Health Insurance (Diagnostic Imaging Services Table) Regulation 2012

Select Legislative Instrument 2012 No. 243 as amended

made under the

Health Insurance Act 1973

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1 Name of regulation [see Note 1]

This regulation is the *Health Insurance (Diagnostic Imaging Services Table) Regulation 2012*.

4 Dictionary

The Dictionary at the end of this regulation defines certain words and expressions and includes references to certain words and expressions that are defined elsewhere in this regulation.

5 Diagnostic imaging services table

For subsection 4AA (1) of the Act, this regulation prescribes a table of diagnostic imaging services set out in Schedule 1.

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Schedule 1 Diagnostic imaging services table

(regulation 5)

Part 1 Preliminary

Division 1.1 Interpretation

1.1.1 Interpretation of table

A reference to a diagnostic imaging service in an item in Part 2 includes a reference to the undertaking of the diagnostic imaging procedure used for rendering the service.

Division 1.2 General application provisions

1.2.1 Meaning of symbols *(R)* and *(NR)* in the table

(1) An item including the symbol ***(R)*** is an R-type diagnostic imaging service.

(2) An item including the symbol ***(NR)*** is an NR-type diagnostic imaging service.

1.2.2 Who may provide a diagnostic imaging service

Unless the contrary intention appears, items in this table relating to diagnostic imaging services apply whether the service is provided by:

(a) a medical practitioner; or

(b) a person, other than a medical practitioner, who:

(i) is employed by a medical practitioner; or

(ii) provides the service under the supervision of a medical practitioner in accordance with accepted medical practice.

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1.2.3 Report requirements for certain services

(1) An item in Part 2 (except an item to which subclause (2) applies) applies only if the providing practitioner gives a report of the service performed to the practitioner, participating midwife or participating nurse practitioner who requested the service.

(2) This subclause applies to the following items:

(a) items 55054, 55130, 55135, 55848, 55850, 57341, 57345, 59312, 59314, 60506, 60509 and 61109, being items of services performed in conjunction with a surgical procedure;

(b) items 60918 and 60927, being items of service performed in preparation for a radiological procedure.

1.2.4 Angiography services—meaning of symbols *(K)* and *(NK)* in items

(1) An item that includes the symbol ***(NK)*** at the end of the item applies to a service that is performed on equipment that is at least 10 years old.

(2) An item that includes the symbol ***(K)*** at the end of the item applies to a service that is performed on equipment that is less than 10 years old.

(3) The date from which the age of equipment is worked out for this clause is:

(a) the date that the equipment was first installed in Australia; or

(b) if the equipment was imported as used equipment—the date of manufacture of the oldest component of the equipment.

1.2.5 Bulk-billing incentive

(1) This clause applies if:

(a) a service that is mentioned in an item in Divisions 2.1 to 2.4 of this table is provided; and

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(b) the service is not provided in a hospital; and

(c) the service is bulk-billed.

(2) The fee for the service is 95% of the fee mentioned in this table for the service.

(3) For paragraph 10 (2) (aa) of the Act, the benefit payable is the amount calculated under subclause (2).

Note Under subparagraph 6EF (b) (ii) of the *Health Insurance Regulations 1975*, the medicare benefit payable is 100% of the amount calculated under subclause (2).

(4) This clause does not apply to the service specified in item 61369.

1.2.5A Bulk-billing—magnetic resonance imaging

(1) This clause applies if:

(a) a service that is mentioned in an item in Division 2.5 of this table is provided; and

(b) the service is not provided in a hospital; and

(c) the service is bulk-billed.

(2) The fee for the service is 100% of the fee mentioned in this table for the service.

(3) For paragraph 10 (2) (aa) of the Act, the benefit payable is the amount calculated under subclause (2).

Note Under subparagraph 6EF (b) (ii) of the *Health Insurance Regulations 1975*, the medicare benefit payable is 100% of the amount calculated under subclause (2).

1.2.6 Multiple services—vascular ultrasound

(1) If a medical practitioner provides 2 or more vascular ultrasound services for the same patient on the same day, the fees specified for the items that apply to the services are affected as follows:

(a) the second highest fee is reduced by 40%;

(b) any other fee, except the highest, is reduced by 50%.

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(2) For subclause (1):

(a) if 2 or more applicable fees are equally the highest, one only of those fees is taken to be the highest fee; and

(b) if paragraph (a) applies—the other, or another, highest fee is taken to be the second highest fee; and

(c) if 2 or more fees are equally second highest, any one of those fees may be taken to be the second highest for the purpose of paragraph (1) (b); and

(d) if a reduced fee calculated under subclause (1) is not a multiple of 5 cents, the reduced fee is taken to be the nearest amount that is a multiple of 5 cents.

(3) This clause does not apply to the fee specified in item 64990 or 64991.

1.2.7 Multiple services

(1) If a medical practitioner renders 2 or more diagnostic imaging services for the same patient on the same day, the fees set out in the items that apply to the services, other than the item with the highest fee, are reduced by $5.

(2) If a medical practitioner renders at least one R-type diagnostic imaging service and at least one consultation service for the same patient on the same day, the highest fee, set out in the items that apply to diagnostic imaging services rendered by the practitioner for that patient on that day, is reduced:

(a) if the fee for the relevant consultation is at least $40—by $35; or

(b) if that fee is less than $40 but more than $15—by $15; or

(c) if that fee is less than $15—by the amount of that fee.

(3) For subclause (2), if more than one consultation has occurred, the relevant consultation is the consultation having the highest fee set out in the items that apply to the consultation.

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(4) If a medical practitioner renders at least one R-type diagnostic imaging service and at least one non-consultation service for the same patient on the same day, the highest fee that applies to any diagnostic imaging services performed by the medical practitioner for the same patient on the same day, is reduced by $5.

(5) If a medical practitioner renders an R-type diagnostic imaging service, a consultation and a non-consultation service for the same patient on the same day, the sum of the reductions under subclauses (2) and (4) must not exceed the highest fee that applies to any diagnostic imaging services rendered by the medical practitioner for the same patient on the same day.

(6) Clauses 1.2.6 and 2.5.8 apply, subject to subclauses (7) and (8), in addition to this clause.

(7) For clause 1.2.6, if a medical practitioner provides:

(a) 2 or more vascular ultrasound services for the same patient on the same day; and

(b) one or more other diagnostic imaging services for that patient on that day;

the amount of the fees payable for the vascular ultrasound services is taken, for this clause, to be an amount payable for one diagnostic imaging service.

(8) For clause 2.5.8, if a medical practitioner provides:

(a) 2 or more MRI services described in Subgroup 12 or 13 of Division 2.5 in this table for the same patient on the same day; and

(b) one 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 this clause, to be an amount payable for one diagnostic imaging service.

(9) This clause does not apply to diagnostic imaging services that are rendered in a remote area by a medical practitioner for whom a remote area exemption under section 23DX of the Act is in force for that area.

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(10) This clause does not apply to the fee specified in item 59103, 64990 or 64991.

(11) In this clause:

consultation means a service under an item listed in Divisions 2.1 to 2.14 of the general medical services table.

highest fee means the highest fee specified for an item in the first claim submitted to the Chief Executive Medicare for the services provided.

non-consultation service means a service under an item listed in the general medical services table other than in Divisions 2.1 to 2.14 of the general medical services table.

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Part 2 Services and fees

Division 2.1 Group I1—Ultrasound

Subdivision A General

2.1.1 Ultrasound services—eligible services

Items in this Division (except items 55600 and 55603) apply to an ultrasound service only if the service is performed:

(a) by a medical practitioner; or

(b) by a registered sonographer on behalf of a medical practitioner.

2.1.2 Ultrasound services—R-type eligible services

(1) Items in this Division (except items 55600 and 55603) marked with the symbol ***(R)*** apply to an ultrasound service (the ***eligible service***) only if the service is performed:

(a) under the professional supervision of a specialist or a consultant physician in the practice of his or her specialty who is available:

(i) to monitor and influence the conduct and diagnostic quality of the examination; and

(ii) if necessary, to attend on the patient personally; or

(b) under the professional supervision of a practitioner who:

(i) is not a specialist or consultant physician; and

(ii) meets the requirement of subclause (2); and

(iii) is available to monitor and influence the conduct and diagnostic quality of the examination and, if necessary, to attend on the patient personally; or

(c) in the circumstance mentioned in subclause (3), and under the professional supervision of a practitioner who is available:

(i) to monitor and influence the conduct and diagnostic quality of the examination; and

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(ii) if necessary, to attend on the patient personally; or

(d) if paragraph (a), (b) or (c) cannot be complied with:

(i) in an emergency; or

(ii) 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.

(2) For subparagraph (1) (b) (ii), the requirement is that, 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 eligible service was rendered, and the rendering of those services entitled payment of medicare benefits.

(3) For paragraph (1) (c), the circumstance is that, between 1 September 1997 and 31 August 1999, at least 50 services were rendered in nursing homes or patients' residences by or on behalf of the practitioner, and the rendering of those services entitled payment of medicare benefits.

Subdivision B Subgroup 1 to 4 of Group I1

2.1.3 Certain items taken to include referred by dental practitioner or referring dental practitioner

(1) In items 55028, 55030 and 55032, the phrase:

(a) 'referred by a medical practitioner' includes referred by a dental practitioner mentioned in subclause (2); and

(b) 'the referring medical practitioner' includes the referring dental practitioner mentioned in subclause (2).

(2) For subclause (1), the dental practitioner is a dental practitioner who is approved by the Minister under paragraph (b) of the definition of ***professional service*** in subsection 3 (1) of the Act.

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Item	Diagnostic imaging service	Fee ($)
Subgroup 1—General		
55028	Head, ultrasound scan of, if: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)	109.10
55029	Head, ultrasound scan of, if the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroup 2 or 3 applies (NR)	37.85
55030	Orbital contents, ultrasound scan of, if: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)	109.10
55031	Orbital contents, ultrasound scan of, if the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroup 2 or 3 applies (NR)	37.85
55032	Neck, one or more structures of, ultrasound scan of, if: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)	109.10
55033	Neck, one or more structures of, ultrasound scan of, if the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroup 2 or 3 applies (NR)	37.85

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Item	Diagnostic imaging service	Fee ($)
55036	Abdomen, ultrasound scan of (including scan of urinary tract when performed), if: (a) the patient is referred by a medical practitioner or participating nurse practitioner for ultrasonic examination; and (b) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) if the patient is referred by a participating nurse practitioner—the referring nurse practitioner does not have a business or financial arrangement with the providing practitioner; and (d) the service is not a service associated with a service to which an item in Subgroup 2 or 3 applies; and (e) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and (f) within 24 hours of the service, a service described in item 55038, 55044 or 55731 is not performed on the same patient by the providing practitioner (R)	111.30
55037	Abdomen, ultrasound scan of (including scan of urinary tract when performed), if: (a) the patient is not referred by a medical practitioner or participating nurse practitioner; and (b) the service is not a service associated with a service to which an item in Subgroup 2 or 3 applies; and (c) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs (NR)	37.85
55038	Urinary tract, ultrasound scan of, if: (a) the patient is referred by a medical practitioner for ultrasonic examination; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and	109.10

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Item	Diagnostic imaging service	Fee ($)
	(c) the service is not a service associated with a service to which an item in Subgroup 2 or 3 applies; and (d) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and (e) within 24 hours of the service, a service described in item 55036, 55044 or 55731 is not performed on the same patient by the providing practitioner (R)	
55039	Urinary tract, ultrasound scan of, if: (a) the patient is not referred by a medical practitioner; and (b) the service is not a service associated with a service to which an item in Subgroup 2 or 3 applies; and (c) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs (NR)	37.85
55044	Pelvis, male, ultrasound scan of, by any or all approaches, if: (a) the patient is referred by a medical practitioner for ultrasonic examination; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not a service associated with a service to which an item in Subgroup 2 or 3 applies; and (d) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs; and (e) within 24 hours of the service, a service described in item 55036 or 55038 is not performed on the same patient by the providing practitioner (R)	111.30
55045	Pelvis, male, ultrasound scan of, by any or all approaches, if: (a) the patient is not referred by a medical practitioner; and (b) the service is not a service associated with a service to which an item in Subgroup 2 or 3 applies; and (c) the service is not solely a transrectal ultrasonic examination of the prostate gland, bladder base and urethra, or any of those organs (NR)	37.85

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Item	Diagnostic imaging service	Fee ($)
55048	Scrotum, ultrasound scan of, if: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)	109.50
55049	Scrotum, ultrasound scan of, if the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroup 2 or 3 applies (NR)	37.85
55054	Ultrasonic cross-sectional echography, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies (R)	109.10
55070	Breast, one, ultrasound scan of, if: (a) the patient is referred by a medical practitioner or participating nurse practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (c) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) if the patient is referred by a participating nurse practitioner—the referring nurse practitioner does not have a business or financial arrangement with the providing practitioner (R)	98.25
55073	Breast, one, ultrasound scan of, if: (a) the patient is not referred by a medical practitioner or participating nurse practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies (NR)	34.05

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Item	Diagnostic imaging service	Fee ($)
55076	Breasts, both, ultrasound scan of, if: (a) the patient is referred by a medical practitioner or participating nurse practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (c) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) if the patient is referred by a participating nurse practitioner—the referring nurse practitioner does not have a business or financial arrangement with the providing practitioner (R)	109.10
55079	Breasts, both, ultrasound scan of, if: (a) the patient is not referred by a medical practitioner or participating nurse practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies (NR)	37.85
55084	Urinary bladder, ultrasound scan of, by any or all approaches, if: (a) the patient is referred by a medical practitioner for ultrasonic examination; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) within 24 hours of the service, a service described in item 11917, 55036, 55038, 55044, 55600, 55603 or 55731 is not performed on the same patient by the providing practitioner (R)	98.25
55085	Urinary bladder, ultrasound scan of, by any or all approaches, if: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and	34.05

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Item	Diagnostic imaging service	Fee ($)
	(c) within 24 hours of the service, a service described in item 11917, 55037, 55039, 55045, 55600, 55603 or 55733 is not performed on the same patient by the providing practitioner (NR)	
Subgroup 2—Cardiac		
55113	M-mode and two-dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows for the investigation of symptoms or signs of cardiac failure, or suspected or known ventricular hypertrophy or dysfunction, or chest pain: (a) with: (i) measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques; and (ii) real time colour flow mapping from at least 2 acoustic windows; and (iii) recordings on video tape or digital media; and (b) not being a service associated with a service to which an item in Subgroup 1 (except item 55054) or 3, or another item in this Subgroup (except items 55118 and 55130), applies (R)	230.65
55114	M-mode and two-dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows for the investigation of suspected or known acquired valvular, aortic, pericardial, thrombotic or embolic disease or heart tumour: (a) with: (i) measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques; and (ii) real time colour flow mapping from at least 2 acoustic windows; and (iii) recordings on video tape or digital media; and (b) not being a service associated with a service to which an item in Subgroup 1 (except item 55054) or 3, or another item in this Subgroup (except items 55118 and 55130), applies (R)	230.65

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Item	Diagnostic imaging service	Fee ($)
55115	M-mode and two-dimensional real time echocardiographic examination of the heart from at least 2 acoustic windows for the investigation of symptoms or signs of congenital heart disease: (a) with: (i) measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques; and (ii) real time colour flow mapping from at least 2 acoustic windows; and (iii) recordings on video tape or digital media; and (b) not being a service associated with a service to which an item in Subgroup 1 (except item 55054) or 3, or another item in this Subgroup (except items 55118 and 55130), applies (R)	230.65
55116	Exercise stress echocardiography performed in conjunction with item 11712: (a) with: (i) two-dimensional recordings before exercise (baseline) from at least 3 acoustic windows; and (ii) matching recordings from the same windows at, or immediately after, peak exercise; and (iii) recordings on digital media with equipment permitting display of baseline and matching peak images on the same screen; and (b) not being a service associated with a service to which an item in Subgroup 1 (except item 55054) or 3, or another item in this Subgroup (except items 55118 and 55130), applies (R)	261.65
55117	Pharmacological stress echocardiography performed in conjunction with item 11712: (a) with: (i) two-dimensional recordings before drug infusion (baseline) from at least 3 acoustic windows; and (ii) matching recordings from the same windows at least twice during drug infusion, including a recording at the peak drug dose; and	261.65

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Item	Diagnostic imaging service	Fee ($)
	(iii) recordings on digital media with equipment permitting display of baseline and matching peak images on the same screen; and (b) not being a service associated with a service to which an item in Subgroup 1 (except item 55054) or 3, or another item in this Subgroup (except items 55118 and 55130), applies (R)	
55118	Heart, two-dimensional real time transoesophageal examination of, from at least 2 levels, and in more than one plane at each level: (a) with: (i) real time colour flow mapping and, if indicated, pulsed wave Doppler examination; and (ii) recordings on video tape or digital medium; and (b) not being an intra-operative service or a service associated with a service to which an item in Subgroup 1 (except item 55054) or 3 applies (R) (Anaes.)	275.50
55130	Intra-operative 2 dimensional real time transoesophageal echocardiography incorporating Doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac surgery incorporating sequential assessment of cardiac function before and after the surgical procedure, not being a service associated with a service to which item 55135 applies (R) (Anaes.)	170.00
55135	Intra-operative 2 dimensional real time transoesophageal echocardiography incorporating Doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac valve surgery (replacement or repair) incorporating sequential assessment of cardiac function and valve competence before and after the surgical procedure, not being a service associated with a service to which item 55130 applies (R) (Anaes.)	353.60
	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 a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	169.50

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Item	Diagnostic imaging service	Fee ($)
55244	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for acute venous thrombosis, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	169.50
55246	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	169.50
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 1 (with the exception of item 55054) or 4 applies (R)	169.50
55252	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the upper limb, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	169.50
55274	Duplex scanning, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of extra-cranial bilateral carotid and vertebral vessels, with or without subclavian and innominate vessels, with or without oculoplethysmography or peri-orbital Doppler examination, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	169.50
55276	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-abdominal, aorta and iliac arteries or inferior vena cava and iliac veins or of intra-abdominal, aorta and iliac arteries and inferior vena cava and iliac veins, excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	169.50

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Item	Diagnostic imaging service	Fee ($)
55278	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of renal or visceral vessels or of renal and visceral vessels, including aorta, inferior vena cava and iliac vessels as required excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	169.50
55280	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-cranial vessels, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	169.50
55282	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements: (a) by spectral analysis of cavernosal artery of the penis following intracavernosal administration of a vasoactive agent; and (b) performed during the period of pharmacological activity of the injected agent, to confirm a diagnosis of vascular aetiology for impotence; and (c) if a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is performed, immediately before or for a period during the performance of the service; and (d) if the specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	169.50
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	169.50

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Item	Diagnostic imaging service	Fee ($)
	(iii) fracture of the tunica; or (iv) arteriovenous malformations; and (c) if a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is performed, immediately before or for a period during the performance of the service; and (d) if the specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	
55292	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of surgically created arteriovenous fistula or surgically created arteriovenous access grafts in the upper or lower limbs, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054) or 4 applies (R)	169.50
55294	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or veins, or both, including any associated skin marking, for mapping of bypass conduit before vascular surgery, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054), 3 or 4 applies (R)	169.50
55296	Duplex scanning, unilateral, involving B mode ultrasound imaging and integrated Doppler flow spectral analysis and marking of veins in the lower limbs below the inguinal ligament before varicose vein surgery, including any associated skin marking, not being a service associated with a service to which an item in Subgroup 1 (with the exception of item 55054), 3 or 4 applies (R)	111.05

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Group I1—Ultrasound

Item	Diagnostic imaging service	Fee ($)
Subgroup 4—Urological		
55600	Prostate, bladder base and urethra, l 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: (i) have a nominal frequency of 7 to 7.5 MHz or a nominal frequency range that includes frequencies of 7 to 7.5 MHz; and (ii) can obtain both axial and sagittal scans in 2 planes at right angles; and (b) following a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology, a consultant physician in medical oncology, who has: (i) examined the patient in the 60 days before the scan; and (ii) recommended the scan for the management of the patient's current prostatic disease (R)	109.10
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: (i) have a nominal frequency of 7 to 7.5 MHz or a nominal frequency range that includes frequencies of 7 to 7.5 MHz; and (ii) can obtain both axial and sagittal scans in 2 planes at right angles; and (b) following a digital rectal examination of the prostate by that medical practitioner; and	109.10

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Item	Diagnostic imaging service	Fee ($)
	(c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology or a consultant physician in medical oncology who has: (i) examined the patient in the 60 days before the scan; and (ii) recommended the scan for the management of the patient's current prostatic disease (R)	

Subdivision C Subgroup 5 of Group I1—Obstetric and gynaecological

2.1.4 Obstetric and gynaecological ultrasound services—limits

(1) For NR-type diagnostic imaging services described in an item in this Subdivision, the specified fee for no more than 3 services provided to the same patient in any one pregnancy applies.

(2) For any patient, items 55706, 55707, 55708, 55709, 55718, 55723, 55759, 55762, 55768 and 55770 are applicable not more than once in a pregnancy.

2.1.5 Obstetric and gynaecological services—clinical indications

(1) For items in which clinical conditions are listed (items 55700, 55704, 55707, 55718, 55759 and 55768), or for which a clinical indication is required for performance of subsequent scans (items 55712, 55721, 55764 and 55772), the referral must identify the relevant clinical indication for the service.

(2) If the service is self-determined (items 55703, 55705, 55708, 55715, 55723, 55725, 55762, 55766, 55770 and 55774), the clinical condition or indication must be recorded in the medical practitioner's clinical notes.

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2.1.6 Obstetric and gynaecological services—referral forms

Items 55712, 55721, 55764 and 55772 apply to a service for which a referral is given by a medical practitioner who has obstetric privileges at a non-metropolitan hospital only if the words 'non-metropolitan obstetric privileges' are specified on the referral form.

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Item	Diagnostic imaging service	Fee ($)
Subgroup 5—Obstetric and gynaecological		
55700	Pelvis or abdomen, pregnancy-related or pregnancy complication, ultrasound scan of, by any or all approaches, if: (a) the patient is referred by a medical practitioner or participating midwife; and (b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) if the patient is referred by a participating midwife—the referring midwife does not have a business or financial arrangement with the providing practitioner; and (f) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma;	60.00

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Item	Diagnostic imaging service	Fee ($)
	(xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (R)	
55703	Pelvis or abdomen, pregnancy-related or pregnancy complication, ultrasound scan of, by any or all approaches, if: (a) the patient is not referred by a medical practitioner or participating midwife; and (b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease;	35.00

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Item	Diagnostic imaging service	Fee ($)
	(vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (NR)	
55704	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) the patient is referred by a medical practitioner or participating midwife; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and	70.00

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Item	Diagnostic imaging service	Fee ($)
	(d) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and	
	(e) if the patient is referred by a participating midwife—the referring midwife does not have a business or financial arrangement with the providing practitioner; and	
	(f) one or more of the following conditions are present:	
	(i) hyperemesis gravidarum;	
	(ii) diabetes mellitus;	
	(iii) hypertension;	
	(iv) toxaemia of pregnancy;	
	(v) liver or renal disease;	
	(vi) autoimmune disease;	
	(vii) cardiac disease;	
	(viii) alloimmunisation;	
	(ix) maternal infection;	
	(x) inflammatory bowel disease;	
	(xi) bowel stoma;	
	(xii) abdominal wall scarring;	
	(xiii) previous spinal or pelvic trauma or disease;	
	(xiv) drug dependency;	
	(xv) thrombophilia;	
	(xvi) significant maternal obesity;	
	(xvii) advanced maternal age;	
	(xviii) abdominal pain or mass;	
	(xix) uncertain dates;	
	(xx) high risk pregnancy;	
	(xxi) previous post dates delivery;	
	(xxii) previous caesarean section;	
	(xxiii) poor obstetric history;	
	(xxiv) suspicion of ectopic pregnancy;	
	(xxv) risk of miscarriage;	
	(xxvi) diminished symptoms of pregnancy;	

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Item	Diagnostic imaging service	Fee ($)
	(xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (R)	
55705	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) the patient is not referred by a medical practitioner or participating midwife; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy;	35.00

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Item	Diagnostic imaging service	Fee ($)
	(xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (NR)	
55706	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the patient is referred by a medical practitioner or participating midwife; and (b) the dating for the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) if the patient is referred by a participating midwife—the referring midwife does not have a business or financial arrangement with the providing practitioner; and (f) the service is not performed in the same pregnancy as item 55709 (R)	100.00
55707	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) the patient is referred by a medical practitioner or participating midwife; and (b) the pregnancy (as confirmed by ultrasound) is dated by a fetal crown rump length of 45 to 84 mm; and	70.00

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Item	Diagnostic imaging service	Fee ($)
	(c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) if the patient is referred by a participating midwife—the referring midwife does not have a business or financial arrangement with the providing practitioner; and (f) at least one condition mentioned in paragraph (f) of item 55704 is present; and (g) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (h) the service is not performed with item 55700, 55703, 55704 or 55705 on the same patient within 24 hours (R)	
55708	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) the patient is not referred by a medical practitioner or participating midwife; and (b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84 mm; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) at lease one condition mentioned in paragraph (f) of item 55704 is present; and (e) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (f) the service is not performed with item 55700, 55703, 55704 or 55705 on the same patient within 24 hours (NR)	35.00
55709	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and	38.00

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Item	Diagnostic imaging service	Fee ($)
	(c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) the service is not performed in the same pregnancy as item 55706 (NR)	
55712	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the patient is referred by a medical practitioner who: (i) is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; or (ii) has a Diploma of Obstetrics; or (iii) has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of Obstetrics; or (iv) has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) further examination is clinically indicated after performance, in the same pregnancy, of a scan mentioned in item 55706 or 55709 (R)	115.00
55715	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, if: (a) the patient is not referred by a medical practitioner; and	40.00

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Item	Diagnostic imaging service	Fee ($)
	(b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) further examination is clinically indicated after performance, in the same pregnancy, of a scan mentioned in item 55706 or 55709 (NR)	
55718	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) the patient is referred by a medical practitioner or participating midwife; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) if the patient is referred by a participating midwife—the referring midwife does not have a business or financial arrangement with the providing practitioner; and (f) the service is not performed in the same pregnancy as item 55723; and (g) one or more of the following conditions are present: (i) known or suspected fetal abnormality or fetal cardiac arrhythmia; (ii) fetal anatomy (late booking or incomplete mid-trimester scan); (iii) malpresentation; (iv) cervical assessment; (v) clinical suspicion of amniotic fluid abnormality; (vi) clinical suspicion of placental or umbilical cord abnormality; (vii) previous complicated delivery;	100.00

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Item	Diagnostic imaging service	Fee ($)
	(viii) uterine scar assessment;	
	(ix) uterine fibroid;	
	(x) previous fetal death in utero or neonatal death;	
	(xi) antepartum haemorrhage;	
	(xii) clinical suspicion of intrauterine growth retardation;	
	(xiii) clinical suspicion of macrosomia;	
	(xiv) reduced fetal movements;	
	(xv) suspected fetal death;	
	(xvi) abnormal cardiotocography;	
	(xvii) prolonged pregnancy;	
	(xviii) premature labour;	
	(xix) fetal infection;	
	(xx) pregnancy after assisted reproduction;	
	(xxi) trauma;	
	(xxii) diabetes mellitus;	
	(xxiii) hypertension;	
	(xxiv) toxaemia of pregnancy;	
	(xxv) liver or renal disease;	
	(xxvi) autoimmune disease;	
	(xxvii) cardiac disease;	
	(xxviii) alloimmunisation;	
	(xxix) maternal infection;	
	(xxx) inflammatory bowel disease;	
	(xxxi) bowel stoma;	
	(xxxii) abdominal wall scarring;	
	(xxxiii) previous spinal or pelvic trauma or disease;	
	(xxxiv) drug dependency;	
	(xxxv) thrombophilia;	
	(xxxvi) gross maternal obesity;	
	(xxxvii) advanced maternal age;	
	(xxxviii) abdominal pain or mass (R)	

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Item	Diagnostic imaging service	Fee ($)
55721	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) the patient is referred by a medical practitioner who: (i) is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; or (ii) has a Diploma of Obstetrics; or (iii) has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of Obstetrics; or (iv) has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (R)	115.00
55723	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) the service is not performed in the same pregnancy as item 55718; and (e) one or more of the following conditions are present: (i) known or suspected fetal abnormality or fetal cardiac arrhythmia;	38.00

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Item	Diagnostic imaging service	Fee ($)
	(ii) fetal anatomy (late booking or incomplete mid-trimester scan);	
	(iii) malpresentation;	
	(iv) cervical assessment;	
	(v) clinical suspicion of amniotic fluid abnormality;	
	(vi) clinical suspicion of placental or umbilical cord abnormality;	
	(vii) previous complicated delivery;	
	(viii) uterine scar assessment;	
	(ix) uterine fibroid;	
	(x) previous fetal death in utero or neonatal death;	
	(xi) antepartum haemorrhage;	
	(xii) clinical suspicion of intrauterine growth retardation;	
	(xiii) clinical suspicion of macrosomia;	
	(xiv) reduced fetal movements;	
	(xv) suspected fetal death;	
	(xvi) abnormal cardiotocography;	
	(xvii) prolonged pregnancy;	
	(xviii) premature labour;	
	(xix) fetal infection;	
	(xx) pregnancy after assisted reproduction;	
	(xxi) trauma;	
	(xxii) diabetes mellitus;	
	(xxiii) hypertension;	
	(xxiv) toxaemia of pregnancy;	
	(xxv) liver or renal disease;	
	(xxvi) autoimmune disease;	
	(xxvii) cardiac disease;	
	(xxviii) alloimmunisation;	
	(xxix) maternal infection;	
	(xxx) inflammatory bowel disease;	
	(xxxi) bowel stoma;	
	(xxxii) abdominal wall scarring;	
	(xxxiii) previous spinal or pelvic trauma or disease;	

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Item	Diagnostic imaging service	Fee ($)
	(xxxiv) drug dependency; (xxxv) thrombophilia; (xxxvi) gross maternal obesity; (xxxvii) advanced maternal age; (xxxviii) abdominal pain or mass (NR)	
55725	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, if: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (d) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (NR)	40.00
55729	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of the umbilical artery, and measured assessment of amniotic fluid volume after the 24th week of gestation, if the patient is referred by a medical practitioner for this procedure and if there is reason to suspect intrauterine growth retardation or a significant risk of fetal death, not being a service associated with a service to which an item in this group applies—examination and report (R)	27.25
55731	Pelvis, female, ultrasound scan of, by any or all approaches, if: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) the service is not performed with item 55036 or 55038 on the same patient within 24 hours (R)	98.00

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Item	Diagnostic imaging service	Fee ($)
55733	Pelvis, female, ultrasound scan of, by any or all approaches, if: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies (NR)	35.00
55736	Pelvis, female, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, if: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (c) the referring medical practitioner is not a member of a group of medical practitioners of which the providing practitioner is a member; and (d) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (R)	127.00
55739	Pelvis, female, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, if: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (c) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (NR)	57.00
55759	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the patient is referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (e) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and	150.00

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Item	Diagnostic imaging service	Fee ($)
	(f) the service described in item 55706, 55709, 55712, 55715 or 55762 is not performed in conjunction with the scan during the same pregnancy (R)	
55762	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (e) the service described in item 55706, 55709, 55712, 55715 or 55759 is not performed in conjunction with the scan during the same pregnancy (NR)	60.00
55764	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, if: (a) the patient is referred by a medical practitioner who: (i) is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; or (ii) has a Diploma of Obstetrics; or (iii) has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of Obstetrics; or (iv) has obstetric privileges at a non-metropolitan hospital; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and	160.00

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Item	Diagnostic imaging service	Fee ($)
	(e) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (f) further examination is clinically indicated in the same pregnancy in which item 55759 or 55762 has been performed; and (g) the service described in item 55706, 55709, 55712 or 55715 is not performed in conjunction with the scan during the same pregnancy (R)	
55766	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner, who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, if: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (e) further examination is clinically indicated in the same pregnancy in which item 55759 or 55762 has been performed; and (f) the service described in item 55706, 55709, 55712 or 55715 is not performed in conjunction with the scan during the same pregnancy (NR)	65.00
55768	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (b) the ultrasound confirms a multiple pregnancy; and (c) the patient is referred by a medical practitioner; and	150.00

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Item	Diagnostic imaging service	Fee ($)
	(d) the service is not performed in the same pregnancy as item 55770; and (e) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (f) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service described in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the scan during the same pregnancy (R)	
55770	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (b) the ultrasound confirms a multiple pregnancy; and (c) the patient is not referred by a medical practitioner; and (d) the service is not performed in the same pregnancy as item 55768; and (e) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (f) the service described in item 55718, 55721, 55723, or 55725 is not performed in conjunction with the scan during the same pregnancy (NR)	60.00
55772	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is referred by a medical practitioner who: (i) is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; or (ii) has a Diploma of Obstetrics; or (iii) has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of Obstetrics; or	160.00

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Item	Diagnostic imaging service	Fee ($)
	(iv) has obstetric privileges at a non-metropolitan hospital; and (c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service described in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the scan during the same pregnancy (R)	
55774	Pelvis or abdomen, pregnancy-related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, if: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (f) the service described in item 55718, 55721, 55723 or 55725 is not performed in conjunction with the scan during the same pregnancy (NR)	65.00

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Subdivision D Subgroup 6 of Group I1—Musculoskeletal ultrasound

2.1.7 Musculoskeletal ultrasound services—personal attendance

Items in this Subdivision apply to a musculoskeletal ultrasound service only if:

(a) the medical practitioner responsible for the conduct and report of the examination personally attends during the performance of the scan and personally examines the patient; or

(b) the service is performed, because of medical necessity, in a location that is more than 30 kilometres by the most direct road route from another practice where services that comply with paragraph (a) are available.

2.1.8 Musculoskeletal ultrasound services—comparison ultra-sonography

The fee applicable for items in this Subdivision includes any views of another part of the patient taken for comparison purposes.

2.1.9 Musculoskeletal ultrasound services—equipment

Items in this Subdivision apply only to an ultrasound service performed using an ultrasound system that has available on-site a transducer capable of operation at a frequency of at least 7.5 MHz.

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Group I1—Ultrasound

Item	Diagnostic imaging service	Fee ($)
	Subgroup 6—Musculoskeletal ultrasound	
55800	Hand or wrist, one or both sides, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is referred by a medical practitioner or participating nurse practitioner; and (c) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) if the patient is referred by a participating nurse practitioner—the referring nurse practitioner does not have a business or financial arrangement with the providing practitioner (R)	109.10
55802	Hand or wrist, one or both sides, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is not referred by a medical practitioner or participating nurse practitioner (NR)	37.85
55804	Forearm or elbow, one or both sides, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is referred by a medical practitioner or participating nurse practitioner; and (c) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) if the patient is referred by a participating nurse practitioner—the referring nurse practitioner does not have a business or financial arrangement with the providing practitioner (R)	109.10
55806	Forearm or elbow, one or both sides, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and	37.85

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Group I1—Ultrasound

Item	Diagnostic imaging service	Fee ($)
	(b) the patient is not referred by a medical practitioner or participating nurse practitioner (NR)	
55808	Shoulder or upper arm, one or both sides, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is referred by a medical practitioner or participating nurse practitioner; and (c) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) if the patient is referred by a participating nurse practitioner—the referring nurse practitioner does not have a business or financial arrangement with the providing practitioner; and (e) 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, infraspinatus); (iii) biceps subluxation; (iv) capsulitis and bursitis; (v) a mass, including a ganglion; (vi) an occult fracture; (vii) acromioclavicular joint pathology (R)	109.10
55810	Shoulder or upper arm, one or both sides, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is not referred by a medical practitioner or participating nurse practitioner; and (c) 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, infraspinatus); (iii) biceps subluxation;	37.85

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Group I1—Ultrasound

Item	Diagnostic imaging service	Fee ($)
	(iv) capsulitis and bursitis; (v) a mass, including a ganglion; (vi) an occult fracture; (vii) acromioclavicular joint pathology (NR)	
55812	Chest or abdominal wall, one or more areas, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is referred by a medical practitioner or participating nurse practitioner; and (c) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) if the patient is referred by a participating nurse practitioner—the referring nurse practitioner does not have a business or financial arrangement with the providing practitioner (R)	109.10
55814	Chest or abdominal wall, one or more areas, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is not referred by a medical practitioner or participating nurse practitioner (NR)	37.85
55816	Hip or groin, one or both sides, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is referred by a medical practitioner or participating nurse practitioner; and (c) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) if the patient is referred by a participating nurse practitioner—the referring nurse practitioner does not have a business or financial arrangement with the providing practitioner (R)	109.10

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Group I1—Ultrasound

Item	Diagnostic imaging service	Fee ($)
55818	Hip or groin, one or both sides, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is not referred by a medical practitioner or participating nurse practitioner (NR)	37.85
55820	Paediatric hip examination for dysplasia, one or both sides, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is referred by a medical practitioner or participating nurse practitioner; and (c) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) if the patient is referred by a participating nurse practitioner—the referring nurse practitioner does not have a business or financial arrangement with the providing practitioner (R)	109.10
55822	Paediatric hip examination for dysplasia one or both sides, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is not referred by a medical practitioner or participating nurse practitioner (NR)	37.85
55824	Buttock or thigh, one or both sides, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is referred by a medical practitioner or participating nurse practitioner; and (c) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and	109.10

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Group I1—Ultrasound

Item	Diagnostic imaging service	Fee ($)
	(d) if the patient is referred by a participating nurse practitioner—the referring nurse practitioner does not have a business or financial arrangement with the providing practitioner (R)	
55826	Buttock or thigh, one or both sides, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is not referred by a medical practitioner or participating nurse practitioner (NR)	37.85
55828	Knee, one or both sides, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is referred by a medical practitioner or participating nurse practitioner; and (c) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) if the patient is referred by a participating nurse practitioner—the referring nurse practitioner does not have a business or financial arrangement with the providing practitioner; and (e) 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 (R)	109.10
55830	Knee, one or both sides, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is not referred by a medical practitioner or participating nurse practitioner; and	37.85

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Group I1—Ultrasound

Item	Diagnostic imaging service	Fee ($)
	(c) 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 (NR)	
55832	Lower leg, one or both sides, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is referred by a medical practitioner or participating nurse practitioner; and (c) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) if the patient is referred by a participating nurse practitioner—the referring nurse practitioner does not have a business or financial arrangement with the providing practitioner (R)	109.10
55834	Lower leg, one or both sides, ultrasound scan of, performed by or on behalf of a medical practitioner, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is not referred by a medical practitioner or participating nurse practitioner (NR)	37.85
55836	Ankle or hind foot, one or both sides, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is referred by a medical practitioner, participating nurse practitioner or podiatrist; and (c) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and	109.10

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Group I1—Ultrasound

Item	Diagnostic imaging service	Fee ($)
	(d) if the patient is referred by a participating nurse practitioner—the referring nurse practitioner does not have a business or financial arrangement with the providing practitioner (R)	
55838	Ankle or hind foot, one or both sides, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is not referred by a medical practitioner or participating nurse practitioner (NR)	37.85
55840	Mid foot or fore foot, one or both sides, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is referred by a medical practitioner, participating nurse practitioner or podiatrist; and (c) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) if the patient is referred by a participating nurse practitioner—the referring nurse practitioner does not have a business or financial arrangement with the providing practitioner (R)	109.10
55842	Mid foot or fore foot, one or both sides, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is not referred by a medical practitioner or participating nurse practitioner (NR)	37.85
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, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is referred by a medical practitioner, participating nurse practitioner or podiatrist; and	87.35

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Group I1—Ultrasound

Item	Diagnostic imaging service	Fee ($)
	(c) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) if the patient is referred by a participating nurse practitioner—the referring nurse practitioner does not have a business or financial arrangement with the providing practitioner (R)	
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, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is not referred by a medical practitioner or participating nurse practitioner (NR)	37.85
55848	Musculoskeletal cross-sectional echography, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies, and not performed in conjunction with item 55054 (R)	109.10
55850	Musculoskeletal cross-sectional echography, in conjunction with a surgical procedure using interventional techniques, inclusive of a diagnostic musculoskeletal ultrasound service, if: (a) the patient is referred by a medical practitioner or participating nurse practitioner; and (b) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) if the patient is referred by a participating nurse practitioner—the referring nurse practitioner does not have a business or financial relationship with the providing practitioner; and (d) the referring medical practitioner or nurse practitioner has indicated on a referral for a musculoskeletal ultrasound that an ultrasound guided intervention be performed if clinically indicated; and	152.85

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Group I1—Ultrasound

Item	Diagnostic imaging service	Fee ($)
	(e) the service is not performed in conjunction with items 55054, or 55800 to 55848 (R)	
55852	Paediatric spine, spinal cord and overlying subcutaneous tissues, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is referred by a medical practitioner or participating nurse practitioner; and (c) if the patient is referred by a medical practitioner—the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) if the patient is referred by a participating nurse practitioner—the referring nurse practitioner does not have a business or financial arrangement with the providing practitioner (R)	109.10
55854	Paediatric spine, spinal cord and overlying subcutaneous tissues, ultrasound scan of, if: (a) the service is not associated with a service to which an item in Subgroup 2 or 3 applies; and (b) the patient is not referred by a medical practitioner or participating nurse practitioner (NR)	37.85

Division 2.2 Group I2—Computed tomography—Examination

2.2.1 CT services—meaning of symbols *(K)* and *(NK)*

(1) In this Division, the symbol ***(K)*** means:

(a) for CT equipment that was first installed and used as new equipment at a site in Australia:

(i) the service was rendered earlier than 10 years after the earliest date on which any component of the equipment was first installed and ready for use; or

(ii) the service was performed in a remote location; or

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(b) for CT equipment imported as pre-used equipment:

(i) the service was rendered earlier than 10 years after the earliest date of manufacture of any component of the equipment; or

(ii) the service was rendered in a remote location.

(2) In this Division, the symbol ***(NK)*** means the service was rendered 10 years or more after:

(a) for CT equipment that was first installed and used as new equipment in Australia—the earliest date on which any component of the equipment was first installed and ready for use; or

(b) for CT equipment imported as pre-used equipment—the earliest date of manufacture of any component of the equipment.

(3) In this clause:

CT equipment imported as pre-used equipment means equipment that has been used to perform CT services before being imported into Australia.

installed and ready for use, for a component, means ready for immediate income-producing purposes, whether or not it is so used.

2.2.2 CT services—eligible services

(1) Items in this Division (other than items 57360 and 57361) apply to a CT service that is:

(a) performed under the professional supervision of a specialist in the specialty of diagnostic radiology who is available:

(i) to monitor and influence the conduct and diagnostic quality of the examination; and

(ii) if necessary, to attend on the patient personally; and

(b) reported by a specialist in the specialty of diagnostic radiology.

(2) Items 57360 and 57361 apply to a CT service that is:

(a) performed under the professional supervision of a specialist or consultant physician who is recognised by the

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Conjoint Committee for the Recognition of Training in CT Coronary Angiography and available:

(i) to monitor and influence the conduct and diagnostic quality of the examination; and

(ii) if necessary, to attend on the patient personally; and

(b) reported by a specialist or consultant physician who is recognised by the Conjoint Committee for the Recognition of Training in CT Coronary Angiography.

(3) However, items in this Division apply to a CT service that does not comply with the requirements mentioned in subclause (1) or (2) if the service is performed:

(a) in an emergency; or

(b) because of medical necessity, in a remote location.

2.2.3 CT services—exclusion of 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.

2.2.4 CT services—exclusion of acoustic neuroma

If an axial scan is performed for the exclusion of acoustic neuroma, item 56001 or 56007 applies instead of any other item in this table that might be taken to apply to the service.

2.2.5 CT services—assessment of headache

(1) If the service described in item 56007 or 56047 is used for the assessment of a headache of a patient to whom this clause applies, the fee mentioned in the item applies only if:

(a) a scan without intravenous contrast medium has been performed on the patient; and

(b) the service is required because the result of the scan is abnormal.

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(2) This clause applies to a patient who:

(a) is under 50 years; and

(b) is (apart from the headache) otherwise well; and

(c) has no localising symptoms or signs; and

(d) has no history of malignancy or immunosuppression.

2.2.6 CT services—number of services

Items 56220 to 56240 and 56619 to 56665 apply once only for a service described in any of those items, regardless of the number of patient attendances required to complete the service.

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Item	Diagnostic imaging service	Fee ($)
56001	Computed tomography—scan of brain without intravenous contrast medium, not being a service to which item 57001 applies (R) (K) (Anaes.)	195.05
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) (K) (Anaes.)	250.00
56010	Computed tomography—scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when performed (R) (K) (Anaes.)	252.10
56013	Computed tomography—scan of orbits with or without intravenous contrast medium and with or without brain scan when performed (R) (K) (Anaes.)	250.00
56016	Computed tomography—scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (K) (Anaes.)	290.00
56022	Computed tomography—scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (K) (Anaes.)	225.00
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) (K) (Anaes.)	336.80

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Item	Diagnostic imaging service	Fee ($)
56030	Computed tomography—scan of facial bones, para nasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (K) (Anaes.)	225.00
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) (K) (Anaes.)	336.80
56041	Computed tomography—scan of brain without intravenous contrast medium, not being a service to which item 57041 applies (R) (NK) (Anaes.)	98.75
56047	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 57047 applies (R) (NK) (Anaes.)	126.10
56050	Computed tomography—scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when performed (R) (NK) (Anaes.)	128.20
56053	Computed tomography—scan of orbits with or without intravenous contrast medium and with or without brain scan when performed (R) (NK) (Anaes.)	128.20
56056	Computed tomography—scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (NK) (Anaes.)	155.45
56062	Computed tomography—scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (NK) (Anaes.)	113.15
56068	Computed tomography—scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sinuses or both before intravenous contrast injection, when performed (R) (NK) (Anaes.)	168.40
56070	Computed tomography—scan of facial bones, para nasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (NK) (Anaes.)	113.15

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Group I2—Computed tomography—Examination

Item	Diagnostic imaging service	Fee ($)
56076	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) (NK) (Anaes.)	168.40
56101	Computed tomography—scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) without intravenous contrast medium, not being a service to which item 56801 applies (R) (K) (Anaes.)	230.00
56107	Computed tomography—scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine)—with intravenous contrast medium and with any scans of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) before intravenous contrast injection, when undertaken, not being a service associated with a service to which item 56807 applies (R) (K) (Anaes.)	340.00
56141	Computed tomography—scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) without intravenous contrast medium, not being a service to which item 56841 applies (R) (NK) (Anaes.)	116.45
56147	Computed tomography—scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine)—with intravenous contrast medium and with any scans of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) before intravenous contrast injection, when performed, not being a service associated with a service to which item 56847 applies (R) (NK) (Anaes.)	171.60
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) (K) (Anaes.)	326.20

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Group I2—Computed tomography—Examination

Item	Diagnostic imaging service	Fee ($)
56220	Computed tomography—scan of spine, cervical region, without intravenous contrast medium (R) (K) (Anaes.)	240.00
56221	Computed tomography—scan of spine, thoracic region, without intravenous contrast medium (R) (K) (Anaes.)	240.00
56223	Computed tomography—scan of spine, lumbosacral region, without intravenous contrast medium (R) (K) (Anaes.)	240.00
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) (K) (Anaes.)	351.40
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) (K) (Anaes.)	351.40
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) (K) (Anaes.)	351.40
56227	Computed tomography—scan of spine, cervical region, without intravenous contrast medium (R) (NK) (Anaes.)	122.50
56228	Computed tomography—scan of spine, thoracic region, without intravenous contrast medium (R) (NK) (Anaes.)	122.50
56229	Computed tomography—scan of spine, lumbosacral region, without intravenous contrast medium (R) (NK) (Anaes.)	122.50
56230	Computed tomography—scan of spine, cervical region, with intravenous contrast medium and with any scans to the cervical region of the spine before intravenous contrast injection when undertaken (R) (NK) (Anaes.)	177.45
56231	Computed tomography—scan of spine, thoracic region, with intravenous contrast medium and with any scans to the cervical region of the spine before intravenous contrast injection when undertaken (R) (NK) (Anaes.)	177.45
56232	Computed tomography—scan of spine, lumbosacral region, with intravenous contrast medium and with any scans to the lumbosacral region of the spine before intravenous contrast injection when undertaken (R) (NK) (Anaes.)	177.45

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Group I2—Computed tomography—Examination

Item	Diagnostic imaging service	Fee ($)
56233	Computed tomography—scan of spine, 2 examinations of the kind referred to in items 56220, 56221 and 56223, without intravenous contrast medium (R) (K) (Anaes.)	240.00
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) (K) (Anaes.)	351.40
56235	Computed tomography—scan of spine, 2 examinations of the kind referred to in items 56227, 56228 and 56229, without intravenous contrast medium (R) (NK) (Anaes.)	122.45
56236	Computed tomography—scan of spine, 2 examinations of the kind referred to in items 56230, 56231 and 56232, with intravenous contrast medium and with any scans of these regions of the spine before intravenous contrast injection when undertaken (R) (NK) (Anaes.)	177.45
56237	Computed tomography—scan of spine, 3 regions cervical, thoracic and lumbosacral, without intravenous contrast medium (R) (K) (Anaes.)	240.00
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) (K) (Anaes.)	351.40
56239	Computed tomography—scan of spine, 3 regions, cervical, thoracic and lumbosacral, without intravenous contrast medium (R) (NK) (Anaes.)	122.45
56240	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) (NK) (Anaes.)	177.45
56259	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) (NK) (Anaes.)	164.80

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Group I2—Computed tomography—Examination

Item	Diagnostic imaging service	Fee ($)
56301	Computed tomography—scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56801 or 57001 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.)	295.00
56307	Computed tomography—scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contrast medium and with any scans of the chest, including lungs, mediastinum, chest wall or pleura and upper abdomen before intravenous contrast injection, when undertaken, not being a service to which item 56807 or 57007 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.)	400.00
56341	Computed tomography—scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56841 or 57041 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.)	149.45
56347	Computed tomography—scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contrast medium and with any scans of the chest, including lungs, mediastinum, chest wall or pleura and upper abdomen before intravenous contrast injection, when undertaken, not being a service to which item 56847 or 57047 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.)	202.00
56401	Computed tomography—scan of upper abdomen only (diaphragm to iliac crest) without intravenous contrast medium, not being a service to which item 56301, 56501, 56801 or 57001 applies (R) (K) (Anaes.)	250.00

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Item	Diagnostic imaging service	Fee ($)
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) (K) (Anaes.)	360.00
56409	Computed tomography—scan of pelvis only (iliac crest to pubic symphysis) without intravenous contrast medium not being a service associated with a service to which item 56401 applies (R) (K) (Anaes.)	250.00
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) (K) (Anaes.)	360.00
56441	Computed tomography—scan of upper abdomen only (diaphragm to iliac crest) without intravenous contrast medium, not being a service to which item 56341, 56541, 56841 or 57041 applies (R) (NK) (Anaes.)	126.80
56447	Computed tomography—scan of upper abdomen only (diaphragm to iliac crest), with intravenous contrast medium, and with any scans of upper abdomen (diaphragm to iliac crest) before intravenous contrast injection, when performed, not being a service to which item 56347, 56547, 56847 or 57047 applies (R) (NK) (Anaes.)	181.50
56449	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 56441 applies (R) (NK) (Anaes.)	126.80
56452	Computed tomography—scan of pelvis only (iliac crest to pubic symphysis), with intravenous contrast medium and with any scans of pelvis (iliac crest to pubic symphysis) before intravenous contrast injection, when undertaken, not being a service to which item 56447 applies (R) (NK) (Anaes.)	181.50
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) (K) (Anaes.)	385.00

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Group I2—Computed tomography—Examination

Item	Diagnostic imaging service	Fee ($)
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) (K) (Anaes.)	480.05
56541	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 56841 or 57041 applies (R) (NK) (Anaes.)	193.15
56547	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 56847 or 57047 applies (R) (NK) (Anaes.)	243.75
56552	Computed tomography—scan of colon for exclusion of colorectal neoplasia in symptomatic or high risk patients if: (a) the patient has had an incomplete colonoscopy in the 3 months before the scan; and (b) the date of incomplete colonoscopy is set out on the request for scan; and (c) the service is not a service to which item 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies (R) (K) (Anaes.)	600.00
56554	Computed tomography—scan of colon for exclusion of colorectal neoplasia in symptomatic or high risk patients if: (a) the request for scan states that one of the following contraindications to colonoscopy is present: (i) suspected perforation of the colon; (ii) complete or high-grade obstruction that will not allow passage of the scope; and (b) the service must not be a service to which item 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies (R) (K) (Anaes.)	600.00
56619	Computed tomography—scan of extremities, one or more regions without intravenous contrast medium (R) (K) (Anaes.)	220.00

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Group I2—Computed tomography—Examination

Item	Diagnostic imaging service	Fee ($)
56625	Computed tomography—scan of extremities, one or more regions with intravenous contrast medium and with any scans of extremities before intravenous contrast injection, when performed (R) (K) (Anaes.)	334.65
56659	Computed tomography—scan of extremities, one or more regions without intravenous contrast medium (R) (NK) (Anaes.)	112.10
56665	Computed tomography—scan of extremities, one or more regions with intravenous contrast medium and with any scans of extremities before intravenous contrast injection, when performed (R) (NK) (Anaes.)	167.40
56801	Computed tomography—scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.)	466.55
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) (K) (Anaes.)	560.00
56841	Computed tomography—scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.)	233.35
56847	Computed tomography—scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck before intravenous contrast injection, when performed, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.)	283.85
57001	Computed tomography—scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.)	466.65

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Item	Diagnostic imaging service	Fee ($)
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) (K) (Anaes.)	567.75
57041	Computed tomography—scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.)	233.40
57047	Computed tomography—scan of brain and chest with or without scans of upper abdomen with intravenous contrast medium and with any scans of brain and chest and upper abdomen before intravenous contrast injection, when performed, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.)	283.90
57201	Computed tomography—pelvimetry (R) (K) (Anaes.)	155.20
57247	Computed tomography—pelvimetry (R) (NK) (Anaes.)	77.55
57341	Computed tomography, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) (K) (Anaes.)	470.00
57345	Computed tomography, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) (NK) (Anaes.)	241.60
57350	Computed tomography—spiral angiography with intravenous contrast medium including any scans performed before intravenous contrast injection—one or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, if: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and	510.00

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Item	Diagnostic imaging service	Fee ($)
	(c) the service has not been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (K) (Anaes.)	
57351	Computed tomography—spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection—one or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, if: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of acute or recurrent pulmonary embolism, acute symptomatic arterial occlusion, post operative complication of arterial surgery, acute ruptured aneurysm, or acute dissection of the aorta, carotid or vertebral artery; and (c) a service to which item 57350 or 57355 applies has been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (K) (Anaes.)	510.00
57355	Computed tomography—spiral angiography with intravenous contrast medium including any scans performed before intravenous contrast injection—one or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, if: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (c) the service has not been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (NK) (Anaes.)	264.15

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Item	Diagnostic imaging service	Fee ($)
57356	Computed tomography—spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection—one or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, if: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of acute or recurrent pulmonary embolism, acute symptomatic arterial occlusion, post operative complication of arterial surgery, acute ruptured aneurysm, or acute dissection of the aorta, carotid or vertebral artery; and (c) the service to which item 57350 or 57355 applies has been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (NK) (Anaes.)	264.15
57360	Computed tomography of the coronary arteries performed on a minimum of a 64 slice (or equivalent) scanner if: (a) the request is made by a specialist or consultant physician; and (b) one of the following applies to the patient: (i) the patient has stable symptoms consistent with coronary ischaemia, is at low to intermediate risk of coronary artery disease and would have been considered for coronary angiography; (ii) the patient requires exclusion of coronary artery anomaly or fistula; (iii) the patient will be undergoing non-coronary cardiac surgery (R) (K) (Anaes.)	700.00
57361	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	350.00

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Item	Diagnostic imaging service	Fee ($)
	(b) one of the following applies to the patient: (i) the patient has stable symptoms consistent with coronary ischaemia, is at low to intermediate risk of coronary artery disease and would have been considered for coronary angiography; (ii) the patient requires exclusion of coronary artery anomaly or fistula; (iii) the patient will be undergoing non-coronary cardiac surgery (R) (NK) (Anaes.)	

Division 2.3 Group I3—Diagnostic radiology

2.3.1 Who must perform diagnostic imaging procedure

(1) For a service mentioned in an item in Subdivision A, C, D or F of this Division, a diagnostic imaging procedure must be performed by:

(a) a medical practitioner; or

(b) a medical radiation practitioner who:

(i) is employed by a medical practitioner; or

(ii) provides the service under the supervision of a medical practitioner in accordance with accepted medical practice.

(2) However, for a service mentioned in items 57901 to 57969, a diagnostic imaging procedure may also be performed by a dental practitioner who:

(a) may request the service because of the operation of subsection 16B (2) of the Act; and

(b) either:

(i) is employed by a medical practitioner; or

(ii) provides the service under the supervision of a medical practitioner in accordance with accepted medical practice.

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(3) Subclauses (1) and (2) do not apply if the procedure is performed:

(a) in RA2, RA3 or RA4; or

(b) both:

(i) in RA1; and

(ii) RRMA4 or RRMA5.

(4) In this clause:

medical radiation practitioner means a person registered or licensed as a medical radiation practitioner under a law of a State or Territory.

RA1 means an inner regional area as classified by the ASGC.

RA2 means an outer regional area as classified by the ASGC.

RA3 means a remote area as classified by the ASGC.

RA4 means a very remote area as classified by the ASGC.

RRMA4 means a small rural centre as classified by the Rural, Remote and Metropolitan Areas Classification.

RRMA5 means a rural centre with an urban centre population of less than 10 000 persons as classified by the Rural, Remote and Metropolitan Areas Classification.

Subdivision A Subgroups 1 to 9 of Group I3

Group I3—Diagnostic radiology

Item	Diagnostic imaging service	Fee ($)
Subgroup 1—Radiographic examination of extremities		
57506	Hand, wrist, forearm, elbow or humerus (NR)	29.75
57509	Hand, wrist, forearm, elbow or humerus (R)	39.75
57512	Hand and wrist, or hand, wrist and forearm, or forearm and elbow, or elbow and humerus (NR)	40.50
57515	Hand and wrist, or hand, wrist and forearm, or forearm and elbow, or elbow and humerus (R)	54.00
57518	Foot, ankle, leg, knee or femur (NR)	32.50
57521	Foot, ankle, leg, knee or femur (R)	43.40

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Group I3—Diagnostic radiology

Item	Diagnostic imaging service	Fee ($)
57524	Foot and ankle, or ankle and leg, or leg and knee, or knee and femur (NR)	49.40
57527	Foot and ankle, or ankle and leg, or leg and knee, or knee and femur (R)	65.75
	Subgroup 2—Radiographic examination of shoulder or pelvis	
57700	Shoulder or scapula (NR)	40.50
57703	Shoulder or scapula (R)	54.00
57706	Clavicle (NR)	32.50
57709	Clavicle (R)	43.40
57712	Hip joint (R)	47.15
57715	Pelvic girdle (R)	60.90
57721	Femur, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (R)	99.25
	Subgroup 3—Radiographic examination of head	
57901	Skull, not in association with item 57902 (R)	64.50
57902	Cephalometry, not in association with item 57901 (R)	64.50
57903	Sinuses (R)	47.30
57906	Mastoids (R)	64.50
57909	Petrous temporal bones (R)	64.50
57912	Facial bones—orbit, maxilla or malar, any or all (R)	47.15
57915	Mandible, not by orthopantomography technique (R)	47.15
57918	Salivary calculus (R)	47.15
57921	Nose (R)	47.15
57924	Eye (R)	47.15
57927	Temporo-mandibular joints (R)	49.65
57930	Teeth—single area (R)	32.90
57933	Teeth—full mouth (R)	78.25
57939	Palato-pharyngeal studies with fluoroscopic screening (R)	64.50
57942	Palato-pharyngeal studies without fluoroscopic screening (R)	49.65

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Group I3—Diagnostic radiology

Item	Diagnostic imaging service	Fee ($)
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)	43.40
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)	47.40
57963	Orthopantomography for diagnosis or management (or both) of any of the following conditions, if the signs and symptoms of the condition is present: (a) impacted teeth; (b) caries; (c) periodontal pathology; (d) periapical pathology (R)	47.40
57966	Orthopantomography for diagnosis or management (or both) of missing or crowded teeth, or developmental anomalies of the teeth or jaws (R)	47.40
57969	Orthopantomography for diagnosis or management (or both) of temporo-mandibular joint arthroses or dysfunction (R)	47.40
Subgroup 4—Radiographic examination of spine		
58100	Spine—cervical (R)	67.15
58103	Spine—thoracic (R)	55.10
58106	Spine—lumbo-sacral (R)	77.00
58108	Spine—4 regions, cervical, thoracic, lumbosacral and sacrococcygeal (R)	110.00
58109	Spine—sacro-coccygeal (R)	47.00
58112	Spine—2 examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R)	97.25
58115	Spine—3 examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R)	110.00
58120	Spine—4 regions, cervical, thoracic, lumbosacral and sacrococcygeal (R), if the service to which item 58120 or 58121 applies has not been performed on the same patient within the same calendar year	110.00

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Group I3—Diagnostic radiology

Item	Diagnostic imaging service	Fee ($)
58121	Spine—3 examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R), if the service to which item 58120 or 58121 applies has not been performed on the same patient within the same calendar year	110.00
	Subgroup 5—Bone age study and skeletal survey	
58300	Bone age study (R)	40.10
58306	Skeletal survey (R)	89.40
	Subgroup 6—Radiographic examination of thoracic region	
58500	Chest (lung fields) by direct radiography (NR)	35.35
58503	Chest (lung fields) by direct radiography (R)	47.15
58506	Chest (lung fields) by direct radiography with fluoroscopic screening (R)	60.75
58509	Thoracic inlet or trachea (R)	39.75
58521	Left ribs, right ribs or sternum (R)	43.40
58524	Left and right ribs, left ribs and sternum, or right ribs and sternum (R)	56.50
58527	Left ribs, right ribs and sternum (R)	69.40
	Subgroup 7—Radiographic examination of urinary tract	
58700	Plain renal only (R)	46.05
58706	Intravenous pyelography, with or without preliminary plain films and with or without tomography (R)	157.90
58715	Antegrade or retrograde pyelography with or without preliminary plain films and with preparation and contrast injection, one side (R)	151.55
58718	Retrograde cystography or retrograde urethrography with or without preliminary plain films and with preparation and contrast injection (R) (Anaes.)	126.10
58721	Retrograde micturating cysto-urethrography, with preparation and contrast injection (R) (Anaes.)	138.25
	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, 58915 or 58924 applies (NR)	35.70

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Group I3—Diagnostic radiology

Item	Diagnostic imaging service	Fee ($)
58903	Plain abdominal only, not being a service associated with a service to which item 58909, 58912, 58915 or 58924 applies (R)	47.60
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)	89.95
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)	110.25
58915	Barium or other opaque meal, small bowel series only, with or without preliminary plain film (R)	78.95
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.)	138.50
58921	Opaque enema, with or without air contrast study and with or without preliminary plain films (R)	135.25
58924	Graham's test (cholecystography), with preliminary plain films and with or without tomography (R)	84.05
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)	76.45
58933	Cholegraphy, percutaneous transhepatic, with or without preliminary plain films and with preparation and contrast injection (R)	205.60
58936	Cholegraphy, drip infusion, with or without preliminary plain films, with preparation and contrast injection and with or without tomography (R)	195.95
58939	Defaecogram (R)	139.30
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)	21.30

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Subdivision B Subgroup 10 of Group I3—Radiographic examination of breasts

2.3.2 Mammography services—eligible services

Items in this Subdivision apply only to a mammography service performed:

(a) under the professional supervision of a specialist in the specialty of diagnostic radiology who is available:
  (i) to monitor and influence the conduct and diagnostic quality of the examination; and
  (ii) if necessary, to attend on the patient personally; or

(b) if paragraph (a) cannot be complied with:
  (i) in an emergency; or
  (ii) because of medical necessity, in a remote location.

Group I3—Diagnostic radiography

Item	Diagnostic imaging service	Fee ($)
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 members of the patient's family; or (b) symptoms or indications of malignancy found on examination of the patient by a medical practitioner (R)	89.50
59303	Mammography of one breast if: (a) the patient is referred with a specific request for a unilateral mammogram; and (b) there is reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on examination of the patient by a medical practitioner (R)	53.95
59306	Mammary ductogram (galactography)—one breast (R)	100.30
59309	Mammary ductogram (galactography)—2 breasts (R)	200.60

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Group I3—Diagnostic radiography

Item	Diagnostic imaging service	Fee ($)
59312	Radiographic examination of both breasts, in conjunction with a surgical procedure on each breast, using interventional techniques (R)	87.00
59314	Radiographic examination of one breast, in conjunction with a surgical procedure using interventional techniques (R)	52.50
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)	47.05

Subdivision C Subgroups 11 to 14 of Group I3

Group I3—Diagnostic radiography

Item	Diagnostic imaging service	Fee ($)
Subgroup 11—Radiographic examination in connection with pregnancy		
59503	Pelvimetry, not being a service associated with a service to which item 57201 applies (R)	89.40
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.)	96.55
59703	Dacryocystography, one side, with or without preliminary plain film and with preparation and contrast injection (R)	75.90
59712	Hysterosalpingography, with or without preliminary plain films and with preparation and contrast injection (R) (Anaes.)	113.70
59715	Bronchography, one side, with or without preliminary plain films and with preparation and contrast injection (R) (Anaes.)	143.55
59718	Phlebography, one side, with or without preliminary plain films and with preparation and contrast injection (R) (Anaes.)	134.65
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.)	226.45

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Group I3—Diagnostic radiography

Item	Diagnostic imaging service	Fee ($)
59733	Sialography, one side, with preparation and contrast injection, not being a service associated with a service to which item 57918 applies (R)	107.70
59736	Vasoepididymography, one side (R)	62.00
59739	Sinogram or fistulogram, one or more regions, with or without preliminary plain films and with preparation and contrast injection (R)	73.75
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)	139.15
59754	Lymphangiography, one or both sides, with preliminary plain films and follow-up radiography and with preparation and contrast injection (R)	219.35
59760	Peritoneogram (herniography) with or without contrast medium including preparation—performed on a person over 14 years of age (R)	115.15
59763	Air insufflation during video—fluoroscopic imaging including associated consultation (R)	133.90
Subgroup 13—Angiography		
59903	Angiocardiography, including the service described in item 59970, 59974 or 61109, not being a service to which item 59912 or 59925 applies (R) (K) (Anaes.)	114.55
59912	Selective coronary arteriography, including the service described in item 59970, 59974 or 61109, not being a service to which item 59903 or 59925 applies (R) (K) (Anaes.)	305.20
59925	Selective coronary arteriography and angiocardiography, including a service described in item 59903, 59912, 59970, 59974 or 61109 (R) (K) (Anaes.)	362.45
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) (K) (Anaes.)	168.30

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Group I3—Diagnostic radiography

Item	Diagnostic imaging service	Fee ($)
59971	Angiocardiography, including the service described in item 59970, 59974 or 61109, not being a service to which item 59972 or 59973 applies (R) (NK) (Anaes.)	57.30
59972	Selective coronary arteriography, including the service described in item 59970, 59974 or 61109, not being a service to which item 59971 or 59973 applies (R) (NK) (Anaes.)	152.60
59973	Selective coronary arteriography and angiocardiography, including a service described in item 59970, 59971, 59972, 59974 or 61109 (R) (NK) (Anaes.)	181.25
59974	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) (NK) (Anaes.)	84.20
60000	Digital subtraction angiography, examination of head and neck with or without arch aortography—1 to 3 data acquisition runs (R) (Anaes.)	564.00
60003	Digital subtraction angiography, examination of head and neck with or without arch aortography—4 to 6 data acquisition runs (R) (Anaes.)	827.10
60006	Digital subtraction angiography, examination of head and neck with or without arch aortography—7 to 9 data acquisition runs (R) (Anaes.)	1176.10
60009	Digital subtraction angiography, examination of head and neck with or without arch aortography—10 or more data acquisition runs (R) (Anaes.)	1376.30
60012	Digital subtraction angiography, examination of thorax—1 to 3 data acquisition runs (R) (Anaes.)	564.00
60015	Digital subtraction angiography, examination of thorax—4 to 6 data acquisition runs (R) (Anaes.)	827.10
60018	Digital subtraction angiography, examination of thorax—7 to 9 data acquisition runs (R) (Anaes.)	1176.10
60021	Digital subtraction angiography, examination of thorax—10 or more data acquisition runs (R) (Anaes.)	1376.30
60024	Digital subtraction angiography, examination of abdomen—1 to 3 data acquisition runs (R) (Anaes.)	564.00

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Group I3—Diagnostic radiography

Item	Diagnostic imaging service	Fee ($)
60027	Digital subtraction angiography, examination of abdomen—4 to 6 data acquisition runs (R) (Anaes.)	827.10
60030	Digital subtraction angiography, examination of abdomen—7 to 9 data acquisition runs (R) (Anaes.)	1176.10
60033	Digital subtraction angiography, examination of abdomen—10 or more data acquisition runs (R) (Anaes.)	1376.30
60036	Digital subtraction angiography, examination of upper limb or limbs—1 to 3 data acquisition runs (R) (Anaes.)	564.00
60039	Digital subtraction angiography, examination of upper limb or limbs—4 to 6 data acquisition runs (R) (Anaes.)	827.10
60042	Digital subtraction angiography, examination of upper limb or limbs—7 to 9 data acquisition runs (R) (Anaes.)	1176.10
60045	Digital subtraction angiography, examination of upper limb or limbs—10 or more data acquisition runs (R) (Anaes.)	1376.30
60048	Digital subtraction angiography, examination of lower limb or limbs—1 to 3 data acquisition runs (R) (Anaes.)	564.00
60051	Digital subtraction angiography, examination of lower limb or limbs—4 to 6 data acquisition runs (R) (Anaes.)	827.10
60054	Digital subtraction angiography, examination of lower limb or limbs—7 to 9 data acquisition runs (R) (Anaes.)	1176.10
60057	Digital subtraction angiography, examination of lower limb or limbs—10 or more data acquisition runs (R) (Anaes.)	1376.30
60060	Digital subtraction angiography, examination of aorta and lower limb or limbs—1 to 3 data acquisition runs (R) (Anaes.)	564.00
60063	Digital subtraction angiography, examination of aorta and lower limb or limbs—4 to 6 data acquisition runs (R) (Anaes.)	827.10
60066	Digital subtraction angiography, examination of aorta and lower limb or limbs—7 to 9 data acquisition runs (R) (Anaes.)	1176.10
60069	Digital subtraction angiography, examination of aorta and lower limb or limbs—10 or more data acquisition runs (R) (Anaes.)	1376.30
60072	Selective arteriography or selective venography by digital subtraction angiography technique—one vessel (NR) (Anaes.)	48.10

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Group I3—Diagnostic radiography

Item	Diagnostic imaging service	Fee ($)
60075	Selective arteriography or selective venography by digital subtraction angiography technique—2 vessels (NR) (Anaes.)	96.10
60078	Selective arteriography or selective venography by digital subtraction angiography technique—3 or more vessels (NR) (Anaes.)	144.25
Subgroup 14—Tomography		
60100	Tomography of any region (R) (Anaes.)	60.75

Subdivision D Subgroup 15 of Group I3—Fluoroscopic examination

Group I3—Diagnostic radiography

Item	Diagnostic imaging service	Fee ($)
Subgroup 15—Fluoroscopic examination		
60500	Fluoroscopy, with general anaesthesia (not being a service associated with a radiographic examination) (R) (Anaes.)	43.40
60503	Fluoroscopy, without general anaesthesia (not being a service associated with a radiographic examination) (R)	29.75
60506	Fluoroscopy using a mobile image intensifier, in conjunction with a surgical procedure lasting less than 1 hour, not being a service associated with a service to which another item in this table applies (R)	63.75
60509	Fluoroscopy using a mobile image intensifier, in conjunction with a surgical procedure lasting 1 hour or more, not being a service associated with a service to which another item in this table applies (R)	98.90

Subdivision E Subgroup 16 of Group I3—Preparation for radiological procedure

2.3.3 Preparation of patients for radiological procedures

Items in this Subdivision apply only to the preparation of a patient for a radiological procedure for a service to which any of items 59903 to 59974 apply by:

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(a) injecting opaque or contrast media; or
(b) removing fluid and replacing it with air, oxygen or other contrast media; or
(c) a similar method.

Group I3—Diagnostic radiography

Item	Diagnostic imaging service	Fee ($)
Subgroup 16—Preparation for radiological procedure		
60918	Arteriography (peripheral) or phlebography—one vessel, when used in association with a service to which item 59903, 59912, 59925, 59970, 59971, 59972, 59973 or 59974 applies, not being a service associated with a service to which any of items 60000 to 60078 apply (NR) (Anaes.)	47.15
60927	Selective arteriogram or phlebogram, when used in association with a service to which item 59903, 59912, 59925, 59970, 59971, 59972, 59973 or 59974 applies, not being a service associated with a service to which any of items 60000 to 60078 apply (NR) (Anaes.)	38.05

Subdivision F Subgroup 17 of Group I3—Interventional techniques

2.3.4 Meaning of *angiography suite* in item 61109

In item 61109:

angiography suite means a room that contains only equipment designed for angiography that is able to perform digital subtraction or rapid-sequence film angiography.

Group I3—Diagnostic radiography

Item	Diagnostic imaging service	Fee ($)
Subgroup 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 table applies (R)	258.90

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Division 2.4 Group I4—Nuclear medicine imaging

2.4.1 Nuclear scanning services—other than PET

Items 61302 to 61505 and item 61650 apply only if:

(a) the performance of the service does not involve the use of positron-emission radio-isotopes or a PET scanner; and

(b) the service is performed:

(i) by a specialist or consultant physician whose name is included in a register, given to the Chief Executive Medicare by the JNMCAC, of participants in the Joint Nuclear Medicine Specialist Credentialling Program of the JNMCAC; or

(ii) by a person acting on behalf of a specialist or consultant physician mentioned in subparagraph (i); and

(c) the final report of the service is compiled by the specialist or consultant physician who performed the preliminary examination of the patient and the estimation and administration of the dosage of radiopharmaceuticals.

2.4.2 PET nuclear scanning services

(1) Items 61523 to 61646 apply only if the service is performed on a person:

(a) at the written request of a specialist or consultant physician (the ***requesting practitioner***) if:

(i) the person is the requesting practitioner's patient; and

(ii) the requesting practitioner decides that the service is necessary; and

(b) in a comprehensive facility; and

(c) in accordance with clause 2.4.3 and 2.4.4.

(2) Also, the items apply only if the owner or operator of the equipment used to perform the service is not in breach of clause 2.4.5.

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2.4.3 PET nuclear scanning services—performance under personal supervision

(1) For clause 2.4.2, the service must be performed on a person by or under the personal supervision of:

(a) a credentialled specialist other than the requesting practitioner; or

(b) a medical practitioner other than the requesting practitioner if the medical practitioner:

(i) is a Fellow of the RACP or RANZCR; and

(ii) has reported 400 or more studies forming part of PET services for which a medicare benefit was payable; and

(iii) is authorised under State or Territory law to prescribe and administer to humans the PET radiopharmaceuticals that are to be administered to the person; and

(iv) met the requirements of subparagraphs (i), (ii) and (iii) before 1 November 2011.

(2) In this clause:

requesting practitioner has the same meaning as in paragraph 2.4.2 (1) (a).

2.4.4 PET nuclear scanning services—equipment

For clause 2.4.2, the service must be performed on a person using equipment that meets the following requirements:

(a) the *Requirements for PET Accreditation (Instrumentation & Radiation Safety)* dated 4 May 2007 issued by the Australian and New Zealand Society of Nuclear Medicine Inc;

(b) the NEMA Standards Publication NU 2-2007, *Performance Measurements of Positron Emission Tomographs*, published by the National Electrical Manufacturers Association (USA).

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2.4.5 PET nuclear scanning services—statutory declaration

(1) The owner or operator mentioned in subclause 2.4.2 (2) must have given a statutory declaration to the Chief Executive Medicare that includes the following information:

(a) whether the owner or operator is a credentialled specialist or a medical practitioner who satisfies the requirements mentioned in subparagraphs 2.4.3 (1) (b) (i) to (iv);

(b) whether the place where the owner or operator provides the service in a comprehensive facility;

(c) whether the equipment meets the requirements mentioned in clause 2.4.4;

(d) the facility's address;

(e) the provider number for the facility given by the Chief Executive Medicare;

(f) the location specific practice number for the facility given by the Minister;

(g) the models, serial numbers and manufacturers of the equipment.

(2) If the matters declared in the statutory declaration change, the owner or operator must give the Chief Executive Medicare written notice of the change as soon as the owner or operator knows about the change.

Group I4—Nuclear medicine imaging

Item	Diagnostic imaging service	Fee ($)
61302	Single stress or rest myocardial perfusion study—planar imaging (R)	448.85
61303	Single stress or rest myocardial perfusion study—with single photon emission tomography and with planar imaging when performed (R)	565.30
61306	Combined stress and rest, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion—planar imaging (R)	709.70

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Group I4—Nuclear medicine imaging

Item	Diagnostic imaging service	Fee ($)
61307	Combined stress and rest, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion—with single photon emission tomography and with planar imaging when performed (R)	834.90
61310	Myocardial infarct-avid-study, with planar imaging and single photon emission tomography, or planar imaging or single photon emission tomography (R)	367.30
61313	Gated cardiac blood pool study, (equilibrium), with planar imaging and single photon emission tomography, or planar imaging or single photon emission tomography (R)	303.35
61314	Gated cardiac blood pool study, and first pass blood flow or cardiac shunt study, with planar imaging and single photon emission tomography, or planar imaging, or single photon emission tomography (R)	420.00
61316	Gated cardiac blood pool study, with intervention, with planar imaging and single photon emission tomography, or planar imaging, or single photon emission tomography (R)	381.15
61317	Gated cardiac blood pool study, with intervention and first pass blood flow study or cardiac shunt study, with planar imaging and single photon emission tomography or planar imaging, or single photon emission tomography (R)	492.40
61320	Cardiac first pass blood flow study or cardiac shunt study, not being a service to which another item in this group applies (R)	228.90
61328	Lung perfusion study, with planar imaging and single photon emission tomography or planar imaging, or single photon emission tomography (R)	227.65
61340	Lung ventilation study using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography or planar imaging or single photon emission tomography (R)	253.00
61348	Lung perfusion study and lung ventilation study using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography, or planar imaging, or single photon emission tomography (R)	443.35
61352	Liver and spleen study (colloid)—planar imaging (R)	259.35

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Group I4—Nuclear medicine imaging

Item	Diagnostic imaging service	Fee ($)
61353	Liver and spleen study (colloid), with single photon emission tomography and with planar imaging when performed (R)	386.60
61356	Red blood cell spleen or liver study, including single photon emission tomography when performed (R)	392.80
61360	Hepatobiliary study, including morphine administration or pre-treatment with cholecystokinin (CCK) when performed (R)	403.35
61361	Hepatobiliary study with formal quantification following baseline imaging, using an infusion of cholecystokinin (CCK) (R)	461.40
61364	Bowel haemorrhage study (R)	496.95
61368	Meckel's diverticulum study (R)	223.10
61369	Indium-labelled octreotide study, including single photon emission tomography when undertaken, if: (a) a gastro-entero-pancreatic endocrine tumour is suspected, based on biochemical evidence, with negative or equivocal conventional imaging; or (b) a surgically amenable gastro-entero-pancreatic endocrine tumour has been identified based on conventional techniques, to exclude additional disease sites (R)	2015.75
61372	Salivary study (R)	223.10
61373	Gastro-oesophageal reflux study, including delayed imaging on a separate occasion when performed (R)	489.70
61376	Oesophageal clearance study (R)	143.35
61381	Gastric emptying study, using single tracer (R)	574.35
61383	Combined solid and liquid gastric emptying study using dual isotope technique or the same isotope on separate days (R)	624.95
61384	Radionuclide colonic transit study (R)	687.70
61386	Renal study, including perfusion and renogram images and computer analysis or cortical study with planar imaging (R)	332.50
61387	Renal cortical study, with single photon emission tomography and planar quantification (R)	430.75
61389	Single renal study with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R)	370.55

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Group I4—Nuclear medicine imaging

Item	Diagnostic imaging service	Fee ($)
61390	Renal study with diuretic administration following a baseline study (R)	409.95
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)	605.50
61397	Cystoureterogram (R)	246.85
61401	Testicular study (R)	162.30
61402	Cerebral perfusion study, with single photon emission tomography and with planar imaging when performed (R)	605.05
61405	Brain study with blood brain barrier agent, with planar imaging and single photon emission tomography, or planar imaging, or single photon emission tomography (R)	346.00
61409	Cerebro-spinal fluid transport study, with imaging on 2 or more separate occasions (R)	873.50
61413	Cerebro-spinal fluid shunt patency study (R)	225.95
61417	Dynamic blood flow study or regional blood volume quantitative study, not being a service associated with a service to which another item in this group applies (R)	118.85
61421	Bone study—whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R)	479.80
61425	Bone study—whole body and single photon emission tomography, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R)	600.70
61426	Whole body study using iodine (R)	554.80
61429	Whole body study using gallium (R)	543.00
61430	Whole body study using gallium, with single photon emission tomography (R)	659.45
61433	Whole body study using cells labelled with technetium (R)	496.95
61434	Whole body study using cells labelled with technetium, with single photon emission tomography (R)	615.40
61437	Whole body study using thallium (R)	542.75

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Group I4—Nuclear medicine imaging

Item	Diagnostic imaging service	Fee ($)
61438	Whole body study using thallium, with single photon emission tomography (R)	672.95
61441	Bone marrow study—whole body using technetium labelled bone marrow agents (R)	489.70
61442	Whole body study, using gallium—with single photon emission tomography of 2 or more body regions acquired separately (R)	752.35
61445	Bone marrow study—localised using technetium labelled agent (R)	286.80
61446	Localised bone or joint study, including when undertaken, blood flow, blood pool and repeat imaging on a separate occasion (R)	333.55
61449	Localised bone or joint study and single photon emission tomography, including when undertaken, blood flow, blood pool and imaging on a separate occasion (R)	456.20
61450	Localised study using gallium (R)	397.55
61453	Localised study using gallium, with single photon emission tomography (R)	514.70
61454	Localised study using cells labelled with technetium (R)	348.10
61457	Localised study using cells labelled with technetium, with single photon emission tomography (R)	470.45
61458	Localised study using thallium (R)	396.95
61461	Localised study using thallium, with single photon emission tomography (R)	527.85
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, 61484 or 61485, if there is no additional administration of radiopharmaceutical and if the previous radionuclide scan was abnormal or equivocal (R)	129.00
61465	Venography (R)	265.50
61469	Lymphoscintigraphy (R)	348.10
61473	Thyroid study including uptake measurement when performed (R)	175.40

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Group I4—Nuclear medicine imaging

Item	Diagnostic imaging service	Fee ($)
61480	Parathyroid study, planar imaging and single photon emission tomography when performed (R)	386.85
61484	Adrenal study (R)	880.85
61485	Adrenal study, with single photon emission tomography (R)	999.20
61495	Tear duct study (R)	223.10
61499	Particle perfusion study (infra-arterial) or Le Veen shunt study (R)	253.00
61505	CT scan performed at the same time and covering the same body area as single photon emission tomography for the purpose of anatomic localisation or attenuation correction if no separate diagnostic CT report is issued and only in association with items 61302 to 61650 (R)	100.00
61523	Whole body FDG PET study, performed for evaluation of a solitary pulmonary nodule, if: (a) the nodule is considered unsuitable for transthoracic fine needle aspiration biopsy; or (b) an attempt at pathological characterisation has failed (R)	953.00
61529	Whole body FDG PET study, performed for the staging of proven non-small cell lung cancer, if curative surgery or radiotherapy is planned (R)	953.00
61538	FDG PET study of the brain for evaluation of suspected residual or recurrent malignant brain tumour based on anatomical imaging findings, after definitive therapy (or during ongoing chemotherapy) in patients who are considered suitable for further active therapy (R)	901.00
61541	Whole body FDG PET study, following initial therapy, performed for the evaluation of suspected residual, metastatic or recurrent colorectal carcinoma in a patient considered suitable for active therapy (R)	953.00
61553	Whole body FDG PET study, following initial therapy, performed for the evaluation of suspected metastatic or recurrent malignant melanoma in a patient considered suitable for active therapy (R)	999.00
61559	FDG PET study of the brain, performed for the evaluation of refractory epilepsy, that is being evaluated for surgery (R)	918.00

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Group I4—Nuclear medicine imaging

Item	Diagnostic imaging service	Fee ($)
61565	Whole body FDG PET study, following initial therapy, performed for the evaluation of suspected residual, metastatic or recurrent ovarian carcinoma in a patient considered suitable for active therapy (R)	953.00
61571	Whole body FDG PET study for the further primary staging of patients with histologically proven carcinoma of the uterine cervix, at FIGO stage IB2 or greater by conventional staging, prior to planned radical radiation therapy or combined modality therapy with curative intent (R)	953.00
61575	Whole body FDG PET study for the further staging of patients with confirmed local recurrence of carcinoma of the uterine cervix considered suitable for salvage pelvic chemoradiotherapy or pelvic exenteration with curative intent (R)	953.00
61577	Whole body FDG PET study, performed for the staging of proven oesophageal or GEJ carcinoma, in a patient considered suitable for active therapy (R)	953.00
61598	Whole body FDG PET study performed for the staging of biopsy-proven, newly-diagnosed or recurrent head and neck cancer (R)	953.00
61604	Whole body FDG PET study performed for the evaluation of a patient with suspected residual head and neck cancer after definitive treatment, and who is suitable for active therapy (R)	953.00
61610	Whole body FDG PET study performed for the evaluation of metastatic squamous cell carcinoma of unknown primary site involving cervical nodes (R)	953.00
61616	Whole body FDG PET study for the initial staging of indolent non-Hodgkin's lymphoma if: (a) clinical, pathological and imaging findings indicated that the stage is I or IIA; and (b) the proposed management is definitive radiotherapy with curative intent (R)	953.00
61620	Whole body FDG PET study for the initial staging of newly diagnosed or previously untreated Hodgkin's or non-Hodgkin's lymphoma (excluding indolent non-Hodgkin's lymphoma) (R)	953.00

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Group I4—Nuclear medicine imaging

Item	Diagnostic imaging service	Fee ($)
61622	Whole body FDG PET study to assess response to first line therapy either during treatment or within 3 months of completing definitive first line treatment for Hodgkin's or non-Hodgkin's lymphoma (excluding indolent non-Hodgkin's lymphoma) (R)	953.00
61628	Whole body FDG PET study for restaging following confirmation of recurrence of Hodgkin's or non-Hodgkin's lymphoma (excluding indolent non-Hodgkin's lymphoma) (R)	953.00
61632	Whole body FDG PET study to assess response to second-line chemotherapy if stem cell transplantation is being considered for Hodgkin's or non-Hodgkin's lymphoma (excluding indolent non-Hodgkin's lymphoma) (R)	953.00
61640	Whole body FDG PET study for initial staging of a patient with biopsy-proven bone or soft tissue sarcoma (excluding gastrointestinal stromal tumour) considered by conventional staging to be potentially curable (R)	999.00
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)	999.00
61650	LeukoScan study of the long bones and feet for suspected osteomyelitis, if patient does not have access to ex-vivo white blood cell scanning (R) *Note* LeukoScan is only indicated for diagnostic imaging in a patient suspected of infection of the long bones and feet, including those with diabetic ulcers. The descriptor does not cover a patient who is being investigated for other sites of infection.	878.70

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Division 2.5 Group I5—Magnetic resonance imaging

Subdivision A General

2.5.1 MRI and MRA services—eligible services

(1) Items 63001 to 63482 apply to an MRI or MRA service performed:

(a) at the request of a specialist or consultant physician in accordance with clause 2.5.2; and

(b) in a permissible circumstance mentioned in clause 2.5.3; and

(c) using eligible equipment mentioned in clause 2.5.5.

(2) Items 63464 to 63476 also apply to an MRI service performed:

(a) at the request of a specialist or consultant physician in accordance with clause 2.5.2; and

(b) in a permissible circumstance mentioned in clause 2.5.3; and

(c) using partial eligible equipment mentioned in clause 2.5.6.

(3) Items 63491 to 63497 apply to an MRI or MRA service performed:

(a) at the request of a medical practitioner in accordance with clause 2.5.2; and

(b) in a permissible circumstance mentioned in clause 2.5.3; and

(c) using:

(i) eligible equipment mentioned in clause 2.5.5; or

(ii) partial eligible equipment mentioned in clause 2.5.6.

(4) Items 63507 to 63522 apply to an MRI service performed:

(a) at the request of a medical practitioner other than a specialist or consultant physician in accordance with clause 2.5.2; and

(b) in a permissible circumstance mentioned in clause 2.5.3; and

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(c) using:
(i) eligible equipment mentioned in clause 2.5.5; or
(ii) partial eligible equipment mentioned in clause 2.5.6.

2.5.2 MRI and MRA services—request

For clause 2.5.1, a request must:
(a) be made in writing; and
(b) identify the clinical indications for the service.

2.5.3 MRI and MRA services—permissible circumstances for performance

A service is performed in a permissible circumstance only if it is:
(a) for clause 2.5.1—both:
(i) performed 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
(ii) reported by an eligible provider; or
(b) for clause 2.5.1 performed:
(i) in an emergency; or
(ii) because of medical necessity, in a remote location.

2.5.4 MRI and MRA services—eligible provider

For clause 2.5.3, the table sets out ***eligible providers*** for an MRI or MRA service.

Item	Person
1	A specialist in diagnostic radiology who satisfies the Chief Executive Medicare that he or she is a participant in the Royal Australian and New Zealand College of Radiologists' Quality and Accreditation Program

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2.5.5 MRI and MRA services—eligible equipment

For clause 2.5.1, the table sets out ***eligible equipment*** for an MRI or MRA service.

Item	Equipment
1	Equipment that: (a) is located at premises of a comprehensive practice; and (b) is made available to the practice by a person: (i) who is subject to a deed with the Commonwealth that relates to the equipment; and (ii) for whom the deed has not been terminated; and (c) is not identified as partial eligible equipment in the deed

2.5.6 MRI and MRA services—partial eligible equipment

For clause 2.5.1, the table sets out ***partial eligible equipment*** for an MRI or MRA service.

Item	Equipment
1	Equipment that: (a) is located at premises of a comprehensive practice; and (b) is made available to the practice by a person: (i) who is subject to a deed with the Commonwealth that relates to the equipment; and (ii) for whom the deed has not been terminated; and (c) is identified as partial eligible equipment in the deed

2.5.7 MRI and MRA services—meaning of *scan*

In items 63001 to 63522:

scan means a minimum of 3 sequences.

2.5.8 MRI and MRA services—multiple services

(1) If an MRI service described in an item in Subgroup 1, 2, 4, 5 or 14 of Group I5 in the table in Subdivision B, and an MRA service described in an item in Subgroup 3 or 15 of that table, are provided to the same person on the same day, only the fee

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specified in the item in Subgroup 1, 2, 4, 5 or 14 applies to the services.

(2) If a medical practitioner provides 2 or more MRI services described in Subgroup 12 or 13 of Group I5 in the table in Subdivision B for the same patient on the same day, the fees specified for the items that apply to the services, other than the item with the highest fee, are reduced by 50%.

(3) For subclause (2):

(a) if 2 or more applicable fees are equally the highest, one only of those fees is taken to be the highest fee; and

(b) if a reduced fee calculated under subclause (2) is not a multiple of 5 cents, the reduced fee is taken to be the nearest amount that is a multiple of 5 cents.

2.5.9 MRI or MRA services—related services that can be claimed in a 12 month period

(1) An MRI or MRA item mentioned in column 2 of the table in subclause (2) does not apply to the service described in that item if the service is provided to a person who, in the 12 months before the service, has been provided with the maximum number of those services mentioned in column 3 of the table for that item.

(2) For subclause (1), the items and maximum number of services are:

Item	MRI or MRA items	Maximum number of services
1	63040 to 63073	3
2	63101	3
3	63125 to 63131	3
4	63161 to 63185	3
5	63219 to 63243	3
6	63271 to 63280	3
7	63322 to 63340	3
8	63361	2

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Item	MRI or MRA items	Maximum number of services
9	63385 to 63391	2
10	63401 and 63404	3
11	63416	1
12	63425 and 63428	2
13	63461, 63464 and 63467	1
14	63482	3
15	63507 to 63522	3

Subdivision B Subgroups 1 to 19 of Group I5

Group I5—Magnetic resonance imaging

Item	Diagnostic imaging service	Fee ($)
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) (Anaes.) (Contrast)	403.20
63004	MRI—scan of head (including MRA, if performed) for inflammation of brain or meninges (R) (Anaes.) (Contrast)	403.20
63007	MRI—scan of head (including MRA, if performed) for skull base or orbital tumour (R) (Anaes.) (Contrast)	403.20
63010	MRI—scan of head (including MRA, if performed) for stereotactic scan of brain, with fiducials in place, for the sole purpose of allowing planning for stereotactic neurosurgery (R) (Anaes.) (Contrast)	336.00
Subgroup 2—Scan of head—for specified conditions		
63040	MRI—scan of head (including MRA, if performed) for acoustic neuroma (R) (Anaes.) (Contrast)	336.00
63043	MRI—scan of head (including MRA, if performed) for pituitary tumour (R) (Anaes.) (Contrast)	358.40
63046	MRI—scan of head (including MRA, if performed) for toxic or metabolic or ischaemic encephalopathy (R) (Anaes.) (Contrast)	403.20
63049	MRI—scan of head (including MRA, if performed) for demyelinating disease of the brain (R) (Anaes.) (Contrast)	403.20

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Group I5—Magnetic resonance imaging

Item	Diagnostic imaging service	Fee ($)
63052	MRI—scan of head (including MRA, if performed) for congenital malformation of the brain or meninges (R) (Anaes.) (Contrast)	403.20
63055	MRI—scan of head (including MRA, if performed) for venous sinus thrombosis (R) (Anaes.) (Contrast)	403.20
63058	MRI—scan of head (including MRA, if performed) for head trauma (R) (Anaes.) (Contrast)	403.20
63061	MRI—scan of head (including MRA, if performed) for epilepsy (R) (Anaes.) (Contrast)	403.20
63064	MRI—scan of head (including MRA, if performed) for stroke (R) (Anaes.) (Contrast)	403.20
63067	MRI—scan of head (including MRA, if performed) for carotid or vertebral artery dissection (R) (Anaes.) (Contrast)	403.20
63070	MRI—scan of head (including MRA, if performed) for intracranial aneurysm (R) (Anaes.) (Contrast)	403.20
63073	MRI—scan of head (including MRA, if performed) for intracranial arteriovenous malformation (R) (Anaes.) (Contrast)	403.20
	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) (Anaes.) (Contrast)	492.80
	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) (Anaes.) (Contrast)	492.80
63114	MRI—scan of head and cervical spine (including MRA, if performed) for inflammation of the central nervous system or meninges (R) (Anaes.) (Contrast)	492.80
	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) (Anaes.) (Contrast)	492.80
63128	MRI—scan of head and cervical spine (including MRA, if performed) for congenital malformation of the central nervous system or meninges (R) (Anaes.) (Contrast)	492.80

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Group I5—Magnetic resonance imaging

Item	Diagnostic imaging service	Fee ($)
63131	MRI—scan of head and cervical spine (including MRA, if performed) for syrinx (congenital or acquired) (R) (Anaes.) (Contrast)	492.80
	Subgroup 6—Scan of spine—one region or 2 contiguous regions—for specified conditions	
63151	MRI—scan of one region or 2 contiguous regions of the spine for infection (R) (Anaes.) (Contrast)	358.40
63154	MRI—scan of one region or 2 contiguous regions of the spine for tumour (R) (Anaes.) (Contrast)	358.40
	Subgroup 7—Scan of spine—one region or 2 contiguous regions—for specified conditions	
63161	MRI—scan of one region or 2 contiguous regions of the spine for demyelinating disease (R) (Anaes.) (Contrast)	358.40
63164	MRI—scan of one region or 2 contiguous regions of the spine for congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Anaes.) (Contrast)	358.40
63167	MRI—scan of one region or 2 contiguous regions of the spine for myelopathy (R) (Anaes.) (Contrast)	358.40
63170	MRI—scan of one region or 2 contiguous regions of the spine for syrinx (congenital or acquired) (R) (Anaes.) (Contrast)	358.40
63173	MRI—scan of one region or 2 contiguous regions of the spine for cervical radiculopathy (R) (Anaes.) (Contrast)	358.40
63176	MRI—scan of one region or 2 contiguous regions of the spine for sciatica (R) (Anaes.) (Contrast)	358.40
63179	MRI—scan of one region or 2 contiguous regions of the spine for spinal canal stenosis (R) (Anaes.) (Contrast)	358.40
63182	MRI—scan of one region or 2 contiguous regions of the spine for previous spinal surgery (R) (Anaes.) (Contrast)	358.40
63185	MRI—scan of one region or 2 contiguous regions of the spine for trauma (R) (Anaes.)	358.40
	Subgroup 8—Scan of spine—3 contiguous or 2 non-contiguous regions—for specified conditions	
63201	MRI—scan of 3 contiguous or 2 non-contiguous regions of the spine for infection (R) (Anaes.) (Contrast)	448.00

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Group I5—Magnetic resonance imaging

Item	Diagnostic imaging service	Fee ($)
63204	MRI—scan of 3 contiguous or 2 non-contiguous regions of the spine for tumour (R) (Anaes.) (Contrast)	448.00
Subgroup 9—Scan of spine—3 contiguous or 2 non-contiguous regions—for specified conditions		
63219	MRI—scan of 3 contiguous or 2 non-contiguous regions of the spine for demyelinating disease (R) (Anaes.) (Contrast)	448.00
63222	MRI—scan of 3 contiguous or 2 non-contiguous regions of the spine for congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Anaes.) (Contrast)	448.00
63225	MRI—scan of 3 contiguous or 2 non-contiguous regions of the spine for myelopathy (R) (Anaes.) (Contrast)	448.00
63228	MRI—scan of 3 contiguous or 2 non-contiguous regions of the spine for syrinx (congenital or acquired) (R) (Anaes.) (Contrast)	448.00
63231	MRI—scan of 3 contiguous or 2 non-contiguous regions of the spine for cervical radiculopathy (R) (Anaes.) (Contrast)	448.00
63234	MRI—scan of 3 contiguous or 2 non-contiguous regions of the spine for sciatica (R) (Anaes.) (Contrast)	448.00
63237	MRI—scan of 3 contiguous or 2 non-contiguous regions of the spine for spinal canal stenosis (R) (Anaes.) (Contrast)	448.00
63240	MRI—scan of 3 contiguous or 2 non-contiguous regions of the spine for previous spinal surgery (R) (Anaes.) (Contrast)	448.00
63243	MRI—scan of 3 contiguous or 2 non-contiguous regions of the spine for trauma (R) (Anaes.)	448.00
Subgroup 10—Scan of cervical spine and brachial plexus—for specified conditions		
63271	MRI—Scan of cervical spine and brachial plexus for tumour (R) (Anaes.) (Contrast)	492.80
63274	MRI—Scan of cervical spine and brachial plexus for trauma (R) (Anaes.) (Contrast)	492.80
63277	MRI—Scan of cervical spine and brachial plexus for cervical radiculopathy (R) (Anaes.) (Contrast)	492.80
63280	MRI—Scan of cervical spine and brachial plexus for previous surgery (R) (Anaes.) (Contrast)	492.80

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Group I5—Magnetic resonance imaging

Item	Diagnostic imaging service	Fee ($)
Subgroup 11—Scan of musculoskeletal system—for specified conditions		
63301	MRI—scan of musculoskeletal system for tumour arising in bone or musculoskeletal system, excluding tumours arising in breast, prostate or rectum (R) (Anaes.) (Contrast)	380.80
63304	MRI—scan of musculoskeletal system for infection arising in bone or musculoskeletal system, excluding infection arising in breast, prostate or rectum (R) (Anaes.) (Contrast)	380.80
63307	MRI—scan of musculoskeletal system for osteonecrosis (R) (Anaes.) (Contrast)	380.80
Subgroup 12—Scan of musculoskeletal system—for specified conditions		
63322	MRI—scan of musculoskeletal system for derangement of hip or its supporting structures (R) (Anaes.) (Contrast)	403.20
63325	MRI—scan of musculoskeletal system for derangement of shoulder or its supporting structures (R) (Anaes.) (Contrast)	403.20
63328	MRI—scan of musculoskeletal system for derangement of knee or its supporting structures (R) (Anaes.) (Contrast)	403.20
63331	MRI—scan of musculoskeletal system for derangement of ankle or foot (or both) or its supporting structures (R) (Anaes.) (Contrast)	403.20
63334	MRI—scan of musculoskeletal system for derangement of one or both temporomandibular joints or their supporting structures (R) (Anaes.) (Contrast)	336.00
63337	MRI—scan of musculoskeletal system for derangement of wrist or hand (or both) or its supporting structures (R) (Anaes.) (Contrast)	448.00
63340	MRI—scan of musculoskeletal system for derangement of elbow or its supporting structures (R) (Anaes.) (Contrast)	403.20
Subgroup 13—Scan of musculoskeletal system—for specified conditions		
63361	MRI—scan of musculoskeletal system for Gaucher disease (R) (Anaes.)	403.20
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) (Anaes.) (Contrast)	448.00
63388	MRI—scan of cardiovascular system for tumour of the heart or a great vessel (R) (Anaes.) (Contrast)	448.00

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Group I5—Magnetic resonance imaging

Item	Diagnostic imaging service	Fee ($)
63391	MRI—scan of cardiovascular system for abnormality of thoracic aorta (R) (Anaes.) (Contrast)	403.20
	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) (Anaes.) (Contrast)	403.20
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) (Anaes.) (Contrast)	403.20
	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) (Anaes.) (Contrast)	403.20
	Subgroup 17—Magnetic resonance imaging—for specified conditions—person under the age of 16 years	
63425	MRI—scan of person under the age of 16 for post-inflammatory or post-traumatic physeal fusion (R) (Anaes.)	403.20
63428	MRI—scan of person under the age of 16 for Gaucher disease (R) (Anaes.)	403.20
	Subgroup 18—Magnetic resonance imaging—for specified conditions—person under the age of 16 years	
63440	MRI—scan of person under the age of 16 for pelvic or abdominal mass (R) (Anaes.) (Contrast)	403.20
63443	MRI—scan of person under the age of 16 for mediastinal mass (R) (Anaes.) (Contrast)	403.20
63446	MRI—scan of person under the age of 16 for congenital uterine or anorectal abnormality (R) (Anaes.) (Contrast)	403.20
	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.)	358.40

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Group I5—Magnetic resonance imaging

Item	Diagnostic imaging service	Fee ($)
63464	MRI—scan of both breasts for the detection of cancer, if a dedicated breast coil is used, the request for scan identifies that the woman is asymptomatic and is younger than 50 years of age, and the request for the scan identifies: (a) that the patient is at high risk of developing breast cancer, due to one of the following: (i) 3 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer; (ii) 2 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer, if any of the following applies to at least one of the relatives: (A) has been diagnosed with bilateral breast cancer; (B) had onset of breast cancer before the age of 40 years; (C) had onset of ovarian cancer before the age of 50 years; (D) has been diagnosed with breast and ovarian cancer, at the same time or at different times; (E) has Ashkenazi Jewish ancestry; (F) is a male relative who has been diagnosed with breast cancer; (iii) one first or second degree relative diagnosed with breast cancer at age 45 years or younger, and another first or second degree relative on the same side of the family with bone or soft tissue sarcoma at age 45 years or younger; or (b) that genetic testing has identified the presence of a high risk breast cancer gene mutation (R) (Anaes.)	690.00
63467	MRI—scan of both breasts for the detection of cancer, if: (a) a dedicated breast coil is used; and (b) the woman has had an abnormality detected as a result of a service described in item 63464 performed in the previous 12 months (R) (Anaes.)	690.00

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Subdivision C Subgroup 20 of Group I5—Scans of pelvis and upper abdomen—for specified conditions

2.5.10 MRI services—limit for items 63470 and 63473

(1) Item 63470 does not apply to the service described in that item if the person to whom the service is provided has previously been provided with that service or a service described in item 63473.

(2) Item 63473 does not apply to the service described in that item if the person to whom the service is provided has previously been provided with that service or a service described in item 63470.

2.5.11 MRI and MRA services—modifying items

(1) Subject to subclauses (2), (3) and (4), if item 63491, 63494 or 63497 applies to an MRI or MRA service, the fee specified in that item applies in addition to the fee specified in the other item in Group I5 of this table that applies to the service.

(2) If 2 or more MRI or MRA services described in item 63494 are performed for a person on the same day, the fee specified in that item applies to one of those services only.

(3) If 2 or more MRI or MRA services described in item 63497 are performed for a person on the same day, the fee specified in that item applies to one of those services only.

(4) If:

(a) one or more MRI or MRA services described in item 63494; and

(b) one or more MRI or MRA services described in item 63497;

are performed for a person on the same day, the fee specified in item 63494 or item 63497, but not both those items, applies to one of those services only.

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Group I5—Magnetic resonance imaging

Item	Diagnostic imaging service	Fee ($)
Subgroup 20—Scans of pelvis and upper abdomen—for specified conditions		
63470	MRI—scan of the pelvis for the staging of histologically diagnosed cervical cancer at FIGO stage 1B or greater, if the request for scan identifies that: (a) a histological diagnosis of carcinoma of the cervix has been made; and (b) the patient has been diagnosed with cervical cancer at FIGO stage 1B or greater (R) (Anaes.) (Contrast)	403.20
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 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) (Anaes.) (Contrast)	627.20
63476	MRI—scan of the pelvis for the initial staging of rectal cancer, if: (a) a phased array body coil is used; and (b) the request for scan identifies that the indication is for the initial staging of rectal cancer (including cancer of the rectosigmoid and anorectum) (R) (Anaes.) (Contrast)	403.20

Subdivision D Subgroups 21 and 22 of Group I5

Group I5—Magnetic resonance imaging

Item	Diagnostic imaging service	Fee ($)
Subgroup 21—Scan of body—for specified conditions		
63482	MRI—scan of pancreas and biliary tree for suspected biliary or pancreatic pathology (R) (Anaes.)	403.20

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Group I5—Magnetic resonance imaging

Item	Diagnostic imaging service	Fee ($)
Subgroup 22—Modifying items		
63491	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 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	44.80
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 in accordance with clause 2.5.1; and (b) the service is performed on a person using intravenous or intra muscular sedation	44.80
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 in accordance with clause 2.5.1; and (b) the service is performed on a person under anaesthetic in the presence of a medical practitioner who is qualified to perform an anaesthetic	156.80

Note Subgroups 23 to 32 of this table are set out in a determination made under subsection 3C (1) of the Act.

Subdivision E Subgroup 33 of Group I5

Group I5—Magnetic resonance imaging

Item	Diagnostic imaging service	Fee ($)
Subgroup 33 —Scan of body—for specified conditions		
63507	MRI—scan of head for a patient under 16 years if the service is for: (a) an unexplained seizure (R) (Anaes.) (Contrast); or (b) an unexplained headache if significant pathology is suspected (R) (Anaes.) (Contrast); or (c) paranasal sinus pathology that has not responded to conservative therapy (R) (Anaes.) (Contrast)	403.20

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Group I5—Magnetic resonance imaging

Item	Diagnostic imaging service	Fee ($)
63510	MRI—scan of spine following radiographic examination for a patient under 16 years if the service is for: (a) significant trauma (R) (Anaes.) (Contrast); or (b) unexplained neck or back pain with associated neurological signs (R) (Anaes.) (Contrast); or (c) unexplained back pain if significant pathology is suspected (R) (Anaes.) (Contrast)	448.00
63513	MRI—scan of knee following radiographic examination for internal joint derangement for a patient under 16 years (R) (Anaes.) (Contrast)	403.20
63516	MRI—scan of hip following radiographic examination for a patient under 16 years if any of the following is suspected: (a) septic arthritis (R) (Anaes.) (Contrast); (b) slipped capital femoral epiphysis (R) (Anaes.) (Contrast); (c) Perthes disease (R) (Anaes.) (Contrast)	403.20
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) (Anaes.) (Contrast)	403.20
63522	MRI—scan of wrist following radiographic examination for a patient under 16 years if a scaphoid fracture is suspected (R) (Anaes.) (Contrast)	448.00

Division 2.6 Group I6—Management of bulk-billed services

2.6.1 Application of items 64990 and 64991

(1) If the diagnostic imaging service described in item 64991 is provided to a person, either that item or item 64990, but not both those items, applies to the service.

(2) If item 64990 or 64991 applies to a diagnostic imaging service, the fee specified in that item applies in addition to the fee specified in any other item in this table that applies to the service.

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(3) For items 64990 and 64991:

Commonwealth concession card holder 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 diagnostic imaging 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 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.

(4) For item 64991:

practice location, for the provision of a diagnostic imaging service, means the place of practice for which the medical practitioner by whom, or on whose behalf, the service is provided, has been allocated a provider number by the Chief Executive Medicare.

regional, rural or remote area means an area classified as RRMAs 3-7 under the Rural, Remote and Metropolitan Areas Classification.

SLA means a Statistical Local Area specified in the ASGC.

SSD means a Statistical Subdivision specified in the ASGC.

Group I6—Management of bulk-billed services

Item	Diagnostic imaging service	Fee ($)
64990	A diagnostic imaging service to which an item in this table (other than this item or item 64991) 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 for the fees for: (i) this item; and (ii) the other item in this table applying to the service	7.05

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Group I6—Management of bulk-billed services

Item	Diagnostic imaging service	Fee ($)
64991	A diagnostic imaging service to which an item in this table (other than this item or item 64990) 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 for 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: (i) a regional, rural or remote area; or (ii) Tasmania; or (iii) a geographical area included in any of the following SSD spatial units: (A) Beaudesert Shire Part A; (B) Belconnen; (C) Darwin City; (D) Eastern Outer Melbourne; (E) East Metropolitan Perth; (F) Frankston City; (G) Gosford-Wyong; (H) Greater Geelong City Part A; (I) Gungahlin-Hall; (J) Ipswich City (Part in BSD); (K) Litchfield Shire; (L) Melton-Wyndham; (M) Mornington Peninsula Shire; (N) Newcastle; (O) North Canberra; (P) Palmerston-East Arm; (Q) Pine Rivers Shire; (R) Queanbeyan; (S) South Canberra; (T) South Eastern Outer Melbourne; (U) Southern Adelaide; (V) South West Metropolitan Perth; (W) Thuringowa City Part A;	10.65

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Group I6—Management of bulk-billed services

Item	Diagnostic imaging service	Fee ($)
	(X) Townsville City Part A; (Y) Tuggeranong; (Z) Weston Creek–Stromlo; (ZA) Woden Valley; (ZB) Yarra Ranges Shire Part A; or (iv) the geographical area included in the SLA spatial unit of Palm Island (AC)	

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Dictionary

(Anaes.)—see clause 2.43.5 of Schedule 1 to the general medical services table.

(K)—see clause 1.2.4 of Schedule 1.

(NK)—see clause 1.2.4 of Schedule 1.

(NR)—see clause 1.2.1 of Schedule 1.

(R)—see clause 1.2.1 of Schedule 1.

Act means the *Health Insurance Act 1973*.

angiography suite—see clause 2.3.4 of Schedule 1.

ANZAPNM means the Australian and New Zealand Association of Physicians in Nuclear Medicine (ABN 99 665 425 983).

ASGC means the document titled *Australian Standard Geographical Classification (ASGC)* (ABS catalogue number 1216.0), published by the Australian Statistician in July 2010.

Note The AGSC is available at www.abs.gov.au.

bulk-billed, for a service, means:

(a) a medicare benefit is payable to a person in relation to the service; and

(b) under an agreement entered into under section 20A of the Act:

(i) the person assigns to the eligible provider by whom, or on whose behalf, the service is provided, his or her right to the payment of the medicare benefit; and

(ii) the eligible provider accepts the assignment in full payment of his or her fee for the service provided.

Commonwealth concession card holder for items 64990 and 64991—see clause 2.6.1 of Schedule 1.

comprehensive facility means a building or part of a building, or more than one building, where all of the following services are performed (whether or not other services are also performed):

(a) PET;

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(b) computed tomography;
(c) diagnostic ultrasound;
(d) medical oncology;
(e) radiation oncology;
(f) surgical oncology;
(g) x-ray.

comprehensive practice means 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).

computed tomography means a service performed (with or without intravenous contrast):

(a) using a detector coupled to an x-ray tube that emits a finely collimated x-ray beam as it rotates within a gantry around a patient either in incremental or helical manner; and
(b) registering a resulting variable amount of x-rays and transforming that information into a cross-sectional image after the application of complex algorithms.

concessional beneficiary for Group I5—see clause 2.5.1 of Schedule 1.

consultation—see clause 1.2.7 of Schedule 1.

credentialled specialist means a specialist or consultant physician 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.

CT means computed tomography.

CT equipment includes the following components:

(a) a gantry;
(b) a couch;
(c) a computer;
(d) an operator station;
(e) a generator.

eligible equipment for Group I5—see clause 2.5.5 of Schedule 1

eligible provider for Group I5—see clause 2.5.4 of Schedule 1.

FDG means ^{18}F-fluorodeoxyglucose.

GEJ means gastro-oesophageal junction.

Group—for a Group in the table, means every item in the Group.

group of practitioners has the same meaning as in subsection 16A (10) of the Act.

highest fee—see clause 1.2.7 of Schedule 1.

item means:

(a) an item mentioned, by number, in column 1 of a table in:
  (i) Schedule 1; or
  (ii) Schedule 1 to the pathology services table; or
  (iii) Schedule 1 to the general medical services table; and

(b) in a reference immediately followed by a number—the item so numbered.

Example

A reference by number to any of items 11240, 11603 to 11612, 30361 and 30488 is a reference to the item so numbered in the general medical services table.

JNMCAC means the Joint Nuclear Medicine Credentialling and Accreditation Committee of the RACP and RANZCR.

MRA means magnetic resonance angiography.

MRI means magnetic resonance imaging.

medical radiation practitioner—see subclause 2.3.1 (4) of Schedule 1.

non-consultation services—see clause 1.2.7 of Schedule 1.

non-metropolitan hospital means a hospital that is located outside the Sydney, Melbourne, Brisbane, Adelaide, Perth, Greater Hobart, Darwin and Canberra major statistical divisions, as defined in the *Australian Standard Geographical Classification (ASGC)* (ABS catalogue number 1216.0), published by the Australian Statistician in July 2010.

partial eligible equipment for Group I5—see clause 2.5.6 of Schedule 1

PET means positron emission tomography.

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practice location for item 64991—see clause 2.6.1 of Schedule 1.

***professional service*—**see subsection 3 (1) of the Act.

providing practitioner, for a service mentioned in an item in Group I1 of Part 2, means the medical practitioner by whom, or under whose supervision or direction, the service was performed.

RRMA4—see subclause 2.3.1 (4) of Schedule 1.

RRMA5—see subclause 2.3.1 (4) of Schedule 1.

RA1—see subclause 2.3.1 (4) of Schedule 1.

RA2—see subclause 2.3.1 (4) of Schedule 1.

RA3—see subclause 2.3.1 (4) of Schedule 1.

RA4—see subclause 2.3.1 (4) of Schedule 1.

RACP means The Royal Australasian College of Physicians (ABN 90 270 343 237).

RANZCR means The Royal Australian and New Zealand College of Radiologists (ABN 37 000 029 863).

regional, rural or remote area for item 64991—see clause 2.6.1 of Schedule 1.

registered sonographer means a person whose name is entered on the Register of Sonographers kept by the Chief Executive Medicare.

remote location means a place within Australia that is more than 30 kilometres by road from:

(a) a hospital that provides a radiology or computed tomography service under the direction of a specialist in the specialty of diagnostic radiology; or

(b) a free-standing radiology or computed tomography facility under the direction of a specialist in the specialty of diagnostic radiology.

report means a report prepared by a medical practitioner.

Rural, Remote and Metropolitan Areas Classification has the meaning given by the general medical services table.

scan for items 63001 to 63482—see clause 2.5.7 of Schedule 1.

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sequence, for a scan, means a series of images collected at the same time with similar image parameters (not including a scan designed to establish patient position and subsequently used to plan other scans).

SLA for item 64991—see clause 2.6.1 of Schedule 1.

SSD for item 64991—see clause 2.6.1 of Schedule 1.

Subgroup for a Subgroup in the table, means every item in the Subgroup.

unreferred service for items 64990 and 64991—see clause 2.6.1 of Schedule 1.

Note Several other words and expressions used in this regulation have a meaning given by subsection 3 (1) of the Act, for example:

- diagnostic imaging service
- general medical services table
- participating midwife
- participating nurse practitioner
- pathology services table
- practitioner
- specialist.

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Notes to the *Health Insurance (Diagnostic Imaging Services Table) Regulation 2012*

Note 1

The *Health Insurance (Diagnostic Imaging Services Table) Regulation 2012* (in force under the *Health Insurance Act 1973*) as shown in this compilation comprise Select Legislative Instrument 2012 No. 243 amended as indicated in the Tables below.

Table of Instruments

Year and Number	Date of FRLI registration	Date of commencement	Application, saving or transitional provisions
2012 No. 234	26 Oct 2012 (*see* F2012L02093)	1 Nov 2012	
2012 No. 295	11 Dec 2012 (*see* F2012L02399)	12 Dec 2012	—

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Table of Amendments

ad. = added or inserted am. = amended rep. = repealed rs. = repealed and substituted

Provision affected	How affected
s. 2	rep. LIA s. 48D
s. 3	rep. LIA s. 48C
Schedule 1	
Part 2	
Division 2.5	
Subdiv. E	am. 2012 No. 295

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