** $13.15 **Benefit:** 75% = $9.90 85% = $11.20 **Future End Date:**
66725	TSH quantitation described in item 66716 and 2 tests described in item 66695

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	(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) **Fee:** $51.05 **Benefit:** 75% = $38.30 85% = $43.40 **Future End Date:**
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) **Fee:** $64.20 **Benefit:** 75% = $48.15 85% = $54.60 **Future End Date:**
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) **Fee:** $77.40 **Benefit:** 75% = $58.05 85% = $65.80 **Future End Date:**
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) **Fee:** $90.55 **Benefit:** 75% = $67.95 85% = $77.00 **Future End Date:**
66743	Quantitation of alpha-fetoprotein in serum or other body fluids during pregnancy except if requested as part of items 66750 or 66751 (See para PN.1.1 of explanatory notes to this Category) **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10 **Future End Date:**
66749	Amniotic fluid, spectrophotometric examination of, and quantitation of: (a) lecithin/sphingomyelin ratio; or

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	(b) palmitic acid, phosphatidylglycerol or lamellar body phospholipid; or (c) bilirubin, including correction for haemoglobin 1 or more tests **Fee:** $32.95 **Benefit:** 75% = $24.75 85% = $28.05 **Future End Date:**
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 (uE_3), alpha-fetoprotein (AFP) - including (if performed) a service described in item 73527 or 73529 - Applicable not more than once in a pregnancy (See para PN.1.1 of explanatory notes to this Category) **Fee:** $39.75 **Benefit:** 75% = $29.85 85% = $33.80 **Future End Date:**
66751	Quantitation, in pregnancy, of any three or more tests described in 66750 (Item is subject to rule 25) (See para PN.1.1 of explanatory notes to this Category) **Fee:** $55.25 **Benefit:** 75% = $41.45 85% = $47.00 **Future End Date:**
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 **Fee:** $24.70 **Benefit:** 75% = $18.55 85% = $21.00 **Future End Date:**
66755	2 or more tests described in item 66752 **Fee:** $38.85 **Benefit:** 75% = $29.15 85% = $33.05 **Future End Date:**
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. **Fee:** $98.30 **Benefit:** 75% = $73.75 85% = $83.60 **Future End Date:**
66757	Quantitation of 10 or more amino acids for monitoring of previously diagnosed inborn errors of metabolism in 1 tissue type. **Fee:** $98.30 **Benefit:** 75% = $73.75 85% = $83.60 **Future End Date:**
66758	Quantitation of angiotensin converting enzyme, or cholinesterase - 1 or more tests **Fee:** $24.70 **Benefit:** 75% = $18.55 85% = $21.00 **Future End Date:**
66761	Test for reducing substances in faeces by any method (except reagent strip or dipstick) **Fee:** $13.15 **Benefit:** 75% = $9.90 85% = $11.20 **Future End Date:**
66764	Examination for faecal occult blood (including tests for haemoglobin and its derivatives in the faeces except by reagent strip or dip stick methods)

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	with a maximum of 3 examinations on specimens collected on separate days in a 28 day period **Fee:** $8.90 **Benefit:** 75% = $6.70 85% = $7.60 **Future End Date:**
66767	2 examinations described in item 66764 performed on separately collected and identified specimens **Fee:** $17.85 **Benefit:** 75% = $13.40 85% = $15.20 **Future End Date:**
66770	3 examinations described in item 66764 performed on separately collected and identified specimens **Fee:** $26.70 **Benefit:** 75% = $20.05 85% = $22.70 **Future End Date:**
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)* **Fee:** $24.65 **Benefit:** 75% = $18.50 85% = $21.00 **Future End Date:**
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 **Fee:** $24.65 **Benefit:** 75% = $18.50 85% = $21.00 **Future End Date:**
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 **Fee:** $39.95 **Benefit:** 75% = $30.00 85% = $34.00 **Future End Date:**
66780	A test described in item 66779 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $39.95 **Benefit:** 75% = $30.00 85% = $34.00 **Future End Date:**
66782	Porphyrins or porphyrins precursors - detection in plasma, red cells, urine or faeces - 1 or more tests **Fee:** $13.15 **Benefit:** 75% = $9.90 85% = $11.20 **Future End Date:**
66783	A test described in item 66782 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $13.15 **Benefit:** 75% = $9.90 85% = $11.20 **Future End Date:**
66785	Porphyrins or porphyrins precursors - quantitation in plasma, red cells, urine or faeces - 1 test (Item is subject to rule 6)

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	Fee: $39.95 **Benefit:** 75% = $30.00 85% = $34.00 **Future End Date:**
66788	Porphyrins or porphyrins precursors - quantitation in plasma, red cells, urine or faeces - 2 or more tests (Item is subject to rule 6) **Fee:** $65.85 **Benefit:** 75% = $49.40 85% = $56.00 **Future End Date:**
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) **Fee:** $39.95 **Benefit:** 75% = $30.00 85% = $34.00 **Future End Date:**
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) **Fee:** $25.90 **Benefit:** 75% = $19.45 85% = $22.05 **Future End Date:**
66791	Porphyrin biosynthetic enzymes - measurement of activity in blood cells or other tissues - 1 or more tests **Fee:** $74.45 **Benefit:** 75% = $55.85 85% = $63.30 **Future End Date:**
66792	A test described in item 66791 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $74.45 **Benefit:** 75% = $55.85 85% = $63.30 **Future End Date:**
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) (See para PN.0.17 of explanatory notes to this Category) **Fee:** $18.15 **Benefit:** 75% = $13.65 85% = $15.45 **Future End Date:**
66803	2 tests described in item 66800 (Item is subject to rule 6) **Fee:** $30.50 **Benefit:** 75% = $22.90 85% = $25.95 **Future End Date:**
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)

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	Fee: $18.15 **Benefit:** 75% = $13.65 85% = $15.45 **Future End Date:**
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) **Fee:** $12.35 **Benefit:** 75% = $9.30 85% = $10.50 **Future End Date:**
66806	3 tests described in item 66800 (Item is subject to rule 6) **Fee:** $41.85 **Benefit:** 75% = $31.40 85% = $35.60 **Future End Date:**
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) (See para PN.0.17 of explanatory notes to this Category) **Fee:** $34.80 **Benefit:** 75% = $26.10 85% = $29.60 **Future End Date:**
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) **Fee:** $59.55 **Benefit:** 75% = $44.70 85% = $50.65 **Future End Date:**
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) **Fee:** $34.80 **Benefit:** 75% = $26.10 85% = $29.60 **Future End Date:**
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) **Fee:** $24.75 **Benefit:** 75% = $18.60 85% = $21.05 **Future End Date:**
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)

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	Fee: $30.60 **Benefit:** 75% = $22.95 85% = $26.05 **Future End Date:**
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) **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05 **Future End Date:**
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) **Fee:** $21.80 **Benefit:** 75% = $16.35 85% = $18.55 **Future End Date:**
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) **Fee:** $52.45 **Benefit:** 75% = $39.35 85% = $44.60 **Future End Date:**
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) **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05 **Future End Date:**
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) **Fee:** $30.60 **Benefit:** 75% = $22.95 85% = $26.05 **Future End Date:**
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) **Fee:** $21.80 **Benefit:** 75% = $16.35 85% = $18.55 **Future End Date:**
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) **Fee:** $52.45 **Benefit:** 75% = $39.35 85% = $44.60 **Future End Date:**
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

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	echocardiogram, where heart failure is suspected based on signs and symptoms but diagnosis is uncertain Applicable once in any 12 month period (See para PN.2.6 of explanatory notes to this Category) **Fee:** $58.50 **Benefit:** 75% = $43.90 85% = $49.75 **Future End Date:**
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) **Fee:** $58.50 **Benefit:** 75% = $43.90 85% = $49.75 **Future End Date:**
66831	Quantitation of copper or iron in liver tissue biopsy **Fee:** $30.95 **Benefit:** 75% = $23.25 85% = $26.35 **Future End Date:**
66832	A test described in item 66831 if rendered by a receiving APP (Item is subject to rule 18A and 22) **Fee:** $30.95 **Benefit:** 75% = $23.25 85% = $26.35 **Future End Date:**
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 **Fee:** $30.05 **Benefit:** 75% = $22.55 85% = $25.55 **Future End Date:**
66834	A test described in item 66833 if rendered by a receiving APP

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	(Item is subject to Rule 18) **Fee:** $30.05 **Benefit:** 75% = $22.55 85% = $25.55 **Future End Date:**
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 **Fee:** $39.05 **Benefit:** 75% = $29.30 85% = $33.20 **Future End Date:**
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 **Fee:** $39.05 **Benefit:** 75% = $29.30 85% = $33.20 **Future End Date:**
66837	A test described in item 66835 or 66836 if rendered by a receiving APP (Item is subject to Rule 18) **Fee:** $39.05 **Benefit:** 75% = $29.30 85% = $33.20 **Future End Date:**
66838	Quantification of either or both of total vitamin B12 and holotranscobalamin Applicable not more than once in 11 months (See para PN.1.2, PN.2.8 of explanatory notes to this Category) **Fee:** $23.60 **Benefit:** 75% = $17.70 85% = $20.10 **Future End Date:**
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 (See para PN.1.2, PN.2.8 of explanatory notes to this Category) **Fee:** $42.95 **Benefit:** 75% = $32.25 85% = $36.55 **Future End Date:**
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 **Fee:** $23.60 **Benefit:** 75% = $17.70 85% = $20.10 **Future End Date:**
66841	Quantitation of HbA1c (glycated haemoglobin) performed for the diagnosis of diabetes in asymptomatic patients at high risk. (Item is subject to rule 25) **Fee:** $16.80 **Benefit:** 75% = $12.60 85% = $14.30 **Future End Date:**
66842	Quantification of one or more of total vitamin B12, holotranscobalamin, methylmalonic acid or homocysteine for a patient: a) who:

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	(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 (See para PN.1.2 of explanatory notes to this Category) **Fee:** $23.60 **Benefit:** 75% = $17.70 85% = $20.10 **Future End Date:**
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.* **Fee:** $77.65 **Benefit:** 75% = $58.25 85% = $66.05 **Future End Date:**

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	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 **Fee:** $12.50 **Benefit:** 75% = $9.40 85% = $10.65 **Future End Date:**
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;

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	specimens from 1 or more sites (See para PN.1.2, PN.1.1 of explanatory notes to this Category) **Fee:** $22.00 **Benefit:** 75% = $16.50 85% = $18.70 **Future End Date:**
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 (See para PN.1.2, PN.1.1 of explanatory notes to this Category) **Fee:** $33.75 **Benefit:** 75% = $25.35 85% = $28.70 **Future End Date:**
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 (See para PN.1.1 of explanatory notes to this Category) **Fee:** $48.15 **Benefit:** 75% = $36.15 85% = $40.95 **Future End Date:**
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 (See para PN.1.2, PN.1.1 of explanatory notes to this Category) **Fee:** $33.75 **Benefit:** 75% = $25.35 85% = $28.70 **Future End Date:**
69316	Detection of Chlamydia trachomatis by any method - 1 test (Item is subject to rule 26) (See para PN.1.1 of explanatory notes to this Category) **Fee:** $28.65 **Benefit:** 75% = $21.50 85% = $24.40 **Future End Date:**
69317	1 test described in item 69494 and a test described in 69316. (Item is subject to rule 26) (See para PN.1.1 of explanatory notes to this Category) **Fee:** $35.85 **Benefit:** 75% = $26.90 85% = $30.50 **Future End Date:**
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

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	(b) a service described in items 69300, 69303, 69306 and 69312; 1 or more tests on 1 or more specimens (See para PN.1.2 of explanatory notes to this Category) **Fee:** $33.75 **Benefit:** 75% = $25.35 85% = $28.70 **Future End Date:**
69319	2 tests described in item 69494 and a test described in 69316. (Item is subject to rule 26) **Fee:** $42.95 **Benefit:** 75% = $32.25 85% = $36.55 **Future End Date:**
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 (See para PN.1.2 of explanatory notes to this Category) **Fee:** $48.15 **Benefit:** 75% = $36.15 85% = $40.95 **Future End Date:**
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 (See para PN.1.1 of explanatory notes to this Category) **Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55 **Future End Date:**
69325	A test described in item 69324 if rendered by a receiving APP (Item is subject to rule 18) **Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55 **Future End Date:**
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 **Fee:** $85.00 **Benefit:** 75% = $63.75 85% = $72.25 **Future End Date:**
69328	A test described in item 69327 if rendered by a receiving APP (Item is subject to rule 18)

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	Fee: $85.00 **Benefit:** 75% = $63.75 85% = $72.25 **Future End Date:**
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 **Fee:** $128.00 **Benefit:** 75% = $96.00 85% = $108.80 **Future End Date:**
69331	A test described in item 69330 if rendered by a receiving APP (Item is subject to rule 18) **Fee:** $128.00 **Benefit:** 75% = $96.00 85% = $108.80 **Future End Date:**
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 (See para PN.2.7 of explanatory notes to this Category) **Fee:** $20.55 **Benefit:** 75% = $15.45 85% = $17.50 **Future End Date:**

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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 **Fee:** $33.45 **Benefit:** 75% = $25.10 85% = $28.45 **Future End Date:**
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 **Fee:** $19.10 **Benefit:** 75% = $14.35 85% = $16.25 **Future End Date:**
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 (See para PN.1.2 of explanatory notes to this Category) **Fee:** $52.90 **Benefit:** 75% = $39.70 85% = $45.00 **Future End Date:**
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 **Fee:** $30.75 **Benefit:** 75% = $23.10 85% = $26.15 **Future End Date:**
69357	2 sets of cultures described in item 69354 **Fee:** $61.45 **Benefit:** 75% = $46.10 85% = $52.25 **Future End Date:**
69360	3 sets of cultures described in item 69354 **Fee:** $92.20 **Benefit:** 75% = $69.15 85% = $78.40 **Future End Date:**
69363	Detection of *Clostridium difficile* or *Clostridium difficile* toxin (except if a service described in item 69345 has been performed) - one or more tests **Fee:** $28.65 **Benefit:** 75% = $21.50 85% = $24.40 **Future End Date:**
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 **Fee:** $180.25 **Benefit:** 75% = $135.20 85% = $153.25 **Future End Date:**

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69379	A test described in item 69378 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $180.25 **Benefit:** 75% = $135.20 85% = $153.25 **Future End Date:**
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 **Fee:** $770.30 **Benefit:** 75% = $577.75 85% = $661.80 **Future End Date:**
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 **Fee:** $180.25 **Benefit:** 75% = $135.20 85% = $153.25 **Future End Date:**
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 **Fee:** $180.25 **Benefit:** 75% = $135.20 85% = $153.25 **Future End Date:**
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) **Fee:** $180.25 **Benefit:** 75% = $135.20 85% = $153.25 **Future End Date:**
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) (See para PN.1.1, PN.0.18 of explanatory notes to this Category) **Fee:** $15.65 **Benefit:** 75% = $11.75 85% = $13.35 **Future End Date:**
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)

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	(Item is subject to rule 6) (See para PN.1.1, PN.0.18 of explanatory notes to this Category) **Fee:** $29.00 **Benefit:** 75% = $21.75 85% = $24.65 **Future End Date:**
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) (See para PN.1.1, PN.0.18 of explanatory notes to this Category) **Fee:** $42.35 **Benefit:** 75% = $31.80 85% = $36.00 **Future End Date:**
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) (See para PN.1.1, PN.0.18 of explanatory notes to this Category) **Fee:** $55.70 **Benefit:** 75% = $41.80 85% = $47.35 **Future End Date:**
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) (See para PN.1.1, PN.0.18 of explanatory notes to this Category) **Fee:** $69.10 **Benefit:** 75% = $51.85 85% = $58.75 **Future End Date:**
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) (See para PN.1.1 of explanatory notes to this Category) **Fee:** $15.65 **Benefit:** 75% = $11.75 85% = $13.35 **Future End Date:**
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

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	(Item is subject to rule 6, 18 and 18A) (See para PN.1.1 of explanatory notes to this Category) **Fee:** $13.35 **Benefit:** 75% = $10.05 85% = $11.35 **Future End Date:**
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 (See para PN.1.2, PN.1.1, PN.0.18 of explanatory notes to this Category) **Fee:** $15.65 **Benefit:** 75% = $11.75 85% = $13.35 **Future End Date:**
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 (See para PN.1.2, PN.1.1, PN.0.18 of explanatory notes to this Category) **Fee:** $29.00 **Benefit:** 75% = $21.75 85% = $24.65 **Future End Date:**
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 (See para PN.1.2, PN.1.1, PN.0.18 of explanatory notes to this Category) **Fee:** $42.35 **Benefit:** 75% = $31.80 85% = $36.00 **Future End Date:**
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 (See para PN.1.2, PN.1.1, PN.0.18 of explanatory notes to this Category) **Fee:** $55.70 **Benefit:** 75% = $41.80 85% = $47.35 **Future End Date:**

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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 (See para PN.1.2, PN.1.1, PN.0.18 of explanatory notes to this Category) **Fee:** $69.10 **Benefit:** 75% = $51.85 85% = $58.75 **Future End Date:**
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 **Fee:** $78.25 **Benefit:** 75% = $58.70 85% = $66.55 **Future End Date:**
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 **Fee:** $85.55 **Benefit:** 75% = $64.20 85% = $72.75 **Future End Date:**
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) **Fee:** $92.20 **Benefit:** 75% = $69.15 85% = $78.40 **Future End Date:**
69451	A test described in item 69445 if rendered by a receiving APP - 1 test. (Item is subject to rule 18 and 25) **Fee:** $92.20 **Benefit:** 75% = $69.15 85% = $78.40 **Future End Date:**
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;

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	(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) (See para PN.3.4 of explanatory notes to this Category) **Fee:** $34.90 **Benefit:** 75% = $26.20 85% = $29.70 **Future End Date:**
69472	Detection of antibodies to Epstein Barr Virus using specific serology - 1 test **Fee:** $15.65 **Benefit:** 75% = $11.75 85% = $13.35 **Future End Date:**
69474	Detection of antibodies to Epstein Barr Virus using specific serology - 2 or more tests **Fee:** $28.65 **Benefit:** 75% = $21.50 85% = $24.40 **Future End Date:**
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) (See para PN.1.2 of explanatory notes to this Category) **Fee:** $15.65 **Benefit:** 75% = $11.75 85% = $13.35 **Future End Date:**
69478	2 tests described in 69475 (Item subject to rule 11) (See para PN.1.2 of explanatory notes to this Category) **Fee:** $29.25 **Benefit:** 75% = $21.95 85% = $24.90 **Future End Date:**
69481	Investigation of infectious causes of acute or chronic hepatitis - 3 tests for hepatitis antibodies or antigens, (Item subject to rule 11) (See para PN.1.2, PN.0.19 of explanatory notes to this Category) **Fee:** $40.55 **Benefit:** 75% = $30.45 85% = $34.50 **Future End Date:**
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) **Fee:** $152.10 **Benefit:** 75% = $114.10 85% = $129.30 **Future End Date:**
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) **Fee:** $152.10 **Benefit:** 75% = $114.10 85% = $129.30 **Future End Date:**
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)

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	(See para PN.1.2 of explanatory notes to this Category) **Fee:** $17.10 **Benefit:** 75% = $12.85 85% = $14.55 **Future End Date:**
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) **Fee:** $180.25 **Benefit:** 75% = $135.20 85% = $153.25 **Future End Date:**
69489	A test described in item 69488 if rendered by a receiving APP (Item is subject to rule 18 and 25) **Fee:** $180.25 **Benefit:** 75% = $135.20 85% = $153.25 **Future End Date:**
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 **Fee:** $204.80 **Benefit:** 75% = $153.60 85% = $174.10 **Future End Date:**
69492	A test described in item 69491 if rendered by a receiving APP - 1 test (Item is subject to rule 18 and 25) **Fee:** $204.80 **Benefit:** 75% = $153.60 85% = $174.10 **Future End Date:**
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) (See para PN.1.2 of explanatory notes to this Category) **Fee:** $28.65 **Benefit:** 75% = $21.50 85% = $24.40 **Future End Date:**
69495	2 tests described in 69494 (Item is subject to rule 6 and 26) (See para PN.1.2 of explanatory notes to this Category) **Fee:** $35.85 **Benefit:** 75% = $26.90 85% = $30.50 **Future End Date:**
69496	3 or more tests described in 69494

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	(Item is subject to rule 6 and 26) (See para PN.1.2 of explanatory notes to this Category) **Fee:** $43.05 **Benefit:** 75% = $32.30 85% = $36.60 **Future End Date:**
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) **Fee:** $28.65 **Benefit:** 75% = $21.50 85% = $24.40 **Future End Date:**
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) **Fee:** $7.20 **Benefit:** 75% = $5.40 85% = $6.15 **Future End Date:**
69499	Detection of hepatitis C viral RNA if: (a) the patient is hepatitis C seropositive; or (aa) the patient's hepatitis C serological status is uncertain after an inconclusive serology test result; or (b) 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 if considered necessary for the clinical management of the patient (Item is subject to rule 25 - not more than once in a 12-month period in total for both items 69499 and 69500) (See para PN.1.2 of explanatory notes to this Category) **Fee:** $92.20 **Benefit:** 75% = $69.15 85% = $78.40 **Future End Date:**
69500	A test described in item 69499 if the test is performed by a receiving APP (Item is subject to rules 18 and 25) (See para PN.1.2 of explanatory notes to this Category) **Fee:** $92.20 **Benefit:** 75% = $69.15 85% = $78.40 **Future End Date:**
69505	Sequencing and analysis of the genome of mycobacterium tuberculosis complex from an isolate or nucleic acid extract: (a) to speciate the organism: (i) at the time of a patient's initial diagnosis and commencement of initial empiric therapy; or (ii) following recurrence of a patient's symptoms or a patient's failure to respond to treatment within the expected timeframe; and (b) for the purpose of:

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	(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 **Fee:** $150.00 **Benefit:** 75% = $112.50 85% = $127.50 **Future End Date:**

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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 **Fee:** $34.60 **Benefit:** 75% = $25.95 85% = $29.45 **Future End Date:**
71058	Examination as described in item 71057 of 2 or more specimen types **Fee:** $53.05 **Benefit:** 75% = $39.80 85% = $45.10 **Future End Date:**
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) **Fee:** $37.45 **Benefit:** 75% = $28.10 85% = $31.85 **Future End Date:**
71060	Examination as described in item 71059 of 2 or more specimen types **Fee:** $46.25 **Benefit:** 75% = $34.70 85% = $39.35 **Future End Date:**
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 **Fee:** $46.25 **Benefit:** 75% = $34.70 85% = $39.35 **Future End Date:**
71064	Detection and quantitation of cryoglobulins or cryofibrinogen - 1 or more tests **Fee:** $21.80 **Benefit:** 75% = $16.35 85% = $18.55 **Future End Date:**
71066	Quantitation of total immunoglobulin A by any method in serum, urine or other body fluid - 1 test

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	Fee: $15.30 **Benefit:** 75% = $11.50 85% = $13.05 **Future End Date:**
71068	Quantitation of total immunoglobulin G by any method in serum, urine or other body fluid - 1 test **Fee:** $15.30 **Benefit:** 75% = $11.50 85% = $13.05 **Future End Date:**
71069	2 tests described in items 71066, 71068, 71072 or 71074 **Fee:** $23.90 **Benefit:** 75% = $17.95 85% = $20.35 **Future End Date:**
71071	3 or more tests described in items 71066, 71068, 71072 or 71074 **Fee:** $32.50 **Benefit:** 75% = $24.40 85% = $27.65 **Future End Date:**
71072	Quantitation of total immunoglobulin M by any method in serum, urine or other body fluid - 1 test **Fee:** $15.30 **Benefit:** 75% = $11.50 85% = $13.05 **Future End Date:**
71073	Quantitation of all 4 immunoglobulin G subclasses **Fee:** $111.55 **Benefit:** 75% = $83.70 85% = $94.85 **Future End Date:**
71074	Quantitation of total immunoglobulin D by any method in serum, urine or other body fluid - 1 test **Fee:** $15.30 **Benefit:** 75% = $11.50 85% = $13.05 **Future End Date:**
71075	Quantitation of immunoglobulin E (total), 1 test. (Item is subject to rule 25) **Fee:** $24.15 **Benefit:** 75% = $18.15 85% = $20.55 **Future End Date:**
71076	A test described in item 71073 if rendered by a receiving APP - 1 test (Item is subject to rule 18) **Fee:** $111.55 **Benefit:** 75% = $83.70 85% = $94.85 **Future End Date:**
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) **Fee:** $28.40 **Benefit:** 75% = $21.30 85% = $24.15 **Future End Date:**
71079	Detection of specific immunoglobulin E antibodies to single or multiple potential allergens, 1 test (Item is subject to rule 25) **Fee:** $28.15 **Benefit:** 75% = $21.15 85% = $23.95 **Future End Date:**
71081	Quantitation of total haemolytic complement **Fee:** $42.60 **Benefit:** 75% = $31.95 85% = $36.25 **Future End Date:**

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71083	Quantitation of complement components C3 and C4 or properdin factor B - 1 test **Fee:** $21.20 **Benefit:** 75% = $15.90 85% = $18.05 **Future End Date:**
71085	2 tests described in item 71083 **Fee:** $30.40 **Benefit:** 75% = $22.80 85% = $25.85 **Future End Date:**
71087	3 or more tests described in item 71083 **Fee:** $39.60 **Benefit:** 75% = $29.70 85% = $33.70 **Future End Date:**
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) **Fee:** $30.65 **Benefit:** 75% = $23.00 85% = $26.10 **Future End Date:**
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) **Fee:** $30.65 **Benefit:** 75% = $23.00 85% = $26.10 **Future End Date:**
71091	2 tests described in item 71089 (Item is subject to rule 6) **Fee:** $55.50 **Benefit:** 75% = $41.65 85% = $47.20 **Future End Date:**
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) **Fee:** $24.90 **Benefit:** 75% = $18.70 85% = $21.20 **Future End Date:**
71093	3 or more tests described in item 71089 (Item is subject to rule 6) **Fee:** $80.35 **Benefit:** 75% = $60.30 85% = $68.30 **Future End Date:**
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 (See para PN.0.20 of explanatory notes to this Category) **Fee:** $42.60 **Benefit:** 75% = $31.95 85% = $36.25 **Future End Date:**
71096	A test described in item 71095 if rendered by a receiving APP. (Item is subject to rule 18)

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	Fee: $42.60 **Benefit:** 75% = $31.95 85% = $36.25 **Future End Date:**
71097	Antinuclear antibodies - detection in serum or other body fluids, including quantitation if required **Fee:** $25.70 **Benefit:** 75% = $19.30 85% = $21.85 **Future End Date:**
Amend 71099	Double-stranded DNA antibodies - quantitation by one or more methods **Fee:** $27.85 **Benefit:** 75% = $20.90 85% = $23.70 **Future End Date:**
71101	Antibodies to 1 or more extractable nuclear antigens - detection in serum or other body fluids **Fee:** $18.25 **Benefit:** 75% = $13.70 85% = $15.55 **Future End Date:**
71103	Characterisation of an antibody detected in a service described in item 71101 (including that service) **Fee:** $54.70 **Benefit:** 75% = $41.05 85% = $46.50 **Future End Date:**
71106	Rheumatoid factor - detection by any technique in serum or other body fluids, including quantitation if required **Fee:** $11.85 **Benefit:** 75% = $8.90 85% = $10.10 **Future End Date:**
71119	Antibodies to tissue antigens not elsewhere specified in this Table - detection, including quantitation if required, of 1 antibody (See para PN.0.33 of explanatory notes to this Category) **Fee:** $18.20 **Benefit:** 75% = $13.65 85% = $15.50 **Future End Date:**
71121	Detection of 2 antibodies specified in item 71119 (See para PN.0.33 of explanatory notes to this Category) **Fee:** $21.85 **Benefit:** 75% = $16.40 85% = $18.60 **Future End Date:**
71123	Detection of 3 antibodies specified in item 71119 (See para PN.0.33 of explanatory notes to this Category) **Fee:** $25.50 **Benefit:** 75% = $19.15 85% = $21.70 **Future End Date:**
71125	Detection of 4 or more antibodies specified in item 71119 (See para PN.0.33 of explanatory notes to this Category) **Fee:** $29.05 **Benefit:** 75% = $21.80 85% = $24.70 **Future End Date:**
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 **Fee:** $185.30 **Benefit:** 75% = $139.00 85% = $157.55

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	Future End Date:
71129	2 tests described in item 71127 **Fee:** $228.90 **Benefit:** 75% = $171.70 85% = $194.60 **Future End Date:**
71131	3 or more tests described in item 71127 **Fee:** $272.45 **Benefit:** 75% = $204.35 85% = $231.60 **Future End Date:**
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 **Fee:** $10.95 **Benefit:** 75% = $8.25 85% = $9.35 **Future End Date:**
71134	Investigation of recurrent infection by quantitative assessment of oxidative pathways by flow cytometric techniques, including a test described in 71133 (if performed) **Fee:** $109.30 **Benefit:** 75% = $82.00 85% = $92.95 **Future End Date:**
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 **Fee:** $218.50 **Benefit:** 75% = $163.90 85% = $185.75 **Future End Date:**
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 **Fee:** $31.80 **Benefit:** 75% = $23.85 85% = $27.05 **Future End Date:**
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 **Fee:** $109.30 **Benefit:** 75% = $82.00 85% = $92.95 **Future End Date:**
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 **Fee:** $207.35 **Benefit:** 75% = $155.55 85% = $176.25 **Future End Date:**
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

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	Fee: $273.15 **Benefit:** 75% = $204.90 85% = $232.20 **Future End Date:**
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 **Fee:** $446.00 **Benefit:** 75% = $334.50 85% = $379.10 **Future End Date:**
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 **Fee:** $109.30 **Benefit:** 75% = $82.00 85% = $92.95 **Future End Date:**
71147	HLA-B27 typing (Item is subject to rule 27) (See para PN.1.2 of explanatory notes to this Category) **Fee:** $42.60 **Benefit:** 75% = $31.95 85% = $36.25 **Future End Date:**
71148	A test described in item 71147 if rendered by a receiving APP. (Item is subject to rule 18 and 27) **Fee:** $42.60 **Benefit:** 75% = $31.95 85% = $36.25 **Future End Date:**
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 **Fee:** $113.75 **Benefit:** 75% = $85.35 85% = $96.70 **Future End Date:**
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 **Fee:** $124.85 **Benefit:** 75% = $93.65 85% = $106.15 **Future End Date:**
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) **Fee:** $36.30 **Benefit:** 75% = $27.25 85% = $30.90 **Future End Date:**
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) **Fee:** $36.30 **Benefit:** 75% = $27.25 85% = $30.90 **Future End Date:**
71155	Detection of 2 antibodies described in item 71153

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	(Item is subject to rule 6 and 23) **Fee:** $49.85 **Benefit:** 75% = $37.40 85% = $42.40 **Future End Date:**
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) **Fee:** $13.50 **Benefit:** 75% = $10.15 85% = $11.50 **Future End Date:**
71157	Detection of 3 antibodies described in item 71153 (Item is subject to rule 6 and 23) **Fee:** $63.35 **Benefit:** 75% = $47.55 85% = $53.85 **Future End Date:**
71159	Detection of 4 or more antibodies described in item 71153 (Item is subject to rule 6 and 23) **Fee:** $76.85 **Benefit:** 75% = $57.65 85% = $65.35 **Future End Date:**
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 **Fee:** $26.00 **Benefit:** 75% = $19.50 85% = $22.10 **Future End Date:**
71164	Two or more tests described in 71163 and including a service described in 71066 (if performed) **Fee:** $41.90 **Benefit:** 75% = $31.45 85% = $35.65 **Future End Date:**
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) **Fee:** $36.30 **Benefit:** 75% = $27.25 85% = $30.90 **Future End Date:**
71166	Detection of 2 antibodies described in item 71165 (Item is subject to rule 6) **Fee:** $49.85 **Benefit:** 75% = $37.40 85% = $42.40

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	Future End Date:
71167	Detection of 3 antibodies described in item 71165 (Item is subject to rule 6) **Fee:** $63.35 **Benefit:** 75% = $47.55 85% = $53.85 **Future End Date:**
71168	Detection of 4 or more antibodies described in item 71165 (Item is subject to rule 6) **Fee:** $76.85 **Benefit:** 75% = $57.65 85% = $65.35 **Future End Date:**
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) **Fee:** $36.30 **Benefit:** 75% = $27.25 85% = $30.90 **Future End Date:**
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) **Fee:** $13.50 **Benefit:** 75% = $10.15 85% = $11.50 **Future End Date:**
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: a. suspected of having NMOSD or MARD; and b. with any of the following: i. recurrent, bilateral or severe optic neuritis; ii. recurrent longitudinal extensive transverse myelitis (LETM); iii. area postrema syndrome (unexplained hiccups, nausea or vomiting); iv. acute brainstem syndrome; v. symptomatic narcolepsy or acute diencephalic clinical syndrome with typical NMOSD magnetic resonance imaging lesions; vi. symptomatic cerebral syndrome with typical NMOSD magnetic resonance imaging lesions; vii. monophasic neuromyelitis optica (no recurrence, and simultaneous or closely related optic neuritis and LETM within 30 days of each other); viii. acute disseminated encephalomyelitis; ix. aseptic meningitis and encephalomyelitis; x. poor recovery from multiple sclerosis relapses Applicable not more than 4 times in 12 months **Fee:** $52.55 **Benefit:** 75% = $39.45 85% = $44.70 **Future End Date:**
71180	Antibody to cardiolipin or beta-2 glycoprotein I - detection, including quantitation if required; one antibody specificity (IgG or IgM) **Fee:** $36.30 **Benefit:** 75% = $27.25 85% = $30.90 **Future End Date:**

P4. IMMUNOLOGY	
71183	Detection of two antibodies described in item 71180 **Fee:** $49.85 **Benefit:** 75% = $37.40 85% = $42.40 **Future End Date:**
71186	Detection of three or more antibodies described in item 71180 **Fee:** $63.35 **Benefit:** 75% = $47.55 85% = $53.85 **Future End Date:**
71189	Detection of specific IgG antibodies to 1 or more respiratory disease allergens not elsewhere specified. **Fee:** $16.25 **Benefit:** 75% = $12.20 85% = $13.85 **Future End Date:**
71192	2 items described in item 71189. **Fee:** $29.80 **Benefit:** 75% = $22.35 85% = $25.35 **Future End Date:**
71195	3 or more items described in item 71189. **Fee:** $42.05 **Benefit:** 75% = $31.55 85% = $35.75 **Future End Date:**
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. **Fee:** $42.60 **Benefit:** 75% = $31.95 85% = $36.25 **Future End Date:**
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. **Fee:** $62.65 **Benefit:** 75% = $47.00 85% = $53.30 **Future End Date:**
71202	Measurable residual disease (MRD) testing by flow cytometry, performed on bone marrow from a patient diagnosed with acute lymphoblastic leukaemia, for the purpose of determining baseline MRD, or facilitating the determination of MRD following combination chemotherapy or after salvage therapy, requested by a specialist or consultant physician practising as a haematologist or oncologist (See para PN.0.35 of explanatory notes to this Category) **Fee:** $577.85 **Benefit:** 75% = $433.40 85% = $491.20 **Future End Date:**
71203	Determination of HLAB5701 status by flow cytometry or cytotoxity assay prior to the initiation of Abacavir therapy including item 73323 if performed. **Fee:** $42.60 **Benefit:** 75% = $31.95 85% = $36.25 **Future End Date:**

P5. TISSUE PATHOLOGY	
	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

P5. TISSUE PATHOLOGY	
	(Item is subject to rule 13) (See para PN.1.2, PN.0.32 of explanatory notes to this Category) **Fee:** $75.10 **Benefit:** 75% = $56.35 85% = $63.85 **Future End Date:**
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. **Fee:** $78.30 **Benefit:** 75% = $58.75 85% = $66.60 **Future End Date:**
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) (See para PN.0.32 of explanatory notes to this Category) **Fee:** $90.70 **Benefit:** 75% = $68.05 85% = $77.10 **Future End Date:**
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) (See para PN.0.32 of explanatory notes to this Category) **Fee:** $101.70 **Benefit:** 75% = $76.30 85% = $86.45 **Future End Date:**
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) (See para PN.0.32 of explanatory notes to this Category) **Fee:** $112.45 **Benefit:** 75% = $84.35 85% = $95.60 **Future End Date:**
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

P5. TISSUE PATHOLOGY	
	(Item is subject to rule 13) (See para PN.0.32 of explanatory notes to this Category) **Fee:** $102.10 **Benefit:** 75% = $76.60 85% = $86.80 **Future End Date:**
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) (See para PN.0.32 of explanatory notes to this Category) **Fee:** $148.50 **Benefit:** 75% = $111.40 85% = $126.25 **Future End Date:**
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) (See para PN.0.32 of explanatory notes to this Category) **Fee:** $189.40 **Benefit:** 75% = $142.05 85% = $161.00 **Future End Date:**
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) (See para PN.0.32 of explanatory notes to this Category) **Fee:** $204.45 **Benefit:** 75% = $153.35 85% = $173.80 **Future End Date:**
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) (See para PN.0.32 of explanatory notes to this Category) **Fee:** $219.50 **Benefit:** 75% = $164.65 85% = $186.60 **Future End Date:**
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) (See para PN.0.32 of explanatory notes to this Category)

P5. TISSUE PATHOLOGY	
	Fee: $234.60 **Benefit:** 75% = $175.95 85% = $199.45 **Future End Date:**
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) (See para PN.0.32 of explanatory notes to this Category) **Fee:** $288.05 **Benefit:** 75% = $216.05 85% = $244.85 **Future End Date:**
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) (See para PN.0.32 of explanatory notes to this Category) **Fee:** $438.30 **Benefit:** 75% = $328.75 85% = $372.60 **Future End Date:**
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) (See para PN.1.2, PN.0.32 of explanatory notes to this Category) **Fee:** $490.50 **Benefit:** 75% = $367.90 85% = $416.95 **Future End Date:**
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 **Fee:** $32.30 **Benefit:** 75% = $24.25 85% = $27.50 **Future End Date:**
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) (See para PN.1.2 of explanatory notes to this Category) **Fee:** $62.65 **Benefit:** 75% = $47.00 85% = $53.30 **Future End Date:**
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) (See para PN.1.2 of explanatory notes to this Category)

P5. TISSUE PATHOLOGY	
	Fee: $93.95 **Benefit:** 75% = $70.50 85% = $79.90 **Future End Date:**
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) (See para PN.1.2 of explanatory notes to this Category) **Fee:** $78.30 **Benefit:** 75% = $58.75 85% = $66.60 **Future End Date:**
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) (See para PN.1.2 of explanatory notes to this Category) **Fee:** $109.60 **Benefit:** 75% = $82.20 85% = $93.20 **Future End Date:**
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) (See para PN.1.2 of explanatory notes to this Category) **Fee:** $125.20 **Benefit:** 75% = $93.90 85% = $106.45 **Future End Date:**
72851	Electron microscopic examination of biopsy material - 1 separately identified specimen (Item is subject to rule 13) (See para PN.1.2 of explanatory notes to this Category) **Fee:** $593.60 **Benefit:** 75% = $445.20 85% = $504.60 **Future End Date:**
72852	Electron microscopic examination of biopsy material - 2 or more separately identified specimens (Item is subject to rule 13) (See para PN.1.2 of explanatory notes to this Category) **Fee:** $791.10 **Benefit:** 75% = $593.35 85% = $682.60 **Future End Date:**
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) **Fee:** $193.65 **Benefit:** 75% = $145.25 85% = $164.65 **Future End Date:**

P5. TISSUE PATHOLOGY	
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) **Fee:** $258.25 **Benefit:** 75% = $193.70 85% = $219.55 **Future End Date:**
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) **Fee:** $301.30 **Benefit:** 75% = $226.00 85% = $256.15 **Future End Date:**
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. (See para PN.0.33 of explanatory notes to this Category) **Fee:** $189.10 **Benefit:** 75% = $141.85 85% = $160.75 **Future End Date:**
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. (See para PN.0.33 of explanatory notes to this Category) **Fee:** $388.75 **Benefit:** 75% = $291.60 85% = $330.45 **Future End Date:**
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 (See para PN.1.2, PR.5.1 of explanatory notes to this Category) **Fee:** $89.30 **Benefit:** 75% = $67.00 85% = $75.95 **Future End Date:**

P6. CYTOLOGY	
	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 **Fee:** $24.00 **Benefit:** 75% = $18.00 85% = $20.40 **Future End Date:**
73045	Cytology (including serial examinations) for malignancy (other than an examination mentioned in item 73076); and including any Group P5 service, if performed on:

P6. CYTOLOGY	
	(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 (See para PN.1.2 of explanatory notes to this Category) **Fee:** $51.05 **Benefit:** 75% = $38.30 85% = $43.40 **Future End Date:**
73047	Cytology of a series of 3 sputum or urine specimens for malignant cells **Fee:** $99.45 **Benefit:** 75% = $74.60 85% = $84.55 **Future End Date:**
73049	Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues - 1 identified site **Fee:** $71.60 **Benefit:** 75% = $53.70 85% = $60.90 **Future End Date:**
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 (See para PN.1.2 of explanatory notes to this Category) **Fee:** $179.00 **Benefit:** 75% = $134.25 85% = $152.15 **Future End Date:**
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) (See para PN.1.2 of explanatory notes to this Category) **Fee:** $45.20 **Benefit:** 75% = $33.90 85% = $38.45 **Future End Date:**
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) (See para PN.1.2 of explanatory notes to this Category) **Fee:** $60.30 **Benefit:** 75% = $45.25 85% = $51.30 **Future End Date:**
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)

P6. CYTOLOGY	
	(Item is subject to rule 13) (See para PN.1.2 of explanatory notes to this Category) **Fee:** $53.80 **Benefit:** 75% = $40.35 85% = $45.75 **Future End Date:**
73062	Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues - 2 or more separately identified sites. **Fee:** $93.50 **Benefit:** 75% = $70.15 85% = $79.50 **Future End Date:**
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 **Fee:** $104.40 **Benefit:** 75% = $78.30 85% = $88.75 **Future End Date:**
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) **Fee:** $75.30 **Benefit:** 75% = $56.50 85% = $64.05 **Future End Date:**
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) **Fee:** $90.35 **Benefit:** 75% = $67.80 85% = $76.80 **Future End Date:**
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 **Fee:** $232.65 **Benefit:** 75% = $174.50 85% = $197.80 **Future End Date:**
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 **Fee:** $135.70 **Benefit:** 75% = $101.80 85% = $115.35 **Future End Date:**
73070	73070

P6. CYTOLOGY	
	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 (See para PN.1.1, PN.0.22 of explanatory notes to this Category) **Fee:** $36.80 **Benefit:** 75% = $27.60 85% = $31.30 **Future End Date:**
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 (See para PN.1.1, PN.0.22 of explanatory notes to this Category) **Fee:** $36.80 **Benefit:** 75% = $27.60 85% = $31.30 **Future End Date:**
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). (See para PN.0.22 of explanatory notes to this Category) **Fee:** $36.80 **Benefit:** 75% = $27.60 85% = $31.30 **Future End Date:**
73074	A test, including partial genotyping, for oncogenic human papillomavirus, for the investigation of a patient following a total hysterectomy. (See para PN.0.22 of explanatory notes to this Category) **Fee:** $36.80 **Benefit:** 75% = $27.60 85% = $31.30 **Future End Date:**

P6. CYTOLOGY	
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 (See para PN.1.1, PN.0.22 of explanatory notes to this Category) **Fee:** $36.80 **Benefit:** 75% = $27.60 85% = $31.30 **Future End Date:**
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 (See para PN.1.1, PN.0.22 of explanatory notes to this Category) **Fee:** $48.30 **Benefit:** 75% = $36.25 85% = $41.10 **Future End Date:**

P7. GENETICS	
	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 (See para PR.7.3 of explanatory notes to this Category) **Fee:** $394.55 **Benefit:** 75% = $295.95 85% = $335.40 **Future End Date:**
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 **Fee:** $358.95 **Benefit:** 75% = $269.25 85% = $305.15 **Future End Date:**
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. (See para PR.7.2 of explanatory notes to this Category) **Fee:** $394.55 **Benefit:** 75% = $295.95 85% = $335.40 **Future End Date:**
73291	Analysis of one or more chromosome regions for specific constitutional genetic abnormalities of blood or fresh tissue in

P7. GENETICS	
	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. **Fee:** $230.95 **Benefit:** 75% = $173.25 85% = $196.35 **Future End Date:**
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. **Fee:** $589.90 **Benefit:** 75% = $442.45 85% = $501.45 **Future End Date:**
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. **Fee:** $230.95 **Benefit:** 75% = $173.25 85% = $196.35 **Future End Date:**
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. **Fee:** $230.95 **Benefit:** 75% = $173.25 85% = $196.35 **Future End Date:**
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 (See para PN.0.23 of explanatory notes to this Category) **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1091.50 **Future End Date:**
73296	Characterisation of germline gene variants, including copy number variation where appropriate, requested by a specialist or consultant physician:

P7. GENETICS	
	(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 (See para PN.0.23 of explanatory notes to this Category) **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1091.50 **Future End Date:**
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 (See para PN.0.23 of explanatory notes to this Category) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
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. **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1091.50 **Future End Date:**
73299	Characterisation of germline gene variants:

P7. GENETICS	
	(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. **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
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 (See para PN.1.2, PN.7.16, PN.0.23 of explanatory notes to this Category) **Fee:** $101.30 **Benefit:** 75% = $76.00 85% = $86.15 **Future End Date:**
73301	A test of tumour tissue from a patient with advanced (FIGO III-IV), high grade serous or high grade epithelial ovarian, fallopian tube or primary peritoneal cancer, requested by a specialist or consultant physician, to determine eligibility relating to BRCA status for access to treatment with a poly (adenosine diphosphate [ADP]-ribose) polymerase (PARP) inhibitor under the Pharmaceutical Benefits Scheme (PBS) Applicable once per primary tumour diagnosis **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1091.50 **Future End Date:**
73302	Characterisation of germline gene variants including copy number variants, in BRCA1 or BRCA2 genes, in a patient who has had a pathogenic or likely pathogenic variant identified in either gene by tumour testing and who has not previously received a service to which items 73295, 73296 or 73297 applies, requested by a specialist or consultant physician. Applicable once per primary tumour diagnosis **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73303	A test of tumour tissue from a patient with metastatic castration-resistant prostate cancer, including subsequent characterisation of germline gene variants should tumour tissue testing undertaken during the same service be inconclusive, requested by a specialist or consultant physician, to determine eligibility relating to BRCA status for access to a relevant treatment under the Pharmaceutical Benefits Scheme;

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	Applicable once per primary tumour diagnosis **Fee:** $1,000.00 **Benefit:** 75% = $750.00 85% = $891.50 **Future End Date:**
73304	Detection of germline BRCA1 or BRCA2 pathogenic or likely pathogenic gene variants, in a patient with metastatic castration-resistant prostate cancer, for whom testing of tumour tissue is not clinically feasible, requested by a specialist or consultant physician, to determine eligibility for a relevant treatment under the Pharmaceutical Benefits Scheme; Applicable once per lifetime (See para PN.0.23 of explanatory notes to this Category) **Fee:** $1,000.00 **Benefit:** 75% = $750.00 85% = $891.50 **Future End Date:**
73305	Detection of mutation of the FMR1 gene by Southern Blot analysis where the results in item 73300 are inconclusive (See para PN.1.2, PN.7.16, PN.0.23 of explanatory notes to this Category) **Fee:** $202.65 **Benefit:** 75% = $152.00 85% = $172.30 **Future End Date:**
73306	Gene expression profiling testing using EndoPredict, for the purpose of profiling gene expression in formalin-fixed, paraffin-embedded primary breast cancer tissue from core needle biopsy or surgical tumour sample to estimate the risk of distant recurrence of breast cancer within 10 years, if: (a) the sample is from a new primary breast cancer, which is suitable for adjuvant chemotherapy; and (b) the sample has been determined to be oestrogen receptor positive and HER2 negative by IHC and ISH respectively on surgically removed tumour; and (c) the sample is axillary node negative or positive (up to 3 nodes) with a tumour size of at least 1 cm and no more than 5 cm determined by histopathology on surgically removed tumour; and (d) the sample has no evidence of distal metastasis; and (e) pre-testing of intermediate risk of distant metastases has shown that the tumour is defined by at least one of the following characteristics: (i) histopathological grade 2 or 3; (ii) one to 3 lymph nodes involved in metastatic disease (including micrometastases but not isolated tumour cells); and (f) the service is not administered for the purpose of altering treatment decisions Applicable once per new primary breast cancer diagnosis for any particular patient **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1091.50 **Future End Date:**
73307	A test of tumour tissue from a patient with advanced (FIGO III-IV), high-grade serous or other high-grade ovarian, fallopian tube or primary peritoneal carcinoma, requested by a specialist or consultant physician, if the test is: (a) to determine eligibility with respect to homologous recombination deficiency (HRD) status, including BRCA1 or BRCA2 status, to provide access to poly (adenosine diphosphate [ADP]-ribose) polymerase (PARP) inhibitor therapy under the Pharmaceutical Benefits Scheme; and

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	(b) including a service described in item 73301 Applicable once per primary tumour diagnosis (See para PN.7.19 of explanatory notes to this Category) **Fee:** $3,000.00 **Benefit:** 75% = $2250.00 85% = $2891.50 **Future End Date:**
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 **Fee:** $36.45 **Benefit:** 75% = $27.35 85% = $31.00 **Future End Date:**
73309	A test described in item 73308, if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $36.45 **Benefit:** 75% = $27.35 85% = $31.00 **Future End Date:**
73310	Measurable residual disease (MRD) testing by next-generation sequencing, performed on bone marrow (or a peripheral blood sample if bone marrow cannot be collected) from a patient diagnosed with acute lymphoblastic leukaemia, for the purpose of determining baseline MRD, or facilitating the determination of MRD following combination chemotherapy or after salvage therapy, requested by a specialist or consultant physician practising as a haematologist or oncologist (See para PN.0.35 of explanatory notes to this Category) **Fee:** $1,550.00 **Benefit:** 75% = $1162.50 85% = $1441.50 **Future End Date:**
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 **Fee:** $36.45 **Benefit:** 75% = $27.35 85% = $31.00 **Future End Date:**
73312	A test described in item 73311, if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $36.45 **Benefit:** 75% = $27.35 85% = $31.00 **Future End Date:**
73313	Development of a quantitative patient-specific molecular assay for measurable residual disease (MRD) testing performed on bone marrow (or a peripheral blood sample if bone marrow cannot be collected) from a patient diagnosed with acute lymphoblastic leukaemia treated with combination chemotherapy or after salvage therapy, including the first service described in item 73316 performed on that bone marrow or peripheral blood sample, requested by a specialist or consultant physician practising as a haematologist or oncologist Applicable once per patient per episode of disease or per relapse (See para PN.7.20 of explanatory notes to this Category) **Fee:** $3,000.00 **Benefit:** 75% = $2250.00 85% = $2891.50 **Future End Date:**
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:

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	(a) acute myeloid leukaemia; or (b) acute promyelocytic leukaemia; or (c) acute lymphoid leukaemia; or (d) chronic myeloid leukaemia; **Fee:** $230.95 **Benefit:** 75% = $173.25 85% = $196.35 **Future End Date:**
73315	A test described in item 73314, if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18) **Fee:** $230.95 **Benefit:** 75% = $173.25 85% = $196.35 **Future End Date:**
73316	Measurable residual disease (MRD) testing by a quantitative patient-specific molecular assay performed on bone marrow (or, in a patient with T-cell acute lymphoblastic leukaemia, performed on a peripheral blood sample if bone marrow cannot be collected) from a patient diagnosed with acute lymphoblastic leukaemia treated with combination chemotherapy or after salvage therapy, requested by a specialist or consultant physician practising as a haematologist or oncologist, other than a service associated with a service to which item 73313 applies (See para PN.7.20 of explanatory notes to this Category) **Fee:** $780.00 **Benefit:** 75% = $585.00 85% = $671.50 **Future End Date:**
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) **Fee:** $36.45 **Benefit:** 75% = $27.35 85% = $31.00 **Future End Date:**
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) **Fee:** $36.45 **Benefit:** 75% = $27.35 85% = $31.00 **Future End Date:**
73319	Detection in tumour tissue of isocitrate dehydrogenase 1 (IDH1) variant status, in a patient with histologically confirmed cholangiocarcinoma, to determine eligibility for a relevant treatment listed under the Pharmaceutical Benefits Scheme. Applicable only once per lifetime (See para PN.1.2 of explanatory notes to this Category) **Fee:** $340.00 **Benefit:** 75% = $255.00 85% = $289.00 **Future End Date:**

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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) (See para PN.1.2 of explanatory notes to this Category) **Fee:** $40.55 **Benefit:** 75% = $30.45 85% = $34.50 **Future End Date:**
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) **Fee:** $40.55 **Benefit:** 75% = $30.45 85% = $34.50 **Future End Date:**
73322	Genetic testing in the DPYD gene to diagnose or predict fluoropyrimidine-induced toxicity in a patient, if: (a) the service is requested by a specialist or consultant physician; and (b) the service is rendered before, during or after systemic administration of chemotherapy or radio-sensitisation, with a fluoropyrimidine, to the patient; and (c) genotyping is performed to detect DPYD variants linked to reduced or absent dihydropyrimidine dehydrogenase activity Applicable once per lifetime (See para PN.7.22 of explanatory notes to this Category) **Fee:** $186.75 **Benefit:** 75% = $140.10 85% = $158.75 **Future End Date:**
73323	Determination of HLAB5701 status by molecular techniques prior to the initiation of Abacavir therapy including item 71203 if performed. **Fee:** $40.55 **Benefit:** 75% = $30.45 85% = $34.50 **Future End Date:**
73324	A test described in item 73323 if rendered by a receiving APP 1 or more tests (Item is subject to Rule 18) **Fee:** $40.95 **Benefit:** 75% = $30.75 85% = $34.85 **Future End Date:**
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 **Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50 **Future End Date:**
73326	Characterisation of the gene rearrangement FIP1L1-PDGFRA in the diagnostic work-up and management of a patient with laboratory evidence of:

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	a) mast cell disease; or b) idiopathic hypereosinophilic syndrome; or c) chronic eosinophilic leukaemia;. 1 or more tests **Fee:** $230.95 **Benefit:** 75% = $173.25 85% = $196.35 **Future End Date:**
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 **Fee:** $51.95 **Benefit:** 75% = $39.00 85% = $44.20 **Future End Date:**
73329	A nucleic acid-based multi-gene panel test of tumour tissue from a patient with cholangiocarcinoma requested by, or on behalf of, a specialist or consultant physician, if the test is to: (a) detect at least IDH1 variant status, and (b) detect the fusion or rearrangement status of at least FGFR2; and (c) determine eligibility for a relevant treatment under the Pharmaceutical Benefits Scheme including a service described in item 73319. Applicable once per lifetime. (See para PN.1.2 of explanatory notes to this Category) **Fee:** $800.00 **Benefit:** 75% = $600.00 85% = $691.50 **Future End Date:**
73331	A test of tumour tissue from a patient with histologically confirmed medullary thyroid cancer requested by, or on behalf of, a specialist or consultant physician if the test is: (a) to detect variants relating to at least the *RET* gene activating variant status, and (b) to determine eligibility for a relevant treatment listed on the Pharmaceutical Benefits Scheme **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
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. (See para PN.1.2 of explanatory notes to this Category) **Fee:** $315.40 **Benefit:** 75% = $236.55 85% = $268.10 **Future End Date:**

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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 (See para PN.0.23 of explanatory notes to this Category) **Fee:** $600.00 **Benefit:** 75% = $450.00 85% = $510.00 **Future End Date:**
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 (See para PN.0.23 of explanatory notes to this Category) **Fee:** $340.00 **Benefit:** 75% = $255.00 85% = $289.00 **Future End Date:**
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

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	(C) the pancreas; or (D) the epididymis; and (b) no germline mutations of the VHL gene identified by genetic testing **Fee:** $470.00 **Benefit:** 75% = $352.50 85% = $399.50 **Future End Date:**
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. (See para PN.1.2 of explanatory notes to this Category) **Fee:** $230.95 **Benefit:** 75% = $173.25 85% = $196.35 **Future End Date:**
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 (See para PN.1.2, PN.7.15 of explanatory notes to this Category) **Fee:** $397.35 **Benefit:** 75% = $298.05 85% = $337.75 **Future End Date:**
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: i. the test is conducted for all clinically relevant mutations on KRAS exons 2, 3 and 4 and NRAS exons 2, 3, and 4; or ii. 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. (See para PN.0.26 of explanatory notes to this Category) **Fee:** $362.60 **Benefit:** 75% = $271.95 85% = $308.25 **Future End Date:**
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) (See para PN.0.23 of explanatory notes to this Category) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**

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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) (See para PN.0.23 of explanatory notes to this Category) **Fee:** $200.00 **Benefit:** 75% = $150.00 85% = $170.00 **Future End Date:**
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 (See para PN.7.15 of explanatory notes to this Category) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
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. **Fee:** $315.40 **Benefit:** 75% = $236.55 85% = $268.10 **Future End Date:**
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 **Fee:** $589.90 **Benefit:** 75% = $442.45 85% = $501.45 **Future End Date:**
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

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	(See para PN.1.2, PN.7.15 of explanatory notes to this Category) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
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. (See para PN.7.3, PN.7.16 of explanatory notes to this Category) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00 **Future End Date:**
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. (See para PN.7.3, PN.7.16 of explanatory notes to this Category) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00 **Future End Date:**
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. (See para PN.7.3, PN.7.16 of explanatory notes to this Category) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00 **Future End Date:**
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). (See para PN.7.3, PN.7.16 of explanatory notes to this Category) **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50 **Future End Date:**
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

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	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. (See para PN.7.3, PN.7.16 of explanatory notes to this Category) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00 **Future End Date:**
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. (See para PN.7.3, PN.7.16 of explanatory notes to this Category) **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50 **Future End Date:**
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. **Fee:** $397.35 **Benefit:** 75% = $298.05 85% = $337.75 **Future End Date:**
73352	Characterisation of germline variants causing familial hypercholesterolaemia (which must include the LDLR, PCSK9 and APOB genes), requested by a specialist or consultant physician, for a patient: (a) for whom no familial mutation has been identified; and (b) who has any of the following: (i) a Dutch Lipid Clinic Network score of at least 6; (ii) an LDL-cholesterol level of at least 6.5 mmol/L in the absence of secondary causes; (iii) an LDL-cholesterol level of between 5.0 and 6.5 mmol/L with signs of premature or accelerated atherogenesis Applicable only once per lifetime **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1091.50 **Future End Date:**
73353	Detection of a familial mutation for a patient who has a first- or second-degree relative with a documented pathogenic germline gene variant for familial hypercholesterolaemia

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	Applicable only once per lifetime **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73354	Characterisation of germline gene variants, including copy number variation, in the MLH1, MSH2, MSH6, PMS2 and EPCAM genes, requested by a specialist or consultant physician, for: (a) a patient with suspected Lynch syndrome following immunohistochemical examination of neoplastic tissue that has demonstrated loss of expression of one or more mismatch repair proteins; or (b) a patient: (i) who has endometrial cancer; and (ii) who is assessed by the specialist or consultant physician as being at a risk of more than 10% of having Lynch syndrome, on the basis of clinical and family history criteria **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1091.50 **Future End Date:**
73355	Characterisation of germline gene variants, including copy number variation, in the APC and MUTYH genes, requested by a specialist or consultant physician, for a patient: (a) who has adenomatous polyposis; and (b) who is assessed by the specialist or consultant physician as being at a risk of more than 10% of having either of the following, on the basis of clinical and family history criteria: (i) familial adenomatous polyposis; (ii) MUTYH-associated polyposis **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1091.50 **Future End Date:**
73356	Characterisation of germline gene variants, including copy number variation, in the SMAD4, BMPR1A, STK11 and GREM1 genes, requested by a specialist or consultant physician, for a patient: (a) who has non-adenomatous polyposis; and (b) who is assessed by the specialist or consultant physician as being at a risk of more than 10% of having any of the following, on the basis of clinical and family history criteria: (i) juvenile polyposis syndrome; (ii) Peutz-Jeghers syndrome; (iii) hereditary mixed polyposis syndrome **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1091.50 **Future End Date:**
73357	Characterisation of germline gene variants, including copy number variation, in the genes mentioned in item 73354, 73355 or 73356, requested by a specialist or consultant physician, for a patient: (a) who has a biological relative with a pathogenic mutation identified in one or more of those genes; and

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	(b) who has not previously received a service to which any of items 73354, 73355 and 73356 apply **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
Amend 73358	Characterisation, via whole exome or genome sequencing and analysis, of germline variants known to cause monogenic disorders, if: (a) the characterisation is: (i) requested by a consultant physician practising as a clinical geneticist; or (ii) requested by a consultant physician practising as a specialist paediatrician; and (b) the patient is aged 10 years or younger and is strongly suspected of having a monogenic condition, based on the presence of: (i) dysmorphic facial appearance and one or more major structural congenital anomalies; or (ii) intellectual disability or global developmental delay of at least moderate severity, as determined by a specialist paediatrician; and (c) the characterisation is performed following the performance for the patient of a service to which item 73292 applies for which the results were non-informative; and (d) the characterisation is not performed in conjunction with a service to which item 73359 applies Applicable only once per lifetime (See para PN.7.4 of explanatory notes to this Category) **Fee:** $2,100.00 **Benefit:** 75% = $1575.00 85% = $1991.50 **Future End Date:**
Amend 73359	Characterisation, via whole exome or genome sequencing and analysis, of germline variants known to cause monogenic disorders, if: (a) the characterisation is: (i) requested by a consultant physician practising as a clinical geneticist; or (ii) requested by a consultant physician practising as a specialist paediatrician; and (b) the request for the characterisation states that singleton testing is inappropriate; and (c) the patient is aged 10 years or younger and is strongly suspected of having a monogenic condition, based on the presence of: (i) dysmorphic facial appearance and one or more major structural congenital anomalies; or (ii) intellectual disability or global developmental delay of at least moderate severity, as determined by a specialist paediatrician; and

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	(d) the characterisation is performed following the performance for the patient of a service to which item 73292 applies for which the results were non-informative; and (e) the characterisation is performed using a sample from the patient and a sample from each of the patient's biological parents; and (f) the characterisation is not performed in conjunction with a service to which item 73358 applies Applicable only once per lifetime (See para PN.7.4 of explanatory notes to this Category) **Fee:** $2,900.00 **Benefit:** 75% = $2175.00 85% = $2791.50 **Future End Date:**
Amend 73360	Re-analysis of whole exome or genome data obtained in performing a service to which item 73358 or 73359 applies, for characterisation of previously unreported germline gene variants related to the clinical phenotype, if: (a) the re-analysis is: (i) requested by a consultant physician practising as a clinical geneticist; or (ii) requested by a consultant physician practising as a specialist paediatrician; and (b) the patient is aged 15 years or younger and is strongly suspected of having a monogenic condition; and (c) the re-analysis is performed at least 18 months after: (i) a service to which item 73358 or 73359 applies; or (ii) a service to which this item applies Applicable only twice per lifetime **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00 **Future End Date:**
73361	Testing of a person (the person tested) for the detection of a single gene variant for diagnostic purposes, if: a. the person tested has a biological sibling (the sibling) with a known monogenic condition; and b. a service described in item 73358, 73359 or 73360 has identified the causative variant for the sibling's condition; and c. the results of the testing performed for the sibling are made available for the purpose of providing the detection for the person tested; and d. the detection is: i. requested by a consultant physician practising as a clinical geneticist; or ii. requested by a consultant physician practising as a specialist paediatrician, following consultation with a clinical geneticist; and e. the detection is not performed in conjunction with a service to which item 73362 or 73363 applies

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	Applicable only once per variant per lifetime **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73362	Testing of a person (the person tested) for the detection of a single gene variant for the purpose of reproductive decision making, if: a. the person tested has a first-degree relative (the relative) with a known monogenic condition; and b. a service described in item 73358, 73359 or 73360 has identified the causative variant for the relative's condition; and c. the results of the testing performed for the relative are made available for the purpose of providing the detection for the person tested; and d. the detection is requested by a consultant physician or specialist; and e. the detection is not performed in conjunction with item 73359, 73361 or 73363 Applicable only once per variant per lifetime **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73363	Testing of a person (the person tested) for the detection of a single gene variant for segregation analysis in relation to another person (the patient), if: a. the patient has a known phenotype of a suspected monogenic condition; and b. a service described in item 73358 or 73360 has identified a potentially causative variant for the patient; and c. the person tested is a biological parent or other biological relative of the patient; and d. a sample from the person tested has not previously been tested in relation to the patient for a service to which item 73359 applies; and e. the results of the testing of the person tested for this service are made available for the purpose of providing the detection for the patient; and f. the detection is: i. requested by a consultant physician practising as a clinical geneticist; or ii. requested by a consultant physician practising as a specialist paediatrician, following consultation with a clinical geneticist; and g. the detection is not performed in conjunction with item 73361 or 73362 Applicable only once per variant per lifetime **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73364	Analysis of tumour tissue, requested by a specialist or consultant physician, that: (a) is for: (i) the characterisation of MYC gene rearrangement; and (ii) if the results of the characterisation mentioned in subparagraph (i) are positive—the characterisation of either or both of BCL2 gene rearrangement and BCL6 gene rearrangement; and (b) is for a patient: (i) for whom MYC immunohistochemistry is non-negative; and

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	(ii) with clinical or laboratory evidence, including morphological features, of diffuse large B-cell lymphoma or high grade B-cell lymphoma; and (c) is not performed in conjunction with item 73365 Applicable only once per lifetime (See para PN.1.2 of explanatory notes to this Category) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73365	Analysis of tumour tissue, requested by a specialist or consultant physician, that: (a) is for the characterisation of MYC gene rearrangement; and (b) is for a patient with clinical or laboratory evidence, including morphological features, of Burkitt lymphoma; and (c) is not performed in conjunction with item 73364 Applicable only once per lifetime **Fee:** $340.00 **Benefit:** 75% = $255.00 85% = $289.00 **Future End Date:**
73366	Analysis of tumour tissue, requested by a specialist or consultant physician, that: (a) is for the characterisation of either or both of the following: (i) CCND1 gene rearrangement; (ii) CCND2 gene rearrangement; and (b) is for a patient with clinical or laboratory evidence, including morphological features, of mantle cell lymphoma Applicable only once per lifetime **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73367	Analysis of tumour tissue, requested by a specialist or consultant physician, that: (a) is for the presence of isochromosome 7q; and (b) is for a patient with clinical or laboratory evidence, including morphological features, of hepatosplenic T-cell lymphoma Applicable only once per lifetime **Fee:** $340.00 **Benefit:** 75% = $255.00 85% = $289.00 **Future End Date:**
73368	Analysis of tumour tissue, requested by a specialist or consultant physician, that: (a) is for the characterisation of either or both of the following: (i) DUSP22 gene rearrangement; (ii) TP63 gene rearrangement; and

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	(b) is for a patient with clinical or laboratory evidence, including morphological features, of ALK negative anaplastic large cell lymphoma Applicable only once per lifetime **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73369	Analysis of blood or bone marrow, requested by a specialist or consultant physician, that: (a) is for the characterisation of either or both of the following: (i) TCL1A gene rearrangement; (ii) MTCP1 gene rearrangement; and (b) is for a patient with clinical or laboratory evidence, including morphological features, of T-cell prolymphocytic leukaemia Applicable only once per lifetime **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73370	Analysis of blood or bone marrow, requested by a specialist or consultant physician, that: (a) is for the characterisation of the following: (i) chromosome translocations t(4;14), t(14;16), t(14;20); (ii) 1q gain; (iii) 17p deletion; and (b) is for a patient with clinical or laboratory evidence, including morphological features, of plasma cell myeloma Applicable only once per lifetime **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00 **Future End Date:**
73371	Analysis of tumour tissue, requested by a specialist or consultant physician, that: (a) is for the detection of chromosome 1p/19q co-deletion; and (b) is for a patient with clinical or laboratory evidence, including morphological features, of glial neoplasm with probable oligodendroglial component Applicable only once per lifetime **Fee:** $340.00 **Benefit:** 75% = $255.00 85% = $289.00 **Future End Date:**
73372	Analysis of tumour tissue, requested by a specialist or consultant physician, that: (a) is for the identification of IDH1/2 pathological variant status; and (b) is for a patient with:

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	(i) negative IDH1 (R132H) immunohistochemistry; and (ii) clinical or laboratory evidence, including morphological features, of glial neoplasm Applicable only once per lifetime **Fee:** $340.00 **Benefit:** 75% = $255.00 85% = $289.00 **Future End Date:**
73373	Analysis of tumour tissue, requested by a specialist or consultant physician, that: (a) is for the characterisation of MGMT promoter methylation status; and (b) is for a patient with clinical or laboratory evidence, including morphological features, of glioblastoma Applicable only once per lifetime **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73374	Analysis of tumour tissue, requested by a specialist or consultant physician, that: (a) is for the characterisation of copy number changes, gene rearrangements, or other molecular changes in genes associated with sarcoma; and (b) is for a patient with clinical or laboratory evidence, including morphological features, of sarcoma— analysis in relation to only one gene Applicable once per tumour diagnostic episode **Fee:** $340.00 **Benefit:** 75% = $255.00 85% = $289.00 **Future End Date:**
73375	An analysis described in item 73374—analysis in relation to only 2 or 3 genes Applicable once per tumour diagnostic episode **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73376	An analysis described in item 73374—analysis in relation to 4 or more genes Applicable once per tumour diagnostic episode **Fee:** $800.00 **Benefit:** 75% = $600.00 85% = $691.50 **Future End Date:**
73377	Analysis of tumour tissue, requested by a specialist or consultant physician, that: (a) is for the detection of FOXL2.402C>G status; and (b) is for a patient with clinical or laboratory evidence, including morphological features, of granulosa cell ovarian tumour Applicable only once per lifetime **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50 **Future End Date:**

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73378	Analysis of tumour tissue, requested by a specialist or consultant physician, that: (a) is for the characterisation of NUTM1 gene status at 15q14; and (b) is for a patient with clinical or laboratory evidence, including morphological features, of midline NUT carcinoma Applicable only once per lifetime **Fee:** $340.00 **Benefit:** 75% = $255.00 85% = $289.00 **Future End Date:**
73379	Analysis of tumour tissue, requested by a specialist or consultant physician, that: (a) is for the characterisation of ETV6-NTRK3 gene rearrangement; and (b) is for a patient with clinical or laboratory evidence, including morphological features, of secretory carcinoma of the breast Applicable only once per lifetime **Fee:** $340.00 **Benefit:** 75% = $255.00 85% = $289.00 **Future End Date:**
73380	Analysis of tumour tissue, requested by a specialist or consultant physician, that: (a) is for the characterisation of MAML2 gene rearrangement; and (b) is for a patient with clinical or laboratory evidence, including morphological features, of mucoepidermoid carcinoma Applicable only once per lifetime **Fee:** $340.00 **Benefit:** 75% = $255.00 85% = $289.00 **Future End Date:**
73381	Analysis of tumour tissue, requested by a specialist or consultant physician, that: (a) is for the characterisation of ETV6-NTRK3 gene rearrangement; and (b) is for a patient with clinical or laboratory evidence, including morphological features, of mammary analogue secretory carcinoma of the salivary gland Applicable only once per lifetime **Fee:** $340.00 **Benefit:** 75% = $255.00 85% = $289.00 **Future End Date:**
73382	Analysis of tumour tissue, requested by a specialist or consultant physician, that: (a) is for the characterisation of EWSR1 gene rearrangement, with or without PLAG1 gene rearrangement; and (b) is for a patient with clinical or laboratory evidence, including morphological features, of hyalinising clear cell carcinoma of the salivary gland Applicable only once per lifetime **Fee:** $340.00 **Benefit:** 75% = $255.00 85% = $289.00 **Future End Date:**

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73383	Analysis of tumour tissue, requested by a specialist or consultant physician, that: (a) is for the characterisation of either or both of the following: (i) TFE3 gene rearrangement; (ii) TFEB gene rearrangement; and (b) is for a patient with clinical or laboratory evidence, including morphological features, of renal cell carcinoma Applicable only once per lifetime (See para PN.1.2 of explanatory notes to this Category) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73384	Genetic analysis, for a patient who is eligible for this service under clause 2.7.3A of the pathology services table (see PR.7.1), of samples from the patient and (if relevant) the patient's reproductive partner, for the purpose of providing an assay for pre-implantation genetic testing, requested by a specialist or consultant physician Applicable not more than once per patient episode per disorder (of a kind described in clause 2.7.3A (PR.7.1)) per reproductive relationship (See para TN.1.4, PR.7.1 of explanatory notes to this Category) **Fee:** $1,736.00 **Benefit:** 75% = $1302.00 85% = $1627.50 **Future End Date:**
73385	Genetic analysis, for a patient who is eligible for this service under clause 2.7.3A of the Pathology Services Table (see PR.7.1), of embryonic tissue from a sample from one embryo, if: (a) the analysis is: (i) requested by a specialist or consultant physician; and (ii) for the purpose of providing a pre-implantation genetic test; and (iii) performed on an embryo that was produced in a single assisted reproductive treatment cycle; and (b) the service is not a service to which item 73386 or 73387 applies for the same assisted reproductive treatment cycle Applicable not more than once per embryo (See para TN.1.4, PR.7.1 of explanatory notes to this Category) **Fee:** $635.00 **Benefit:** 75% = $476.25 85% = $539.75 **Future End Date:**
73386	Genetic analysis, for a patient who is eligible for this service under clause 2.7.3A of the Pathology Services Table (see PR.7.1), of embryonic tissue from samples from 2 embryos, if: (a) the analysis is: (i) requested by a specialist or consultant physician; and (ii) for the purpose of providing a pre-implantation genetic test; and

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	(iii) performed on embryos that were produced in a single assisted reproductive treatment cycle; and (b) the service is not a service to which item 73385 or 73387 applies for the same assisted reproductive treatment cycle Applicable not more than once per assisted reproductive treatment cycle for the 2 embryos tested (See para TN.1.4, PR.7.1 of explanatory notes to this Category) **Fee:** $1,270.00 **Benefit:** 75% = $952.50 85% = $1161.50 **Future End Date:**
73387	Genetic analysis, for a patient who is eligible for this service under clause 2.7.3A of the Pathology Services Table (see PR.7.1), of embryonic tissue from samples from 3 or more embryos, if: (a) the analysis is: (i) requested by a specialist or consultant physician; and (ii) for the purpose of providing a pre-implantation genetic test; and (iii) performed on embryos that were produced in a single assisted reproductive treatment cycle; and (b) the service is not a service to which item 73385 or 73386 applies for the same assisted reproductive treatment cycle Applicable not more than once per assisted reproductive treatment cycle for the 3 or more embryos tested (See para TN.1.4, PR.7.1 of explanatory notes to this Category) **Fee:** $1,905.00 **Benefit:** 75% = $1428.75 85% = $1796.50 **Future End Date:**
73388	Analysis of chromosomes by genome-wide microarray, of a sample from amniocentesis or chorionic villus sampling, including targeted assessment of specific regions for constitutional genetic abnormalities in diagnostic studies of a fetus, if a. one or more major fetal structural abnormalities have been detected on ultrasound; or b. nuchal translucency was greater than 3.5 mm Applicable only once per fetus (See para PR.7.3 of explanatory notes to this Category) **Fee:** $589.90 **Benefit:** 75% = $442.45 85% = $501.45 **Future End Date:**
73389	Analysis of products of conception from a patient with suspected hydatidiform mole for the characterisation of ploidy status Applicable once per pregnancy (See para PN.1.2 of explanatory notes to this Category) **Fee:** $340.00 **Benefit:** 75% = $255.00 85% = $289.00 **Future End Date:**

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73391	Analysis of chromosomes by genome-wide microarray in diagnostic studies of a patient with multiple myeloma Applicable once per lifetime (See para PR.7.2 of explanatory notes to this Category) **Fee:** $589.90 **Benefit:** 75% = $442.45 85% = $501.45 **Future End Date:**
73392	Characterisation of pathogenic or likely pathogenic germline gene variants, requested by a specialist or consultant physician: (a) in at least the following genes: (i) MYBPC3; (ii) MYH7; (iii) TNNI3; (iv) TNNT2; (v) TPM1; (vi) ACTC1; (vii) MYL2; (viii) MYL3; (ix) PRKAG2; (x) LAMP2; (xi) GLA; (xii) LMNA; (xiii) SCN5A; (xiv) TTN; (xv) RBM20; (xvi) PLN; (xvii) DSP; (xviii) DSC2; (xix) DSG2; (xx) JUP; (xxi) PKP2;

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	(xxii) TMEM43; and (b) for a patient for whom clinical history, family history or laboratory findings suggest there is a high probability of one or more of the following heritable cardiomyopathies in the patient: (i) hypertrophic cardiomyopathy; (ii) dilated cardiomyopathy; (iii) arrhythmogenic cardiomyopathy Applicable once per lifetime (See para PN.0.23, PN.0.27 of explanatory notes to this Category) **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1091.50 **Future End Date:**
73393	Characterisation of one or more pathogenic or likely pathogenic germline gene variants, requested by a specialist or consultant physician, if: (a) a service described in item 73392 has not previously been performed for the patient; and (b) the patient is a first-degree biological relative (or a second-degree biological relative if a first-degree biological relative is unavailable) of a person who has a pathogenic or likely pathogenic germline gene variant that is confirmed by laboratory findings; and (c) the service is performed for the purpose of assessing present or future risk of any of the following heritable cardiomyopathies in the patient: (i) hypertrophic cardiomyopathy; (ii) dilated cardiomyopathy; (iii) arrhythmogenic cardiomyopathy Applicable once per variant per lifetime (See para PN.0.23 of explanatory notes to this Category) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73394	Characterisation of one or more recessive pathogenic or likely pathogenic germline genes, requested by a specialist or consultant physician, for the purpose of determining the reproductive risk of heritable cardiomyopathy in a patient: (a) who is a reproductive partner of a known carrier of a pathogenic or likely pathogenic germline gene that is confirmed by laboratory findings ; and (b) for whom carrier status of a pathogenic or likely pathogenic germline gene is unknown; and (c) who has a clinical history, family history or laboratory findings suggesting there is a low probability of heritable cardiomyopathy Applicable once per gene per lifetime (See para PN.0.23 of explanatory notes to this Category) **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1091.50 **Future End Date:**

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73395	Re-analysis of whole exome or genome data that is obtained in performing a service to which item 73392 applies, for characterisation of previously unreported germline gene variants related to the clinical phenotype, if: (a) the re-analysis is requested by a consultant physician practising as a clinical geneticist or a cardiologist; and (b) the patient is strongly suspected of having a heritable cardiomyopathy; and (c) the re-analysis is performed at least 18 months after a service to which item 73392 or this item applies is performed for the patient Applicable twice per lifetime (See para PN.0.23 of explanatory notes to this Category) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00 **Future End Date:**
73396	Characterisation of variants in the JAK2 exon 12 in the diagnostic work-up of a patient with clinical and laboratory evidence of polycythaemia vera, requested by a specialist or consultant physician **Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50 **Future End Date:**
73397	Characterisation of variants in both the CALR and MPL genes in the diagnostic work-up of a patient with clinical and laboratory evidence of essential thrombocythaemia or primary myelofibrosis, requested by a specialist or consultant physician **Fee:** $200.00 **Benefit:** 75% = $150.00 85% = $170.00 **Future End Date:**
73398	Characterisation of variants in at least 8 genes, which must include all of the following genes: (a) JAK2 (including exons 12 and 14); (b) CALR; (c) MPL; in the diagnostic work-up of a patient with clinical and laboratory evidence of polycythaemia vera or essential thrombocythaemia, requested by a specialist or consultant physician Applicable to one test per diagnostic episode **Fee:** $420.00 **Benefit:** 75% = $315.00 85% = $357.00 **Future End Date:**
73399	Characterisation of variants in at least 20 genes, which must include all of the following genes: (a) JAK2 (including exons 12 and 14); (b) CALR; (c) MPL; in the diagnostic work-up of a patient, with clinical and laboratory evidence of primary myelofibrosis, who is eligible for a stem cell transplant, requested by a specialist or consultant physician Applicable to one test per diagnostic episode **Fee:** $700.00 **Benefit:** 75% = $525.00 85% = $595.00

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	Future End Date:
73400	Genetic testing for at least 2 HLA variants to predict the patient's risk of a severe drug hypersensitivity reaction to carbamazepine or oxcarbazepine, if the service is conducted before or during the initiation of treatment with carbamazepine or oxcarbazepine Applicable once per lifetime (See para PN.7.23 of explanatory notes to this Category) **Fee:** $139.00 **Benefit:** 75% = $104.25 85% = $118.15 **Future End Date:**
73401	Characterisation, by whole exome or genome sequencing and analysis, of germline gene variants in one or more of the genes implicated in heritable cystic kidney disease, if: (a) the service is requested by a consultant physician practising as: (i) a clinical geneticist; or (ii) a specialist nephrologist; and (b) the patient has a renal abnormality and is strongly suspected of having a monogenic condition Applicable once per lifetime **Fee:** $2,100.00 **Benefit:** 75% = $1575.00 85% = $1991.50 **Future End Date:**
73402	Characterisation, by whole exome or genome sequencing and analysis, of germline gene variants in one or more of the genes implicated in heritable kidney disease, if: (a) the service is requested by a consultant physician practising as: (i) a clinical geneticist; or (ii) a specialist nephrologist; and (b) the patient has chronic kidney disease (other than cystic disease or Alport syndrome) and is strongly suspected of having a monogenic condition Applicable once per lifetime **Fee:** $2,100.00 **Benefit:** 75% = $1575.00 85% = $1991.50 **Future End Date:**
73403	Re-analysis of genetic data obtained in performing a service to which item 73401 or 73402 applies, for characterisation of previously unreported germline gene variants related to the clinical phenotype, if: (a) the re-analysis is requested by a consultant physician practising as a clinical geneticist or a specialist paediatrician; and (b) the patient has a strong clinical suspicion of a monogenic condition; and (c) a service to which item 73401, 73402 or this item applies has not been performed for the patient in the previous 18 months Applicable twice per lifetime **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00 **Future End Date:**

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73404	Detection of a single gene variant in a patient, if: (a) the service is requested by: (i) a clinical geneticist; or (ii) a specialist or consultant physician providing professional genetic counselling services; and (b) the patient has a first-degree relative with a known monogenic cause of kidney disease; and (c) a service described in item 73401, 73402, or 73403 has identified the causative variant for the disease for the relative Applicable once per variant per lifetime **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73405	Detection of one or more variants of a single gene known to cause heritable kidney disease, for the purpose of reproductive decision making, if: (a) the detection is requested by a consultant physician practising as: (i) a clinical geneticist; or (ii) a specialist nephrologist; and (b) the patient is the reproductive partner of an individual known to be a carrier of a pathogenic variant that causes heritable kidney disease that has a recessive mode of inheritance; and (c) a service described in item 73401, 73402, 73403 or 73404 has identified the causative gene for the patient's partner; and (d) the detection test methodology has sufficient diagnostic range and sensitivity to detect at least 95% of pathogenic variants likely to be present in the patient **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1091.50 **Future End Date:**
73406	Testing of a pregnant patient, for the purpose of determining whether monogenic variants are present in the fetus, if: (a) the service is requested by a consultant physician practising as: (i) a clinical geneticist; or (ii) a specialist nephrologist; and (b) the patient or the patient's reproductive partner (or both) are known to be affected by, or are carriers of, a known pathogenic variant that causes heritable kidney disease; and (c) the fetus is at risk, of at least 25%, of inheriting a monogenic variant known to cause kidney disease **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73410	Deletion testing of HBA1 and HBA2 for:

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	(a) the diagnosis of alpha thalassaemia in a patient of reproductive age: (i) who has abnormal red cell indices; and (ii) for whom thalassaemia screening was suggestive of thalassaemia; and (iii) who does not have a concurrent iron deficiency (or who, irrespective of iron status, is pregnant); and (iv) who has no historic normal cell indices; or (b) the determination of carrier status in a person: (i) who is a reproductive partner of a person with alpha thalassaemia; and (ii) who has abnormal red cell indices; and (iii) who does not have a concurrent iron deficiency; or (c) the determination of carrier status in a person: (i) who is a reproductive partner of a person with alpha thalassaemia and heterozygous 2-gene deletion; and (ii) who has normal red cell indices (See para PN.1.2, PN.7.5 of explanatory notes to this Category) **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00 **Future End Date:**
73411	Sequencing of HBA1 or HBA2, if the results of deletion testing described in item 73410 were inconclusive and a less common or rare variant is suspected, either: (a) for the diagnosis of alpha thalassaemia in a patient of reproductive age; or (b) for the determination of carrier status in a reproductive partner of a person with alpha thalassaemia Applicable once per gene per lifetime (See para PN.1.2 of explanatory notes to this Category) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73412	Deletion testing of HBA1 and HBA2, if the results of deletion testing described in item 73410 were inconclusive and a large deletion variant is suspected, either: (a) for the diagnosis of alpha thalassaemia in a patient of reproductive age; or (b) for the determination of carrier status in a reproductive partner of a person with alpha thalassaemia (See para PN.1.2 of explanatory notes to this Category) **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50 **Future End Date:**
73413	Non-deletion testing of HBA1 and HBA2 using techniques other than sequencing, if the results of deletion testing described in item 73410 were inconclusive, either:

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	(a) for the diagnosis of alpha thalassaemia in a patient of reproductive age ; or (b) for the determination of carrier status in a reproductive partner of a person with alpha thalassaemia (See para PN.1.2 of explanatory notes to this Category) **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50 **Future End Date:**
73416	Detection of germline gene variants, including copy number variation, requested by a specialist or consultant physician: (a) in at least the following genes: (i) KCNQ1; (ii) KCNH2; (iii) SCN5A; (iv) KCNE1; (v) KCNE2; (vi) KCNJ2; (vii) CACNA1C; (viii) RYR2; (ix) CASQ2; (x) CAV3; (xi) SCN4B; (xii) AKAP9; (xiii) SNTA1; (xiv) KCNJ5; (xv) ALG10; (xvi) CALM1; (xvii) CALM2; (xviii) ANK2; (xix) TECRL; (xx) TRDN; and (b) for a patient for whom clinical or family history criteria is suggestive of inherited cardiac arrhythmias or channelopathies that place the patient at greater than 10% risk of having a pathogenic variant

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	Applicable once per lifetime (See para PN.0.23, PN.0.27 of explanatory notes to this Category) **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1091.50 **Future End Date:**
73417	Characterisation of one or more pathogenic or likely pathogenic germline gene variants, requested by a specialist or consultant physician, if: (a) the patient is a first-degree or second-degree biological relative of a person with a pathogenic or likely pathogenic germline gene variant that is confirmed by laboratory findings; and (b) the service is performed for the purpose of assessing present or future risk of a cardiac arrhythmia or channelopathy; and (c) a service to which item 73416 applies has not previously been performed for the patient Applicable once per variant per lifetime (See para PN.0.23 of explanatory notes to this Category) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73418	Characterisation of one or more recessive pathogenic or likely pathogenic germline genes, requested by a specialist or consultant physician, for the purpose of determining the reproductive risk of cardiac arrhythmia or channelopathy in a patient: (a) who is a reproductive partner of a person who is a known carrier of a pathogenic or likely pathogenic germline gene variant of a gene confirmed by laboratory findings; and (b) for whom a service to which item 73416 applies has not previously been performed; and (c) for whom carrier status of a pathogenic or likely pathogenic germline gene variant is unknown; and (d) who has a clinical history, family history or laboratory findings suggesting there is a low probability of cardiac arrhythmia or channelopathy Applicable once per gene per lifetime (See para PN.0.23 of explanatory notes to this Category) **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1091.50 **Future End Date:**
73419	Re-analysis of whole exome or genome data that was obtained in performing a service to which item 73416 applies, for characterisation of previously unreported germline gene variants related to the clinical phenotype, if: (a) the re-analysis is requested by a consultant physician practising as a clinical geneticist or a cardiologist; and (b) the patient is strongly suspected of having inheritable cardiac arrhythmia or channelopathies; and (c) the service is performed at least 18 months after a service to which item 73416 or this item applies was performed for the patient Applicable twice per lifetime (See para PN.0.23 of explanatory notes to this Category)

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	Fee: $500.00 **Benefit:** 75% = $375.00 85% = $425.00 **Future End Date:**
73420	Non-invasive prenatal testing of blood from an RhD negative pregnant patient for the detection of the RHD gene from fetal DNA circulating in maternal blood, if the patient has not been previously alloimmunised against RhD (See para PN.1.1 of explanatory notes to this Category) **Fee:** $150.40 **Benefit:** 75% = $112.80 85% = $127.85 **Future End Date:**
73421	Non-invasive prenatal testing of blood from an RhD negative pregnant patient for the detection of the RHD gene from fetal DNA circulating in maternal blood, if the patient has been previously alloimmunised against RhD (See para PN.1.1, PN.7.21 of explanatory notes to this Category) **Fee:** $550.00 **Benefit:** 75% = $412.50 85% = $467.50 **Future End Date:**
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 (See para PN.7.6 of explanatory notes to this Category) **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1091.50 **Future End Date:**
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 **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00 **Future End Date:**
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 **Fee:** $1,600.00 **Benefit:** 75% = $1200.00 85% = $1491.50 **Future End Date:**
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

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	(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 **Fee:** $1,800.00 **Benefit:** 75% = $1350.00 85% = $1691.50 **Future End Date:**
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 **Fee:** $2,400.00 **Benefit:** 75% = $1800.00 85% = $2291.50 **Future End Date:**
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 **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1091.50 **Future End Date:**
73428	Re-analysis of whole genome or exome data obtained in performing a service described in item 73422, 73425 or 73426, for characterisation of previously unreported gene variants related to the clinical phenotype, if the re-analysis is requested by: (a) a consultant physician practicing as a clinical geneticist; or (b) a consultant physician practising as a specialist paediatrician, following consultation with a clinical geneticist Applicable twice per lifetime

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	(See para PN.7.7 of explanatory notes to this Category) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00 **Future End Date:**
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 (See para PN.1.2, PN.7.10 of explanatory notes to this Category) **Fee:** $887.90 **Benefit:** 75% = $665.95 85% = $779.40 **Future End Date:**
73430	Fluorescence in-situ hybridisation (FISH) test of tumour tissue from a patient with locally advanced or metastatic solid tumour, if: (a) the tumour is at risk of being caused by a neurotrophic receptor tyrosine kinase (NTRK) gene fusion as determined by either: (i) occurring in a child less than 18 years of age; or (ii) being mammary analogue secretory carcinoma of the salivary gland; or (iii) being secretory breast carcinoma; and (b) the test is requested by a specialist or consultant physician to determine if requirements relating to NTRK gene fusion status for access to a tropomyosin receptor kinase (Trk) inhibitor under the Pharmaceutical Benefits Scheme are fulfilled This item cannot be claimed if item 73433 has been claimed for the same patient during the same cancer diagnosis Applicable only once per cancer diagnosis **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73431	Two tests described in item 73430

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	Fee: $533.00 **Benefit:** 75% = $399.75 85% = $453.05 **Future End Date:**
73432	Three or more tests described in item 73430 **Fee:** $667.00 **Benefit:** 75% = $500.25 85% = $566.95 **Future End Date:**
Amend 73433	Next generation sequencing test for neurotrophic receptor tyrosine kinase (NTRK1, NTRK2, NTRK3) fusions by RNA or DNA in tumour tissue from a patient with locally advanced or metastatic solid tumour, if: (a) the tumour is at risk of being caused by an NTRK gene fusion as determined by either: (i) occurring in a child less than 18 years of age; or (ii) being mammary analogue secretory carcinoma of the salivary gland; or (iii) being secretory breast carcinoma; or (iv) being glioma, glioneuronal tumour or glioblastoma; and (b) the test is requested by a specialist or consultant physician for NTRK gene fusion status to determine eligibility for a relevant treatment under the Pharmaceutical Benefits Scheme This item cannot be claimed if item 73430, 73431 or 73432 has been claimed for the same patient during the same cancer diagnosis Applicable only once per cancer diagnosis **Fee:** $1,000.00 **Benefit:** 75% = $750.00 85% = $891.50 **Future End Date:**
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 (See para PN.7.12, PN.7.11 of explanatory notes to this Category) **Fee:** $392.00 **Benefit:** 75% = $294.00 85% = $333.20 **Future End Date:**
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

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	Fee: $1,000.00 **Benefit:** 75% = $750.00 85% = $891.50 **Future End Date:**
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 (See para PN.1.2, PN.7.15 of explanatory notes to this Category) **Fee:** $397.35 **Benefit:** 75% = $298.05 85% = $337.75 **Future End Date:**
73437	A nucleic acid-based multi-gene panel 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) to detect variants in at least EGFR, BRAF, KRAS and MET exon 14 to determine eligibility for a relevant treatment under the Pharmaceutical Benefits Scheme; and (b) to detect the fusion status of at least ALK, ROS1, RET, NTRK1, NTRK2 and NTRK3 to determine eligibility for a relevant treatment under the PBS; and (c) not associated with a service to which item 73438, 73439, 73337, 73341, 73344, 73436 or 73351 applies (See para PN.1.2, PN.7.15 of explanatory notes to this Category) **Fee:** $1,247.00 **Benefit:** 75% = $935.25 85% = $1138.50 **Future End Date:**
73438	A DNA-based multi-gene panel 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) to detect variants in at least EGFR, BRAF, KRAS and MET exon 14; and (b) to determine eligibility for a relevant treatment under the Pharmaceutical Benefits Scheme; and (c) not associated with a service to which item 73437, 73337, 73436 or 73351 applies (See para PN.1.2, PN.7.15 of explanatory notes to this Category) **Fee:** $682.35 **Benefit:** 75% = $511.80 85% = $580.00 **Future End Date:**
73439	A nucleic acid-based multi-gene panel test of tumour tissue from a patient with a new diagnosis of non-small cell lung cancer and with documented absence of activating variants of the EGFR gene, KRAS, BRAF and MET exon14, requested by, or on behalf of, a specialist or consultant physician, if the test is: (a) for fusion status of at least ALK, ROS1, RET, NTRK1, NTRK2, and NTRK3 to determine eligibility for a relevant treatment under the Pharmaceutical Benefits Scheme; and (b) not associated with a service to which item 73437, 73341, 73344 or 73351 applies (See para PN.1.2, PN.7.15 of explanatory notes to this Category) **Fee:** $682.35 **Benefit:** 75% = $511.80 85% = $580.00 **Future End Date:**

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73440	Genomic testing and copy number variant analysis of genes known to be causative or likely causative of childhood hearing loss in a patient, if: (a) the testing and analysis is requested by a specialist or consultant physician; and (b) the patient has congenital or childhood onset hearing loss that presented before the patient was 18 years of age and is permanent moderate, severe, or profound (>40 dB in the worst ear over 3 frequencies) and classified as sensorineural, auditory neuropathy or mixed; and (c) the patient is not eligible for a service to which item 73358 or 73359 applies; and (d) the testing and analysis is not associated with a service to which item 73441 applies Applicable once per lifetime (See para PN.7.13, PN.0.23 of explanatory notes to this Category) **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1091.50 **Future End Date:**
73441	Genomic testing and copy number variant analysis of relevant genes known to be causative or likely causative of childhood hearing loss in a patient, if: (a) the testing and analysis is requested by a specialist or consultant physician; and (b) the patient has congenital or childhood onset hearing loss that presented before the patient was 18 years of age and is permanent moderate, severe, or profound (>40 dB in the worst ear over 3 frequencies) and classified as sensorineural, auditory neuropathy or mixed; and (c) the testing and analysis is performed using a sample from the patient and a sample from each of the patient's biological parents; and (d) the patient is not eligible for a service to which item 73358 or 73359 applies; and (e) the testing and analysis is not associated with a service to which item 73440 applies Applicable once per lifetime (See para PN.7.13, PN.0.23 of explanatory notes to this Category) **Fee:** $2,100.00 **Benefit:** 75% = $1575.00 85% = $1991.50 **Future End Date:**
73442	Re-analysis of whole exome or genome data obtained under a service to which item 73440 or 73441 applies, for characterisation of previously unreported germline gene variants for childhood hearing loss in a patient, if: (a) the re-analysis is requested by a specialist or consultant physician; and (b) the re-analysis is performed at least 24 months after: (i) the service to which items 73440 or 73441 applies has been provided to the patient; or (ii) a service to which this item applies is performed for the patient Applicable twice per lifetime (See para PN.0.23 of explanatory notes to this Category) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00 **Future End Date:**
73443	Characterisation of one or more familial germline gene variants known to be causative or likely causative of childhood hearing loss in a person, if: (a) the person tested is a biological relative of a patient with a germline gene variant known to be causative or likely causative of hearing loss confirmed by laboratory findings; and (b) the result of a previous proband testing is made available to the laboratory undertaking the characterisation (See para PN.7.13, PN.0.23 of explanatory notes to this Category) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73444	Characterisation of all germline variants in one or more genes known to cause hearing loss in a person, if: (a) the characterisation is requested by a specialist or consultant physician; and

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	(b) the characterisation is for the reproductive partner of a patient with a pathogenic or likely pathogenic recessive germline gene variant known to cause hearing loss confirmed by laboratory findings; and (c) the result of the patient's previous testing is made available to the laboratory undertaking the characterisation (See para PN.7.13, PN.0.23 of explanatory notes to this Category) **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1091.50 **Future End Date:**
73445	Characterisation of a variant or variants in a panel of at least 25 genes using DNA and RNA, requested by a specialist or consultant physician, to determine the diagnosis, prognosis and/or management of a patient presenting with a clinically suspected haematological malignancy of myeloid origin Applicable once per diagnostic episode, at diagnosis, disease progression or relapse (See para PN.7.14 of explanatory notes to this Category) **Fee:** $1,100.00 **Benefit:** 75% = $825.00 85% = $991.50 **Future End Date:**
73446	Characterisation of a variant or variants in a panel of at least 25 genes using DNA and RNA, requested by a specialist or consultant physician, to determine the diagnosis, prognosis and/or management of a patient presenting with a clinically suspected haematological malignancy of lymphoid origin Applicable once per diagnostic episode, at diagnosis, disease progression or relapse (See para PN.7.14 of explanatory notes to this Category) **Fee:** $1,100.00 **Benefit:** 75% = $825.00 85% = $991.50 **Future End Date:**
73447	Characterisation of a variant or variants in a panel of at least 25 genes using DNA, requested by a specialist or consultant physician, to determine the diagnosis, prognosis and/or management of a patient presenting with a clinically suspected haematological malignancy of myeloid origin Applicable once per diagnostic episode, at diagnosis, disease progression or relapse (See para PN.7.14 of explanatory notes to this Category) **Fee:** $927.90 **Benefit:** 75% = $695.95 85% = $819.40 **Future End Date:**
73448	Characterisation of a variant or variants in a panel of at least 25 genes using DNA, requested by a specialist or consultant physician, to determine the diagnosis, prognosis and/or management of a patient presenting with a clinically suspected haematological malignancy of lymphoid origin Applicable once per diagnostic episode, at diagnosis, disease progression or relapse (See para PN.7.14 of explanatory notes to this Category) **Fee:** $927.90 **Benefit:** 75% = $695.95 85% = $819.40 **Future End Date:**
73451	Testing of a patient (who is pregnant or planning pregnancy) to identify carrier status for pathogenic or likely pathogenic variants in a gene mentioned in paragraph (a), (b) or (c), to determine: (a) for the cystic fibrosis transmembrane conductance regulator (CFTR) gene—reproductive risk of cystic fibrosis; (b) for the survival motor neuron 1 (SMN1) gene—reproductive risk of spinal muscular atrophy;

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	(c) for the fragile X messenger ribonucleoprotein 1 (FMR1) gene—reproductive risk of fragile X syndrome; (other than a service associated with a service to which item 73300, 73305, 73345, 73346, 73347, 73348, 73349 or 73350 applies) One test per lifetime (See para PN.7.16 of explanatory notes to this Category) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73452	Testing of the reproductive partner of a patient who has been found to be a carrier of a pathogenic or likely pathogenic variant in the CFTR or SMN1 gene identified by testing under item 73451, for the purpose of determining the couple's reproductive risk of cystic fibrosis or spinal muscular atrophy One test per condition per lifetime (See para PN.7.16 of explanatory notes to this Category) **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**
73453	Characterisation of germline pathogenic or likely pathogenic gene variants: (a) in at least the following genes: (i) ASPA; (ii) BLM; (iii) CFTR; (iv) ELP1; (v) FANCA; (vi) FANCC; (vii) FANCG; (viii) FMR1; (ix) G6PC1; (x) GBA1; (xi) HEXA; (xii) MCOLN1; (xiii) SLC37A4; (xiv) SMN1; (xv) SMPD1; and (b) in a patient of reproductive age who is of Ashkenazi Jewish descent for the purpose of ascertaining the patient's carrier status for the following:

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	(i) Bloom syndrome (ii) Canavan disease (iii) Cystic fibrosis (iv) Familial dysautonomia (v) Fanconi anaemia type C (vi) Fragile-X syndrome (vii) Gaucher disease (viii) Glycogen storage disease type I (ix) Mucolipidosis type IV (x) Niemann-Pick disease type A 7 (xi) Spinal muscular atrophy (xii) Tay-Sachs disease Applicable once per lifetime (See para PN.7.18 of explanatory notes to this Category) **Fee:** $425.00 **Benefit:** 75% = $318.75 85% = $361.25 **Future End Date:**
73454	Whole gene sequencing of a gene or genes described in item 73453, in a patient who is the reproductive partner of an individual who is affected by, or is a known genetic carrier of, one or more conditions described in item 73453 (other than cystic fibrosis, fragile-X syndrome or spinal muscular atrophy), for the purpose of determining the couple's combined reproductive risk of the conditions, if: (a) the patient is not eligible for a service to which item 73453 applies; and (b) the patient has not received a service to which item 73453 applies; and (c) the patient has not received a service to which this item applies for the purpose of determining the patient's reproductive risk with the patient's current reproductive partner Applicable once per couple per lifetime **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1091.50 **Future End Date:**
73455	Testing of a pregnant patient, if at least one prospective parent is known to be affected by, or is a genetic carrier of, one or more conditions described in item 73453, for the purpose of determining whether a familial variant or variants are present in the fetus, if: (a) the testing is requested by a specialist or consultant physician; and (b) there is at least a 25% risk of the fetus inheriting a condition described in paragraph (b) of item 73453 **Fee:** $1,600.00 **Benefit:** 75% = $1200.00 85% = $1491.50

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	Future End Date:
	Characterisation by whole genome sequencing, or by either or both whole exome sequencing and mitochondrial DNA sequencing, of germline variants present in nuclear DNA and in mitochondrial DNA of a patient with a strong suspicion of a mitochondrial disease, if: (a) the characterisation is requested by a specialist or consultant physician; and (b) the characterisation is requested because of the onset of one or more clinical features indicative of mitochondrial disease, including at least one or more of the following: (i) meeting the clinical criteria of a probable indicator of mitochondrial disease on a relevant scoring system; (ii) evident mitochondrial dysfunction or decompensation; (iii) unexplained hypotonia or weakness, profound hypoglycaemia or "failure to thrive" in the presence of a metabolic acidosis; (iv) unexplained single or multi-organ dysfunction or fulminant failure (including, but not limited to, neuropathies, myopathies, hepatopathy, pancreatic and/or bone marrow failure); (v) refractory or atypical seizures, developmental delays or cognitive regression, or progressive encephalopathy or progressive encephalomyopathy; (vi) cardiomyopathy and/or cardiac arrythmias; (vii) rapid hearing or painless visual loss or ptosis; (viii) stroke-like episodes or nonvasculitic strokes; (ix) ataxia, encephalopathy, seizures, muscle fatigue or weakness; (x) external ophthalmoplegia; (xi) hearing loss, diabetes, unexplained short stature, or endocrinopathy; (xii) family history of mitochondrial disease, or any of the above; and (c) the service is not a service associated with a service to which item 73358, 73359 or 73457 applies Applicable only once per lifetime **Fee:** $2,100.00 **Benefit:** 75% = $1575.00 85% = $1991.50
73456	**Future End Date:**

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73457	Characterisation by whole genome sequencing, or either or both whole exome sequencing and mitochondrial DNA sequencing, of germline variants present in nuclear DNA and in mitochondrial DNA, of a patient with a strong suspicion of a mitochondrial disease, if: (a) the characterisation is performed using a sample from the patient and a sample from each of the patient's biological parents; and (b) the request for the characterisation states that singleton testing is inappropriate; and (c) the characterisation is requested by a specialist or consultant physician; and (d) the characterisation is requested because of the onset of one or more clinical features indicative of mitochondrial disease, including at least one or more of the following: (i) meeting the clinical criteria of a probable indicator of mitochondrial disease on a relevant scoring system; (ii) evident mitochondrial dysfunction or decompensation; (iii) unexplained hypotonia or weakness, profound hypoglycaemia or "failure to thrive" in the presence of a metabolic acidosis; (iv) unexplained single or multi-organ dysfunction or fulminant failure (including, but not limited to, neuropathies, myopathies, hepatopathy, pancreatic and/or bone marrow failure); (v) refractory or atypical seizures, developmental delays or cognitive regression, or progressive encephalopathy or progressive encephalomyopathy; (vi) cardiomyopathy and/or cardiac arrythmias; (vii) rapid hearing or painless visual loss or ptosis; (viii) stroke-like episodes or nonvasculitic strokes; (ix) ataxia, encephalopathy, seizures, muscle fatigue or weakness; (x) external ophthalmoplegia; (xi) hearing loss, diabetes, unexplained short stature, or endocrinopathy; (xii) family history of mitochondrial disease; and (e) the service is not a service associated with a service to which item 73358, 73359 or 73456 applies Applicable only once per lifetime **Fee:** $3,300.00 **Benefit:** 75% = $2475.00 85% = $3191.50 **Future End Date:**
73458	Re-analysis of whole genome or whole exome or mitochondrial DNA data obtained in performing a service to which item 73456 or 73457 applies, for characterisation of previously unreported germline variants related to the clinical phenotype, if: (a) the re-analysis is requested by a specialist or consultant physician; and (b) the patient is strongly suspected of having a monogenic mitochondrial disease; and

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	(c) the re-analysis is performed at least 24 months after: (i) the service to which item 73456 or 73457 applies; or (ii) a service to which this item applies Applicable twice per lifetime **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $425.00 **Future End Date:**
73459	Testing for diagnostic purposes of a pregnant patient, for detection in the fetus of a gene variant or variants present in the parents, if: (a) the gene variant or variants are: (i) a variant or variants in the mitochondrial genome identified in the oocyte donating parent; or (ii) autosomal recessive variants identified in both biological parents within the same gene; or (iii) an autosomal dominant or X-linked variant identified in either biological parent; or (iv) identified in a biological sibling of the fetus; and (b) the causative variant or variants for the condition of the fetus' first-degree relative have been confirmed by laboratory findings; and (c) the detection is requested by a specialist or consultant physician; and (d) the service is not a service associated with a service to which item 73361, 73362, 73363 or 73462 applies **Fee:** $1,600.00 **Benefit:** 75% = $1200.00 85% = $1491.50 **Future End Date:**
73460	Characterisation of mitochondrial DNA deletion or variant for diagnostic purposes in a patient suspected to have mitochondrial disease, if: (a) the characterisation is requested by the specialist or consultant physician managing the patient's treatment; and (b) the patient displays onset of one or more clinical features indicative of mitochondrial disease, including at least one or more of the following: (i) meeting the clinical criteria of a probable indicator of mitochondrial disease on a relevant scoring system; (ii) evident mitochondrial dysfunction or decompensation; (iii) unexplained hypotonia or weakness, profound hypoglycaemia or 'failure to thrive' in the presence of a metabolic acidosis; (iv) unexplained single or multi-organ dysfunction or fulminant failure (including, but not limited to, neuropathies, myopathies, hepatopathy, pancreatic and/or bone marrow failure); (v) refractory or atypical seizures, developmental delays or cognitive regression, or progressive encephalopathy or progressive encephalomyopathy;

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	(vi) cardiomyopathy and/or cardiac arrythmias; (vii) rapid hearing or painless visual loss or ptosis; (viii) stroke-like episodes or nonvasculitic strokes; (ix) ataxia, encephalopathy, seizures, muscle fatigue or weakness; (x) external ophthalmoplegia; (xi) hearing loss, diabetes, unexplained short stature, or endocrinopathy; (xii) family history of mitochondrial disease; and (c) the service is performed following a service to which items 73292, 73358, 73359, 73456 or 73457 applies for the same patient if the results were non-informative Applicable 3 times per lifetime **Fee:** $450.00 **Benefit:** 75% = $337.50 85% = $382.50 **Future End Date:**
73461	Whole gene testing of a person for the characterisation of all germline gene variants within the same gene in which the person's reproductive partner has a pathogenic or likely pathogenic germline recessive gene variant for mitochondrial disease, if: (a) the partner's germline recessive gene variant is confirmed by laboratory findings; and (b) the characterisation is requested by a specialist or consultant physician **Fee:** $1,200.00 **Benefit:** 75% = $900.00 85% = $1091.50 **Future End Date:**
73462	Testing of a person for the detection of a single gene variant, if: (a) the person tested has a biological relative with a known pathogenic or likely pathogenic mitochondrial disease variant confirmed by laboratory findings; and (b) the testing is requested by a specialist or consultant physician; and (c) the service is not a service associated with a service to which item 73361, 73362 or 73363 applies **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00 **Future End Date:**

P8. INFERTILITY AND PREGNANCY TESTS	
	Group P8. Infertility And Pregnancy Tests
73521	Semen examination for presence of spermatozoa or examination of cervical mucus for spermatozoa (Huhner's test) (See para TN.1.4 of explanatory notes to this Category) **Fee:** $10.20 **Benefit:** 75% = $7.65 85% = $8.70 **Future End Date:**
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

P8. INFERTILITY AND PREGNANCY TESTS	
	(c) morphology; and (if performed) (d) differential count and 1 or more chemical tests; (Item is subject to rule 25) **Fee:** $43.85 **Benefit:** 75% = $32.90 85% = $37.30 **Future End Date:**
73525	Sperm antibodies - sperm-penetrating ability - 1 or more tests (See para TN.1.4 of explanatory notes to this Category) **Fee:** $29.80 **Benefit:** 75% = $22.35 85% = $25.35 **Future End Date:**
73527	Human chorionic gonadotrophin (HCG) - detection in serum or urine by 1 or more methods for diagnosis of pregnancy - 1 or more tests **Fee:** $10.50 **Benefit:** 75% = $7.90 85% = $8.95 **Future End Date:**
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 (See para PN.1.1, PN.0.33 of explanatory notes to this Category) **Fee:** $30.10 **Benefit:** 75% = $22.60 85% = $25.60 **Future End Date:**

P9. SIMPLE BASIC PATHOLOGY TESTS	
	Group P9. Simple Basic Pathology Tests
73801	Semen examination for presence of spermatozoa **Fee:** $6.90 **Benefit:** 75% = $5.20 85% = $5.90 **Future End Date:**
73802	Leucocyte count, erythrocyte sedimentation rate, examination of blood film (including differential leucocyte count), haemoglobin, haematocrit or erythrocyte count - 1 test **Fee:** $4.55 **Benefit:** 75% = $3.45 85% = $3.90 **Future End Date:**
73803	2 tests described in item 73802 **Fee:** $6.35 **Benefit:** 75% = $4.80 85% = $5.40 **Future End Date:**
73804	3 or more tests described in item 73802 **Fee:** $8.15 **Benefit:** 75% = $6.15 85% = $6.95 **Future End Date:**
73805	Microscopy of urine, excluding dipstick testing. **Fee:** $4.55 **Benefit:** 75% = $3.45 85% = $3.90 **Future End Date:**
73806	Pregnancy test by 1 or more immunochemical methods **Fee:** $10.15 **Benefit:** 75% = $7.65 85% = $8.65 **Future End Date:**
73807	Microscopy for wet film other than urine, including any relevant stain

P9. SIMPLE BASIC PATHOLOGY TESTS	
	Fee: $6.90 **Benefit:** 75% = $5.20 85% = $5.90 **Future End Date:**
73808	Microscopy of Gram-stained film, including (if performed) a service described in item 73805 or 73807 **Fee:** $8.65 **Benefit:** 75% = $6.50 85% = $7.40 **Future End Date:**
73809	Chemical tests for occult blood in faeces by reagent stick, strip, tablet or similar method **Fee:** $2.35 **Benefit:** 75% = $1.80 85% = $2.00 **Future End Date:**
73810	Microscopy for fungi in skin, hair or nails - 1 or more sites **Fee:** $6.90 **Benefit:** 75% = $5.20 85% = $5.90 **Future End Date:**
73811	Mantoux test **Fee:** $11.20 **Benefit:** 75% = $8.40 85% = $9.55 **Future End Date:**
73812	Quantitation of glycated haemoglobin (HbA1c) performed in the management of established diabetes, if performed: (a) as a point-of-care test; and (b) by or on behalf of a medical practitioner who works in a general practice that is accredited to the Royal Australian College of General Practitioners Standards for point-of-care testing under the National General Practice Accreditation Scheme; and (c) using a method certified by the National Glycohemoglobin Standardization Program (NGSP), if the instrumentation used has a total coefficient variation less than 3.0% at 48 mmol/mol (6.5%) Applicable not more than 3 times per 12 months per patient (See para PR.9.4 of explanatory notes to this Category) **Fee:** $11.80 **Benefit:** 75% = $8.85 85% = $10.05 **Future End Date:**
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 (See para PR.9.5 of explanatory notes to this Category) **Fee:** $117.65 **Benefit:** 85% = $100.05 **Future End Date:**
73825	Detection performed by a participating nurse 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 (See para PN.1.1, PR.9.6 of explanatory notes to this Category) **Fee:** $117.65 **Benefit:** 85% = $100.05 **Future End Date:**

P9. SIMPLE BASIC PATHOLOGY TESTS	
73826	Quantitation of glycated haemoglobin (HbA1c) performed by a participating nurse practitioner in the management of established diabetes when performed: (a) as a point-of-care test; (b) by a nurse 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 and instrument certified by the National Glycohemoglobin Standardization Program (NGSP), if the instrument has a total coefficient variation less than 3.0% at 48 mmol/mol (6.5%) Applicable not more than 3 times per 12 months per patient (See para PN.1.1, PR.9.3 of explanatory notes to this Category) **Fee:** $11.80 **Benefit:** 75% = $8.85 85% = $10.05 **Future End Date:**
73828	Semen examination for presence of spermatozoa by a participating nurse practitioner (See para PN.1.1 of explanatory notes to this Category) **Fee:** $6.90 **Benefit:** 85% = $5.90 **Future End Date:**
73829	Leucocyte count, erythrocyte sedimentation rate, examination of blood film (including differential leucocyte count), haemoglobin, haematocrit or erythrocyte count by a participating nurse practitioner - 1 test (See para PN.1.1 of explanatory notes to this Category) **Fee:** $4.55 **Benefit:** 85% = $3.90 **Future End Date:**
73830	2 tests described in item 73829 by a participating nurse practitioner (See para PN.1.1 of explanatory notes to this Category) **Fee:** $6.35 **Benefit:** 85% = $5.40 **Future End Date:**
73831	3 or more tests described in item 73829 by a participating nurse practitioner (See para PN.1.1 of explanatory notes to this Category) **Fee:** $8.15 **Benefit:** 85% = $6.95 **Future End Date:**
73832	Microscopy of urine, excluding dipstick testing by a participating nurse practitioner. (See para PN.1.1 of explanatory notes to this Category) **Fee:** $4.55 **Benefit:** 85% = $3.90 **Future End Date:**
73833	Pregnancy test by 1 or more immunochemical methods by a participating nurse practitioner (See para PN.1.1 of explanatory notes to this Category) **Fee:** $10.15 **Benefit:** 85% = $8.65 **Future End Date:**
73834	Microscopy for wet film other than urine, including any relevant stain by a participating nurse practitioner (See para PN.1.1 of explanatory notes to this Category)

P9. SIMPLE BASIC PATHOLOGY TESTS	
	Fee: $6.90 **Benefit:** 85% = $5.90 **Future End Date:**
73835	Microscopy of Gram-stained film, including (if performed) a service described in item 73832 or 73834 by a participating nurse practitioner (See para PN.1.1 of explanatory notes to this Category) **Fee:** $8.65 **Benefit:** 85% = $7.40 **Future End Date:**
73836	Chemical tests for occult blood in faeces by reagent stick, strip, tablet or similar method by a participating nurse practitioner (See para PN.1.1 of explanatory notes to this Category) **Fee:** $2.35 **Benefit:** 85% = $2.00 **Future End Date:**
73837	Microscopy for fungi in skin, hair or nails by a participating nurse practitioner - 1 or more sites (See para PN.1.1 of explanatory notes to this Category) **Fee:** $6.90 **Benefit:** 85% = $5.90 **Future End Date:**
73839	Quantitation of HbA1c (glycated haemoglobin) performed for the diagnosis of diabetes in asymptomatic patients at high risk - not more than once in a 12 month period. (See para PR.9.1 of explanatory notes to this Category) **Fee:** $16.80 **Benefit:** 85% = $14.30 **Future End Date:**
73840	Quantitation of glycosylated haemoglobin performed in the management of established diabetes – each test to a maximum of 4 tests in a 12 month period (See para PR.9.1 of explanatory notes to this Category) **Fee:** $17.00 **Benefit:** 85% = $14.45 **Future End Date:**
73844	Quantitation of urinary albumin/creatine ratio in urine on a random spot collection in the management of patients with established diabetes or patients at risk of microalbuminuria. (See para PR.9.1 of explanatory notes to this Category) **Fee:** $20.35 **Benefit:** 85% = $17.30 **Future End Date:**

P10. PATIENT EPISODE INITIATION	
	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 **Fee:** $5.95 **Benefit:** 75% = $4.50 85% = $5.10 **Future End Date:**
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. **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05 **Future End Date:**
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

P10. PATIENT EPISODE INITIATION	
	Fee: $2.40 **Benefit:** 75% = $1.80 85% = $2.05 **Future End Date:**
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) **Fee:** $8.20 **Benefit:** 75% = $6.15 85% = $7.00 **Future End Date:**
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 **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05 **Future End Date:**
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. **Fee:** $14.65 **Benefit:** 75% = $11.00 85% = $12.50 **Future End Date:**
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. **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05 **Future End Date:**
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. **Fee:** $8.20 **Benefit:** 75% = $6.15 85% = $7.00 **Future End Date:**
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. **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05 **Future End Date:**
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 **Fee:** $5.95 **Benefit:** 75% = $4.50 85% = $5.10 **Future End Date:**
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

P10. PATIENT EPISODE INITIATION	
	authority, who conducts a prescribed laboratory, if the specimen is collected in an approved pathology collection centre **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05 **Future End Date:**
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 **Fee:** $5.95 **Benefit:** 75% = $4.50 85% = $5.10 **Future End Date:**
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 **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05 **Future End Date:**
Amend 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 care home; 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. **Fee:** $10.25 **Benefit:** 75% = $7.70 85% = $8.75 **Future End Date:**
Amend 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 care home; 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 **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05 **Future End Date:**

P10. PATIENT EPISODE INITIATION	
Amend 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 care home; 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 **Fee:** $17.60 **Benefit:** 75% = $13.20 85% = $15.00 **Future End Date:**
Amend 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 care home; 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 **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05 **Future End Date:**
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. **Fee:** $5.95 **Benefit:** 75% = $4.50 85% = $5.10 **Future End Date:**
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 **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05 **Future End Date:**
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 **Fee:** $7.95 **Benefit:** 75% = $6.00 85% = $6.80 **Future End Date:**
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

P10. PATIENT EPISODE INITIATION	
	Fee: $2.40 **Benefit:** 75% = $1.80 85% = $2.05 **Future End Date:**

P11. SPECIMEN REFERRED	
	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 (See para PN.0.33 of explanatory notes to this Category) **Fee:** $10.25 **Benefit:** 75% = $7.70 85% = $8.75 **Future End Date:**

P12. MANAGEMENT OF BULK-BILLED SERVICES	
	Group P12. Management Of Bulk-Billed Services
74990	A pathology service to which an item in this table (other than this item or item 74991, 75861, 75862, 75863 or 75864) applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in respect of the fees for: (i) this item; and (ii) the other item in this table applying to the service (See para PN.0.24, PN.0.33 of explanatory notes to this Category) **Fee:** $8.25 **Benefit:** 85% = $7.05 **Future End Date:**
74991	A pathology service to which an item in this table (other than this item or items 74990, 75861, 75862, 75863 or 75864) applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in respect of the fees for: (i) this item; and (ii) the other item in this table applying to the service; and

P12. MANAGEMENT OF BULK-BILLED SERVICES	
	(e) the service is provided at, or from, a practice location in a Modified Monash 2 area. (See para PN.0.24, PN.0.33 of explanatory notes to this Category) **Fee:** $12.50 **Benefit:** 85% = $10.65 **Future End Date:**
75861	A pathology service to which an item in this table (other than this item or item 74990, 74991, 75862, 75863 or 75864) applies if: (a) the service is an unreferred service; and (b) the service is rendered to a person who is under the age of 16 or is a concessional beneficiary; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in respect of the fees for: (i) this item; and (ii) the other item in this Schedule applying to the service; and (e) the service is rendered at, or from, a practice location in: (i) a Modified Monash 3 area; or (ii) a Modified Monash 4 area (See para PN.0.24, PN.0.33 of explanatory notes to this Category) **Fee:** $13.30 **Benefit:** 85% = $11.35 **Future End Date:**
75862	A pathology service to which an item in this Schedule (other than this item or item 74990, 74991, 75861, 75863, or 75864) applies if: (a) the service is an unreferred service; and (b) the service is rendered to a person who is under the age of 16 or is a concessional beneficiary; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) the other item in this Schedule applying to the service; and (e) the service is rendered at, or from, a practice location in a Modified Monash 5 area (See para PN.0.24, PN.0.33 of explanatory notes to this Category) **Fee:** $14.05 **Benefit:** 85% = $11.95 **Future End Date:**
75863	A pathology service to which an item in this Schedule (other than this item or item 74990, 74991, 75861, 75862 or 75864) applies if: (a) the service is an unreferred service; and (b) the service is rendered to a person who is under the age of 16 or is a concessional beneficiary; and

P12. MANAGEMENT OF BULK-BILLED SERVICES	
	(c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in respect of the fees for: (i) this item; and (ii) the other item in this Schedule applying to the service; and (e) the service is rendered at, or from, a practice location in a Modified Monash 6 area (See para PN.0.24, PN.0.33 of explanatory notes to this Category) **Fee:** $15.00 **Benefit:** 85% = $12.75 **Future End Date:**
75864	A pathology service to which an item in this Schedule (other than this item or item 74990, 74991, 75861, 75862 or 75863) applies if: (a) the service is an unreferred service; and (b) the service is rendered to a person who is under the age of 16 or is a concessional beneficiary; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) the other item in this Schedule applying to the service; and (e) the service is rendered at, or from, a practice location in a Modified Monash 7 area (See para PN.0.24, PN.0.33 of explanatory notes to this Category) **Fee:** $16.35 **Benefit:** 85% = $13.90 **Future End Date:**

P13. BULK-BILLING INCENTIVE	
	Group P13. Bulk-Billing Incentive
74992	A payment when the episode is bulk billed and includes item 73920. **Fee:** $1.60 **Benefit:** 75% = $1.20 85% = $1.40 **Future End Date:**
74993	A payment when the episode is bulk billed and includes item 73922 or 73926. **Fee:** $3.75 **Benefit:** 75% = $2.85 85% = $3.20 **Future End Date:**
74994	A payment when the episode is bulk billed and includes item 73924. **Fee:** $3.25 **Benefit:** 75% = $2.45 85% = $2.80 **Future End Date:**
74995	A payment when the episode is bulk billed and includes item 73899, 73900, 73928, 73930 or 73936. **Fee:** $4.00 **Benefit:** 75% = $3.00 85% = $3.40 **Future End Date:**

P13. BULK-BILLING INCENTIVE	
74996	A payment when the episode is bulk billed and includes item 73932 or 73940. **Fee:** $3.70 **Benefit:** 75% = $2.80 85% = $3.15 **Future End Date:**
74997	A payment when the episode is bulk billed and includes item 73934. **Fee:** $3.30 **Benefit:** 75% = $2.50 85% = $2.85 **Future End Date:**
74998	A payment when the episode is bulk billed and includes item 73938. **Fee:** $2.00 **Benefit:** 75% = $1.50 85% = $1.70 **Future End Date:**
74999	A payment when the episode is bulk billed and includes item 73923, 73925, 73927, 73929, 73931, 73933, 73935, 73937 or 73939. **Fee:** $1.60 **Benefit:** 75% = $1.20 85% = $1.40 **Future End Date:**

COMPLEXITY LEVELS FOR HISTOPATHOLOGY ITEMS

Specimen Type	Complexity level
Adrenal resection, neoplasm	5
Adrenal resection, not neoplasm	4
Anus, all specimens not otherwise specified	3
Anus, neoplasm, biopsy	4
Anus, neoplasm, radical resection	6
Anus, submucosal resection – neoplasm	5
Appendix	3
Artery, all specimens not otherwise specified	3
Artery, biopsy	4
Bartholin's gland - cyst	3
Bile duct, resection - all specimens	6
Bone, biopsy, curettings or fragments - lesion	5
Bone, biopsy or curettings quantitation - metabolic disease	6
Bone, femoral head	4
Bone, resection, neoplasm - all sites and types	6
Bone marrow, biopsy	4
Bone - all specimens not otherwise specified	4
Brain neoplasm, resection - cerebello-pontine angle	4
Brain or meninges, biopsy - all lesions	5
Brain or meninges, not neoplasm - temporal lobe	6
Brain or meninges, resection - neoplasm (intracranial)	5
Brain or meninges, resection - not neoplasm	4
Branchial cleft, cyst	4
Breast, excision biopsy, guidewire localisation - non-palpable lesion	6
Breast, excision biopsy, or radical resection, malignant neoplasm or atypical proliferative disease - all specimen types	6
Breast, incision biopsy or needle biopsy, malignant neoplasm - all specimen types	4
Breast – microdochectomy	6
Breast, orientated wide local excision for carcinoma, with margin assessment	7
Breast tissue - all specimens not otherwise specified	4
Bronchus, biopsy	4
Carotid body - neoplasm	5
Cholesteatoma	3
Digits, amputation - not traumatic	4
Digits, amputation - traumatic	2
Ear, middle and inner - not cholesteatoma	4
Endocrine neoplasm - not otherwise specified	5

Specimen Type	Complexity level
Extremity, amputation or disarticulation – neoplasm	6
Extremity, amputation - not otherwise specified	4
Eye, conjunctiva - biopsy or pterygium	3
Eye, cornea	4
Eye, enucleation or exenteration - all lesions	6
Eye - not otherwise specified	4
Fallopian tube, biopsy	4
Fallopian tube, ectopic pregnancy	4
Fallopian tube, sterilization	2
Fetus with dissection	6
Foreskin - new born	2
Foreskin - not new born	3
Gallbladder	3
Gallbladder and porta hepatis-radical resection	6
Ganglion cyst, all sites	3
Gum or oral mucosa, biopsy	4
Heart valve	4
Heart - not otherwise specified	5
Hernia sac	2
Hydrocele sac	2
Jaw, upper or lower, including bone, radical resection for neoplasm	6
Joint and periarticular tissue, without bone - all specimens	3
Joint tissue, including bone - all specimens	4
Kidney, biopsy including transplant	5
Kidney, nephrectomy transplant	5
Kidney, partial or total nephrectomy or nephroureterectomy - neoplasm	6
Kidney, partial or total nephrectomy - not neoplasm	4
Large bowel (including rectum), biopsy - all sites	4
Large bowel, colostomy - stoma	3
Large bowel (including rectum), biopsy, for confirmation or exclusion of Hirschsprung’s Disease	5
Large bowel (including rectum), polyp	4
Large bowel, segmental resection - colon, not neoplasm	5
Large bowel (including rectum), segmental resection, neoplasm	6
Large bowel (including rectum), submucosal resection – neoplasm	5
Larynx, biopsy	4
Larynx, partial or total resection	5
Larynx, resection with nodes or pharynx or both	6
Lip, biopsy - all specimens not otherwise specified	3
Lip, wedge resection or local excision with orientation	4
Liver, hydatid cyst or resection for trauma	4
Liver, total or subtotal hepatectomy - neoplasm	6

Specimen Type	Complexity level
Liver - all specimens not otherwise specified	5
Lung, needle or transbronchial biopsy	4
Lung, resection - neoplasm	6
Lung, wedge biopsy	5
Lung segment, lobar or total resection	6
Lymph node, biopsy - all sites	4
Lymph node, biopsy – for lymphoma or lymphoproliferative disorder	5
Lymph nodes, regional resection - all sites	5
Mediastinum mass	5
Muscle, biopsy	6
Nasopharynx or oropharynx, biopsy	4
Nerve, biopsy neuropathy	5
Nerve, neurectomy or removal of neoplasm	4
Nerve - not otherwise specified	3
Nose, mucosal biopsy	4
Nose or sinuses, polyps	3
Odontogenic neoplasm	5
Odontogenic or dental cyst	4
Oesophagus, biopsy	4
Oesophagus, diverticulum	3
Oesophagus, partial or total resection	6
Oesophagus, submucosal resection – neoplasm	5
Omentum, biopsy	4
Ovary with or without tube - neoplasm	5
Ovary with or without tube - not neoplasm	4
Pancreas, biopsy	5
Pancreas, cyst	4
Pancreas, subtotal or total with or without splenectomy	6
Parathyroid gland(s)	4
Penisectomy with node dissection	5
Penisectomy - simple	4
Peritoneum, biopsy	4
Pituitary neoplasm	4
Placenta – live birth at any gestation	5
Placenta – live birth at any gestation, associated with neonatal death within 7 days of birth	6
Placenta – second trimester pregnancy at or after 12 weeks gestation but less than 20 weeks gestation, excluding specimens from dilation and curettage procedure	5
Placenta – stillbirth of a baby delivered at or after 20 weeks gestation	6
Pleura or pericardium, biopsy or tissue	4
Products of conception - first trimester pregnancy (at less than 12 weeks gestation) excluding termination of pregnancy, or second	4

Specimen Type	Complexity level
trimester pregnancy at or after 12 weeks gestation but less than 20 weeks gestation with specimens from dilation and curettage procedure only	
Products of conception, termination of pregnancy less than 12 weeks gestation	3
Prostate, radical prostatectomy or cystoprostatectomy for carcinoma	7
Prostate, radical resection	6
Prostate - all types of specimen not otherwise specified	4
Retroperitoneum, neoplasm	5
Salivary gland, Mucocele	3
Salivary gland, neoplasm - all sites	5
Salivary gland - all specimens not otherwise specified	4
Sinus, paranasal, biopsy	4
Sinus, paranasal, resection - neoplasm	6
Skin, biopsy - blistering skin diseases	4
Skin biopsy - for investigation of alopecia other than for male pattern baldness, where serial horizontal sections are taken	5
Skin, biopsy - for investigation of lymphoproliferative disorder	5
Skin, biopsy - inflammatory dermatosis	4
Skin, eyelid, wedge resection	4
Skin, local resection - orientation	4
Skin, resection of malignant melanoma or melanoma in-situ	5
Skin - all specimens not otherwise specified including all neoplasms and cysts	3
Small bowel - biopsy, all sites	4
Small bowel, diverticulum	3
Small bowel, resection - neoplasm	6
Small bowel – resection, all specimens	5
Small bowel, submucosal resection – neoplasm	5
Soft tissue, infiltrative lesion, extensive resections at least 5cm in maximal dimension	6
Soft tissue, lipoma and variants	3
Soft tissue, neoplasm, not lipoma - all specimens	5
Soft tissue - not otherwise specified	4
Spleen	5
Stomach, endoscopic biopsy or endoscopic polypectomy	4
Stomach, resection, neoplasm - all specimens	6
Stomach, submucosal resection – neoplasm	5
Stomach - all specimens not otherwise specified	4
Tendon or tendon sheath, giant cell neoplasm	4
Tendon or tendon sheath - not otherwise specified	3
Testis, biopsy	5
Testis and adjacent structures, castration	2
Testis and adjacent structures, neoplasm with or without nodes	5

Specimen Type	Complexity level
Testis and adjacent structures, vas deferens sterilization	2
Testis and adjacent structures - not otherwise specified	3
Thymus - not otherwise specified	5
Thyroglossal duct - all lesions	4
Thyroid - all specimens	5
Tissue or organ not otherwise specified, abscess	3
Tissue or organ not otherwise specified, haematoma	3
Tissue or organ not otherwise specified, malignant neoplasm with regional nodes	6
Tissue or organ not otherwise specified, neoplasm local	4
Tissue or organ not otherwise specified, pilonidal cyst or sinus	3
Tissue or organ not otherwise specified, thrombus or embolus	3
Tissue or organ not otherwise specified, veins varicosity	3
Tissue or organ - all specimens not otherwise specified	3
Tongue, biopsy	4
Tongue or tonsil, neoplasm local	5
Tongue or tonsil, neoplasm with nodes	6
Tonsil, biopsy - excluding resection of whole organ	4
Tonsil or adenoids or both	2
Trachea, biopsy	4
Ureter, biopsy	4
Ureter, resection	5
Urethra, biopsy	4
Urethra, resection	5
Urinary bladder, partial or total with or without prostatectomy	6
Urinary bladder, transurethral resection of neoplasm	5
Urinary bladder - all specimens not otherwise specified	4
Uterus, cervix, curettings or biopsy	4
Uterus, cervix cone, biopsy (including LLETZ or LEEP biopsy)	5
Uterus, endocervix, polyp	3
Uterus, endometrium, polyp	3
Uterus with or without adnexa, malignant neoplasm - all specimen types not otherwise specified	6
Uterus with or without adnexa, neoplasm, Wertheim's or pelvic clearance	6
Uterus and/or cervix - all specimens not otherwise specified	4
Vagina, biopsy	4
Vagina, radical resection	6
Vaginal mucosa, incidental	3
Vulva or labia, biopsy	4
Vulval, subtotal or total with or without nodes	6

CATEGORY 7: CLEFT AND CRANIOFACIAL SERVICES

SUMMARY OF CHANGES FROM 01/11/2026

The 01/11/2026 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

There are no changes to this Category for 01/11/2026

CN.0.2 Where Medicare Benefits are not Payable

Medicare benefits are not payable in respect of a professional service where the medical expenses for the service:-

(a) are paid/payable to a public hospital;

(b) are for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability. (Please note that if the medical expenses relate to a compensable injury/illness for which the insurer/compensation agency is disputing liability, then Medicare benefits are payable until the liability is accepted);

(c) are for a medical examination for the purposes of life insurance, superannuation, a provident account scheme, or admission to membership of a friendly society; or

(d) are incurred in mass immunisation.

Unless the Minister otherwise directs, Medicare benefits are not payable where:

(a) the service is rendered by or on behalf of, or under an arrangement with the Australian Government, a State or Territory, a local government body or an authority established under Commonwealth, State or Territory law;

(b) the medical expenses are incurred by the employer of the person to whom the service is rendered;

(c) the person to whom the service is rendered is employed in an industrial undertaking and that service is rendered for the purposes related to the operation of the undertaking; or

(d) the services is a health screening service.

Benefits are not payable for items 75150 to 75621 unless the patient was referred by letter of Referral by an eligible orthodontist.

CN.0.3 Limiting Rule

In no circumstances will the benefit payable for a professional service exceed the fee charged for the service.

CN.0.4 Penalties

Penalties of up to $10,000 or imprisonment for up to five years, or both, may be imposed on any person who makes a statement (oral or written) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used with a claim for benefits. In addition, any practitioner who is found guilty of such offences by a court shall be subject to examination by a Medicare Participation Review Committee and may be counselled or reprimanded or may have services wholly or partially disqualified from the Medicare benefit arrangements.

A penalty of up to $1,000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on a direct-billing form without the obligatory details having been entered on the form before the person signs, or who fails to cause a patient to be given a copy of the completed form.

CN.0.7 Interpretation of the Cleft and Craniofacial Services

Each professional service listed in the Schedule is a complete medical service in itself. Where a service is rendered partly by one practitioner and partly by another, only the one amount of benefit is payable.

CN.0.8 Multiple Operation Rule

The Schedule fee for two or more operations performed on a patient on the one occasion is calculated by the following rule:

· 100% for the item with the greatest Schedule fee, plus 50% for the item with the next greatest Schedule fee, plus 25% for each other item.

NOTE:

1. Fees so calculated which result in a sum which is not a multiple of 5 cents are taken to the next higher multiple of 5 cents.

2. Where two or more operations performed on the one occasion have fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.

3. The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

The above rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient by different dental practitioners unless either practitioner assists the other. In this case, the fees and benefits specified in the Schedule apply. For these purposes the term "operation" includes items 75200 to 75610.

If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

CN.0.9 Administration of Anaesthetics

When a medical practitioner administers an anaesthetic in connection with a dental procedure prescribed for the payment of Medicare benefits (and the procedure has been performed by an eligible dental practitioner), Medicare benefits are payable for the administration of the anaesthetic on the same basis as if the procedure had been rendered by a medical practitioner.

To ascertain the Schedule fee for the anaesthetic, medical practitioners should refer to Group T10 - Relative Value Guide for Anaesthesia - of the Medicare Benefits Schedule Book.

CN.0.10 Definitions

Orthodontic treatment planning

Orthodontic treatment planning is defined as the measurement and analysis of the face and jaws and occlusion providing a diagnosis and planned prescription of appliances and treatment required.

Study models

Study models are defined as physical or virtual models of the upper and lower teeth and alveolar processes. This does not include working models.

CN.0.11 Referral of Oral and Maxillofacial Surgical Services

Benefits are payable for items 75002 to 75621 only where the service has been rendered to a patient who has been referred by letter of referral by a medical practitioner or referring dentist.

Item 75621 may be claimed in association with items 46150 to 46161 where the service is performed by a practitioner holding a FRACDS (OMS) qualification.

CN.0.12 General and Prosthodontic Services - (Item 75800)

Item number 75800 refers to an attendance by a dental practitioner for the management, prevention, and prophylaxis of the patient’s eligible condition, and includes such services as dietary advice, oral hygiene, and fluoride treatment.

CN.0.13 Over-servicing

Over-servicing must be avoided. In the case of denture services, examples of over-servicing might be:-

· Unjustifiably frequent replacement of dentures;

· Provision of new dentures when relining or re-modelling of an existing prosthesis would meet the clinical need;

· Provision of metal dentures where an acrylic denture would meet the clinical need.

The Schedule includes an item for metal dentures to allow for the provision of a precise, long-term prosthesis. The item is not intended for use during the period of growth, where prostheses must be replaced or altered frequently, unless there is some definite and extraordinary clinical requirement.

CN.0.14 Commonwealth Department of Health, Disability and Ageing Addresses

Postal : GPO Box 9848 in each Capital City

Contact details: please visit www.health.gov.au

CN.1.1 Introduction - Medicare Benefits

The Medicare Benefits Schedule includes certain professional services in respect of the treatment of cleft lip and craniofacial conditions for which Medicare benefits are payable. These services are normally described as dental services. However, for the purposes of these Notes the word "medical" is to be interpreted to include "dental". The definition of professional service as contained in the *Health Insurance Act 1973* provides that such a service must be "clinically relevant". A clinically relevant service means a service rendered by a medical or dental practitioner or optometrist that is generally accepted in the medical, dental or optometrical profession (as the case may be) as being necessary for the appropriate treatment of the patient to whom it is rendered.

Medicare benefits are payable in respect of services listed in Schedule 2 of the *Health Insurance (Section 3C General Medical Services - Cleft and Craniofacial Services) Determination 2024*, when the services are rendered by an eligible dental practitioner to patients who have been diagnosed with an eligible cleft or craniofacial condition.

CN.2.1 Dental Practitioner Eligibility

In order to attract Medicare benefits, all treatment must be carried out by eligible medical practitioners or eligible dental practitioners in Australia. For the purposes of cleft and craniofacial services, groupings for eligible practitioners include:

- Dental practitioner: all registered dental practitioners, including practitioners who hold qualifications and are registered in the specialty of orthodontics, paediatric dentistry, oral and maxillofacial surgery, and prosthodontics.

- Eligible orthodontist: dental practitioners who are registered in the specialty of orthodontics and who hold qualifications as an orthodontic specialist can provide relevant Medicare Benefits Schedule (MBS) cleft and craniofacial services.

- Eligible prosthodontist: dental practitioners who are registered in the specialty of prosthodontics and who hold qualifications as a prosthodontic specialist can provide relevant MBS cleft and craniofacial services.

- Eligible paediatric dentist: dental practitioners who hold qualifications as a paediatric dentist and are registered in the specialty of paediatric dentistry can provide relevant MBS cleft and craniofacial services.

- Eligible oral and maxillofacial surgeon: oral and maxillofacial services may be performed, following a referral from a medical practitioner or referring dentist, by:

- medical practitioners who are specialists in the practice of their specialty of oral and maxillofacial surgery; or
- dental practitioners who were approved by the Minister prior to 1 November 2004 for the purposes of subsection 3 (1) of the *Health Insurance Act 1973* (the Act) to carry out prescribed medical services (oral and maxillofacial surgery) contained in the MBS.

Dental practitioners who were previously accredited to provide cleft and craniofacial services who do not meet the registration requirements as a dental practitioner will be grandfathered under legislative arrangements that came into force on 1 November 2012.

All eligible dental practitioners are entitled to perform services covered by items 75009, 75023, 75200, 75203, 75206, 75400, 75402, 75800, 75802, 75815, 75818, 75820, 75833, 75836, 75842, 75845, 75848, 75851 and 75854.

All eligible orthodontists are entitled to perform services covered by items 75002, 75005, 75007, 75012, 75015, 75024, 75027, 75030, 75032, 75034, 75039, 75042, 75045, 75048, 75049, 75050, 75051, 75618 and 75621.

All eligible prosthodontists are entitled to perform services covered by items 75002, 75005, 75007, 75618 and 75621.

All eligible paediatric dentists are entitled to perform services covered by items 75002, 75005, 75007, 75024, 75027, 75600 and 75603.

All eligible oral and maxillofacial surgeons and dental practitioners who, immediately prior to 1 November 2012, held an approval granted by the Minister for the purposes of the definition of professional service in subsection 3(1) of the Act, are entitled to perform services covered by items 75002, 75005, 75007, 75012, 75015, 75405, 75600, 75603, 75606, 75609, 75610, 75618 and 75621.

Items 75002, 75005, 75200, 75203, 75206, 75400, 75402, 75600, 75603, 75618 and 75621 apply only to a service provided by an eligible oral and maxillofacial surgeon if the patient has been referred by a referring dentist or medical practitioner.

CN.3.1 Patient Eligibility

To be eligible to claim benefits for cleft and dental services performed by eligible medical and registered dental practitioners, a patient must satisfy the following criteria:

a. The patient must be an Australian resident or any other person or class of persons whom the Minister declares to be eligible. All eligible persons will be issued with a Medicare card on application as evidence of their eligibility; and

b. The patient must be diagnosed with an eligible cleft or craniofacial condition specified in the *Health Insurance (Section 3C General Medical Services - Cleft and Craniofacial Services) Determination 2024*.

The *Health Insurance (Section 3C General Medical Services - Cleft and Craniofacial Services) Determination 2024* specifies the eligible cleft or craniofacial conditions listed below:

1. Oral and/or facial clefting	
Limited to	Cleft lip, alveolus and/or palate
	Tessier facial cleft
2. Congenital or hereditary craniofacial malformation, deformation or disruption	
Limited to	Achondroplasia
	Branchial arch disorders including: Hemifacial/craniofacial microsomia, Goldenhar syndrome, DiGeorge syndrome, Velocardiofacial syndrome, Auriculo-condylar syndrome
	CHARGE syndrome

	Congenital hemifacial hyperplasia
	Congenital lymphatic and/or vascular malformations of the head & neck, cystic hygroma, Sturge-Weber syndrome, excluding haemangiomas, birth marks and naevi
	Craniofacial Neurofibromatosis Type 1
	Craniometaphyseal dysplasia
	Congenital lymphatic and vascular malformations and segmental haemangiomas involving the jaws and associated soft tissues including cystic hygroma and Sturge-Weber syndrome
	Ectodermal dysplasia
	Hemifacial atrophy (Parry Romberg syndrome)
	Mandibulofacial dysostosis (Treacher Collins syndrome)
	Maxillonasal dysplasia (Binder syndrome)
	Oral-facial digital syndrome Type 1
	Osteogenesis imperfercta
	Pierre Robin sequence
	Rubinstein-Taybi syndrome
	Shprintzen-Goldberg syndrome
	Solitary median maxillary central incisor syndrome
	Stickler syndrome
	Syndromic craniosynostoses including: Apert, Crouzon, Pfeiffer, Saethre Chotzen, and Muenke syndromes
	Trichorhinophalangeal syndrome Type 1
3. Hereditary conditions presenting with the absence of 6 (six) or more permanent teeth, excluding 3rd molars	
4. Hereditary conditions where the presence of supernumerary teeth is a major feature	
Limited to	Cleidocranial dysplasia
	Gardner's syndrome
5. Development or hereditary conditions affecting the formation of enamel and/or dentine of all teeth	
Limited to	Amelogenesis imperfecta
	Dentinogenesis imperfecta
	Regional odontodysplasia

CN.3.3 Visitors to Australia

Medicare benefits for the Cleft and Craniofacial Scheme are generally not payable to visitors to Australia or temporary residents.

CN.3.4 Health Care Expenses Incurred Overseas

Medicare does not cover medical or hospital expenses incurred outside Australia.

C1. CLEFT AND CRANIOFACIAL SERVICES	
	Group C1. Cleft and Craniofacial Services
75002	Initial professional attendance, in a single course of treatment (other than a service associated with a service to which item 75009, 75012, 75015 or 75023 applies) (See para CN.2.1 of explanatory notes to this Category) **Fee:** $102.35 **Benefit:** 75% = $76.80 85% = $87.00 **Extended Medicare Safety Net Cap:** $307.05 **Future End Date:**
75005	Subsequent professional attendance in a single course of treatment (other than a service associated with a service to which item 75009, 75012, 75015 or 75023 applies) (See para CN.2.1 of explanatory notes to this Category) **Fee:** $51.50 **Benefit:** 75% = $38.65 85% = $43.80 **Extended Medicare Safety Net Cap:** $154.50 **Future End Date:**
75007	Production of dental study models (other than a service associated with a service to which item 75002 or 75005 applies) prior to provision of a service to which: (a) item 75030, 75032, 75039, 75045 or 75051 apply; or (b) an item in Group T8 or Groups O3 to O9 apply; or (c) item 52321, 53212 or 75618 apply; or (d) any of items 52330 to 52382, 52600 to 52630, 53400 to 53409 or 53415 to 53429 apply; in a single treatment (See para CN.2.1, CN.0.10 of explanatory notes to this Category) **Fee:** $91.20 **Benefit:** 75% = $68.40 85% = $77.55 **Future End Date:**
75009	Orthodontic radiography—orthopantomography (panoramic radiography), including any consultation on the same occasion (See para CN.2.1 of explanatory notes to this Category) **Fee:** $81.60 **Benefit:** 75% = $61.20 85% = $69.40 **Future End Date:**
75010	Orthodontic radiography – anteroposterior or lateral cephalometric radiography, with cephalometric tracings, and orthopantomography, including any consultation on the same occasion (See para CN.2.1 of explanatory notes to this Category) **Fee:** $155.75 **Benefit:** 75% = $116.85 85% = $132.40 **Future End Date:**
75011	Orthodontic radiography – anteroposterior and lateral cephalometric radiography, with cephalometric tracings, and orthopantomography, including any consultation on the same occasion (See para CN.2.1 of explanatory notes to this Category) **Fee:** $203.05 **Benefit:** 75% = $152.30 85% = $172.60 **Future End Date:**

C1. CLEFT AND CRANIOFACIAL SERVICES	
75012	Orthodontic anteroposterior cephalometric radiography with cephalometric tracings or lateral cephalometric radiography with cephalometric tracings, including any consultation on the same occasion (See para CN.2.1 of explanatory notes to this Category) **Fee:** $129.35 **Benefit:** 75% = $97.05 85% = $109.95 **Future End Date:**
75015	Radiography anteroposterior and lateral cephalometric radiography with cephalometric tracings, including any consultation on the same occasion (See para CN.2.1 of explanatory notes to this Category) **Fee:** $177.75 **Benefit:** 75% = $133.35 85% = $151.10 **Future End Date:**
75023	Intraoral radiography—single area, periapical or bitewing film (See para CN.2.1 of explanatory notes to this Category) **Fee:** $55.55 **Benefit:** 75% = $41.70 85% = $47.25 **Future End Date:**
75024	Pre-surgical infant maxillary arch repositioning including nasoalveolar moulding, supply of appliances and all adjustments of appliances, and supervision of all components of the service—if 1 appliance is used (See para CN.2.1 of explanatory notes to this Category) **Fee:** $718.25 **Benefit:** 75% = $538.70 85% = $610.55 **Future End Date:**
75027	Pre-surgical infant maxillary arch repositioning including nasoalveolar moulding, supply of appliances and all adjustments of appliances, and supervision of all components of the service—if 2 appliances are used (See para CN.2.1 of explanatory notes to this Category) **Fee:** $984.90 **Benefit:** 75% = $738.70 85% = $876.40 **Future End Date:**
75030	Maxillary arch expansion (other than a service associated with a service to which item 75039, 75042, 75045 or 75048 applies), including supply of appliances and all adjustments of appliances, removal of appliances and retention (See para CN.2.1 of explanatory notes to this Category) **Fee:** $876.95 **Benefit:** 75% = $657.75 85% = $768.45 **Future End Date:**
75032	Mixed dentition treatment including incisor alignment (mandibular and/or maxillary) lateral arch expansion, including supply of appliances and all adjustments of appliances, removal of appliances and retention (See para CN.2.1 of explanatory notes to this Category) **Fee:** $1,974.50 **Benefit:** 75% = $1480.90 85% = $1866.00 **Future End Date:**
75034	Mixed dentition treatment—incisor alignment with or without lateral arch expansion using a removable appliance in the maxillary arch, including supply of all appliances, and associated adjustments and retention (See para CN.2.1 of explanatory notes to this Category) **Fee:** $731.60 **Benefit:** 75% = $548.70 85% = $623.10 **Future End Date:**

C1. CLEFT AND CRANIOFACIAL SERVICES	
75039	Permanent dentition treatment—single arch (mandibular or maxillary) treatment (correction and alignment) using orthodontic fixed appliances or aligners, including supply of appliances and aligners—initial 3 months of active treatment (See para CN.2.1 of explanatory notes to this Category) **Fee:** $664.65 **Benefit:** 75% = $498.50 85% = $565.00 **Future End Date:**
75042	Permanent dentition treatment—single arch (mandibular or maxillary) treatment (correction and alignment) using orthodontic fixed appliances or aligners, including supply of appliances and aligners—each subsequent 3 months of active treatment (including all adjustments and maintenance and removal of the appliances) after the initial three months of active treatment for a maximum of a further 33 months (See para CN.2.1 of explanatory notes to this Category) **Fee:** $248.40 **Benefit:** 75% = $186.30 85% = $211.15 **Future End Date:**
75045	Permanent dentition treatment—2 arch (mandibular and maxillary) treatment (correction and alignment) using orthodontic fixed appliances or aligners, including supply of appliances or aligners—initial 3 months of active treatment (See para CN.2.1 of explanatory notes to this Category) **Fee:** $1,330.40 **Benefit:** 75% = $997.80 85% = $1221.90 **Future End Date:**
75048	Permanent dentition treatment—2 arch (mandibular and maxillary) treatment (correction and alignment) using orthodontic fixed appliances or aligners, including supply of appliances or aligners—each subsequent 3 months of active treatment (including all adjustments and maintenance, and removal of the appliances) after the initial three months of active treatment for a maximum of a further 33 months (See para CN.2.1 of explanatory notes to this Category) **Fee:** $341.20 **Benefit:** 75% = $255.90 85% = $290.05 **Future End Date:**
75049	Retention, fixed or removable, single arch (mandibular or maxillary)—supply of retainer and supervision of retention (See para CN.2.1 of explanatory notes to this Category) **Fee:** $399.30 **Benefit:** 75% = $299.50 85% = $339.45 **Future End Date:**
75050	Retention, fixed or removable, 2-arch (mandibular and maxillary)—supply of retainers and supervision of retention (See para CN.2.1 of explanatory notes to this Category) **Fee:** $770.85 **Benefit:** 75% = $578.15 85% = $662.35 **Future End Date:**
75051	Jaw growth guidance using removable or functional appliances, including supply of appliances and all adjustments to appliances (See para CN.2.1 of explanatory notes to this Category) **Fee:** $1,183.35 **Benefit:** 75% = $887.55 85% = $1074.85 **Future End Date:**
75200	Removal of tooth or tooth fragment (other than treatment to which item 75402 or 75405 applies) (See para CN.2.1, CN.0.8 of explanatory notes to this Category) **Fee:** $65.70 **Benefit:** 75% = $49.30 85% = $55.85 **Future End Date:**

C1. CLEFT AND CRANIOFACIAL SERVICES	
75203	Removal of tooth or tooth fragment under general anaesthesia (H) (See para GN.1.2, CN.2.1, CN.0.8 of explanatory notes to this Category) **Fee:** $98.60 **Benefit:** 75% = $73.95 **Future End Date:**
75206	Removal of each additional tooth or tooth fragment if provided in association with a service to which item 75200 or 75203 applies (See para CN.2.1, CN.0.8 of explanatory notes to this Category) **Fee:** $32.75 **Benefit:** 75% = $24.60 85% = $27.85 **Future End Date:**
75400	Surgical removal of erupted tooth (See para CN.2.1, CN.0.8 of explanatory notes to this Category) **Fee:** $197.20 **Benefit:** 75% = $147.90 85% = $167.65 **Future End Date:**
75402	Surgical removal of tooth, or tooth fragment requiring incision of soft tissue only (See para CN.2.1, CN.0.8 of explanatory notes to this Category) **Fee:** $194.90 **Benefit:** 75% = $146.20 85% = $165.70 **Future End Date:**
75405	Surgical removal of tooth, or tooth fragment requiring removal of bone, where the patient is referred by a referring dentist or medical practitioner (See para CN.2.1, CN.0.8 of explanatory notes to this Category) **Fee:** $249.20 **Benefit:** 75% = $186.90 85% = $211.85 **Future End Date:**
75600	Surgical exposure and packing of unerupted tooth (See para CN.2.1, CN.0.8 of explanatory notes to this Category) **Fee:** $277.75 **Benefit:** 75% = $208.35 85% = $236.10 **Future End Date:**
75603	Surgical exposure of unerupted tooth for the purpose of fitting a traction device or placement of a temporary anchorage device (See para CN.2.1, CN.0.8 of explanatory notes to this Category) **Fee:** $326.45 **Benefit:** 75% = $244.85 85% = $277.50 **Future End Date:**
75606	Surgical repositioning of unerupted tooth where the patient is referred by a referring dentist or medical practitioner (See para CN.2.1, CN.0.8 of explanatory notes to this Category) **Fee:** $326.45 **Benefit:** 75% = $244.85 85% = $277.50 **Future End Date:**
75609	Transplantation of tooth bud where the patient is referred by a referring dentist or medical practitioner (See para CN.2.1, CN.0.8 of explanatory notes to this Category) **Fee:** $487.40 **Benefit:** 75% = $365.55 85% = $414.30 **Future End Date:**
75610	Surgical procedure for intraoral implantation of an osseointegrated fixture and placement of transmucosal abutments where the patient is referred by a referring dentist or medical practitioner (H) (See para CN.2.1, CN.0.8 of explanatory notes to this Category) **Fee:** $413.20 **Benefit:** 75% = $309.90

C1. CLEFT AND CRANIOFACIAL SERVICES	
	Future End Date:
75618	Fabrication and fitting of a bite rising appliance or dental splint for the management of temporomandibular joint dysfunction syndrome (See para CN.2.1 of explanatory notes to this Category) **Fee:** $277.15 **Benefit:** 75% = $207.90 85% = $235.60 **Future End Date:**
75621	The fabrication and fitting of surgical splint or guide in conjunction with orthognathic surgical procedures and implant treatment, if provided in association with a service to which: (a) any item in the following series applies: (i) any of items 46150 to 46161 apply; or (ii) any of items 52342 to 52375 apply; or (b) item 52380 or 52382 applies; (c) item 75610 applies (See para CN.2.1, CN.0.11 of explanatory notes to this Category) **Fee:** $277.15 **Benefit:** 75% = $207.90 85% = $235.60 **Future End Date:**
75800	Attendance involving consultation, preventive treatment and prophylaxis, of not less than 30 minutes in duration for each attendance to a maximum of 3 attendances in any 12 month period (other than a service associated with a service to which item 75009, 75012, 75015 or 75023 applies) (See para CN.2.1, CN.0.12 of explanatory notes to this Category) **Fee:** $98.60 **Benefit:** 75% = $73.95 85% = $83.85 **Future End Date:**
75802	Fabrication and fitting of acrylic base partial denture, including retainers—1 to 4 teeth (See para CN.2.1 of explanatory notes to this Category) **Fee:** $503.65 **Benefit:** 75% = $377.75 85% = $428.15 **Future End Date:**
75815	Fabrication and fitting of acrylic base partial denture, including retainers—5 to 9 teeth (See para CN.2.1 of explanatory notes to this Category) **Fee:** $743.20 **Benefit:** 75% = $557.40 85% = $634.70 **Future End Date:**
75818	Fabrication and fitting of acrylic base partial denture or complete denture or overdenture, including retainers—10 to 12 teeth (See para CN.2.1 of explanatory notes to this Category) **Fee:** $876.95 **Benefit:** 75% = $657.75 85% = $768.45 **Future End Date:**
75820	Fabrication and fitting of metal framework partial denture, including all components—1 to 4 teeth (See para CN.2.1 of explanatory notes to this Category) **Fee:** $874.05 **Benefit:** 75% = $655.55 85% = $765.55 **Future End Date:**
75833	Fabrication and fitting of metal framework partial denture including all components—5 to 9 teeth (See para CN.2.1 of explanatory notes to this Category)

C1. CLEFT AND CRANIOFACIAL SERVICES	
	Fee: $1,266.75 **Benefit:** 75% = $950.10 85% = $1158.25 **Future End Date:**
75836	Fabrication and fitting of metal framework partial denture or complete denture or overdenture including all components—10 to 12 teeth (See para CN.2.1 of explanatory notes to this Category) **Fee:** $1,449.55 **Benefit:** 75% = $1087.20 85% = $1341.05 **Future End Date:**
75842	Adjustment of denture (other than a service associated with a service to which item 75802, 75815, 75818, 75820, 75833 or 75836 applies) (See para CN.2.1 of explanatory notes to this Category) **Fee:** $48.75 **Benefit:** 75% = $36.60 85% = $41.45 **Future End Date:**
75845	Relining of denture by laboratory process and associated fitting (See para CN.2.1 of explanatory notes to this Category) **Fee:** $243.75 **Benefit:** 75% = $182.85 85% = $207.20 **Future End Date:**
75848	Remodelling and fitting of denture of more than 4 teeth (See para CN.2.1 of explanatory notes to this Category) **Fee:** $292.30 **Benefit:** 75% = $219.25 85% = $248.50 **Future End Date:**
75851	Repair to metal framework of denture—1 or more points (See para CN.2.1 of explanatory notes to this Category) **Fee:** $146.20 **Benefit:** 75% = $109.65 85% = $124.30 **Future End Date:**
75854	Addition of a tooth or teeth to a denture to replace extracted tooth or teeth, including taking of necessary impression (See para CN.2.1 of explanatory notes to this Category) **Fee:** $146.20 **Benefit:** 75% = $109.65 85% = $124.30 **Future End Date:**

CATEGORY 8: MISCELLANEOUS SERVICES

SUMMARY OF CHANGES FROM 01/11/2026

The 01/11/2026 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

Description Amended

10955 10957 10959 10997

Changes to general medical services

From 1 November 2026, changes will be made relating to general medical services. These changes include:

- Administrative amendment to correct a typographical error in item 10997; and
- Administrative amendments to replace references to the term “residential aged care facility” with “residential care home” to align with terminology in the *Aged Care Act 2024*.

MISCELLANEOUS SERVICES NOTES

MN.0.1 Eligibility criteria for MBS Nurse Practitioner (NP) telehealth (video and phone)

It is a legislative requirement that nurse practitioner (using items from Group M18 Subgroup 5, 10) must only perform a telehealth service when they are the patient's eligible telehealth practitioner.

An eligible telehealth practitioner is defined as

- the nurse practitioner who performs the service has provided a face-to-face service to the patient in the last 12 months; or
- the nurse practitioner is located at a practice where the patient has received at least one MBS billed face-to-face service arranged by that practice in the 12 months preceding the telehealth attendances (including services performed by another medical or nurse practitioner located at the practice, an Approved Medical Deputising Service provider deputised by that practice, or by another health professional located at the practice, such as a practice nurse or Aboriginal and Torres Strait Islander health practitioner or Aboriginal and Torres Strait Islander health worker performing an on behalf of service for a medical practitioner);or
- there are exemptions to the eligible telehealth practitioner requirement.

The eligible telehealth practitioner requirement does not apply to:

- a person who is under the age of 12 months,
- a person who is experiencing homelessness,
- a person receiving treatment through Blood Borne Virus, Sexual or Reproductive Health telehealth,
- a person living in a natural disaster affected area,
- a person who receives the service from a nurse practitioner located at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service, or
- a person isolating because of a COVID-related State or Territory public health order, or in COVID-19 quarantine because of a State or Territory public health order.

A person who is experiencing homelessness means when a person does not have suitable accommodation alternatives, they are considered homeless if their current living arrangement:

(a) is in a dwelling that is inadequate; or

(b) has no tenure, or if their initial tenure is short and not extendable; or

(c) does not allow them to have control of, and access to space for social relations.

A person receiving treatment through Blood Borne Virus, Sexual or Reproductive Health telehealth items means services must meet the general medically accepted interpretation as what is defined as these services. Note artificial reproductive technology and antenatal services cannot be claimed under this exemption.

A person living in a natural disaster affected area is defined as a State or Territory local government area which is currently declared as a natural disaster area by a State or Territory Government until that declaration is deemed to have expired.

It is a legislated requirement that providers document in patient clinical notes the exemption and the clinical reasoning.

A patient's participation in a previous video or phone consultation does not constitute a face-to-face service for the purposes of ongoing telehealth eligibility.

MN.1.1 Bulk Billing Incentives

SUMMARY

Bulk billing incentives (BBIs) are additional payments made to medical practitioners when they bulk bill unreferred services.

Admitted hospital patients are not eligible for BBIs.

The specific BBI item that should be co-claimed with an eligible medical service depends on:

- The geographic location of the practice (by Modified Monash area). This can be checked on the Health Workforce Locator.
- The specific medical service (MBS item) provided, and
- In some cases, whether the patient is registered at the practice providing the service through the MyMedicare program. Information on MyMedicare is available on the Department of Health, Disability and Ageing's website.

Claiming tables are available for each Modified Monash area:

- MN.1.3 – Modified Monash 1
- MN.1.4 – Modified Monash 2
- MN.1.5 – Modified Monash 3-4
- MN.1.6 – Modified Monash 5
- MN.1.7 – Modified Monash 6
- MN.1.8 – Modified Monash 7

USE OF THE ITEMS

BBIs can be claimed when a medical practitioner bulk bills an unreferred service.

What is an unreferred service?

The *Health Insurance (General Medical Services Table) Regulations 2021* defines an unreferred service as a "*medical service provided by, or on behalf of, a medical practitioner to a patient who has not been referred to the practitioner for the service.*"

Which bulk billing incentive should be used?

There are 20 BBI items broken into three categories. Each category includes a BBI item number for use in each Modified Monash area (see table below). The Modified Monash area used to determine the appropriate BBI is the area where the medical practitioner's practice is located. BBI items within each category should be used with:

- Category 1: any unreferred services not covered by category 2 or 3 including, but not limited to:
    - Level A general attendances (and equivalents)
    - Level C, D, E telehealth (phone and video) attendances where the patient is not registered with the practice through MyMedicare
    - Chronic condition management and health assessment items
    - Better Access mental health and eating disorder items
    - Antenatal attendances
    - Minor procedures
- Category 2: any Level B general attendances (face to face, phone, video), and Level C, D and E face to face consultations. This category also includes the equivalent items used in residential care homes, out of consulting rooms, and after-hours
- Category 3: for patients registered with the practice through MyMedicare only, Level C, D and E video and Level C and D phone

The **practice location** is the location associated with the Medicare provider number used by the medical practitioner when providing the service. In general, the practice location associated with the provider number is used regardless of where the medical service is provided (e.g. out of consulting rooms, in a residential care home) or, in the case of telehealth (phone and video), the location of the patient. However, for the after-hours BBIs (10992 and 75872), both

the practice location and the patient location are considered. These items can only be claimed with specific after-hours MBS items in limited circumstances.

Practice Location:	**MM1** Metropolitan Areas	**MM1** (but service is provided after-hours in MM 2-7)	**MM2** Regional centres	**MM3-4** Large or medium rural towns	**MM5** Small rural towns	**MM6** Remote communities	**MM7** Very remote communities
Level B, C, D, E (face to face) **Level B (phone and video)**	75870	75872	75871	75873	75874	75875	75876
Level C, D, E (phone and video) and the patient is registered in MyMedicare	75880	NA	75881	75882	75883	75884	75885
All other eligible services not covered above	10990	10992	10991	75855	75856	75857	75858

Additional information on the after-hours BBIs – MBS items **10992** and **75872**

Items **10992** and **75872** can only be claimed in conjunction with specified after-hours MBS items. In addition to the standard requirements for use of BBIs, the following additional requirements apply:

- The service is not provided in consulting rooms
- The service is provided in a Modified Monash 2-7 area, and
- The service is provided by, or on behalf of, a medical practitioner whose practice is in a Modified Monash 1 area.

CO-CLAIMING RESTRICTIONS

BBIs must be claimed in conjunction with an eligible MBS item. BBIs can only be claimed when the patient is bulk billed for the medical service. Only one BBI can be claimed in conjunction with each medical service (i.e. each MBS item) that is provided.

BBIs cannot be claimed in conjunction with diagnostic imaging or pathology services. A separate set of incentives are available to use in conjunction with diagnostic imaging and pathology services.

ELIGIBLE PATIENTS

All patients eligible for Medicare are eligible for BBIs when relevant services are bulk billed. Admitted hospital patients are not eligible for BBIs.

ELIGIBLE PRACTITIONERS

All medical practitioners who bulk bill a relevant medical service can claim BBIs.

Different BBIs are payable for practice locations in different Modified Monash areas. The relevant Modified Monash area is determined by the location associated with the medical practitioner's provider number used to provide the service. This means that if the service is provided away from the practice location (e.g. in a residential care home or home visits), the location of the practice, not the location of the consultation, is used to determine the relevant Modified Monash area for BBI purposes (except in relation to items 10992 and 75872).

The Modified Monash area for your practice can be checked on the Health Workforce Locator.

RECORD KEEPING AND REPORTING REQUIREMENTS

Medicare benefits are patient benefits. It is a legal requirement that the patient assigns their benefit to the medical practitioner when a service is bulk billed. Information about recording assignment of benefit is available on the Services Australia website.

The Department of Health, Disability and Ageing undertakes regular post payment auditing to ensure that BBIs are claimed appropriately. Practitioners should ensure they keep relevant and contemporaneous records.

RELEVANT LEGISLATION

BBIs are specified in the *Health Insurance (General Medical Services Table) Regulations 2021*.

MN.1.3 Bulk Billing Incentives in Modified Monash Area 1

General Practitioners[1]

Bulk billing incentives – Modified Monash 1 (Metropolitan Area)[2]

Applicable BBI Item	**10990**	**75870**	**75880 (MyMedicare registered patients only)**
Standard hours consultations - in consulting rooms	3	23, 36, 44, 123	
Standard hours consultations - out of consulting rooms	4	24, 37, 47, 124	
Standard hours consultations - residential care home	90020	90035, 90043, 90051, 90054	
Video consultations	91790 (all) 91801, 91802, 91920 if not MyMedicare registered	91800	91801, 91802, 91920
Phone consultations	91890	91891	91900, 91910
After-hours consultations - in consulting rooms	5000	5020, 5040, 5060, 5071	
After-hours consultations - out of consulting rooms	5003[3]	5023[4], 5043[4], 5063[4], 5076[4]	
After-hours consultations - residential care home	5010[3]	5028[4], 5049[4], 5067[4], 5077[4]	

Other	All other “unreferred services”, including but not limited to: chronic condition management items, Better Access mental health items, health assessments, minor procedures etc.		

[1] For the definition of GP for MBS purposes see GN.4.13

[2] Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

[4] If service is provided in an MM 2 – 7 area by a GP whose practice is located in an MM 1 area, then BBI item number 10992 is claimed

[5] If service is provided in an MM 2 – 7 area by a GP whose practice is located in an MM 1 area, then BBI item number 75872 is claimed

Medical Practitioners[1]

Bulk billing incentives – Modified Monash 1 (Metropolitan Area)[2]

Applicable BBI Item	**10990**	**75870**	**75880 (MyMedicare registered patients only)**
Standard hours consultations - in consulting rooms	52	53, 54, 57, 151	
Standard hours consultations - out of consulting rooms	58	59, 60, 65, 165	
Standard hours consultations - residential care home	90092	90093, 90095, 90096, 90098	
Video consultations	91792 (all) 91804, 91805, 91923 if not MyMedicare registered	91803	91804, 91805, 91923
Phone consultations	91892	91893	91903, 91913
After-hours consultations - in consulting rooms	5200, *733*	5203, 5207, 5208, 5209, *737, 741, 745, 2197*	
After-hours consultations - out of consulting rooms	5220[3], *761*[3]	5223[4], 5227[4], 5228[4], 5261[4], *763*[4], *766*[4], *769*[4], *2198*[4]	
After-hours consultations - residential care home	5260[3], *772*[3]	5263[4], 5265[4], 5267[4], 5262[4], *776*[4], *788*[4], *789*[4], *2200*[4]	
Other	All other “unreferred services”, including but not		

	limited to: chronic condition management items, Better Access mental health items, health assessments, minor procedures etc.		

[1] Items in italics can only be claimed by prescribed medical practitioners, that is, medical practitioners that are not GPs, specialists or consultant physicians. Other items can be claimed by medical practitioners that are not GPs.

[2] Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

[3] If service is provided in an MM 2 – 7 area by a OMP whose practice is located in an MM 1 area, then BBI item number 10992 is claimed

[4] If service is provided in an MM 2 – 7 area by a OMP whose practice is located in an MM 1 area, then BBI item number 75872 is claimed

MN.1.4 Bulk Billing Incentives in Modified Monash Area 2

General Practitioners[1]

Bulk billing incentives for eligible patients[2] – Modified Monash 2 (Regional Centre)[3]

Applicable BBI Item	**10991**	**75871**	**75881 (MyMedicare registered patients only)**
Standard hours consultations - in consulting rooms	3	23, 36, 44, 123	
Standard hours consultations - out of consulting rooms	4	24, 37, 47, 124	
Standard hours consultations - residential care home	90020	90035, 90043, 90051, 90054	
Video consultations	91790 (all) 91801, 91802, 91920 if not MyMedicare enrolled	91800	91801, 91802, 91920
Phone consultations	91890	91891	91900, 91910
After-hours consultations - in consulting rooms	5000	5020, 5040, 5060, 5071	
After-hours consultations - out of consulting rooms	5003	5023, 5043, 5063, 5076	
After-hours consultations - residential care home	5010	5028, 5049, 5067, 5077	
Other	All other “unreferred services”, including but not limited to: chronic condition management items, Better Access mental health items, health assessments, minor procedures etc.		

[1] For the definition of GP for MBS purposes see GN.4.13

[2] Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

Medical Practitioners[1]

Bulk billing incentives - Modified Monash 2 (Regional Centre)[2]

Applicable BBI Item	**10991**	**75871**	**75881 (MyMedicare registered patients only)**
Standard hours consultations - in consulting rooms	52, *179*	53, 54, 57, 151, *185, 189, 203, 301*	
Standard hours consultations - out of consulting rooms	58, *181*	59, 60, 65, 165, *187, 191, 206, 303*	
Standard hours consultations - residential care home	90092, *90183*	90093, 90095, 90096, 90098, *90188, 90202, 90212, 90215*	
Video consultations	91792, *91794* (all) 91804, 91805, 91923, *91807, 91808, 91926* if not MyMedicare registered	91803, *91806*	91804, 91805, 91923, *91807, 91808, 91926*
Phone consultations	91892	91893	91903, 91913, *91906, 91916*
After-hours consultations - in consulting rooms	5200, *733*	5203, 5207, 5208, 5209, *737, 741, 745, 2197*	
After-hours consultations - out of consulting rooms	5220, *761*	5223, 5227, 5228, 5261, *763, 766, 769, 2198*	
After-hours consultations - residential care home	5260, *772*	5263, 5265, 5267, 5262, *776, 788, 789, 2200*	
Other	All other “unreferred services”, including but not limited to: chronic condition management items, Better Access mental health items, health assessments, minor procedures etc		

[1] Items in italics can only be claimed by prescribed medical practitioners, that is, medical practitioners that are not GPs, specialists or consultant physicians. Other items can be claimed by medical practitioners that are not GPs.

[2] Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

MN.1.5 Bulk Billing Incentives in Modified Monash Area 3 and 4

General Practitioners[1]

Bulk billing incentives – Modified Monash 3 and 4 (Medium and Large Rural Towns)[2]

Applicable BBI Item	75855	75873	75882 (MyMedicare registered patients only)
Standard hours consultations - in consulting rooms	3	23, 36, 44, 123	
Standard hours consultations - out of consulting rooms	4	24. 37, 47, 124	
Standard hours consultations - residential care home	90020	90035, 90043, 90051, 90054	
Video consultation	91790 (all) 91801, 91802, 91920 if not MyMedicare registered	91800	91801, 91802, 91920
Phone consultation	91890	91891	91900, 91910
After-hours consultations - in consulting rooms	5000	5020, 5040, 5060, 5071	
After-hours consultations - out of consulting rooms	5003	5023, 5043, 5063, 5076	
After-hours consultations - residential care home	5010	5028, 5049, 5067, 5077	
Other	All other "unreferred services", including but not limited to: chronic condition management items, Better Access mental health items, health assessments, minor procedures etc.		

[1] For the definition of GP for MBS purposes see GN.4.13

[2] Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

Medical Practitioners[1]

Bulk billing incentives – Modified Monash 3 and 4 (Medium and Large Rural Towns)[2]

Applicable BBI Item	75855	75873	75882 (MyMedicare registered patients only)
Standard hours consultations - in consulting rooms	52, *179*	53, 54, 57, 151, *185, 189, 203, 301*	
Standard hours consultations - out of consulting rooms	58, *181*	59, 60, 65, 165, *187, 191, 206, 303*	

Standard hours consultations - residential care home	90092, *90183*	90093, 90095, 90096, 90098, *90188, 90202, 90212, 90215*	
Video consultations	91792, 91794 (all) 91804, 91805, 91923, *91807, 91808, 91926* if not MyMedicare registered	91803, *91806*	91804, 91805, 91923, *91807, 91808, 91926*
Phone consultations	91892	91893	91903, 91913, *91906, 91916*
After-hours consultations - in consulting rooms	5200, *733*	5203, 5207, 5208, *5209, 737, 741, 745, 2197*	
After-hours consultations - out of consulting rooms	5220, *761*	5223, 5227, 5228, 5261, *763, 766, 769, 2198*	
After-hours consultations - residential care home	5260, *772*	5263, 5265, 5267, 5262, *776, 788, 789, 2200*	
Other	All other "unreferred services", including but not limited to: chronic condition management items, Better Access mental health items, health assessments, minor procedures etc.		

[1] Items in italics can only be claimed by prescribed medical practitioners, that is, medical practitioners that are not GPs, specialists or consultant physicians. Other items can be claimed by medical practitioners that are not GPs.

[2] Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/healt

MN.1.6 Bulk Billing Incentives in Modified Monash Area 5

General Practitioners[1]

Bulk billing incentives – Modified Monash 5 (Small Rural Towns)[2]

Applicable BBI Item	**75856**	**75874**	**75883 (MyMedicare registered patients only)**
Standard hours consultations - in consulting rooms	3	23, 36, 44, 123	
Standard hours consultations - out of consulting rooms	4	24, 37, 47, 124	
Standard hours consultations - residential care home	90020	90035, 90043, 90051, 90054	
Video consultations	91790 (all)	91800	91801, 91802, 91920

	91801, 91802, 91920 if not MyMedicare registered		
Phone consultations	91890	91891	91900, 91910
After-hours consultations - in consulting rooms	5000	5020, 5040, 5060, 5071	
After-hours consultations - out of consulting rooms	5003	5023, 5043, 5063, 5076	
After-hours consultations - residential care home	5010	5028, 5049, 5067, 5077	
Other	All other "unreferred services", including but not limited to: chronic condition management items, Better Access mental health items, health assessments, minor procedures etc.		

[1] For the definition of GP for MBS purposes see GN.4.13

[2] Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

Medical Practitioners[1]

Bulk billing incentives – Modified Monash 5 (Small Rural Towns)[2]

Applicable BBI Item	**75856**	**75874**	**75883 (MyMedicare registered patients only)**
Standard hours consultations - in consulting rooms	52, *179*	53, 54, 57, 151, *185, 189, 203, 301*	
Standard hours consultations - out of consulting rooms	58, *181*	59, 60, 65, 165, *187, 191, 206, 303*	
Standard hours consultations - residential care home	90092, *90183*	90093, 90095, 90096, 90098, *90188, 90202, 90212, 90215*	
Video consultations	91792, 91794 (all) 91804, 91805, 91923, *91807, 91808, 91926* if not MyMedicare registered	91803, *91806*	91804, 91805, 91923, *91807, 91808, 91926*
Phone consultations	91892	91893	91903, 91913, *91906, 91916*
After-hours consultations - in consulting rooms	5200, *733*	5203, 5207, 5208, 5209, *737, 741, 745, 2197*	
After-hours consultations - out of consulting rooms	5220, *761*	5223, 5227, 5228, 5261, *763, 766, 769, 2198*	

After-hours consultations - residential care home	5260, *772*	5263, 5265, 5267, 5262, *776, 788, 789, 2200*	
Other	All other "unreferred services", including but not limited to: chronic condition management items, Better Access mental health items, health assessments, minor procedures etc.		

[1] Items in italics can only be claimed by prescribed medical practitioners, that is, medical practitioners that are not GPs, specialists or consultant physicians. Other items can be claimed by medical practitioners that are not GPs.

[2] Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

MN.1.7 Bulk Billing Incentives in Modified Monash Area 6

General Practitioners[1]

Bulk billing incentives – Modified Monash 6 (Remote Communities)[2]

Applicable BBI Item	**75857**	**75875**	**75884 (MyMedicare registered patients only)**
Standard hours consultations - in consulting rooms	3	23, 36, 44, 123	
Standard hours consultations - out of consulting rooms	4	24, 37, 47, 124	
Standard hours consultations - residential care home	90020	90035, 90043, 90051, 90054	
Video consultations	91790 (all) 91801, 91802, 91920 if not MyMedicare registered	91800	91801, 91802, 91920
Phone consultations	91890	91891	91900, 91910
After-hours consultations - in consulting rooms	5000	5020, 5040, 5060, 5071	
After-hours consultations - out of consulting rooms	5003	5023, 5043, 5063, 5076	
After-hours consultations - residential care home	5010	5028, 5049, 5067, 5077	
Other	All other "unreferred services", including but not limited to: chronic condition management items, Better Access mental health items,		

	health assessments, minor procedures etc.		

[1] For the definition of GP for MBS purposes see GN.4.13

[2] Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

Medical Practitioners[1]

Bulk billing incentives – Modified Monash 6 (Remote Communities)[2]

Applicable BBI Item	**75857**	**75875**	**75884 (MyMedicare registered patients only)**
Standard hours consultations - in consulting rooms	52, *179*	53, 54, 57, 151, *185, 189, 203, 301*	
Standard hours consultations - out of consulting rooms	58, *181*	59, 60, 65, 165, *187, 191, 206, 303*	
Standard hours consultations - residential care home	90092, *90183*	90093, 90095, 90096, 90098, *90188, 90202, 90212, 90215*	
Video consultations	91792, 91794 (all) 91804, 91805, 91923, *91807, 91808, 91926* if not MyMedicare registered	91803, *91806*	91804, 91805, 91923, *91807, 91808, 91926*
Phone consultations	91892	91893	91903, 91913, *91906, 91916*
After-hours consultations - in consulting rooms	5200, *733*	5203, 5207, 5208, 5209, *737, 741, 745, 2197*	
After-hours consultations - out of consulting rooms	5220, *761*	5223, 5227, 5228, 5261, *763, 766, 769, 2198*	
After-hours consultations - residential care home	5260, *772*	5263, 5265, 5267, 5262, *776, 788, 789, 2200*	
Other	All other "unreferred services", including but not limited to: chronic condition management items, Better Access mental health items, health assessments, minor procedures etc.		

[1] Items in italics can only be claimed by prescribed medical practitioners, that is, medical practitioners that are not GPs, specialists or consultant physicians. Other items can be claimed by medical practitioners that are not GPs.

[2] Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

MN.1.8 Bulk Billing Incentives in Modified Monash Area 7

General Practitioners[1]

Bulk billing incentives – Modified Monash 7 (Very Remote Communities)[2]

Applicable BBI Item	75858	75876	75885 (MyMedicare registered patients only)
Standard hours consultations - in consulting rooms	3	23, 36, 44, 123	
Standard hours consultations - out of consulting rooms	4	24, 37, 47, 124	
Standard hours consultations - residential care home	90020	90035, 90043, 90051, 90054	
Video consultations	91790 (all) 91801, 91802, 91920 if not MyMedicare registered	91800	91801, 91802, 91920
Phone consultations	91890	91891	91900, 91910
After-hours consultations - in consulting rooms	5000	5020, 5040, 5060, 5071	
After-hours consultations - out of consulting rooms	5003	5023, 5043, 5063, 5076	
After-hours consultations - residential care home	5010	5028, 5049, 5067, 5077	
Other	All other "unreferred services", including but not limited to: chronic condition management items, Better Access mental health items, health assessments, minor procedures etc.		

[1] For the definition of GP for MBS purposes see GN.4.13

[2] Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

Medical Practitioners[1]

Bulk billing incentives – Modified Monash 7 (Very Remote communities)[2]

Applicable BBI Item	75858	75876	75885 (MyMedicare registered patients only)

Standard hours consultations - in consulting rooms	52, *179*	53, 54, 57, 151, *185, 189, 203, 301*	
Standard hours consultations - out of consulting rooms	58, *181*	59, 60, 65, 165, *187, 191, 206, 303*	
Standard hours consultations - residential care home	90092, *90183*	90093, 90095, 90096, 90098, *90188, 90202, 90212, 90215*	
Video consultations	91792, 91794 (all) 91804, 91805, 91923, *91807, 91808, 91926* if not MyMedicare registered	91803, *91806*	91804, 91805, 91923, *91807, 91808, 91926*
Phone consultations	91892	91893	91903, 91913, *91906, 91916*
After-hours consultations - in consulting rooms	5200, *733*	5203, 5207, 5208, 5209, *737, 741, 745, 2197*	
After-hours consultations - out of consulting rooms	5220, *761*	5223, 5227, 5228, 5261, *763, 766, 769, 2198*	
After-hours consultations - residential care home	5260, *772*	5263, 5265, 5267, 5262, *776, 788, 789, 2200*	
Other	All other "unreferred services", including but not limited to: chronic condition management items, Better Access mental health items, health assessments, minor procedures etc.		

[1] Items in italics can only be claimed by prescribed medical practitioners, that is, medical practitioners that are not GPs, specialists or consultant physicians. Other items can be claimed by medical practitioners that are not GPs.

[2] Practice located in Modified Monash area www.health.gov.au/resources/apps-and-tools/health-workforce-locator/app

MN.3.1 Individual Allied Health and Aboriginal and Torres Strait Islander Health and Wellbeing Services (health services) for Treating Chronic Conditions (Items 10950-10970, 93000, 93013)

SUMMARY

This note sets out the requirements for the individual health services for patients with a chronic condition. These services are part of the MBS framework for patient with a chronic condition (see AN.15.3).

Individual health services are available to patients with a GP chronic condition management plan (see AN.15.4) or residents of a residential care home that have a multidisciplinary care plan (see AN.15.8). Until 1 July 2027 these services are also available to patients that have both a GP management plan and team care arrangement (see AN.15.5).

These health services must be consistent with the patient's plan and a GP or prescribed medical practitioner must refer the patient for the service (see AN.15.6).

Patients can access up to 5 MBS-supported individual health services each calendar year (January to December).

On 1 July 2025 GP management plans and team care arrangements were replaced with new GP chronic condition management plan (see AN.15.3) items. These new items provide a streamlined and simplified approach to multidisciplinary care for patients with a chronic condition. Transition arrangements are in place for existing patients with a GP management plan and team care arrangement (see AN.15.5). New requirements for referrals to health services written on or after 1 July 2025 also came into effect (see AN.15.6).

References in this note to the term "Management Plan" refer to any of a GP chronic condition management plan, GP management plan and team care arrangement, or a multidisciplinary care plan for a resident of a residential care home.

USE OF THE ITEMS

The requirements of the items for individual health services are set out in the *Health Insurance (Section 3C General Medical Services - Allied Health and Other Primary Health Care Services) Determination 2024* (the Determination) and the *Health Insurance (Section 3C General Medical Services – Telehealth and Telephone Attendances) Determination 2021* (Telehealth Determination).

Is there a minimum length for the service?

Yes, the service must last at least 20 minutes.

The service I provide must be consistent with the Management Plan. How do I know what is in the Management Plan?

Subject to the patient's consent, you will be given the relevant parts of the Management Plan. In addition, you will receive a referral from the treating medical practitioner (see AN.15.6).

How long does a referral last?

For referrals written on or after 1 July 2025, referrals will be valid for the length of time specified in the referral, or if no timeframe is specified, 18 months from the date of the first service provided; under the referral. The referral may also specify the number of services to be provided, however, this is not required.

For referrals written prior to 1 July 2025 the referral must specify the number of services. The referral remains valid until all services are provided.

For further information on referrals see (AN.15.6).

Should the referral be for a named specific health professional?

No. The patient can take the referral to any eligible health professional of the same profession/type specified in the referral of their choosing. For example, a referral to physiotherapy services can be taken to any physiotherapist, but it cannot be used to access chiropractic services.

For further information on referrals see (AN.15.6).

How many individual health services can be claimed for a patient?

Patients can access up to 5 MBS-supported individual health services per calendar year (January to December). The 5 services can be made up of one type of service (e.g. 5 physiotherapy services) or a combination of different types of services (e.g. 1 dietetic and 4 podiatry services).

Aboriginal and Torres Strait Islander patients can claim additional health services under MBS Group M11 (see MN.11.1).

My patient's Management Plan identifies more than 5 individual health services. Which ones should be billed to the MBS?

The MBS benefit is the patient's benefit. Ultimately it is up to the patient to decide how they use their MBS benefits. Some patients can access additional services using private health insurance extras cover, non-MBS services (e.g. through state or PHN programs), or self-funding.

Providers should obtain informed financial consent from patients for the service. Therefore, it is important that you clarify with the patient whether they would like to use their MBS-benefit for the service.

Can the patient claim for a service under Medicare and private health insurance?

No. Patients cannot claim MBS benefits and payments under their private health insurance fund for the same service.

How do I know how many individual health services a patient has already used this year?

You can check a patient's eligibility for a service through the MBS Items Online Checker Check MBS Item numbers - Health professionals - Services Australia and view their care plan history through HPOS Patient details in HPOS - Health professionals - Services Australia. Patients can also check their care plan service history through their Medicare Online Account.

My patient has elected not to claim MBS benefits for the service. Do I still need to meet all of the requirements of the MBS item?

No. However, it is still good practice to provide regular updates to the patient's GP about their progress.

Am I required to provide information back to the referring medical practitioner?

Yes. The Determination requires that the health professional provide a written report to the referring medical practitioner:

> *"i. if the service is the only service under the referral—in relation to that service; or*
>
> *ii. if the service is the first or last service under the referral—in relation to that service; or*
>
> *iii. if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of —in relation to those matters."*

What should I include in a report back to the referring medical practitioner?

Generally, written reports should include:

- any investigations, tests, and/or assessments carried out on the patient;
- any treatment provided; and
- advice regarding future management of the patient's condition or problem.

ELIGIBLE PATIENTS

Patients are eligible for an individual health service if:

- they have a:
    - GP chronic condition management plan that has been put in place or reviewed in the last 18 months, or

- Until 1 November 2026, a GP management plan and team care arrangement that were in place before 1 November 2024, or
- Are a resident of a residential care home and have a multidisciplinary care plan

- the service provided is consistent with the Management Plan, and
- they have a referral from their GP or prescribed medical practitioner for the service.

ELIGIBLE PRACTITIONERS

Health professionals are eligible to provide these services if they meet the qualification and credentialling requirements set out in the Determination (see AN.15.4). To provide MBS services eligible health professionals must have a Medicare Provider Number.

There are MBS item numbers for each health service for face-to-face services. However, all service types are provided using the same items for video (93000), or phone (93013) services. The treating health professional must satisfy themselves that a service is appropriate to be delivered by video or telephone. The limit of 5 services per year for the patient applies across all modes of service.

Service	**Eligible health professionals (must meet any relevant credentialling requirements)**	**MBS item number (face to face service)**
Aboriginal and Torres Strait Islander health and wellbeing service	Aboriginal and Torres Strait Islander health worker Aboriginal and Torres Strait Islander health practitioner	10950
Audiology health service	Audiologist	10952
Chiropractic health service	Chiropractor	10964
Diabetes education health service	Credentialled diabetes educator	10951
Dietetics health service	Accredited practising dietitian	10954
Exercise physiology health service	Accredited exercise physiologist	10953
Mental health service	Aboriginal and Torres Strait Islander health worker Aboriginal and Torres Strait Islander health practitioner Credentialled mental health nurse Occupational therapist Psychologist (general registration) Social worker	10956
Occupational therapy health service	Occupational therapist	10958
Osteopathy health service	Osteopath	10966
Physiotherapy health service	Physiotherapist	10960
Podiatry health service	Podiatrist	10962

Psychology health service	Psychologist (general registration)	10968
Speech pathology health service	Certified practising speech pathologist	10970

RECORD KEEPING AND REPORTING REQUIREMENTS

The Determination requires that the health professional provide a written report to the referring medical practitioner:

> *"i. if the service is the only service under the referral—in relation to that service; or*
>
> *ii. if the service is the first or last service under the referral—in relation to that service; or*
>
> *iii. if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of —in relation to those matters."*

It is a requirement that, where an item specifies the creation of a document (however described), the document must be retained for a period of 2 years. This includes records made by the health provider for reporting back to the referring medical practitioner.

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements and they may be required to submit evidence for compliance checks related to Medicare claims. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item can be found on the Federal Register of Legislation at www.legislation.gov.au. Individual allied health and Aboriginal and Torres Strait Islander health and wellbeing items are set out in two regulatory instruments:

- *Health Insurance (Section 3C General Medical Services – Allied Health and Other Primary Health Care Services) Determination 2024* – items 10950, 10952, 10964, 10951, 10954, 10953, 10956, 10958, 10966, 10960, 10962, 10968 and 10970

- *Health Insurance (Section 3C General Medical Services – Telehealth and Telephone Attendances) Determination 2021* - items 93000 and 93013

MN.3.2 Multidisciplinary Case Conferencing for Chronic Condition Management (Items 10955, 10957, 10959)

These items provide MBS benefits for eligible allied health and Aboriginal and Torres Strait Islander primary health care professionals (health professionals) to participate in a multidisciplinary case conference team in a community case conference with a patient's GP or prescribed medical practitioner and other providers.

A prescribed medical practitioner is a medical practitioner other than a GP, specialist, or consultant physician. A multidisciplinary case conference means a process by which a multidisciplinary case conference team carries out all the following activities:

- discussing a patient's history;
- identifying the patient's multidisciplinary care needs;
- identifying outcomes to be achieved by members of the multidisciplinary case conference team giving care and service to the patient;
- identifying tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the multidisciplinary case conference team;
- assessing whether previously identified outcomes (if any) have been achieved.

These items apply to non-hospital admitted patients for chronic condition management under the care of a GP/prescribed medical practitioner in either the community or for a resident of a residential care home.

Eligible health professionals may claim reimbursement for participating in case conferences through the following time-tiered items:

- 15–19 minutes (10955)
- 20–39 minutes (10957)
- 40 minutes or longer (10959)

Eligible Health Professionals

For the purpose of these items, eligible health professionals must meet the eligibility requirements as set out in the *Health Insurance (Section 3C General Medical Services – Allied Health and other Primary Health Care Services) Determination 2024* and include the following:

- Aboriginal and Torres Strait Islander health worker
- Aboriginal and Torres Strait Islander health practitioner
- audiologist
- chiropractor
- diabetes educator
- dietitian
- exercise physiologist
- mental health worker (health professionals that meet the requirements of a mental health service namely, Aboriginal and Torres Strait Islander health practitioners, Aboriginal and Torres Strait Islander health workers, mental health nurses, occupational therapists, psychologists and social workers
- nurse practitioner
- occupational therapist
- osteopath
- physiotherapist
- podiatrist
- psychologist
- speech pathologist

Organisation of a case conference

The case conference must be organised by the GP/prescribed medical practitioner. The multidisciplinary case conference team must include a GP/prescribed medical practitioner and at least 2 other members providing different kinds of care to the patient. The multidisciplinary case conference team requirements include:

- each member must provide a different kind of care or service to the patient; and
- each member must not be an unpaid carer of the patient; and
- one member may be another GP/prescribed medical practitioner.

The patient and family members or carers can attend the case conference but will not count towards the minimum team member requirements.

Only eligible health professionals can claim payment for their participation. Non-claiming attendees can include other health professionals, home and community service providers and care organisers, including the following:

- asthma educators
- dental therapists
- dentists
- optometrists
- orthoptists
- orthotists or prosthetists

- pharmacists
- podiatrists
- registered nurses
- education providers
- “meals on wheels” providers
- personal care workers
- probation officers

In some instances, health professionals from the same profession may participate in the same case conference, where they provide different aspects of care to the patient. For example, they may have different specialisations that are clinically relevant to the same patient. In this instance, each health professional can claim the items.

Participation in a case conference

A referral is not required for a health professional to access the multidisciplinary case conferencing items for chronic condition management. However, the health professional must be invited to participate in the case conference by the patient’s treating GP/prescribed medical practitioner.

The patient must agree to the health professional participating in the case conference and be informed that Medicare will be accessed to fund the service. The patient may agree through discussion with their GP/prescribed medical practitioner. The GP/prescribed medical practitioner should ensure that the patient has agreed and that their agreement has been recorded appropriately.

Health professionals claiming a case conferencing item should record the day, start, and end times, the names of all participants and all matters discussed in the patient’s medical record.

The health professional is not required to have a pre-existing relationship with the patient. However, the patient should agree to their participation in the case conference and be informed that Medicare will be accessed to fund the service.

The case conference may lead to an agreed care plan between all participating providers, including the number of individual health services required and how they are allocated among professions within a patient’s entitlement.

The case conferencing items can be accessed in person, via video or telephone, using the same item number. There is no requirement that all participants use the same communication method.

Frequency limitations

These items cannot be claimed if the service has been performed in the last 3 months, unless in exceptional circumstances. An exceptional circumstance means there has been a significant change in the patient's clinical condition or care circumstances that necessitate the performance of the service.

MN.6.2 Provision of Psychological Therapy

Provision of Psychological Therapy

Associated Items: 80000, 80005, 80010, 80015, 80020, 80021, 80022, 80023, 80024, 80025, 91166, 91167, 91181, 91182.

Services attracting Medicare benefits

There are 14 Medicare Benefits Schedule (MBS) items for the provision of psychological therapy services to eligible patients by an eligible clinical psychologist. These consist of:

Individual Psychological Therapy Services:

- Face-to-Face items: 80000, 80005, 80010 and 80015

- Video and Phone items: 91166, 91167, 91181 and 91182

Group Psychological Therapy Services:

- Face-to-Face items: 80020, 80022, and 80024
- Video items: 80021, 80023 and 80025

To provide these services, eligible clinical psychologists must meet the provider eligibility requirements set out below and be registered with Services Australia.

For group psychological therapy services provided via video, additional restrictions apply. Please see the Group psychological therapy services - telehealth (video) requirements section below for further information.

Eligible referral services

Referrals for treatment services under the Better Access initiative should be utilised for patients who require at least a moderate level of support.

For the purposes of Better Access treatment services, a Medicare benefit will be not payable unless patients meet the eligibility and referral requirements outlined in explanatory note AN.0.78 | Better Access Initiative.

Service length and type

Services provided by eligible clinical psychologists under these items must meet the time period requirements specified within the item descriptor.

It is expected that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

In addition to psychoeducation, it is recommended that cognitive-behaviour therapy be provided. However, other evidence-based therapies may be used if considered clinically relevant.

Number of services per year

Medicare benefits are available for up to 10 individual and 10 group therapy mental health treatment services in a calendar year. The services may consist of:

- psychological therapy services delivered by eligible clinical psychologists; and/or
- focussed psychological strategies services delivered by eligible GPs, eligible Prescribed Medical Practitioners (PMPs), eligible psychologists (registered), eligible social workers and eligible occupational therapists (refer to explanatory note MN.7.4 – Provision of Focussed Psychological Strategies).

Course of treatment and reporting back to the referring medical practitioner or referring practice

Eligible patients must be referred to psychological therapy services by either a GP or PMP at the general practice in which the patient is enrolled in MyMedicare, or regardless of whether the patient is enrolled in MyMedicare, by the patient's usual medical practitioner who is managing the patient under a Mental Health Treatment Plan. This also includes a GP or PMP who is located at a medical practice that has provided the majority of their care over the previous 12 months or will be providing the majority of their care over the next 12 months. In addition, eligible patients can be referred under a Psychiatrist Assessment and Management Plan, or on direct referral from a psychiatrist or paediatrician. For additional information on Better Access referral requirements, please see explanatory note MN.6.3 - Referral requirements for Better Access Treatment Services.

The eligible clinical psychologist providing the service must be in receipt of the referral at the first mental health consultation. The eligible clinical psychologist must also retain the referral for 2 years (24 months) from the date the first treatment service was rendered.

The referring practitioner can decide how many services the patient will receive in a course of treatment, within the maximum service limit for the course of treatment. The maximum service limit for each course of treatment is set out below:

- Initial course of treatment - a maximum of 6 services.
- Subsequent course of treatment - a maximum of 6 services up to the patient's cap of 10 services per calendar year (for example, if the patient received 6 services in their initial course of treatment, they could only receive 4 services in a subsequent course of treatment provided within the same calendar year).

On completion of the initial course of treatment, the eligible clinical psychologist must provide a written report to the referring practitioner, which includes information on:

- assessments carried out on the patient;
- treatment provided; and
- recommendations on future management of the patient's disorder (e.g. if they require a subsequent course of treatment as the initial course of individual services is only up to 6 services, with the subsequent being no more than the maximum of 10 services per calendar year), noting further treatment under the Better Access initiative should be utilised for patients who require at least a moderate level of support.

A written report must also be provided to the referring practitioner at the completion of any subsequent course(s) of treatment provided to the patient.

Group psychological therapy services

In addition to individual psychological therapy services, eligible patients may also claim up to 10 separate group psychological therapy service MBS items within a calendar year for group therapy mental health treatment services. Group psychological therapy service MBS items can be claimed for groups of 4 to 10 patients. However, eligible clinical psychologists can claim these MBS items if 4 patients were due to attend and 1 patient is unable to attend, regardless of the reason.

Group psychological therapy services - telehealth (video) requirements

Group therapy mental health treatment services may only be delivered via video in certain circumstances. To be eligible for group therapy mental health treatment services via video, the patient must be located in a Modified Monash Model area 4-7 at the time of the consultation, and at least 15 kilometres apart by road from the eligible clinical psychologist delivering the service. The patient or eligible clinical psychologist is not permitted to travel to an area outside the minimum 15 kilometres distance in order to claim a video consultation item.

More information about the Modified Monash Model, including a search tool to identify the classification of a specific location, is available at:

https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm

Record Keeping

Eligible clinical psychologists providing psychological therapy services must keep contemporaneous notes of the consultation including documenting the date, time and people who attended. Only clinical details recorded at the time of attendance count towards the time of the consultation. Other notes or reports added at a later time are not included. For information on what constitutes adequate and contemporaneous records, refer to explanatory note GN.15.39 - Practitioners should maintain adequate and contemporaneous records.

Allied health professional eligibility for the provision of psychological therapy services

Psychological therapy services under the MBS may only be provided by eligible clinical psychologists.

A person is an eligible allied health professional in relation to the provision of a psychological therapy health service if the person:

a. holds general registration in the health profession of psychology with the Psychology Board of Australia; and
b. is endorsed by the Psychology Board of Australia to practice in clinical psychology.

Registering with Services Australia

Advice about registering with Services Australia to provide Better Access services is available from the Services Australia provider enquiry line on 132 150.

Further information

For further information on the Better Access Initiative, refer to explanatory note AN.0.78 – Better Access Initiative.

For further information about Medicare Benefits Schedule items, please visit the MBS online website at www.health.gov.au/mbsonline.

Further information is available for providers from the Services Australia provider enquiry line on 132 150.

If you are a patient seeking advice about Medicare services, patient benefits, or your Medicare claims, please contact Services Australia on the Medicare General enquiry line on 132 011.

MN.6.3 Referral Requirements for Better Access Treatment Services

Referral Requirements for Better Access Treatment Services

Associated items: 2721, 2723, 2725, 2727, 91818, 91819, 91842, 91843, 283, 285, 286, 287, 91820, 91821, 91844, 91845, 80100, 80105, 80110, 80115, 91169, 91170, 91183, 91184, 80125, 80130, 80135, 80140, 91172, 91173, 91185, 91186, 80150, 80155, 80160, 80165, 91175, 91176, 91187, 91188, 80120, 80122, 80127, 80121, 80123, 80128, 80145, 80147, 80152, 80146, 80148, 80153, 80170, 80172, 80174, 80171, 80173, 80175, 80000, 80010, 80005, 80015, 91166, 91167, 91181, 91182, 80020, 80021, 80022, 80023, 80024, 80025, 80002, 80006, 80012, 80016, 91171, 91199, 91168, 91198

Services requiring referral

Medicare Benefits Schedule (MBS) mental health treatment services under the Better Access initiative (refer to explanatory note AN.0.78 – Better Access Initiative) require an eligible referral for a Medicare benefit to be claimed. Medicare benefits are available for up to 10 individual and 10 group therapy mental health treatment services in a calendar year. These services may consist of:

- psychological therapy services (refer to explanatory note MN.6.2 - Provision of Psychological Therapy) and/or
- focussed psychological strategies (refer to explanatory note MN.7.4 - Provision of Focussed Psychological Strategies).

Up to 2 of a patient's individual services may be used for family and carer participation items per calendar year. For additional information, refer to explanatory note MN.7.5 – Family and Carer Participation.

Eligible referral services

Referrals for treatment services under the Better Access initiative should be utilised for patients who require at least a moderate level of support.

For the purposes of Better Access treatment services, a Medicare benefit will be not payable unless patients meet the eligibility and referral requirements outlined in explanatory note AN.0.78 | Better Access Initiative.

Referrals from psychiatrists and paediatricians must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109 and items 91822, 91823 and 91833. For consultant physician psychiatrists the relevant eligible Medicare services cover

any of the consultant psychiatrist items 293 to 308, 310, 312, 314, 316, 318 or 319 through 349; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 133.

Course of treatment and specifying the number of services in a referral

Under the Better Access initiative, a patient may be referred for up to 10 individual and 10 group therapy mental health treatment services within a calendar year. Eligible patients must be referred to mental health treatment services by either a general practitioner (GP) or a prescribed medical practitioner (PMP) at the general practice in which the patient is enrolled in MyMedicare, or regardless of whether the patient is enrolled in MyMedicare, by the patient's usual medical practitioner who is managing the patient under a Mental Health Treatment Plan. This also includes a GP or PMP who is located at a medical practice that has provided the majority of their care over the previous 12 months or will be providing the majority of their care over the next 12 months. In addition, eligible patients can be referred under a Psychiatrist Assessment and Management Plan, or on direct referral from an psychiatrist or paediatrician.

The referring practitioner can decide how many services the patient will receive in a course of treatment, within the maximum service limit for the course of treatment. The maximum service limit for each course of treatment is set out below:

- Initial course of treatment - a maximum of 6 individual services.
- Subsequent course of treatment - remaining individual services up to the patient's cap of 10 services per calendar year (for example, if the patient received 6 services in their initial course of treatment, they could only receive 4 services in a subsequent course of treatment provided within the same calendar year).
- Up to a maximum of 10 group therapy mental health treatment services per calendar year.

On completion of the initial course of treatment, the eligible allied health professional providing the service must provide a written report to the referring practitioner, which includes information on:

- assessments carried out on the patient;
- treatment provided; and
- recommendations on future management of the patient's disorder (e.g. if they require a subsequent course of treatment as the initial course of individual services is only up to 6 services, with the subsequent being no more than the maximum of 10 services per calendar year), noting further treatment under the Better Access initiative should be utilised for patients who require at least a moderate level of support.

This report will aid the referring practitioner in determining whether another course of treatment is appropriate for the management of the patient's mental disorder.

If, in their referral, the referring practitioner:

- Does not specify the number of services
- Specifies a number of services above the maximum allowed for the course of treatment
- Specifies a number of services above the maximum allowed for the calendar year (including any services the patient has already received that year),

The eligible allied health professional must contact the referring practitioner to determine the required number of services required. If the referring practitioner cannot be contacted to confirm the required number of services, the eligible allied health professional may use their clinical judgment to provide services under the referral, noting the patient cannot receive more than:

- the maximum number of services allowed for that particular course of treatment; and
- the maximum number of services allowed in a calendar year.

Where the patient's maximum allocation per course of treatment is unknown, the allied health professional should contact Services Australia on the Medicare Provider Enquiry Line (132 150) to confirm the patient's remaining allocation of services.

Referral requirements

Referrals for treatment services under the Better Access initiative should be utilised for patients who require at least a moderate level of support.

Referring practitioners are not required to use a specific Medicare form to refer patients for these services, however, AN.15.6 – Referral requirements for allied health and Aboriginal and Torres Strait Islander Health and Wellbeing Services sets out the requirements when referring patients to MBS supported allied health services.

In addition to the referral requirements outlined in AN.15.6, it must be noted that a Mental Health Treatment Plan is not considered a referral, and a referral for mental health services under Better Access should be in writing (signed and dated by the referring practitioner [which can be by an electronic signature]) and include:

- the patient's name, date of birth and address;
- the patient's symptoms or diagnosis;
- a list of any current medications;
- the number of services the patient is being referred for; and
- a statement about whether the patient has had a Mental Health Treatment Plan or a Psychiatrist Assessment and Management Plan prepared.

A referral should include all the above details, and any additional information outlined in AN.15.6 to assist with any auditing undertaken by the Department of Health, Disability and Ageing. Eligible GPs and eligible PMPs who provide focussed psychological strategies services do so as part of an arrangement for the treatment of an assessed mental health disorder under a Mental Health Treatment Plan. Where appropriate, and with the patient's agreement, a copy of the Mental Health Treatment Plan can be attached to the referral.

Use of referrals across different calendar years

If a patient has not used all their psychological therapy services and/or focussed psychological strategies services covered by a referral within the calendar year, it is not necessary to obtain a new referral for the "unused" services. However, any "unused" services received from 1 January in the following year under that referral will count as part of the total services for which the patient is eligible in that calendar year.

When a patient has used all of their referred services, they will need to obtain a new referral from either their GP or PMP at their MyMedicare registered practice or by their usual medical practitioner if they are eligible for further services.

It is not necessary to have a new Mental Health Treatment Plan and/or Psychiatrist Assessment and Management Plan prepared each calendar year in order to access a new referral(s) for psychological therapy services and/or focussed psychological strategies services. A Mental Health Treatment Plan or a Psychiatrist Assessment and Management Plan does not expire. A new Mental Health Treatment Plan or a Psychiatrist Assessment and Management Plan should not be created unless exceptional circumstances exist. An exceptional circumstance may be where the patient has had a significant change to their mental health or the treating practitioner is unable to obtain a copy of their Mental Health Treatment Plan or Psychiatrist Assessment and Management Plan.

Patients continue to be eligible for benefits for psychological therapy services and/or focussed psychological strategies services while they are being managed under a Mental Health Treatment Plan and/or a Psychiatrist Assessment and Management Plan as long as the need for eligible services continues to be recommended. However, patients will only receive a Medicare benefit for psychological therapy services and/or focussed psychological strategies services by eligible allied health professionals if they obtained a referral from a GP or PMP at their MyMedicare registered practice or by their usual medical practitioner.

Receipt of referral

The treating eligible allied health professional providing the relevant treatment service (refer to explanatory notes MN.6.2 – Provision of Psychological Therapy and MN.7.4 – Provision of Focussed Psychological Strategies) must be in receipt of the referral at the first consultation. The treating eligible allied health professional must also retain

the referral for a period of 2 years (24 months) from the date the first treatment service was rendered. For more information on record keeping and reporting requirements, refer to explanatory note AN.0.78 – Better Access Initiative.

Further information

For further information on the Better Access Initiative, refer to explanatory note AN.0.78 – Better Access Initiative.

For further information about Medicare Benefits Schedule items, please visit the MBS online website at www.health.gov.au/mbsonline.

Further information is available for providers from the Services Australia provider enquiry line on 132 150.

If you are a patient seeking advice about Medicare services, patient benefits, or your Medicare claims, please contact Services Australia on the Medicare General enquiry line on 132 011.

MN.7.4 Provision of Focussed Psychological Strategies

Provision of Focussed Psychological Strategies

Associated Items: 283, 285, 286, 287, 2721, 2723, 2725, 2727, 80100, 80105, 80110, 80115, 80120, 80121, 80122, 80123, 80125, 80127, 80128, 80130, 80135, 80140, 80145, 80146, 80147, 80148, 80150, 80152, 80153, 80155, 80160, 80165, 80170, 80171, 80172, 80173, 80174, 80175, 91818, 91819, 91842, 91843, 91820, 91821, 91844, 91845, 91169, 91170, 91183, 91184, 91172, 91173, 91185, 91186, 91175, 91176, 91187 , 91188

Services attracting Medicare benefits

There are 58 Medicare Benefits Schedule (MBS) items for the provision of focussed psychological strategy services to eligible patients by an eligible general practitioner (GP), eligible prescribed medical practitioner (PMP), eligible psychologist (registered), eligible occupational therapist, or eligible social worker. These consist of:

Individual focussed psychological strategies:

GP services:

- face-to-face items: 2721, 2723, 2725 and 2727
- video and phone items: 91818, 91819, 91842 and 91843

PMP services:

- face-to-face items: 283, 285, 286 and 287
- video and phone items: 91820, 91821, 91844 and 91845

Psychologist (registered) services:

- face-to-face items: 80100, 80105, 80110 and 80115
- video and phone items: 91169, 91170, 91183 and 91184

Occupational therapist services:

- face-to-face items: 80125, 80130, 80135 and 80140
- video and phone items: 91172, 91173, 91185 and 91186

Social worker services:

- face-to-face items: 80150, 80155, 80160 and 80165
- video and phone items: 91175, 91176, 91187, and 91188

Group focussed psychological strategies:

Psychologist (registered) services:

- face-to-face items: 80120, 80122 and 80127
- video items: 80121, 80123 and 80128

Occupational therapist services:

- face-to-face items: 80145, 80147, 80152
- video items: 80146, 80148, 80153

Social worker services:

- face-to-face items: 80170, 80172, 80174
- video items: 80171, 80173, 80175

To provide these services, eligible health professionals must meet the provider eligibility requirements set out below and be registered with Services Australia.

For group focussed psychological strategies services provided via video, additional restrictions apply. Please see the group focussed psychological strategies services - telehealth (video) requirements section below for further information.

Eligible referral services

Referrals for treatment services under the Better Access initiative should be utilised for patients who require at least a moderate level of support.

For the purposes of Better Access treatment services, a Medicare benefit will be not payable unless patients meet the eligibility and referral requirements outlined in explanatory note AN.0.78 | Medicare Benefits Schedule.

Service length and type

Services provided by eligible health professionals under these items must meet the time period requirements specified within the item descriptor.

It is expected that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

A range of acceptable strategies has been approved for use by eligible health professionals utilising the focussed psychological strategies items.

These are:

- psycho-education
- cognitive-behavioural therapy that involves cognitive or behavioural interventions
- relaxation strategies
- skills training
- interpersonal therapy
- eye movement desensitisation and reprocessing; and
- narrative therapy (for Aboriginal and Torres Strait Islander peoples).

Number of services per year

Medicare benefits are available for up to 10 individual and 10 group therapy mental health treatment services in a calendar year. The services may consist of:

- psychological therapy services delivered by eligible clinical psychologists (refer to explanatory note MN.6.2 - Provision of Psychological Therapy); and/or
- focussed psychological strategies services delivered by eligible GPs, eligible PMPs, eligible psychologists (registered), eligible social workers and eligible occupational therapists.

Course of treatment and reporting back to the referring medical practitioner or practice

Eligible patients must be referred for focussed psychological strategies services by either a GP or PMP at the general practice in which the patient is enrolled in MyMedicare, or regardless of whether the patient is enrolled in MyMedicare, by the patient's usual medical practitioner who is managing the patient under a Mental Health Treatment Plan. This also includes a GP or PMP who is located at a medical practice that has provided the majority of care over the previous 12 months or will be providing the majority of their care over the next 12 months. In addition, eligible patients can be referred under a Psychiatrist Assessment and Management Plan, or on direct referral from a psychiatrist or paediatrician. For additional information on Better Access referral requirements, refer to explanatory note MN.6.3 - Referral Requirements for Better Access Treatment Services.

Focussed psychological strategies services are available to any patient from any eligible GP and eligible PMP who has the appropriate training recognised by the General Practice Mental Health Standards Collaboration. GPs and PMPs who provide focussed psychological strategies services do so as part of an arrangement for the treatment of an assessed mental disorder under a Mental Health Treatment Plan.

The treating eligible allied health professional providing the service must be in receipt of the referral at the first mental health consultation. The treating eligible allied health professional must also retain the referral for 2 years (24 months) from the date the service was rendered.

The referring practitioner can decide how many services the patient will receive in a course of treatment, within the maximum service limit for the course of treatment. The maximum service limit for each course of treatment is set out below:

- Initial course of treatment - a maximum of 6 services.
- Subsequent course of treatment - a maximum of 6 services up to the patient's cap of 10 services per calendar year (for example, if the patient received 6 services in their initial course of treatment, they could only receive 4 services in a subsequent course of treatment provided within the same calendar year).

On completion of the initial course of treatment, the treating eligible health professional providing the service must provide a written report to the referring practitioner, which includes information on:

- assessments carried out on the patient;
- treatment provided; and
- recommendations on future management of the patient's disorder (e.g. if they require a subsequent course of treatment as the initial course of individual services is only up to 6 services, with the subsequent being no more than the maximum of 10 services per calendar year), noting further treatment under the Better Access initiative should be utilised for patients who require at least a moderate level of support.

A written report must also be provided to the referring practitioner at the completion of any subsequent course(s) of treatment provided to the patient.

Group focussed psychological strategies services

In addition to individual focussed psychological strategies services, eligible patients may also claim up to 10 separate group focussed psychological strategies service MBS items within a calendar year for group therapy mental health treatment services provided by eligible allied health professionals. Group focussed psychological strategy services can be claimed for groups of 4 to 10 patients. However, the eligible allied health professional providing the service can claim these MBS items if 4 patients were due to attend and 1 patient is unable to attend, regardless of the reason.

Group focussed psychological strategies services - telehealth (video) requirements

Group therapy mental health treatment services may only be delivered via video in certain circumstances. To be eligible for group therapy mental health treatment services via video, the patient must be located in a Modified Monash Model area 4-7 at the time of the consultation, and at least 15 kilometres apart by road from the eligible allied health professional delivering the service. The patient or eligible allied health professional is not permitted to travel to an area outside the minimum 15 kilometres distance in order to claim a video consultation item.

More information about the Modified Monash Model, including a search tool to identify the classification of a specific location, is available at:

https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm

Record Keeping

Eligible GPs or eligible PMPs or eligible allied health professionals providing focussed psychological strategies services must keep contemporaneous notes of the consultation including documenting the date, time and people who attended. Only clinical details recorded at the time of attendance count towards the time of the consultation. Other notes or reports added at a later time are not included. For information on what constitutes adequate and contemporaneous records, refer to explanatory note GN.15.39 - Practitioners should maintain adequate and contemporaneous records.

Professional eligibility to provide focussed psychological strategy services

Under the Better Access initiative, focussed psychological strategies services may only be provided by an eligible GP, eligible PMP, eligible psychologist (registered), eligible occupational therapist, or eligible social worker. The eligibility requirements for each profession are set out below.

A person is an eligible GP or eligible PMP in relation to the provision of focussed psychological strategies if the person:

a. is entered in the register maintained by the Chief Executive Medicare under section 33 of the *Human Services (Medicare) Regulations 2017*;
b. is identified in the register as a medical practitioner who can provide focussed psychological strategies services; and
c. meets the relevant training and skills requirements, as determined by the General Practice Mental Health Standards Collaboration.

A person is an eligible allied health professional in relation to the provision of a focussed psychological strategies health service if the person meets 1 of the following requirements:

a. the person holds general registration in the health profession of psychology with the Psychology Board of Australia; or
b. the person is a member of the Australian Association of Social Workers (AASW) and accredited by AASW as meeting the accreditation criteria set out in the document published by AASW titled 'AASW Accredited Mental Health Social Worker Application Criteria' as in force on 1 July 2022; or
c. the person:
    i. holds registration in the health profession of occupational therapy with the Occupational Therapy Board of Australia; and
    ii. is accredited by Occupational Therapy Australia as meeting the criteria for mental health endorsement as set out in the document published by Occupational Therapy Australia titled 'Occupational Therapy Australia Mental Health Endorsement Criteria' as in force on 1 March 2023.

Continuing professional development for occupational therapists and social workers providing focussed psychological strategies services

In addition to meeting the relevant professional eligibility requirements, eligible occupational therapists and eligible social workers are required to have completed 10 one-hour units of focussed psychological strategies continuing

professional development per year to provide focussed psychological strategies services. A year for the purposes of these items is from 1 July to 30 June annually. Part-time allied health professionals are required to complete 10 units of focussed psychological strategies related continual professional development, the same as full-time allied health professionals.

Continual professional development units must relate to the delivery of focussed psychological strategies in any of the following areas:

a. psycho-education;

b. cognitive-behavioural therapy including;

i. behavioural interventions;
ii. behaviour modification;
iii. exposure techniques;
iv. activity scheduling;

c. cognitive interventions including:

i. cognitive therapy;

d. relaxation strategies including;

i. progressive muscle relaxation;
ii. controlled breathing;

e. skills training including;

i. problem solving skills and training;
ii. anger management;
iii. social skills training;
iv. communication training;
v. stress management;
vi. parent management training;

f. interpersonal therapy;

g. eye movement desensitisation and reprocessing;

h. narrative therapy (for Aboriginal and Torres Strait Islander people);

i. clinical skills to undertake a full assessment of a patient in order to form a diagnosis and commence treatment planning.

Acceptable continual development activities where the content is related to focussed psychological strategies can include formal postgraduate education, workshops, seminars, lectures, journal reading, writing papers, receipt of supervision and peer consultation, and online training. There is flexibility in the continual professional activities that can be undertaken to meet individual professional needs and their practice/client base and client needs. For example, activities could also include assessment and treatment of specific disorders and client types such as youth, or different modalities and delivery such as working with groups.

A person required to complete focussed psychological strategies continuing professional development must keep written records of completion of focussed psychological strategies continuing professional development for a period of 2 years from the end of the continuing professional year to which the focussed psychological strategies continuing professional development relates.

Eligible occupational therapists and eligible social workers who register to provide focussed psychological strategies during the continual professional development year (1 July – 30 June), are obligated to undertake continual

professional development on a pro-rata basis. The amount of continual professional development units will be calculated from the 1st of the month immediately succeeding the month they obtained initial registration.

Registering with Services Australia

Advice about registering with Services Australia to provide Better Access services is available from the Services Australia provider enquiry line on 132 150.

Further information

For further information on the Better Access Initiative, refer to explanatory note AN.0.78 – Better Access Initiative.

For further information about Medicare Benefits Schedule items, please visit the MBS online website at www.health.gov.au/mbsonline.

Further information is available for providers from the Services Australia provider enquiry line on 132 150.

If you are a patient seeking advice about Medicare services, patient benefits, or your Medicare claims, please contact Services Australia on the Medicare General enquiry line on 132 011.

MN.7.5 Family and Carer Participation

Family and Carer Participation

Associated Items: 309, 311, 313, 315, 91862, 91863, 91866, 91867, 2739, 2741, 2743, 2745, 91859, 91861, 91864, 91865, 80102, 80106, 80112, 80116, 91174, 91177, 91200, 91201 80129, 80131, 80137, 80141, 91194, 91195, 91202, 91203, 80154, 80156, 80162, 80166, 91196, 91197, 91204, 91205 80002, 80006, 80012, 80016, 91168, 91171, 91198, 91199

Overview

The Family and Carer participation Medicare Benefits Schedule (MBS) items recognise the important role another person, such as a family member or carer, can play in supporting patients with a clinically diagnosed mental disorder, and the benefits that can result from involving them in treatment. Under these MBS items, Medicare benefits are available to a patient for up to 2 services provided to another person per calendar year.

Any services delivered using these items count towards the patient's individual course of treatment and calendar year allocations under the Better Access Initiative. For further information on patient allocations, please see explanatory note AN.0.78 – Better Access Initiative. For Medicare benefit purposes, claims relating to services covered by these MBS items should be raised against the patient rather than against the person receiving the service.

Services attracting Medicare benefits

Medicare benefits are available to a patient for up to 2 services provided to another person per calendar year. These services may be accessed at any stage of a patient's course of treatment and do not need to be accessed consecutively. The 2 services may consist of:

Focussed Psychological Strategies provided by eligible:

Prescribed medical practitioners (PMPs):

- Face-to-face items: 309, 311, 313 and 315
- Video and phone items: 91862, 91863, 91866 and 91867

General Practitioners (GPs):

- Face-to-face items: 2739, 2741, 2743 and 2745
- Video and phone items: 91859, 91861, 91864 and 91865

Psychologists (registered):

- Face-to-face items: 80102, 80106, 80112 and 80116
- Video and phone items: 91174, 91177, 91200 and 91201

Occupational therapists:

- Face-to-face items: 80129, 80131, 80137 and 80141
- Video and phone items: 91194, 91195, 91202 and 91203

Social workers:

- Face-to-face items: 80154, 80156, 80162 and 80166
- Video and phone items: 91196, 91197, 91204 and 91205

and;

Psychological Therapy provided by eligible Clinical psychologists:

- Face-to-face items: 80002, 80006, 80012 and 80016
- Video and phone items: 91168, 91171, 91198 and 91199.

To provide and claim these services under the MBS, the eligible GP or eligible PMP or eligible allied health professional providing treatment services to the patient must meet the relevant provider eligibility requirements. For further information, please see explanatory notes MN.6.2 -Provision of Psychological Therapy and MN.7.4 - Provision of Focussed Psychological Strategies.

Any services delivered using these MBS items count towards:

- the maximum service limit for each course of treatment under Better Access, and
- the patient's calendar year allocation for individual services under Better Access.

These MBS items are not for the purposes of providing mental health treatment to the family member or carer supporting the patient. Should the family member or carer require mental health treatment themselves, they should be advised to see their GP or PMP for an assessment to be made on their mental health. For information on Better Access patient requirements, refer to explanatory note AN.0.78 – Better Access Initiative.

Eligible referral services

Referrals for treatment services under the Better Access initiative should be utilised for patients who require at least a moderate level of support.

For the purposes of Better Access treatment services, a Medicare benefit will be not payable unless patients meet the eligibility requirements outlined in explanatory note AN.0.78 | Better Access Initiative.

For more information on referral requirements for Better Access services, refer to explanatory note MN.6.3 - Referral Requirements for Better Access Treatment Services.

Service requirements

A patient can involve another person in their treatment under the Better Access initiative where:

- the patient has been referred for Better Access services;
- the referring practitioner, or eligible practice providing the service determines it is clinically appropriate;
- the patient consents for the service to be provided to the other person as part of their treatment;
- the service is part of the patient's treatment; and
- the patient is not in attendance during the provision of the service.

When utilising family and carer items, the patient must not be in attendance during the provision of the service. In addition, the eligible GP or eligible PMP or eligible allied health professional must also consider whether the requirements of the patient MBS items for delivering Better Access services have been met. For further information, please refer to explanatory note AN.0.78 – Better Access Initiative.

Obtaining and recording patient consent

Before a treating eligible GP or eligible PMP or eligible allied health professional can provide a family and carer participation service, the patient must consent to another person receiving a mental health service as a part of their treatment. The treating eligible GP or eligible PMP or eligible allied health professional providing the service must:

- explain the service to the patient;
- obtain the patient's consent for the service to be provided to the other person as part of the patient's treatment; and
- make a written record of the patient's consent.

The patient may withdraw their consent at any time. In the case of a child, the general laws relating to consent to medical treatment apply. These may differ between states and territories, and the health practitioner should be aware of the requirements in the relevant state or territory.

Eligible mental health treatment services

Treating eligible GPs or eligible PMPs or eligible allied health professionals must use their professional judgement to determine what would be an appropriate mental health treatment service to deliver to another person as part of the patient's treatment. For information on approved treatment services, including provider eligibility requirements to provide these services, please refer to explanatory notes MN.6.2 - Provision of Psychological Therapy and MN.7.4 - Provision of Focussed Psychological Strategies.

Further Information

For further information on the Better Access Initiative, refer to explanatory note AN.0.78 – Better Access Initiative.

For further information about Medicare Benefits Schedule items, please visit the MBS online website at www.health.gov.au/mbsonline.

Further information is available for providers from the Services Australia provider enquiry line on 132 150.

If you are a patient seeking advice about Medicare services, patient benefits, or your Medicare claims, please contact Services Australia on the Medicare General enquiry line on 132 011.

MN.8.1 Pregnancy Support Counselling - Eligible Patients - (Items 81000 - 81010, 93026 and 93029)

Medicare benefits are available for non-directive pregnancy support counselling services provided to a person who is pregnant or who has been pregnant in the 12 months preceding the first service to which item 81000, 81005, 81010, 93026 and 93029 applies in relation to that pregnancy. Services can be provided either by an eligible GP/medical practitioner or by an eligible psychologist, social worker or mental health nurse on referral from a GP or medical practitioner.

The items may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

MN.8.2 Pregnancy Support Counselling - Eligible Services - (Items 81000, 81005, 81010, 93026 and 93029)

There are 5 in person MBS items for the provision of non-directive pregnancy support counselling services:

- Item 4001 - services provided by an eligible GP;
- Item 792 - services provided by an eligible medical practitioner;
- Item 81000 - services provided by an eligible psychologist;

- Item 81005 - services provided by an eligible social worker; and
- Item 81010 - services provided by an eligible mental health nurse.

There are 6 telehealth (video and phone) MBS items for the provision of non-directive pregnancy support counselling services:

- Item 92136 - services provided by an eligible GP by video
- Item 92138 - services provided by an eligible GP by phone
- Item 92137 - services provided by an eligible medical practitioner by video
- Item 92139 - services provided by an eligible medical practitioner by phone
- Item 93026 - services provided by an eligible psychologist, social worker or mental health nurse by video
- Item 93029 - services provided by an eligible psychologist, social worker or mental health nurse by phone

These notes relate to items 81000, 81005, 81010, 93026 and 93029. Each individual allied health professional must meet the provider eligibility requirements set out below and be registered with Services Australia.

Service length and type

Non-directive pregnancy support counselling services provided by eligible psychologists, social workers and mental health nurses using items 81000, 81005, 81010, 93026 and 93029 must be of at least 30 minutes duration and provided to an individual patient. For items 81000, 81005 and 81010, the allied health professional must personally attend the patient.

The service involves the psychologist, social worker or mental health nurse undertaking a safe, confidential process that helps the patient explore concerns they have about a current pregnancy or a pregnancy that occurred in the preceding 12 months. This includes providing, on request, unbiased, evidence-based information about all options and services available to the patient.

Non-directive counselling is a form of counselling that is based on the understanding that, in many situations, people can resolve their own problems without being provided with a solution by the counsellor. The counsellor's role is to encourage the person to express their feelings but not suggest what decision the person should make. By listening and reflecting back what the person reveals to them, the counsellor helps them explore and understand their feelings. With this understanding, the person is able to make the decision that is best for them.

Number of services per year

Medicare benefits are available for a maximum of 3 services (including services to which items 792, 4001, 81000, 81005, and 81010 in the general medical services table, or items 92136, 92137, 92138, 92139, 93026, or 93029 in the Telehealth and Telephone Determination apply) for each pregnancy.

Where the patient is unsure of the number of Medicare benefits for non-directive pregnancy support counselling services they have already accessed, the patient may check with Services Australia on 132 011. Alternatively, the psychologist, social worker or mental health nurse may check with Services Australia.

Partners of eligible patients may attend each or any counselling session, however, only one fee applies to each service.

Out-of-pocket expenses and Medicare Safety Net

Charges in excess of the Medicare benefit for these items are the responsibility of the patient. However, such out-of-pocket costs will count toward the Medicare safety net for that patient. Non-directive pregnancy support counselling services in excess of 3 per pregnancy will not attract a Medicare benefit and the safety net arrangements will not apply to costs incurred by the patient for such services.

Publicly funded services

Items 81000, 81005, 81010, 93026 and 93029 do not apply for services that are provided by any other Commonwealth or State funded services or provided to an admitted patient of a hospital.

However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or state/territory clinic, these items can be claimed for services provided by an eligible psychologist, social worker or mental health nurse salaried by or contracted to the service, where all requirements of the relevant item are met, including registration with Services Australia. These services must be bulk billed (that is, the Medicare benefit is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance general treatment cover (also known as ancillary or extras cover) cover to pay for these services. Patients cannot use their general treatment cover to 'top up' the Medicare benefit paid for the services.

MN.8.3 Pregnancy Support Counselling - Referral Requirements (Items 81000, 81005, 81010, 93026 and 93029)

Patients must be referred for non-directive pregnancy support counselling services by a GP or medical practitioner. GPs/medical practitioners are not required to use a specific form to refer patients for these services. The referral may be a letter or note to an eligible allied health professional signed and dated by the referring GP/medical practitioner.

Patients may be referred by a GP or medical practitioner to more than one eligible allied health professional for eligible non-directive pregnancy support counselling services (for example, where a patient does not wish to continue receiving services from the provider they were referred to in the first instance).

The relevant allied health professional must be in receipt of the referral at the first non-directive pregnancy support counselling service and must retain the referral for 2 years from the date the service was rendered, for Services Australia auditing purposes.

A copy of the referral is not required to accompany Medicare claims. However, referral details are required to be included on patients' itemised accounts/receipts or Medicare assignment of benefit agreements.

Referral validity

The referral is valid for up to 3 non-directive pregnancy support counselling services, per patient, per pregnancy.

Subsequent Referrals

A new referral is required where the patient seeks to access non-directive pregnancy support counselling in relation to a different pregnancy or where the patient wishes to be referred to a different allied health professional than the one they were referred to in the first instance.

MN.8.4 Pregnancy Support Counselling - Allied Health Professional Eligibility (Items 81000, 81005, 81010, 93026 and 93029)

Eligible allied health professionals

Items 81000, 81005, 81010, 93026 and 93029 can only be claimed for services provided by psychologists, social workers and mental health nurses who meet the following specific eligibility requirements, and are registered with Services Australia.

To be eligible to provide services using MBS items 81000, 93026 and 93029, a psychologist must hold general registration in the health profession of psychology under the applicable law in force in the state or territory in which the service is provided and be certified by the Australian Psychological Society as appropriately trained in non-directive pregnancy counselling.

To be eligible to provide services using MBS items 81005, 93026 and 93029, a social worker must be a 'Member' of the Australian Association of Social Workers (AASW), be certified by AASW either as meeting the standards for mental health set out in the document published by AASW titled ‘Practice Standards for Mental Health Social Workers 2014’ as in force on 25 September 2014 and certified by AASW as appropriately trained in non-directive pregnancy counselling.

To be eligible to provide services using MBS items 81010, 93026 and 93029, a mental health nurse must be a 'Credentialled Mental Health Nurse' as certified by the Australian College of Mental Health Nurses, and be appropriately trained in non-directive pregnancy counselling.

Registering with Services Australia

Advice about registering with Services Australia to provide non-directive pregnancy support counselling services using items 81000 – 81010, 93026 and 93029 is available from Services Australia provider inquiry line on 132 150.

Further information

Additional information can be found on the Department of Health, Disability and Ageing and Services Australia website by searching 'allied health'.

Further information is also available for providers from the Services Australia provider inquiry line on 132 150.

MN.9.1 Assessing suitability for group allied health services for patients with Type 2 diabetes (MBS items 81100, 81110, 81120, 93284)

SUMMARY

This note sets out the requirements for assessing a patient with type 2 diabetes suitability for group diabetes education, dietetics or exercise physiology allied health services to support their diabetes management. These services are part of the MBS framework for patients with a chronic condition (see AN.15.3).

Assessments of suitability for group allied health services are available to patients with type 2 diabetes with a GP chronic condition management plan (see AN.15.3) or residents of a residential care home that have a multidisciplinary care plan (see AN.15.8). Until 1 July 2027 these services are also available to patients that have a GP management plan (see AN.15.3).

The service must be consistent with the patient’s plan and a medical practitioner must refer the patient for the service (see AN.15.6).

Patients can access 1 group allied health assessment service each calendar year.

On 1 July 2025 GP management plans were replaced with new GP chronic condition management plan (see AN.15.3) items. Transition arrangements are in place for existing patients with a GP management plan (see AN.15.5). New requirements for referrals to allied health services written on or after 1 July 2025 also came into effect (see AN.15.6).

USE OF THE ITEMS

These services are to assess a patient’s suitability for group diabetes education, dietetics and/or exercise physiology services to support the management of their type 2 diabetes. The assessment includes:

- Taking a comprehensive patient history
- Identifying an appropriate group services program based on the patient's needs, and

- Preparing the person for group services.

The requirements of the items for assessments of a patient's suitability for group allied health services are set out in the *Health Insurance (Section 3C General Medical Services - Allied Health and other Primary Health Care Services) Determination 2024* (Health Determination) and the *Health Insurance (Section 3C General Medical Services – Telehealth and Telephone Attendances) Determination 2021* (Telehealth Determination).

Is there a minimum length for the assessment?

Yes, the Health and Telehealth Determination specifies that the assessment must last at least 45 minutes.

This is an assessment for group services. Is it provided to a group or the individual?

The assessment must be provided to an individual. While it is an assessment of the patient's suitability for group services the assessment must not be provided in a group setting.

I am a diabetes educator. If I find the patient suitable, can they only access group diabetes education services?

No. You are assessing their suitability for group services relating to the management of type 2 diabetes. If they are assessed as suitable, they will be able to access any combination of diabetes education, dietetics and exercise physiology group services.

Am I required to provide information back to the referring medical practitioner?

Yes. You must provide a written report back to the referring GP or prescribed medical practitioner.

How many group allied health assessment services can be claimed for a patient?

Patients can access one suitability assessment for group allied health services per calendar year.

How long does a referral last?

For referrals written on or after 1 July 2025, referrals will be valid for the length of time specified in the referral, or if no timeframe is specified, 18 months from the date of the first service provided under the referral.

For referrals written where the assessment was undertaken prior to 1 July 2025 the referral with the completed assessment must specify the number of services. The referral remains valid until all services are provided.

For further information on referrals see AN.15.6.

Should the referral be for a specific allied health professional?

No. The patient can take the referral to any eligible allied health professional of the same profession/type specified in the referral of their choosing. For example, a referral to credentialled diabetes educator for an assessment can be taken to any credentialled diabetes educator but it cannot be taken to an accredited exercise physiologist.

For further information on referrals see AN.15.6.

ELIGIBLE PATIENTS

To be eligible for this MBS service a patient must:

- Have type 2 diabetes
- Be being managed by a GP or prescribed medical practitioner under:
    - a GP chronic condition management plan that has been put in place of reviewed in the last 18 months, or
    - Until 1 July 2027, a GP management plan that was in place before 1 July 2025, or

- Are a resident of a residential care home and have a multidisciplinary care plan, and

- Be referred for the service by their GP or prescribed medical practitioner (see AN.15.6).

ELIGIBLE PRACTITIONERS

These services can be provided by credentialled diabetes educators, accredited practising dietitians and accredited exercise physiologists. These allied health practitioners must have a Medicare Provider Number to provide these services. For further information on the qualification requirements for allied health professionals to provide MBS services see AN.15.4.

Name of Service	Face to Face	Video/Telephone
Diabetes education	81100	NA
Dietetics	81120	93284/93286
Exercise physiology	81110	NA

RECORD KEEPING AND REPORTING REQUIREMENTS

The Health Determination requires that the allied health provider that performs the assessment provides a written report back to the referring medical practitioner.

It is a requirement that, where an item specifies the creation of a document (however described) and a document is created, the document must be retained for a period of 2 years. This includes records made by the allied health provider for reporting back to the referring medical practitioner.

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements and they may be required to submit evidence for compliance checks related to Medicare claims. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item(s) can be found on the Federal Register of Legislation at www.legislation.gov.au. These items are set out in the following regulatory instruments:

- *Health Insurance (Section 3C General Medical Services – Allied Health and other Primary Health Care Services) Determination 2014* – items 8110, 81110, 81190
- *Health Insurance (Section 3C General Medical Services – Telehealth and Telephone Attendances) Determination 2021* – items 93284, 93286

MN.9.2 Group Allied Health Services for Patients with Type 2 Diabetes (MBS items 81105, 81115, 81125, 93285)

SUMMARY

This note sets out the requirements for group diabetes education, dietetics and exercise physiology allied health services for patients with type 2 diabetes to support the management of their condition. These services are part of the MBS framework for patients with a chronic condition (see AN.15.3).

Patients are eligible for group allied health services if they have type 2 diabetes and have been assessed as suitable for group health services by a credentialled diabetes educator, accredited practising dietitian or an accredited exercise physiologist (see MN.9.1). Assessments are available to patients with a GP chronic condition management plan (see AN.15.3) and residents of a residential care home with a multidisciplinary care plan (see AN.15.8). Until 1 July 2027 they are also available to patients with a GP management plan that was put in place prior to 1 July 2025 (see AN.15.5).

Patients can access up to 8 group allied health services per calendar year.

On 1 July 2025 GP management plans and team care arrangements were replaced with new GP chronic condition management plan items (see AN.15.3). New requirements for referrals to eligible health services written on or after 1 July 2025 also came into effect (see AN.15.6).

USE OF THE ITEMS

Group allied health services are available for diabetes education, dietetics and exercise physiology for the management of type 2 diabetes.

The requirements of the items for group allied health services are set out in the *Health Insurance (Section 3C General Medical Services - Allied Health and other Primary Health Care Services) Determination 2024* (the Health Determination) and the *Health Insurance (Section 3C General Medical Services – Telehealth and Telephone Attendances) Determination 2021* (Telehealth Determination).

Is there a minimum length for the assessment?

Yes, the Health and Telehealth Determinations specifies that the assessment must last at least 45 minutes.

How many group allied health therapy services can be claimed for a patient?

Patients can access 8 group allied health therapy services per calendar year. This is in addition to any individual allied health services the patient may be eligible for.

It is February. Does my patient need another assessment to continue group therapy services this year?

No. Once a patient has been assessed as suitable for group services, they do not require another assessment to continue. However, in some circumstances their medical practitioner may request another assessment, for example, if there has been a significant change in their condition.

How many patients need to be in the group?

To use the MBS items there must be a minimum of two and maximum of 12 patients in attendance. The diabetes educator, dietician or exercise physiologist providing the service must keep an attendance record for the group.

My patient was assessed as suitable for a group health service by a diabetes educator. Can they only access group diabetes education services?

No. They have been assessed as suitable for group health services relating to the management of type 2 diabetes. They can access any combination of diabetes education, dietetics and exercise physiology group services.

Can one session cover more than one of diabetes education, dietetics and exercise physiology?

A collaborative approach, where diabetes educators, exercise physiologists and dietitians work together to develop group service programs in their local area, is encouraged. However, for more than one MBS group service to be delivered on a day the requirements of both items must be met.

For example, a credentialled diabetes educator delivers a 60-minute group diabetes education service to the patient and the patient then attends a 60-minute dietitians group health session for an accredited practising dietician later in the day. These two services cannot be delivered in the same 60-minute period.

Am I required to provide information back to the referring medical practitioner?

Yes, if the service is the last group service in the program the diabetes educator, dietitian or exercise physiologist who delivered the service must prepare or contribute to a written report back to the referring medical practitioner to meet the requirements of the item.

ELIGIBLE PATIENTS

Patients are eligible for group health services if they have type 2 diabetes and have been assessed as suitable for group health services under items 81100, 81110, 81120 or 93284 (see MN.9.1).

Patients being managed by the GP or prescribed medical practitioner through a GP chronic condition management plan (see AN.15.3) need to have had their plan put in place or reviewed within the last 18 months to be eligible for services.

Patients with a multidisciplinary care plan must be a resident of a residential care home to be eligible for these services.

Until 1 July 2027, patients who have a GP management plan that was put in place before 1 July 2025 can continue to access these services under that plan.

ELIGIBLE PRACTITIONERS

These services can be provided by credentialled diabetes educators, accredited practising dieticians and accredited exercise physiologists. These allied health practitioners must have a Medicare provider number to provide these services. For further information on the qualification requirements for allied health professionals to provide MBS services (see AN.15.4).

Name of service	Face to face	Video
Diabetes education	81105	NA
Dietetics	81125	93285
Exercise physiology	81115	NA

RECORD KEEPING AND REPORTING REQUIREMENTS

If the service is the last group service in the program the diabetes educator, dietitian or exercise physiologist who delivered the service must prepare or contribute to a written report back to the referring medical practitioner to meet the requirements of the item.

It is a requirement that, where an item specifies the creation of a document (however described) and a document is created, the document must be retained for a period of 2 years. This includes the report/s back to the referring GP or prescribed medical practitioner that the allied health professional is required to write or contribute to under these items.

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements and they may be required to submit evidence for compliance checks related to Medicare claims. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records (see GN.15.39).

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item can be found on the Federal Register of Legislation at www.legislation.gov.au. These items are set out in:

- *Health Insurance (Section 3C General Medical Services – Allied Health and other Primary Health Care Services) Determination 2024* – items 81105, 81115, 81125
- *Health Insurance (Section 3C General Medical Services – Telehealth and Telephone Attendances) Determination 2021* – item 93285

MN.10.1 Assessment to assist with Diagnostic Formulation and Contribution to a Treatment and Management Plan by Eligible Allied Health Practitioner(s) for Complex Neurodevelopmental Disorder (such as Autism Spectrum Disorder) or Eligible Disability Services

These allied health items provide a benefit for:

- the assessment of patients for the purpose of assisting the referring eligible medical practitioner with the diagnosis (including a differential diagnosis) of a complex Neurodevelopmental Disorder (such as Autism Spectrum Disorder) or an eligible disability; or
- to contribute to a treatment and management plan that is being developed by the referring eligible medical practitioner.

The list of eligible disabilities can be found at MN.10.3.

Number of services

- A maximum of 8 services can be claimed per patient per lifetime, including services consisting of any combination of 82000, 82005, 82010, 82030, 93032, 93033, 93040 or 93041.
- A course of assessment means up to 4 services.
- Up to 4 of these services may be provided to the same patient on the same day.
- Where a patient requires more than 4 services from the same eligible allied health provider, review and agreement is required by the referring medical practitioner before further Medicare eligible services can be claimed.

Provision of assessment services and need for review and agreement by the referring eligible medical practitioner

- An eligible allied health practitioner can provide up to 4 assessment services without the need for review and agreement by the referring eligible medical practitioner.
- If an eligible allied health professional has provided 4 assessment services to a patient and proposes to provide more assessment services to that patient, review and agreement from the referring eligible medical practitioner must be obtained prior.
- The referring eligible medical practitioner may specify the type of review that should be undertaken as part of the original referral. If it is not specified, an acceptable means of review includes: a case conference, phone call, written correspondence, secure online messaging exchange, or attendance with the referring eligible medical practitioner.
- The review and agreement by the referring eligible medical practitioner should be recorded by the eligible allied health practitioner in the patient notes.

Referral requirements

For an MBS benefit to be claimed for these services, a valid referral from an eligible medical practitioner (or subsequent interdisciplinary referral) is required. The general requirements for referrals under group M10 (subgroup 1) are detailed in Note AN.15.6 '*Referral requirements for allied health services'*.

The eligible medical practitioner referral is only valid if the referring eligible medical practitioner used any of the following MBS items* for the suspected diagnosis of:

- **complex Neurodevelopmental Disorders** referred by a:

  - **consultant psychiatrist** using items 296 to 308, 310, 312, 314, 316, 318 or 319 to 349 of the general medical services table or items 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 92437, 92455, 92456 or 92457 of the Telehealth Attendance Determination.

  - **consultant paediatrician** using items 110 to 131 of the general medical services table or items 91824, 91825, 91826 or 91836 of the Telehealth Attendance Determination.

- **eligible disability** referred by a:

- **specialist or consultant physician** using items 104 to 131, 296 to 308, 310, 312, 314, 316, 318 or 319 to 349 of the general medical services table or items 91822 to 91839, 92437, 92455, 92456 or 92457 of the Telehealth Attendance Determination.

- **GP** using items 3 to 47 of the general medical services table or item 91790, 91800, 91801, 91802, 91890 or 91891 of the Telehealth Attendance Determination.

* Note that more information on the telehealth (video and phone) items that can be claimed for these services can be found in Note AN.40.1.

A separate referral from the eligible medical practitioner is required for each eligible allied health practitioner providing the service. A Medicare claim must be submitted for the referring MBS service before a benefit for the subsequent referred allied health service can be paid.

Allied health practitioners should retain referrals for 24 months from the date the service was rendered for Medicare auditing purposes.

Interdisciplinary referrals

If an eligible allied health practitioner seeks to make an interdisciplinary referral of the patient to another eligible allied health professional, this must be undertaken in consultation and agreement with, but without the need for a physical attendance by, the original referring eligible medical practitioner (such as but not limited to, a phone call, written correspondence or secure online messaging exchange). This consultation and agreement should be documented in the patient notes by the eligible allied health practitioner and included in the interdisciplinary referral. The referral may be a letter or note to an eligible allied health practitioner, signed and dated by the referring eligible allied health practitioner. There is no specific form to refer patients for these services. The referral should include a copy of the original referral by the eligible medical practitioner.

Interdisciplinary referrals will only be valid where the referring eligible medical practitioner's referral (whose original referral initiated the assessment and assisting with a diagnosis service/contribution to a treatment and management plan) remains valid.

Reporting requirements for assessment services

After completion of the final assessment service by an eligible allied health practitioner, a written report must be provided to the referring eligible medical practitioner that outlines the assessment findings. Preparation of the report is not counted towards the service time under the item.

The written report must include information on:

- the assessment/s provided;
- the results of the assessment/s that may assist with diagnostic formulation or development of a treatment and management plan by the referring eligible medical practitioner; and
- if applicable, advice on further assessments that could be undertaken by other eligible allied health practitioners to assist with the referring medical practitioners' diagnostic formulation or development of a treatment and management plan by the referring eligible medical practitioner.

MN.10.2 Treatment Services by Eligible Allied Health Practitioners for Complex Neurodevelopmental Disorders (such as Autism Spectrum Disorder) and Eligible Disability Services

These allied health items are available for patients that have been diagnosed with a complex Neurodevelopmental Disorder (such as Autism Spectrum Disorder) or an eligible disability. It is expected that eligible allied health practitioners will deliver treatment under these items that is consistent with the complex Neurodevelopmental Disorder or eligible disability treatment and management plan prepared by the referring eligible medical practitioner and is in keeping with commonly established interventions as practised by their profession and appropriate for the age and particular needs of the patient being treated.

It is anticipated that professional attendances at places other than consulting rooms will be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

Number of services

- A maximum of 20 services can be claimed per patient per lifetime, including services consisting of any combination of 82015, 82020, 82025, 82035, 93035, 93036, 93043 or 93044.
- A course of treatment means up to 10 treatment services.
- Up to 4 of these services may be provided to the same patient on the same day.
- It is the responsibility of the referring eligible medical practitioner to allocate these services in keeping with the patient's individual treatment needs and to refer the patient to the appropriate allied health professional(s) accordingly.

Referral Requirements

For a Medicare benefit to be paid, the eligible allied health practitioner providing the service must be in receipt of a current referral provided by an eligible medical practitioner. A separate referral from an eligible medical practitioner is required for each eligible allied health practitioner. The referral is only valid if the referring provider uses any of the following MBS items*:

- For a **complex Neurodevelopmental Disorder** referred by a:

  - **consultant psychiatrist** using item 289 of the general medical services table or item 92434 of the Telehealth Attendance Determination.

  Note. If a patient has previously been provided with a service mentioned in item 289, a consultant physician specialising in the practice of the consultant physician's field of psychiatry may only refer the patient for a service to which any of items 296 to 308, 310, 312, 314, 316, 318 or 319 to 349 of the general medical services table or items 91827, 91828, 91829, 91830, 91831, 91837, 91838, 91839, 92437, 92455, 92456 or 92457 of the Telehealth Attendance Determination applies.

  - **paediatrician** using item 135 of the general medical services table or item 92140 of the Telehealth Attendance Determination.

  Note. If a patient has previously been provided with a service mentioned in item 135 of the general medical services table or item 92140 of the Telehealth Attendance Determination, a consultant physician specialising in the practice of the consultant physician's field of paediatrics may only refer the patient for a service to which any of items 110 to 131 of the general medical services table or items 91824, 91825, 91826 or 91836 of the Telehealth Attendance Determination applies.

  If a patient has previously been provided with a service mentioned in item 137 or 139 of the general medical services table or item 92141 or 92142 of the Telehealth Attendance Determination, the medical practitioner cannot refer the patient for a service to which item 135 or 289 of the general medical services table or item 92140 or 92434 of the Telehealth Attendance Determination applies.

- For an **eligible disability** referred by a:

  - **specialist or consultant physician** using item 137 of the general medical services table or item 92141 of the Telehealth Attendance Determination.

  - **GP** using item 139 of the general medical services table or item 92142 of the Telehealth Attendance Determination.

  Note. If a patient has previously been provided with a service mentioned in item 135 or 289 of the general medical services table or item 92140 or 92434 of the Telehealth Attendance Determination, the medical practitioner cannot refer the patient for a service to which item 137 or 139 of the general medical services table or item 92141 or 92142 of the Telehealth Attendance Determination applies.

* Note that more information on the telehealth (video and phone) items that can be claimed for these services can be found in Note AN.40.1.

The referral may be a letter or note to an eligible allied health practitioner, signed and dated by the referring eligible medical practitioner. Referring eligible medical practitioners are not required to use a specific form to refer patients for these services. A Medicare claim must be submitted for the referring service before a benefit for the subsequent referred allied health service can be paid.

The referred service consists of the number of allied health services stated on the patient's referral. This enables the referring practitioner to consider a report from the allied health practitioners about the services provided to the patient, and the need for further treatment.

Within the maximum service allocation of 20 services for the treatment items, the eligible allied health practitioner/s can provide one or more courses of treatment. A new referral is required for each new course of treatment (up to 10 services). The amount of services in each course of treatment is determined by the referring eligible medical practitioner. The referring eligible medical practitioner should review the written report provided by the eligible allied health practitioner after completion of a course of treatment and prior to referring for a subsequent course of treatment.

Eligible allied health practitioners should retain the referral for 24 months from the date the service was rendered for Medicare auditing purposes.

Reporting requirements

On completion of a course of treatment (and any subsequent courses of treatment), the eligible allied health practitioner must provide a written report to the referring eligible medical practitioner which includes information on:

- treatment provided;
- recommendations on future management of the patient's disorder or disability; and
- if applicable, any advice provided to third parties (for example: parents, schools, places of employment).

The writing of the report is not counted towards the service time under the item.

MN.10.3 Eligibility for allied health assessment and treatment services for complex neurodevelopmental disorder and eligible disability services

Eligible patients

These items provide Medicare benefits for allied health services provided to patients under 25 years old with a suspected or diagnosed complex Neurodevelopmental Disorder (NDD) such as autism spectrum disorder (autism), or one or more of the eligible disabilities.

Eligible disabilities

'Eligible disabilities' for the purpose of these services means any of the following conditions:

(a) sight impairment that results in vision of less than or equal to 6/18 vision or equivalent field loss in the better eye, with correction;

(b) hearing impairment that results in:

- a hearing loss of 40 decibels or greater in the better ear, across 4 frequencies; or
- permanent conductive hearing loss and auditory neuropathy.

(c) deafblindness;

(d) cerebral palsy;

(e) Down syndrome;

(f) fragile X syndrome;

(g) Prader-Willi syndrome;

(h) Williams syndrome;

(i) Angelman syndrome;

(j) Kabuki syndrome;

(k) Smith-Magenis syndrome;

(l) CHARGE syndrome;

(m) Cri du Chat syndrome;

(n) Cornelia de Lange syndrome;

(o) microcephaly if a child has:

- a head circumference less than the third percentile for age and sex; and
- a functional level at or below 2 standard deviations below the mean for age on a standard developmental test, or an IQ score of less than 70 on a standardised test of intelligence;*

(p) Rett syndrome;

(q) fetal alcohol spectrum disorder (FASD);

(r) Lesch-Nyhan syndrome;

(s) 22q deletion syndrome;

(t) stuttering;

(u) speech sound disorders, including articulation and phonological disorders, childhood apraxia of speech (also known as dyspraxia, developmental verbal dyspraxia, or speech apraxia), and dysarthria;

(v) cleft lip, cleft palate, or cleft lip and palate.

*"standard developmental test" refers to tests such as the Bayley Scales of Infant Development or the Griffiths Mental Development Scales; "standardised test of intelligence" means the Wechsler Intelligence Scale for Children (WISC) or the Wechsler Preschool and Primary Scale of Intelligence (WPPSI). It is up to the clinical judgement of the practitioner to determine which tests are appropriate to be used.

Eligible allied health practitioners

The allied health assessment and treatment services can be provided by eligible audiologists, dietitians, exercise physiologists, occupational therapists, optometrists, orthoptists, physiotherapists, psychologists and speech pathologists.

To provide services under these items eligible allied health practitioners must meet the eligibility requirements as set out in the *Health Insurance (Section 3C General Medical Services –Allied Health Services) Determination 2024*.

It is expected that eligible providers will 'self-select' for the complex NDD and eligible disability items (i.e. possess the skills and experience appropriate for provision of these services and be oriented to work with patients with a complex NDD or an eligible disability).

MN.10.4 Multidisciplinary Case Conferencing for Complex Neurodevelopmental Conditions and Disabilities (Items 82001, 82002 and 82003)

These items provide MBS benefits for eligible allied health and Aboriginal and Torres Strait Islander primary health care professionals (health professionals) to participate in a multidisciplinary case conference team in a community case conference with a patient's medical practitioner and other providers.

A multidisciplinary case conference means a process by which a multidisciplinary case conference team carries out all of the following activities:

- discussing a patient's history;
- identifying the patient's multidisciplinary care needs;
- identifying outcomes to be achieved by members of the multidisciplinary case conference team giving care and service to the patient;
- identifying tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the multidisciplinary case conference team;
- assessing whether previously identified outcomes (if any) have been achieved.

These items apply to non-hospital admitted patients who are under 25 years old and have either been diagnosed with, or are suspected of having:

- a complex neurodevelopmental condition (such as autism); or
- an eligible disability.

Eligible health professionals may claim reimbursement for participating in case conferences through three time-tiered items:

- 15–19 minutes (82001)
- 20–39 minutes (82002)
- over 40 minutes (82003)

There are no frequency restrictions for case conferencing items for patients with or suspected of having a complex neurodevelopmental condition or an eligible disability.

Eligible health professionals

For the purposes of these items, eligible health professional means:

- an eligible Aboriginal and Torres Strait Islander health practitioner
- an eligible Aboriginal and Torres Strait Islander health worker
- an eligible audiologist
- an eligible dietitian
- an eligible exercise physiologist
- an eligible mental health nurse
- an eligible mental health worker (health professionals that meet the requirements of a mental health service, namely, Aboriginal and Torres Strait Islander health practitioners, Aboriginal and Torres Strait Islander health workers, mental health nurses, occupational therapists, psychologists and social workers)
- an eligible occupational therapist
- an eligible optometrist
- an eligible orthoptist
- an eligible physiotherapist
- an eligible psychologist
- an eligible speech pathologist.

Eligible health professionals must meet the eligibility requirements as set out in the *Health Insurance* (*Section 3C General Medical Services – Allied Health and other Primary Health Care Services*) *Determination 2024*.

Eligible patients

These items apply to non-hospital admitted patients who are under 25 years old and have either been diagnosed with, or are suspected of having:

- a complex neurodevelopmental condition; or
- an eligible disability.

Organisation of a case conference

The case conference must be organised by the medical practitioner. The multidisciplinary case conference team must include a medical practitioner and at least 2 other members providing different kinds of care to the patient. The multidisciplinary case conference team requirements include:

- each member must provide a different kind of care or service to the patient; and
- each member must not be an unpaid carer of the patient; and
- one member may be another medical practitioner.

The patient and family members or carers can attend the case conference but will not count towards the minimum team member requirements.

Only eligible health professionals can claim payment for their participation.

Non-claiming attendees can include other health professionals, home and community service providers and care organisers, including the following:

- asthma educators
- dental therapists
- dentists
- diabetes educators
- education providers
- “meals on wheels” providers
- orthotists or prosthetists
- personal care workers
- pharmacists
- podiatrists
- probation officers
- registered nurses
- social workers.

In some instances, 2 eligible health professionals from the same profession may participate in the same case conference, where both provide different aspects of care to the patient. For example, the 2 providers from the same profession have different specialisations that are clinically relevant to the same patient and cannot be provided by one of the providers alone. In this instance, both providers will be able to claim the new items.

Participation in a case conference

A referral is not required for eligible health professionals to access the case conferencing items for complex neurodevelopmental condition and disability services. However, the health professional must be invited to participate in the case conference by the patient’s treating medical practitioner.

The patient must agree to the health professional participating in the case conference and be informed that Medicare will be accessed to fund the service. The patient may agree through discussion with their medical practitioner. The health professional should ensure that the patient has agreed and that their agreement has been recorded appropriately.

Health professionals claiming a case conferencing item should record the day, start and end times, the names of all participants and all matters discussed in the patient's medical record.

The health professional is not required to have a pre-existing relationship with the patient. However, the patient must agree to the health professional participating in the case conference and be informed that Medicare will be accessed to fund the service.

The case conference may lead to an agreed care plan between all participating providers, including the number of individual health professional services required and how they are allocated among eligible health professionals within a patient's entitlement.

The case conferencing items can be accessed in person, via video or telephone, using the same item number. There is no requirement that all participants use the same communication method.

MN.11.1 Individual Allied Health and Aboriginal and Torres Strait Islander Health and Wellbeing Services (health services) for the Management of Chronic Conditions for Aboriginal and Torres Strait Islander Patients (Items 81300-81360, 93048 and 93061)

SUMMARY

This note sets out the requirements for the individual health services specifically for Aboriginal and Torres Strait Islander patients with a chronic condition, or whose need for those services was identified through a health assessment.

Aboriginal and Torres Strait Islander patients are also eligible for the individual health services available to all other patients through chronic condition management plan arrangements, (see MN.3.1).

This note also explains the rules around the 10 individual health services available to Aboriginal and Torres Strait Islander patients per calendar year.

The need for health services must be:

- identified as a necessary follow up services by a GP or prescribed medical practitioner when undertaking the patient's health assessment, or
- for patients with a chronic condition, recommended in a patient's GP chronic condition management plan (see AN.15.3), or for residents of a residential care home recommended in a patient's multidisciplinary care plan (see AN.15.8). Until 1 July 2027, these services are also available to patients that have both a GP management plan and team care arrangement (see AN.15.5) and any individual health services would then need to be recommended in their team care arrangement.

On 1 July 2025 GP management plans and team care arrangements were replaced with new GP chronic condition management plan (see AN.15.3) items. These new items provide a streamlined and simplified approach to multidisciplinary care for patients with a chronic condition. Transition arrangements are in place for existing patients with a GP management plan and team care arrangement (seeAN.15.5). New requirements for referrals to health services written on or after 1 July 2025 also came into effect on this date (see AN.15.6).

References in this note to the term "Management Plan" refer to any of a GP chronic condition management plan, GP management plan and team care arrangement, or a multidisciplinary care plan for a resident of a residential care home.

USE OF THE ITEMS

The requirements of the items for individual health services are set out in the *Health Insurance (Section 3C General Medical Services - Allied Health and other Primary Health Care Services) Determination 2024* (the Determination) and the *Health Insurance (Section 3C General Medical Services – Telehealth and Telephone Attendances) Determination 2021* (Telehealth Determination).

Is there a minimum length for the service?

Yes, the Determination and Telehealth Determination specifies that the service must last at least 20 minutes.

How many individual health services can be claimed for a patient?

Aboriginal and Torres Strait Islander patients can access up to 10 MBS-supported individual health services per calendar year (January to December).

The annual total limit of 10 individual health services per patient can include a combination of the following items, up to a maximum of 10 services:

- up to 5 services under a GP chronic condition management plan or, for residents of a residential care home, a multidisciplinary care plan (10950, 10951, 10952, 10953, 10954, 10956, 10958, 10960, 10962, 10964, 10966, 10968, 10970, 93000 and 93013 - MBS Group M3 and equivalent telehealth services) (see MN.3.1).
- up to 10 services under MBS Group M11 and equivalent telehealth services (81300 to 81360, 93048 and 93061).

The 10 services can be made up of one type of service (e.g. 10 physiotherapy services) or a combination of different types of services (e.g. 2 dietetic and 8 podiatry services).

The patient must have an identified need through a health assessment, or the service provided must be recommended in the patient's Management Plan. How does the health provider know what is in the health assessment or Management Plan?

Subject to the patient's consent, the patient's health provider should be given the relevant parts of the Management Plan. In addition, the treating health provider must also receive a referral from the treating medical practitioner (see AN.15.6).

How long does a referral last?

For referrals written on or after 1 July 2025, referrals will be valid for the length of time specified in the referral, or if no timeframe is specified, 18 months from the date of the first service provided under the referral. The referral may also specify the number of services to be provided, however, this is not required.

For referrals written prior to 1 July 2025, the referral must specify the number of services. The referral remains valid until all services are provided.

For further information on referrals see AN.15.6.

Should the referral be for a specific health professional?

No. The patient can take the referral to any eligible health professional of the same profession/type specified in the referral of their choosing. For example, a referral to physiotherapy services can be taken to any physiotherapist, but it cannot be used to access chiropractic services.

For further information on referrals see AN.15.6.

My patient has more than 10 individual health services identified/recommended. Which ones should be billed to the MBS?

The MBS benefit is the patient's benefit. It is up to the patient to decide how they use their MBS benefits. Some patients can access additional services using private health insurance extras cover, non-MBS services (e.g. through state or Primary Health Network programs), or self-funding.

Providers should obtain informed financial consent from patients before a service. Therefore, it is important that you clarify with the patient whether they would like to use their MBS benefit for the service.

Can the patient claim for a service under Medicare and private health insurance?

No. Patients cannot claim MBS benefits and payments under their private health insurance fund for the same service.

How do I know how many individual health services a patient has already used this year?

You can check a patient's eligibility for a service through the MBS Items Online Checker Check MBS Item numbers - Health professionals - Services Australia and view their care plan history through HPOS Patient details in HPOS - Health professionals - Services Australia. Patients can also check their care plan service history through their Medicare Online Account.

My patient has elected not to claim MBS benefits for the service. Do I still need to meet all of the requirements of the MBS item?

No. However, it is still good practice to provide regular updates to the patient's medical practitioner about their progress.

Am I required to provide information back to the referring medical practitioner?

Yes. The Determination requires that the health professional provide a written report to the referring medical practitioner:

"i. if the service is the only service under the referral—in relation to that service; or

ii. if the service is the first or last service under the referral—in relation to that service; or

iii. if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of—in relation to those matters."

What should I include in a report back to the referring medical practitioner?

Generally, written reports should include:

- any investigations, tests, and/or assessments carried out on the patient
- any treatment provided, and
- future management of the patient's condition or problem

ELIGIBLE PATIENTS

Aboriginal and Torres Strait Islander patients are eligible for these individual health services if they have been referred (see AN.15.6) by a GP or prescribed medical practitioner and:

- they have had a health assessment undertaken by a GP or prescribed medical practitioner which identified the need for follow-up health services, or
- they have a chronic condition and:
    - GP chronic condition management plan that has been put in place or reviewed in the last 18 months, or
    - until 1 July 2027, a GP management plan and team care arrangement that were in place before 1 July 2025, or
    - are a resident of a residential care home and have a multidisciplinary care plan, and

- the service provided is consistent with the Management Plan.

ELIGIBLE PRACTITIONERS

Health professionals are eligible to provide these services if they meet the qualification and credentialling requirements set out in the Determination (see AN.15.4). To provide MBS services, eligible health professionals must have a Medicare Provider Number.

There are MBS item numbers for each type of health service for face-to-face services. However, all service types are provided using the same items for video (93048), or telephone (93061) services. The treating health professional must satisfy themselves that a service is appropriate to be delivered by video or telephone. The service cap applies across all modalities.

Service	**Eligible health professionals (must meet all relevant credentialling requirements)**	**MBS item number (face to face service)**
Aboriginal and Torres Strait Islander health and wellbeing service	Aboriginal and Torres Strait Islander health worker Aboriginal and Torres Strait Islander health practitioner	81300
Audiology health service	Audiologist	81310
Chiropractic health service	Chiropractor	81345
Diabetes education health service	Credentialled diabetes educator	81305
Dietetics health service	Accredited practising dietitian	81320
Exercise physiology health service	Accredited exercise physiologist	81315
Mental health service	Aboriginal and Torres Strait Islander health worker Aboriginal and Torres Strait Islander health practitioner Credentialled mental health nurse Occupational therapist Psychologist (general registration) Social worker	81325
Occupational therapy health service	Occupational therapist	81330
Osteopathy health service	Osteopath	81350
Physiotherapy health service	Physiotherapist	81335
Podiatry health service	Podiatrist	81340
Psychology health service	Psychologist (general registration)	81355
Speech pathology health service	Certified practising speech pathologist	81360

RECORD KEEPING AND REPORTING REQUIREMENTS

The Determination requires that the health professional provide a written report to the referring medical practitioner:

"*i. if the service is the only service under the referral—in relation to that service; or*

ii. if the service is the first or last service under the referral—in relation to that service; or

iii. if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of—in relation to those matters."

It is a requirement that, where an item specifies the creation of a document (however described) and a document it created, the document must be retained for the period of 2 years. This includes records made by the health provider for reporting back to the referring medical practitioner.

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements and they may be required to submit evidence for compliance checks related to Medicare claims. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item(s) can be found on the Federal Register of Legislation at www.legislation.gov.au. Individual health items are set out in two regulatory instruments:

Health Insurance (Section 3C General Medical Services – Allied Health and other Primary Health Care Services) Determination 2024 – items 81300, 81305, 81310, 81315, 81320, 81325, 81330, 81335, 81340, 81345, 81350, 81355 and 81360.
Health Insurance (Section 3C General Medical Services – Telehealth and Telephone Attendances) Determination 2021 - items 93048 and 93061

MN.12.1 Immunisation services provided by an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner - (MBS Item 10988)

SUMMARY

This note outlines the requirements for item 10988 for the provision of immunisation services provided by an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner.

USE OF THE ITEM

Note: The requirements in this note must be met in addition to the requirements for 'on behalf of' items contained in MN.12.6.

This item is used to administer vaccinations to patients by an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner.

Health practitioners should refer to the Australian Immunisation Handbook and the National Immunisation Program Schedule for guidance when assessing patient vaccine eligibility and administering vaccinations to patients.

Can I charge the patient for the cost of the vaccine if this service is bulk billed?

Yes, under certain circumstances. Where the patient is bulk billed, an additional charge can only be raised against the patient by the practitioner where the patient is provided with a vaccine or vaccines from the practitioner's own supply held on the practitioner's premises.

If the cost of the vaccine supplied in connection with a service described in item 10988 is not subsidised by government (Commonwealth or State), the service is taken not to include the supply of that vaccine.

For example, it would not be acceptable to bulk bill an Aboriginal adult patient and levy a charge for the cost of an influenza vaccine as the vaccine is covered by the National Immunisation Program. However, if an influenza vaccine is administered for an adult who is not eligible under the National Immunisation Program (patient under the age of 65 years who is not of Aboriginal and Torres strait Islander descent, not pregnant and has no specified medical risk conditions) or relevant State subsidised vaccine program, the patient could be bulk billed and a charge levied for the cost of the vaccine if it is taken from the practitioner's own supply.

Is it ever appropriate to co-claim the immunisation item and another item?

Yes. Co-claiming may be appropriate where the service provided by the Aboriginal and Torres Strait Islander health practitioner is a separate and clinically relevant service, all the requirements of each item has been independently met and there is no duplication of services.

However, where a patient receives more than one vaccine during the service, item 10988 may only be claimed once.

Can an Aboriginal and Torres Strait Islander health practitioner administer any vaccine under this item?

The service must be provided in accordance with any relevant Commonwealth, State and Territory laws. Aboriginal and Torres Strait Islander health practitioners and supervising medical practitioners should refer to relevant State and Territory laws for the regulation, control, supply and use of drugs and therapeutic goods for further information on vaccine administration arrangements.

ELIGIBLE PATIENTS

This item is available to all Medicare-eligible patients who require an immunisation, provided they are not admitted patients of a hospital.

ELIGIBLE PRACTITIONERS

These items are medical practitioner items. The services are delivered by an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner. The medical practitioner must claim the MBS item and retain responsibility for the health, safety and clinical outcomes for the patient.

The Aboriginal and Torres Strait Islander health practitioner delivering the service on behalf of the medical practitioner must be appropriately qualified and trained to deliver immunisation services.

The *Health Insurance Act 1973* requires the person rendering the service to be in Australia. As the medical practitioner's Medicare provider number is used to claim the service, they are considered to be the person who renders the service.

Information on supervision arrangements can be found in MN.12.6 (overarching note).

RECORD KEEPING AND REPORTING REQUIREMENTS

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements and they may be required to submit evidence for compliance checks related to Medicare claims. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item(s) can be found on the Federal Register of Legislation at www.legislation.gov.au. This item is set out in the *Health Insurance (General Medical Services Table) Regulations 2021*.

MN.12.2 Wound management services provided by an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner (MBS Item 10989)

SUMMARY

This note outlines the requirements for item 10989 for the provision of wound management services provided by an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner.

This service may be delivered to a patient once per visit.

The medical practitioner who supervises and claims the item is not required to assess the patient's wound each time the wound management service is delivered, unless clinically indicated.

USE OF THE ITEMS

Note: The requirements in this note must be met in addition to the requirements for 'on behalf of' items contained in MN.12.6.

This item is used for the treatment of a patient's wound(s) provided by an Aboriginal and Torres Strait Islander health practitioner, on behalf of, and under the supervision of a medical practitioner.

To use this item, the *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations) state that:

- the Aboriginal and Torres Strait islander health practitioner must be appropriately qualified and trained to treat wounds
- a medical practitioner under whose supervision the health practitioner provides the treatment has conducted an initial assessment of the person
- the health practitioner has been instructed by the medical practitioner about the treatment of the wound, and
- the medical practitioner retains responsibility for the health, safety and clinical outcomes of the person.

Does a medical practitioner have to assess the patient's wound on the same day each time a wound management service is delivered by the health practitioner?

No. The medical practitioner who supervises the health practitioner for the item must conduct an initial assessment of the patient's wound and provide instructions to the Aboriginal and Torres Strait Islander health practitioner about how the wound is to be managed and treated. This can occur on the same day or a different day as the first service under MBS item 10989.

After this initial assessment, the medical practitioner is not required to assess the patient's wound each time the wound management service is delivered, unless clinically indicated.

If the condition of the wound changes and, in the health practitioner's clinical judgement, it is relevant for the patient to be re assessed, the medical practitioner may assess the patient again and provide updated instructions for the ongoing management of the wound.

The patient is being bulk billed for this service. Can wound care consumables used during this service be separately billed?

No. Where a wound management service is bulk billed, the Medicare benefit is taken to be the full payment for the service. Patients must not be charged separately for consumables, such as dressings or bandages used to perform the service. Further information about Medicare billing procedures can be found at GN.7.17.

The Australian Government's Chronic Wound Consumables Scheme (CWCS) covers the cost of wound consumable products for people who have diabetes and a chronic wound, and who are aged 65 years and over, or aged 50 years

and over for First Nations people. Information on this scheme is available at https://www.health.gov.au/our-work/cwcs.

Can I co-claim this item with an attendance item, or with another item delivered by a health provider on behalf of a medical practitioner?

Yes, in certain circumstances. Item 10989 may be claimed on the same day as an different service provided on behalf of a medical practitioner (items 10988, 10987, 10997 and 10983) where both items are distinctly and clinically relevant services consistent with the patient's health needs, there is no duplication of services and the requirements of each item (including time requirements) are fully and independently met.

Where the medical practitioner provides a professional attendance to the patient (in addition to the wound service provided by the Aboriginal and Torres Strait Islander health practitioner), the medical practitioner may also claim for the professional attendance they provide to the patient.

ELIGIBLE PATIENTS

This item is available for Medicare-eligible patients who are not an admitted patient of a hospital, who have received an initial assessment by a medical practitioner and require wound management services.

ELIGIBLE PRACTITIONERS

This item is a medical practitioner item. The service is delivered by an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner. The medical practitioner must claim the MBS item and retain responsibility for the health, safety and clinical outcomes for the patient.

The Aboriginal and Torres Strait Islander health practitioner delivering the service on behalf of the medical practitioner must be appropriately qualified and trained to deliver wound management services.

The *Health Insurance Act 1973* requires the person rendering the service to be in Australia. As the medical practitioner's Medicare provider number is used to claim the service, they are considered to be the person who renders the service.

Information on supervision arrangements can be found in MN.12.6 (overarching note).

RECORD KEEPING AND REPORTING REQUIREMENTS

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements and they may be required to submit evidence for compliance checks related to Medicare claims. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item can be found on the Federal Register of Legislation at www.legislation.gov.au. This item is set out in the *Health Insurance (General Medical Services Table) Regulations 2021*.

MN.12.3 Follow up service provided on behalf of a medical practitioner for an Aboriginal and Torres Strait Islander person who has received a health assessment (MBS Item 10987, 93200, 93202))

SUMMARY

This note outlines the requirements for items 10987 (face to face), 93200 (video) and 93202 (telephone) for the provision of follow up services provided by a practice nurse or Aboriginal and Torres Strait Islander health

practitioner, on behalf of a medical practitioner, for an Aboriginal and Torres Strait Islander person who has received a health assessment (see AN.0.36 or AN.0.43).

This service may be claimed up to a maximum of 10 times per eligible patient per calendar year (1 January to 31 December).

USE OF THE ITEMS

Note: The requirements in this note must be met in addition to the requirements for 'on behalf of' items contained in associated note MN.12.6.

These items are intended for ongoing care, monitoring and support consistent with the patient's health assessment. The services are provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of and under the supervision of a medical practitioner.

What types of services can be provided?

Any services provided to the patient using these items must be consistent with the needs of the patient identified in their health assessment(s).

Services delivered by the health practitioner must be within the accepted scope of practice of the health practitioner, in accordance with accepted medical practice and delivered under the supervision of the medical practitioner.

A practice nurse or Aboriginal and Torres Strait Islander health practitioner is assisting in completing the health assessment. Can I use items 10987, 93200, 93202 for their time?

No. Health assessment items (see AN.0.36 and AN.0.43) are complete medical services and provide the full MBS benefit for the services.

Time spent by practice nurses or Aboriginal and Torres Strait Islander health practitioners in assisting medical practitioners with health assessments can be counted towards the total time taken for the health assessment. However, assistance with the health assessment item cannot be itemised as an additional service e.g. under item 10987.

Are the follow up services (MSB items 10987, 93200, 9320) available only to patients who have received an Aboriginal and Torres Strait Islander Health Assessment (item 715, 228, 92004 and 92011)?

No. Patients who are of Aboriginal or Torres Strait Islander descent are eligible for follow up services after any MBS health assessment service, where the follow up service is consistent with the needs identified through the health assessment. See AN.0.36 and AN.0.43 for more information on eligible health assessment services.

My patient has a GP chronic condition management plan and is of Aboriginal and Torres Strait Islander descent. Can they access MBS items 10987, 93200 or 93202 without undertaking a health assessment?

No. A GP chronic condition management plan does not provide access to items 10987, 93200 or 93202. These items are only available for eligible patients who have received a health assessment.

Note: MBS items 10997, 93201 or 93203 (services provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner to a person with a chronic condition) may be appropriate to bill in these circumstances, where the requirements of the billed item have been met. Further information on these items is available in MN.12.4.

Are there similar items where my patient has a GP chronic condition management plan and is of Aboriginal and Torres Strait Islander descent?

Patients of Aboriginal or Torres Strait Islander descent may access up to 10 individual allied health and Aboriginal and Torres Strait Islander health and wellbeing services each calendar year, where:

- the need for the individual health and wellbeing services has been identified in the patient's health assessment; and/or
- where the patient has been referred for individual health and wellbeing services under a Chronic Conditions Management plan.

See MN.11.1 for further information on individual allied health and Aboriginal and Torres Strait Islander health and wellbeing services.

If my patient has received more than one type of health assessment in a calendar year, are they eligible for more than 10 follow up services provided on behalf of a medical practitioner (10987, 93200 and 93202)?

No. Patients can receive a maximum of 10 follow up services delivered on behalf of a medical practitioner each calendar year, regardless of whether they have had more than one health assessment.

My patient only used 7 services last year. Can my patient access the remaining 3 services, as well as another 10 services, this year?

No, unused services do not rollover. Patients are only eligible for up to a maximum of 10 services per calendar year (1 January to 31 December).

Can my patient access more services by using both face to face and telehealth items, or by seeing both a practice nurse and an Aboriginal and Torres Straight Island health practitioner?

No, patients are eligible for a maximum of 10 follow up services in total per calendar year (1 January to 31 December). The 10 services can be made up of any combination of item 10987, 93200, and 93202.

ELIGIBLE PATIENTS

These items are available for patients who identify as an Aboriginal or Torres Strait Islander person, who are not admitted patients of a hospital and have received a health assessment which identifies their need for follow up services.

Patients are eligible for up to 10 services (total) under these items each calendar year (1 January to 31 December). The service provided must be consistent with needs identified through their health assessment(s).

ELIGIBLE PRACTITIONERS

These items are medical practitioner items. The services are delivered by either a practice nurse or an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner. The medical practitioner must claim the MBS item and retain responsibility for the health, safety and clinical outcomes for the patient.

The practice nurse or Aboriginal and Torres Strait Islander health practitioner delivering the service on behalf of the medical practitioner must be appropriately qualified and trained to deliver the follow up service.

The *Health Insurance Act 1973* requires the person rendering the service to be in Australia. As the medical practitioner's Medicare provider number is used to claim the service, they are considered to be the person who renders the service.

Information on supervision arrangements can be found in MN.12.6 (overarching note).

RECORD KEEPING AND REPORTING REQUIREMENTS

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements and they may be required to submit evidence for compliance checks related to Medicare claims. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item(s) can be found on the Federal Register of Legislation at www.legislation.gov.au. These items are set out in the following regulatory instruments:

- *Health Insurance (General Medical Services Table) Regulations 2021* – item 10987
- *Health Insurance (Section 3C General Medical Services – Telehealth Attendances) Determination 2021* – items 93200, 93202

MN.12.4 Services for a person with a chronic medical condition by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner (MBS Items 10997, 93201, 93203)

SUMMARY

This note outlines the requirement for items 10997 (face to face), 93201 (video) and 93203 (telephone) for the provision of services for the management of a patient's chronic condition. The service is provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner and must be consistent with the patient's GP chronic condition management plan (see AN.0.47), multidisciplinary care plan (see AN.15.7), or the former GP management plan and team care arrangement items (see AN.15.5).

A patient is eligible for up to 5 services per calendar year (1 January to 31 December).

USE OF THE ITEMS

Note: The requirements below must be met in addition to the requirements for 'on behalf of' items contained in MN.12.6.

These items are intended for ongoing care, monitoring and support, as well as routine treatment consistent with the patient's GP chronic condition management plan (see AN.0.47), GP management plan, team care arrangement (see AN.15.5), or multidisciplinary care plan (see AN.15.7), between reviews of the patient by a GP or prescribed medical practitioner. The services are provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of and under the supervision of a medical practitioner.

What types of services can be provided?

Any services provided to the patient using these items must be consistent with their GP chronic condition management plan or multidisciplinary care plan. Examples of the types of services that can be provided include but are not limited to:

- Providing immunisations consistent with the plan
- monitoring a patient's progress between reviews and recording the results
- dressing wounds
- providing advice to the patient on the self-management of their condition.

A practice nurse is assisting in preparing or reviewing my patient's chronic condition management plan. Can I use items 10997, 93201 or 93203 for their time?

No. The items for preparing and reviewing GP chronic condition management plans (see AN.0.47) and multidisciplinary care plans (see AN.15.7 and AN.15.8) are complete medical services and provide the full MBS benefit for the services. You cannot co-claim a second item for the provision of these services.

Is it ever appropriate to co-claim a planning or review item and items 10997, 93201 or 93203?

Yes. Co-claiming may be appropriate where the service provided by the practice nurse or Aboriginal and Torres Strait Islander health practitioner is separate from, but consistent with, the patient's plan development or review. The following are examples of scenarios where co-claiming would be appropriate:

Review and wound treatment (e.g., diabetic wounds)

A patient with a chronic medical condition and an existing GP chronic condition management plan attends a consultation in which the GP and patient review the patient's plan and fully meet the requirements of item 967.

The patient and GP discuss a wound the patient has developed, which is caused by their chronic medical condition. They include treatment of the wound and teaching the patient about wound care in the patient's GP chronic condition management plan.

The practice nurse is available to dress the wound that day. The practice nurse, for and on behalf of the GP, dresses the wound and provides advice to the patient on caring for the wound. The practice nurse has provided a separate, clinically relevant service, as outlined in the patient's plan.

It is therefore appropriate to claim both the item 967 and 10997 on the same day provided all the requirements of each item have been completed.

Plan/review and need for immunisation identified

A patient is assessed as having a chronic medical condition during an attendance with their GP. The GP and the patient have agreed to establishing a GP chronic condition management plan and the plan is being completed in this appointment.

As part of the plan, the GP identifies that the patient's chronic medical condition puts them at a higher risk of a disease for which there are vaccines available, but that the patient's vaccinations are not up to date. The GP and patient agree that keeping the patient's vaccinations up to date should be included in their GP chronic condition management plan.

The practice nurse is available to see the patient that same day. The patient gives consent for the vaccine to be administered and the practice nurse, for and on behalf of the GP, checks that the patient is eligible for the vaccination and administers the vaccine. The practice nurse has provided a separate, clinically relevant service, as outlined in the patient's GP chronic condition management plan.

It is therefore appropriate to claim both items 965 and 10997 on the same day provided all the requirements of each item have been completed.

Plan/review and administration of parenteral medication (e.g., B12 injection, or denosumab)

A patient with an existing GP chronic condition management plan for their chronic medical condition has booked two appointments on the same day.

The first is for a parenteral medication to help treat their chronic medical condition. It is not appropriate for the patient to self-administer the medication (for example an intramuscular or intravenous injection) and the need for the treatment is identified in the patient's GP chronic condition management plan. The patient has also booked their regular review of the plan.

The practice nurse, for and on behalf of the GP, administers the medication. The patient has their review of the GP chronic condition management plan with the doctor. The practice nurse has provided a separate, clinically relevant service, as outlined in the patient's GP chronic condition management plan, in addition to any contribution to the reviews of the GP chronic condition management plan.

It is therefore appropriate to claim items 967 and 10997 on the same day provided the requirements of each item have been completed.

It's January. Do I need to review my patient's plan to trigger their eligibility for the 5 services this calendar year?

No, patients' eligibility is reset on 1 January every year automatically. You are not required to review their plan to enable services or otherwise reset the count, provided patients continue to meet the eligibility requirements for the service.

However, patients with a GP chronic condition management plan must have had their plan prepared or reviewed in the previous 18 months to continue to access services.

My patient only used 3 services last year. Can my patient access the remaining 2 services, as well as another 5 services this year?

No, unused services do not rollover. Patients are eligible for a maximum of 5 services per calendar year (1 January to 31 December).

Can my patient access more services by using both face to face and telehealth items, or seeing both a practice nurse and an Aboriginal and Torres Straight Islander health practitioner?

No, patients are eligible for a maximum of 5 services per calendar year in total, whatever modality is used to provide the service. The 5 services can be made up of any combination of 10997, 93201 and 93203.

My patient is a Torres Strait Islander. Can they access additional services under their GP chronic condition management plan using MBS item 10987?

No. The GP chronic condition management plan does not provide access to item 10987. Item 10987 is only available for eligible patients who have had a health assessment.

ELIGIBLE PATIENTS

These items are available for patients with at least one chronic condition and are not an admitted patient of a hospital and who have one of the following plans in place for the management of that condition:

- a GP chronic condition management plan prepared or reviewed in the previous 18 months
- until 1 July 2027:
    - a GP management plan, or
    - Team Care Arrangements, or
- a multidisciplinary care plan

Patients are eligible for up to 5 services (total) under these items each calendar year (1 January to 31 December). The service provided must be consistent with their management plan.

ELIGIBLE PRACTITIONERS

These items are medical practitioner items. The services are delivered by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner. The medical practitioner must claim the MBS item and retain responsibility for the health, safety and clinical outcomes for the patient.

The practice nurse or Aboriginal and Torres Strait Islander health practitioner delivering the service on behalf of the medical practitioner must be appropriately qualified and trained to deliver the service.

The *Health Insurance Act 1973* requires the person rendering the service to be in Australia. As the medical practitioner's Medicare provider number is used to claim the service, they are considered to be the person who renders the service.

Information on supervision arrangements can be found in MN.12.6 (overarching note).

RECORD KEEPING AND REPORTING REQUIREMENTS

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements and they may be required to submit evidence for compliance checks related to Medicare claims. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item can be found on the Federal Register of Legislation at www.legislation.gov.au. These items are set out in the following instruments:

- *Health Insurance (General Medical Services Table) Regulations 2021* – item 10997
- *Health Insurance (Section 3C General Medical Services – Telehealth Attendances) Determination 2021* – items 93201, 93203

MN.12.5 Patient-end Support Video Services by Health Professionals

These notes provide information on the video MBS attendance items for health professionals to provide clinical support to their patients during video consultations with a specialist, consultant physicians and psychiatrists under items 10945 and 10946 in Group A10 which are available for participating optometrists and item 10983 in Group M12 for practice nurses, Aboriginal and Torres Strait Islander health practitioners or Aboriginal and Torres Strait Islander health workers for services provided for and on behalf of a medical practitioner.

From 1 January 2022, items 10945, 10946 and 10983 apply Australia wide.

Video patient-end support services can only be claimed where:

- a Medicare eligible specialist service is claimed;
- the service is rendered in Australia; and
- where this is necessary for the provision of the specialist service.

Clinical indications

The specialist, consultant physician or psychiatrist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the specialist, consultant physician or psychiatrist.

Video specialist services can be provided to patients when there is no patient-end support service provided.

Restrictions

The MBS video attendance items are not payable for services to an admitted hospital patient (this includes hospital in the home patients). Benefits for patient-end support are not payable for telephone or email consultations. In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a visual and audio link with the patient, an MBS benefit for a video attendance is not payable.

Record Keeping

Participating practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Multiple attendances on the same day

In some situations, a patient may receive a video consultation and a face-to-face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Aftercare Rule

Video consultations are subject to the same aftercare rules as face-to-face consultations.

Referrals

The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Technical requirements

In order to fulfil the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, an MBS benefit for a video attendance is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a video conference meets the applicable laws for security and privacy.

Duration of attendance

The practitioner attending at the patient end of the video consultation does not need to be present for the entire consultation, only as long as is clinically relevant - this can be established in consultation with the specialist. The MBS fee payable for the supporting practitioner will be determined by the total time spent assisting the patient. This time does not need to be continuous.

Aboriginal and Torres Strait Islander health workers

For the purpose of item 10983 an Aboriginal and Torres Strait Islander health worker means a person who:

a) has a Certificate III or above in Aboriginal and/or Torres Strait Islander Primary Health Care from the Health (HLT) training package; and

b) is employed by, or whose services are otherwise retained by a medical practitioner or their practice. This includes health service in relation to which a direction made under subsection 19(2) of the Act applies.

Aboriginal and Torres Strait Islander health practitioners

For the purpose of item 10983 an Aboriginal and Torres Strait Islander health practitioner means a person who is registered as an Aboriginal and Torres Strait Islander health practitioner with the Aboriginal and Torres Strait Islander Health Practice Board of Australia. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the *Health Insurance Act 1973*.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

Practice Nurse

For the purpose of item 10983 a practice nurse means a registered or enrolled nurse who is employed by, or whose services are otherwise retained by a medical practitioner or their practice. This includes a health service in relation to which a direction made under subsection 19(2) of the *Health Insurance Act 1973* applies.

MN.12.6 Services provided on behalf of a medical practitioner by a practice nurse and/or Aboriginal and Torres Strait Islander primary health care professionals (MBS Items 10983, 10987, 10988, 10989, 10997, 93200, 93201, 93202, 93203)

SUMMARY

This note sets out the common requirements for MBS services that can be provided on behalf of a medical practitioner by practice nurses, Aboriginal and Torres Strait Islander health workers and/or Aboriginal and Torres Strait Islander health practitioners (items 10983, 10987, 10988, 10989, 10997, 93200, 93201, 93202, 93203).

The item requirements and health providers eligible to provide a service differs for each item. Details on item specific requirements are as follows:

Service	Eligible provider/s	Item/s	Associated Note
Immunisation	Aboriginal and Torres Strait Islander health practitioner	10988	MN.12.1
Wound Management	Aboriginal and Torres Strait Islander health practitioner	10989	MN.12.2
Health assessment follow up (patients of Aboriginal and Torres Strait Islander descent only)	Practice nurse or Aboriginal and Torres Strait Islander health practitioner	10987 93200 93202	MN.12.3
Treatment under a GP chronic condition management plan or multidisciplinary care plan	Practice nurse or Aboriginal and Torres Strait Islander health practitioner	10997 93201 93203	MN.12.4
Patient end video support	Practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal and Torres Strait Islander health worker	10983	MN.12.5

USE OF THE ITEMS

Note: The requirements set out in this note must be met in addition to the requirements contained in each item's relevant associated note. Refer to the table in the Summary section for the relevant associated notes.

These items are used by medical practitioners when specified services are provided on their behalf by eligible practice nurses, Aboriginal and Torres Strait Islander health workers and/or Aboriginal and Torres Strait Islander health practitioners to deliver relevant services to patients (as specified in each item).

Services delivered by the health practitioner must be within the accepted scope of practice of the health practitioner, in accordance with accepted medical practice and under the supervision of the medical practitioner.

These items may be claimed with a single bulk billing incentive when they are bulk billed. Information on bulk billing incentives is available in MN.1.1.

The regulations state that the service must be provided under the supervision of a medical practitioner. Does that mean the medical practitioner must be in the same room as the person delivering the service?

No. Supervision at a distance is acceptable. However, in order to claim Medicare benefits, the medical practitioner must be in Australia and be readily contactable to provide timely clinical advice as required. The medical practitioner retains overall responsibility for the patient's care.

I am qualified health professional (not a medical practitioner) and I am able to practice independently within my scope of practice. Why do I need supervision when providing these services?

The MBS considers these items to be medical practitioner items. This means the service can be provided by another health professional on behalf of the medical practitioner but the medical practitioner remains legally responsible for the service.

Supervision in these items refers to the legal responsibility under the MBS. MBS supervision requirements are distinct and separate to supervision requirements, including ability to practice independently, under the National Boards and the Australian health Practitioner Regulation Agency (Aphra).

The health practitioner that provides the service on behalf of the medical practitioner is still subject to their professional standards, scope of practice and State and Territory laws.

Can I provide remote supervision from overseas?

No. The *Health Insurance Act 1973* requires the person rendering the service to be in Australia. As the medical practitioner's Medicare provider number is used to claim the service, they are considered to be the person who renders the service.

We have a nurse practitioner at the practice. Can they provide practice nurse services under these items?

Yes. Nurse practitioners are registered nurses with an endorsement as a nurse practitioner. Therefore, provided they are working in general practice or a health service with a relevant section 19(2) exemption to the *Health Insurance Act 1973*, they meet the definition of a practice nurse for the purposes of these items.

Nurse practitioners may also provide services using nurse practitioner attendance items (see MN.14.12). If a nurse practitioner provides a service to a patient on behalf of a medical practitioner and an attendance service on the same day, the services must be independent services and clinically necessary. Both items cannot be claimed for the same service/time.

Is it ever appropriate to co-claim another item with an 'on behalf of' item during a patient's visit?

Yes. Co-claiming may be appropriate where both services provided by the practitioner(s) are distinct and clinically relevant services consistent with the patient's health needs, there is no duplication of services, the requirements of each item (including time requirements) are fully and independently met and there are no relevant co-claiming restrictions on the other item.

ELIGIBLE PATIENTS

Any patient who is eligible to receive Medicare benefits, is not an admitted patient of a hospital, and meets the criteria for one or more of the following items may receive one of these services, subject to the specified service limits:

Service	Eligible patients	Service limits	Items	Associated Note
Immunisation	Medicare-eligible patients	As required	10988	MN.12.1

Wound management	Medicare-eligible patients	As required	10989	MN.12.2
Health assessment follow up (patients of Aboriginal and Torres Strait Islander descent only)	Patients of Aboriginal or Torres Strait Islander descent requiring follow-up care identified during a health assessment	Up to 10 services per patient per calendar year	10987 93200 93202	MN.12.3
Treatment under a GP chronic condition management plan or multidisciplinary care plan	Patients with at least one chronic condition and who have an eligible plan in place for the management of that condition. For patients with a GP chronic condition management plan the plan must have been prepared or reviewed within the last 18 months	Up to 5 services per patient per calendar year	10997 93201 93203	MN.12.4
Patient end video support	Patients requiring clinical assistance during a specialist consultation conducted via video attendance	As required	10983	MN.12.5

ELIGIBLE PRACTITIONERS

These items are medical practitioner items. The services are delivered by an eligible practitioner on behalf of, and under the supervision of, a medical practitioner.

The medical practitioner must claim the MBS item and retains responsibility for the health, safety and clinical outcomes for the patient. The health practitioner delivering the service on behalf of the medical practitioner must be appropriately qualified and trained to deliver the service.

Services must be rendered according to the provisions of the relevant Commonwealth, State and Territory laws. For example, practitioners may only administer a vaccine where the service is in line with the provisions of relevant State and Territory laws for the regulation, control, supply and use of drugs and therapeutic goods.

As set out in the table below, depending on the item rendered, eligible providers may be practice nurses, Aboriginal and Torres Strait Islander health practitioners and/or Aboriginal and Torres Strait Islander health workers.

Service	Eligible Providers	Item	Associated Note
Immunisation	Aboriginal and Torres Strait Islander health practitioners	10988	MN.12.1
Wound management	Aboriginal and Torres Strait Islander health practitioners	10989	MN.12.2
Health assessment follow up (patients of Aboriginal	Practice nurses	10987	MN.12.3

and Torres Strait Islander descent only)	Aboriginal and Torres Strait Islander health practitioners	93200 93202	
Treatment under a GP chronic condition management plan or multidisciplinary care plan	Practice nurses Aboriginal and Torres Strait Islander health practitioners	10997 93201 93203	MN.12.4
Patient end video support	Practice nurses Aboriginal and Torres Strait Islander health workers Aboriginal and Torres Strait Islander health practitioners	10983	MN.12.5

The terms 'practice nurse', 'Aboriginal and Torres Strait Islander health worker' and 'Aboriginal and Torres Strait Islander health practitioner' are defined in the *Health Insurance (General Medical Services Table) Regulations 2021* (the Regulations).

The Regulations define a practice nurse as "*a registered or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice or by a health service to which a direction made under subsection 19(2) of the [Health Insurance] Act applies.*"

The Regulations define an Aboriginal and Torres Strait Islander health worker as *"a person:*

a. *who holds a qualification of Certificate III or higher in Aboriginal and/or Torres Strait Islander Primary Health Care from the Health (HLT) training package; and*
b. *who is engaged by a medical practitioner in a general practice or a health service to which a direction made under subsection 19(2) of the [Health Insurance] Act applies."*

The Regulations define an Aboriginal and Torres Strait Islander health practitioner as "*a person:*

a. *who is registered under the national law in the Aboriginal and Torres Strait Islander health practice profession; and*
b. *who is employed by, or whose services are otherwise retained by, a medical practitioner in a general practice or a health service to which a direction made under subsection 19(2) of the [Health Insurance] Act applies."*

RECORD KEEPING AND REPORTING REQUIREMENTS

Providers are responsible for ensuring services claimed from Medicare using their provider number meet all legislative requirements and they may be required to submit evidence for compliance checks related to Medicare claims. Practitioners should ensure they keep adequate and contemporaneous records. For information on what constitutes adequate and contemporaneous records see GN.15.39.

RELEVANT LEGISLATION

Details about the legislative requirements of the MBS item(s) can be found on the Federal Register of Legislation at www.legislation.gov.au. These items are set out in the following regulatory instruments:

- *Health Insurance (General Medical Services Table) Regulations 2021* – item 10983, 10987, 10988, 10989, 10997
- *Health Insurance (Section 3C General Medical Services – Telehealth Attendances) Determination 2021* – items 93200, 93201, 93202, 93203

MN.13.1 Maternity Services by Participating Midwives - Overview

As at 1 November 2010, Medicare benefits are payable for antenatal, intrapartum and postnatal care for the first 6 weeks after the delivery, provided by eligible privately practising midwives. Eligible midwives can also request certain pathology and diagnostic imaging services for their patients and refer patients to obstetricians and paediatricians, as the clinical need arises. Each service that attracts a Medicare benefit is identified in the Medicare Benefits Schedule (MBS) by an item number. Each item describes the service that the item covers.

MN.13.3 Eligible Midwives

Under the legislation, to be an eligible midwife the midwife must be registered or authorised (however described) under State and Territory law to practice midwifery. The midwife must also demonstrate that he or she has the appropriate qualifications and experience to meet the registration standard developed by the Nursing and Midwifery Board of Australia.

Information regarding eligibility can be found on the Nursing and Midwifery Board of Australia (NMBA) site of the Australian Health Practitioner Regulatory Agency (AHPRA) website at:

http://www.nursingmidwiferyboard.gov.au/.

MN.13.4 Midwife Professional Indemnity Insurance

Under National Law, which governs the National Registration and Accreditation Scheme (NRAS), it is a requirement for midwives to have appropriate professional indemnity insurance. All privately practising midwives who wish to provide private midwifery services in must have appropriate professional indemnity insurance from the date the State or Territory in which they were registered enacted National Law.

Further information about professional indemnity insurance for midwives can be found at:

http://www.health.gov.au/internet/main/publishing.nsf/Content/Maternity+Services+Review-Q&A-PIMI

MN.13.6 Provider Numbers

To access the Medicare arrangements, eligible midwives will need to apply to Services Australia for a provider number. A separate provider number is required for each location at which a midwife practices.

Provider registration forms may be obtained from the Services Australia website or by contacting on Services Australia at 132 150.

MN.13.7 Schedule Fees and Medicare Benefits

Each midwifery service is identified in the MBS by an item number. The fee set for any item in the MBS is known as the "Schedule fee". The Schedule fee and Medicare benefit for each service is listed in the item description.

There are two levels of benefit payable for midwifery services:

75% of the Schedule fee for midwifery services rendered as part of an episode of hospital treatment (other than for public patients) - see GN.1.2; or

85% of the Schedule fee for all other antenatal and postnatal services.

MN.13.8 Safety Nets

Where practitioners charge more than the Medicare benefit, the resultant out-of-pocket costs are the responsibility of the patient.

Assistance is provided to families and singles for out-of-pocket costs for out-of-hospital services through the "original" and "extended" Medicare safety nets:

- the original safety net provides that once the threshold is met, the Medicare benefit increases to 100 per cent of the Schedule fee; and

- under the Extended Medicare Safety Net (EMSN), once certain thresholds are met, Medicare reimburses 80 per cent of the out-of-pocket costs. However, where the item has an EMSN benefit cap, there is a maximum limit on the EMSN benefit that will be paid for that item.

MN.13.10 Where Medicare Benefits are not payable

Medicare benefits are not available:

a. for services listed on the MBS, where the service rendered does *not* meet the item description and associated requirements;

b. where the midwifery service is *not* personally performed by the participating midwife;

c. for MBS services that are time based, the inclusion of any time period in the consultation periods when the patient is *not* receiving active attention e.g. the time the provider may take to travel to the patient's home or where the patient is resting between blood pressure readings; and

d. services provided where the patient is not in attendance, such as the issuing of repeat prescriptions;

e. group sessions; or

f. for services provided by a lactation consultant. Medicare benefits are payable for breast feeding support as part of the postnatal care provided by the participating midwife.

The fee charged under Medicare must not include the cost of services that are not part of the MBS service being claimed. Medicare benefits are not payable for goods or appliances associated with the service, such as bandages or other skin dressings

Unless the Minister otherwise directs, Medicare benefits are not payable where funding has already been provided under an arrangement with the Commonwealth, state or a local governing body.

MN.13.11 Billing of Patient

Where the practitioner bills the patient for medical services rendered, the patient needs a properly itemised account/receipt to enable a claim to be made for Medicare benefits.

Under the provisions of the *Health Insurance Act 1973* and Regulations, Medicare benefits are not payable in respect of a professional service unless there is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of the service, the following particulars:

(a) Patient's name;

(b) The date on which the professional service was rendered;

(c) An item number or a description of the professional service sufficient to identify the item that relates to that service, including an indication where the service is rendered to a person while hospital treatment is provided in a hospital "admitted patient" immediately preceding the description of the service or an asterisk "*" directly after an item number where used;

(d) The name and practice address and provider number of the participating midwife who actually rendered the service; (where the participating midwife has more than one practice location recorded with Services Australia, the provider number used should be that which is applicable to the practice location at or from which the service was given).

Only one original itemised account should be issued in respect of any one service, and any duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

MN.13.12 Assignment of Benefits (Bulk-Billing) Arrangements

Assignment of Benefit (Bulk-Billing) Arrangements

Under the *Health Insurance Act 1973*, the assignment of benefit (bulk-billing) facility for professional services is available to all eligible persons under the Medicare program.

Where a participating midwife elects to bulk-bill, the midwife agrees to accept the relevant Medicare benefit as the full payment for the service rendered. No additional charges relating to that service (regardless of their purpose or description) may be levied on the patient.

From 1 July 2026, a patient's benefit can be assigned either *before* or *after* a service is rendered. The *Health Insurance Regulations 2018* Part 65C outlines the information that must be recorded in an agreement in writing (physically or electronically):

For a pre-episodic assignment agreement for all midwife MBS items (i.e. a patient's assignment is obtained before a service is rendered), the following information is required:

(i) name of the individual who will receive the service;

(ii) name and practice address OR provider number of the professional who will render the service;

(iii) that the agreement is a pre-episodic assignment;

(iv) date on which the agreement is made;

(v) date the service will be rendered;

(vi) the Basic Service Description;

(vii) whether the assignor is the patient (yes or no);

(viii) be signed by the patient (or their assignor).

For a post-episodic assignment agreement (i.e. a patient's assignment is obtained after a service is rendered):

(i) name of the individual who will receive the service;

(ii) name and practice address OR provider number of the professional who will render the service;

(iii) that the agreement is a post-assignment;

(iv) date on which the agreement was made;

(v) date the service was rendered;

(vi) the MBS item;

(vii) whether the assignor is the patient (yes or no);

(viii) be signed by the patient (or their assignor).

Services Australia is responsible for administering bulk-billing arrangements under Medicare and the payment of Medicare benefits on patient claims. All enquiries regarding these matters should be directed to Services Australia.

Recordkeeping Obligations

From 1 July 2026, patients are to be provided with a copy of the assignment only upon request. Participating midwives must retain all Medicare claim documentation for a minimum of two years from the date of claim submission.

MN.13.13 Assignment of Benefit Agreements

Assignment of Benefit (Bulk-Billing) Arrangements

Under the *Health Insurance Act 1973*, the assignment of benefit (bulk-billing) facility for professional services is available to all eligible persons under the Medicare program.

Where a participating midwife elects to bulk-bill, the midwife agrees to accept the relevant Medicare benefit as the full payment for the service rendered. No additional charges relating to that service (regardless of their purpose or description) may be levied on the patient.

From 1 July 2026, a patient's benefit can be assigned either before or after a service is rendered. The *Health Insurance Regulations 2018* Part 65C outlines the information that must be recorded in an agreement in writing (physically or electronically):

For a pre-episodic assignment agreement for all midwife MBS items (i.e. a patient's assignment is obtained before a service is rendered), the following information is required:

(i) name of the individual who will receive the service;

(ii) name and practice address OR provider number of the professional who will render the service;

(iii) that the agreement is a pre-episodic assignment;

(iv) date on which the agreement is made;

(v) date the service will be rendered;

(vi) the Basic Service Description;

(vii) whether the assignor is the patient (yes or no);

(viii) be signed by the patient (or their assignor).

For a post-episodic assignment agreement (i.e. a patient's assignment is obtained after a service is rendered):

(i) name of the individual who will receive the service;

(ii) name and practice address OR provider number of the professional who will render the service;

(iii) that the agreement is a post-assignment;

(iv) date on which the agreement was made;

(v) date the service was rendered;

(vi) the MBS item;

(vii) whether the assignor is the patient (yes or no);

(viii) be signed by the patient (or their assignor).

Services Australia is responsible for administering bulk-billing arrangements under Medicare and the payment of Medicare benefits on patient claims. All enquiries regarding these matters should be directed to Services Australia.

Recordkeeping Obligations

From 1 July 2026, patients are to be provided with a copy of the assignment only upon request. Participating midwives must retain all Medicare claim documentation for a minimum of two years from the date of claim submission.

MN.13.14 Time Limits Applicable to Lodgement of Claims for Assigned Benefits

A time limit of 1 year applies to making claims with Medicare under the direct billing (assignment of benefit) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than 1 year earlier than the date the claim was made with Medicare. For services rendered prior to 5 September 2025, this timeframe is up to 2 years from the date of service.

Provision exists whereby in certain circumstances (e.g. hardship cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the processing centre to which assigned claims are directed.

MN.13.15 Overview of the Maternity Items

Face to Face Services

Antenatal, intrapartum and postnatal care provided by participating midwives are covered by MBS items 82100, 82105, 82110, 82102, 82103, 82115, 82116, 82118, 82120, 82123, 82125, 82127, 82130, 82135, 82104, 82140. These items cover 16 specific types of service that allow the participating midwife to:

- undertake an initial antenatal attendance lasting at least 60 minutes (item 82100);
- provide a short antenatal attendance lasting at least 10 minutes (item 82105);
- provide a routine antenatal attendance lasting at least 40 minutes duration (item 82110);
- provide a long antenatal attendance lasting at least 90 minutes (item 82102);
- provide a complex antenatal attendance leading to a hospital admission, lasting at least 3 hours (item 82103);
- make an assessment of and prepare a maternity care plan for a patient across a pregnancy that has progressed beyond 28 weeks and there have been at least two antenatal attendances with the claiming participating midwife in the preceding six months (item 82115);
- undertake management of labour (excluding birth) out of hospital for up to 6 hours (item 82116);
- undertake management of labour (including birth where performed) in hospital by the first participating midwife for a total of up to 6 hours (item 82118);
- undertake management of labour (including birth where performed) by the first participating midwife for a total of 6 to 12 hours, including birth (item 82120);
- undertake management of labour (including birth where performed) in hospital by the second participating midwife for a total of up to 6 hours (item 82123);
- undertake management of labour (including birth where performed) by the second participating midwife for a total of 6 to 12 hours including birth (item 82125);
- undertake management of labour (including birth where performed) in hospital by the third participating midwife for a total of up to 6 hours (item 82127);
- provide a short postnatal attendance lasting at least 20 minutes (item 82130);
- provide a routine postnatal attendance of at least 40 minutes duration (item 82135);
- provide a long postnatal attendance of at least 90 minutes (item 82104); and

- provide a comprehensive postnatal check to a patient between 4 and 8 weeks after the birth of the baby (item 82140).

Telehealth (video and phone) Services

- A service may only be provided by telehealth where it is safe and clinically appropriate to do so.
- These MBS telehealth items are for out-of-hospital patients.
- Providers are expected to obtain informed financial consent from patients prior to providing the service including providing details regarding their fees and any out-of-pocket costs.

The participating midwife telehealth items are:

Service	Video items via video-conference	Phone items for when video-conferencing is not available
Short antenatal attendance lasting at least 10 minutes	91211	91218
Routine antenatal attendance lasting at least 40 minutes	91212	91219
Short postnatal attendance lasting at least 20 minutes	91214	91221
Routine postnatal attendance lasting at least 40 minutes	91215	91222

MN.13.16 Maternity Services Attracting Medicare Benefits

Medicare benefits are only payable for clinically relevant services. Clinically relevant in relation to midwifery care means a service generally accepted by the midwifery profession as necessary to the appropriate treatment of the patient's clinical condition.

Medicare benefits are only payable where the participating midwife provides care to not more than one patient on the one occasion.

Antenatal Care

Eligible maternity care plan service

MBS item 82115 is the one MBS item available for participating midwife practitioners to undertake a comprehensive assessment and prepare a written maternity care plan for a patient, who is not an admitted patient of a hospital, across a pregnancy that has progressed beyond 28 weeks.

It is expected that the care plan would be agreed with the patient and detail such things as agreed expectation, health problems and care needs and appropriate referrals, medication and diagnostic tests.

To claim item 82115, the participating midwife is required to have had at least two antenatal attendances (82100, 82105, 82110, 82102, 91211, 91212, 91218 or 91219) with the patient in the preceding six months; and the provider who undertakes the care plan should intend to remain the primary health care provider for the remainder of the pregnancy.

There was a six month transition period for the restriction on the claiming participating midwife having at least two antenatal attendances in the preceding six months. This transition period acknowledged that in the six months prior to 1 March 2022 (before this requirement was legislated), participating midwives may not have had the required two antenatal visits with the patient to claim 82115 as at the time they were not aware of the upcoming requirement. The transition period ended on 1 September 2022.

Item 82115 cannot be claimed if items 16590 or 16591 have previously been claimed during a single pregnancy, except in exceptional circumstances. An exceptional circumstance in which the creation of a new maternity care plan may be required includes a significant change in the patient's clinical condition or maternity care requirements.

For claiming purposes, the exceptional circumstance requiring another maternity care plan needs to be recorded in the patient's notes, and "exceptional circumstance" notated when submitting the claim.

Number of services: Only one (1) midwifery care plan (82115) is payable per pregnancy.

Antenatal Attendances

Medicare benefits are payable for an antenatal service where a participating midwife provides a clinically relevant service in respect of a miscarriage. Medicare benefits are not payable for an antenatal attendance associated with the labour. The labour items (82116-82127) include all associated intrapartum attendances.

Any clinically relevant indication that requires an antenatal attendance by a participating midwife on an admitted patient in hospital, but that is not associated with the labour, will attract a Medicare benefit.

Number of services: Only one (1) initial antenatal attendance under item 82100 is payable per pregnancy. There is no limit attached to the provision of short, routine and long antenatal attendances (82105, 82110, 82102, 91211, 91212, 91218 and 91219) by a participating midwife. However, only clinically relevant attendances should be itemised under Medicare and services provided by participating midwives will be subject to Medicare Audit and Professional Review Processes.

Complex Antenatal Care

MBS item 82103 provides Medicare benefits for complex antenatal care so that women can continue to receive care from their primary carer when admitted to hospital. Medicare benefits are payable for over-night hospital treatment, but also for an admission that requires part of same-day hospital treatment. The item is not intended to be payable for an antenatal attendance associated with the intrapartum items (82116-82127).

Item 82103 is intended for instances where the midwife is required to complete the admission procedure, clinical assessment, testing, care planning and any fetal monitoring. The three hours is expected to be a continuous attendance from presentation to hospital through to the finalisation of admission and stabilisation of the patient.

Number of services: Item 82103 is claimable up to three (3) times per pregnancy. A separate antenatal attendance can be claimed on the same day, provided that the subsequent attendance is not a continuation of the first attendance, both services are clinically relevant and distinct, and the item requirements are met for both attendances.

Management of labour

The MBS includes six items for management of labour by a participating midwife;

- undertake management of labour (excluding birth) out of hospital for up to 6 hours (item 82116)
- undertake management of labour (including birth where performed) in hospital by the first participating midwife for a total of up to 6 hours (item 82118)
- undertake management of labour (including birth where performed) by the first participating midwife for a total of 6 to 12 hours, including birth (item 82120)
- undertake management of labour (including birth where performed) in hospital by the second participating midwife for a total of up to 6 hours (item 82123)
- undertake management of labour (including birth where performed) by the second participating midwife for a total of 6 to 12 hours including birth (item 82125)
- undertake management of labour (including birth where performed) in hospital by the third participating midwife for a total of up to 6 hours (item 82127)

Management of labour out of hospital

Item 82116 is for the management of labour out of hospital for up to six hours. This item is intended to provide benefits for patients whose births occur in hospital. This item is not intended to provide benefits for planned home births.

This item is not claimable if the management of labour and birth is intended to be transferred to an obstetrician, medical practitioner or non-participating midwife. The total attendance time is to be documented in the patient notes.

Management of labour in hospital

The intrapartum items (82118-82127) are claimable for the participating midwife's total attendance managing the patient's labour in hospital. These items are claimable from when the patient is admitted to hospital. The time taken to conduct a patient handover to another participating midwife is counted towards the total attendance. Breaks taken to manage the participating midwife's fatigue are not counted towards the total claimable time. The total attendance time for each participating midwife is to be documented in the patient notes.

Example One:

- The first participating midwife manages the patient's labour at the patient's home for five hours and then for three hours in hospital. To manage their fatigue, the first participating midwife hands over care to a second participating midwife and takes a 10 hour break.
- The second participating midwife takes over the patient's care and manages the labour for 10 hours before handing over care to the first participating midwife to manage their own fatigue.
- The first participating midwife takes over the patient's care and manages their labour and birth for 6 hours.

In this scenario, the first participating midwife would be eligible to claim 82116 (for the five hours in attendance out of hospital) and 82120 (for the total of nine hours in hospital attendance). The second participating midwife would claim 82125 (for the total of 10 hours in hospital attendance).

Example Two:

- The first participating midwife manages the patient's labour in hospital for two hours and as they have been at another birth just prior to this attendance, needs to take a break to manage their fatigue. They handover the patient's care to the second participating midwife before taking a 10 hour break.
- The second participating midwife takes over the patient's care and manages the labour in hospital for six hours before handing over care to the third participating midwife to manage their fatigue.
- The third participating midwife takes over the patient's care. The third midwife has already managed a different patient's labour and birth earlier that day and is able to manage this patient's labour for four hours before handing over care to the first participating midwife to manage their fatigue.
- The first participating midwife manages the labour and birth for four hours.

In this scenario, the first participating midwife would claim 82118 (for the six hours in hospital attendance). The second participating midwife would claim 82123 (for the six hours in hospital attendance) and the third participating midwife would claim 82127 (for the four hours in hospital attendance).

Medicare benefits are payable under items 82118-82127 whether or not the participating midwife undertakes the birth i.e. including where the patient's care is escalated to an obstetrician during labour or for the birth.

Medicare benefits are only payable where the service is provided to an admitted patient of a hospital, including a hospital birthing centre. Labour is taken to commence when the participating midwife attends a patient that is in labour and who has been admitted to the hospital for labour and birth. The time period for these items is the period for which the participating midwife is in exclusive attendance on the patient for labour, and birth where performed.

Medicare benefits are only payable for management of labour where the participating midwife undertaking the service has provided the patient's antenatal care or who is a member of a practice that provided the patient's antenatal care.

It is not intended that these items be claimed routinely by participating midwives who do not intend to undertake the birth i.e. where the participating midwife has arranged beforehand for a medical practitioner to undertake the birth. Where the participating midwife does not undertake the birth it is because:

- In order to manage the participating midwife's fatigue, care was transferred to another participating midwife for management of labour; or
- There was a clinical need to escalate care to an obstetrician or medical practitioner who provides obstetric services.

Number of services: Intrapartum items 82116-82127 can only be claimed once per pregnancy.

Postnatal Care

The MBS provides for long, routine and short attendance items for postnatal care in the first six weeks post birth. There are routine and short postnatal attendance items available via video, and phone for when video is not available.

In addition to the postnatal attendance items, MBS benefits are payable for a comprehensive postnatal check (82140), which can be provided at any time between four and eight weeks following birth, after which care is transferred to the patient's nominated primary provider.

Number of services: Only one (1) postnatal check (82140) by a participating midwife is payable per pregnancy. There is no limit attached to the provision of long, routine and short postnatal attendances (82130, 82135, 82104, 91214, 91215, 91221 and 91222) by a participating midwife. However, only clinically relevant attendances should be claimed under Medicare. Services provided by participating midwives will be subject to Medicare Audit and Professional Review Processes.

MN.13.17 Conditions Governing the Provision and Claiming of Items

Service length and type

- Services under these items must be for the time period specified within the item descriptor.
- Professional attendance for MBS items 82100, 82105, 82110, 82102, 82115, 82116, 82130, 82135, 82104 and 82140 may be provided in an appropriate setting that includes but is not limited to: the patient's home, a midwifery group practice, a participating midwife practitioner's rooms or a medical practice.
- Professional attendance item 82103 is intended to be provided to patients who are admitted to hospital.
- Items 91211, 91212, 91214, 91215 are for services provided by video, and items 91218, 91219, 91221, 91222 are for services provided by phone when video is not available.

MN.13.18 Referral Requirements

A participating midwife will be able to refer a patient to specialist obstetricians and paediatricians as clinical services dictate.

A referral is valid for 12 months. A new pregnancy represents a new episode of care. Should there be a new pregnancy in that period, a new referral will be required.

A referral to a specialist must be in writing in the form of a letter or a note to the specialist and must be signed and dated by the referring participating midwife. The referral must contain any information relevant to the patient and the specialist must have received the referral on or prior to providing a specialist consultation.

If a referral is lost, stolen or destroyed, the participating midwife would need to provide a replacement referral as soon as is practicable after the service is provided.

If a specialist provides a consultation without a referral, the specialist's consultation would not attract Medicare benefits at the specialist rate.

There are exemptions from this requirement in an emergency if the participating midwife considers the patient's condition requires immediate attention without a referral. In that situation, the specialist must decide that it is necessary in the patient's interests to render the professional service specified in the item as soon as practicable and they must begin rendering a service within 30 minutes of the patient's presentation.

If the patient is a privately admitted patient of a hospital a letter or note is not required. The referring participating midwife would make a notation in the patient's notes, which they would sign, approving the referral.

A referral is not required to transfer a patient's care during the intra-partum period under items 16527 and 16528. The participating midwife would make a signed notation in the patient's notes approving the transfer of care.

If a participating midwife refers a patient to an allied health practitioner or an Aboriginal and Torres Strait Islander primary health care worker or practitioner no benefits would be payable for that service.

A written referral is not required to refer the patient back to their primary carer for the ongoing care of patient and baby. It is sufficient for the participating midwife to provide a discharge summary to the primary carer outlining the maternity history and any relevant clinical issues.

MN.13.19 Requesting Requirements

Pathology Services

Determination of Necessity of Service

The participating midwife requesting a pathology service for a woman must determine that the pathology service is necessary.

Request for Service

The service may only be provided in response to a request from the treating practitioner and the request must be in writing (or, if oral, confirmed in writing within fourteen days).

Pathology Services approved for participating midwives

FBC (item 65070)	vaginal /anal swab/GBS (69312)* varicella 69384 - 69401 (antibody test) parvo virus 69384 - 69401
Hb (item 65060)	rubella titre syphilis Hep B/C - items 69405, 69408, 69411, 69413 or 69415 HIV
Group and antibodies (items 65090, 65093, 65096) glucose load (items 66545, 66548)	Serum Bilirubin (SBR); 66500
Downs Syndrome/ Spina Bifida (items 66743, 66750, 66751)	Direct Coombs; 65114
eye swab (69303)	Blood glucose level (item 66500)
skin swab (69306)	Cord PH and gases cord (O2 and CO2) (Item 66566)
skin scrapings (69309)	Group and Hold (item 65099)
Chlamydia (item 69316)	Coagulation Studies (items 65129, 65070)
Gonorrhea (item 69317)	Mid stream urine (item 69324)
Cervical screening (items 73070, 73071, 73075, 73076)	HCG (item 73529)

Diagnostic Imaging Services

Determination of Necessity of Service

The participating midwife requesting a diagnostic imaging service for a woman must determine that the diagnostic imaging service is necessary for the appropriate professional care of the patient.

Request for Service

The service may only be provided in response to a request from the treating practitioner, and the request must be in writing, signed and dated.

The request does not have to be in a particular form. However, legislation provides that a request must be in writing and contain sufficient information, in terms that are generally understood by the profession, to clearly identify the item/s of service requested. This includes, where relevant, noting on the request the clinical indication(s) for the requested service. The provision of additional relevant clinical information can often assist the service provider, and enhance the overall service provided to the patient.

It is not necessary that a written request for a diagnostic imaging service be addressed to a particular provider or that, if the request is addressed to a particular provider, the service must be rendered by that provider.

A single request may be used to order a number of diagnostic imaging services. However, all services provided under this request must be rendered within seven days after rendering the first service.

Ultrasound:

Routine morphology scan (item 55706)	Nuchal Translucency (item 55707)
Early dating scan (item 55700)	Post 22 weeks scan (item 55718)
Scan at 12-16 weeks (item 55704)	

MN.14.1 Participating Nurse Practitioners Services - Overview

As at 1 November 2010, Medicare benefits are payable for services provided by privately practising participating nurse practitioners in collaboration with other health care providers. Participating nurse practitioners can also request certain pathology and diagnostic imaging services for their patients and refer patients to specialist, as the clinical need arises. The nurse practitioner services that attract a Medicare benefit are identified in the Medicare Benefits Schedule (MBS) by an item number and the each item describes the service requirements and schedule fee.

MN.14.2 Eligible Nurse Practitioners

Under the legislation, to be an eligible nurse practitioner the nurse practitioner must be registered or authorised (however described) under State and Territory law. The nurse practitioner must also demonstrate that he or she has the appropriate qualifications and experience to meet the registration standard developed by the Nursing and Midwifery Board of Australia (NMBA).

This standard was developed for the purposes of the National Registration and Accreditation Scheme (NRAS), a single regulation and accreditation scheme for health professionals, including nurse practitioners. Additional information is available at the Australian Health Practitioners Regulation Agency (AHPRA) website at: http://www.ahpra.gov.au/index.php

MN.14.3 Provider Numbers

To access the Medicare arrangements, eligible nurse practitioners will need to apply to Services Australia for a provider number. A separate provider number is required for each location at which a nurse practitioner practices.

Provider registration forms may be obtained from the Services Australia website or by contacting on Services Australia at 132 150.

MN.14.6 Schedule Fees and Medicare Benefits

Each nurse practitioner service is identified in the MBS by an item number. The fee set for any item in the MBS is known as the "Schedule fee". The Schedule fee and Medicare benefit for each service is listed in the item

description. The Medicare benefit for nurse practitioner services rendered to non-admitted patients is 85% of the Schedule fee.

MN.14.7 Where Medicare Benefits are not payable

Medicare benefits are not available:

a. where the service rendered does not meet the item description and associated requirements;

b. where the nurse practitioner service is not personally performed by the participating nurse practitioner;

c. for any time period in the consultation periods when the patient is not receiving active attention e.g. the time the provider may take to travel to the patient's home or where the patient is resting between blood pressure readings;

d. services provided where the patient is not in attendance, such as the issuing of repeat prescriptions;

e. for telephone attendances; and

f. group sessions.

The fee charged under Medicare must not include the cost of services that are not part of the MBS service being claimed. Medicare benefits are not payable for good or appliances associated with the service, such as bandages or other skin dressings.

Unless the Minister otherwise directs, Medicare benefits are not payable where funding has already been provided under an arrangement with the Commonwealth, state or a local governing body.

MN.14.8 Billing of the Patient

Where the nurse practitioner bills the patient for medical services rendered, the patient needs a properly itemised account/receipt to enable a claim to be made for Medicare benefits.

Under the provisions of the *Health Insurance Act 1973*, Medicare benefits are not payable in respect of a professional service unless there is record on the account setting out the fee for the service or on the receipt for the fee in respect of the service, the following particulars:

(a) Patient's name;

(b) The date on which the professional service was rendered;

(c) An item number or a description of the professional service sufficient to identify the item that relates to that service, including an indication where the service is rendered to a person while hospital treatment is provided in a hospital "admitted patient" immediately preceding the description of the service or an asterisk "*" directly after an item number where used;

(d) The name and practice address and provider number of the participating nurse practitioner who actually rendered the service; (where the participating nurse practitioner has more than one practice location recorded with Services Australia, the provider number used should be that which is applicable to the practice location at or from which the service was given).

Only one original itemised account should be issued in respect of any one service and any duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

MN.14.9 Assignment of Benefits (Bulk-Billing) Arrangements

Assignment of Benefit (Bulk-Billing) Arrangements

Under the *Health Insurance Act 1973*, the assignment of benefit (bulk-billing) facility for professional services is available to all eligible persons under the Medicare program.

Where a nurse practitioner elects to bulk-bill, the nurse practitioner agrees to accept the relevant Medicare benefit as full payment for the service rendered. No additional charges relating to that service (regardless of their purpose or description) may be levied on the patient.

From 1 July 2026, a patient's benefit can be assigned either before or after a service is rendered. The *Health Insurance Regulations 2018* Part 65C outlines the information that must be recorded in an agreement in writing (physically or electronically):

For a pre-episodic assignment agreement for all nurse practitioner MBS items (i.e. a patient's assignment is obtained before a service is rendered), the following information is required:

(i) name of the individual who will receive the service;

(ii) name and practice address OR provider number of the professional who will render the service;

(iii) that the agreement is a pre-episodic assignment;

(iv) date on which the agreement is made;

(v) date the service will be rendered;

(vi) the Basic Service Description;

(vii) whether the assignor is the patient (yes or no);

(viii) be signed by the patient (or their assignor).

For a post-episodic assignment agreement (i.e. a patient's assignment is obtained after a service is rendered):

(i) name of the individual who will receive the service;

(ii) name and practice address OR provider number of the professional who will render the service;

(iii) that the agreement is a post-assignment;

(iv) date on which the agreement was made;

(v) date the service was rendered;

(vi) the MBS item;

(vii) whether the assignor is the patient (yes or no);

(viii) be signed by the patient (or their assignor).

Where a patient is unable to sign the assignment agreement, an 'assignor' can sign on the patient's behalf (for example, a partner, parent, guardian, carer or person with Power of Attorney). Staff employed in medical facilities where patients receive care should not act as an assignor unless they would otherwise meet the cost of the patient's care. An assignment agreement is not complete unless signed by the patient or the patient's assignor.

Services Australia is responsible for administering bulk-billing arrangements under Medicare and the payment of Medicare benefits on patient claims. All enquiries regarding these matters should be directed to Services Australia.

The bulk-billing stationary required for nurse practitioners is available from Services Australia. For more details about obtaining bulk-billing stationary, you can contact Services Australia on 132 150.

Recordkeeping Obligations

From 1 July 2026, patients are to be provided with a copy of the assignment only upon request. Participating nurse practitioners must retain all Medicare claim documentation for a minimum of two years from the date of claim submission.

MN.14.12 Overview of the Nurse Practitioner items

Services provided by participating nurse practitioners are covered by five MBS items 82200, 82205, 82210, 82215 and 82216. These also have phone equivalents 91193, 91189, 91190, 91191 and video equivalents 91192, 91178, 91179, 91180 and 91206.

These items provide for:

professional attendance for an obvious problem, straight forward in nature, with limited examination and management required (item 82200)

professional attendance for a patient lasting no less than 6 minutes and no more than 20 minutes duration (item 82205)

professional attendance for a patient lasting at least 20 minutes duration (item 82210);

professional attendance for a patient lasting at least 40 minutes duration (item 82215);

professional attendance for a patient lasting at least 60 minutes duration (item 82216).

MN.14.13 Nurse Practitioner services attracting Medicare benefits

Medicare Benefits are only payable for clinically relevant services. Clinically relevant in relation to nurse practitioner care means a service generally accepted by the nursing profession as necessary to the appropriate treatment of the patient's clinical condition.

Medicare benefits are only payable where the participating nurse practitioner provides care to not more than one patient on one occasion.

MN.14.14 Conditions governing the provision and claiming of items

Service length and type

Services under these items must be for the time period specified within the item descriptor.

Professional attendance for MBS items 82200, 82205, 82210, 82215, may be provided in an appropriate setting that includes but is not limited to: the patient's home, a nurse practitioner group practice, a nurse practitioner's rooms or a medical practice.

MN.14.15 Referral requirements

A participating nurse practitioner will be able to refer private patients to a specialist and consultant physician as clinical services dictate.

This measure does not include referral by a nurse practitioner for allied or Aboriginal and Torres Strait Islander primary health care worker or practitioner health care. If a participating nurse practitioner refers a patient to an allied health practitioner or an Aboriginal and Torres Strait Islander primary health care worker or practitioner, no benefits would be payable for that service.

A referral given by a participating nurse practitioner is valid until 12 months after the first service given in accordance with the referral.

If the referral is lost, stolen or destroyed, the nurse practitioner would need to provide a replacement referral as soon as is practicable after the service is provided.

A referral to a specialist must be in writing in the form of a letter or a note to the specialist and must be signed and dated by the referring nurse practitioner. The referral must contain any information relevant to the patient and the specialist must have received the referral on or prior to providing a specialist consultation.

There are exemptions from this requirement in an emergency if the specialist considers the patient's condition requires immediate attention without a referral. In that situation, the specialist is taken to be the referring practitioner.

MN.14.16 Requesting requirements

Pathology Services

Determination of Necessity of Service

The participating nurse practitioner requesting a pathology service for a patient must determine that the pathology service is necessary.

Request for Service

The service may only be provided in response to a request from the treating practitioner and the request must be in writing (or, if oral, confirmed in writing within fourteen days).

Pathology Services approved for participating nurse practitioners

Nurse practitioners may request MBS pathology items in any Groups P1 to P8 or any of items 73826 to 73837 of the pathology services table. Requesting pathology services must be within the nurse practitioner's scope of practice.

Further information

For further information about Medicare Benefits Schedule items, please refer to the Department of Health, Disability and Ageing's website at www.health.gov.au/mbsonline.

Diagnostic Imaging Services

Determination of Necessity of Service

The participating nurse practitioner requesting a diagnostic imaging service for a patient must determine that the diagnostic imaging service is necessary for the appropriate professional care of the patient.

Request for Service

The service may only be provided in response to a request from the treating nurse practitioner, and the request must be in writing, signed and dated. The legislation provides that a request must be in writing and contain sufficient information, in terms that are generally understood by the profession, to clearly identify the item/s of service requested. This includes, where relevant, noting on the request the clinical indication(s) for the requested service. The provision of additional relevant clinical information can often assist the service provider, and enhance the overall service provided to the patient.

It is not necessary that a written request for a diagnostic imaging service be addressed to a particular provider or that, if the request is addressed to a particular provider, the service must be rendered by that provider.

A single request may be used to order a number of diagnostic imaging services. However, all services provided under this request must be rendered within seven days after rendering the first service.

Further Information

For further information on Medical Benefit Schedule items nurse practitioners can request for Diagnostic Imaging services please refer to note IN.0.6, which can be found here.

MN.14.17 Items for Long-Acting Reversible Contraceptive Services

Long-acting reversible contraceptive (LARC) services provided by participating nurse practitioners are covered by three MBS items.

The items provide for:

- an intra-uterine device (IUD) insertion (MBS item 82201)
- a hormonal implant removal (MBS item 82202)
- a hormonal implant implantation (MBS item 82203)

Additional information

- Applicable clinical practice guidelines are available from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).
- Item 82203 is not payable for artificial insemination or rendered in conjunction with assisted reproductive technology MBS services.
- The "(Anaes.)" annotation indicates that the MBS item can be provided with an anaesthetic service. Anaesthetic MBS items can be billed by the medical provider in conjunction with the participating nurse practitioner billing the LARC service procedure items.

Loading Item

- Item 82204 provides a ‘loading’ of 40% of the fee for relevant LARC insertion/removal items, when a patient’s LARC insertion or removal service, and any associated services such as consultations, are bulk billed.

This item provides for:

- New loading item 82204 is intended to support bulk billing of patients who are having a LARC inserted or removed.
- For loading item 82204 to be payable, participating nurse practitioners must:
    - ensure all item requirements are met
    - bulk bill the patient for each MBS item they claim during the patient’s LARC appointment that is related to the LARC insertion/removal, including any other item in Subgroup 1 of Group M14 or items 73832 and 73833 applying to the service.

Services to which loading applies:

- MBS loading item 82204 only applies where a service meeting one or more of the following is performed:
    - An IUD insertion (MBS item 82201)
    - a hormonal implant removal (MBS item 82202)

    - a hormonal implant implantation (MBS item 82203)
- A removal and insertion item may both be claimed if these services are conducted on the same day in the same appointment (for example removal and insertion of a new hormonal implant).
- IUD removal as a standalone procedure can be billed under any appropriate MBS attendance item. In this case item 82204 will not apply.

MN.14.18 Discontinued LARC Procedures - Nurse Practitioners

Item 82206 applies when a procedure outlined in item 82201 or 82202 has commenced, but is then discontinued for clinical reasons, or for other reasons that are beyond the participating nurse practitioner's control.

Item 82206 is a derived fee item. It applies half of the schedule fee for the item it is billed with.

Examples of commenced procedure for LARC

Commenced procedure for IUD insertion means:

- The patient is in the procedure room or on the bed where the procedure is to be performed; and
- The patient has been exposed (i.e. clothing removed) and positioned on the bed where the procedure is to be performed; and
- Sterile equipment has been opened; and
- Attempts at speculum insertion have been made.

Commenced procedure for Implanon removal means:

- The patient is in the procedure room or on the bed where the procedure is to be performed; and
- The patient has been exposed (i.e. clothing removed) and positioned on the bed where the procedure is to be performed; and
- Sterile equipment has been opened; and
- Local anaesthetic has been infiltrated.

Additional information

Services Australia does not require claims for this item to be accompanied by details of the proposed procedure and the reasons why the procedure was discontinued. However, the participating nurse practitioner must maintain a clinical record of this information, which may be subject to audit.

82203 is not subject to the discontinued procedure rule.

MN.14.19 Multiple Operation Rule - Nurse Practitioners LARC Procedures

The multiple operation rule applies where two or more operations are performed on a patient on the one occasion. It will apply if you bill MBS items 82201 and 82202 for procedures you performed on a patient on one occasion.

The fees for co-claimed items 82201 and 82202, performed on a patient on the one occasion are calculated by the following rule:

- 100% for the item with the greatest Schedule fee; plus
- 50% for the item with the next greatest Schedule fee.

Note:

(a) Fees so calculated that result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents.

(b) The Schedule fee for benefit purposes is the aggregate of the fees calculated in accordance with the above formula.

(c) For these purposes the term "procedure" only refers to item 82201 and 82202.

(d) 82203 is not subject to the multiple operation rule.

If MBS items 82201 and 82202 are billed for procedures performed on the same patient on the one occasion by different practitioners who do not assist each other, the rule will not apply.

MN.15.2 Non-Determinate Audiometry - (Item 82306)

This refers to audiometry covering those services, one or more, referred to in Items 82309-82318 when not performed under the conditions set out in paragraph M15.3.

MN.15.3 Conditions for Audiology Services - (Items 82309 to 82324)

A service specified in items 82309 to 82324 should be rendered:

(a) in conditions that allow the establishment of determinate thresholds, including better ear threshold in free field testing;

(b) in a sound attenuated environment with background noise conditions that comply with Australian Standard AS/NZS 1269.3-2005; and

(c) using calibrated equipment that complies with Australian Standard AS IEC 60645.1-22002, ASIEC60645.2-2002 and AS IEC 60645.3-2002.

MN.15.4 Oto-Acoustic Emission Audiometry - (Item 82332)

Medicare benefits are not payable under Item 82332 for routine screening of infants. The equipment used to provide this service must be capable of displaying the recorded emission and not just a pass/fail indicator.

MN.15.5 Provision of Diagnostic Audiology Services by Audiologists - (Items 82300 to 82332)

OVERVIEW

The diagnostic audiology services available through MBS items 82300 to 82332 (excepting 82301, 82302 and 82304) enable an eligible audiologist to perform diagnostic tests upon written request from a medical practitioner. MBS items 82301, 82302 and 82304, for the programming of an auditory implant or the sound processor of an auditory implant, do not require a request from a medical practitioner.

These diagnostic audiology services assist medical practitioners, including ENT specialists and neurologists, in their medical diagnosis and/or treatment and/or management of ear disease or related disorders. The diagnostic audiology items supplement Otolaryngology items for services delivered by, or on behalf of medical practitioners (MBS items 11300 to 11345, excluding 11304).

Requesting arrangements

The written request must be in writing and must contain:

(a) the date of the request; and

(b) the name of the medical practitioner who requested the service and either the address of his or her place of practice or the provider number in respect of his or her place of practice; and

(c) a description of the service which provides sufficient information to identify the service as relating to a particular item (but need not specify the item number).

Written requests should, where possible, note the clinical indication/s for the requested service/s.

A request may be for the performance of more than one diagnostic audiology service making up a single audiological assessment but cannot be for more than one audiological assessment. This means that for Medicare benefits to be payable, any re-evaluation of the patient should be made at the discretion of the medical practitioner through a separate request.

Audiologists do not have the discretion to self-determine diagnostic tests under items 82300 to 82332 (excepting items 82301, 82302 and 82304). If a written request is incomplete or requires clarification, the audiologist should contact the requesting medical practitioner for further information. If an audiologist considers that additional tests may be necessary, the audiologist should contact the requesting medical practitioner to discuss the need and if the requesting practitioner determines that additional tests are necessary, an amended or separate written request must be arranged.

It is recommended that audiologists retain the written request for 24 months from the date the service was rendered (for Medicare auditing purposes). A copy of the written request is not required to accompany Medicare claims or be attached to patients' itemised accounts/receipts or assignment of benefit agreement.

Eligibility requirements for audiologists

The diagnostic audiology items (82300 to 82332) can only be claimed by audiologists who are registered with Services Australia. To be eligible to register with the Services Australia to provide these services, audiologists must meet the following requirements:

Audiologists must be either:

· a 'Full Member' of Audiology Australia who is an Audiology Australia Accredited Audiologist; or

· an 'Ordinary Member - Audiologist' or 'Fellow Audiologist' of the Australian College of Audiology (ACAud).

Registering with Services Australia

Provider registration forms may be obtained from Medicare on 132 150 or at www.servicesaustralia.gov.au.

Changes to provider details

Audiologists must notify Services Australia in writing of all changes to mailing details to ensure that they continue to receive information about Medicare services.

Reporting requirements

Where an audiologist provides diagnostic audiology service/s to the patient under a written request, they must provide a copy of the results of the service/s performed together with relevant written comments on those results to the requesting medical practitioner. It is recommended that these be provided within 7 days of the date the service was performed.

Out-of-pocket expenses and Medicare Safety Net

Audiologists can determine their own fees for the professional service. Charges in excess of the Medicare benefit are the responsibility of the patient. However, out-of-pocket costs will count toward the Medicare Safety Net for that patient.

Publicly funded services

Items 82300 to 82332 do not apply for services that are provided by any Commonwealth or state funded services or provided to an admitted patient of a hospital. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or state/territory government health clinic, items 82300 to 82332 can be claimed for services provided by audiologists salaried by, or contracted to, the service or health clinic. All requirements of the relevant item must be met, including registration

of the audiologist with Services Australia. Medicare services provided under a subsection 19(2) exemption must be bulk billed (i.e., the Medicare benefit is accepted as full payment for services).

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare benefit paid for the services.

MN.16.1 Overview of Eating Disorder Treatment and Management Summary

This explanatory note provides an overview of Eating Disorder Treatment and Management under the Medicare Benefits Schedule (MBS). Under the MBS, eligible patients may access Medicare benefits for evidence-based treatment provided under an Eating Disorder Treatment and Management Plan. Eating Disorder Treatment and Management services may be provided by eligible general practitioners (GPs), eligible medical practitioners, eligible consultant psychiatrists, eligible consultant paediatricians, eligible psychologists (clinical and registered), eligible social workers, eligible occupational therapists, and eligible dietitians.

All MBS explanatory notes that are associated with Eating Disorder Treatment and Management are listed below:

Explanatory Note	Item Numbers
AN.36.3 - Preparation and Review of Eating Disorder Treatment and Management Plans	90250, 90251, 90252, 90253, 90254, 90255, 90256, 90257, 90260, 90261, 90264, 90265, 90266, 90267, 92146, 92147, 92148, 92149, 92150, 92151, 92152, 92153, 92162, 92163, 92170, 92171, 92172, 92173, 92176, 92177, 92441, 92442
MN.16.3 - Provision of Eating Disorder Psychological Treatment Services	82352, 82354, 82355, 82357, 82358, 82359, 82360, 82362, 82363, 82365, 82366, 82367, 82368, 82370, 82371, 82373, 82374, 82375, 82376, 82378, 82379, 82381, 82382, 82383, 90271, 90272, 90273, 90274, 90275, 90276, 90277, 90278, 92182, 92184, 92186, 92188, 92194, 92196, 92198, 92200, 93076, 93079, 93084, 93087, 93092, 93095, 93100, 93103, 93110, 93113, 93118, 93121, 93126, 93129, 93134, 93137
MN.16.2 - Provision of Eating Disorder Dietetic Treatment Services	82350, 93074, 93108
AN.15.1 - Mental Health Case Conferencing	930, 933, 935, 937, 943, 945, 946, 948, 959, 961, 962, 964, 80176, 80177, 80178, 969, 971, 972, 973, 975, 986

Services provided under Eating Disorder Treatment and Management

The Eating Disorder Treatment and Management MBS items define services for which Medicare benefits are payable where service providers undertake assessment and management of eligible patients with a diagnosed eating disorder. These services consist of:

- Eating Disorder Treatment and Management Plan preparation and review services provided by GPs, medical practitioners, consultant psychiatrists and consultant paediatricians (refer explanatory note AN.36.3 – Preparation and Review of Eating Disorder Treatment and Management Plans)
- Eating Disorder Psychological Treatment Services provided by eligible GPs, eligible medical practitioners, eligible psychologists (clinical and registered), eligible social workers, and eligible occupational therapists (refer explanatory note MN.16.3 – Provision of Eating Disorder Psychological Treatment Services)
- Eating Disorder Dietetic Treatment Services provided by eligible dieticians (refer explanatory note MN.16.2 – Provision of Eating Disorder Dietetic Treatment Services)

- Mental Health Case Conferencing services (refer explanatory note AN.15.1 - Mental Health Case Conferences)

Eating Disorder Treatment and Management Plans are valid for a period of 12 months commencing from the date the plan is prepared. Once a plan expires, a new plan must be prepared for the patient to continue accessing Eating Disorder Treatment and Management services.

Under the Eating Disorder Treatment and Management MBS items, eligible patients can claim a Medicare Benefit for up to 40 eating disorder psychological treatment services and 20 eating disorder dietetic health services within a 12-month period.

Patient eligibility for Eating Disorder Treatment and Management

Eating Disorder Treatment and Management services apply to patients who:

A. Have a clinical diagnosis of anorexia nervosa; or
B. Meet the eligibility criteria (outlined below) and have a clinical diagnosis of any of the following conditions:
    a. bulimia nervosa;
    b. binge-eating disorder; or
    c. other specified feeding or eating disorder.

The eligibility criteria, for a patient, is:

- the patient has been assessed as having an eating disorder classified as severe based on clinical screening tool results; and
- the condition is characterised by rapid weight loss, or frequent binge eating or inappropriate compensatory behaviour as manifested by 3 or more occurrences per week; and
- a person who has at least two of the following indicators:

1. clinically underweight with a body weight less than 85% of expected weight where weight loss is directly attributable to the eating disorder;
2. current or high risk of medical complications due to eating disorder behaviours and symptoms;
3. serious comorbid medical or psychological conditions significantly impacting on medical or psychological health status with impacts on function;
4. the person has been admitted to a hospital for an eating disorder in the previous 12 months;
5. inadequate treatment response to evidence-based eating disorder treatment over the past six months despite active and consistent participation.

Where a patient meets the eligibility requirements and it is clinically appropriate, eating disorder treatment and management services may be provided, including the preparation of an Eating Disorder Treatment and Management Plan.

Referral requirements for Allied Health Treatment Services

Eating Disorder Treatment and Management MBS treatment items will not attract a Medicare benefit unless the patient has a valid Eating Disorder Treatment and Management Plan and has been appropriately referred by a referring practitioner for these services as part of their treatment options. For the purposes of these services, a referring practitioner means a GP, medical practitioner, consultant paediatrician, or consultant psychiatrist who has referred the patient for treatment as part of an Eating Disorder Treatment and Management Plan (refer explanatory note AN.36.3 – Preparation and Review of Eating Disorder Treatment and Management Plans)

If there is any doubt about a patient's eligibility, Services Australia will be able to confirm whether a Eating Disorder Treatment and Management Plan is in place and claimed, as well as the number of Eating Disorder Treatment and Management services already claimed by the patient.

Allied health professionals can call Services Australia on 132 150 to check this information, while unsure patients can seek clarification by calling 132 011 or view their care plan history in their Medicare online account through myGov to help track services that have been claimed.

If the referring service has not yet been claimed, Services Australia will not be aware of the patient's eligibility. In this case, the treating practitioner or allied health professional should, with the patient's permission, contact the referring practitioner to ensure an appropriate referring service has been provided to the patient.

For more information on referral requirements for Eating Disorder Treatment and Management services, refer to explanatory note AN.36.3 – Preparation and Review of Eating Disorder Treatment and Management Plans.

Clinical guidelines and other resources

It is expected that medical practitioners and allied health professionals providing services under these items should have the appropriate skills, knowledge and experience to provide eating disorder treatment services. However, there are several resources which may be of assistance to practitioners in providing these services. These include:

- The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Referred Patient Assessment and Management Plan Guidelines
- ANZAED eating disorder treatment principles and general clinical practice and training standards: Heruc, G., Hurst, K., Casey, A. et al. ANZAED eating disorder treatment principles and general clinical practice and training standards. J Eat Disord 8, 63 (2020).
- ANZAED practice and training standards for dietitians providing eating disorder treatment: Heruc, G., Hart, S., Stiles, G. et al. ANZAED practice and training standards for dietitians providing eating disorder treatment. J Eat Disord 8, 77 (2020).
- ANZAED practice and training standards for mental health professionals providing eating disorder treatment: Hurst, K., Heruc, G., Thornton, C. et al. ANZAED practice and training standards for mental health professionals providing eating disorder treatment. J Eat Disord 8, 58 (2020).
- National Eating Disorders Collaboration Eating Disorders: a professional resources for general practitioners available at: www.nedc.com.au/
- The InsideOut GP Hub for Eating Disorders available at: www.gp.insideoutinstitute.org.au/

Note: This information is provided as a guide only and each case should be addressed according to a patient's individual needs.

Links to other Medicare Services

Mental health support is also available under the Better Access initiative, which provides eligible patients with Medicare benefits for up to 10 individual and 10 group mental health treatment services per calendar year when accessed under a Mental Health Treatment Plan.

There is nothing that precludes eligible patients from accessing services concurrently under an Eating Disorder Treatment and Management Plan and a Mental Health Treatment Plan. However, the creation of multiple plans would only occur where the patient has significant co-occurring mental health conditions that require psychological treatment which extends beyond eating disorder specific care.

It is important to note that service cap limits continue to apply for patients accessing care under both an Eating Disorder Treatment and Management Plan and a Mental Health Treatment Plan. Better Access mental health treatment services do not count toward the Eating Disorder Treatment and Management Plan psychological treatment service caps if they are delivered before the plan is prepared. However, they do count toward the service caps if delivered whilst an Eating Disorder Treatment and Management Plan is active.

For example, if a patient has an active Eating Disorder Treatment and Management Plan and a Mental Health Treatment Plan concurrently, they may access a combined maximum of 40 individual psychological treatment services. This total comprises eating disorder psychological treatment services and up to 10 individual services combined across focussed psychological strategy services and psychological therapy services where the relevant eligibility requirements are met. Conversely, if a patient has accessed Better Access mental health treatment services

prior to the preparation of an Eating Disorder Treatment and Management Plan, they remain eligible to access up to 40 individual eating disorder psychological treatment services. In these circumstances, the previously claimed Better Access services do not count towards the eating disorder psychological treatment service cap.

For further information on the Better Access initiative, refer to explanatory note AN.0.78 – Better Access Initiative.

Out-of-pocket expenses and Medicare safety net

Charges in excess of the Medicare benefit for Eating Disorder Treatment and Management MBS items are the responsibility of the patient. However, any out-of-pocket costs will count towards the Medicare safety net for that patient. The out-of-pocket costs for eating disorder services which are not Medicare eligible do not count towards the Medicare safety net (refer to explanatory note GN.10.27 - Medicare Safety Nets).

Publicly funded services

Eating Disorder Treatment and Management MBS items do not apply for services that are provided by any other Commonwealth or state funded services or provided to an admitted patient of a hospital. Unless an exemption under subsection 19(2) of the *Health Insurance Act 1973* applies for a Medicare benefit to be payable, all requirements of the service must be met, including registration with Services Australia.

Private health insurance

Patients need to decide if they will use Medicare or their private health insurance ancillary cover to pay for these services. Patients cannot use their private health insurance ancillary cover to 'top up' the Medicare benefit paid for the services. If a patient has exhausted their services for which a Medicare benefit is payable for the year, and if they have appropriate private health insurance which covers psychological and/or dietetic health services, they may claim from their private health fund. The benefit payable to members of private health funds will vary based on the level of their ancillary cover.

Record keeping and reporting requirements

The Department of Health, Disability and Ageing undertakes regular post payment auditing to ensure MBS items are claimed appropriately. All practitioners providing Eating Disorder Treatment and Management services should ensure they keep adequate and contemporaneous records, including documenting the date, time and people who attended. Only clinical details recorded at the time of attendance count towards the time of the consultation. Other notes or reports added at a later time are not included. For information on what constitutes adequate and contemporaneous records, refer to explanatory note GN.15.39 - Practitioners should maintain adequate and contemporaneous records.

Relevant Legislation

Details about the legislative requirements of the Eating Disorder Treatment and Management MBS items can be found on the Federal Register of Legislation at www.legislation.gov.au.

Attendance items are set out in 3 regulatory instruments:

- *Health Insurance (Section 3C General Medical Services – Allied Health and other Primary Health Care Services) Determination 2024* - Eligible psychologist (clinical and registered), eligible social worker, eligible occupational therapist, and eligible dietician items.
- *Health Insurance (General Medical Services Table) Regulations 2021* – General practitioner, prescribed medical practitioner, consultant paediatrician, and consultant psychiatrist items, including items related to Eating Disorder Psychological Treatment Services for eligible general practitioners and eligible medical practitioners.
- *Health Insurance (Section 3C General Medical Services – Telehealth Attendances) Determination 2021 - telehealth (video and phone) items* – General practitioner, medical practitioner, psychiatrist, paediatrician, eligible psychologist (clinical and registered), eligible social worker, eligible occupational therapist, and

eligible dietician items. In addition, items related to Eating Disorder Psychological Treatment Services for eligible general practitioners and eligible medical practitioners are included in this instrument.

Further information

For further information about Medicare Benefits Schedule items, please visit the MBS Online website at www.health.gov.au/mbsonline.

For providers, further information is also available from the Services Australia provider enquiry line on 132 150.

If you are a patient seeking advice about Medicare services, patient benefits, or your Medicare claims, please contact Services Australia on the Medicare General enquiry line on 132 011.

MN.16.2 Provision of Eating Disorder Dietetic Treatment Services

Associated items: 82350, 93074, 93108

Services attracting Medicare benefits

There are 3 Medicare Benefits Schedule (MBS) items for the provision of eating disorder dietetic treatment services provided by eligible dieticians. These are:

- Face-to Face item: 82350
- Telehealth (video and phone) items: 93074 and 93108

Eligible referral services

Referrals for eating disorder dietetic treatment services must only be utilised for patients with an active Eating Disorder Treatment and Management Plan.

For the purposes of eating disorder dietetic treatment services, a Medicare benefit will be not payable unless patients meet the eligibility and referral requirements outlined in explanatory note MN.16.1 – Overview of Eating Disorder Treatment and Management.

Service length and type

Services provided by eligible dieticians under these items must meet the time-period requirements specified within the item descriptor.

Number of services per year

Medicare benefits are available for up to 20 eating disorder dietetic treatment services within a 12-month period commencing from the date an Eating Disorder Treatment and Management Plan is prepared.

Referrals and reporting back to the referring practitioner

Eligible patients must be referred for eating disorder dietetic treatment services by a GP, medical practitioner, consultant psychiatrist or consultant paediatrician who is managing the patient under an active Eating Disorder Treatment and Management Plan.

Eligible dieticians providing eating disorder dietetic treatment services must be in receipt of the referral at the first consultation. Treating dieticians must also retain the referral for 2 years (24 months) from the date the service is rendered.

The referring practitioner can decide how many services the patient will receive, noting patients may be referred for a maximum of 20 eating disorder dietetic treatment services within a 12-month period.

Treating dieticians must provide a written report to the referring practitioner:

- after the first service; and
- as clinically required following subsequent services; and
- after the final service

The written report must include information regarding:

- assessments carried out on the patient; and
- treatment provided; and
- recommendations on future management of the patient's condition

The written report will assist the referring practitioner in monitoring the patient's progress and assessing the need for additional treatment.

Record Keeping

Eligible dieticians providing eating disorder dietetic treatment services must keep contemporaneous notes of the consultation including documenting the date, time and people who attended. Only clinical details recorded at the time of attendance count towards the time of the consultation. Other notes or reports added at a later time are not included. For information on what constitutes adequate and contemporaneous records, refer to explanatory note GN.15.39 - Practitioners should maintain adequate and contemporaneous records.

Professional eligibility to provide eating disorder dietetic treatment services

Eating disorder dietetic treatment services may only be provided by an eligible dietician. A person is an eligible dietician in relation to the provision of a dietetic treatment service if the person is accredited by Dietitians Australia as an 'Accredited Practising Dietitian'.

Registering with Services Australia

Advice about registering with Services Australia to provide eating disorder dietetic treatment services is available from the Services Australia provider enquiry line on 132 150.

Further information

For further information on Eating Disorder Treatment and Management MN.16.1 – Overview of Eating Disorder Treatment and Management.

For further information about Medicare Benefits Schedule items, please visit the MBS online website at www.health.gov.au/mbsonline.

Further information is available for providers from the Services Australia provider enquiry line on 132 150.

If you are a patient seeking advice about Medicare services, patient benefits, or your Medicare claims, please contact Services Australia on the Medicare General enquiry line on 132 011.

MN.16.3 Provision of Eating Disorder Psychological Treatment Services

Associated Items: 90271, 90272, 90273, 90274, 92182, 92184, 92194, 92196, 90275, 90276, 90277, 90278, 92186, 92188, 92198, 92200, 82352, 82354, 82355, 82357, 93076, 93110, 93079, 93113, 82360, 82362, 82363, 82365, 93084, 93087, 93118, 93121, 82376, 82378, 82379, 82381, 93100, 93103, 93134, 93137, 82368, 82370, 82371, 82373, 93092, 93095, 93126, 93129, 82358, 82359, 82366, 82367, 82382, 82383, 82374, 82375

This explanatory note provides information on the provision of Eating Disorder Psychological Treatment Services for eligible patients with an Eating Disorder Treatment and Management Plan. For information on eating disorder treatment and management, refer to explanatory note MN.16.1 – Overview of Eating Disorder Treatment and Management.

Services attracting Medicare benefits

Individual Eating Disorder Psychological Treatment Services

There are 48 Medicare Benefits Schedule (MBS) items for the provision of individual eating disorder psychological treatment services provided by eligible medical practitioners and eligible allied health professionals. These consist of:

Individual Eating Disorder Psychological Treatment Services:

General Practitioner (GP) services:

- Face-to-Face items: 90271, 90272, 90273, and 90274
- Video and Phone items: 92182, 92184, 92194, and 92196

Medical Practitioner services:

- Face-to-Face items: 90275, 90276, 90277, and 90278
- Video and Phone items: 92186, 92188, 92198, and 92200

Clinical Psychologist Services:

- Face-to-Face items: 82352, 82354, 82355, and 82357
- Video and Phone items: 93076, 93110, 93079, and 93113

Registered Psychologist Services:

- Face-to-Face items: 82360, 82362, 82363, and 82365
- Video and Phone items: 93084, 93087, 93118, and 93121

Social Worker Services:

- Face-to-Face items: 82376, 82378, 82379, and 82381
- Video and Phone items: 93100, 93103, 93134, and 93137

Occupational Therapist Services:

- Face-to-Face items: 82368, 82370, 82371, and 82373
- Video and Phone items: 93092, 93095, 93126, and 93129

Group Eating Disorder Psychological Treatment Services:

There are 8 MBS items for the provision of group eating disorder psychological treatment services provided by eligible allied health professionals. These consist of:

Clinical Psychologist Services:

- Face-to-Face item: 82358
- Video item: 82359

Registered Psychologist Services:

- Face-to-Face item: 82366
- Video item: 82367

Social Worker Services:

- Face-to-Face item: 82382

- Video item: 82383

Occupational Therapist Services:

- Face-to-Face item: 82374
- Video item: 82375

To provide these services, eligible providers must meet the provider eligibility requirements set out below and be registered with Services Australia.

For group eating disorder psychological treatment services provided via video, additional restrictions apply. Please see the group eating disorder psychological treatment services - telehealth (video) requirements section below for further information.

Eligible referral services

Referrals for eating disorder treatment services must be utilised for patients with an active Eating Disorder Treatment and Management Plan.

For the purposes of eating disorder treatment services, a Medicare benefit will be not payable unless patients meet the eligibility and referral requirements outlined in explanatory note MN.16.1 – Overview of Eating Disorder Treatment and Management.

Service length and type

Services provided by eligible GPs, eligible medical practitioners and eligible allied health professionals under these items must meet the time-period requirements specified within the item descriptor.

It is expected that professional attendances at places other than consulting rooms would be provided where treatment in other environments is necessary to achieve therapeutic outcomes.

A range of acceptable mental health care management strategies have been approved for use by eligible health professionals utilising the eating disorder psychological treatment items. These are:

- family based treatment (including whole family, parent based therapy, parent only or separated therapy)
- adolescent focused therapy;
- cognitive behavioural therapy;
- specialist supportive clinical management;
- maudsley model of anorexia treatment in adults;
- interpersonal therapy for bulimia nervosa and binge-eating disorder;
- dialectical behavioural therapy for bulimia nervosa and binge-eating disorder; and
- focal psychodynamic therapy

Additionally, eligible allied health professionals are also permitted to provide:

- cognitive behavioural therapy for anorexia nervosa; and
- cognitive behavioural therapy for bulimia nervosa and binge-eating disorder

Number of eating disorder psychological treatment services per year

Medicare benefits are available for up to 40 eating disorder psychological treatment services within a 12-month period commencing from the date an Eating Disorder Treatment and Management Plan is prepared. These services may consist of individual and/or group eating disorder psychological treatment services.

A patient may only be referred for a maximum of 10 eating disorder psychological treatment services within a course of treatment. To access additional eating disorder psychological treatment services, a review of a patient's

Eating Disorder Treatment and Management Plan is required (refer explanatory note AN.36.3 – Preparation and Review of Eating Disorder Treatment and Management Plans).

Course of treatment and reporting back to the referring practitioner

Eligible patients must be referred for eating disorder psychological treatment services by a GP, medical practitioner, consultant psychiatrist or consultant paediatrician who is managing the patient under an active Eating Disorder Treatment and Management Plan. The referring practitioner can decide how many services the patient will be referred for, noting a maximum of 10 eating disorder psychological treatment services may be provided within a single course of treatment. To access additional services, a review of a patient's Eating Disorder Treatment and Management Plan is required (refer explanatory note AN.36.3 – Preparation and Review of Eating Disorder Treatment and Management Plans).

Eating disorder psychological treatment services may be provided by eligible GPs and eligible medical practitioners who have the appropriate training and skills as recognised by the General Practice Mental Health Standards Collaboration. GPs and medical practitioners providing eating disorder psychological treatment services must do so as part of an arrangement for the treatment of an assessed eating disorder under an Eating Disorder Treatment and Management Plan.

Treating eligible allied health professionals providing eating disorder psychological treatment services must be in receipt of the referral at the first consultation. Treating eligible allied health professionals must also retain the referral for 2 years (24 months) from the date the service is rendered.

Treating allied health professionals must provide a written report to the referring practitioner:

- after the first service; and
- as clinically required following subsequent services; and
- after the final service within a course of treatment

The written report must include information regarding:

- assessments carried out on the patient; and
- treatment provided; and
- recommendations on future management of the patient's condition

The written report will assist the referring practitioner in monitoring the patient's progress and assessing the need for additional treatment.

Group eating disorder psychological treatment services

In addition to individual eating disorder psychological treatment services, eligible patients may also access items for group eating disorder psychological treatment services provided by eligible allied health professionals. Group services count towards the patient's cap of 40 eating disorder psychological treatment services within a 12-month period. Group eating disorder psychological treatment services can be claimed for groups of 6 to 10 patients.

Group eating disorder psychological treatment services - telehealth (video) requirements

Group eating disorder psychological treatment services may only be delivered via video in certain circumstances. To be eligible for group eating disorder psychological treatment services via video, the patient must be located in a Modified Monash Model area 4-7 at the time of the consultation, and at least 15 kilometres apart by road from the eligible allied health professional delivering the service. The patient or eligible allied health professional is not permitted to travel to an area outside the minimum 15 kilometres distance in order to claim a video consultation item.

More information about the Modified Monash Model, including a search tool to identify the classification of a specific location, is available at:

https://www.health.gov.au/topics/rural-health-workforce/classifications/mmm

Record Keeping

Eligible GPs, eligible medical practitioners and eligible allied health professionals providing eating disorder psychological treatment services must keep contemporaneous notes of the consultation including documenting the date, time and people who attended. Only clinical details recorded at the time of attendance count towards the time of the consultation. Other notes or reports added at a later time are not included. For information on what constitutes adequate and contemporaneous records, refer to explanatory note GN.15.39 - Practitioners should maintain adequate and contemporaneous records.

Professional eligibility to provide eating disorder psychological treatment services

Eating disorder psychological treatment services may only be provided by an eligible GP, eligible medical practitioner, eligible psychologist (clinical and registered), eligible occupational therapist, or eligible social worker. The eligibility requirements for each profession are set out below.

A person is an eligible medical practitioner in relation to the provision of eating disorder psychological treatment services if the person:

- is entered in the register maintained by the Chief Executive Medicare under section 33 of the Human Services (Medicare) Regulations 2017; and
- is identified in the register as a medical practitioner who can provide services to which items in Subgroup 2 of Group A20, and items 283, 285, 286 and 287, apply; and
- meets the relevant training and skills requirements determined by the General Practice Mental Health Standards Collaboration for providing these services

A person is an eligible allied health professional in relation to the provision of eating disorder psychological treatment services if the person meets one of the following requirements:

- the person holds general registration in the health profession of psychology with the Psychology Board of Australia; or
- the person holds registration in the health profession of occupational therapy with the Occupational Therapy Board of Australia; or
- the person is a Member of the Australian Association of Social Workers (AASW)

Registering with Services Australia

Advice about registering with Services Australia to provide eating disorder psychological treatment services is available from the Services Australia provider enquiry line on 132 150.

Further information

For further information on Eating Disorder Treatment and Management, refer to explanatory note MN.16.1 – Overview of Eating Disorder Treatment and Management

For further information about Medicare Benefits Schedule items, please visit the MBS online website at www.health.gov.au/mbsonline.

Further information is available for providers from the Services Australia provider enquiry line on 132 150.

If you are a patient seeking advice about Medicare services, patient benefits, or your Medicare claims, please contact Services Australia on the Medicare General enquiry line on 132 011

MN.33.1 Assistance at Operations - Items 93718 to 93724

Items covering operations which are eligible for benefits for surgical assistance under items 93718 and 93719 have been identified by the inclusion of the word “Assist.” in the item description.

Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified, with the exception of items 93720, 93721, 93722, 93723, 93724.

Items 93720, 93721, 93722, 93723 and 93724 provide for surgical assistance at operations under the specific circumstances set out in their item descriptors.

For items 93718 to 93724:

- The assistance must be rendered by a participating nurse practitioner.
- Where more than one person (whether medical practitioners, participating nurse practitioners or a combination thereof) provides assistance to a surgeon, no additional benefits are payable. Only one benefit is payable irrespective of the number of people assisting.

Assistance at Multiple Operations

Where surgical assistance is provided at two or more operations performed on a patient on the one occasion the multiple operation formula is applied to all the operations to determine the surgeon's fee for Medicare benefits purposes. The multiple-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for surgical assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Item 93718 or 93724).

Multiple Operation Rule – Surgeon	Multiple Operation Rule – Assistant
Item A – $300@100%	Item A (Assist.) – $300@100%
Item B – $250@50%	Item B (No Assist.)
Item C – $200@25%	Item C (Assist.) – $200@50%
Item D – $150@25%	Item D (Assist.) – $150@25%

The derived fee applicable to items 93719 and 93722 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery which attracts an assistance benefit.

Surgeons Operating Independently

Where two surgeons operate independently (i.e. neither assists the other or administers the anaesthetic) the procedures they perform are considered as two separate operations, and therefore, where a participating nurse practitioner is engaged by each, or one of the surgeons, benefits for surgical assistance are payable in the same manner as if the surgeons were operating separately.

See TN.9.1 for surgical assistance provided by medical practitioners.

MN.33.2 Benefits Payable under Item 93718

Medicare benefits are payable under item 93718 for assistance rendered by a participating nurse practitioner at any operation identified by the word "Assist." for which the fee does not exceed the fee threshold specified in the item descriptor, or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee threshold specified in the item descriptor has not been exceeded.

MN.33.3 Benefits Payable under Item 93719

Medicare benefits are payable under item 93719 for assistance rendered by a participating nurse practitioner at any operation identified by the word "Assist." for which the fee exceeds the fee threshold specified in the item descriptor

or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee exceeds the threshold specified in the item descriptor.

MN.33.4 Benefits Payable Under Item 93721

Medicare benefits are payable under item 93721 for assistance rendered by a participating nurse practitioner at any operation identified by the word "Assist." or a series or combination of operations identified by the word "Assist." and assistance at a birth involving Caesarean section.

Where assistance is provided at a Caesarean section birth and at a procedure or procedures which have not been identified by the word "Assist.", benefits are payable under item 93720.

MN.33.5 Assistance at Cataract and Intraocular Lens Surgery - (Item 93724)

The reference to "previous significant surgical complication" covers vitreous loss, rupture of posterior capsule, loss of nuclear material into the vitreous, intraocular haemorrhage, intraocular infection (endophthalmitis), cystoid macular oedema, corneal decompensation or retinal detachment.

M1. MANAGEMENT OF BULK-BILLED SERVICES	1. MANAGEMENT OF GENERAL BULK BILLED SERVICES
	Group M1. Management Of Bulk-Billed Services
	Subgroup 1. Management of general bulk billed services
10990	A medical service to which an item in this Schedule (other than this item) applies, if: (a) the service is an unreferred service; and (b) the service is provided to a person who is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) any other item in this Schedule applying to the service; other than a service associated with a service: (e) to which another item in this Group applies; or (f) that is a general practice support service; or (g) that is a MyMedicare service (See para MN.1.3, MN.1.1 of explanatory notes to this Category) **Fee:** $8.80 **Benefit:** 85% = $7.50 **Future End Date:**
10991	A medical service to which an item in this Schedule (other than this item) applies, if: (a) the service is an unreferred service; and (b) the service is provided to a person who is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) any other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in a Modified Monash 2 area; other than a service associated with a service: (f) to which another item in this Group applies; or (g) that is a general practice support service; or (h) that is a MyMedicare service (See para MN.1.4, MN.1.1 of explanatory notes to this Category) **Fee:** $13.35 **Benefit:** 85% = $11.35 **Future End Date:**
10992	A medical service to which:

	(a) item 585, 588, 591, 594, 599, 600, 5003, 5010, 5220 or 5260 applies; or (b) item 761 or 772 applies (see the *Health Insurance (Section 3C General Medical Services – Other Medical Practitioner) Determination 2018*); if: (c) the service is an unreferred service; and (d) the service is provided to a person who is not an admitted patient of a hospital; and (f) the service is not provided in consulting rooms; and (g) the service is provided in any of the following areas: (i) a Modified Monash 2 area; (ii) a Modified Monash 3 area; (iii) a Modified Monash 4 area; (iv) a Modified Monash 5 area; (v) a Modified Monash 6 area; (vi) a Modified Monash 7 area; and (h) the service is provided by, or on behalf of, a medical practitioner whose practice location is not in an area mentioned in paragraph (g); and (i) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) the other item mentioned in paragraph (a) or (b) applying to the service (See para MN.1.3, MN.1.3, MN.1.4, MN.1.1 of explanatory notes to this Category) **Fee:** $13.35 **Benefit:** 85% = $11.35 **Future End Date:**
75855	A medical service to which an item in this Schedule (other than this item) applies, if: (a) the service is an unreferred service; and (b) the service is provided to a person who is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) any other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in: (i) a Modified Monash 3 area; or

	(ii) a Modified Monash 4 area; other than a service associated with a service: (f) to which another item in this Group applies; or (g) that is a general practice support service; or (h) that is a MyMedicare service (See para MN.1.5, MN.1.1 of explanatory notes to this Category) **Fee:** $14.10 **Benefit:** 85% = $12.00 **Future End Date:**
75856	A medical service to which an item in this Schedule (other than this item) applies, if: (a) the service is an unreferred service; and (b) the service is provided to a person who is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) any other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in a Modified Monash 5 area; other than a service associated with a service: (f) to which another item in this Group applies; or (g) that is a general practice support service; or (h) that is a MyMedicare service (See para MN.1.6, MN.1.1 of explanatory notes to this Category) **Fee:** $15.10 **Benefit:** 85% = $12.85 **Future End Date:**
75857	A medical service to which an item in this Schedule (other than this item) applies, if: (a) the service is an unreferred service; and (b) the service is provided to a person who is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) any other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in a Modified Monash 6 area; other than a service associated with a service: (f) to which another item in this Group applies; or

M1. MANAGEMENT OF BULK-BILLED SERVICES	1. MANAGEMENT OF GENERAL BULK BILLED SERVICES
	(g) that is a general practice support service; or (h) that is a MyMedicare service (See para MN.1.7, MN.1.1 of explanatory notes to this Category) **Fee:** $15.85 **Benefit:** 85% = $13.50 **Future End Date:**
75858	A medical service to which an item in this Schedule (other than this item) applies, if: (a) the service is an unreferred service; and (b) the service is provided to a person who is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) any other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in a Modified Monash 7 area; other than a service associated with a service: (f) to which another item in this Group applies; or (g) that is a general practice support service; or (h) that is a MyMedicare service (See para MN.1.8, MN.1.1 of explanatory notes to this Category) **Fee:** $16.95 **Benefit:** 85% = $14.45 **Future End Date:**

M1. MANAGEMENT OF BULK-BILLED SERVICES	2. GENERAL SUPPORT SERVICE
	Group M1. Management Of Bulk-Billed Services
	Subgroup 2. General support service
75870	Professional attendance (the attendance service) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if: (a) the attendance service is provided to a patient who is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the general practice support service item applying to the attendance service; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75883, 75884 or 75885 applies Subgroup 2

	NOTE: this item can be claimed with face to face level B, C, D and E general attendance items, and level B video and phone general attendance items. (See para MN.1.3, MN.1.1 of explanatory notes to this Category) **Fee:** $26.35 **Benefit:** 85% = $22.40 **Future End Date:**
75871	Professional attendance (the attendance service) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if: (a) the attendance service is provided to a patient who is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the general practice support service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 2 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75883, 75884 or 75885 applies Subgroup 2 NOTE: this item can be claimed with face to face level B, C, D and E general attendance items, and level B video and phone general attendance items. (See para MN.1.4, MN.1.1 of explanatory notes to this Category) **Fee:** $40.10 **Benefit:** 85% = $34.10 **Future End Date:**
75872	Professional attendance (the attendance service) if: (a) item 763, 766, 769, 776, 788, 789, 2198, 2200, 5023, 5028, 5043, 5049, 5063, 5067, 5076, 5077, 5223, 5227, 5228, 5261, 5263, 5265, 5267 or 5262 applies; and (b) the attendance service is an unreferred service; and (c) the attendance service is provided to a patient who is not an admitted patient of a hospital; and (e) the attendance service is not provided in consulting rooms; and (f) the attendance service is provided in any of the following areas: (i) a Modified Monash 2 area; (ii) a Modified Monash 3 area; (iii) a Modified Monash 4 area; (iv) a Modified Monash 5 area; (v) a Modified Monash 6 area; (vi) a Modified Monash 7 area; and

	(g) the attendance service is provided by, or on behalf of, a general practitioner, a medical practitioner or a prescribed medical practitioner whose practice location is not in an area mentioned in paragraph (f); and (h) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) an item mentioned in paragraph (a) that applies to the service (See para MN.1.3, MN.1.3, MN.1.1 of explanatory notes to this Category) **Fee:** $40.10 **Benefit:** 85% = $34.10 **Future End Date:**
75873	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if: (a) the attendance service is provided to a patient who is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the general practice support service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in: (i) a Modified Monash 3 area; or (ii) a Modified Monash 4 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75874, 75875, 75876, 75880, 75881, 75882, 75883, 75884 or 75885 applies Subgroup 2 NOTE: this item can be claimed with face to face level B, C, D and E general attendance items, and level B video and phone general attendance items. (See para MN.1.5, MN.1.1 of explanatory notes to this Category) **Fee:** $42.60 **Benefit:** 85% = $36.25 **Future End Date:**
75874	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if: (a) the attendance service is provided to a patient who is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the general practice support service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 5 area;

	other than an attendance service associated with a service which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75875, 75876, 75880, 75881, 75882, 75883, 75884 or 75885 applies Subgroup 2 NOTE: this item can be claimed with face to face level B, C, D and E general attendance items, and level B video and phone general attendance items. (See para MN.1.6, MN.1.1 of explanatory notes to this Category) **Fee:** $45.30 **Benefit:** 85% = $38.55 **Future End Date:**
75875	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if: (a) the attendance service is provided to a patient who is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the general practice support service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 6 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75876, 75880, 75881, 75882, 75883, 75884 or 75885 applies Subgroup 2 NOTE: this item can be claimed with face to face level B, C, D and E general attendance items, and level B video and phone general attendance items. (See para MN.1.7, MN.1.1 of explanatory notes to this Category) **Fee:** $47.80 **Benefit:** 85% = $40.65 **Future End Date:**
75876	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if: (a) the attendance service is provided to a patient who is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the general practice support service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 7 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75880, 75881, 75882, 75883, 75884 or 75885 applies Subgroup 2

M1. MANAGEMENT OF BULK-BILLED SERVICES	2. GENERAL SUPPORT SERVICE
	NOTE: this item can be claimed with face to face level B, C, D and E general attendance items, and level B video and phone general attendance items. (See para MN.1.8, MN.1.1 of explanatory notes to this Category) **Fee:** $50.75 **Benefit:** 85% = $43.15 **Future End Date:**

M1. MANAGEMENT OF BULK-BILLED SERVICES	3. PATIENTS ENROLLED IN MYMEDICARE
	Group M1. Management Of Bulk-Billed Services
	Subgroup 3. Patients enrolled in MyMedicare
75880	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if: (a) the attendance service is provided to a patient who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the MyMedicare service item applying to the attendance service; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75881, 75882, 75883, 75884 or 75885 applies Subgroup 3 NOTE: this item can be claimed with level C, D, and E video general attendance items, and level C and D phone general attendance items, where the patient is registered with MyMedicare. (See para MN.1.3, MN.1.1 of explanatory notes to this Category) **Fee:** $26.35 **Benefit:** 85% = $22.40 **Future End Date:**
75881	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if: (a) the attendance service is provided to a patient who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the MyMedicare service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 2 area;

	other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75882, 75883, 75884 or 75885 applies Subgroup 3 NOTE: this item can be claimed with level C, D, and E video general attendance items, and level C and D phone general attendance items, where the patient is registered with MyMedicare. (See para MN.1.4, MN.1.1 of explanatory notes to this Category) **Fee:** $40.10 **Benefit:** 85% = $34.10 **Future End Date:**
75882	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if: (a) the attendance service is provided to a patient who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the MyMedicare service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in: (i) a Modified Monash 3 area; or (ii) a Modified Monash 4 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75883, 75884 or 75885 applies Subgroup 3 NOTE: this item can be claimed with level C, D, and E video general attendance items, and level C and D phone general attendance items, where the patient is registered with MyMedicare. (See para MN.1.5, MN.1.1 of explanatory notes to this Category) **Fee:** $42.60 **Benefit:** 85% = $36.25 **Future End Date:**
75883	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if: (a) the attendance service is provided to a patient who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and

	(ii) the MyMedicare service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 5 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75884 or 75885 applies Subgroup 3 NOTE: this item can be claimed with level C, D, and E video general attendance items, and level C and D phone general attendance items, where the patient is registered with MyMedicare. (See para MN.1.6, MN.1.1 of explanatory notes to this Category) **Fee:** $45.30 **Benefit:** 85% = $38.55 **Future End Date:**
75884	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if: (a) the attendance service is provided to a patient who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the MyMedicare service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 6 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75883 or 75885 applies Subgroup 3 NOTE: this item can be claimed with level C, D, and E video general attendance items, and level C and D phone general attendance items, where the patient is registered with MyMedicare. (See para MN.1.7, MN.1.1 of explanatory notes to this Category) **Fee:** $47.80 **Benefit:** 85% = $40.65 **Future End Date:**
75885	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if: (a) the attendance service is provided to a patient who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and

	(ii) the MyMedicare service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 7 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75883 or 75884 applies Subgroup 3 NOTE: this item can be claimed with level C, D, and E video general attendance items, and level C and D phone general attendance items, where the patient is registered with MyMedicare. (See para MN.1.8, MN.1.1 of explanatory notes to this Category) **Fee:** $50.75 **Benefit:** 85% = $43.15 **Future End Date:**

	Group M3. Allied health and Aboriginal and Torres Strait Islander health and wellbeing services
	Subgroup 1. Individual chronic condition management services
10950	Aboriginal and Torres Strait Islander health and wellbeing service provided to a patient by an eligible Aboriginal and Torres Strait Islander health worker or eligible Aboriginal and Torres Strait Islander health practitioner if: (a) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and (b) the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; and (c) the service is of at least 20 minutes duration; to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.3.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
10951	Diabetes education health service provided to a patient by an eligible diabetes educator if:

	(a) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and (b) the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; and (c) the service is of at least 20 minutes duration; to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.3.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
10952	Audiology health service provided to a patient by an eligible audiologist if: (a) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and (b) the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; and (c) the service is of at least 20 minutes duration; to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.3.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
10953	Exercise physiology health service provided to a patient by an eligible exercise physiologist if:

	(a) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and (b) the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; and (c) the service is of at least 20 minutes duration; to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.3.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
10954	Dietetics health service provided to a patient by an eligible dietitian if: (a) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and (b) the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; and (c) the service is of at least 20 minutes duration; to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.3.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
10956	Mental health service provided to a patient by an eligible mental health worker if:

	(a) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and (b) the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; and (c) the service is of at least 20 minutes duration; to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.3.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
10958	Occupational therapy health service provided to a patient by an eligible occupational therapist if: (a) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and (b) the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; and (c) the service is of at least 20 minutes duration; to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.3.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
10960	Physiotherapy health service provided to a patient by an eligible physiotherapist if:

	(a) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and (b) the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; and (c) the service is of at least 20 minutes duration; to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.3.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
10962	Podiatry health service provided to a patient by an eligible podiatrist if: (a) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and (b) the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; and (c) the service is of at least 20 minutes duration; to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.3.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
10964	Chiropractic health service provided to a patient by an eligible chiropractor if:

	(a) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and (b) the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; and (c) the service is of at least 20 minutes duration; to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.3.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
10966	Osteopathy health service provided to a patient by an eligible osteopath if: (a) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and (b) the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; and (c) the service is of at least 20 minutes duration; to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.3.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
10968	Psychology health service provided to a patient by an eligible psychologist if:

	(a) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and (b) the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; and (c) the service is of at least 20 minutes duration; to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.3.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
10970	Speech pathology health service provided to a patient by an eligible speech pathologist if: (a) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and (b) the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; and (c) the service is of at least 20 minutes duration; to a maximum of 5 services (including any services to which this item or any other item in this Subgroup or item 93000 or 93013 in the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.3.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**

	Group M3. Allied health and Aboriginal and Torres Strait Islander health and wellbeing services
	Subgroup 2. Individual chronic condition management case conference services
Amend 10955	Attendance by an eligible allied health practitioner, or eligible Aboriginal and Torres Strait Islander primary health care professional, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential care home; if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which another item in this Group applies) (See para MN.3.2, AN.15.3, AN.15.5, AN.15.6, GN.2.4 of explanatory notes to this Category) **Fee:** $58.50 **Benefit:** 85% = $49.75 **Extended Medicare Safety Net Cap:** $175.50 **Future End Date:**
Amend 10957	Attendance by an eligible allied health practitioner, or eligible Aboriginal and Torres Strait Islander primary health care professional, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential care home; if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which another item in this Group applies) (See para MN.3.2, AN.15.3, AN.15.5, AN.15.6, GN.2.4 of explanatory notes to this Category) **Fee:** $100.30 **Benefit:** 85% = $85.30 **Extended Medicare Safety Net Cap:** $300.90 **Future End Date:**
Amend 10959	Attendance by an eligible allied health practitioner or eligible Aboriginal and Torres Strait Islander primary health care professional, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential care home; if the conference lasts for at least 40 minutes (other than a service associated with a service to which another item in this Group applies) (See para MN.3.2, AN.15.3, AN.15.5, AN.15.6, GN.2.4 of explanatory notes to this Category) **Fee:** $166.85 **Benefit:** 85% = $141.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

	Group M6. Psychological Therapy Services
	Subgroup 1. Psychological therapy health services
80000	Psychological therapy health service provided to a patient in consulting rooms by an eligible clinical psychologist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible clinical psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 30 minutes but less than 50 minutes duration (See para GN.2.4, MN.6.3, MN.6.2, AN.0.78 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**
80002	Psychological therapy health service provided in consulting rooms by an eligible clinical psychologist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible clinical psychologist by a referring practitioner; and (c) the service lasts at least 30 minutes but less than 50 minutes (See para GN.2.4, MN.6.3, MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**
80005	Psychological therapy health service provided to a patient at a place other than consulting rooms by an eligible clinical psychologist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible clinical psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 30 minutes but less than 50 minutes duration (See para GN.2.4, MN.6.3, MN.6.2, AN.0.78 of explanatory notes to this Category) **Fee:** $149.25 **Benefit:** 85% = $126.90

	Extended Medicare Safety Net Cap: $447.75 **Future End Date:**
80006	Psychological therapy health service provided at a place other than consulting rooms by an eligible clinical psychologist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible clinical psychologist by a referring practitioner; and (c) the service lasts at least 30 minutes but less than 50 minutes (See para GN.2.4, MN.6.3, MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $149.25 **Benefit:** 85% = $126.90 **Extended Medicare Safety Net Cap:** $447.75 **Future End Date:**
80010	Psychological therapy health service provided to a patient in consulting rooms by an eligible clinical psychologist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible clinical psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 50 minutes duration (See para GN.2.4, MN.6.3, MN.6.2, AN.0.78 of explanatory notes to this Category) **Fee:** $175.30 **Benefit:** 85% = $149.05 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
80012	Psychological therapy health service provided in consulting rooms by an eligible clinical psychologist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible clinical psychologist by a referring practitioner; and (c) the service lasts at least 50 minutes (See para GN.2.4, MN.6.3, MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $175.30 **Benefit:** 85% = $149.05 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
80015	Psychological therapy health service provided to a patient at a place other than consulting rooms by an eligible clinical psychologist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and

	(c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible clinical psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 50 minutes duration (See para GN.2.4, MN.6.3, MN.6.2, AN.0.78 of explanatory notes to this Category) **Fee:** $205.10 **Benefit:** 85% = $174.35 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
80016	Psychological therapy health service provided at a place other than consulting rooms by an eligible clinical psychologist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible clinical psychologist by a referring practitioner; and (c) the service lasts at least 50 minutes (See para GN.2.4, MN.6.3, MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $205.10 **Benefit:** 85% = $174.35 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
80020	Psychological therapy health service provided to a patient as part of a group of 4 to 10 patients by an eligible clinical psychologist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided in person; and (c) the service is at least 60 minutes duration (See para GN.2.4, MN.6.3, MN.6.2, AN.0.78 of explanatory notes to this Category) **Fee:** $44.50 **Benefit:** 85% = $37.85 **Extended Medicare Safety Net Cap:** $133.50 **Future End Date:**
80021	Psychological therapy health service provided to a patient as part of a group of 4 to 10 patients by an eligible clinical psychologist if: (a) the patient is referred by a referring practitioner; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and (e) the service is at least 60 minutes duration (See para GN.2.4, MN.6.3, MN.6.2, AN.0.78 of explanatory notes to this Category) **Fee:** $44.50 **Benefit:** 85% = $37.85

	Extended Medicare Safety Net Cap: $133.50 **Future End Date:**
80022	Psychological therapy health service provided to a patient as part of a group of 4 to 10 patients by an eligible clinical psychologist if: (a) the patient is referred for a course of treatment by a referring practitioner; and (b) the service is provided in person; and (c) the service is at least 90 minutes duration (See para GN.2.4, MN.6.3, MN.6.2, AN.0.78 of explanatory notes to this Category) **Fee:** $60.65 **Benefit:** 85% = $51.60 **Extended Medicare Safety Net Cap:** $181.95 **Future End Date:**
80023	Psychological therapy health service provided to a patient as part of a group of 4 to 10 patients by an eligible clinical psychologist if: (a) the patient is referred by a referring practitioner; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and (e) the service is at least 90 minutes duration (See para GN.2.4, MN.6.3, MN.6.2, AN.0.78 of explanatory notes to this Category) **Fee:** $60.65 **Benefit:** 85% = $51.60 **Extended Medicare Safety Net Cap:** $181.95 **Future End Date:**
80024	Psychological therapy health service provided to a patient as part of a group of 4 to 10 patients by an eligible clinical psychologist if: (a) the patient is referred for a course of treatment by a referring practitioner; and (b) the service is provided in person; and (c) the service is at least 120 minutes duration (See para GN.2.4, MN.6.3, MN.6.2, AN.0.78 of explanatory notes to this Category) **Fee:** $82.40 **Benefit:** 85% = $70.05 **Extended Medicare Safety Net Cap:** $247.20 **Future End Date:**
80025	Psychological therapy health service provided to a patient as part of a group of 4 to 10 patients by an eligible clinical psychologist if: (a) the patient is referred by a referring practitioner; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and

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	(d) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and (e) the service is at least 120 minutes duration (See para GN.2.4, MN.6.3, MN.6.2, AN.0.78 of explanatory notes to this Category) **Fee:** $82.40 **Benefit:** 85% = $70.05 **Extended Medicare Safety Net Cap:** $247.20 **Future End Date:**

M7. FOCUSSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	1. FOCUSSED PSYCHOLOGICAL STRATEGIES HEALTH SERVICES
	Group M7. Focussed Psychological Strategies (Allied Mental Health)
	Subgroup 1. Focussed psychological strategies health services
80100	Focussed psychological strategies health service provided to a patient in consulting rooms by an eligible psychologist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 20 minutes but less than 50 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $84.65 **Benefit:** 85% = $72.00 **Extended Medicare Safety Net Cap:** $253.95 **Future End Date:**
80102	Focussed psychological strategies health service provided in consulting rooms by an eligible psychologist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible psychologist by a referring practitioner; and (c) the service lasts at least 20 minutes but less than 50 minutes (See para GN.2.4, MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $84.65 **Benefit:** 85% = $72.00 **Extended Medicare Safety Net Cap:** $253.95 **Future End Date:**
80105	Focussed psychological strategies health service provided to a patient at a place other than consulting rooms by an eligible psychologist if: (a) the patient is referred by a referring practitioner; and

	(b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 20 minutes but less than 50 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $115.10 **Benefit:** 85% = $97.85 **Extended Medicare Safety Net Cap:** $345.30 **Future End Date:**
80106	Focussed psychological strategies health service provided at a place other than consulting rooms by an eligible psychologist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible psychologist by a referring practitioner; and (c) the service lasts at least 20 minutes but less than 50 minutes (See para GN.2.4, MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $115.10 **Benefit:** 85% = $97.85 **Extended Medicare Safety Net Cap:** $345.30 **Future End Date:**
80110	Focussed psychological strategies health service provided to a patient in consulting rooms by an eligible psychologist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 50 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**
80112	Focussed psychological strategies health service provided in consulting rooms by an eligible psychologist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible psychologist by a referring practitioner; and

	(c) the service lasts at least 50 minutes (See para GN.2.4, MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**
80115	Focussed psychological strategies health service provided to a patient at a place other than consulting rooms by an eligible psychologist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 50 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $150.00 **Benefit:** 85% = $127.50 **Extended Medicare Safety Net Cap:** $450.00 **Future End Date:**
80116	Focussed psychological strategies health service provided at a place other than consulting rooms by an eligible psychologist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible psychologist by a referring practitioner; and (c) the service lasts at least 50 minutes (See para GN.2.4, MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $150.00 **Benefit:** 85% = $127.50 **Extended Medicare Safety Net Cap:** $450.00 **Future End Date:**
80120	Focussed psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible psychologist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided in person; and (c) the service is at least 60 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $30.45 **Benefit:** 85% = $25.90 **Extended Medicare Safety Net Cap:** $91.35 **Future End Date:**
80121	Focussed psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible psychologist if:

	(a) the patient is referred by a referring practitioner; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the psychologist; and (e) the service is at least 60 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $30.45 **Benefit:** 85% = $25.90 **Extended Medicare Safety Net Cap:** $91.35 **Future End Date:**
80122	Focussed psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible psychologist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided in person; and (c) the service is at least 90 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $41.50 **Benefit:** 85% = $35.30 **Extended Medicare Safety Net Cap:** $124.50 **Future End Date:**
80123	Focussed psychological strategies health service provided to a patient as part of a group of 4 to 10 by an eligible psychologist if: (a) the patient is referred by a referring practitioner; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the psychologist; and (e) the service is at least 90 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $41.50 **Benefit:** 85% = $35.30 **Extended Medicare Safety Net Cap:** $124.50 **Future End Date:**
80125	Focussed psychological strategies health service provided to a patient in consulting rooms by an eligible occupational therapist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and

	(c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible occupational therapist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 20 minutes but less than 50 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
80127	Focussed psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible psychologist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided in person; and (c) the service is at least 120 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $56.40 **Benefit:** 85% = $47.95 **Extended Medicare Safety Net Cap:** $169.20 **Future End Date:**
80128	Focussed psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible psychologist if: (a) the patient is referred by a referring practitioner; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the psychologist; and (e) the service is at least 120 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $56.40 **Benefit:** 85% = $47.95 **Extended Medicare Safety Net Cap:** $169.20 **Future End Date:**
80129	Focussed psychological strategies health service provided in consulting rooms by an eligible occupational therapist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible occupational therapist by a referring practitioner; and (c) the service lasts at least 20 minutes but less than 50 minutes (See para GN.2.4, MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40

	Extended Medicare Safety Net Cap: $223.65 **Future End Date:**
80130	Focussed psychological strategies health service provided to a patient at a place other than consulting rooms by an eligible occupational therapist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible occupational therapist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 20 minutes but less than 50 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $105.00 **Benefit:** 85% = $89.25 **Extended Medicare Safety Net Cap:** $315.00 **Future End Date:**
80131	Focussed psychological strategies health service provided at a place other than consulting rooms by an eligible occupational therapist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible occupational therapist by a referring practitioner; and (c) the service lasts at least 20 minutes but less than 50 minutes (See para GN.2.4, MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $105.00 **Benefit:** 85% = $89.25 **Extended Medicare Safety Net Cap:** $315.00 **Future End Date:**
80135	Focussed psychological strategies health service provided to a patient in consulting rooms by an eligible occupational therapist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible occupational therapist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 50 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**

80137	Focussed psychological strategies health service provided in consulting rooms by an eligible occupational therapist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible occupational therapist by a referring practitioner; and (c) the service lasts at least 50 minutes (See para GN.2.4, MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**
80140	Focussed psychological strategies health service provided to a patient at a place other than consulting rooms by an eligible occupational therapist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible occupational therapist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 50 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $135.65 **Benefit:** 85% = $115.35 **Extended Medicare Safety Net Cap:** $406.95 **Future End Date:**
80141	Focussed psychological strategies health service provided at a place other than consulting rooms by an eligible occupational therapist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible occupational therapist by a referring practitioner; and (c) the service lasts at least 50 minutes (See para GN.2.4, MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $135.65 **Benefit:** 85% = $115.35 **Extended Medicare Safety Net Cap:** $406.95 **Future End Date:**
80145	Focussed psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible occupational therapist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided in person; and (c) the service is at least 60 minutes duration

	(See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $26.70 **Benefit:** 85% = $22.70 **Extended Medicare Safety Net Cap:** $80.10 **Future End Date:**
80146	Focussed psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible occupational therapist if: (a) the patient is referred by a referring practitioner; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the occupational therapist; and (e) the service is at least 60 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $26.70 **Benefit:** 85% = $22.70 **Extended Medicare Safety Net Cap:** $80.10 **Future End Date:**
80147	Focussed psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible occupational therapist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided in person; and (c) the service is at least 90 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $36.30 **Benefit:** 85% = $30.90 **Extended Medicare Safety Net Cap:** $108.90 **Future End Date:**
80148	Focussed psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible occupational therapist if: (a) the patient is referred by a referring practitioner; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the occupational therapist; and (e) the service is at least 90 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $36.30 **Benefit:** 85% = $30.90 **Extended Medicare Safety Net Cap:** $108.90 **Future End Date:**

M7. FOCUSSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	1. FOCUSSED PSYCHOLOGICAL STRATEGIES HEALTH SERVICES
80150	Focussed psychological strategies health service provided to a patient in consulting rooms by an eligible social worker if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible social worker gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 20 minutes but less than 50 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
80152	Focussed psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible occupational therapist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided in person; and (c) the service is at least 120 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $49.50 **Benefit:** 85% = $42.10 **Extended Medicare Safety Net Cap:** $148.50 **Future End Date:**
80153	Focussed psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible occupational therapist if: (a) the patient is referred by a referring practitioner; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the occupational therapist; and (e) the service is at least 120 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $49.50 **Benefit:** 85% = $42.10 **Extended Medicare Safety Net Cap:** $148.50 **Future End Date:**
80154	Focussed psychological strategies health service provided in consulting rooms by an eligible social worker to a person other than the patient, if:

	(a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible social worker by a referring practitioner; and (c) the service lasts at least 20 minutes but less than 50 minutes (See para GN.2.4, MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
80155	Focussed psychological strategies health service provided to a patient at a place other than consulting rooms by an eligible social worker if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible social worker gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 20 minutes but less than 50 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $105.00 **Benefit:** 85% = $89.25 **Extended Medicare Safety Net Cap:** $315.00 **Future End Date:**
80156	Focussed psychological strategies health service provided at a place other than consulting rooms by an eligible social worker to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible social worker by a referring practitioner; and (c) the service lasts at least 20 minutes but less than 50 minutes (See para GN.2.4, MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $105.00 **Benefit:** 85% = $89.25 **Extended Medicare Safety Net Cap:** $315.00 **Future End Date:**
80160	Focussed psychological strategies health service provided to a patient in consulting rooms by an eligible social worker if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and

	(d) on the completion of the course of treatment, the eligible social worker gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 50 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**
80162	Focussed psychological strategies health service provided in consulting rooms by an eligible social worker to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible social worker by a referring practitioner; and (c) the service lasts at least 50 minutes (See para GN.2.4, MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**
80165	Focussed psychological strategies health service provided to a patient at a place other than consulting rooms by an eligible social worker if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually and in person; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible social worker gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 50 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $135.65 **Benefit:** 85% = $115.35 **Extended Medicare Safety Net Cap:** $406.95 **Future End Date:**
80166	Focussed psychological strategies health service provided at a place other than consulting rooms by an eligible social worker to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible social worker by a referring practitioner; and (c) the service lasts at least 50 minutes (See para GN.2.4, MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $135.65 **Benefit:** 85% = $115.35 **Extended Medicare Safety Net Cap:** $406.95

	Future End Date:
80170	Focussed psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible social worker if: (a) the patient is referred by referring practitioner; and (b) the service is provided in person; and (c) the service is at least 60 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $26.70 **Benefit:** 85% = $22.70 **Extended Medicare Safety Net Cap:** $80.10 **Future End Date:**
80171	Focussed psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible social worker if: (a) the patient is referred by a referring practitioner; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the social worker; and (e) the service is at least 60 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $26.70 **Benefit:** 85% = $22.70 **Extended Medicare Safety Net Cap:** $80.10 **Future End Date:**
80172	Focussed psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible social worker if: (a) the patient is referred by a referring practitioner; and (b) the service is provided in person; and (c) the service is at least 90 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $36.30 **Benefit:** 85% = $30.90 **Extended Medicare Safety Net Cap:** $108.90 **Future End Date:**
80173	Focussed psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible social worker if: (a) the patient is referred by a referring practitioner; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and

M7. FOCUSSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	1. FOCUSSED PSYCHOLOGICAL STRATEGIES HEALTH SERVICES
	(d) the patient is, at the time of the attendance, at least 15 kilometres by road from the social worker; and (e) the service is at least 90 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $36.30 **Benefit:** 85% = $30.90 **Extended Medicare Safety Net Cap:** $108.90 **Future End Date:**
80174	Focussed psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible social worker if: (a) the patient is referred by a referring practitioner; and (b) the service is provided in person; and (c) the service is at least 120 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $49.50 **Benefit:** 85% = $42.10 **Extended Medicare Safety Net Cap:** $148.50 **Future End Date:**
80175	Focussed psychological strategies health service provided to a patient as part of a group of 4 to 10 patients by an eligible social worker if: (a) the patient is referred by a referring practitioner; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the social worker; and (e) the service is at least 120 minutes duration (See para GN.2.4, MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $49.50 **Benefit:** 85% = $42.10 **Extended Medicare Safety Net Cap:** $148.50 **Future End Date:**

M7. FOCUSSED PSYCHOLOGICAL STRATEGIES (ALLIED MENTAL HEALTH)	2. PSYCHOLOGICAL THERAPY HEALTH, FOCUSSED PSYCHOLOGICAL STRATEGIES HEALTH AND EATING DISORDER CASE CONFERENCE SERVICES
	Group M7. Focussed Psychological Strategies (Allied Mental Health)
	Subgroup 2. Psychological therapy health, focussed psychological strategies health and eating disorder case conference services
80176	Attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference if the conference lasts for at least 15 minutes, but for less than 20 minutes

	(See para GN.2.4, AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $58.50 **Benefit:** 85% = $49.75 **Extended Medicare Safety Net Cap:** $175.50 **Future End Date:**
80177	Attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference if the conference lasts for at least 20 minutes, but for less than 40 minutes (See para GN.2.4, AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $100.30 **Benefit:** 85% = $85.30 **Extended Medicare Safety Net Cap:** $300.90 **Future End Date:**
80178	Attendance by an eligible allied health practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference if the conference lasts for at least 40 minutes (See para GN.2.4, AN.15.1, AN.0.78 of explanatory notes to this Category) **Fee:** $166.85 **Benefit:** 85% = $141.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

M8. PREGNANCY SUPPORT COUNSELLING

	Group M8. Pregnancy Support Counselling
81000	Non-directive pregnancy support counselling health service provided to a patient who is currently pregnant or who has been pregnant in the preceding 12 months, by an eligible psychologist if: (a) the patient is concerned about a current pregnancy or a pregnancy that occurred in the 12 months preceding the provision of the first service; and (b) the patient is referred by a medical practitioner who is not a specialist or consultant physician; and (c) the eligible psychologist does not have a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination; and (d) the service is at least 30 minutes duration; to a maximum of 3 services (including services to which items 81000, 81005 or 81010, items 792 or 4001 in the general medical services table, or items 92136, 92138, 93026, 93029, 92137 or 92139 in the Telehealth Attendance Determination apply) for each pregnancy (See para GN.2.4, AN.15.6, MN.8.1, MN.8.4, MN.8.2, MN.8.3 of explanatory notes to this Category) **Fee:** $87.50 **Benefit:** 85% = $74.40 **Extended Medicare Safety Net Cap:** $262.50 **Future End Date:**
81005	Non-directive pregnancy support counselling health service provided to a patient, who is currently pregnant or who has been pregnant in the preceding 12 months, by an eligible social worker if: (a) the patient is concerned about a current pregnancy or a pregnancy that occurred in the 12 months preceding the provision of the first service; and (b) the patient is referred by a medical practitioner who is not a specialist or consultant physician; and

M8. PREGNANCY SUPPORT COUNSELLING	
	(c) the eligible social worker does not have a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination; and (d) the service is at least 30 minutes duration; to a maximum of 3 services (including services to which items 81000, 81005 or 81010, items 792 or 4001 in the general medical services table, or items 92136, 92138, 93026, 93029, 92137 or 92139 in the Telehealth Attendance Determination apply) for each pregnancy (See para GN.2.4, AN.15.6, MN.8.1, MN.8.4, MN.8.2, MN.8.3 of explanatory notes to this Category) **Fee:** $87.50 **Benefit:** 85% = $74.40 **Extended Medicare Safety Net Cap:** $262.50 **Future End Date:**
81010	Non-directive pregnancy support counselling health service provided to a patient, who is currently pregnant or who has been pregnant in the preceding 12 months, by an eligible mental health nurse if: (a) the patient is concerned about a current pregnancy or a pregnancy that occurred in the 12 months preceding the provision of the first service; and (b) the patient is referred by a medical practitioner who is not a specialist or consultant physician; and (c) the eligible mental health nurse does not have a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination; and (d) the service is at least 30 minutes duration; to a maximum of 3 services (including services to which items 81000, 81005 or 81010, items 792 or 4001 in the general medical services table, or items 92136, 92138, 93026, 93029, 92137 or 92139 in the Telehealth Attendance Determination apply) for each pregnancy (See para GN.2.4, AN.15.6, MN.8.1, MN.8.4, MN.8.2, MN.8.3 of explanatory notes to this Category) **Fee:** $87.50 **Benefit:** 85% = $74.40 **Extended Medicare Safety Net Cap:** $262.50 **Future End Date:**

M9. ALLIED HEALTH GROUP SERVICES 1. DIABETES EDUCATION SERVICES	
	Group M9. Allied Health Group Services
	Subgroup 1. Diabetes education services
81100	Diabetes education health service provided to a patient by an eligible diabetes educator for assessing the patient's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs and preparing the patient for the group services if: (a) the patient has type 2 diabetes; and (b) the patient is being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan prepared prior to 1 July 2025; or

M9. ALLIED HEALTH GROUP SERVICES	1. DIABETES EDUCATION SERVICES
	(iii) a multidisciplinary care plan; and (c) the patient is referred to an eligible diabetes educator by the medical practitioner; and (d) the service is provided to the patient individually and in person; and (e) the service is of at least 45 minutes duration; and (f) after the service, the eligible diabetes educator gives a written report to the referring medical practitioner mentioned in paragraph (c); payable once in a calendar year for this or any other assessment for group services item (including services in items 81100, 81110 and 81120 or items 93284 or 93286 of the Telehealth Attendance Determination) (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.9.1, MN.9.2 of explanatory notes to this Category) **Fee:** $95.65 **Benefit:** 85% = $81.35 **Extended Medicare Safety Net Cap:** $286.95 **Future End Date:**
81105	Diabetes education health service provided to a patient by an eligible diabetes educator, as a group service for the management of type 2 diabetes if: (a) the patient has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120 or items 93284 or 93286 of the Telehealth Attendance Determination; and (b) the service is provided to a patient who is part of a group of between 2 and 12 patients; and (c) the service is provided in person; and (d) the service is of at least 60 minutes duration; and (e) after the last service in the group services program provided to the patient under item 81105, 81115 or 81125 or item 93285 of the Telehealth Attendance Determination, the eligible diabetes educator prepares, or contributes to, a written report to be provided to the referring medical practitioner; and (f) an attendance record for the group is maintained by the eligible diabetes educator; to a maximum of 8 group services in a calendar year (including services in items 81105, 81115 and 81125 or item 93285 of the Telehealth Attendance Determination) (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3 of explanatory notes to this Category) **Fee:** $23.80 **Benefit:** 85% = $20.25 **Extended Medicare Safety Net Cap:** $71.40 **Future End Date:**

M9. ALLIED HEALTH GROUP SERVICES	2. EXERCISE PHYSIOLOGY SERVICES
	Group M9. Allied Health Group Services
	Subgroup 2. Exercise physiology services
81110	Exercise physiology health service provided to a person by an eligible exercise physiologist for assessing the person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs and preparing the person for the group services if:

	(a) the person has type 2 diabetes; and (b) the patient is being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and (c) the patient is referred to an eligible exercise physiologist by the medical practitioner; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 45 minutes duration; and (f) after the service, the eligible exercise physiologist gives a written report to the referring medical practitioner mentioned in paragraph (c); payable once in a calendar year for this or any other assessment for group services item (including services in items 81100, 81110 and 81120 or items 93284 or 93286 of the Telehealth Attendance Determination) (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.9.1, MN.9.2 of explanatory notes to this Category) **Fee:** $95.65 **Benefit:** 85% = $81.35 **Extended Medicare Safety Net Cap:** $286.95 **Future End Date:**
81115	Exercise physiology health service provided to a person by an eligible exercise physiologist, as a group service for the management of type 2 diabetes if: (a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120 or items 93284 or 93286 of the Telehealth Attendance Determination; and (b) the service is provided to a person who is part of a group of between 2 and 12 patients; and (c) the service is provided in person; and (d) the service is of at least 60 minutes duration; and (e) after the last service in the group services program provided to the person under item 81105, 81115 or 81125 or item 93285 of the Telehealth Attendance Determination, the eligible exercise physiologist prepares, or contributes to, a written report to be provided to the referring medical practitioner; and (f) an attendance record for the group is maintained by the eligible exercise physiologist; to a maximum of 8 group services in a calendar year (including services in items 81105, 81115 and 81125 or item 93285 of the Telehealth Attendance Determination) (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3 of explanatory notes to this Category) **Fee:** $23.80 **Benefit:** 85% = $20.25 **Extended Medicare Safety Net Cap:** $71.40 **Future End Date:**

	Group M9. Allied Health Group Services
	Subgroup 3. Dietetics services
81120	Dietetics health service provided to a person by an eligible dietitian for assessing the person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs and preparing the person for the group services if: (a) the person has type 2 diabetes; and (b) the patient is being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and (c) the patient is referred to an eligible dietitian by the medical practitioner; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 45 minutes duration; and (f) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (c); payable once in a calendar year for this or any other assessment for group services item (including services in items 81100, 81110 and 81120 or items 93284 or 93286 of the Telehealth Attendance Determination) (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.9.1, MN.9.2 of explanatory notes to this Category) **Fee:** $95.65 **Benefit:** 85% = $81.35 **Extended Medicare Safety Net Cap:** $286.95 **Future End Date:**
81125	Dietetics health service provided to a person by an eligible dietitian, as a group service for the management of type 2 diabetes if: (a) the person has been assessed as suitable for a type 2 diabetes group service under assessment item 81100, 81110 or 81120 or items 93284 or 93286 of the Telehealth Attendance Determination; and (b) the service is provided to a person who is part of a group of between 2 and 12 patients; and (c) the service is provided in person; and (d) the service is of at least 60 minutes duration; and (e) after the last service in the group services program provided to the person under item 81105, 81115 or 81125 or item 93285 of the Telehealth Determination, the eligible dietitian prepares, or contributes to, a written report to be provided to the referring medical practitioner; and (f) an attendance record for the group is maintained by the eligible dietitian;

M9. ALLIED HEALTH GROUP SERVICES	3. DIETETICS SERVICES
	to a maximum of 8 group services in a calendar year (including services to which items 81105, 81115 and 81125 or item 93285 of the Telehealth Attendance Determination apply) (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3 of explanatory notes to this Category) **Fee:** $23.80 **Benefit:** 85% = $20.25 **Extended Medicare Safety Net Cap:** $71.40 **Future End Date:**

M10. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY SERVICES	1. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY
	Group M10. Complex neurodevelopmental disorder and disability services
	Subgroup 1. Complex neurodevelopmental disorder and disability
82000	Psychology health service provided to a patient aged under 25 years by an eligible psychologist if: (a) the patient was referred by an eligible medical practitioner, or by an eligible allied health practitioner following referral by an eligible medical practitioner, to: (i) assist the eligible medical practitioner with diagnostic formulation where the patient has a suspected complex neurodevelopmental disorder or eligible disability; or (ii) contribute to the patient's treatment and management plan developed by the referring eligible medical practitioner where a complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability is confirmed; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 50 minutes duration Up to 4 services to which this item or any of items 82005, 82010, 82030, 93032, 93033, 93040 or 93041 apply may be provided to the same patient on the same day (See para GN.2.4, AN.15.6, MN.10.3, MN.10.1, AN.0.25, AN.0.24, AN.0.72, AN.0.73 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**
82005	Speech pathology health service provided to a patient aged under 25 years by an eligible speech pathologist if: (a) the patient was referred by an eligible medical practitioner, or by an eligible allied health practitioner following referral by an eligible medical practitioner, to: (i) assist the eligible medical practitioner with diagnostic formulation where the patient has a suspected complex neurodevelopmental disorder or eligible disability; or (ii) contribute to the patient's treatment and management plan developed by the referring eligible medical practitioner where a complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability is confirmed; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 50 minutes duration

	Up to 4 services to which this item or any of items 82000, 82010, 82030, 93032, 93033, 93040 or 93041 apply may be provided to the same patient on the same day (See para GN.2.4, AN.15.6, MN.10.3, MN.10.1, AN.0.25, AN.0.24, AN.0.72, AN.0.73 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**
82010	Occupational therapy health service provided to a patient aged under 25 years by an eligible occupational therapist if: (a) the patient was referred by an eligible medical practitioner, or by an eligible allied health practitioner following referral by an eligible medical practitioner, to: (i) assist the eligible medical practitioner with diagnostic formulation where the patient has a suspected complex neurodevelopmental disorder or eligible disability; or (ii) contribute to the patient's treatment and management plan developed by the referring eligible medical practitioner where a complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability is confirmed; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 50 minutes duration Up to 4 services to which this item or any of items 82000, 82005, 82030, 93032, 93033, 93040 or 93041 apply may be provided to the same patient on the same day (See para GN.2.4, AN.15.6, MN.10.3, MN.10.1, AN.0.25, AN.0.24, AN.0.72, AN.0.73 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**
82015	Psychology health service provided to a patient aged under 25 years for the treatment of a diagnosed complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability by an eligible psychologist, if: (a) the patient has a treatment and management plan in place and has been referred by an eligible medical practitioner for a course of treatment consistent with that treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 30 minutes duration; and (d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring eligible medical practitioner on assessments (if performed), treatment provided and recommendations on future management of the patient's condition Up to 4 services to which this item or any of items 82020, 82025, 82035, 93035, 93036, 93043 or 93044 apply may be provided to the same patient on the same day (See para GN.2.4, AN.15.6, MN.10.3, MN.10.2, AN.0.25, AN.0.24, AN.0.72, AN.0.73 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35

	Future End Date:
82020	Speech pathology health service provided to a patient aged under 25 years for the treatment of a diagnosed complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability by an eligible speech pathologist, if: (a) the patient has a treatment and management plan in place and has been referred by an eligible medical practitioner for a course of treatment consistent with that treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 30 minutes duration; and (d) on the completion of the course of treatment, the eligible speech pathologist gives a written report to the referring eligible medical practitioner on assessments (if performed), treatment provided and recommendations on future management of the patient's condition Up to 4 services to which this item or any of items 82015, 82025, 82035, 93035, 93036, 93043 or 93044 apply may be provided to the same patient on the same day (See para GN.2.4, AN.15.6, MN.10.3, MN.10.2, AN.0.25, AN.0.24, AN.0.72, AN.0.73 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**
82025	Occupational therapy health service provided to a patient aged under 25 years for the treatment of a diagnosed complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability by an eligible occupational therapist, if: (a) the patient has a treatment and management plan in place and has been referred by an eligible medical practitioner for a course of treatment consistent with that treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 30 minutes duration; and (d) on the completion of the course of treatment, the eligible occupational therapist gives a written report to the referring eligible medical practitioner on assessments (if performed), treatment provided and recommendations on future management of the patient's condition Up to 4 services to which this item or any of items 82015, 82020, 82035, 93035, 93036, 93043 or 93044 apply may be provided to the same patient on the same day (See para GN.2.4, AN.15.6, MN.10.3, MN.10.2, AN.0.25, AN.0.24, AN.0.72, AN.0.73 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**
82030	Audiology, dietetic, exercise physiology, optometry, orthoptic or physiotherapy health service provided to a patient aged under 25 years by an eligible audiologist, dietitian, exercise physiologist, optometrist, orthoptist or physiotherapist if: (a) the patient was referred by an eligible medical practitioner, or by an eligible allied health practitioner following referral by an eligible medical practitioner, to:

	(i) assist the eligible medical practitioner with diagnostic formulation where the patient has a suspected complex neurodevelopmental disorder or eligible disability; or (ii) contribute to the patient's treatment and management plan developed by the referring eligible medical practitioner where a complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability is confirmed; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 50 minutes duration Up to 4 services to which this item or any of items 82000, 82005, 82010, 93032, 93033, 93040 or 93041 apply may be provided to the same patient on the same day (See para GN.2.4, AN.15.6, MN.10.3, MN.10.1, AN.0.25, AN.0.24, AN.0.72, AN.0.73 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**
82035	Audiology, dietetic, exercise physiology, optometry, orthoptic or physiotherapy health service provided to a patient aged under 25 years for the treatment of a diagnosed complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability by an eligible audiologist, dietitian, exercise physiologist, optometrist, orthoptist or physiotherapist, if: (a) the patient has a treatment and management plan in place and has been referred by an eligible medical practitioner for a course of treatment consistent with that treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 30 minutes duration; and (d) on the completion of the course of treatment, the eligible audiologist, dietitian, exercise physiologist, optometrist, orthoptist or physiotherapist gives a written report to the referring eligible medical practitioner on assessments (if performed), treatment provided and recommendations on future management of the patient's condition Up to 4 services to which this item or any of items 82015, 82020, 82025, 93035, 93036, 93043 or 93044 apply may be provided to the same patient on the same day (See para GN.2.4, AN.15.6, MN.10.3, MN.10.2, AN.0.25, AN.0.24, AN.0.72, AN.0.73 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**

	Group M10. Complex neurodevelopmental disorder and disability services
	Subgroup 2. Complex neurodevelopmental disorder and disability case conference services
82001	Attendance by an eligible allied health practitioner or eligible Aboriginal and Torres Strait Islander primary health care professional, as a member of a multidisciplinary case conference team, to

	participate in a community case conference if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which another item in this Group applies) (See para GN.2.4, MN.10.4 of explanatory notes to this Category) **Fee:** $58.50 **Benefit:** 85% = $49.75 **Extended Medicare Safety Net Cap:** $175.50 **Future End Date:**
82002	Attendance by an eligible allied health practitioner or eligible Aboriginal and Torres Strait Islander primary health care professional, as a member of a multidisciplinary case conference team, to participate in a community case conference if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which another item in this Group applies) (See para GN.2.4, MN.10.4 of explanatory notes to this Category) **Fee:** $100.30 **Benefit:** 85% = $85.30 **Extended Medicare Safety Net Cap:** $300.90 **Future End Date:**
82003	Attendance by an eligible allied health practitioner or eligible Aboriginal and Torres Strait Islander primary health care professional, as a member of a multidisciplinary case conference team, to participate in a community case conference if the conference lasts for at least 40 minutes (other than a service associated with a service to which another item in this Group applies) (See para GN.2.4, MN.10.4 of explanatory notes to this Category) **Fee:** $166.85 **Benefit:** 85% = $141.85 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

M11. HEALTH SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

	Group M11. Health services for Aboriginal and Torres Strait Islander people
81300	Aboriginal and Torres Strait Islander health and wellbeing service provided to a patient of Aboriginal or Torres Strait Islander descent by an eligible Aboriginal and Torres Strait Islander health worker or eligible Aboriginal and Torres Strait Islander health practitioner if the service is of at least 20 minutes duration and: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up Aboriginal and Torres Strait Islander health and wellbeing services; or (b) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and

	the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.11.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
81305	Diabetes education health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible diabetes educator if the service is of at least 20 minutes duration and: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or (b) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.11.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
81310	Audiology health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible audiologist if the service is of at least 20 minutes duration and: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or (b) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or

	(iii) a multidisciplinary care plan; and the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.11.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
81315	Exercise physiology health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible exercise physiologist if the service is of at least 20 minutes duration and: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or (b) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.11.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
81320	Dietetics health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible dietitian if the service is of at least 20 minutes duration and: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or (b) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or

	(ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.11.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
81325	Mental health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible mental health worker if the service is of at least 20 minutes duration and: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or (b) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.11.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
81330	Occupational therapy health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible occupational therapist if the service is of at least 20 minutes duration and: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or (b) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under:

	(i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.11.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
81335	Physiotherapy health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible physiotherapist if the service is of at least 20 minutes duration and: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or (b) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.11.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
81340	Podiatry health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible podiatrist if the service is of at least 20 minutes duration and: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or

	(b) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.11.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
81345	Chiropractic health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible chiropractor if the service is of at least 20 minutes duration and: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or (b) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.11.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
81350	Osteopathy health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible osteopath if the service is of at least 20 minutes duration and:

	(a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or (b) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.11.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
81355	Psychology health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible psychologist if the service is of at least 20 minutes duration and: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or (b) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.11.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**

M11. HEALTH SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE	
	Speech pathology health service provided to a patient who is of Aboriginal or Torres Strait Islander descent by an eligible speech pathologist if the service is of at least 20 minutes duration and: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or (b) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; to a maximum of 10 services (including any services to which this item or any other item in this Group or Subgroup 1 of Group M3 or item 93000, 93013, 93048 or 93061 of the Telehealth Attendance Determination applies) in a calendar year (See para GN.2.4, AN.15.5, AN.15.6, AN.15.3, MN.11.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65
81360	**Future End Date:**

M12. SERVICES PROVIDED BY A PRACTICE NURSE, AN ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKER OR AN ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER	1. VIDEO CONFERENCING CONSULTATION SUPPORT SERVICE PROVIDED BY A PRACTICE NURSE, AN ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKER OR AN ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER
	Group M12. Services Provided by a Practice Nurse, an Aboriginal and Torres Strait Islander Health Worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a Medical Practitioner
	Subgroup 1. Video conferencing consultation support service provided by a practice nurse, an Aboriginal and Torres Strait Islander health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner
	Attendance by a practice nurse, an Aboriginal and Torres Strait Islander health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner, to provide clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist, consultant physician or psychiatrist; and (b) is not an admitted patient (See para MN.12.5, MN.12.6 of explanatory notes to this Category)
10983	**Fee:** $38.85 **Benefit:** 100% = $38.85

M12. SERVICES PROVIDED BY A PRACTICE NURSE, AN ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKER OR AN ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER	1. VIDEO CONFERENCING CONSULTATION SUPPORT SERVICE PROVIDED BY A PRACTICE NURSE, AN ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKER OR AN ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER
	Extended Medicare Safety Net Cap: $116.55 **Future End Date:**

M12. SERVICES PROVIDED BY A PRACTICE NURSE, AN ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKER OR AN ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER	3. SERVICES PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER
	Group M12. Services Provided by a Practice Nurse, an Aboriginal and Torres Strait Islander Health Worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a Medical Practitioner
	Subgroup 3. Services Provided By A Practice Nurse Or Aboriginal And Torres Strait Islander Health Practitioner On Behalf Of A Medical Practitioner
10987	Follow-up service, to a maximum of 10 services per patient in a calendar year, provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner, on behalf of a medical practitioner, for an Indigenous person who has received a health check if: (a) the service is provided on behalf of and under the supervision of a medical practitioner; and (b) the person is not an admitted patient of a hospital; and (c) the service is consistent with the needs identified through the health assessment. (See para AN.14.3, MN.12.6, MN.12.3 of explanatory notes to this Category) **Fee:** $28.70 **Benefit:** 100% = $28.70 **Extended Medicare Safety Net Cap:** $86.10 **Future End Date:**
10988	Immunisation provided to a person by an Aboriginal and Torres Strait Islander health practitioner if: (a) the immunisation is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the person is not an admitted patient of a hospital. (See para MN.12.6, MN.12.1 of explanatory notes to this Category) **Fee:** $14.35 **Benefit:** 100% = $14.35 **Extended Medicare Safety Net Cap:** $43.05 **Future End Date:**
10989	Treatment of a person's wound (other than normal aftercare) provided by an Aboriginal and Torres Strait Islander health practitioner if: (a) the treatment is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the person is not an admitted patient of a hospital. (See para MN.12.6, MN.12.2 of explanatory notes to this Category)

M12. SERVICES PROVIDED BY A PRACTICE NURSE, AN ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKER OR AN ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER	3. SERVICES PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER ON BEHALF OF A MEDICAL PRACTITIONER
	Fee: $14.35 **Benefit:** 100% = $14.35 **Extended Medicare Safety Net Cap:** $43.05 **Future End Date:**
Amend 10997	Service provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner to a person with a chronic condition, if: (a) the service is provided on behalf of and under the supervision of a medical practitioner; and (b) the person is not an admitted patient of a hospital; and (c) the person has in place: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP management plan, or team care arrangements, prepared before 1 July 2025; or (iii) a multidisciplinary care plan; and (d) the service is consistent with the plan or arrangements Applicable up to a total of 5 services to which this item, item 93201 or item 93203 applies in a calendar year (See para AN.15.3, AN.15.5, MN.12.4, MN.12.6, AN.14.3 of explanatory notes to this Category) **Fee:** $14.35 **Benefit:** 100% = $14.35 **Extended Medicare Safety Net Cap:** $43.05 **Future End Date:**

M13. MIDWIFERY SERVICES	1. MBS ITEMS FOR PARTICIPATING MIDWIVES
	Group M13. Midwifery Services
	Subgroup 1. MBS Items For Participating Midwives
82100	Initial antenatal professional attendance by a participating midwife, lasting at least 60 minutes, including all of the following: (a) taking a detailed patient history; (b) performing a comprehensive examination; (c) performing a risk assessment; (d) based on the risk assessment — arranging referral or transfer of the patient's care to an obstetrician; (e) requesting pathology and diagnostic imaging services, when necessary

	Payable only once per pregnancy (See para MN.13.10, MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $89.00 **Benefit:** 85% = $75.65 **Extended Medicare Safety Net Cap:** $27.30 **Future End Date:**
82102	Long antenatal professional attendance by a participating midwife, lasting at least 90 minutes (See para GN.2.4, MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $133.45 **Benefit:** 75% = $100.10 85% = $113.45 **Future End Date:**
82103	Complex antenatal professional attendance by a participating midwife leading to a hospital admission and lasting at least 3 hours. A maximum of 3 services per pregnancy. Not being a service associated with a service to which intrapartum items 82116, 82118, 82120, 82123, 82125 or 82127 applies (H) (See para GN.2.4, MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $246.05 **Benefit:** 75% = $184.55 **Future End Date:**
82104	Long postnatal professional attendance by a participating midwife, lasting at least 90 minutes, within 6 weeks after birth (See para GN.2.4, MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $196.20 **Benefit:** 75% = $147.15 85% = $166.80 **Future End Date:**
82105	Short antenatal professional attendance by a participating midwife, lasting at least 10 minutes (See para MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $38.75 **Benefit:** 75% = $29.10 85% = $32.95 **Extended Medicare Safety Net Cap:** $20.40 **Future End Date:**
82110	Routine antenatal professional attendance by a participating midwife, lasting at least 40 minutes (See para MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $89.00 **Benefit:** 75% = $66.75 85% = $75.65 **Extended Medicare Safety Net Cap:** $27.30 **Future End Date:**
82115	Professional attendance by a participating midwife, lasting at least 90 minutes, for assessment and preparation of a maternity care plan for a patient whose pregnancy has progressed beyond 28 weeks, where the participating midwife has had at least 2 antenatal attendances with the patient in the preceding 6 months, if: (a) the patient is not an admitted patient of a hospital; and (b) the participating midwife undertakes a comprehensive assessment of the patient; and (c) the participating midwife develops a written maternity care plan that contains: (i) outcomes of the assessment; and (ii) details of agreed expectations for care during pregnancy, labour and birth; and

	(iii) details of any health problems or care needs; and (iv) details of any medication taken by the patient during the pregnancy, and any additional medication that may be required by the patient; and (v) details of any referrals or requests for pathology services or diagnostic imaging services for the patient during the pregnancy, and any additional referrals or requests that may be required for the patient; and (d) the maternity care plan is explained and agreed with the patient; and (e) the fee does not include any amount for the management of labour and birth; (Includes any antenatal attendance provided on the same occasion) Payable only once for any pregnancy; This item cannot be claimed if items 16590 or 16591 have previously been claimed during a single pregnancy, except in exceptional circumstances (See para MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $381.75 **Benefit:** 85% = $324.50 **Extended Medicare Safety Net Cap:** $68.20 **Future End Date:**
82116	Management of labour for up to 6 hours, not including birth, at a place other than a hospital if: (a) the attendance is by the participating midwife who: (i) provided the patient's antenatal care or (ii) is a member of a practice that has provided the patient's antenatal care; and (b) the total attendance time is documented in the patient notes; This item does not apply if birth is performed during the attendance; Only claimable once per pregnancy (See para GN.2.4, MN.13.10, MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $901.65 **Benefit:** 85% = $793.15 **Future End Date:**
82118	Management of labour for up to 6 hours total attendance, including birth where performed if: (a) the patient is an admitted patient of a hospital; and (b) the attendance is by the first participating midwife who: (i) assisted or provided the patient's antenatal care; or (ii) is a member of a practice that has provided the patient's antenatal care; and (c) the total attendance time is documented in the patient notes. (Includes all hospital attendances related to the labour by the first participating midwife) Only claimable once per pregnancy;

	Not being a service associated with a service to which item 82120 applies (H) (See para GN.2.4, MN.13.10, MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $901.65 **Benefit:** 75% = $676.25 **Future End Date:**
82120	Management of labour between 6 and 12 hours total attendance, including birth where performed, if: (a) the patient is an admitted patient of a hospital; and (b) the attendance is by the first participating midwife who: (i) assisted or provided the patient's antenatal care; or (ii) is a member of a practice that provided the patient's antenatal care; and (c) the total attendance time is documented in the patient notes; (Includes all hospital attendances related to the labour by the first participating midwife) Only claimable once per pregnancy; Not being a service associated with a service to which item 82118 applies (H) (See para GN.2.4, MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $1,803.35 **Benefit:** 75% = $1352.55 **Future End Date:**
82123	Management of labour for up to 6 hours total attendance, including birth where performed if: (a) the patient is an admitted patient of a hospital; and (b) the attendance is by the second participating midwife who either: (i) assisted or provided the patient's antenatal care; or (ii) is a member of a practice that has provided the patient's antenatal care; and (c) the total attendance time is documented in the patient notes; (Includes all hospital attendances related to the labour by the second participating midwife) Only claimable once per pregnancy; Not being a service associated with a service to which item 82125 applies (H) (See para GN.2.4, MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $901.65 **Benefit:** 75% = $676.25 **Future End Date:**
82125	Management of labour between 6 and 12 hours total attendance, including birth where performed, if: (a) the patient is an admitted patient of a hospital; and (b) the attendance is by the second participating midwife who either: (i) assisted or provided the patient's antenatal care; or (ii) is a member of a practice that provided the patient's antenatal care; and

	(c) the total attendance time is documented in the patient notes; (Includes all hospital attendances related to the labour by the second participating midwife) Only claimable once per pregnancy; Not being a service associated with a service to which item 82123 or 82127 applies (H) (See para GN.2.4, MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $1,803.35 **Benefit:** 75% = $1352.55 **Future End Date:**
82127	Management of labour for up to 6 hours total attendance, including birth where performed if: (a) the patient is an admitted patient of a hospital; and (b) the attendance is by a third participating midwife who either: (i) assisted or provided the patient's antenatal care; or (ii) is a member of a practice that has provided the patient's antenatal care; and (c) an attendance to which item 82123 applies has been provided by a second participating midwife who is a member of a practice that has provided the patient's antenatal care; and (d) the total attendance time is documented in the patient notes; (Includes all hospital attendances related to the labour by the third participating midwife) Only claimable once per pregnancy; Not being a service associated with a service to which item 82125 applies (H) (See para GN.2.4, MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $901.65 **Benefit:** 75% = $676.25 **Future End Date:**
82130	Short postnatal professional attendance by a participating midwife, lasting at least 20 minutes, within 6 weeks after birth (See para MN.13.10, MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $63.90 **Benefit:** 75% = $47.95 85% = $54.35 **Extended Medicare Safety Net Cap:** $20.40 **Future End Date:**
82135	Routine postnatal professional attendance by a participating midwife, lasting at least 40 minutes, within 6 weeks after birth (See para MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $130.80 **Benefit:** 75% = $98.10 85% = $111.20 **Extended Medicare Safety Net Cap:** $27.30 **Future End Date:**
82140	Postnatal professional attendance by a participating midwife on a patient, not less than 4 weeks but not more than 8 weeks after birth of a baby, lasting at least 60 minutes, including all of the following: (a) a comprehensive examination of the patient and baby to ensure normal postnatal recovery; (b) a labour and birth debrief;

	(c) a mental health assessment or where the patient declines a mental health assessment, the participating midwife records the patient's decision in the clinical notes; (d) referral of the patient to a primary carer for the ongoing care of the patient and baby or where the patient declines a referral to a primary carer, the participating midwife records the patient's decision in the clinical notes Payable only once per pregnancy (See para MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $63.90 **Benefit:** 85% = $54.35 **Extended Medicare Safety Net Cap:** $20.40 **Future End Date:**

	Group M14. Nurse Practitioners
	Subgroup 1. Nurse Practitioners
82200	Professional attendance by a participating nurse 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 (See para GN.2.4, MN.14.15, MN.14.12, MN.14.16 of explanatory notes to this Category) **Fee:** $14.95 **Benefit:** 85% = $12.75 **Extended Medicare Safety Net Cap:** $44.85 **Future End Date:**
82205	Professional attendance by a participating nurse practitioner lasting at least 6 minutes and less than 20 minutes and including any of the following: a) taking a history; b) undertaking clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; for 1 or more health related issues, with appropriate documentation (See para GN.2.4, MN.14.15, MN.14.12, MN.14.16 of explanatory notes to this Category) **Fee:** $32.65 **Benefit:** 85% = $27.80 **Extended Medicare Safety Net Cap:** $97.95 **Future End Date:**
82210	Professional attendance by a participating nurse practitioner lasting at least 20 minutes and including any of the following: a) taking a detailed history; b) undertaking clinical examination; c) arranging any necessary investigation;

	d) implementing a management plan; e) providing appropriate preventive health care; for 1 or more health related issues, with appropriate documentation (See para GN.2.4, MN.14.15, MN.14.12, MN.14.16 of explanatory notes to this Category) **Fee:** $61.80 **Benefit:** 85% = $52.55 **Extended Medicare Safety Net Cap:** $185.40 **Future End Date:**
82215	Professional attendance by a participating nurse practitioner lasting at least 40 minutes and including any of the following: a) taking an extensive history; b) undertaking clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; for 1 or more health related issues, with appropriate documentation (See para GN.2.4, MN.14.15, MN.14.12, MN.14.16 of explanatory notes to this Category) **Fee:** $91.20 **Benefit:** 85% = $77.55 **Extended Medicare Safety Net Cap:** $273.60 **Future End Date:**
82216	Professional attendance by a participating nurse practitioner lasting at least 60 minutes and including any of the following: (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 (See para GN.2.4, MN.14.15, MN.14.12 of explanatory notes to this Category) **Fee:** $137.85 **Benefit:** 85% = $117.20 **Extended Medicare Safety Net Cap:** $413.55 **Future End Date:**
82226	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, by a participating nurse practitioner—each attendance at which the procedure is performed Not applicable for skin reactions secondary to radiotherapy (See para GN.2.4 of explanatory notes to this Category) **Fee:** $43.50 **Benefit:** 75% = $32.65 85% = $37.00

	Extended Medicare Safety Net Cap: $130.50 **Future End Date:**
82227	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, by a participating nurse practitioner—each attendance at which the procedure is performed Not applicable for skin reactions secondary to radiotherapy (See para GN.2.4 of explanatory notes to this Category) **Fee:** $55.60 **Benefit:** 75% = $41.70 85% = $47.30 **Extended Medicare Safety Net Cap:** $166.80 **Future End Date:**
82228	Nipple or areola or both, intradermal colouration of, by a participating nurse practitioner, following breast reconstruction after mastectomy or for congenital absence of nipple (See para GN.2.4 of explanatory notes to this Category) **Fee:** $236.80 **Benefit:** 75% = $177.60 85% = $201.30 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

	Group M14. Nurse Practitioners
	Subgroup 4. Nurse Practitioner Procedures
82201	Introduction of an intra-uterine device for abnormal uterine bleeding or contraception or for endometrial protection during oestrogen replacement therapy (Anaes.) (See para MN.14.17, MN.14.18, MN.14.19 of explanatory notes to this Category) **Fee:** $221.55 **Benefit:** 75% = $166.20 85% = $188.35 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
82202	Removal of etonogestrel subcutaneous implant (Anaes.) (See para MN.14.17, MN.14.18, MN.14.19 of explanatory notes to this Category) **Fee:** $107.90 **Benefit:** 75% = $80.95 85% = $91.75 **Extended Medicare Safety Net Cap:** $323.70 **Future End Date:**
82203	Hormone or living tissue implantation by cannula (See para MN.14.17 of explanatory notes to this Category) **Fee:** $103.00 **Benefit:** 75% = $77.25 85% = $87.55 **Extended Medicare Safety Net Cap:** $309.00 **Future End Date:**
82204	A service rendered by a participating nurse practitioner to which item 82201, 82202 or 82203 applies, if the service is bulk-billed in relation to the fees for: (a) that item; and (b) any other item in Subgroup 1 of Group M14 or item 73832 and 73833 applying to the service (See para MN.14.17 of explanatory notes to this Category) **Derived Fee:** 40% of the fee for items 82201, 82202, or 82203.

M14. NURSE PRACTITIONERS	4. NURSE PRACTITIONER PROCEDURES
	Extended Medicare Safety Net Cap: 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**
82206	A procedure, being a service to which an item in Subgroup 4 of Group M14 would have applied had the procedure not been discontinued on clinical grounds, other than a service to which 82203 applies (See para MN.14.17, MN.14.18 of explanatory notes to this Category) **Derived Fee:** 50% of the fee which would have applied had the procedure not been discontinued **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount **Future End Date:**

M14. NURSE PRACTITIONERS	5. PARTICIPATING NURSE PRACTITIONER PATIENT END SUPPORT FOR VIDEO CONFERENCING CONSULTATIONS WITH SPECIALISTS OR CONSULTANT PHYSICIANS
	Group M14. Nurse Practitioners
	Subgroup 5. Participating nurse practitioner patient end support for video conferencing consultations with specialists or consultant physicians
82250	Professional attendance by a participating nurse 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 participating nurse practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $53.15 **Benefit:** 85% = $45.20 **Extended Medicare Safety Net Cap:** $159.45 **Future End Date:**
82251	Professional attendance by a participating nurse 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 participating nurse practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $53.15 **Benefit:** 85% = $45.20 **Extended Medicare Safety Net Cap:** $159.45 **Future End Date:**
82252	Professional attendance by a participating nurse 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 participating nurse practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $82.35 **Benefit:** 85% = $70.00 **Extended Medicare Safety Net Cap:** $247.05 **Future End Date:**

82253	Professional attendance by a participating nurse 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 participating nurse practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $82.35 **Benefit:** 85% = $70.00 **Extended Medicare Safety Net Cap:** $247.05 **Future End Date:**
82254	Professional attendance by a participating nurse 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 participating nurse practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $111.75 **Benefit:** 85% = $95.00 **Extended Medicare Safety Net Cap:** $335.25 **Future End Date:**
82255	Professional attendance by a participating nurse 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 participating nurse practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $111.75 **Benefit:** 85% = $95.00 **Extended Medicare Safety Net Cap:** $335.25 **Future End Date:**
82256	Professional attendance by a participating nurse 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 participating nurse practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $158.35 **Benefit:** 85% = $134.60 **Extended Medicare Safety Net Cap:** $475.05 **Future End Date:**
82257	Professional attendance by a participating nurse 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

M14. NURSE PRACTITIONERS	5. PARTICIPATING NURSE PRACTITIONER PATIENT END SUPPORT FOR VIDEO CONFERENCING CONSULTATIONS WITH SPECIALISTS OR CONSULTANT PHYSICIANS
	(c) the participating nurse practitioner is located in the same room as the patient for the whole of the attendance **Fee:** $158.35 **Benefit:** 85% = $134.60 **Extended Medicare Safety Net Cap:** $475.05 **Future End Date:**

M15. DIAGNOSTIC AUDIOLOGY SERVICES	
	Group M15. Diagnostic Audiology Services
82300	Audiology health service, consisting of brain stem evoked response audiometry, performed on a patient by an eligible audiologist if: (a) the service is not for the purposes of programming either an auditory implant or the sound processors of an auditory implant; and (b) the service is performed pursuant to a written request made by a medical practitioner to assist in the diagnosis, treatment or management of ear disease or a related disorder in the patient; and (c) the service is not performed for the purpose of a hearing screening; and (d) the service is performed on the patient individually and in person; and (e) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the medical practitioner who requested the service; and (f) a service to which item 11300 applies has not been performed on the patient on the same day (See para GN.2.4, MN.15.5 of explanatory notes to this Category) **Fee:** $184.25 **Benefit:** 85% = $156.65 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
82301	Audiology health service, consisting of programming an auditory implant or the sound processor of an auditory implant, unilateral, performed on a patient by an eligible audiologist if: (a) the service is performed on the patient individually and in person; and (b) a service to which item 11302, 11342 or 11345 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 82302 or item 82304 applies on the same day (See para GN.2.4, MN.15.5 of explanatory notes to this Category) **Fee:** $184.25 **Benefit:** 85% = $156.65 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
82302	Audiology health service by video attendance for programming of an auditory implant, or the sound processor of an auditory implant, unilateral, performed on a patient by an eligible audiologist if:

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	(a) the service is not performed for the purpose of a hearing screening; and (b) a service to which item 11302, 11342 or 11345 applies not been performed on the patient on the same day Applicable up to a total of 4 services to which this item, item 82301 or item 82304 applies on the same day (See para GN.2.4, MN.15.5 of explanatory notes to this Category) **Fee:** $184.25 **Benefit:** 85% = $156.65 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
82304	Audiology health service by phone attendance for programming of an auditory implant, or the sound processor of an auditory implant, unilateral, performed on a patient by an eligible audiologist if: (a) the service is not performed for the purpose of a hearing screening; and (b) a service to which item 11302, 11342 or 11345 applies not been performed on the patient on the same day Applicable up to a total of 4 services to which this item, item 82301 or item 82302 applies on the same day (See para GN.2.4, MN.15.5 of explanatory notes to this Category) **Fee:** $184.25 **Benefit:** 85% = $156.65 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
82306	Audiology health service, consisting of non-determinate audiometry performed on a patient by an eligible audiologist if: (a) the service is performed pursuant to a written request made by a medical practitioner to assist in the diagnosis, treatment or management of ear disease or a related disorder in the patient; and (b) the service is not performed for the purpose of a hearing screening; and (c) the service is performed on the patient individually and in person; and (d) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the medical practitioner who requested the service; and (e) a service to which item 11306 applies has not been performed on the patient on the same day (See para GN.2.4, MN.15.2, MN.15.5 of explanatory notes to this Category) **Fee:** $20.95 **Benefit:** 85% = $17.85 **Extended Medicare Safety Net Cap:** $62.85 **Future End Date:**
82309	Audiology health service, consisting of an air conduction audiogram performed on a patient by an eligible audiologist if: (a) the service is performed pursuant to a written request made by a medical practitioner to assist in the diagnosis, treatment or management of ear disease or a related disorder in the patient; and (b) the service is not performed for the purpose of a hearing screening; and

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	(c) the service is performed on the patient individually and in person; and (d) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the medical practitioner who requested the service; and (e) a service to which item 11309 applies has not been performed on the patient on the same day (See para GN.2.4, MN.15.3, MN.15.5 of explanatory notes to this Category) **Fee:** $25.15 **Benefit:** 85% = $21.40 **Extended Medicare Safety Net Cap:** $75.45 **Future End Date:**
82312	Audiology health service, consisting of an air and bone conduction audiogram or air conduction and speech discrimination audiogram performed on a patient by an eligible audiologist if: (a) the service is performed pursuant to a written request made by a medical practitioner to assist in the diagnosis, treatment or management of ear disease or a related disorder in the patient; and (b) the service is not performed for the purpose of a hearing screening; and (c) the service is performed on the patient individually and in person; and (d) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the medical practitioner who requested the service; and (e) a service to which item 11312 applies has not been performed on the patient on the same day (See para GN.2.4, MN.15.3, MN.15.5 of explanatory notes to this Category) **Fee:** $35.60 **Benefit:** 85% = $30.30 **Extended Medicare Safety Net Cap:** $106.80 **Future End Date:**
82315	Audiology health service, consisting of an air and bone conduction and speech discrimination audiogram performed on a patient by an eligible audiologist if: (a) the service is performed pursuant to a written request made by a medical practitioner to assist in the diagnosis, treatment or management of ear disease or a related disorder in the patient; and (b) the service is not performed for the purpose of a hearing screening; and (c) the service is performed on the patient individually and in person; and (d) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the medical practitioner who requested the service; and (e) a service to which item 11315 applies has not been performed on the patient on the same day (See para GN.2.4, MN.15.3, MN.15.5 of explanatory notes to this Category) **Fee:** $47.10 **Benefit:** 85% = $40.05 **Extended Medicare Safety Net Cap:** $141.30 **Future End Date:**
82318	Audiology health service, consisting of an air and bone conduction and speech discrimination audiogram with other cochlear tests performed on a patient by an eligible audiologist if:

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	(a) the service is performed pursuant to a written request made by a medical practitioner to assist in the diagnosis, treatment or management of ear disease or a related disorder in the patient; and (b) the service is not performed for the purpose of a hearing screening; and (c) the service is performed on the patient individually and in person; and (d) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the medical practitioner who requested the service; and (e) a service to which item 11318 applies has not been performed on the patient on the same day (See para GN.2.4, MN.15.3, MN.15.5 of explanatory notes to this Category) **Fee:** $58.15 **Benefit:** 85% = $49.45 **Extended Medicare Safety Net Cap:** $174.45 **Future End Date:**
82324	Audiology health service, consisting of an impedance audiogram involving tympanometry and measurement of static compliance and acoustic reflex performed on a patient by an eligible audiologist if: (a) the service is performed pursuant to a written request made by a medical practitioner to assist in the diagnosis, treatment or management of ear disease or a related disorder in the patient; and (b) the service is not performed for the purpose of a hearing screening; and (c) the service is performed on the patient individually and in person; and (d) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the medical practitioner who requested the service; and (e) a service to which item 11324 applies has not been performed on the patient on the same day (See para GN.2.4, MN.15.3, MN.15.5 of explanatory notes to this Category) **Fee:** $19.15 **Benefit:** 85% = $16.30 **Extended Medicare Safety Net Cap:** $57.45 **Future End Date:**
82332	Audiology health service, consisting of an oto-acoustic emission audiometry for the detection of outer hair cell functioning in the cochlea, performed by an eligible audiologist, when middle ear pathology has been excluded, if: (a) the service is performed pursuant to a written request made by a medical practitioner to assist in the diagnosis, treatment or management of ear disease or a related disorder in the patient; and (b) the service is performed: (i) on an infant or child who is at risk of permanent hearing impairment; or (ii) on a patient who is at risk of oto-toxicity due to medications or medical intervention; or (iii) on a patient at risk of noise induced hearing loss; or (iv) to assist in the diagnosis of auditory neuropathy; and

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	(c) the service is performed on the patient individually and in person; and (d) after the service, the eligible audiologist provides a copy of the results of the service performed, together with relevant comments in writing that the eligible audiologist has on those results, to the medical practitioner who requested the service; and (e) a service to which item 11332 applies has not been performed on the patient on the same day (See para GN.2.4, MN.15.4, MN.15.5 of explanatory notes to this Category) **Fee:** $56.10 **Benefit:** 85% = $47.70 **Extended Medicare Safety Net Cap:** $168.30 **Future End Date:**

M16. EATING DISORDERS SERVICES	1. EATING DISORDERS DIETITIAN HEALTH SERVICES
	Group M16. Eating Disorders Services
	Subgroup 1. Eating disorders dietitian health services
82350	Dietetics health service provided to an eligible patient by an eligible dietitian if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is of at least 20 minutes in duration (See para GN.2.4, AN.36.2, MN.16.1, MN.16.2 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**

M16. EATING DISORDERS SERVICES	2. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE CLINICAL PSYCHOLOGISTS
	Group M16. Eating Disorders Services
	Subgroup 2. Eating disorder psychological treatment services provided by eligible clinical psychologists
82352	Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible clinical psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 30 minutes but less than 50 minutes in duration (See para GN.2.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**

M16. EATING DISORDERS SERVICES	2. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE CLINICAL PSYCHOLOGISTS
82354	Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible clinical psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 30 minutes but less than 50 minutes in duration (See para GN.2.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $149.25 **Benefit:** 85% = $126.90 **Extended Medicare Safety Net Cap:** $447.75 **Future End Date:**
82355	Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible clinical psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 50 minutes in duration (See para GN.2.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $175.30 **Benefit:** 85% = $149.05 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
82357	Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible clinical psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 50 minutes in duration (See para GN.2.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $205.10 **Benefit:** 85% = $174.35 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
82358	Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible clinical psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided in person; and (c) the service is at least 60 minutes in duration (See para GN.2.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $44.50 **Benefit:** 85% = $37.85 **Extended Medicare Safety Net Cap:** $133.50 **Future End Date:**

M16. EATING DISORDERS SERVICES	2. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE CLINICAL PSYCHOLOGISTS
	Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible clinical psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and (e) the service is at least 60 minutes in duration (See para GN.2.4, MN.16.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $44.50 **Benefit:** 85% = $37.85 **Extended Medicare Safety Net Cap:** $133.50
82359	**Future End Date:**

M16. EATING DISORDERS SERVICES	3. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE PSYCHOLOGISTS
	Group M16. Eating Disorders Services
	Subgroup 3. Eating disorder psychological treatment services provided by eligible psychologists
	Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 20 minutes but less than 50 minutes in duration (See para GN.2.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $84.65 **Benefit:** 85% = $72.00 **Extended Medicare Safety Net Cap:** $253.95
82360	**Future End Date:**
	Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 20 minutes but less than 50 minutes in duration (See para GN.2.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $115.10 **Benefit:** 85% = $97.85 **Extended Medicare Safety Net Cap:** $345.30
82362	**Future End Date:**

M16. EATING DISORDERS SERVICES	3. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE PSYCHOLOGISTS
82363	Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 50 minutes in duration (See para GN.2.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**
82365	Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 50 minutes in duration (See para GN.2.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $150.00 **Benefit:** 85% = $127.50 **Extended Medicare Safety Net Cap:** $450.00 **Future End Date:**
82366	Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided in person; and (c) the service is at least 60 minutes in duration (See para GN.2.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $30.45 **Benefit:** 85% = $25.90 **Extended Medicare Safety Net Cap:** $91.35 **Future End Date:**
82367	Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and

M16. EATING DISORDERS SERVICES	3. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE PSYCHOLOGISTS
	(e) the service is at least 60 minutes in duration (See para GN.2.4, MN.16.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $30.45 **Benefit:** 85% = $25.90 **Extended Medicare Safety Net Cap:** $91.35 **Future End Date:**

M16. EATING DISORDERS SERVICES	4. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE OCCUPATIONAL THERAPISTS
	Group M16. Eating Disorders Services
	Subgroup 4. Eating disorder psychological treatment services provided by eligible occupational therapists
82368	Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible occupational therapist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 20 minutes but less than 50 minutes in duration (See para GN.2.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
82370	Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible occupational therapist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 20 minutes but less than 50 minutes in duration (See para GN.2.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $105.00 **Benefit:** 85% = $89.25 **Extended Medicare Safety Net Cap:** $315.00 **Future End Date:**
82371	Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible occupational therapist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 50 minutes in duration (See para GN.2.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75

M16. EATING DISORDERS SERVICES	4. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE OCCUPATIONAL THERAPISTS
	Future End Date:
82373	Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible occupational therapist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 50 minutes in duration (See para GN.2.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $135.65 **Benefit:** 85% = $115.35 **Extended Medicare Safety Net Cap:** $406.95 **Future End Date:**
82374	Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible occupational therapist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided in person; and (c) the service is at least 60 minutes in duration (See para GN.2.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $26.70 **Benefit:** 85% = $22.70 **Extended Medicare Safety Net Cap:** $80.10 **Future End Date:**
82375	Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible occupational therapist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and (e) the service is at least 60 minutes in duration (See para GN.2.4, MN.16.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $26.70 **Benefit:** 85% = $22.70 **Extended Medicare Safety Net Cap:** $80.10 **Future End Date:**

M16. EATING DISORDERS SERVICES	5. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE SOCIAL WORKERS
	Group M16. Eating Disorders Services
	Subgroup 5. Eating disorder psychological treatment services provided by eligible social workers

M16. EATING DISORDERS SERVICES	5. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE SOCIAL WORKERS
82376	Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible social worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 20 minutes but less than 50 minutes in duration (See para GN.2.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
82378	Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible social worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 20 minutes but less than 50 minutes in duration (See para GN.2.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $105.00 **Benefit:** 85% = $89.25 **Extended Medicare Safety Net Cap:** $315.00 **Future End Date:**
82379	Eating disorder psychological treatment service provided to an eligible patient in consulting rooms by an eligible social worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 50 minutes in duration (See para GN.2.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**
82381	Eating disorder psychological treatment service provided to an eligible patient at a place other than consulting rooms by an eligible social worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually and in person; and (c) the service is at least 50 minutes in duration (See para GN.2.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $135.65 **Benefit:** 85% = $115.35 **Extended Medicare Safety Net Cap:** $406.95 **Future End Date:**

M16. EATING DISORDERS SERVICES	5. EATING DISORDER PSYCHOLOGICAL TREATMENT SERVICES PROVIDED BY ELIGIBLE SOCIAL WORKERS
82382	Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible social worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided in person; and (c) the service is at least 60 minutes in duration (See para GN.2.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $26.70 **Benefit:** 85% = $22.70 **Extended Medicare Safety Net Cap:** $80.10 **Future End Date:**
82383	Eating disorder psychological treatment service provided to an eligible patient as part of a group of 6 to 10 patients by an eligible social worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the attendance is by video conference; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the clinical psychologist; and (e) the service is at least 60 minutes in duration (See para GN.2.4, MN.16.4, MN.16.1, MN.16.3 of explanatory notes to this Category) **Fee:** $26.70 **Benefit:** 85% = $22.70 **Extended Medicare Safety Net Cap:** $80.10 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	1. PSYCHOLOGICAL THERAPIES VIDEO SERVICES
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 1. Psychological therapies video services
91166	Psychological therapy health service provided by video attendance by an eligible clinical psychologist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible clinical psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 30 minutes but less than 50 minutes duration

	(See para MN.6.3, MN.6.2, AN.0.30, AN.0.78 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**
91167	Psychological therapy health service provided by video attendance by an eligible clinical psychologist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible clinical psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 50 minutes duration (See para MN.6.3, MN.6.2, AN.0.30, AN.0.78 of explanatory notes to this Category) **Fee:** $175.30 **Benefit:** 85% = $149.05 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
91168	Video attendance for a psychological therapy health service provided by an eligible clinical psychologist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible clinical psychologist by a referring practitioner; and (c) the service lasts at least 30 minutes but less than 50 minutes (See para MN.6.3, MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**
91171	Video attendance for a psychological therapy health service provided by an eligible clinical psychologist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible clinical psychologist by a referring practitioner; and (c) the service lasts at least 50 minutes (See para MN.6.3, MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $175.30 **Benefit:** 85% = $149.05 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 2. Psychologist focussed psychological strategies video services
91169	Focussed psychological strategies health service provided by video attendance by an eligible psychologist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 20 minutes but less than 50 minutes duration (See para MN.6.3, MN.7.4, AN.0.30, AN.0.78 of explanatory notes to this Category) **Fee:** $84.65 **Benefit:** 85% = $72.00 **Extended Medicare Safety Net Cap:** $253.95 **Future End Date:**
91170	Focussed psychological strategies health service provided by video attendance by an eligible psychologist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 50 minutes duration (See para MN.6.3, MN.7.4, AN.0.30, AN.0.78 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**
91174	Video attendance for a focussed psychological strategies health service provided by an eligible psychologist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible psychologist by a referring practitioner; and (c) the service lasts at least 20 minutes but less than 50 minutes (See para MN.7.5, AN.0.78 of explanatory notes to this Category)

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	2. PSYCHOLOGIST FOCUSSED PSYCHOLOGICAL STRATEGIES VIDEO SERVICES
	Fee: $84.65 **Benefit:** 85% = $72.00 **Extended Medicare Safety Net Cap:** $253.95 **Future End Date:**
91177	Video attendance for a focussed psychological strategies health service provided by an eligible psychologist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible psychologist by a referring practitioner; and (c) the service lasts at least 50 minutes (See para MN.7.5 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	3. OCCUPATIONAL THERAPIST FOCUSSED PSYCHOLOGICAL STRATEGIES VIDEO SERVICES
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 3. Occupational Therapist focussed psychological strategies video services
91172	Focussed psychological strategies health service provided by video attendance by an eligible occupational therapist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible occupational therapist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 20 minutes but less than 50 minutes duration (See para AN.0.30 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
91173	Focussed psychological strategies health service provided by video attendance by an eligible occupational therapist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually; and

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	3. OCCUPATIONAL THERAPIST FOCUSSED PSYCHOLOGICAL STRATEGIES VIDEO SERVICES
	(c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible occupational therapist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 50 minutes in duration (See para AN.0.30 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**
91194	Video attendance for a focussed psychological strategies health service provided by an eligible occupational therapist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible occupational therapist by a referring practitioner; and (c) the service lasts at least 20 minutes but less than 50 minutes (See para MN.7.5 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
91195	Video attendance for a focussed psychological strategies health service provided by an eligible occupational therapist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible occupational therapist by a referring practitioner; and (c) the service lasts at least 50 minutes (See para MN.7.5 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	4. SOCIAL WORKER FOCUSSED PSYCHOLOGICAL STRATEGIES VIDEO SERVICES
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 4. Social Worker focussed psychological strategies video services
91175	Focussed psychological strategies health service provided by video attendance by an eligible social worker if: (a) the patient is referred by a referring practitioner; and

	(b) the service is provided to the patient individually; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible social worker gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 20 minutes but less than 50 minutes duration (See para AN.0.30 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
91176	Focussed psychological strategies health service provided by video attendance by an eligible social worker if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible social worker gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 50 minutes duration (See para AN.0.30 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**
91196	Video attendance for a focussed psychological strategies health service provided by an eligible social worker to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible social worker by a referring practitioner and (c) the service lasts at least 20 minutes but less than 50 minutes (See para MN.7.5 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
91197	Video attendance for a focussed psychological strategies health service provided by an eligible social worker to a person other than the patient, if: (a) the service is part of the patient's treatment;

	(b) the patient has been referred to the eligible social worker by a referring practitioner; and (c) the service lasts at least 50 minutes (See para MN.7.5 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**

	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 5. Nurse practitioner video services
91178	Video attendance by a participating nurse practitioner lasting at least 6 minutes and less than 20 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care (See para AN.1.1, MN.14.15, MN.14.12, MN.14.16, MN.0.1 of explanatory notes to this Category) **Fee:** $32.65 **Benefit:** 85% = $27.80 **Extended Medicare Safety Net Cap:** $97.95 **Future End Date:**
91179	Video attendance by a participating nurse practitioner lasting at least 20 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a detailed history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care (See para AN.1.1, MN.14.15, MN.0.1 of explanatory notes to this Category) **Fee:** $61.80 **Benefit:** 85% = $52.55 **Extended Medicare Safety Net Cap:** $185.40 **Future End Date:**
91180	Video attendance by a participating nurse practitioner lasting at least 40 minutes if the attendance includes any of the following that are clinically relevant: (a) taking an extensive history; (b) arranging any necessary investigation;

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	5. NURSE PRACTITIONER VIDEO SERVICES
	(c) implementing a management plan; (d) providing appropriate preventive health care (See para AN.1.1, MN.14.15, MN.14.12, MN.14.16, MN.0.1 of explanatory notes to this Category) **Fee:** $91.20 **Benefit:** 85% = $77.55 **Extended Medicare Safety Net Cap:** $273.60 **Future End Date:**
91192	Video attendance by a participating nurse practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited management (See para MN.14.15, MN.14.12, MN.14.16, MN.0.1 of explanatory notes to this Category) **Fee:** $14.95 **Benefit:** 85% = $12.75 **Extended Medicare Safety Net Cap:** $44.85 **Future End Date:**
91206	Video attendance by a participating nurse practitioner 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 (See para MN.14.15, MN.14.12, MN.0.1 of explanatory notes to this Category) **Fee:** $137.85 **Benefit:** 85% = $117.20 **Extended Medicare Safety Net Cap:** $413.55 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	6. PSYCHOLOGICAL THERAPIES PHONE SERVICES
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 6. Psychological therapies phone services
91181	Psychological therapy health service provided by phone attendance by an eligible clinical psychologist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually; and

	(c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible clinical psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 30 minutes but less than 50 minutes duration (See para MN.6.3, MN.6.2, AN.0.78 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**
91182	Psychological therapy health service provided by phone attendance by an eligible clinical psychologist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible clinical psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 50 minutes duration (See para MN.6.3, MN.6.2, AN.0.78 of explanatory notes to this Category) **Fee:** $175.30 **Benefit:** 85% = $149.05 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
91198	Phone attendance for a psychological therapy health service provided by an eligible clinical psychologist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible clinical psychologist by a referring practitioner; and (c) the service lasts at least 30 minutes but less than 50 minutes (See para MN.6.3, MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**
91199	Phone attendance for a psychological therapy health service provided by an eligible clinical psychologist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible clinical psychologist by a referring practitioner; and (c) the service lasts at least 50 minutes

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	6. PSYCHOLOGICAL THERAPIES PHONE SERVICES
	(See para MN.6.3, MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $175.30 **Benefit:** 85% = $149.05 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	7. PSYCHOLOGIST FOCUSSED PSYCHOLOGICAL STRATEGIES PHONE SERVICE
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 7. Psychologist focussed psychological strategies phone service
91183	Focussed psychological strategies health service provided by phone attendance by an eligible psychologist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 20 minutes but less than 50 minutes duration (See para MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $84.65 **Benefit:** 85% = $72.00 **Extended Medicare Safety Net Cap:** $253.95 **Future End Date:**
91184	Focussed psychological strategies health service provided by phone attendance by an eligible psychologist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 50 minutes duration (See para MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	7. PSYCHOLOGIST FOCUSSED PSYCHOLOGICAL STRATEGIES PHONE SERVICE
91200	Phone attendance for a focussed psychological strategies health service provided by an eligible psychologist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible psychologist by a referring practitioner; and (c) the service lasts at least 20 minutes but less than 50 minutes (See para MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $84.65 **Benefit:** 85% = $72.00 **Extended Medicare Safety Net Cap:** $253.95 **Future End Date:**
91201	Phone attendance for a focussed psychological strategies health service provided by an eligible psychologist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible psychologist by a referring practitioner; and (c) the service lasts at least 50 minutes (See para MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	8. OCCUPATIONAL THERAPIST FOCUSSED PSYCHOLOGICAL STRATEGIES PHONE SERVICES
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 8. Occupational therapist focussed psychological strategies phone services
91185	Focussed psychological strategies health service provided by phone attendance by an eligible occupational therapist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible occupational therapist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 20 minutes but less than 50 minutes duration (See para MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	8. OCCUPATIONAL THERAPIST FOCUSSED PSYCHOLOGICAL STRATEGIES PHONE SERVICES
91186	Focussed psychological strategies health service provided by phone attendance by an eligible occupational therapist if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible occupational therapist gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 50 minutes in duration (See para MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**
91202	Phone attendance for a focussed psychological strategies health service provided by an eligible occupational therapist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible occupational therapist by a referring practitioner; and (c) the service lasts at least 20 minutes but less than 50 minutes (See para MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
91203	Phone attendance for a focussed psychological strategies health service provided by an eligible occupational therapist to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible occupational therapist by a referring practitioner; and (c) the service lasts at least 50 minutes (See para MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	9. SOCIAL WORKER FOCUSSED PSYCHOLOGICAL STRATEGIES PHONE SERVICES
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 9. Social worker focussed psychological strategies phone services

91187	Focussed psychological strategies health service provided by phone attendance by an eligible social worker if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible social worker gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 20 minutes but less than 50 minutes duration (See para MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
91188	Focussed psychological strategies health service provided by phone attendance by an eligible social worker if: (a) the patient is referred by a referring practitioner; and (b) the service is provided to the patient individually; and (c) at the completion of a course of treatment, the referring practitioner reviews the need for a further course of treatment; and (d) on the completion of the course of treatment, the eligible social worker gives a written report to the referring practitioner on assessments carried out, treatment provided and recommendations on future management of the patient's condition; and (e) the service is at least 50 minutes duration (See para MN.6.3, MN.7.4, AN.0.78 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**
91204	Phone attendance for a focussed psychological strategies health service provided by an eligible social worker to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible social worker by a referring practitioner; and (c) the service lasts at least 20 minutes but less than 50 minutes (See para MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	9. SOCIAL WORKER FOCUSSED PSYCHOLOGICAL STRATEGIES PHONE SERVICES
91205	Phone attendance for a focussed psychological strategies health service provided by an eligible social worker to a person other than the patient, if: (a) the service is part of the patient's treatment; (b) the patient has been referred to the eligible social worker by a referring practitioner; and (c) the service lasts at least 50 minutes (See para MN.7.5, AN.0.78 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	10. NURSE PRACTITIONER PHONE SERVICES
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 10. Nurse practitioner phone services
91189	Phone attendance by a participating nurse practitioner lasting at least 6 minutes and less than 20 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a short history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care (See para MN.14.15, MN.14.12, MN.14.16, MN.0.1 of explanatory notes to this Category) **Fee:** $32.65 **Benefit:** 85% = $27.80 **Extended Medicare Safety Net Cap:** $97.95 **Future End Date:**
91190	Phone attendance by a participating nurse practitioner lasting at least 20 minutes if the attendance includes any of the following that are clinically relevant: (a) taking a detailed history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care. (See para MN.14.15, MN.14.12, MN.14.16, MN.0.1 of explanatory notes to this Category) **Fee:** $61.80 **Benefit:** 85% = $52.55 **Extended Medicare Safety Net Cap:** $185.40 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	10. NURSE PRACTITIONER PHONE SERVICES
91191	Phone attendance by a participating nurse practitioner lasting at least 40 minutes if the attendance includes any of the following that are clinically relevant: (a) taking an extensive history; (b) arranging any necessary investigation; (c) implementing a management plan; (d) providing appropriate preventive health care. (See para MN.14.15, MN.14.12, MN.14.16, MN.0.1 of explanatory notes to this Category) **Fee:** $91.20 **Benefit:** 85% = $77.55 **Extended Medicare Safety Net Cap:** $273.60 **Future End Date:**
91193	Phone attendance by a participating nurse practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited management. (See para MN.14.15, MN.14.12, MN.14.16, MN.0.1 of explanatory notes to this Category) **Fee:** $14.95 **Benefit:** 85% = $12.75 **Extended Medicare Safety Net Cap:** $44.85 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	11. GENERAL ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE VIDEO SERVICES
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 11. General allied health and other primary health care video services
93000	Video attendance by an eligible allied health practitioner or Aboriginal and Torres Strait Islander primary health care professional if: (a) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and (b) the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; and (c) the person is referred to the eligible health practitioner by the medical practitioner; and (d) the service is provided to the person individually; and

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	11. GENERAL ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE VIDEO SERVICES
	(e) the service is of at least 20 minutes duration; and (f) after the service, the eligible health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral—in relation to that service; or (ii) if the service is the first or last service under the referral—in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of —in relation to those matters; to a maximum of 5 services (including any services to which this item, item 93013 or any item in Subgroup 1 of Group M3 of the Allied Health and other Primary Health Care Services Determination applies) in a calendar year (See para MN.3.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	12. GENERAL ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE PHONE SERVICES
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 12. General allied health and other primary health care phone services
93013	Phone attendance by an eligible allied health practitioner or Aboriginal and Torres Strait Islander primary health care professional if: (a) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and (b) the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; and (c) the person is referred to the eligible health practitioner by the medical practitioner; and (d) the service is provided to the person individually; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (c): (i) if the service is the only service under the referral—in relation to that service; or

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	12. GENERAL ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE PHONE SERVICES
	(ii) if the service is the first or last service under the referral—in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of —in relation to those matters; to a maximum of 5 services (including any services to which this item, item 93000 or any item in Subgroup 1 of Group M3 of the Allied Health and other Primary Health Care Services Determination applies) in a calendar year (See para MN.3.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	13. PREGNANCY SUPPORT COUNSELLING VIDEO SERVICES
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 13. Pregnancy support counselling video services
93026	Non directive pregnancy support counselling health service provided to a person who is currently pregnant or who has been pregnant in the preceding 12 months by an eligible psychologist, eligible social worker or eligible mental health nurse as a video attendance if: (a) the person is concerned about a current pregnancy or a pregnancy that occurred in the 12 months preceding the provision of the first service; and (b) the person is referred by a medical practitioner who is not a specialist or consultant physician; and (c) the service is provided to the person individually; and (d) the eligible psychologist, eligible social worker or eligible mental health nurse does not have a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination; and (e) the service is at least 30 minutes duration; to a maximum of 3 services (including services to which items 81000, 81005, 81010, 4001 and item 93029, 92136 and 92138 apply) for each pregnancy. The service may be used to address any pregnancy related issues for which non directive counselling is appropriate (See para MN.8.1, MN.8.4, MN.8.2, MN.8.3 of explanatory notes to this Category) **Fee:** $87.50 **Benefit:** 85% = $74.40 **Extended Medicare Safety Net Cap:** $262.50 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	14. PREGNANCY SUPPORT COUNSELLING PHONE SERVICES
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 14. Pregnancy support counselling phone services

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	14. PREGNANCY SUPPORT COUNSELLING PHONE SERVICES
93029	Non directive pregnancy support counselling health service provided to a person, who is currently pregnant or who has been pregnant in the preceding 12 months by an eligible psychologist, eligible social worker or eligible mental health nurse as a phone attendance if: (a) the person is concerned about a current pregnancy or a pregnancy that occurred in the 12 months preceding the provision of the first service; and (b) the person is referred by a medical practitioner who is not a specialist or consultant physician; and (c) the service is provided to the person individually; and (d) the eligible psychologist, eligible social worker or eligible mental health nurse does not have a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination; and (e) the service is at least 30 minutes duration; to a maximum of 3 services (including services to which items 81000, 81005, 81010, 4001 and item 93026, 92136 and 92138 apply) for each pregnancy. The service may be used to address any pregnancy related issues for which non directive counselling is appropriate (See para MN.8.1, MN.8.4, MN.8.2, MN.8.3 of explanatory notes to this Category) **Fee:** $87.50 **Benefit:** 85% = $74.40 **Extended Medicare Safety Net Cap:** $262.50 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	15. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY VIDEO SERVICES
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 15. Complex neurodevelopmental disorder and disability video services
93032	Psychology health service provided by video attendance to a patient aged under 25 years by an eligible psychologist if: (a) the patient was referred by an eligible medical practitioner, or by an eligible allied health practitioner following referral by an eligible medical practitioner, to: (i) assist the eligible medical practitioner with diagnostic formulation where the patient has a suspected complex neurodevelopmental disorder or eligible disability; or (ii) contribute to the patient's treatment and management plan developed by the referring eligible medical practitioner where a complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability is confirmed; and (b) the service is provided to the patient individually; and (c) the service is at least 50 minutes duration

	Up to 4 services to which this item or any of items 82000, 82005, 82010, 82030, 93033, 93040 or 93041 apply may be provided to the same patient on the same day (See para MN.10.3, MN.10.1, AN.0.25, AN.0.24, AN.0.72, AN.0.73 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**
93033	Audiology, dietetic, exercise physiology, occupational therapy, optometry, orthoptic, physiotherapy or speech pathology health service provided by video attendance to a patient aged under 25 years by an eligible audiologist, dietitian, exercise physiologist, occupational therapist, optometrist, orthoptist, physiotherapist or speech pathologist if: (a) the patient was referred by an eligible medical practitioner, or by an eligible allied health practitioner following referral by an eligible medical practitioner, to: (i) assist the eligible medical practitioner with diagnostic formulation where the patient has a suspected complex neurodevelopmental disorder or eligible disability; or (ii) contribute to the patient's treatment and management plan developed by the referring eligible medical practitioner where a complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability is confirmed; and (b) the service is provided to the patient individually; and (c) the service is at least 50 minutes duration Up to 4 services to which this item or any of items 82000, 82005, 82010, 82030, 93032, 93040 or 93041 apply may be provided to the same patient on the same day (See para MN.10.3, MN.10.1, AN.0.25, AN.0.24, AN.0.72, AN.0.73 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**
93035	Psychology health service provided by video attendance to a patient aged under 25 years for the treatment of a diagnosed complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability by an eligible psychologist, if: (a) the patient has a treatment and management plan in place and has been referred by an eligible medical practitioner for a course of treatment consistent with that treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 30 minutes duration; and (d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring eligible medical practitioner on assessments (if performed), treatment provided and recommendations on future management of the patient's condition Up to 4 services to which this item or any of items 82015, 82020, 82025, 82035, 93036, 93043 or 93044 apply may be provided to the same patient on the same day

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	15. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY VIDEO SERVICES
	(See para MN.10.3, MN.10.2, AN.0.25, AN.0.24, AN.0.72, AN.0.73 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**
93036	Audiology, dietetic, exercise physiology, occupational therapy, optometry, orthoptic, physiotherapy or speech pathology health service provided by video attendance to a patient aged under 25 years for the treatment of a diagnosed complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability by an eligible audiologist, dietitian, exercise physiologist, occupational therapist, optometrist, orthoptist, physiotherapist or speech pathologist, if: (a) the patient has a treatment and management plan in place and has been referred by an eligible medical practitioner for a course of treatment consistent with that treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 30 minutes duration; and (d) on the completion of the course of treatment, the eligible audiologist, dietitian, exercise physiologist, occupational therapist, optometrist, orthoptist, physiotherapist or speech pathologist gives a written report to the referring eligible medical practitioner on assessments (if performed), treatment provided and recommendations on future management of the patient's condition Up to 4 services to which this item or any of items 82015, 82020, 82025, 82035, 93035, 93043 or 93044 apply may be provided to the same patient on the same day (See para MN.10.3, MN.10.2, AN.0.25, AN.0.24, AN.0.72, AN.0.73 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	16. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY PHONE SERVICES
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 16. Complex neurodevelopmental disorder and disability phone services
93040	Psychology health service provided by phone attendance to a patient aged under 25 years by an eligible psychologist if: (a) the patient was referred by an eligible medical practitioner, or by an eligible allied health practitioner following referral by an eligible medical practitioner, to: (i) assist the eligible medical practitioner with diagnostic formulation where the patient has a suspected complex neurodevelopmental disorder or eligible disability; or (ii) contribute to the patient's treatment and management plan developed by the referring eligible medical practitioner where a complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability is confirmed; and (b) the service is provided to the patient individually; and

	(c) the service is at least 50 minutes duration Up to 4 services to which this item or any of items 82000, 82005, 82010, 82030, 93032, 93033 or 93041 apply may be provided to the same patient on the same day Further information on the requirements for this item are available in the explanatory notes to this Category (See para MN.10.3, MN.10.1, AN.0.25, AN.0.24, AN.0.72, AN.0.73 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**
93041	Audiology, dietetic, exercise physiology, occupational therapy, optometry, orthoptic, physiotherapy or speech pathology health service provided by phone attendance to a patient aged under 25 years by an eligible audiologist, dietitian, exercise physiologist, occupational therapist, optometrist, orthoptist, physiotherapist or speech pathologist if: (a) the patient was referred by an eligible medical practitioner, or by an eligible allied health practitioner following referral by an eligible medical practitioner, to: (i) assist the eligible medical practitioner with diagnostic formulation where the patient has a suspected complex neurodevelopmental disorder or eligible disability; or (ii) contribute to the patient's treatment and management plan developed by the referring eligible medical practitioner where a complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability is confirmed; and (b) the service is provided to the patient individually; and (c) the service is at least 50 minutes duration Up to 4 services to which this item or any of items 82000, 82005, 82010, 82030, 93032, 93033 or 93040 apply may be provided to the same patient on the same day Further information on the requirements for this item are available in the explanatory notes to this Category (See para MN.10.3, MN.10.1, AN.0.25, AN.0.24, AN.0.72, AN.0.73 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**
93043	Psychology health service provided by phone attendance to a patient aged under 25 years for the treatment of a diagnosed complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability by an eligible psychologist, if: (a) the patient has a treatment and management plan in place and has been referred by an eligible medical practitioner for a course of treatment consistent with that treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 30 minutes duration; and

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	16. COMPLEX NEURODEVELOPMENTAL DISORDER AND DISABILITY PHONE SERVICES
	(d) on the completion of the course of treatment, the eligible psychologist gives a written report to the referring eligible medical practitioner on assessments (if performed), treatment provided and recommendations on future management of the patient's condition Up to 4 services to which this item or any of items 82015, 82020, 82025, 82035, 93035, 93036 or 93044 apply may be provided to the same patient on the same day Further information on the requirements for this item are available in the explanatory notes to this Category (See para MN.10.3, MN.10.2, AN.0.25, AN.0.24, AN.0.72, AN.0.73 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**
93044	Audiology, dietetic, exercise physiology, occupational therapy, optometry, orthoptic, physiotherapy or speech pathology health service provided by phone attendance to a patient aged under 25 years for the treatment of a diagnosed complex neurodevelopmental disorder (such as autism spectrum disorder) or eligible disability by an eligible audiologist, dietitian, exercise physiologist, occupational therapist, optometrist, orthoptist, physiotherapist or speech pathologist, if: (a) the patient has a treatment and management plan in place and has been referred by an eligible medical practitioner for a course of treatment consistent with that treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 30 minutes duration; and (d) on the completion of the course of treatment, the eligible audiologist, dietitian, exercise physiologist, occupational therapist, optometrist, orthoptist, physiotherapist, or speech pathologist gives a written report to the referring eligible medical practitioner on assessments (if performed), treatment provided and recommendations on future management of the patient's condition Up to 4 services to which this item or any of items 82015, 82020, 82025, 82035, 93035, 93036 or 93043 apply may be provided to the same patient on the same day Further information on the requirements for this item are available in the explanatory notes to this Category (See para MN.10.3, MN.10.2, MN.10.1, AN.0.25, AN.0.24, AN.0.72, AN.0.73 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	17. VIDEO ATTENDANCE TO PERSON OF ABORIGINAL AND TORRES STRAIT ISLANDER DESCENT
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 17. Video attendance to person of Aboriginal and Torres Strait Islander descent

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	17. VIDEO ATTENDANCE TO PERSON OF ABORIGINAL AND TORRES STRAIT ISLANDER DESCENT
	Video attendance provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible allied health practitioner or Aboriginal and Torres Strait Islander primary health care professional if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up health services; or (b) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; (c) the person is referred to the eligible health practitioner by a medical practitioner; and (d) the service is provided to the person individually; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral—in relation to that service; or (ii) if the service is the first or the last service under the referral—in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of—in relation to those matters; to a maximum of 10 services (including any services to which this item or 93000, 93013 or 93061 or any item in Subgroup 1 of Group M3 or any item in Group M11 of the Allied Health and other Primary Health Care Services Determination applies) in a calendar year (See para MN.11.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65
93048	**Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	18. PHONE ATTENDANCE TO PERSON OF ABORIGINAL AND TORRES STRAIT ISLANDER DESCENT
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 18. Phone attendance to person of Aboriginal and Torres Strait Islander descent

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	18. PHONE ATTENDANCE TO PERSON OF ABORIGINAL AND TORRES STRAIT ISLANDER DESCENT
93061	Phone attendance provided to a person who is of Aboriginal or Torres Strait Islander descent by an eligible allied health or Aboriginal and Torres Strait Islander primary health care professional if: (a) a medical practitioner has undertaken a health assessment and identified a need for follow-up health services; or (b) the patient has a chronic condition and complex care needs being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and the service is recommended in the patient's plan or arrangements as part of the management of the patient's chronic condition and complex care needs; (c) the person is referred to the eligible health practitioner by a medical practitioner; and (d) the service is provided to the person individually; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (b): (i) if the service is the only service under the referral—in relation to that service; or (ii) if the service is the first or the last service under the referral—in relation to that service; or (iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably expect to be informed of—in relation to those matters; to a maximum of 10 services (including any services to which this item or item 93000, 93013, 93048 or any item in Subgroup 1 of Group M3 or any item in Group M11 of the Allied Health and other Primary Health Care Services Determination applies) in a calendar year (See para MN.11.1 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	19. EATING DISORDER DIETETICS VIDEO SERVICES
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 19. Eating disorder dietetics video services
93074	Dietetics health service provided by video attendance to an eligible patient by an eligible dietitian:

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	19. EATING DISORDER DIETETICS VIDEO SERVICES
	(a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is of at least 20 minutes in duration (See para MN.16.2 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	20. EATING DISORDER PSYCHOLOGICAL TREATMENT VIDEO SERVICES
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 20. Eating disorder psychological treatment video services
93076	Eating disorder psychological treatment service provided by video attendance to an eligible patient by an eligible clinical psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 30 minutes but less than 50 minutes in duration **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**
93079	Eating disorder psychological treatment service provided by video attendance to an eligible patient by an eligible clinical psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 50 minutes in duration (See para MN.16.4 of explanatory notes to this Category) **Fee:** $175.30 **Benefit:** 85% = $149.05 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
93084	Eating disorder psychological treatment service provided by video attendance to an eligible patient by an eligible psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 20 minutes but less than 50 minutes in duration (See para MN.16.4 of explanatory notes to this Category) **Fee:** $84.65 **Benefit:** 85% = $72.00 **Extended Medicare Safety Net Cap:** $253.95

	Future End Date:
93087	Eating disorder psychological treatment service provided by video attendance to an eligible patient by an eligible psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 50 minutes in duration (See para MN.16.4 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**
93092	Eating disorder psychological treatment service provided by video attendance to an eligible patient by an eligible occupational therapist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 20 minutes but less than 50 minutes in duration (See para MN.16.4 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
93095	Eating disorder psychological treatment service provided by video attendance to an eligible patient by an eligible occupational therapist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 50 minutes in duration (See para MN.16.4 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**
93100	Eating disorder psychological treatment service provided by video attendance to an eligible patient by an eligible social worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 20 minutes but less than 50 minutes in duration

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	20. EATING DISORDER PSYCHOLOGICAL TREATMENT VIDEO SERVICES
	Fee: $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
93103	Eating disorder psychological treatment service provided by video attendance to an eligible patient by an eligible social worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 50 minutes in duration (See para MN.16.4 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	21. EATING DISORDER DIETETICS PHONE SERVICES
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 21. Eating disorder dietetics phone services
93108	Dietetics health service provided by phone attendance to an eligible patient by an eligible dietitian: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is of at least 20 minutes in duration. (See para MN.16.4, MN.16.2 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	22. EATING DISORDER PSYCHOLOGICAL TREATMENT PHONE SERVICES
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 22. Eating disorder psychological treatment phone services
93110	Eating disorder psychological treatment service provided by phone attendance to an eligible patient by an eligible clinical psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and

	(c) the service is at least 30 minutes but less than 50 minutes in duration. (See para MN.16.4 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**
93113	Eating disorder psychological treatment service provided by phone attendance to an eligible patient by an eligible clinical psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 50 minutes in duration. (See para MN.16.4 of explanatory notes to this Category) **Fee:** $175.30 **Benefit:** 85% = $149.05 **Extended Medicare Safety Net Cap:** $500.00 **Future End Date:**
93118	Eating disorder psychological treatment service provided by phone attendance to an eligible patient by an eligible psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 20 minutes but less than 50 minutes in duration. (See para MN.16.4 of explanatory notes to this Category) **Fee:** $84.65 **Benefit:** 85% = $72.00 **Extended Medicare Safety Net Cap:** $253.95 **Future End Date:**
93121	Eating disorder psychological treatment service provided by phone attendance to an eligible patient by an eligible psychologist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 50 minutes in duration.

	(See para MN.16.4 of explanatory notes to this Category) **Fee:** $119.45 **Benefit:** 85% = $101.55 **Extended Medicare Safety Net Cap:** $358.35 **Future End Date:**
93126	Eating disorder psychological treatment service provided by phone attendance to an eligible patient by an eligible occupational therapist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 20 minutes but less than 50 minutes in duration (See para MN.16.4 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**
93129	Eating disorder psychological treatment service provided by phone attendance to an eligible patient by an eligible occupational therapist if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 50 minutes in duration. (See para MN.16.4 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**
93134	Eating disorder psychological treatment service provided by phone attendance to an eligible patient by an eligible social worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 20 minutes but less than 50 minutes in duration. (See para MN.16.4 of explanatory notes to this Category) **Fee:** $74.55 **Benefit:** 85% = $63.40 **Extended Medicare Safety Net Cap:** $223.65 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	22. EATING DISORDER PSYCHOLOGICAL TREATMENT PHONE SERVICES
93137	Eating disorder psychological treatment service provided by phone attendance to an eligible patient by an eligible social worker if: (a) the service is recommended in the patient's eating disorder treatment and management plan; and (b) the service is provided to the patient individually; and (c) the service is at least 50 minutes in duration. (See para MN.16.4 of explanatory notes to this Category) **Fee:** $105.25 **Benefit:** 85% = $89.50 **Extended Medicare Safety Net Cap:** $315.75 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	23. FOLLOW UP SERVICE PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER – VIDEO SERVICES
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 23. Follow up service provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner – Video Services
93200	Follow-up video attendance provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner, on behalf of a medical practitioner, for an Indigenous person who has received a health check if: (a) the service is provided on behalf of and under the supervision of a medical practitioner; and (b) the service is consistent with the needs identified through the health assessment (See para MN.12.6, MN.12.3 of explanatory notes to this Category) **Fee:** $33.70 **Benefit:** 85% = $28.65 **Extended Medicare Safety Net Cap:** $101.10 **Future End Date:**
93201	Video attendance provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner to a person with a chronic condition, if: (a) the service is provided on behalf of and under the supervision of a medical practitioner; and (b) the person has in place: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements, prepared before 1 July 2025; or (iii) a multidisciplinary care plan; and

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	23. FOLLOW UP SERVICE PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER – VIDEO SERVICES
	(c) the service is consistent with the plan or arrangements (See para AN.15.3, MN.12.6, MN.12.4 of explanatory notes to this Category) **Fee:** $17.00 **Benefit:** 85% = $14.45 **Extended Medicare Safety Net Cap:** $51.00 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	24. FOLLOW UP SERVICE PROVIDED BY A PRACTICE NURSE OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER – PHONE SERVICES
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 24. Follow up service provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner – Phone Services
93202	Follow-up phone attendance provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner, on behalf of a medical practitioner, for an Indigenous person who has received a health check if: (a) the service is provided on behalf of and under the supervision of a medical practitioner; and (b) the service is consistent with the needs identified through the health assessment. (See para MN.12.6, MN.12.3 of explanatory notes to this Category) **Fee:** $33.70 **Benefit:** 85% = $28.65 **Extended Medicare Safety Net Cap:** $101.10 **Future End Date:**
93203	Phone attendance provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner to a person with a chronic condition, if: (a) the service is provided on behalf of and under the supervision of a medical practitioner; and (b) the person has in place: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan and Team Care Arrangements, prepared before 1 July 2025; or (iii) a multidisciplinary care plan; and (c) the service is consistent with the plan or arrangements (See para AN.15.3, MN.12.6, MN.12.4 of explanatory notes to this Category) **Fee:** $17.00 **Benefit:** 85% = $14.45 **Extended Medicare Safety Net Cap:** $51.00 **Future End Date:**

	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 25. Allied health, group dietetics video services
93284	Video attendance by an eligible dietitian to provide a dietetics health service to a person for assessing the person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs and preparing the person for the group services if: (a) the person has type 2 diabetes; and (b) the patient is being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and (c) the patient is referred to an eligible diabetes educator by the medical practitioner; and (d) the service is provided to the person individually; and (e) the service is of at least 45 minutes duration; and (f) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (c); payable once in a calendar year for this or any other assessment for group services item (including services to which this item, item 92386, or items 81100, 81110 and 81120 apply) (See para MN.9.1, MN.9.2 of explanatory notes to this Category) **Fee:** $95.65 **Benefit:** 85% = $81.35 **Extended Medicare Safety Net Cap:** $286.95 **Future End Date:**
93285	Video attendance by an eligible dietitian to provide a dietetics health service, as a group service for the management of type 2 diabetes if: (a) the person has been assessed as suitable for a type 2 diabetes group service under assessment items 81100, 81110, 81120, 93284 or 93286; and (b) the service is provided to a person who is part of a group of between 2 and 12 patients; and (c) the service is of at least 60 minutes duration; and (d) after the last service in the group services program provided to the person under this item or items 81105, 81115 or 81125, the eligible dietitian prepares, or contributes to, a written report to be provided to the referring medical practitioner; and (e) an attendance record for the group is maintained by the eligible dietitian;

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	25. ALLIED HEALTH, GROUP DIETETICS VIDEO SERVICES
	to a maximum of 8 group services in a calendar year (including services to which this item or items 81105, 81115 and 81125 apply) (See para MN.9.2 of explanatory notes to this Category) **Fee:** $23.80 **Benefit:** 85% = $20.25 **Extended Medicare Safety Net Cap:** $71.40 **Future End Date:**

M18. ALLIED HEALTH AND OTHER PRIMARY HEALTH CARE TELEHEALTH SERVICES	26. ALLIED HEALTH, GROUP DIETETICS PHONE
	Group M18. Allied Health and other primary health care telehealth services
	Subgroup 26. Allied health, group dietetics phone
93286	Phone attendance by an eligible dietitian to provide a dietetics health service to a person for assessing the person's suitability for group services for the management of type 2 diabetes, including taking a comprehensive patient history, identifying an appropriate group services program based on the patient's needs and preparing the person for the group services if: (a) the person has type 2 diabetes; and (b) the patient is being managed by a medical practitioner (other than a specialist or consultant physician) under: (i) a GP chronic condition management plan that has been prepared or reviewed in the last 18 months; or (ii) until the end of 30 June 2027—a GP Management Plan prepared prior to 1 July 2025; or (iii) a multidisciplinary care plan; and (c) the patient is referred to an eligible diabetes educator by the medical practitioner; and (d) the service is provided to the person individually; and (e) the service is of at least 45 minutes duration; and (f) after the service, the eligible dietitian gives a written report to the referring medical practitioner mentioned in paragraph (c); payable once in a calendar year for this or any other assessment for group services item (including services to which this item, item 92384, or in items 81100, 81110 and 81120 apply) (See para MN.9.1, MN.9.2 of explanatory notes to this Category) **Fee:** $95.65 **Benefit:** 85% = $81.35 **Extended Medicare Safety Net Cap:** $286.95 **Future End Date:**

M19. MIDWIFERY TELEHEALTH SERVICES	1. MIDWIFERY VIDEO SERVICES
	Group M19. Midwifery telehealth services
	Subgroup 1. Midwifery video services

M19. MIDWIFERY TELEHEALTH SERVICES	1. MIDWIFERY VIDEO SERVICES
91211	Short antenatal video attendance by a participating midwife, lasting at least 10 minutes (See para MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $38.75 **Benefit:** 85% = $32.95 **Extended Medicare Safety Net Cap:** $116.25 **Future End Date:**
91212	Routine antenatal video attendance by a participating midwife, lasting at least 40 minutes (See para MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $89.00 **Benefit:** 85% = $75.65 **Extended Medicare Safety Net Cap:** $267.00 **Future End Date:**
91214	Short postnatal video attendance by a participating midwife, lasting at least 20 minutes (See para MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $63.90 **Benefit:** 85% = $54.35 **Extended Medicare Safety Net Cap:** $191.70 **Future End Date:**
91215	Routine postnatal video attendance by a participating midwife, lasting at least 40 minutes (See para MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $130.80 **Benefit:** 85% = $111.20 **Extended Medicare Safety Net Cap:** $392.40 **Future End Date:**

M19. MIDWIFERY TELEHEALTH SERVICES	2. MIDWIFERY PHONE SERVICES
	Group M19. Midwifery telehealth services
	Subgroup 2. Midwifery phone services
91218	Short antenatal phone attendance by a participating midwife, lasting at least 10 minutes (See para MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $38.75 **Benefit:** 85% = $32.95 **Extended Medicare Safety Net Cap:** $116.25 **Future End Date:**
91219	Routine antenatal phone attendance by a participating midwife, lasting at least 40 minutes (See para MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $89.00 **Benefit:** 85% = $75.65 **Extended Medicare Safety Net Cap:** $267.00 **Future End Date:**

M19. MIDWIFERY TELEHEALTH SERVICES	2. MIDWIFERY PHONE SERVICES
91221	Short postnatal phone attendance by a participating midwife, lasting at least 20 minutes (See para MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $63.90 **Benefit:** 85% = $54.35 **Extended Medicare Safety Net Cap:** $191.70 **Future End Date:**
91222	Routine postnatal phone attendance by a participating midwife, lasting at least 40 minutes (See para MN.13.17, MN.13.18, MN.13.16, MN.13.15 of explanatory notes to this Category) **Fee:** $130.80 **Benefit:** 85% = $111.20 **Extended Medicare Safety Net Cap:** $392.40 **Future End Date:**

M33. NON-MEDICAL ASSISTANCE AT OPERATIONS	1. ASSISTANCE AT OPERATIONS PROVIDED BY A NURSE PRACTITIONER
	Group M33. Non-Medical Assistance at Operations
	Subgroup 1. Assistance at operations provided by a nurse practitioner
93718	Assistance by a participating nurse practitioner at any operation mentioned in an item in Group T8 that includes "(Assist.)" for which the fee does not exceed $668.25 or at a series or combination of operations mentioned in an item in Group T8 that include "(Assist.)" for which the aggregate fee does not exceed $668.25 (See para MN.33.1, MN.33.2 of explanatory notes to this Category) **Fee:** $103.25 **Benefit:** 75% = $77.45 85% = $87.80 **Future End Date:**
93719	Assistance by a participating nurse practitioner at any operation mentioned in an item in Group T8 that includes "(Assist.)" for which the fee exceeds $668.25 or at a series or combination of operations mentioned in an item in Group T8 that include "(Assist.)" for which the aggregate fee exceeds $668.25 (See para MN.33.1, MN.33.3 of explanatory notes to this Category) **Derived Fee:** For assistance at an operation or series or combination of operations, means 20% of the sum of the fees payable under the Act for the services provided at that operation, or series of operations, by the practitioner to whom the assistance was given. **Future End Date:**
93720	Assistance by a participating nurse practitioner at a birth involving Caesarean section (H) (See para MN.33.1 of explanatory notes to this Category) **Fee:** $149.25 **Benefit:** 75% = $111.95 **Future End Date:**
93721	Assistance by a participating nurse practitioner at a series or combination of operations that include "(Assist.)" and assistance by a participating nurse practitioner at a birth involving Caesarean section (H) (See para MN.33.1, MN.33.4 of explanatory notes to this Category) **Derived Fee:** (a) 20% of the sum of the fees payable under the Act for the services provided at those operations by the practitioner to whom the assistance was given; or (b) for the caesarean section component of the operations—the fee mentioned in item 16520. **Future End Date:**

93722	Assistance by a participating nurse practitioner at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615 and 16627 (H) (See para TN.4.11, MN.33.1 of explanatory notes to this Category) **Derived Fee:** 20% of the sum of the fees payable under the Act for the services provided at that procedure or combination of procedures by the practitioner to whom the assistance was given. **Future End Date:**
93723	Assistance by a participating nurse practitioner at cataract and intraocular lens surgery covered by item 42698, 42701, 42702, 42704, 42705 or 42707, when performed in association with services covered by item 42551 to 42569, 42653, 42656, 42725, 42746, 42749, 42752, 42776 or 42779 (H) (See para MN.33.1 of explanatory notes to this Category) **Fee:** $326.05 **Benefit:** 75% = $244.55 **Future End Date:**
93724	Assistance at cataract and intraocular lens surgery by a participating nurse practitioner, 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) (See para MN.33.1, MN.33.5 of explanatory notes to this Category) **Fee:** $215.20 **Benefit:** 75% = $161.40 **Future End Date:**