Health Insurance (General Medical Services Table) Regulation 2013

Select Legislative Instrument No. 248, 2013

I, Quentin Bryce AC CVO, Governor-General of the Commonwealth of Australia, acting with the advice of the Federal Executive Council, make the following regulation under the *Health Insurance Act 1973*.

Dated 21 November 2013

Quentin Bryce
Governor-General

By Her Excellency's Command

Peter Dutton
Minister for Health

OPC60087 - C

Contents

1 Name of regulation

This regulation is the *Health Insurance (General Medical Services Table) Regulation 2013*.

2 Commencement

This regulation commences on the day after it is registered.

3 Authority

This regulation is made under the *Health Insurance Act 1973*.

4 Schedule(s)

Each instrument that is specified in a Schedule to this instrument is amended or repealed as set out in the applicable items in the Schedule concerned, and any other item in a Schedule to this instrument has effect according to its terms.

5 General medical services table

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

6 Dictionary

The Dictionary in Part 3 of Schedule 1 defines certain words and expressions that are used in this regulation, and includes references to certain words and expressions that are defined elsewhere in this regulation.

Schedule 1—General medical services table

Note: See section 5.

Part 1—Preliminary

Division 1.1—Interpretation

1.1.1 Meaning of *eligible non-vocationally recognised medical practitioner*

(1) In the table:

eligible non-vocationally recognised medical practitioner means:

(a) a medical practitioner (including an overseas trained practitioner or a temporary resident medical practitioner) who:

(i) is registered as a medical practitioner under the Rural Other Medical Practitioners' Program; and

(ii) is providing general medical services in accordance with that Program; or

(b) a medical practitioner who:

(i) is registered as a medical practitioner under the Outer Metropolitan (Other Medical Practitioners) Relocation Incentive Program; and

(ii) is providing general medical services in accordance with that Program; and

(iii) is not vocationally registered under section 3F of the Act, but is required under that Program to undertake additional training or other activities:

(A) that could enable vocational registration within 4 years or, on written application, 5 years, after commencing the training or other activities; and

(B) of which the Chief Executive Medicare has written notice; or

(c) a medical practitioner who:

(i) is registered as a medical practitioner under the MedicarePlus for Other Medical Practitioners Program; and

(ii) is providing general medical services in accordance with that Program; and

(iii) is not vocationally registered under section 3F of the Act; or

(d) a medical practitioner who:

(i) is registered as a medical practitioner under the After Hours Other Medical Practitioners Program; and

(ii) is providing general medical services in accordance with that Program; and

(iii) is not vocationally registered under section 3F of the Act.

(2) In subclause (1):

After Hours Other Medical Practitioners Program means a program administered by the Chief Executive Medicare that, for medical services provided in accordance with the Program, provides a particular level of medicare benefits.

MedicarePlus for Other Medical Practitioners Program means a program administered by the Chief Executive Medicare that, for medical services provided in accordance with the Program, provides a particular level of medicare benefits.

Outer Metropolitan (Other Medical Practitioners) Relocation Incentive Program means a program administered by the Department that, for medical services provided in accordance with the Program, provides a particular level of medicare benefits.

Rural Other Medical Practitioners' Program means a program administered by the Chief Executive Medicare that, for medical services provided in accordance with the Program, provides a particular level of medicare benefits.

1.1.1A Meaning of *general practitioner*

In the table:

general practitioner means:

(a) a practitioner who is vocationally registered under section 3F of the Act; or

(b) a practitioner who:

(i) is a Fellow of the RACGP; and

(ii) participates in the quality assurance and continuing medical education program of the RACGP; and

(iii) meets the RACGP requirements for quality assurance and continuing education; or

(c) a practitioner in relation to whom a determination is in force under regulation 6DA of the *Health Insurance Regulations 1975* recognising that he or she meets the fellowship standards of the ACRRM; or

(d) a practitioner who is undertaking a placement in general practice that is approved by the RACGP:

(i) as part of a training program for general practice leading to the award of Fellowship of the RACGP; or

(ii) as part of another training program recognised by the RACGP as being of an equivalent standard; or

(e) an eligible non-vocationally recognised medical practitioner; or

(f) a practitioner who is undertaking a placement in general practice as part of the Pre-vocational General Practice Placements Program administered by the GPET; or

(g) a practitioner who is undertaking a placement in general practice as part of the Remote Vocational Training Scheme administered by Remote Vocational Training Scheme Limited.

1.1.2 Meaning of *multidisciplinary case conference*

A ***multidisciplinary case conference*** means a process by which a multidisciplinary case conference team carries out all of the following activities:

(a) discussing a patient's history;

(b) identifying the patient's multidisciplinary care needs;

(c) identifying outcomes to be achieved by members of the multidisciplinary case conference team giving care and service to the patient;
(d) identifying tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the multidisciplinary case conference team;
(e) assessing whether previously identified outcomes (if any) have been achieved.

1.1.3 Meaning of *multidisciplinary case conference team*

(1) A multidisciplinary case conference team for a patient:
(a) includes a medical practitioner; and
(b) either:
(i) for items 735 to 758—includes at least 2 other members; or
(ii) for an item mentioned in subclause (3)—includes at least 3 other members; and
(c) may also include a family member of the patient.

(2) For the members mentioned in paragraph (b):
(a) each member must provide a different kind of care or service to the patient; and
(b) each member must not be a family carer of the patient; and
(c) one member may be another medical practitioner.

Example: Other members may be allied health professionals, home and community service providers and care organisers, including the following:
(a) Aboriginal health workers;
(b) asthma educators;
(c) audiologists;
(d) dental therapists;
(e) dentists;
(f) diabetes educators;
(g) dieticians;
(h) mental health workers;
(i) occupational therapists;
(j) optometrists;
(k) orthoptists;

(l) orthotists or prosthetists;
(m) pharmacists;
(n) physiotherapists;
(o) podiatrists;
(p) psychologists;
(q) registered nurses;
(r) social workers;
(s) speech pathologists;
(t) education providers;
(u) "meals on wheels" providers;
(v) personal care workers;
(w) probation officers.

(3) For subparagraph (1)(b)(ii), the items are items 820, 822, 823, 830, 832, 834, 2946, 2949, 2954, 2978, 2984, 2988, 3032, 3040, 3044, 3069 and 3074.

1.1.4 Meaning of *single course of treatment*

(1) Use this clause for:
(a) items 104 to 131, 133, 384 to 388, 2799, 2801 to 2840, 3003, 3005 to 3028, 6004, 6007 to 6015, 16401, 16404, 16406, 51700 and 51703; and
(b) the meaning of ***attendance*** in clause 1.1.1; and
(c) the meaning of symbol ***(S)*** in clause 1.1.10; and
(d) the definition of ***minor attendance*** in the Dictionary.

(2) A single course of treatment for a patient:
(a) includes:
(i) the initial attendance on the patient by a specialist or consultant physician; and
(ii) the continuing management or treatment up to and including the stage when the patient is referred back to the care of the referring practitioner; and
(iii) any subsequent review of the patient's condition by the specialist or consultant physician that may be necessary, whether the review is initiated by the referring practitioner or by the specialist or consultant physician; but

(b) does not include:

(i) referral of the patient to the specialist or consultant physician; or

(ii) an attendance (the ***later attendance***) on the patient by the specialist or consultant physician, after the end of the period of validity of the last referral to have application under regulation 31 of the *Health Insurance Regulations 1975* if:

(A) the referring practitioner considers the later attendance necessary for the patient's condition to be reviewed; and

(B) the patient was most recently attended by the specialist or consultant physician more than 9 months before the later attendance.

1.1.5 Meaning of symbol *(G)*

An item including the symbol ***(G)*** applies only to a service not provided by a specialist in the practice of his or her specialty.

1.1.6 Meaning of symbol *(H)*

An item including the symbol ***(H)*** applies only to a service performed or provided in a hospital.

1.1.7 Meaning of symbol *(S)*

(1) An item including the symbol ***(S)*** applies only to a service performed by a specialist in the practice of his or her specialty, if:

(a) the service is:

(i) provided to a patient who has been referred to the specialist; and

(ii) the first service performed by the specialist in accordance with the referral; or

(b) the service is:

(i) provided to a patient who has been referred to the specialist; and

(ii) part of a single course of treatment given for the condition identified in the referral or, if no condition was identified in the referral, part of a single course of treatment for the condition identified by the specialist; and

(iii) provided within the period of validity of the referral that is applicable under regulation 31 of the *Health Insurance Regulations 1975*; or

(c) the service is:

(i) provided to a patient who has declared that a written referral completed by a named referring practitioner has been lost, stolen or destroyed before the service was provided; and

(ii) the first service performed by the specialist in accordance with the referral; or

(d) the service is:

(i) provided to a patient who has not been referred to the specialist; and

(ii) a service that, in an emergency, the specialist decides is necessary in the patient's interests to be provided as soon as practicable without a referral.

(2) In this clause:

emergency has the same meaning as in subregulation 30(5) of the *Health Insurance Regulations 1975*.

Division 1.2—General application provisions

1.2.1 Application

An item in Part 2 does not apply to a service provided in contravention of a law of the Commonwealth, a State or Territory.

1.2.2 Attendance by specialist or consultant physician

(1) Use this clause for items 99 to 137, 141 to 149, 288 to 389, 2799, 2801 to 2840, 3003, 3005 to 3028, 6004, 6007 to 6016, 13210, 16399, 16401, 16404, 17609 and 17640 to 17655.

(2) An attendance on a patient by a specialist or consultant physician:

(a) includes an attendance on a patient if:

(i) the patient declares that a written referral of the patient was completed by a medical practitioner; or

(ii) in an emergency, the patient has not been referred to the specialist, or consultant physician, if the specialist or consultant physician decides that it is necessary in the patient's interests to provide the service mentioned in the item as soon as practicable without a referral; but

(b) does not include an attendance on a patient if:

(i) the attendance forms part of a single course of treatment for the patient in which the first service was provided to the patient more than 12 months (or another period, if any, set by the referring practitioner in, or in connection with, the referral) before the attendance; and

(ii) a later referral has not been made.

(3) In this clause:

emergency has the same meaning as in subregulation 30(5) of the *Health Insurance Regulations 1975*.

1.2.3 Professional attendance services

(1) Use this clause for items 3 to 338, 348 to 389, 410 to 417, 501 to 600, 900, 903, 2497 to 2840, 3003, 3005 to 3028, 5000 to 5267, 6004, 6007 to 6016, 10900 to 10929, 13210, 16399, 16401, 16404, 16406, 16590, 16591 and 17609 to 17690.

(2) A professional attendance includes the provision, for a patient, of any of the following services:

(a) evaluating the patient's condition or conditions including, if applicable, evaluation using a health screening service mentioned in subsection 19(5) of the Act;

(b) formulating a plan for the management and, if applicable, for the treatment of the patient's condition or conditions;

(c) giving advice to the patient about the patient's condition or conditions and, if applicable, about treatment;

(d) if authorised by the patient—giving advice to another person, or other persons, about the patient's condition or conditions and, if applicable, about treatment;

(e) providing appropriate preventive health care;

(f) recording the clinical details of the service or services provided to the patient.

(3) However, a professional attendance does not include the supply of a vaccine to a patient if:

(a) the vaccine is supplied to the patient in connection with a professional attendance mentioned in any of items 3 to 96 and 5000 to 5267; and

(b) the cost of the vaccine is not subsidised by the Commonwealth or a State.

1.2.4 Personal attendance by medical practitioners generally

(1) Use this clause for items 3 to 149, 173 to 338, 348 to 536, 597 to 600, 2100 to 2220, 2497 to 2840, 3003, 3005 to 3028, 4001 to 10816, 11012 to 11021, 11212, 11304, 11500, 11600, 11627, 11701, 11724, 11921 to 12003, 12201, 13030 to 13112, 13209, 13210, 13290 to 13700, 13815 to 13888, 14100 to 14200, 14203 to 14212, 14224, 15600, 16003 to 16512 and 16515 to 51318.

(2) The item applies to a service provided in the course of a personal attendance by a single medical practitioner on a single patient on a single occasion.

(3) A personal attendance by the medical practitioner on the patient includes any of the following:
  (a) a telepsychiatry consultation to which any of items 353 to 361 applies;
  (b) the planning, management and supervision of the patient on home dialysis to which item 13104 applies;
  (c) participating in a video conferencing consultation referred to in items 99, 112 to 114, 149, 288, 384, 389, 2100, 2122, 2125, 2126, 2137, 2138, 2143, 2147, 2179, 2195, 2199, 2220, 2799, 2820, 3003, 3015, 6004, 6016, 13210, 16399 and 17609.

1.2.5 Personal attendance by medical practitioners

(1) Use this clause for items 3 to 723, 732, 900 to 10816, 11012 to 11021, 11212, 11304, 11500, 11600, 11627, 11701, 11722, 11724, 11820, 11823, 11921, 12000, 12003, 12201, 13030 to 13112, 13209, 13210, 13290 to 13700, 13815 to 13888, 14100 to 14200, 14203 to 14212, 14224, 15600, 16003 to 16512, 16515 to 51318.

(2) The item applies to a service provided during a personal attendance by:
  (a) a medical practitioner (other than a medical practitioner employed by the proprietor of a hospital that is not a private hospital); or
  (b) a medical practitioner who:
    (i) is employed by the proprietor of a hospital that is not a private hospital; and
    (ii) provides the service otherwise than in the course of employment by that proprietor.

(3) Subclause (2) applies whether or not another person provides essential assistance to the medical practitioner in accordance with accepted medical practice.

(4) A personal attendance by the medical practitioner on the patient includes any of the following:

(a) a telepsychiatry consultation to which any of items 353 to 361 applies;

(b) the planning, management and supervision of the patient on home dialysis to which item 13104 applies;

(c) participating in a video conferencing consultation referred to in items 99, 112 to 114, 149, 288, 384, 389, 2100, 2122, 2125, 2126, 2137, 2138, 2143, 2147, 2179, 2195, 2199, 2220, 2799, 2820, 3003, 3015, 6004, 6016, 13210, 16399 and 17609.

1.2.6 Consultant occupational physician

A fee specified for an attendance by a consultant occupational physician applies only if the attendance relates to one or more of the following matters:

(a) evaluating and assessing a patient's rehabilitation requirements when, in the consultant's opinion, the patient has an accepted medical condition that:

(i) may be affected by the patient's working environment; or

(ii) affects the patient's capacity to be employed;

(b) managing an accepted medical condition that, in the consultant's opinion, may affect a patient's capacity for continued employment, or return to employment, following a non-compensable accident, injury or ill-health;

(c) evaluating and forming an opinion about, including management as the case requires, a patient's medical condition when causation may be related to acute or chronic exposure to scientifically acknowledged environmental hazards or toxins.

1.2.7 Application of items 3 to 10943

Items 3 to 10943 do not apply to a service mentioned in the item if the service is provided at the same time as, or in connection with, a non-medicare service.

1.2.8 Services that may be provided by persons other than medical practitioners

(1) Use this clause for items 10983 to 10989, 10997, 11000, 11003, 11004, 11005, 11006, 11009, 11024, 11027, 11200, 11203, 11204, 11205, 11210, 11211, 11215, 11218, 11221, 11222, 11224, 11225, 11235, 11237, 11240, 11241, 11242, 11243, 11244, 11300, 11303, 11306, 11309, 11312, 11315, 11318, 11321, 11324, 11327, 11330, 11332, 11333, 11336, 11339, 11503, 11506, 11509, 11512, 11602, 11604, 11605, 11610, 11611, 11612, 11614, 11615, 11700, 11702, 11708, 11709, 11710, 11711, 11712, 11713, 11715, 11718, 11721, 11727, 11800, 11810, 11830, 11833, 11900, 11903, 11906, 11909, 11912, 11915, 11919, 12012, 12015, 12018, 12021, 12200, 12203, 12207, 12210, 12213, 12215, 12217, 12250, 12500 to 12530, 13015, 13020, 13025, 13200 to 13203, 13206, 13212, 13215, 13218, 13221, 13703, 13706, 13709, 13750, 13755, 13757, 13760, 13915 to 13948, 14050, 14053, 14218, 14221, 15000 to 15336, 15339 to 15357, 15500 to 15539 and 16514.

(2) The item applies whether the medical service is given by:

(a) a medical practitioner; or

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

(i) is employed by a medical practitioner; or

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

1.2.9 Meaning of *participating in a video conferencing consultation*

A medical practitioner is ***participating in a video conferencing consultation*** if the medical practitioner attends a patient who is receiving a service under an item in the table from a specialist or consultant physician who is providing the service:

(a) in relation to his or her speciality to the patient; and

(b) by way of a video conferencing consultation.

Part 2—Services and fees

Division 2.1—Groups A1 to A10

Note: Groups A1 to A10 include Groups A1, A2, A3, A4, A28, A5, A6, A7, A8, A12, A13, A21, A11, A14, A15, A17, A18, A19, A20, A24, A27, A22, A23, A26, A9 and A10.

2.1.1 Meaning of *amount under clause 2.1.1*

In an item of the table mentioned in column 1 of table 2.1.1:

amount under clause 2.1.1 means the sum of:

(a) the fee mentioned in column 2 for the item; and

(b) either:

(i) if a practitioner attends not more than 6 patients in a single attendance—the amount mentioned in column 3 for the item, divided by the number of patients attended; or

(ii) if a practitioner attends more than 6 patients in a single attendance—the amount mentioned in column 4 for the item.

Table 2.1.1—Amount under clause 2.1.1

Item	Column 1 Item/s of the table	Column 2 Fee	Column 3 Amount if not more than 6 patients (to be divided by the number of patients) ($)	Column 4 Amount if more than 6 patients ($)
1	4	The fee for item 3	25.45	1.95
2	20	The fee for item 3	45.80	3.25
3	24	The fee for item 23	25.45	1.95
4	35	The fee for item 23	45.80	3.25
5	37	The fee for item 36	25.45	1.95
6	43	The fee for item 36	45.80	3.25

Table 2.1.1—Amount under clause 2.1.1

Item	Column 1 Item/s of the table	Column 2 Fee	Column 3 Amount if not more than 6 patients (to be divided by the number of patients) ($)	Column 4 Amount if more than 6 patients ($)
7	47	The fee for item 44	25.45	1.95
8	51	The fee for item 44	45.80	3.25
9	58	$8.50	15.50	0.70
10	59, 2610, 2631, 2673	$16.00	17.50	0.70
11	60, 2613, 2633, 2675	$35.50	15.50	0.70
12	65, 2616, 2635, 2677	$57.50	15.50	0.70
13	92	$8.50	27.95	1.25
14	93	$16.00	31.55	1.25
15	95	$35.50	27.95	1.25
16	96	$57.50	27.95	1.25
17	195	The fee for item 193	25.45	1.95
18	414	The fee for item 410	25.45	1.95
19	415	The fee for item 411	25.45	1.95
20	416	The fee for item 412	25.45	1.95
21	417	The fee for item 413	25.45	1.95
22	2503	The fee for item 2501	25.45	1.95
23	2506	The fee for item 2504	25.45	1.95
24	2509	The fee for item 2507	25.45	1.95
25	2518	The fee for item 2517	25.45	1.95
26	2522	The fee for item 2521	25.45	1.95
27	2526	The fee for item 2525	25.45	1.95
28	2547	The fee for item 2546	25.45	1.95

Table 2.1.1—Amount under clause 2.1.1

Item	Column 1 Item/s of the table	Column 2 Fee	Column 3 Amount if not more than 6 patients (to be divided by the number of patients) ($)	Column 4 Amount if more than 6 patients ($)
29	2553	The fee for item 2552	25.45	1.95
30	2559	The fee for item 2558	25.45	1.95
31	5003	The fee for item 5000	25.45	1.95
32	5010	The fee for item 5000	45.80	3.25
33	5023	The fee for item 5020	25.45	1.95
34	5028	The fee for item 5020	45.80	3.25
35	5043	The fee for item 5040	25.45	1.95
36	5049	The fee for item 5040	45.80	3.25
37	5063	The fee for item 5060	25.45	1.95
38	5067	The fee for item 5060	45.80	3.25
39	5220	$18.50	15.50	0.70
40	5223	$26.00	17.50	0.70
41	5227	$45.50	15.50	0.70
42	5228	$67.50	15.50	0.70
43	5260	$18.50	27.95	1.25
44	5263	$26.00	31.55	1.25
45	5265	$45.50	27.95	1.25
46	5267	$67.50	27.95	1.25

Division 2.2—Group A1: General practitioner attendances to which no other item applies

Group A1—General practitioner attendances to which no other item applies		
Item	**Description**	**Fee**
3	Professional attendance at consulting rooms (other than a service to which another item applies) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management—each attendance	$16.60
4	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies) that requires a short patient history and, if necessary, limited examination and management—an attendance on one or more patients at one place on one occasion—each patient	Amount under clause 2.1.1
20	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in a residential aged care facility (other than accommodation in a self-contained unit) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1
23	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation;	$36.30

Group A1—General practitioner attendances to which no other item applies		
Item	**Description**	**Fee**
	(d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—each attendance	
24	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one place on one occasion—each patient	Amount under clause 2.1.1
35	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1
36	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant:	$70.30

Group A1—General practitioner attendances to which no other item applies		
Item	**Description**	**Fee**
	(a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—each attendance	
37	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one place on one occasion—each patient	Amount under clause 2.1.1
43	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1

Group A1—General practitioner attendances to which no other item applies		
Item	**Description**	**Fee**
44	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—each attendance	$103.50
47	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one place on one occasion—each patient	Amount under clause 2.1.1

Group A1—General practitioner attendances to which no other item applies		
Item	**Description**	**Fee**
51	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1

Division 2.3—Group A2: Other non-referred attendances to which no other item applies

2.3.1 Effect of determination under section 106TA of Act

(1) This clause applies to a general practitioner, if:

(a) the practitioner is the subject of a final determination that is in force under section 106TA of the Act; and

(b) the determination contains a direction, given under subparagraph 106U(1)(g)(i) of the Act, that the practitioner be disqualified for a professional service; and

(c) the determination states that the practitioner is disqualified for a service mentioned in an item in Group A1; and

(d) the practitioner provides a service mentioned in an item in Group A2.

(2) The determination applies to the service mentioned in paragraph (1)(d).

Group A2—Other non-referred attendances to which no other item applies		
Item	**Description**	**Fee**
52	Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which any other item applies)—each attendance, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies	$11.00
53	Professional attendance at consulting rooms of more than 5 minutes in duration but not more than 25 minutes (other than a service to which any other item applies)—each attendance, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies	$21.00
54	Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45 minutes (other than	$38.00

Group A2—Other non-referred attendances to which no other item applies		
Item	**Description**	**Fee**
	a service to which any other item applies)—each attendance, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies	
57	Professional attendance at consulting rooms of more than 45 minutes in duration (other than a service to which any other item applies)—each attendance, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies	$61.00
58	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies), not more than 5 minutes in duration—an attendance on one or more patients at one place on one occasion—each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies	Amount under clause 2.1.1
59	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 5 minutes in duration but not more than 25 minutes—an attendance on one or more patients at one place on one occasion—each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies	Amount under clause 2.1.1
60	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 25 minutes in duration but not more than 45 minutes—an attendance on one or more patients at one place on one occasion—each patient, by:	Amount under clause 2.1.1

Group A2—Other non-referred attendances to which no other item applies		
Item	**Description**	**Fee**
	(a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies	
65	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 45 minutes in duration—an attendance on one or more patients at one place on one occasion—each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies	Amount under clause 2.1.1
92	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self-contained unit) of not more than 5 minutes in duration—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies	Amount under clause 2.1.1
93	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self-contained unit) of more than 5 minutes in duration but not more than 25 minutes—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, by: (a) a medical practitioner (who is not a general practitioner); or	Amount under clause 2.1.1

Group A2—Other non-referred attendances to which no other item applies		
Item	**Description**	**Fee**
	(b) a general practitioner to whom clause 2.3.1 applies	
95	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self-contained unit) of more than 25 minutes in duration but not more than 45 minutes—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies	Amount under clause 2.1.1
96	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self-contained unit) of more than 45 minutes in duration—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies	Amount under clause 2.1.1

Division 2.4—Group A3: Specialist attendances to which no other item applies

2.4.1 Limitation of item 99

Item 99 does not apply if the patient or the specialist travels to a place to satisfy the requirement in sub-subparagraph (d)(i)(B) of the item.

Group A3—Specialist attendances to which no other item applies		
Item	**Description**	**Fee**
99	Professional attendance on a patient by a specialist practising in his or her specialty if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 104 lasting more than 10 minutes; or (ii) provided with item 105; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies	50% of the fee for item 104 or 105
104	Professional attendance at consulting rooms or hospital by a specialist in the practice of his or her specialty after referral of the patient to him or her—each attendance, other than a second or subsequent attendance, in a single course of treatment, other than a service to which item 106, 109 or 16401 applies	$85.55
105	Professional attendance by a specialist in the practice of his or	$43.00

Group A3—Specialist attendances to which no other item applies		
Item	**Description**	**Fee**
	her specialty following referral of the patient to him or her—an attendance after the first in a single course of treatment, if that attendance is at consulting rooms or hospital	
106	Professional attendance by a specialist in the practice of his or her specialty of ophthalmology and following referral of the patient to him or her—an attendance (other than a second or subsequent attendance in a single course of treatment) at which the only service provided is refraction testing for the issue of a prescription for spectacles or contact lenses, if that attendance is at consulting rooms or hospital (other than a service to which any of items 104, 109 and 10801 to 10816 applies)	$71.00
107	Professional attendance by a specialist in the practice of his or her specialty following referral of the patient to him or her—an attendance (other than a second or subsequent attendance in a single course of treatment), if that attendance is at a place other than consulting rooms or hospital	$125.50
108	Professional attendance by a specialist in the practice of his or her specialty following referral of the patient to him or her—each attendance after the first in a single course of treatment, if that attendance is at a place other than consulting rooms or hospital	$79.45
109	Professional attendance by a specialist in the practice of his or her specialty of ophthalmology following referral of the patient to him or her—an attendance (other than a second or subsequent attendance in a single course of treatment) at which a comprehensive eye examination, including pupil dilation, is performed on: (a) a patient aged 9 years or younger; or (b) a patient aged 14 years or younger with developmental delay; (other than a service to which any of items 104, 106 and 10801 to 10816 applies)	$192.80
113	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist in the practice of his or her speciality if: (a) the attendance is by video conference; and	$64.20

Group A3—Specialist attendances to which no other item applies		
Item	**Description**	**Fee**
	(b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment	

Division 2.5—Group A4: Consultant physician (other than psychiatry) attendances to which no other item applies

2.5.1 Limitation of items 112 to 114

Items 112, 113 and 114 do not apply if the patient, specialist or physician travels to a place to satisfy the requirement in:

(a) for item 112—sub-subparagraph (d)(i)(B) of the item; and

(b) for items 113 and 114—sub-subparagraph (c)(i)(B) of the item.

Group A4—Consultant physician attendances to which no other item applies

Item	Description	Fee
110	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—initial attendance in a single course of treatment	$150.90
112	Professional attendance on a patient by a consultant physician practising in his or her specialty if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 110 lasting more than 10 minutes; or (ii) provided with item 116, 119, 132 or 133; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health	50% of the fee for item 110, 116, 119, 132 or 133

Group A4—Consultant physician attendances to which no other item applies		
Item	**Description**	**Fee**
	Service; for which a direction made under subsection 19(2) of the Act applies	
114	Initial professional attendance of 10 minutes or less in duration on a patient by a consultant physician practising in his or her specialty if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment	$113.20
116	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—each attendance (other than a service to which item 119 applies) after the first in a single course of treatment	$75.50
119	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—each minor attendance after the first in a single course of treatment	$43.00
122	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—initial	$183.10

Group A4—Consultant physician attendances to which no other item applies		
Item	**Description**	**Fee**
	attendance in a single course of treatment	
128	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—each attendance (other than a service to which item 131 applies) after the first in a single course of treatment	$110.75
131	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—each minor attendance after the first in a single course of treatment	$79.75
132	Professional attendance by a consultant physician in the practice of his or her specialty (other than psychiatry) of at least 45 minutes in duration for an initial assessment of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders) following referral of the patient to him or her by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) a consultant physician treatment and management plan of significant complexity is prepared and provided to the referring practitioner, which involves: (i) an opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) medication recommendations; and (c) an attendance on the patient to which item 110, 116 or 119 applies did not take place on the same day by the same consultant physician; and (d) this item has not applied to an attendance on the patient in the preceding 12 months by the same consultant physician	$263.90
133	Professional attendance by a consultant physician in the practice	$132.10

Group A4—Consultant physician attendances to which no other item applies		
Item	**Description**	**Fee**
	of his or her specialty (other than psychiatry) of at least 20 minutes in duration after the first attendance in a single course of treatment for a review of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders) if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified consultant physician treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on the diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient to which item 110, 116 or 119 applies did not take place on the same day by the same consultant physician; and (d) item 132 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same consultant physician who claimed item 132 or a locum tenens; and (f) this item has not applied more than twice in any 12 month period	

Division 2.5A—Group A29: Early intervention services for children with autism, pervasive developmental disorder or disability

2.5A.1 Meanings of *eligible allied health provider* and *risk assessment*

In items 135, 137 and 139:

eligible allied health provider means any of the following:

(a) an audiologist;
(b) an occupational therapist;
(c) a participating optometrist;
(d) an orthoptist;
(e) a physiotherapist;
(f) a psychologist;
(g) a speech pathologist.

risk assessment means an assessment of:

(a) the risk to the patient of a contributing co-morbidity; and
(b) environmental, physical, social and emotional risk factors that may apply to the patient or to another individual.

2.5A.2 Meaning of *eligible disability*

An ***eligible disability*** means any of the following:

(a) sight impairment that results in vision of less than or equal to 6/18 vision or equivalent field loss in the better eye, with correction;
(b) hearing impairment that results in:
  (i) a hearing loss of 40 decibels or greater in the better ear, across 4 frequencies; or
  (ii) permanent conductive hearing loss and auditory neuropathy;
(c) deafblindness;
(d) cerebral palsy;

(e) Down syndrome;
(f) Fragile X syndrome;
(g) Prader-Willi syndrome;
(h) Williams syndrome;
(i) Angelman syndrome;
(j) Kabuki syndrome;
(k) Smith-Magenis syndrome;
(l) CHARGE syndrome;
(m) Cri du Chat syndrome;
(n) Cornelia de Lange syndrome;
(o) microcephaly, if a child has:
(i) a head circumference less than the third percentile for age and sex; and
(ii) a functional level at or below 2 standard deviations below the mean for age on a standard development test or an IQ score of less than 70 on a standardised test of intelligence.

Group A29—Early intervention services for children with autism, pervasive developmental disorder or disability

Item	Description	Fee ($)
135	Professional attendance of at least 45 minutes in duration at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty of paediatrics, following referral of the patient to the consultant by a referring practitioner, for assessment, diagnosis and preparation of a treatment and management plan for a patient aged under 13 years with autism or another pervasive developmental disorder, if the consultant paediatrician does all of the following: (a) undertakes a comprehensive assessment and makes a diagnosis (if appropriate, using information provided by an eligible allied health provider); (b) develops a treatment and management plan, which must include the following: (i) an assessment and diagnosis of the patient's condition; (ii) a risk assessment; (iii) treatment options and decisions;	263.90

Group A29—Early intervention services for children with autism, pervasive developmental disorder or disability		
Item	**Description**	**Fee ($)**
	(iv) if necessary—medical recommendations; (c) provides a copy of the treatment and management plan to: (i) the referring practitioner; and (ii) one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 137, 139 or 289)	
137	Professional attendance of at least 45 minutes in duration at consulting rooms or hospital, by a specialist or consultant physician (not including a general practitioner) following referral of the patient to the consultant by a referring practitioner, for assessment, diagnosis and preparation of a treatment and management plan for a patient under 13 years with an eligible disability if the specialist or consultant physician does all of the following: (a) undertakes a comprehensive assessment and makes a diagnosis (if appropriate, using information provided by an eligible allied health provider); (b) develops a treatment and management plan, which must include the following: (i) an assessment and diagnosis of the patient's condition; (ii) a risk assessment; (iii) treatment options and decisions; (iv) if necessary—medication recommendations; (c) provides a copy of the treatment and management plan to one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 139 or 289)	263.90
139	Professional attendance of at least 45 minutes in duration at consulting rooms only, by a general practitioner (not including a specialist or consultant physician) for assessment, diagnosis and preparation of a treatment and management plan for a patient under 13 years with an eligible disability if the general practitioner does all of the following:	129.90

Group A29—Early intervention services for children with autism, pervasive developmental disorder or disability		
Item	**Description**	**Fee ($)**
	(a) undertakes a comprehensive assessment and makes a diagnosis (if appropriate, using information provided by an eligible allied health provider); (b) develops a treatment and management plan, which must include the following: (i) an assessment and diagnosis of the patient's condition; (ii) a risk assessment; (iii) treatment options and decisions; (iv) if necessary—medication recommendations; (c) provides a copy of the treatment and management plan to one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 137 or 289)	

Division 2.6—Group A28: Geriatric medicine

2.6.1 Limitation of item 149

Item 149 does not apply if the patient, physician or specialist travels to a place to satisfy the requirement in sub-subparagraph (d)(i)(B) of the item.

Group A28—Geriatric medicine		
Item	**Description**	**Fee**
141	Professional attendance of more than 60 minutes in duration at consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine, if: (a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and (c) during the attendance: (i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail using appropriately validated assessment tools if indicated (the ***assessment***); and (ii) the patient's various health problems and care needs are identified and prioritised (the ***formulation***); and (iii) a detailed management plan is prepared (the ***management plan***) setting out: (A) the prioritised list of health problems and care needs; and (B) short and longer term management goals; and (C) recommended actions or intervention strategies to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are	$452.65

Group A28—Geriatric medicine		
Item	**Description**	**Fee**
	readily available and acceptable to the patient and the patient's family and carers; and (iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and (v) the management plan is communicated in writing to the referring practitioner; and (d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (e) an attendance to which this item or item 145 applies has not been provided to the patient by the same practitioner in the preceding 12 months	
143	Professional attendance of more than 30 minutes in duration at consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under item 141 or 145, if: (a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and (b) during the attendance: (i) the patient's health status is reassessed; and (ii) a management plan prepared under item 141 or 145 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies was not provided to the patient on the same day by the same practitioner; and (d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and (e) an attendance to which this item or item 147 applies has not been provided to the patient in the preceding 12 months,	$282.95

Group A28—Geriatric medicine		
Item	**Description**	**Fee**
	unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review	
145	Professional attendance of more than 60 minutes in duration at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine, if: (a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and (c) during the attendance: (i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail utilising appropriately validated assessment tools if indicated (the ***assessment***); and (ii) the patient's various health problems and care needs are identified and prioritised (the ***formulation***); and (iii) a detailed management plan is prepared (the ***management plan***) setting out: (A) the prioritised list of health problems and care needs; and (B) short and longer term management goals; and (C) recommended actions or intervention strategies, to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient, the patient's family and any carers; and (iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and (v) the management plan is communicated in writing to the referring practitioner; and	$548.85

Group A28—Geriatric medicine		
Item	**Description**	**Fee**
	(d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (e) an attendance to which this item or item 141 applies has not been provided to the patient by the same practitioner in the preceding 12 months	
147	Professional attendance of more than 30 minutes in duration at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under items 141 or 145, if: (a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and (b) during the attendance: (i) the patient's health status is reassessed; and (ii) a management plan that was prepared under item 141 or 145 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and (e) an attendance to which this item or 143 applies has not been provided by the same practitioner in the preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review	$343.10
149	Professional attendance on a patient by a consultant physician or specialist practising in his or her specialty of geriatric medicine if:	50% of the fee for

Group A28—Geriatric medicine		
Item	**Description**	**Fee**
	(a) the attendance is by video conference; and (b) item 141 or 143 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the physician or specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service: for which a direction made under subsection 19(2) of the Act applies	item 141 or 143

Division 2.7—Group A5: Prolonged attendances to which no other item applies

2.7.1 Application of items 160 to 164

(1) Items 160 to 164 apply only to a service provided in the course of a personal attendance by one or more medical practitioners on a single patient on a single occasion.

(2) If the personal attendance is provided by one or more medical practitioners concurrently, each practitioner may claim an attendance fee.

(3) However, if the personal attendance is not continuous, the occasion on which the service is provided is taken to be the total time of the attendance.

Group A5—Prolonged attendances to which no other item applies

Item	Description	Fee ($)
160	Professional attendance for a period of not less than 1 hour but less than 2 hours (other than a service to which another item applies) on a patient in imminent danger of death	217.15
161	Professional attendance for a period of not less than 2 hours but less than 3 hours (other than a service to which another item applies) on a patient in imminent danger of death	361.90
162	Professional attendance for a period of not less than 3 hours but less than 4 hours (other than a service to which another item applies) on a patient in imminent danger of death	506.50
163	Professional attendance for a period of not less than 4 hours but less than 5 hours (other than a service to which another item applies) on a patient in imminent danger of death	651.50
164	Professional attendance for a period of 5 hours or more (other than a service to which another item applies) on a patient in imminent danger of death	723.90

Division 2.8—Group A6: Group therapy

Group A6—Group therapy		
Item	**Description**	**Fee ($)**
170	Professional attendance for the purpose of Group therapy of not less than 1 hour in duration given under the direct continuous supervision of a medical practitioner (other than a consultant physician in the practice of his or her specialty of psychiatry) involving members of a family and persons with close personal relationships with that family—each Group of 2 patients	115.25
171	Professional attendance for the purpose of Group therapy of not less than 1 hour in duration given under the direct continuous supervision of a medical practitioner (other than a consultant physician in the practice of his or her specialty of psychiatry) involving members of a family and persons with close personal relationships with that family—each Group of 3 patients	121.40
172	Professional attendance for the purpose of Group therapy of not less than 1 hour in duration given under the direct continuous supervision of a medical practitioner (other than a consultant physician in the practice of his or her specialty of psychiatry) involving members of a family and persons with close personal relationships with that family—each Group of 4 or more patients	147.75

Division 2.9—Group A7: Acupuncture

2.9.1 Meaning of *qualified medical acupuncturist*

A general practitioner is a ***qualified medical acupuncturist***, for an item, if the Chief Executive Medicare has received a written notice from the Royal Australian College of General Practitioners stating that the general practitioner meets the skills requirements for providing the service described in the item.

Group A7—Acupuncture

Item	Description	Fee
173	Professional attendance at which acupuncture is performed by a medical practitioner by application of stimuli on or through the surface of the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture was performed	$21.65
193	Professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	$36.30
195	Professional attendance by a general practitioner who is a qualified medical acupuncturist, on one or more patients at a hospital, lasting less than 20 minutes and including any of	Amount under clause 2.1.1

Group A7—Acupuncture		
Item	**Description**	**Fee**
	the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	
197	Professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	$70.30
199	Professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination;	$103.50

Group A7—Acupuncture		
Item	**Description**	**Fee**
	(c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	

Division 2.10—Group A8: Consultant physician in practice of psychiatry for attendances to which no other item applies

2.10.1 Application of items 291, 293 and 359

Items 291, 293 and 359 may only apply once in a 12 month period.

2.10.2 Application of items 342, 344 and 346

Items 342, 344 and 346 apply only to a service provided in the course of a personal attendance by a single medical practitioner.

2.10.3 Restriction of telepsychiatry consultations to regional, rural and remote areas

Items 353 to 361 apply only to a consultation that is provided to a patient in a regional, rural or remote area.

2.10.4 Limitation of item 288

Item 288 does not apply if the patient or physician travels to a place to satisfy the requirement in sub-subparagraph (d)(i)(B) of the item.

2.10.5 Meanings of *eligible allied health provider* and *risk assessment*

In item 289:

eligible allied health provider means any of the following:

(a) an audiologist;
(b) an occupational therapist;
(c) a participating optometrist;
(d) an orthoptist;
(e) a physiotherapist;
(f) a psychologist;
(g) a speech pathologist.

risk assessment means an assessment of:

(a) the risk to the patient of a contributing co-morbidity; and

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

Group A8—Consultant psychiatrist attendances to which no other item applies

Item	Description	Fee
288	Professional attendance on a patient by a consultant physician practising in his or her specialty of psychiatry if: (a) the attendance is by video conference; and (b) item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 348, 350 or 352 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies	50% of the fee for item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 348, 350 or 352
289	Professional attendance of at least 45 minutes in duration at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty of psychiatry, following referral of the patient to the consultant by a referring practitioner, for assessment, diagnosis and preparation of a treatment and management plan for a patient under 13 years with autism or another pervasive developmental disorder, if the consultant psychiatrist does all of the following: (a) undertakes a comprehensive assessment and makes a diagnosis (if appropriate, using information provided by an eligible allied health provider); (b) develops a treatment and management plan which must include the following:	$263.90

Group A8—Consultant psychiatrist attendances to which no other item applies		
Item	**Description**	**Fee**
	(i) an assessment and diagnosis of the patient's condition; (ii) a risk assessment; (iii) treatment options and decisions; (iv) if necessary—medication recommendations; (c) provides a copy of the treatment and management plan to the referring practitioner; (d) provides a copy of the treatment and management plan to one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 137 or 139)	
291	Professional attendance of more than 45 minutes in duration at consulting rooms by a consultant physician in the practice of his or her specialty of psychiatry, if: (a) the attendance follows referral of the patient to the consultant for an assessment or management by a medical practitioner in general practice (including a general practitioner, but not a specialist or consultant physician) or a participating nurse practitioner; and (b) during the attendance, the consultant: (i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (c) the consultant decides that it is clinically appropriate for the patient to be managed by the referring practitioner without ongoing treatment by the consultant; and (d) within 2 weeks after the attendance, the consultant: (i) prepares a written diagnosis of the patient; and (ii) prepares a written management plan for the patient that: (A) covers the next 12 months; and (B) is appropriate to the patient's diagnosis; and (C) comprehensively evaluates the patient's biological, psychological and social issues; and (D) addresses the patient's diagnostic psychiatric issues; and (E) makes management recommendations addressing	$452.65

Group A8—Consultant psychiatrist attendances to which no other item applies		
Item	**Description**	**Fee**
	the patient's biological, psychological and social issues; and (iii) gives the referring practitioner a copy of the diagnosis and the management plan; and (iv) if clinically appropriate, explains the diagnosis and management plan, and a gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees	
293	Professional attendance of more than 30 minutes but not more than 45 minutes in duration at consulting rooms by a consultant physician in the practice of his or her specialty of psychiatry, if: (a) the patient is being managed by a medical practitioner or a participating nurse practitioner in accordance with a management plan prepared by the consultant in accordance with item 291; and (b) the attendance follows referral of the patient to the consultant for review of the management plan by the medical practitioner or a participating nurse practitioner managing the patient; and (c) during the attendance, the consultant: (i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (iv) reviews the management plan; and (d) within 2 weeks after the attendance, the consultant: (i) prepares a written diagnosis of the patient; and (ii) revises the management plan; and (iii) gives the referring practitioner a copy of the diagnosis and the revised management plan; and (iv) if clinically appropriate, explains the diagnosis and the revised management plan, and gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees; and (e) in the preceding 12 months, a service to which item 291 applies has been provided; and (f) in the preceding 12 months, a service to which this item or	$282.95

Group A8—Consultant psychiatrist attendances to which no other item applies		
Item	**Description**	**Fee**
	item 293 applies has not been provided	
296	Professional attendance of more than 45 minutes in duration by a consultant physician in the practice of his or her speciality of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance at consulting rooms if the patient: (a) is a new patient for this consultant psychiatrist; or (b) has not received a professional attendance from this consultant psychiatrist in the preceding 24 months; other than attendance on a patient in relation to whom this item, item 297 or 299, or any of items 300 to 346, 353 to 358 and 361 to 370, has applied in the preceding 24 months	$260.30
297	Professional attendance of more than 45 minutes by a consultant physician in the practice of his or her speciality of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance at hospital if the patient: (a) is a new patient for this consultant psychiatrist; or (b) has not received a professional attendance from this consultant psychiatrist in the preceding 24 months; other than attendance on a patient in relation to whom this item, item 296 or 299, or any of items 300 to 346, 353 to 358 and 361 to 370, has applied in the preceding 24 months (H)	$260.30
299	Professional attendance of more than 45 minutes by a consultant physician in the practice of his or her speciality of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance at a place other than consulting rooms or a hospital if the patient: (a) is a new patient for this consultant psychiatrist; or (b) has not received a professional attendance from this consultant psychiatrist in the preceding 24 months; other than attendance on a patient in relation to whom this item, item 296 or 297, or any of items 300 to 346, 353 to 358 and 361 to 370, has applied in the preceding 24 months	$311.30
300	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the	$43.35

Group A8—Consultant psychiatrist attendances to which no other item applies		
Item	**Description**	**Fee**
	patient to him or her by a referring practitioner—an attendance of not more than 15 minutes in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	
302	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance of more than 15 minutes, but not more than 30 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$86.45
304	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance of more than 30 minutes, but not more than 45 minutes, in duration at consulting rooms), if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$133.10
306	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance of more than 45 minutes, but not more than 75 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$183.65
308	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance of more than 75 minutes in duration at consulting rooms), if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$213.15
310	Professional attendance by a consultant physician in the practice	$21.60

Group A8—Consultant psychiatrist attendances to which no other item applies		
Item	**Description**	**Fee**
	of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance of not more than 15 minutes in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient	
312	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance of more than 15 minutes, but not more than 30 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient	$43.35
314	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance of more than 30 minutes, but not more than 45 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient	$66.65
316	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance of more than 45 minutes, but not more than 75 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient	$91.95
318	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance of more than 75 minutes in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient	$106.60

Group A8—Consultant psychiatrist attendances to which no other item applies		
Item	**Description**	**Fee**
319	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance of more than 45 minutes in duration at consulting rooms, if the patient has: (a) been diagnosed as suffering severe personality disorder, anorexia nervosa, bulimia nervosa, dysthymic disorder, substance-related disorder, somatoform disorder or a pervasive development disorder; and (b) for persons 18 years and over—been rated with a level of functional impairment within the range 1 to 50 according to the Global Assessment of Functioning Scale; if that attendance and another attendance to which any of items 296, 300 to 319, 353 to 358 and 361 to 370 applies have not exceeded 160 attendances in a calendar year for the patient	$183.65
320	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance of not more than 15 minutes in duration at hospital	$43.35
322	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance of more than 15 minutes, but not more than 30 minutes, in duration at hospital	$86.45
324	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance of more than 30 minutes, but not more than 45 minutes, in duration at hospital	$133.10
326	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance of more than 45 minutes, but not more than 75 minutes, in duration at hospital	$183.65
328	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance	$213.15

Group A8—Consultant psychiatrist attendances to which no other item applies

Item	Description	Fee
	of more than 75 minutes in duration at hospital	
330	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance of not more than 15 minutes in duration if that attendance is at a place other than consulting rooms or hospital	$79.55
332	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance of more than 15 minutes, but not more than 30 minutes, in duration if that attendance is at a place other than consulting rooms or hospital	$124.65
334	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance of more than 30 minutes, but not more than 45 minutes, in duration if that attendance is at a place other than consulting rooms or hospital	$181.65
336	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance of more than 45 minutes, but not more than 75 minutes, in duration if that attendance is at a place other than consulting rooms or hospital	$219.75
338	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—an attendance of more than 75 minutes in duration if that attendance is at a place other than consulting rooms or hospital	$249.55
342	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which Group therapy is conducted) of not less than 1 hour in duration given under the continuous direct supervision of a consultant physician in the practice of his or her specialty of psychiatry, involving a Group of 2 to 9 unrelated patients or a family Group of more than 3 patients, each of whom is referred to the consultant physician by a referring	$49.30

Group A8—Consultant psychiatrist attendances to which no other item applies		
Item	**Description**	**Fee**
	practitioner—each patient	
344	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which Group therapy is conducted) of not less than 1 hour in duration given under the continuous direct supervision of a consultant physician in the practice of his or her specialty of psychiatry, involving a family Group of 3 patients, each of whom is referred to the consultant physician by a referring practitioner—each patient	$65.45
346	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which Group therapy is conducted) of not less than 1 hour in duration given under the continuous direct supervision of a consultant physician in the practice of his or her specialty of psychiatry, involving a family Group of 2 patients, each of whom is referred to the consultant physician by a referring practitioner—each patient	$96.80
348	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, following referral of the patient to him or her by a referring practitioner, involving an interview of a person other than the patient of not less than 20 minutes, but less than 45 minutes, in duration, in the course of initial diagnostic evaluation of a patient	$126.75
350	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, following referral of the patient to him or her by a referring practitioner, involving an interview of a person other than the patient of not less than 45 minutes in duration, in the course of initial diagnostic evaluation of a patient	$175.00
352	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, following referral of the patient to him or her by a referring practitioner, involving an interview of a person other than the patient of not less than 20 minutes in duration, in the course of continuing management of a patient—if that attendance and another attendance to which this item applies have not exceeded 4 in a calendar year for the patient	$126.75

Group A8—Consultant psychiatrist attendances to which no other item applies		
Item	**Description**	**Fee**
353	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—a telepsychiatry consultation of not more than 15 minutes in duration, if: (a) that attendance and another attendance to which any of items 353 to 358 and 361 applies have not exceeded 12 attendances in a calendar year for the patient; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$57.20
355	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—a telepsychiatry consultation of more than 15 minutes, but not more than 30 minutes, in duration, if: (a) that attendance and another attendance to which any of items 353 to 358 and 361 applies have not exceeded 12 attendances in a calendar year for the patient; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$114.45
356	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—a telepsychiatry consultation of more than 30 minutes, but not more than 45 minutes, in duration, if: (a) that attendance and another attendance to which any of items 353 to 358 and 361 applies have not exceeded 12 attendances in a calendar year for the patient; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$167.80
357	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—a	$231.45

Group A8—Consultant psychiatrist attendances to which no other item applies		
Item	**Description**	**Fee**
	telepsychiatry consultation of more than 45 minutes, but not more than 75 minutes, in duration, if: (a) that attendance and another attendance to which any of items 353 to 358 and 361 applies have not exceeded 12 attendances in a calendar year for the patient; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	
358	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—a telepsychiatry consultation of more than 75 minutes in duration, if: (a) that attendance and another attendance to which any of items 353 to 358 and 361 applies have not exceeded 12 attendances in a calendar year for the patient; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$282.00
359	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry—a telepsychiatry consultation of more than 30 minutes but not more than 45 minutes in duration, if: (a) the patient is being managed by a medical practitioner or a participating nurse practitioner in accordance with a management plan prepared by the consultant psychiatrist in accordance with item 291; and (b) the attendance follows referral of the patient to the consultant for review of the management plan by the referring practitioner managing the patient; and (c) during the attendance, the consultant: (i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (iv) reviews the management plan; and (d) within 2 weeks after the attendance, the consultant: (i) prepares a written diagnosis of the patient; and	$325.35

Group A8—Consultant psychiatrist attendances to which no other item applies		
Item	**Description**	**Fee**
	(ii) revises the management plan; and (iii) gives the referring practitioner a copy of the diagnosis and the revised management plan; and (iv) if clinically appropriate, explains the diagnosis and the revised management plan, and gives a copy, to: (A) the patient; and (B) the patient's carer (if any), if the patient agrees; and (e) the patient is located in a regional, rural or remote area; and (f) in the preceding 12 months, a service to which item 291 applies has been performed; and (g) in the preceding 12 months, a service to which this item or item 293 applies has not been performed	
361	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—a telepsychiatry consultation of more than 45 minutes in duration, if the patient: (a) either: (i) is a new patient for this consultant psychiatrist; or (ii) has not received a professional attendance from this consultant psychiatrist in the preceding 24 months; and (b) is located in a regional, rural or remote area; other than attendance on a patient in relation to whom this item, item 296, 297 or 299, or any of items 300 to 346 and 353 to 370, has applied in the preceding 24 month period	$299.30
364	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—a face-to-face consultation of not more than 15 minutes in duration, if: (a) the patient has had a telepsychiatry consultation to which any of items 353 to 358 and 361 applies before that attendance; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not	$43.35

Group A8—Consultant psychiatrist attendances to which no other item applies		
Item	**Description**	**Fee**
	exceeded 50 attendances in a calendar year for the patient	
366	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—a face-to-face consultation of more than 15 minutes, but not more than 30 minutes, in duration, if: (a) the patient has had a telepsychiatry consultation to which any of items 353 to 358 and 361 applies before that attendance; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$86.45
367	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—a face-to-face consultation of more than 30 minutes, but not more than 45 minutes, in duration, if: (a) the patient has had a telepsychiatry consultation to which any of items 353 to 358 and 361 applies before that attendance; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$133.10
369	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—a face-to-face consultation of more than 45 minutes, but not more than 75 minutes, in duration, if: (a) the patient has had a telepsychiatry consultation to which any of items 353 to 358 and 361 applies before that attendance; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	$183.80
370	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner—a face-to-face	$213.15

Group A8—Consultant psychiatrist attendances to which no other item applies		
Item	**Description**	**Fee**
	consultation of more than 75 minutes in duration, if: (a) the patient has had a telepsychiatry consultation to which any of items 353 to 358 and 361 applies before that attendance; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	

Division 2.11—Group A12: Consultant occupational physician attendances to which no other item applies

2.11.1 Limitation of items 384 and 389

Items 384 and 389 do not apply if the patient or physician travels to a place to satisfy the requirement in:

(a) for item 384—sub-subparagraph (c)(i)(B) of the item; and

(b) for item 389—sub-subparagraph (d)(i)(B) of the item.

Group A12—Consultant occupational physician attendances to which no other item applies

Item	Description	Fee
384	Initial professional attendance of 10 minutes or less in duration on a patient by a consultant occupational physician practising in his or her specialty of occupational medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment	$64.20
385	Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine following referral of the	$85.55

Group A12—Consultant occupational physician attendances to which no other item applies		
Item	**Description**	**Fee**
	patient to him or her by a referring practitioner—initial attendance in a single course of treatment	
386	Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine following referral of the patient to him or her by a referring practitioner—each attendance after the first in a single course of treatment	$43.00
387	Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine following referral of the patient to him or her by a referring practitioner—initial attendance in a single course of treatment	$125.50
388	Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine following referral of the patient to him or her by a referring practitioner—each attendance after the first in a single course of treatment	$79.45
389	Professional attendance on a patient by a consultant occupational physician practising in his or her specialty of occupational medicine if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 385 lasting more than 10 minutes; or (ii) provided with item 386; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or	50% of the fee for item 385 or 386

Group A12—Consultant occupational physician attendances to which no other item applies		
Item	**Description**	**Fee**
	(B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies	

Division 2.12—Group A13: Public health physician attendances to which no other item applies

2.12.1 Public health physicians

Items 410 to 417 apply to an attendance on a patient by a public health physician only if the attendance relates to one or more of the following matters:

(a) management of a patient's vaccination requirements for immunisation programs;

(b) prevention or management of sexually transmitted disease;

(c) prevention or management of disease caused by scientifically accepted environmental hazards or toxins;

(d) prevention or management of infection arising from an outbreak of an infectious disease;

(e) prevention or management of an exotic disease.

Note: An exotic disease is medically accepted as a disease that is of foreign origin.

Group A13—Public health physician attendances to which no other item applies

Item	Description	Fee
410	Professional attendance at consulting rooms by a public health physician in the practice of his or her specialty of public health medicine—attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management	$19.55
411	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan;	$42.75

Group A13—Public health physician attendances to which no other item applies		
Item	**Description**	**Fee**
	(e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	
412	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	$82.65
413	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	$121.70
414	Professional attendance at other than consulting rooms by a public health physician in the practice of his or her specialty of public health medicine—attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management	Amount under clause 2.1.1
415	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at other than consulting rooms, lasting less than 20 minutes and	Amount under clause 2.1.1

Group A13—Public health physician attendances to which no other item applies		
Item	**Description**	**Fee**
	including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	
416	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at other than consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	Amount under clause 2.1.1
417	Professional attendance by a public health physician in the practice of his or her specialty of public health medicine at other than consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	Amount under clause 2.1.1

Division 2.13—Miscellaneous services

Note: Reserved for future use.

Division 2.14—Group A21: Emergency physician attendances to which no other item applies

2.14.1 Meaning of *recognised emergency department*

In this Division:

recognised emergency department, of a private hospital, means a department of the hospital that is licensed, under a law of the State or Territory in which the hospital is located, to operate as an emergency department.

2.14.2 Meaning of *problem focussed history*

In items 501, 503 and 507:

problem focussed history, for a patient, means a history focussing on the medical condition of the patient that necessitates the patient presenting for emergency attention.

2.14.3 Attendance for emergency evaluation of critically ill patients

In items 519 to 536, an attendance, for an emergency evaluation of a critically ill patient with an immediately life threatening problem, is an attendance that requires:

(a) immediate and rapid assessment; and
(b) initiation of resuscitation and electronic monitoring of vital signs; and
(c) taking a comprehensive history and evaluation while undertaking resuscitative measures; and
(d) ordering and evaluation of appropriate investigations; and
(e) transitional evaluation and monitoring; and
(f) formulation and documentation of a diagnosis and management plan in relation to one or more problems; and
(g) initiation of appropriate treatment interventions; and

(h) liaison with relevant health care professionals and discussion with, as appropriate, the patient or the patient's relatives or agent.

Group A21—Emergency physician attendances to which no other item applies

Item	Description	Fee ($)
501	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of his or her specialty of emergency medicine—attendance for the unscheduled evaluation and management of a patient, involving straightforward medical decision making that requires: (a) taking a problem focussed history; and (b) limited examination; and (c) diagnosis; and (d) initiation of appropriate treatment interventions	34.20
503	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of his or her specialty of emergency medicine—attendance for the unscheduled evaluation and management of a patient, involving medical decision making of low complexity that requires: (a) taking an expanded problem focussed history; and (b) expanded examination of one or more systems; and (c) formulation and documentation of a diagnosis and management plan in relation to one or more problems; and (d) initiation of appropriate treatment interventions	57.80
507	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of his or her specialty of emergency medicine—attendance for the unscheduled evaluation and management of a patient, involving medical decision making of moderate complexity that requires: (a) taking an expanded problem focussed history; and (b) expanded examination of one or more systems; and (c) ordering and evaluation of appropriate investigations; and (d) formulation and documentation of a diagnosis and management plan in relation to one or more problems; and (e) initiation of appropriate treatment interventions	97.05
511	Professional attendance at a recognised emergency department of	137.30

Group A21—Emergency physician attendances to which no other item applies		
Item	**Description**	**Fee ($)**
	a private hospital by a specialist in the practice of his or her specialty of emergency medicine—attendance for the unscheduled evaluation and management of a patient, involving medical decision making of moderate complexity that requires: (a) taking a detailed history; and (b) detailed examination of one or more systems; and (c) ordering and evaluation of appropriate investigations; and (d) formulation and documentation of a diagnosis and management plan in relation to one or more problems; and (e) initiation of appropriate treatment interventions; and (f) liaison with relevant health care professionals and discussion with, as appropriate, the patient or the patient's relatives or agent	
515	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of his or her specialty of emergency medicine—attendance for the unscheduled evaluation and management of a patient, involving medical decision making of high complexity that requires: (a) taking a comprehensive history; and (b) comprehensive examination of one or more systems; and (c) ordering and evaluation of appropriate investigations; and (d) formulation and documentation of a diagnosis and management plan in relation to one or more problems; and (e) initiation of appropriate treatment interventions; and (f) liaison with relevant health care professionals and discussion with, as appropriate, the patient or the patient's relatives or agent	212.60
519	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of his or her specialty of emergency medicine—attendance for a total period (whether or not continuous) of at least 30 minutes but less than 1 hour (before the patient's admission to an in-patient hospital bed) for emergency evaluation of a critically ill patient with an immediately life threatening problem	146.20
520	Professional attendance at a recognised emergency department of	280.85

Group A21—Emergency physician attendances to which no other item applies		
Item	**Description**	**Fee ($)**
	a private hospital by a specialist in the practice of his or her specialty of emergency medicine—attendance for a total period (whether or not continuous) of at least 1 hour but less than 2 hours (before the patient's admission to an in-patient hospital bed) for emergency evaluation of a critically ill patient with an immediately life threatening problem	
530	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of his or her specialty of emergency medicine—attendance for a total period (whether or not continuous) of at least 2 hours but less than 3 hours (before the patient's admission to an in-patient hospital bed) for emergency evaluation of a critically ill patient with an immediately life threatening problem	460.30
532	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of his or her specialty of emergency medicine—attendance for a total period (whether or not continuous) of at least 3 hours but less than 4 hours (before the patient's admission to an in-patient hospital bed) for emergency evaluation of a critically ill patient with an immediately life threatening problem	639.75
534	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of his or her specialty of emergency medicine—attendance for a total period (whether or not continuous) of at least 4 hours but less than 5 hours (before the patient's admission to an in-patient hospital bed) for emergency evaluation of a critically ill patient with an immediately life threatening problem	819.35
536	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of his or her specialty of emergency medicine—attendance for a total period (whether or not continuous) of at least 5 hours (before the patient's admission to an in-patient hospital bed) for emergency evaluation of a critically ill patient with an immediately life threatening problem	909.10

Division 2.15—Group A11: Urgent attendances after hours

2.15.1 Meaning of *patient's medical condition requires urgent treatment*

(1) For items 597 to 600, a patient's medical condition requires urgent treatment if:

(a) medical opinion is to the effect that the patient's medical condition requires treatment within the unbroken after-hours period in, or before, which the attendance mentioned in the item was requested; and

(b) treatment could not be delayed until the start of the next in-hours period.

(2) For subclause (1), medical opinion is to a particular effect if:

(a) the attending practitioner is of that opinion; and

(b) in the circumstances that existed and on the information available when the opinion was formed, that opinion would be acceptable to the general body of medical practitioners.

2.15.2 Meaning of *responsible person*

For items 597 to 600, a ***responsible person***, for a patient:

(a) includes a spouse, parent, carer or guardian of the patient; but

(b) does not include:

(i) the attending medical practitioner; or

(ii) an employee of the attending medical practitioner; or

(iii) a person contracted by, or an employee or member of, the general practice of which the attending medical practitioner is a contractor, employee or member; or

(iv) a call centre; or

(v) a reception service.

2.15.3 Application of Group A11

Items 597 to 600 do not apply to a service provided by a medical practitioner if:

(a) the service is provided at consulting rooms; and

(b) the practitioner:

(i) routinely provides services to patients in after-hours periods at consulting rooms; or

(ii) provides the service (as a contractor, employee, member or otherwise) for a general practice or clinic that routinely provides services to patients in after-hours periods at consulting rooms.

2.15.4 Effect of determination under section 106TA of Act

(1) This clause applies to a general practitioner if:

(a) the practitioner is the subject of a final determination that is in force under section 106TA of the Act; and

(b) the determination contains a direction, given under subparagraph 106U(1)(g)(i) of the Act, that the practitioner be disqualified for a professional service; and

(c) the determination specifies the practitioner is disqualified in relation to a service mentioned in an item in Group A1; and

(d) the practitioner provides a service mentioned in item 598 or 600.

(2) The determination applies to the service mentioned in paragraph (1)(d).

Group A11—Urgent attendances after hours

Item	Description	Fee ($)
597	Professional attendance by a general practitioner on not more than one patient on one occasion—each attendance (other than an attendance in unsociable hours) in an after-hours period if: (a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after-hours period, and the patient's medical condition requires urgent treatment; and	127.25

Group A11—Urgent attendances after hours		
Item	**Description**	**Fee ($)**
	(b) if the attendance is performed at consulting rooms—it must be necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	
598	Professional attendance by a medical practitioner (other than a general practitioner), or a general practitioner to whom clause 2.15.4 applies, on not more than one patient on one occasion—each attendance (other than an attendance in unsociable hours) in an after-hours period if: (a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after-hours period, and the patient's medical condition requires urgent treatment; and (b) if the attendance is at consulting rooms—it must be necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	104.75
599	Professional attendance by a general practitioner on not more than one patient on one occasion—each attendance in unsociable hours if: (a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after-hours period, and the patient's medical condition requires urgent treatment; and (b) if the attendance is at consulting rooms—it must be necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	150.00
600	Professional attendance by a medical practitioner (other than a general practitioner), or a general practitioner to whom clause 2.15.4 applies, on not more than one patient on one occasion—each attendance in unsociable hours if: (a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after-hours period, and the patient's medical condition requires urgent treatment; and (b) if the attendance is at consulting rooms—it must be necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	124.25

Division 2.16—Group A14: Health assessments

2.16.1 Application of Group A14

Items 701 to 715 apply only to a service provided in the course of a personal attendance by a single medical practitioner on a single patient.

2.16.2 Types of health assessments

(1) The following health assessments may be performed under item 701, 703, 705 or 707:

(a) a Healthy Kids Check, in accordance with clause 2.16.4, for a patient if the patient is:

(i) at least 3 years old and under 5 years old; and

(ii) receiving or has received the immunisation recommended for a 4 year old child; and

(iii) not an in-patient of a hospital;

(b) a Type 2 Diabetes Risk Evaluation, in accordance with clause 2.16.5, for a patient if the patient:

(i) is at least 40 years old and under 50 years old; and

(ii) has a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool; and

(iii) is not an in-patient of a hospital;

(c) a 45 year old Health Assessment, in accordance with clause 2.16.6, for a patient if the patient is:

(i) at least 45 years old and under 50 years old; and

(ii) at risk of developing a chronic disease; and

(iii) not an in-patient of a hospital or a care recipient in a residential aged care facility;

(d) an Older Person's Health Assessment, in accordance with clause 2.16.7, for a patient if the patient is:

(i) at least 75 years old; and

(ii) not an in-patient of a hospital or a care recipient in a residential aged care facility;

(e) a Comprehensive Medical Assessment, in accordance with clause 2.16.8, for a patient if the patient is a permanent resident of a residential aged care facility;

(f) a health assessment, in accordance with clause 2.16.9, for a person with an intellectual disability, if the patient is not an in-patient of a hospital or a care recipient in a residential aged care facility;

(g) a health assessment, in accordance with clause 2.16.10, for a patient if the patient is a refugee or humanitarian entrant, with eligibility for Medicare, and the person:

(i) either:

(A) holds a relevant visa that the person has held for less than 12 months at the time of the assessment; or

(B) first entered Australia less than 12 months before the assessment is performed; and

(ii) is not an in-patient of a hospital or a care recipient in a residential aged care facility.

Note: In 2013, the Australian Type 2 Diabetes Risk Assessment Tool was accessible at http://www.health.gov.au.

(2) In this clause:

relevant visa means any of the following visas granted under the *Migration Act 1958*:

(a) Subclass 070 Bridging (Removal Pending) visa;

(b) Subclass 200 (Refugee) visa;

(c) Subclass 201 (In-country Special Humanitarian) visa;

(d) Subclass 202 (Global Special Humanitarian) visa;

(e) Subclass 203 (Emergency Rescue) visa;

(f) Subclass 204 (Woman at Risk) visa;

(g) Subclass 695 (Return Pending) visa;

(h) Subclass 786 (Temporary (Humanitarian Concern)) visa;

(i) Subclass 866 (Protection) visa.

2.16.3 Application of item 715 to certain patients only

(1) The following health assessments may be performed under item 715:

(a) an Aboriginal and Torres Strait Islander child health assessment, in accordance with clause 2.16.11, for a patient if the patient is:

(i) of Aboriginal or Torres Strait Islander descent; and

(ii) under 15 years old; and

(iii) not an in-patient of a hospital;

(b) an Aboriginal and Torres Strait Islander adult health assessment, in accordance with clause 2.16.12, for a patient if the patient is:

(i) of Aboriginal or Torres Strait Islander descent; and

(ii) at least 15 years old and under 55 years old; and

(iii) not an in-patient of a hospital or a care recipient in a residential aged care facility;

(c) an Aboriginal and Torres Strait Islander Older Person's Health Assessment, in accordance with clause 2.16.13, for a patient if the patient is:

(i) of Aboriginal or Torres Strait Islander descent; and

(ii) at least 55 years old; and

(iii) not an in-patient of a hospital or a care recipient in a residential aged care facility.

(2) For this clause and item 715, a person is of Aboriginal or Torres Strait Islander descent if the person identifies himself or herself as being of that descent.

2.16.4 Healthy Kids Check

(1) A Healthy Kids Check is the assessment of:

(a) a patient's physical health, general wellbeing and development; and

(b) whether any medical intervention is required for the patient.

(2) The following may perform a Healthy Kids Check:

(a) a medical practitioner (including a general practitioner);

(b) a practice nurse or an Aboriginal and Torres Strait Islander health practitioner on behalf, and under the supervision, of a medical practitioner.

(3) If a practice nurse or a registered Aboriginal health worker performs a Healthy Kids Check for a patient and identifies any problems, the patient must be reviewed by the patient's usual medical practitioner, who must arrange referrals and follow-up services as required.

(4) A Healthy Kids Check for a patient must include the following basic physical examinations and assessments:

(a) measurement of the patient's height and weight to calculate the patient's body mass index and position on the growth curve;

(b) eyesight;

(c) hearing;

(d) oral health (teeth and gums);

(e) toileting;

(f) allergies.

(5) A Healthy Kids Check for a patient must also include:

(a) information collection, including taking a patient history and performing examinations and investigations, as required; and

(b) making an overall assessment of the patient; and

(c) initiating interventions or referrals, as appropriate; and

(d) giving health advice and information to the patient's parent or carer, using the *Get Set 4 Life—habits for healthy kids* guide.

Note: In 2013, the *Get Set 4 Life—habits for healthy kids* guide was accessible at http://www.health.gov.au.

(6) The person performing a Healthy Kids Check must:

(a) note if a copy of the guide mentioned in paragraph (5)(d) has been given to the patient's parent or carer; and

(b) record evidence that the immunisation recommended for a 4 year old child has been given to the patient.

(7) The immunisation recommended for a 4 year old child may be given to a patient when he or she has a Healthy Kids Check, and may be claimed separately.

(8) The Healthy Kids Check must not be provided more than once to an eligible person.

2.16.5 Type 2 Diabetes Risk Evaluation

(1) A Type 2 Diabetes Risk Evaluation must include:
  (a) a review of the risk factors underlying a patient's high risk score as identified by the Australian Type 2 Diabetes Risk Assessment Tool; and
  (b) initiating interventions, if appropriate, to address risk factors or to exclude diabetes.

Note: In 2013, the Australian Type 2 Diabetes Risk Assessment Tool was accessible at http://www.health.gov.au.

(2) The Type 2 Diabetes Risk Evaluation for a patient must also include:
  (a) assessing the patient's high risk score as determined by the Australian Type 2 Diabetes Risk Assessment Tool (to be completed by the patient within 3 months before performing the Type 2 Diabetes Risk Evaluation); and
  (b) updating the patient's history and performing physical examinations and clinical investigations; and

Note: Guidelines for examination and assessment include the Royal Australian College of General Practitioners publications *"Putting Prevention into Practice"* and *"Guidelines for Preventive Activities in General Practice"*. In 2013, these documents were accessible at http://www.racgp.org.au.

  (c) making an overall assessment of the patient's risk factors and the results of examinations and investigations; and
  (d) initiating interventions, if appropriate, including referrals and follow-up services relating to the management of any risk factors identified; and
  (e) giving the patient advice and information, including strategies to achieve lifestyle and behaviour changes if appropriate.

(3) A Type 2 Diabetes Risk Evaluation must not be provided more than once every 3 years to an eligible person.

(4) For this clause, ***risk factors*** includes:
   (a) lifestyle risk factors (for example smoking, physical inactivity or poor nutrition); and
   (b) biomedical risk factors (for example high blood pressure, impaired glucose metabolism or excess weight); and
   (c) a family history of a chronic disease.

2.16.6 45 year old Health Assessment

(1) A 45 year old Health Assessment is an assessment for a patient if the patient, in the clinical judgement of the attending medical practitioner based on the identification of a specific risk factor, is at risk of developing a chronic disease.

(2) The 45 year old Health Assessment must include:
   (a) information collection, including taking a patient's history and performing examinations and investigations, as required; and
   (b) making an overall assessment of the patient; and
   (c) initiating interventions or referrals, as appropriate; and
   (d) giving health advice and information to the patient.

(3) The medical practitioner providing the assessment is responsible for the overall health assessment of the patient.

(4) A 45 year old Health Assessment must not be given more than once to an eligible person.

(5) In this clause:

chronic disease means a disease that has been, or is likely to be, present for at least 6 months, including asthma, cancer, cardiovascular illness, diabetes mellitus, a mental health condition, arthritis or a musculoskeletal condition.

specific risk factors includes:

(a) lifestyle risk factors (for example smoking, physical inactivity, poor nutrition or alcohol misuse); and
(b) biomedical risk factors (for example high cholesterol, high blood pressure, impaired glucose metabolism or excess weight); and
(c) a family history of a chronic disease.

2.16.7 Older Person's Health Assessment

(1) An Older Person's Health Assessment is the assessment of:
(a) a patient's health and physical, psychological and social function; and
(b) whether preventive health care and education should be offered to the patient, to improve the patient's health and physical, psychological and social function.

(2) An Older Person's Health Assessment must include:
(a) personal attendance by a medical practitioner; and
(b) measurement of the patient's blood pressure, pulse rate and rhythm; and
(c) assessment of the patient's medication; and
(d) assessment of the patient's continence; and
(e) assessment of the patient's immunisation status for influenza, tetanus and pneumococcus; and
(f) assessment of the patient's physical functions, including the patient's activities of daily living and whether or not the patient has had a fall in the last 3 months; and
(g) assessment of the patient's psychological function, including the patient's cognition and mood; and
(h) assessment of the patient's social function, including:
(i) the availability and adequacy of paid, and unpaid, help; and
(ii) whether the patient is responsible for caring for another person.

(3) An Older Person's Health Assessment must also include:
(a) keeping a record of the health assessment; and

(b) offering the patient a written report on the health assessment, with recommendations about matters covered by the health assessment; and

(c) offering the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

(4) An Older Person's Health Assessment must not be provided more than once every 12 months to an eligible person.

2.16.8 Comprehensive Medical Assessment for permanent resident of residential aged care facility

(1) A Comprehensive Medical Assessment of a permanent resident of a residential aged care facility includes an assessment of the resident's health and physical and psychological function.

(2) A Comprehensive Medical Assessment must include:

(a) a personal attendance by a medical practitioner; and

(b) taking a detailed patient history of the resident; and

(c) conducting a comprehensive medical examination of the resident; and

(d) developing a list of diagnoses and medical problems based on the medical history and examination; and

(e) giving a written copy of a summary of the outcomes of the assessment to the residential aged care facility for the resident's medical records.

(3) A Comprehensive Medical Assessment must also include:

(a) making a written summary of the Comprehensive Medical Assessment; and

(b) giving a copy of the summary to the residential aged care facility; and

(c) offering the resident a copy of the summary.

(4) A Comprehensive Medical Assessment may be provided:

(a) on admission to a residential aged care facility, if a Comprehensive Medical Assessment has not already been

provided in another residential aged care facility in the last 12 months; and

(b) at 12 month intervals after that assessment.

(5) A Comprehensive Medical Assessment may be performed in conjunction with a consultation for another purpose, but must be claimed separately.

2.16.9 Health assessment for a person with an intellectual disability

(1) A health assessment for a person with an intellectual disability is an assessment of:

(a) the patient's physical, psychological and social function; and

(b) whether any medical intervention and preventive health care is required.

(2) The health assessment for a person with an intellectual disability must include the following matters to the extent that they are relevant to the patient:

(a) checking dental health (including dentition);

(b) conducting an aural examination (including arranging a formal audiometry if an audiometry has not been conducted within the last 5 years);

(c) assessing ocular health (arrange review by an ophthalmologist or optometrist if a comprehensive eye examination has not been conducted within the last 5 years);

(d) assessing nutritional status (including weight and height measurements) and a review of growth and development;

(e) assessing bowel and bladder function (particularly for incontinence or chronic constipation);

(f) assessing medications including:

(i) non-prescription medicines taken by the patient, prescriptions from other doctors, medications prescribed but not taken, interactions, side effects and review of indications; and

(ii) advice to carers on the common side-effects and interactions; and

(iii) consideration of the need for a formal medication review;

(g) checking immunisation status (including influenza, tetanus, hepatitis A and B, measles, mumps, rubella and pneumococcal vaccinations) with reference to the Australian Immunisation Handbook, for appropriate vaccination schedules;

Note: In 2013, the Australian Immunisation Handbook was accessible at http://www.health.gov.au.

(h) checking exercise opportunities (with the aim of moderate exercise for at least 30 minutes each day);

(i) checking whether the support provided for activities of daily living adequately and appropriately meets the patient's needs, and considering formal review if required;

(j) considering the need for breast examination, mammography, papanicolaou smears, testicular examination, lipid measurement and prostate assessment as for the general population;

(k) checking for dysphagia and gastro-oesophageal disease (especially for patients with cerebral palsy) and arranging for investigation or treatment as required;

(l) assessing risk factors for osteoporosis (including diet, exercise, Vitamin D deficiency, hormonal status, family history, medication and fracture history) and arranging for investigation or treatment as required;

(m) for a patient diagnosed with epilepsy—reviewing seizure control (including anticonvulsant drugs) and considering referral to a neurologist at appropriate intervals;

(n) screening for thyroid disease at least every 2 years (or yearly for patients with Down syndrome);

(o) for a patient without a definitive aetiological diagnosis—considering referral to a genetic clinic every 5 years;

(p) assessing or reviewing treatment for co-morbid mental health issues;

(q) considering timing of puberty and management of sexual development, sexual activity and reproductive health;

(r) considering whether there are any signs of physical, psychological or sexual abuse.

(3) A health assessment for a person with an intellectual disability must also include:
(a) keeping a record of the health assessment; and
(b) offering the patient a written report on the health assessment; and
(c) offering the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report; and
(d) offering relevant disability professionals (if the medical practitioner considers it appropriate and the patient or, if appropriate, the patient's carer, agrees) a copy of the report or extracts of the report.

(4) A health assessment for a person with an intellectual disability must not be provided more than once every 12 months to an eligible person.

2.16.10 Health assessment for a refugee or other humanitarian entrant

(1) A health assessment for a refugee or other humanitarian entrant is the assessment of:
(a) the patient's health and physical, psychological and social function; and
(b) whether preventive health care and education should be offered to the patient to improve their health and physical, psychological or social function.

(2) A health assessment for a refugee or other humanitarian entrant must include:
(a) a personal attendance by a medical practitioner; and
(b) taking the patient's history; and
(c) examining the patient; and
(d) performing or arranging any required investigations; and

(e) assessing the patient, using the information gained in paragraphs (b), (c) and (d); and

(f) developing a management plan addressing the patient's health care needs, health problems and relevant conditions; and

(g) making or arranging any necessary interventions and referrals.

(3) A health assessment for a refugee or other humanitarian entrant must also include:

(a) keeping a record of the health assessment; and

(b) offering to provide the patient with a written report of the health assessment.

(4) A health assessment for a refugee or other humanitarian entrant must not be provided to a patient more than once.

2.16.11 Aboriginal and Torres Strait Islander child health assessment

(1) An Aboriginal and Torres Strait Islander child health assessment is the assessment of:

(a) a patient's health and physical, psychological and social function; and

(b) whether preventive health care, education and other assistance should be offered to the patient, or the patient's parent or carer, to improve the patient's health and physical, psychological or social function.

(2) An Aboriginal and Torres Strait Islander child health assessment must include:

(a) a personal attendance by a medical practitioner; and

(b) taking the patient's history, including the following:

(i) mother's pregnancy history;

(ii) birth and neo-natal history;

(iii) breastfeeding history;

(iv) weaning, food access and dietary history;

(v) physical activity engaged in;

(vi) previous presentations, hospital admissions and medication use;
(vii) relevant family medical history;
(viii) immunisation status;
(ix) vision and hearing (including neo-natal hearing screening);
(x) development (including achievement of age-appropriate milestones);
(xi) family relationships, social circumstances and whether the person is cared for by another person;
(xii) exposure to environmental factors (including tobacco smoke);
(xiii) environmental and living conditions;
(xiv) educational progress;
(xv) stressful life events experienced;
(xvi) mood (including incidence of depression and risk of self-harm);
(xvii) substance use;
(xviii) sexual and reproductive health;
(xix) dental hygiene (including access to dental services); and

(c) examination of the patient, including the following:
(i) measurement of the patient's height and weight to calculate the patient's body mass index and position on the growth curve;
(ii) newborn baby check (if not previously completed);
(iii) vision (including red reflex in a newborn);
(iv) ear examination (including otoscopy);
(v) oral examination (including gums and dentition);
(vi) trachoma check, if indicated;
(vii) skin examination, if indicated;
(viii) respiratory examination, if indicated;
(ix) cardiac auscultation, if indicated;
(x) development assessment, to determine whether age-appropriate milestones have been achieved, if indicated;

(xi) assessment of parent and child interaction, if indicated;

(xii) other examinations in accordance with national or regional guidelines or specific regional needs, or as indicated by a previous child health assessment; and

(d) performing or arranging any required investigation, in particular considering the need for the following tests:

(i) haemoglobin testing for those at a high risk of anaemia;

(ii) audiometry, especially for school age children; and

(e) assessing the patient using the information gained in the child health assessment; and

(f) making or arranging any necessary interventions and referrals, and documenting a strategy for the good health of the patient; and

(g) both:

(i) keeping a record of the health assessment; and

(ii) offering the patient, or the patient's parent or carer, a written report on the health assessment, with recommendations on matters covered by the health assessment (including a strategy for the good health of the patient).

2.16.12 Aboriginal and Torres Strait Islander adult health assessment

(1) An Aboriginal and Torres Strait Islander adult health assessment is the assessment of:

(a) a patient's health and physical, psychological and social function; and

(b) whether preventive health care, education and other assistance should be offered to the patient to improve their health and physical, psychological or social function.

(2) An Aboriginal and Torres Strait Islander adult health assessment must include:

(a) personal attendance by a medical practitioner; and

(b) taking the patient's history, including the following:

(i) current health problems and risk factors;

(ii) relevant family medical history;
(iii) medication use (including medication obtained without prescription or from other doctors);
(iv) immunisation status, by reference to the appropriate current age and sex immunisation schedule;
(v) sexual and reproductive health;
(vi) physical activity, nutrition and alcohol, tobacco or other substance use;
(vii) hearing loss;
(viii) mood (including incidence of depression and risk of self-harm);
(ix) family relationships and whether the patient is a carer, or is cared for by another person;
(x) vision; and

(c) examination of the patient, including the following:
(i) measurement of the patient's blood pressure, pulse rate and rhythm;
(ii) measurement of height and weight to calculate the patient's body mass index and, if indicated, measurement of waist circumference for central obesity;
(iii) oral examination (including gums and dentition);
(iv) ear and hearing examination (including otoscopy and, if indicated, a whisper test);
(v) urinalysis (by dipstick) for proteinuria;
(vi) eye examination; and

(d) performing or arranging any required investigation, in particular considering the need for the following tests (in accordance with national or regional guidelines or specific regional needs):
(i) fasting blood sugar and lipids (by laboratory-based test on venous sample) or, if necessary, random blood glucose levels;
(ii) papanicolaou smear;
(iii) examination for sexually transmitted infection (by urine or endocervical swab for chlamydia and gonorrhoea, especially for those 15 to 35 years old);

(iv) mammography, if eligible (by scheduling appointments with visiting services or facilitating direct referral); and

(e) assessing the patient using the information gained in the health assessment; and

(f) making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.

(3) An Aboriginal and Torres Strait Islander adult health assessment must also include:

(a) keeping a record of the health assessment; and

(b) offering the patient a written report on the health assessment, with recommendations on matters covered by the health assessment (including a simple strategy for the good health of the patient).

2.16.13 Aboriginal and Torres Strait Islander Older Person's Health Assessment

(1) An Aboriginal and Torres Strait Islander Older Person's Health Assessment is the assessment of:

(a) a patient's health and physical, psychological and social function; and

(b) whether preventive health care and education should be offered to the patient, to improve the patient's health and physical, psychological or social function.

(2) An Aboriginal and Torres Strait Islander Older Person's Health Assessment must include:

(a) personal attendance by a medical practitioner; and

(b) measurement of the patient's blood pressure, pulse rate and rhythm; and

(c) assessment of the patient's medication; and

(d) assessment of the patient's continence; and

(e) assessment of the patient's immunisation status for influenza, tetanus and pneumococcus; and

(f) assessment of the patient's physical functions, including the patient's activities of daily living and whether or not the patient has had a fall in the last 3 months; and

(g) assessment of the patient's psychological function, including the patient's cognition and mood; and

(h) assessment of the patient's social function, including:

(i) the availability and adequacy of paid, and unpaid, help; and

(ii) whether the patient is responsible for caring for another person; and

(i) an examination of the patient's eyes.

(3) An Aboriginal and Torres Strait Islander Older Person's Health Assessment must also include:

(a) keeping a record of the health assessment; and

(b) offering the patient a written report on the health assessment, with recommendations on matters covered by the health assessment; and

(c) offering the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

2.16.14 Restrictions on health assessments for Group A14

(1) A health assessment mentioned in an item in Group A14 must not include a health screening service.

(2) A separate consultation must not be performed in conjunction with a health assessment, unless clinically necessary.

(3) A health assessment must be performed by the patient's usual medical practitioner, if reasonably practicable.

(4) Practice nurses and Aboriginal and Torres Strait Islander health practitioners may assist medical practitioners in performing a health assessment, in accordance with accepted medical practice, and under the supervision of the medical practitioner.

(5) For subclause (4), assistance may include activities associated with:

(a) information collection, and
(b) at the direction of the medical practitioner—provision to patients of information on recommended interventions.

(6) In this clause:

health screening service has the same meaning as in subsection 19(5) of the Act.

Group A14—Health assessments

Item	Description	Fee ($)
701	Professional attendance by a medical practitioner (other than a specialist or consultant physician) to perform a brief health assessment, lasting not more than 30 minutes and including: (a) collection of relevant information, including taking a patient history; and (b) a basic physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing the patient with preventive health care advice and information	58.20
703	Professional attendance by a medical practitioner (other than a specialist or consultant physician) to perform a standard health assessment, lasting more than 30 minutes but less than 45 minutes, including: (a) detailed information collection, including taking a patient history; and (b) an extensive physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing a preventive health care strategy for the patient	135.20
705	Professional attendance by a medical practitioner (other than a specialist or consultant physician) to perform a long health assessment, lasting at least 45 minutes but less than 60 minutes, including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition and physical function; and	186.55

Group A14—Health assessments		
Item	**Description**	**Fee ($)**
	(c) initiating interventions and referrals as indicated; and (d) providing a basic preventive health care management plan for the patient	
707	Professional attendance by a medical practitioner (other than a specialist or consultant physician) to perform a prolonged health assessment (lasting at least 60 minutes) including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition, and physical, psychological and social function; and (c) initiating interventions or referrals as indicated; and (d) providing a comprehensive preventive health care management plan for the patient	263.55
715	Professional attendance by a medical practitioner (other than a specialist or consultant physician) at consulting rooms or in another place other than a hospital or residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent—not more than once in a 9 month period	208.10

Division 2.17—Group A15: GP management plans, team care arrangements and multidisciplinary care plans and case conferences

Subdivision A—General

2.17.1 Service by medical practitioners

(1) Items 729 to 866 apply only to a service provided by:

(a) a medical practitioner (other than a medical practitioner employed by the proprietor of a hospital that is not a private hospital); or

(b) a medical practitioner who:

(i) is employed by the proprietor of a hospital that is not a private hospital; and

(ii) provides the service otherwise than in the course of employment by that proprietor.

(2) Paragraph (1)(b) applies whether or not another person provides essential assistance to the medical practitioner in accordance with accepted medical practice.

Subdivision B—Subgroup 1 of Group A15

2.17.2 Meaning of *associated medical practitioner*

In item 732 ***associated medical practitioner*** means a general practitioner who, if not engaged in the same general practice as the medical practitioner mentioned in the item, performs the service mentioned in the item at the request of the patient (or the patient's guardian).

2.17.3 Meaning of *contribute to a multidisciplinary care plan*

In items 729 and 731:

contribute to a multidisciplinary care plan, for a patient, includes the following:

(a) preparing part of a multidisciplinary care plan and adding a copy of that part of the plan to the patient's medical records;

(b) preparing amendments to part of a multidisciplinary care plan and adding a copy of the amendments to the patient's medical records;

(c) giving advice to a person who prepares part of a multidisciplinary care plan and recording in writing, on the patient's medical records, any advice provided to the person;

(d) giving advice to a person who reviews part of a multidisciplinary care plan and recording in writing, on the patient's medical records, any advice provided to the person.

2.17.4 Meaning of *coordinating the development of team care arrangements*

(1) In item 723:

coordinating the development of team care arrangements means a process by which a medical practitioner:

(a) in consultation with at least 2 collaborating providers, each of whom provides a different kind of treatment or service, and one of whom may be another medical practitioner, makes arrangements for the multidisciplinary care of the patient; and

(b) prepares a document that describes the following:

(i) treatment and service goals for the patient;

(ii) treatment and services that collaborating providers will provide to the patient;

(iii) actions to be taken by the patient;

(iv) arrangements to review the matters mentioned in subparagraphs (b)(i), (ii) and (iii) by a day mentioned in the document; and

(c) undertakes all of the following activities:

(i) explains the steps involved in the development of the arrangements to the patient and the patient's carer (if

any, and if the practitioner considers it appropriate and the patient agrees);

(ii) discusses with the patient the collaborating providers who will contribute to the development of team care arrangements, and provide treatment and services to the patient under those arrangements;

(iii) records the patient's agreement to the development of team care arrangements;

(iv) gives the collaborating provider a copy of those parts of the document that relate to the collaborating provider's treatment of the patient's condition;

(v) offers a copy of the document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);

(vi) adds a copy of the document to the patient's medical records.

(2) For this clause, a ***collaborating provider*** is a person who:

(a) provides treatment or a service to a patient; and

(b) is not a family carer of the patient.

2.17.5 Meaning of *coordinating a review of team care arrangements*

(1) In item 732:

coordinating a review of team care arrangements means a process by which a medical practitioner:

(a) in consultation with at least 2 collaborating providers, each of whom provides a different kind of treatment or service, and one of whom may be another medical practitioner, reviews the matters mentioned in paragraphs 2.17.4(1)(b) and 2.17.7(a), as applicable; and

(b) if different arrangements need to be made—makes amendments to the plan, or to the document mentioned in paragraph 2.17.4(1)(b), that:

(i) state the new arrangements; and

(ii) provide for the review of the amended plan or document by a date stated in the plan or document; and

(c) explains the steps involved in the review to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and

(d) records the patient's agreement to the review of team care arrangements or the plan; and

(e) gives the collaborating provider a copy of those parts of the amended document, or the amended plan, that relate to the collaborating provider's treatment of the patient's condition; and

(f) offers a copy of the amended document, or plan, to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and

(g) adds a copy of the amended document or plan to the patient's medical records.

(2) For this clause, a ***collaborating provider*** is a person who:

(a) provides treatment or a service to a patient; and

(b) is not a family carer of the patient.

2.17.6 Meaning of *multidisciplinary care plan*

(1) In items 729 and 731:

multidisciplinary care plan, for a patient, means a written plan that:

(a) is prepared for the patient by:

(i) a medical practitioner, in consultation with 2 other collaborating providers, each of whom provides a different kind of treatment or service to the patient, and one of whom may be another medical practitioner; or

(ii) a collaborating provider (other than a medical practitioner), in consultation with at least 2 other collaborating providers, each of whom provides a different kind of treatment or service to the patient; and

(b) describes, at least, treatment and services to be provided to the patient by the collaborating providers.

(2) For this clause, a ***collaborating provider*** is a person, including a medical practitioner, who:

(a) provides treatment or a service to a patient; and
(b) is not a family carer of the patient.

2.17.7 Meaning of *preparing a GP management plan*

In item 721:

preparing a GP management plan, for a patient, means a process by which a medical practitioner:

(a) prepares a written plan for the patient that describes:
  (i) the patient's condition and associated health care needs; and
  (ii) management goals with which the patient agrees; and
  (iii) actions to be taken by the patient; and
  (iv) treatment and services the patient is likely to need; and
  (v) arrangements for providing the treatment and services mentioned in subparagraph (a)(iv); and
  (vi) arrangements to review the plan by a day mentioned in the plan.
(b) explains to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in preparing the plan; and
(c) records the plan; and
(d) records the patient's agreement to the preparation of the plan; and
(e) offers a copy of the plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
(f) adds a copy of the plan to the patient's medical records.

2.17.8 Meaning of *reviewing a GP management plan*

In item 732:

reviewing a GP management plan means a process by which a medical practitioner:

(a) reviews the matters mentioned in paragraph (a) of the definition of ***preparing a GP management plan*** in clause 2.17.7; and

(b) if different arrangements need to be made—makes amendments to the plan that:

(i) state the new arrangements; and

(ii) provide for a further review of the amended plan by a date stated in the plan; and

(c) explains to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in the review; and

(d) records the patient's agreement to the review of the plan; and

(e) if amendments are made to the plan:

(i) offers a copy of the amended plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and

(ii) adds a copy of the amended plan to the patient's medical records.

2.17.9 Application of items 721, 723, 729, 731 and 732

(1) An item of the table mentioned in column 1 of table 2.17.9 applies only to a service for a patient who:

(a) suffers from at least one medical condition that:

(i) has been (or is likely to be) present for at least 6 months; or

(ii) is terminal; and

(b) is described in column 2 of table 2.17.9.

Table 2.17.9—Application of items 721, 723, 729, 731 and 732

Item	Column 1 Items of the table	Column 2 Description of patient
1	721 and 732 (if the service is for preparing a GP management plan or reviewing a GP	The patient: (a) is a private in-patient of a hospital; or (b) is not a public in-patient of a hospital or a care recipient in a residential aged care facility

Table 2.17.9—Application of items 721, 723, 729, 731 and 732

Item	Column 1 Items of the table	Column 2 Description of patient
	management plan)	
2	723 and 732 (if the service is for the creation or review of team care arrangements)	The patient: (a) requires ongoing care from at least 3 collaborating providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner; and (b) either: (i) is a private in-patient of a hospital; or (ii) is not a public in-patient of a hospital or a care recipient in a residential aged care facility
3	729	The patient: (a) requires ongoing care from at least 3 collaborating providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner; and (b) is not a care recipient in a residential aged care facility
4	731	The patient: (a) requires ongoing care from at least 3 collaborating providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner; and (b) is a care recipient in a residential aged care facility

(2) For this clause, a ***collaborating provider*** is a person who:
(a) provides treatment or a service to a patient; and
(b) is not a family carer of the patient.

2.17.10 Application of items 701 to 723 and 732

Items 701 to 723 and 732 apply only to a service provided in the course of personal attendance by a single medical practitioner on a single patient.

2.17.11 Limitation on items 721, 723, 729, 731 and 732

(1) This clause applies to the performances of services for a patient for whom exceptional circumstances do not exist.

(2) Items 721, 723, 729, 731 and 732 apply in the circumstances mentioned in table 2.17.11.

Table 2.17.11—Limitation on items 721, 723, 729, 731 and 732

Item	Item of the table	Circumstances
1	721	(a) In the 3 months before performance of the service, being a service to which item 729, 731 or 732 (for reviewing a GP management plan) applies but had not been performed for the patient; and (b) the service is not performed more than once in a 12 month period; and (c) the service is not performed by a general practitioner: (i) who is a recognised specialist in palliative medicine; and (ii) who is treating a palliative patient that has been referred to the general practitioner; and (iii) to which an item in Subgroup 3 or 4 of Group A24 applies because of the treatment of the palliative patient by the general practitioner
2	723	(a) In the 3 months before performance of the service, being a service to which item 732 (for coordinating a review of team care arrangements, a multi-disciplinary community care plan or a multi-disciplinary discharge care plan) applies but had not been performed for the patient; and (b) the service is performed not more than once in a 12 month period; and (c) the service is not performed by a general practitioner: (i) who is a recognised specialist in palliative medicine; and (ii) who is treating a palliative patient that has been referred to the general practitioner; and (iii) to which an item in Subgroup 3 or 4 of Group A24 applies because of the treatment of the palliative patient by the general practitioner

Table 2.17.11—Limitation on items 721, 723, 729, 731 and 732

Item	Item of the table	Circumstances
3	729	(a) either: (i) in the 3 months before performance of the service, being a service to which item 731 or 732 applies but had not been performed for the patient; or (ii) in the 12 months before performance of the service, being a service that has not been performed for the patient: (A) by the medical practitioner who performs the service to which item 729 would, but for this item, apply; and (B) for which a payment has been made under item 721 or 723; and (b) the service is performed not more than once in a 3 month period
4	731	(a) In the 3 months before performance of the service, being a service to which item 721, 723, 729 or 732 applies but had not been performed for the patient; and (b) the service is performed not more than once in a 3 month period
5	732	Each service may be performed: (a) once in a 3 month period; and (b) on the same day; but (c) may not be performed by a general practitioner: (i) who is a recognised specialist in palliative medicine; and (ii) who is treating a palliative patient that has been referred to the general practitioner; and (iii) to which an item in Subgroup 3 or 4 of Group A24 applies because of the treatment of the palliative patient by the general practitioner

(3) In this clause:

exceptional circumstances, for a patient, means there has been a significant change in the patient's clinical condition or care

circumstances that necessitates the performance of the service for the patient.

Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences		
Item	**Description**	**Fee ($)**
Subgroup 1—GP management plans, team care arrangements and multidisciplinary care plans		
721	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 735 to 758 apply)	141.40
723	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 735 to 758 apply)	112.05
729	Contribution by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 735 to 758 apply)	69.00
731	Contribution by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), to: (a) a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or (b) a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider (other than a service associated with a service to which items 735 to 758 apply)	69.00
732	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) to review or coordinate a review of:	70.65

Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences		
Item	**Description**	**Fee ($)**
	(a) a GP management plan prepared by a medical practitioner (or an associated medical practitioner) to which item 721 applies; or (b) team care arrangements which have been coordinated by the medical practitioner (or an associated medical practitioner) to which item 723 applies	

Subdivision C—Subgroup 2 of Group A15

2.17.12 Meaning of *multidisciplinary discharge case conference*

In items 735, 739, 743, 747, 750 and 758:

multidisciplinary discharge case conference means a multidisciplinary case conference carried out for a patient before the patient is discharged from a hospital.

2.17.13 Meaning of *multidisciplinary case conference in a residential aged care facility*

In items 735, 739, 743, 747, 750 and 758:

multidisciplinary case conference in a residential aged care facility means a multidisciplinary case conference carried out for a care recipient in a residential aged care facility.

2.17.14 Meaning of *organise and coordinate*

In items 735, 739, 743, 820, 822, 823, 825, 826, 828, 830, 832, 834, 835, 837, 838, 855, 857, 858, 861, 864 and 866:

organise and coordinate, for a conference mentioned in the item, means undertaking all of the following activities:

(a) explaining to the patient the nature of the conference;
(b) asking the patient whether the patient agrees to the conference taking place;

(c) recording the patient's agreement to the conference;
(d) recording the day the conference was held and the times the conference started and ended;
(e) recording the names of the participants;
(f) recording the activities mentioned in the definition of ***multidisciplinary case conference*** in clause 1.1.2 and putting a copy of that record in the patient's medical records;
(g) offering the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees), and giving each other member of the team, a summary of the conference;
(h) discussing the outcomes of the conference with the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees).

2.17.15 Meaning of *participate*

In items 747, 750, 758, 825, 826, 828, 835, 837 and 838:

participate, for a conference mentioned in the item, means participation that:

(a) does not include organising and coordinating the conference; and
(b) involves undertaking all of the following activities in relation to the conference:
  (i) explaining to the patient the nature of the conference;
  (ii) asking the patient whether the patient agrees to the practitioner's participation in the conference;
  (iii) recording the patient's agreement to the practitioner's participation in the conference;
  (iv) recording the day the conference was held and the times the conference started and ended;
  (v) recording the names of the participants;
  (vi) recording the matters mentioned in clause 1.1.2 and putting a copy of that record in the patient's medical records.

2.17.16 Meaning of *coordinating*

In item 880:

coordinating, for a case conference, means undertaking all of the following activities:

(a) coordinating and facilitating the case conference;

(b) resolving any disagreement or conflict to enable the members of the case conference team giving care and service to the patient to agree on the outcomes to be achieved;

(c) identifying tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team;

(d) recording the input of each member and the outcome of the case conference.

2.17.17 Meaning of *case conference team*

For item 880, a case conference team:

(a) includes a specialist, or consultant physician, in the practice of his or her specialty of geriatric or rehabilitation medicine; and

(b) includes at least 2 other allied health professionals, each of whom provides a different kind of care or service to the patient and is not a medical practitioner or family carer of the patient; and

(c) may include the patient, a family carer of the patient or a medical practitioner.

Example: For paragraph (b), persons who may be included in a team are the following:

(a) dieticians;
(b) mental health workers;
(c) occupational therapists;
(d) pharmacists;
(e) physiotherapists;
(f) podiatrists;
(g) psychologists;
(h) social workers;
(i) speech pathologists.

2.17.18 Application of item 880

(1) Item 880 applies if:

(a) the attendance is by a specialist, or consultant physician, in the specialty of geriatric medicine or rehabilitation medicine; and

(b) the attendance is on a patient who:

(i) is an admitted patient of a hospital; and

(ii) is not a care recipient in a residential aged care facility; and

(iii) is being provided with one of the following types of specialist care:

(A) geriatric evaluation and management;

(B) rehabilitation care.

(2) In this clause:

geriatric evaluation and management means care provided to a patient with a disability or psychosocial problem for the purpose of maximising the patient's health status or optimising the patient's living arrangements.

rehabilitation care means care provided to a patient with an impairment or disability for the purpose of improving the patient's functional status.

Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences		
Item	**Description**	**Fee ($)**
Subgroup 2—Case conferences		
735	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference;	69.25

Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences		
Item	**Description**	**Fee ($)**
	if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which items 721 to 732 apply)	
739	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which items 721 to 732 apply)	118.60
743	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 40 minutes (other than a service associated with a service to which items 721 to 732 apply)	197.70
747	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which	50.90

Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences		
Item	**Description**	**Fee ($)**
	items 721 to 732 apply)	
750	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which items 721 to 732 apply)	87.25
758	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 40 minutes (other than a service associated with a service to which items 721 to 732 apply)	145.30
820	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	139.10
822	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	208.70
823	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 45 minutes,	278.15

Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences		
Item	**Description**	**Fee ($)**
	with a multidisciplinary team of at least 3 other formal care providers of different disciplines	
825	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	99.90
826	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	159.30
828	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	218.75
830	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	139.10
832	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	208.70
834	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	278.15

Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences		
Item	**Description**	**Fee ($)**
835	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	99.90
837	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	159.30
838	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	218.75
855	Attendance by a consultant physician in the practice of his or her specialty of psychiatry, as a member of a case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	139.10
857	Attendance by a consultant physician in the practice of his or her specialty of psychiatry, as a member of a case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	208.70
858	Attendance by a consultant physician in the practice of his or her specialty of psychiatry, as a member of a case conference team, to organise and coordinate a community case conference of at least 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	278.15
861	Attendance by a consultant physician in the practice of his or her	139.10

Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences		
Item	**Description**	**Fee ($)**
	specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	
864	Attendance by a consultant physician in the practice of his or her specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	208.70
866	Attendance by a consultant physician in the practice of his or her specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	278.15
871	Attendance by a medical practitioner (including a specialist or consultant physician in the practice of his or her specialty or a general practitioner), as a member of a case conference team, to lead and coordinate a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 3 other medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers	80.30
872	Attendance by a medical practitioner (including a specialist or consultant physician in the practice of his or her specialty or a general practitioner), as a member of a case conference team, to participate in a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 4 medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers	37.40
880	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of geriatric or rehabilitation medicine, as a member of a case conference team, to coordinate a case conference of at least 10 minutes but less than 30 minutes—for	48.65

Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences		
Item	**Description**	**Fee ($)**
	any particular patient, one attendance only in a 7 day period (other than attendance on the same day as an attendance for which item 832, 834, 835, 837 or 838 was applicable in relation to the patient) (H)	

Division 2.18—Group A17: Domiciliary and residential medication management reviews

2.18.1 Meaning of *living in a community setting*

For item 900, a patient is ***living in a community setting*** if the patient is not an in-patient of a hospital or a care recipient in a residential aged care facility.

2.18.2 Meaning of *residential medication management review*

(1) In item 903:

residential medication management review means a collaborative service provided by a medical practitioner and a pharmacist to review the medication management needs of a permanent resident of a residential aged care facility.

(2) A medical practitioner's involvement in a residential medication management review includes all of the following:

(a) discussing the proposed review with the resident and seeking the resident's consent to the review;

(b) collaborating with the reviewing pharmacist about the pharmacist's involvement in the review;

(c) providing input from the resident's most recent comprehensive medical assessment or, if such an assessment has not been undertaken, providing relevant clinical information for the review and for the resident's records;

(d) subject to subclause (4), participating in a post-review discussion (either face-to-face or by telephone) with the pharmacist to discuss the outcomes of the review including:

(i) the findings of the review; and

(ii) medication management strategies; and

(iii) means to ensure that the strategies are implemented and reviewed, including any issues for implementation and follow-up;

(e) developing or revising the resident's medication management plan after discussion with the reviewing pharmacist, and finalising the plan after discussion with the resident.

(3) A medical practitioner's involvement in a residential medication management review also includes:
(a) offering a copy of the medication management plan to the resident (or the resident's carer or representative if appropriate); and
(b) providing copies of the plan for the resident's records and for the nursing staff of the residential aged care facility; and
(c) discussing the plan with nursing staff if necessary.

(4) A post-review discussion is not required if:
(a) there are no recommended changes to the resident's medication management arising out of the review; or
(b) any changes are minor in nature and do not require immediate discussion; or
(c) the pharmacist and medical practitioner agree that issues arising out of the review should be considered in a case conference.

2.18.3 Application of items 900 and 903

Items 900 and 903 apply only to a service provided in the course of personal attendance by a single medical practitioner on a single patient.

Group A17—Domiciliary medication management review		
Item	**Description**	**Fee ($)**
900	Participation by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) in a Domiciliary Medication Management Review (DMMR) for patients living in a community setting, in which the medical practitioner: (a) assesses a patient's medication management needs and, following that assessment, refers the patient to a community pharmacy or an accredited pharmacist for a DMMR and, with	151.75

Group A17—Domiciliary medication management review		
Item	**Description**	**Fee ($)**
	the patient's consent, provides relevant clinical information required for the review; and (b) discusses with the reviewing pharmacist the results of that review including suggested medication management strategies; and (c) develops a written medication management plan following discussion with the patient For any particular patient—applicable not more than once in each 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR	
903	Participation by a medical practitioner (including a general practitioner but not including a specialist or consultant physician) in a residential medication management review (RMMR) for a patient who is a permanent resident of a residential aged care facility—other than an RMMR for a resident in relation to whom, in the preceding 12 months, this item has applied, unless there has been a significant change in the resident's medical condition or medication management plan requiring a new RMMR	103.90

Division 2.18A—Group A30: Medical practitioner video conferencing consultation

2.18A.1 Application of items

(1) An item in Group A30 may be claimed if:
  (a) the service described in the item is undertaken in association with a service described in an item mentioned in sub-clause (2); and
  (b) no other service described in an item in Group A30 is provided to the patient on the same occasion.

(2) For subclause (1), the items are 99, 112, 113, 114, 149, 288, 384, 389, 2799, 2820, 3003, 3015, 6004, 6016, 13210, 16399 and 17609.

2.18A.2 Application of items 2125, 2138, 2179 and 2220

For items 2125, 2138, 2179 and 2220, professional attendance may be provided by the medical practitioner at consulting rooms in the residential care service if the patient is a care recipient.

2.18A.3 Meaning of *amount under clause 2.18A.3*

An ***amount under clause 2.18A.3***, for an item mentioned in column 1 of table 2.18A.3, means the sum of:
  (a) the fee for the item mentioned in column 2 of the table; and
  (b) the fee for the item mentioned in:
    (i) if the medical practitioner attends no more than 6 patients in a single attendance—the amount mentioned in column 3 of the table, divided by the number of patients attended; or
    (ii) if the medical practitioner attends more than 6 patients in a single attendance—the amount mentioned in column 4 of the table.

Table 2.18A.3—Amount under clause 2.18A.3

Item	Column 1 Item of the table	Column 2 Fee	Column 3 Amount if not more than 6 patients (to be divided by the number of patients) ($)	Column 4 Amount per patient if more than 6 patients ($)
1	2122	The fee for item 2100	25.45	1.95
2	2125	The fee for item 2100	45.80	3.25
3	2137	The fee for item 2126	25.45	1.95
4	2138	The fee for item 2126	45.80	3.25
5	2147	The fee for item 2143	25.45	1.95
6	2179	The fee for item 2143	45.80	3.25
7	2199	The fee for item 2195	25.45	1.95
8	2220	The fee for item 2195	45.80	3.25

2.18A.4 Limitation of items

Items 2100, 2122, 2126, 2137, 2143, 2147, 2195 and 2199 do not apply if the patient or the specialist or consultant physician mentioned in paragraph (a) of the item travels to a place to satisfy the requirement:

(a) for items 2100, 2126, 2143 and 2195—in sub-subparagraph (c)(i)(B) of the item; and

(b) for items 2122, 2137, 2147 and 2199—in subparagraph (d)(ii) of the item.

Group A30—Medical Practitioner (including a general practitioner, specialist or consultant physician) video conferencing consultation		
Item	**Description**	**Fee**
Subgroup 1—Video conferencing consultation attendance at consulting rooms, home visit or other institution		
2100	Professional attendance at consulting rooms of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service: for which a direction made under subsection 19(2) of the Act applies	$22.45
2122	Professional attendance not in consulting rooms of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion—each patient	Amount under table 2.18A.3
2126	Professional attendance at consulting rooms of less than 20	$48.95

Group A30—Medical Practitioner (including a general practitioner, specialist or consultant physician) video conferencing consultation		
Item	**Description**	**Fee**
	minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies	
2137	Professional attendance not in consulting rooms of less than 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion—each patient	Amount under table 2.18A.3
2143	Professional attendance at consulting rooms of at least 20 minutes in duration (whether or not continuous) by a medical practitioner who provides clinical support to a patient who: (a) is participating in a video conferencing consultation with a	$94.95

Group A30—Medical Practitioner (including a general practitioner, specialist or consultant physician) video conferencing consultation		
Item	**Description**	**Fee**
	specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service: for which a direction made under subsection 19(2) of the Act applies	
2147	Professional attendance not in consulting rooms of at least 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion—each patient	Amount under table 2.18A.3
2195	Professional attendance at consulting rooms of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either:	$139.70

Group A30—Medical Practitioner (including a general practitioner, specialist or consultant physician) video conferencing consultation		
Item	**Description**	**Fee**
	(i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies	
2199	Professional attendance not in consulting rooms of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion—each patient	Amount under table 2.18A.3
Subgroup 2—Video conferencing consultation attendance at a residential aged care service		
2125	Professional attendance of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one	Amount under table 2.18A.3

Group A30—Medical Practitioner (including a general practitioner, specialist or consultant physician) video conferencing consultation		
Item	**Description**	**Fee**
	occasion—each patient	
2138	Professional attendance of less than 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion—each patient	Amount under table 2.18A.3
2179	Professional attendance of at least 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion—each patient	Amount under table 2.18A.3
2220	Professional attendance of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion—each patient	Amount under table 2.18A.3

Division 2.19—Groups A18 (General practitioner attendances associated with PIP payments) and A19 (Other non-referral attendances associated with PIP payments to which no other item applies)

2.19.1 Application of Subgroup 2 of Groups A18 and A19

(1) An item in Subgroup 2 of Group A18 or A19 does not apply to a service that is provided to a patient who has already been provided, in the previous 11 months, with another service mentioned in that Subgroup.

(2) For an item in Subgroup 2 of Group A18 or A19, a professional attendance ***completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus*** if the attendance completes a series of attendances that involve, over a period of at least 11 months and up to 13 months, (the ***current cycle***), the following:

(a) at least one assessment of the patient's diabetes control, by measuring the patient's HbA_{1c};

(b) subject to subclause (3), if the patient has not had a comprehensive eye examination in the cycle of care ending immediately before the current cycle—at least one comprehensive eye examination;

(c) measurement of the patient's weight and height, and calculation of the patient's BMI;

(d) 2 further measurements of the patient's weight with each measurement being taken at least 5 months after the previous measurement;

(e) 2 measurements of the patient's blood pressure, taken at least 5 months but not more than 7 months apart;

(f) subject to subclause (3), 2 examinations of the patient's feet, carried out at least 5 months but not more than 7 months apart;

(g) at least one measurement of the patient's total cholesterol, triglycerides and HDL cholesterol;

(h) at least one test of the patient's microalbuminuria;

(ha) at least one measurement of the patient's estimated Glomerular Filtration Rate (eGFR);

(i) provision to the patient of self-management education regarding diabetes;

(j) a review of the patient's diet, and provision to the patient of information about appropriate dietary choices;

(k) a review of the patient's level of physical activity, and provision to the patient of information about the appropriate level of physical activity;

(l) checking the patient's tobacco smoking activity, and, if relevant, encouraging the patient to stop smoking;

(m) a review of the patient's medication.

(3) For a patient with established diabetes mellitus who has a condition that is mentioned in table 2.19.1, the minimum requirements of a cycle of care for the patient in relation to paragraphs (2)(b) and (f) may be completed as set out in that table.

Table 2.19.1—Minimum requirements of a cycle of care

Item	Patient's condition	How minimum requirements completed
1	A patient who is blind	Without an eye examination
2	A patient who has sight in only one eye	Examination of that eye
3	A patient who does not have any feet	Without a foot examination
4	A patient who has only one foot	Examination of that foot

2.19.2 Application of Subgroup 3 of Groups A18 and A19

(1) An item in Subgroup 3 of Group A18 or A19 does not apply to a service that:

(a) is provided to a patient who has already been provided, in the previous 12 months, with another service mentioned in Subgroup 3 of Group A18 or A19; and

(b) is not clinically indicated.

(2) For an item in Subgroup 3 of Group A18 or A19, a professional attendance ***completes the minimum requirements of the Asthma Cycle of Care*** if the attendance completes a series of attendances that involves:

(a) documented diagnosis and documented assessment of level of asthma control and severity of asthma; and

(b) at least 2 asthma-related consultations within 12 months (at least one of which (the ***review consultation***) is a consultation that was planned at a previous consultation and includes the review mentioned in subparagraph (iv)) that involve the following for a patient with moderate to severe asthma:

(i) a review of the patient's use of and access to asthma related medication and devices;

(ii) either:

(A) provision to the patient of a written asthma action plan; or

(B) if the patient is unable to use a written asthma action plan—discussion with the patient about an alternative method of providing an asthma action plan, and documentation of the discussion in the patient's medical records;

(iii) provision of asthma self-management education to the patient;

(iv) at the review consultation:

(A) a review of the patient's written or documented asthma action plan; and

(B) if necessary, adjustment of that plan.

Group A18—General practitioner attendances associated with Practice Incentives Program (PIP) payments

Item	Description	Fee
Subgroup 1—Taking of a cervical smear from an unscreened or significantly underscreened woman		
2497	Professional attendance at consulting rooms by a general	$16.60

Group A18—General practitioner attendances associated with Practice Incentives Program (PIP) payments		
Item	**Description**	**Fee**
	practitioner: (a) involving taking a short patient history and, if required, limited examination and management; and (b) at which a cervical smear is taken from a person between the ages of 20 and 69 years (inclusive) who has not had a cervical smear in the last 4 years	
2501	Professional attendance by a general practitioner at consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a papanicolaou smear is taken from a person at least 20 years old and not older than 69 years old, who has not had a papanicolaou smear in the last 4 years	$36.30
2503	Professional attendance by a general practitioner at a place other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a papanicolaou smear is taken from a person at least 20 years old and not older than 69 years old, who has not had a papanicolaou smear in the last 4 years	Amount under clause 2.1.1
2504	Professional attendance by a general practitioner at	$70.30

Group A18—General practitioner attendances associated with Practice Incentives Program (PIP) payments		
Item	**Description**	**Fee**
	consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a papanicolaou smear is taken from a person at least 20 years old and not older than 69 years old, who has not had a papanicolaou smear in the last 4 years	
2506	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a papanicolaou smear is taken from a person at least 20 years old and not older than 69 years old, who has not had a papanicolaou smear in the last 4 years	Amount under clause 2.1.1
2507	Professional attendance by a general practitioner at consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan;	$103.50

Group A18—General practitioner attendances associated with Practice Incentives Program (PIP) payments		
Item	**Description**	**Fee**
	(e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a papanicolaou smear is taken from a person at least 20 years old and not older than 69 years old, who has not had a papanicolaou smear in the last 4 years	
2509	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a papanicolaou smear is taken from a person at least 20 years old and not older than 69 years old, who has not had a papanicolaou smear in the last 4 years	Amount under clause 2.1.1
Subgroup 2—Completion of a cycle of care for patients with established diabetes mellitus		
2517	Professional attendance by a general practitioner at consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus	$36.30

Group A18—General practitioner attendances associated with Practice Incentives Program (PIP) payments

Item	Description	Fee
2518	Professional attendance by a general practitioner at a place other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus	Amount under clause 2.1.1
2521	Professional attendance by a general practitioner at consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus	$70.30
2522	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care;	Amount under clause 2.1.1

Group A18—General practitioner attendances associated with Practice Incentives Program (PIP) payments		
Item	**Description**	**Fee**
	for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus	
2525	Professional attendance by a general practitioner at consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus	$103.50
2526	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus	Amount under clause 2.1.1
Subgroup 3—Completion of the Asthma Cycle of Care		
2546	Professional attendance by a general practitioner at consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history;	$36.30

Group A18—General practitioner attendances associated with Practice Incentives Program (PIP) payments

Item	Description	Fee
	(b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care	
2547	Professional attendance by a general practitioner at a place other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care	Amount under clause 2.1.1
2552	Professional attendance by a general practitioner at consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care	$70.30
2553	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant:	Amount under clause 2.1.1

Group A18—General practitioner attendances associated with Practice Incentives Program (PIP) payments		
Item	**Description**	**Fee**
	(a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care	
2558	Professional attendance by a general practitioner at consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care	$103.50
2559	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care	Amount under clause 2.1.1

Group A19—Other non-referred attendances associated with Practice Incentives Program (PIP) payments to which no other item applies		
Item	**Description**	**Fee**
Subgroup 1—Taking of a cervical smear from an unscreened or significantly underscreened woman		
2598	Professional attendance at consulting rooms of less than 5 minutes in duration by a medical practitioner who practices in general practice (other than a general practitioner) at which a cervical smear is taken from a person between the ages of 20 and 69 years (inclusive) who has not had a cervical smear in the last 4 years	$11.00
2600	Professional attendance at consulting rooms of more than 5, but not more than 25 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), at which a cervical smear is taken from a person between the ages of 20 and 69 (inclusive) who has not had a cervical smear in the last 4 years	$21.00
2603	Professional attendance at consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), at which a cervical smear is taken from a person between the ages of 20 and 69 (inclusive) who has not had a cervical smear in the last 4 years	$38.00
2606	Professional attendance at consulting rooms of more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), at which a cervical smear is taken from a person between the ages of 20 and 69 (inclusive) who has not had a cervical smear in the last 4 years	$61.00
2610	Professional attendance at a place other than consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), at which a cervical smear is taken from a person between the ages of 20 and 69 (inclusive) who has not had a cervical smear in the last 4 years	Amount under clause 2.1.1

Group A19—Other non-referred attendances associated with Practice Incentives Program (PIP) payments to which no other item applies		
Item	**Description**	**Fee**
2613	Professional attendance at a place other than consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), at which a cervical smear is taken from a person between the ages of 20 and 69 (inclusive) who has not had a cervical smear in the last 4 years	Amount under clause 2.1.1
2616	Professional attendance at a place other than consulting rooms of more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), at which a cervical smear is taken from a person between the ages of 20 and 69 (inclusive) who has not had a cervical smear in the last 4 years	Amount under clause 2.1.1
Subgroup 2—Completion of a cycle of care for patients with established diabetes mellitus		
2620	Professional attendance at consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus	$21.00
2622	Professional attendance at consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the requirements for a cycle of care of a patient with established diabetes mellitus	$38.00
2624	Professional attendance at consulting rooms of more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus	$61.00
2631	Professional attendance at a place other than consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner who practises in	Amount under clause 2.1.1

Group A19—Other non-referred attendances associated with Practice Incentives Program (PIP) payments to which no other item applies		
Item	**Description**	**Fee**
	general practice (other than a general practitioner), that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus	
2633	Professional attendance at a place other than consulting rooms of more than 25 minutes but not more than 45 minutes, in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus	Amount under clause 2.1.1
2635	Professional attendance at a place other than consulting rooms of more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus	Amount under clause 2.1.1
Subgroup 3—Completion of the Asthma Cycle of Care		
2664	Professional attendance at consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care	$21.00
2666	Professional attendance at consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care	$38.00
2668	Professional attendance at consulting rooms of more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care	$61.00
2673	Professional attendance at a place other than consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner who practises in	Amount under clause 2.1.1

Group A19—Other non-referred attendances associated with Practice Incentives Program (PIP) payments to which no other item applies

Item	Description	Fee
	general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care	
2675	Professional attendance at a place other than consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care	Amount under clause 2.1.1
2677	Professional attendance at a place other than consulting rooms of more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care	Amount under clause 2.1.1

Division 2.20—Group A20: Mental health care

2.20.1 Definitions

In this Division:

focussed psychological strategies means any of the following mental health care management strategies which have been derived from evidence-based psychological therapies:

(a) psycho-education;
(b) cognitive-behavioural therapy which involves cognitive or behavioural interventions;
(c) relaxation strategies;
(d) skills training;
(e) interpersonal therapy.

mental disorder means a significant impairment of any or all of an individual's cognitive, affective and relational abilities that:

(a) may require medical intervention; and
(b) may be a recognised, medically diagnosable illness or disorder; and
(c) is not dementia, delirium, tobacco use disorder or mental retardation.

Note: In relation to this definition, attention is drawn to the Diagnostic and Management Guidelines for Mental Disorders in Primary Care (ICD-10, Chapter 5, Primary Care Version), developed by the World Health Organisation and published in 1996.

outcome measurement tool means a tool used to monitor changes in a patient's health that occur in response to treatment received by the patient.

2.20.2 Meaning of *amount under clause 2.20.2*

In items 2723 and 2727:

amount under clause 2.20.2, for an item mentioned in column 1 of table 2.20.2, means the sum of:

(a) the fee mentioned in column 2 for the item; and
(b) either:
(i) if not more than 6 patients are attended at a single attendance—the amount mentioned in column 3 for the item, divided by the number of patients attended; or
(ii) if more than 6 patients are attended at a single attendance—the amount mentioned in column 4 for the item.

Table 2.20.2—Amount under clause 2.20.2

Item	Column 1 Item of the table	Column 2 Fee	Column 3 Amount if not more than 6 patients (to be divided by the number of patients) ($)	Column 4 Amount if more than 6 patients ($)
1	2723	The fee for item 2721	25.45	1.95
2	2727	The fee for item 2725	25.45	1.95

2.20.3 Meaning of *preparation of a GP mental health treatment plan*

(1) The ***preparation of a GP mental health treatment plan***, for a patient, means each of the following:
(a) preparation of a written plan by a medical practitioner for the patient that includes:
(i) an assessment of the patient's mental disorder, including administration of an outcome measurement tool (except if considered clinically inappropriate); and
(ii) formulation of the mental disorder, including provisional diagnosis or diagnosis; and
(iii) treatment goals with which the patient agrees; and
(iv) any actions to be taken by the patient; and
(v) a plan for either or both of the following:
(A) crisis intervention;
(B) relapse prevention; and

(vi) referral and treatment options for the patient; and
(vii) arrangements for providing the referral and treatment options mentioned in subparagraph (a)(vi); and
(viii) arrangements to review the plan;

(b) explaining to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in preparing the plan;
(c) recording the plan;
(d) recording the patient's agreement to the preparation of the plan;
(e) offering the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees):
(i) a copy of the plan; and
(ii) suitable education about the mental disorder;
(f) adding a copy of the plan to the patient's medical records.

(2) In subparagraph (1)(a)(vi), ***referral and treatment options***, for a patient, includes:
(a) support services for the patient; and
(b) psychiatric services for the patient; and
(c) subject to the applicable limitations:
(i) psychological therapies provided to the patient by a clinical psychologist (items 80000 to 80020); and
(ii) focussed psychological strategies services provided to the patient by a medical practitioner mentioned in paragraph 2.20.7(1)(b) to provide those services (items 2721 to 2727); and
(iii) focussed psychological strategies services provided to the patient by an allied mental health professional (items 80100 to 80170).

Note: For items 80000 to 80020 and 80100 to 80170, see the determination about allied health services under subsection 3C(1) of the Act.

2.20.4 Meaning of *review of a GP mental health treatment plan*

A ***review of a GP mental health treatment plan*** means a process by which a medical practitioner:

(a) reviews the matters mentioned in paragraph (a) of the definition of ***preparation of a GP mental health treatment plan*** in clause 2.20.3; and
(b) checks, reinforces and expands any education given under the plan; and
(c) if appropriate and if not previously provided—prepares a plan for either or both of the following:
  (i) crisis intervention;
  (ii) relapse prevention;
(d) re-administers the outcome measurement tool used in the assessment mentioned in subparagraph (1)(a)(i) of the definition of ***preparation of a GP mental health treatment plan*** in clause 2.20.3 (except if considered clinically inappropriate); and
(e) if different arrangements need to be made—makes amendments to the plan that state those new arrangements; and
(f) explains to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in the review of the plan; and
(g) records the patient's agreement to the review of the plan; and
(h) if amendments are made to the plan:
  (i) offers a copy of the amended plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
  (ii) adds a copy of the amended plan to the patient's medical records.

2.20.5 Meaning of *associated medical practitioner*

associated medical practitioner means a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) who, if not engaged in the same general practice as the medical practitioner mentioned in that item, performs the service mentioned in the item at the request of the patient (or the patient's guardian).

2.20.6 Application of Subgroup 1 of Group A20

(1) Items 2700, 2701, 2712, 2713, 2715 and 2717 apply only to a patient with a mental disorder.

(2) Items 2700, 2701, 2712, 2715 and 2717 apply only to:
  (a) a patient in the community; and
  (b) a private in-patient (including a private in-patient who is a resident of an aged care facility) being discharged from hospital; and
  (c) a service provided in the course of personal attendance by a single medical practitioner on a single patient.

(3) Unless exceptional circumstances exist, items 2700, 2701, 2715 and 2717 cannot be claimed:
  (a) with a service to which items 735 to 758, or item 2713 apply; or
  (b) more than once in a 12 month period from the provision of any of the items for a particular patient; or
  (c) within 3 months following the provision of a service to which item 2712, or item 2719 of the *Health Insurance (Review of GP Mental Health Treatment Plan) Determination 2011* (as in force on 29 February 2012), applies; or
  (d) more than once in a 12 month period from the provision of a service to which item 2702 or 2710 of the *Health Insurance (General Medical Services Table) Regulations 2010* (as in force on 31 October 2011) applies for the patient.

(4) Item 2712 applies only if one of the following services has been provided to the patient:
  (a) the preparation of a GP mental health treatment plan under:
    (i) items 2700, 2701, 2715 and 2717; or
    (ii) items 2702 and 2710 of the *Health Insurance (General Medical Services Table) Regulations 2010* (as in force on 31 October 2011);
  (b) a review of a GP mental health treatment plan under item 2712, or item 2719 of the *Health Insurance (Review of*

GP Mental Health Treatment Plan) Determination 2011 (as in force on 29 February 2012);

(c) a psychiatrist assessment and management plan under item 291.

(5) Item 2712 does not apply:

(a) to a service to which items 735 to 758, or item 2713 apply; or

(b) unless exceptional circumstances exist for the provision of the service:

(i) more than once in a 3 month period; or

(ii) within 4 weeks following the preparation of a GP mental health treatment plan (item 2700, 2701, 2715 or 2717); or

(c) unless exceptional circumstances exist for the provision of the service to a patient within 3 months after the patient is provided a service to which item 2719 of the *Health Insurance (Review of GP Mental Health Treatment Plan) Determination 2011* (as in force on 29 February 2012) applies.

(6) Item 2713 applies only:

(a) to a surgery consultation; and

(b) to an attendance of at least 20 minutes in duration.

(7) Item 2713 does not apply in association with a service to which item 2700, 2701, 2715, 2717 or 2712 applies.

(8) Items 2715 and 2717 apply only if the medical practitioner providing the service has successfully completed mental health skills training accredited by the General Practice Mental Health Standards Collaboration.

Note: The General Practice Mental Health Standards Collaboration operates under the auspices of the Royal Australian College of General Practitioners.

(9) In this clause:

exceptional circumstances means a significant change in:

(a) the patient's clinical condition; or

(b) the patient's care circumstances.

2.20.7 Focussed psychological strategies

(1) An item in Subgroup 2 of Group A20 applies to a service which:

(a) is clinically indicated under a GP mental health treatment plan or a psychiatrist assessment and management plan; and

(b) is provided by a medical practitioner:

(i) whose name is entered in the register maintained by the Chief Executive Medicare under regulation 30 of the *Human Services (Medicare) Regulations 1975*; and

(ii) who is identified in the register as a practitioner who can provide services to which Subgroup 2 of Group A20 applies; and

(iii) who meets any training and skills requirements, as determined by the General Practice Mental Health Standards Collaboration for providing services to which Subgroup 2 of Group A20 applies.

(2) An item in Subgroup 2 of Group A20 does not apply to:

(a) a service which:

(i) is provided to a patient who, in a calendar year, has already been provided with 6 services to which any of the items in Subgroup 2 applies; and

(ii) is provided before the medical practitioner managing the GP mental health treatment plan or the psychiatrist assessment and management plan has conducted a patient review and recorded in the patient's records a recommendation that the patient have additional sessions of focussed psychological strategies in the same calendar year; or

(b) a service which:

(i) for the period from 1 March 2012 to 31 December 2012—is provided to a patient who has already been provided, in the calendar year, with 10 (or if exceptional circumstances exist—16) other services to which any of the items in Subgroup 2, or items 80000 to 80015, 80100 to 80115, 80125 to 80140 or 80150 to 80165 apply; and

(ii) for each subsequent calendar year—is provided to a patient who has already been provided, in the calendar year, with 10 other services to which any of the items in Subgroup 2, or items 80000 to 80015, 80100 to 80115, 80125 to 80140 or 80150 to 80165 apply.

Note: For items 80000 to 80015, 80100 to 80115, 80125 to 80140 and 80150 to 80165, see the determination about allied health services under subsection 3C(1) of the Act.

Group A20—Mental health care

Item	Description	Fee
Subgroup 1—GP mental health treatment plans		
2700	Professional attendance by a medical practitioner (including a general practitioner who has not undertaken mental health skills training, but not including a specialist or consultant physician) of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	$70.30
2701	Professional attendance by a medical practitioner (including a general practitioner who has not undertaken mental health skills training, but not including a specialist or consultant physician) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	$103.50
2712	Professional attendance by a medical practitioner (not including a specialist or consultant physician) to review a GP mental health treatment plan which he or she, or an associated medical practitioner has prepared, or to review a Psychiatrist Assessment and Management Plan	$70.30
2713	Professional attendance by a medical practitioner (not including a specialist or consultant physician) in relation to a mental disorder and of at least 20 minutes in duration, involving taking relevant history and identifying the presenting problem (to the extent not previously recorded), providing treatment and advice and, if appropriate, referral for other services or treatments, and documenting the outcomes of the consultation	$70.30
2715	Professional attendance by a medical practitioner (including	$89.25

Group A20—Mental health care		
Item	**Description**	**Fee**
	a general practitioner who has undertaken mental health skills training, but not including a specialist or consultant physician) of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	
2717	Professional attendance by a medical practitioner (including a general practitioner who has undertaken mental health skills training, but not including a specialist or consultant physician) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient	$131.45
Subgroup 2—Focussed psychological strategies		
2721	Professional attendance at consulting rooms by a medical practitioner who practises in general practice (other than a specialist or a consultant physician), for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes	$90.95
2723	Professional attendance at a place other than consulting rooms by a medical practitioner who practises in general practice (other than a specialist or a consultant physician), for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes	Amount under clause 2.20.2
2725	Professional attendance at consulting rooms by a medical practitioner who practises in general practice (other than a specialist or a consultant physician), for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes	$130.15
2727	Professional attendance at a place other than consulting	Amount

Group A20—Mental health care		
Item	**Description**	**Fee**
	rooms by a medical practitioner who practises in general practice (other than a specialist or a consultant physician), for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes	under clause 2.20.2

Division 2.21—Group A24: Palliative and pain medicine

2.21.1 Meaning of *organise and coordinate*

In the items mentioned in Subgroups 2 and 4 of Group A24:

organise and coordinate, for a conference mentioned in the item, means undertaking all of the following activities:

(a) explaining to the patient the nature of the conference;
(b) asking the patient whether the patient agrees to the conference taking place;
(c) recording the patient's agreement to the conference;
(d) recording the day the conference was held and the times the conference started and ended;
(e) recording the names of the participants;
(f) recording the activities mentioned in the definition of ***multidisciplinary case conference*** in clause 1.1.2 and putting a copy of that record in the patient's medical records;
(g) offering the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees), and giving each other member of the team, a summary of the conference;
(h) discussing the outcomes of the conference with the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees).

2.21.2 Meaning of *participate*

In items 2958, 2972, 2974, 2992, 2996, 3000, 3051, 3055, 3062, 3083, 3088 and 3093:

participate, for a conference mentioned in the item, means participation that:

(a) if the conference is a community case conference—is at the request of the person who organises and coordinates the conference; and

(b) involves undertaking all of the following activities in relation to the conference:
  (i) explaining to the patient the nature of the conference;
  (ii) asking the patient whether the patient agrees to the practitioner's participation in the conference;
  (iii) recording the patient's agreement to the practitioner's participation in the conference;
  (iv) recording the day the conference was held and the times the conference started and ended;
  (v) recording the names of the participants;
  (vi) recording the activities mentioned in the definition of ***multidisciplinary case conference*** in clause 1.1.2 and putting a copy of that record in the patient's medical records; but

(c) if the conference is a community case conference—does not include organising and coordinating the conference.

2.21.3 Application of Group A24

(1) Subgroups 1 and 2 of Group A24 apply only if the attendance is by a medical practitioner who is recognised as a specialist, or consultant physician, in the specialty of pain medicine for the purposes of the Act.

(2) Subgroups 3 and 4 of Group A24 apply only if the attendance is by a medical practitioner who is recognised as a specialist, or consultant physician, in the specialty of palliative medicine for the purposes of the Act.

2.21.4 Limitation on items

The items in Subgroups 2 and 4 of Group A24 may only apply to a patient 5 times in a 12 month period.

2.21.5 Limitation of items

Items 2799, 2820, 3003 and 3015 do not apply if the patient, specialist or physician travels to a place to satisfy the requirement in:

(a) for items 2799 and 3003—sub-subparagraph(c)(i)(B) of the item; and
(b) for items 2820 and 3015—sub-subparagraph (d)(i)(B) of the item.

Group A24—Palliative and pain medicine		
Item	**Description**	**Fee**
Subgroup 1—Pain medicine attendances		
2799	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist or consultant physician practising in his or her specialty of pain medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment	$113.20
2801	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner—initial attendance in a single course of treatment	$150.90
2806	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner—each attendance (other than a service to which item 2814 applies) after the first in a single course of treatment	$75.50

Group A24—Palliative and pain medicine		
Item	**Description**	**Fee**
2814	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner—each minor attendance after the first attendance in a single course of treatment	$43.00
2820	Professional attendance on a patient by a specialist or consultant physician practising in his or her specialty of pain medicine if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 2801 lasting more than 10 minutes; or (ii) provided with item 2806 or 2814; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies	50% of the fee for item 2801, 2806 or 2814
2824	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner—initial attendance in a single course of treatment	$183.10
2832	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner—each attendance (other than a service to which item 2840 applies) after the first in a single course of	$110.75

Group A24—Palliative and pain medicine		
Item	**Description**	**Fee**
	treatment	
2840	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner—each minor attendance after the first attendance in a single course of treatment	$79.75
Subgroup 2—Pain medicine case conferences		
2946	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes	$139.10
2949	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes	$208.70
2954	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 45 minutes	$278.15
2958	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes	$99.90
2972	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes	$159.30
2974	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member	$218.75

Group A24—Palliative and pain medicine		
Item	**Description**	**Fee**
	of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes	
2978	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	$139.10
2984	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	$208.70
2988	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H)	$278.15
2992	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	$99.90
2996	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	$159.30
3000	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a	$218.75

Group A24—Palliative and pain medicine		
Item	**Description**	**Fee**
	discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H)	
Subgroup 3—Palliative medicine attendances		
3003	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist or consultant physician practising in his or her specialty of palliative medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment	$113.20
3005	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner—initial attendance in a single course of treatment	$150.90
3010	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner—each attendance (other than a service to which item 3014 applies) after the first in a single course of treatment	$75.50
3014	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her	$43.00

Group A24—Palliative and pain medicine		
Item	**Description**	**Fee**
	specialty of palliative medicine following referral of the patient to him or her by a referring practitioner—each minor attendance after the first attendance in a single course of treatment	
3015	Professional attendance on a patient by a specialist or consultant physician practising in his or her specialty of palliative medicine if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 3005 lasting more than 10 minutes; or (ii) provided with item 3010 or 3014; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist or physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies	50% of the fee for item 3005, 3010 or 3014
3018	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner—initial attendance in a single course of treatment	$183.10
3023	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner—each attendance (other than a service to which item 3028 applies) after the first in a single course of treatment	$110.75

Group A24—Palliative and pain medicine		
Item	**Description**	**Fee**
3028	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner—each minor attendance after the first attendance in a single course of treatment	$79.75
Subgroup 4—Palliative medicine case conferences		
3032	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes	$139.10
3040	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes	$208.70
3044	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 45 minutes	$278.15
3051	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes	$99.90
3055	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	$159.30
3062	Attendance by a specialist, or consultant physician, in the	$218.75

Group A24—Palliative and pain medicine		
Item	**Description**	**Fee**
	practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes	
3069	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	$139.10
3074	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	$208.70
3078	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H)	$278.15
3083	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	$99.90
3088	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	$159.30
3093	Attendance by a specialist, or consultant physician, in the	$218.75

Group A24—Palliative and pain medicine		
Item	**Description**	**Fee**
	practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H)	

Division 2.22—Group A27: Pregnancy support counselling

2.22.1 Application of item 4001

(1) A service to which item 4001 applies must not be provided by a medical practitioner who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination.

(2) Item 4001 does not apply if a patient has already been provided, for the same pregnancy, with 3 services to which that item or item 81000, 81005 or 81010 applies.

Note: For items 81000, 81005 and 81010, see the determination about allied health services under subsection 3C(1) of the Act.

(3) In item 4001:

non-directive pregnancy support counselling means counselling provided by a medical practitioner to a woman in which:

(a) information and issues relating to pregnancy are discussed; but

(b) the medical practitioner does not impose his or her views or values about what the woman should or should not do in relation to the pregnancy.

(4) A service to which item 4001 applies may be used to address any pregnancy-related issue.

Group A27—Pregnancy support counselling

Item	Description	Fee ($)
4001	Professional attendance of at least 20 minutes in duration at consulting rooms by a medical practitioner (including a general practitioner but not including a specialist or consultant physician) who is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service for the purpose of providing non-directive pregnancy support counselling to a woman who is concerned about a current pregnancy or a pregnancy that occurred in the 12 months preceding the provision	75.10

Group A27—Pregnancy support counselling		
Item	**Description**	**Fee ($)**
	of the first service to which this item or item 81000, 81005 or 81010 applies in relation to that pregnancy Note: For items 81000, 81005 and 81010, see the determination about allied health services under subsection 3C(1) of the Act.	

Division 2.23—Group A22: General practitioner after-hours attendances to which no other item applies

2.23.1 Application of Group A22

(1) Items 5000, 5020, 5040 and 5060 apply only to a professional attendance that is provided:
  (a) on a public holiday; or
  (b) on a Sunday; or
  (c) before 8 am, or after 1 pm, on a Saturday; or
  (d) before 8 am, or after 8 pm, on a day other than a day mentioned in paragraphs (a) to (c).

(2) Items 5003, 5010, 5023, 5028, 5043, 5049, 5063 and 5067 apply only to a professional attendance that is provided in an after-hours period.

Group A22—General practitioner after-hours attendances to which no other item applies

Item	Description	Fee
5000	Professional attendance at consulting rooms (other than a service to which another item applies) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management—each attendance	$28.45
5003	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies) that requires a short patient history and, if necessary, limited examination and management—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1
5010	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or	Amount under clause 2.1.1

Group A22—General practitioner after-hours attendances to which no other item applies		
Item	**Description**	**Fee**
	professional attendance at consulting rooms situated within such a complex, if the patient is accommodated in a residential aged care facility (other than accommodation in a self-contained unit) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	
5020	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—each attendance	$48.05
5023	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1
5028	Professional attendance by a general practitioner (other than	Amount

Group A22—General practitioner after-hours attendances to which no other item applies		
Item	**Description**	**Fee**
	a service to which another item in the table applies), at a residential aged care facility to residents of the facility, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	under clause 2.1.1
5040	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—each attendance	$82.30

Group A22—General practitioner after-hours attendances to which no other item applies		
Item	**Description**	**Fee**
5043	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1
5049	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1
5060	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination;	$115.45

Group A22—General practitioner after-hours attendances to which no other item applies		
Item	**Description**	**Fee**
	(c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—each attendance	
5063	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1
5067	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1

Division 2.24—Group A23: Other non-referred after-hours attendances to which no other item applies

2.24.1 Application of Group A23

(1) Items 5200, 5203, 5207 and 5208 apply only to a professional attendance that is provided:

(a) on a public holiday; or

(b) on a Sunday; or

(c) before 8 am, or after 1 pm, on a Saturday; or

(d) before 8 am, or after 8 pm, on a day other than a day mentioned in paragraphs (a) to (c).

(2) Items 5220 to 5267 apply only to a professional attendance that is provided in an after-hours period.

Group A23—Other non-referred after-hours attendances to which no other item applies

Item	Description	Fee
5200	Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)—each attendance	$21.00
5203	Professional attendance at consulting rooms of more than 5 minutes in duration but not more than 25 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)—each attendance	$31.00
5207	Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)—each attendance	$48.00
5208	Professional attendance at consulting rooms of more than 45 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general	$71.00

Group A23—Other non-referred after-hours attendances to which no other item applies		
Item	**Description**	**Fee**
	practitioner)—each attendance	
5220	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting not more than 5 minutes—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1
5223	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 5 minutes, but not more than 25 minutes—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1
5227	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 25 minutes, but not more than 45 minutes—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1
5228	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 45 minutes—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1
5260	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of not more than 5 minutes in duration by a medical practitioner (other than a general practitioner)—an attendance on one or more patients at one	Amount under clause 2.1.1

Group A23—Other non-referred after-hours attendances to which no other item applies		
Item	**Description**	**Fee**
	residential aged care facility on one occasion—each patient	
5263	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of more than 5 minutes in duration but not more than 25 minutes in duration by a medical practitioner (other than a general practitioner)—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1
5265	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of more than 25 minutes in duration but not more than 45 minutes by a medical practitioner (other than a general practitioner)—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1
5267	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of more than 45 minutes in duration by a medical practitioner (other than a general practitioner)—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1

Division 2.26—Group A26: Neurosurgery attendances to which no other item applies

2.26.1 Limitation of items 6004 and 6016

Items 6004 and 6016 do not apply if the patient or specialist travels to a place to satisfy the requirement in:

(a) for item 6004—sub-subparagraph (c)(i)(B) of the item; and

(b) for item 6016—sub-subparagraph (d)(i)(B) of the item.

Group A26—Neurosurgery attendances to which no other item applies		
Item	**Description**	**Fee**
6004	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist practising in his or her specialty of neurosurgery if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment	$97.20
6007	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to him or her—an attendance (other than a second or subsequent attendance in a single course of treatment) at consulting rooms or hospital	$129.60
6009	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to him or her—a	$43.00

Group A26—Neurosurgery attendances to which no other item applies		
Item	**Description**	**Fee**
	minor attendance after the first in a single course of treatment at consulting rooms or hospital	
6011	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to him or her—an attendance after the first in a single course of treatment, involving an extensive and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 15 minutes in duration but not more than 30 minutes in duration at consulting rooms or hospital	$85.55
6013	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to him or her—an attendance after the first in a single course of treatment, involving a detailed and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 30 minutes in duration but not more than 45 minutes in duration at consulting rooms or hospital	$118.50
6015	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to him or her—an attendance after the first in a single course of treatment, involving an exhaustive and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 45 minutes in duration at consulting rooms or hospital	$150.90
6016	Professional attendance on a patient by a specialist practising in his or her specialty of neurosurgery if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 6007 lasting more than 10 minutes; or (ii) provided with item 6009, 6011, 6013 or 6015; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and	50% of the fee for item 6007, 6009, 6011, 6013 or 6015

Group A26—Neurosurgery attendances to which no other item applies		
Item	**Description**	**Fee**
	(B) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies	

Division 2.27—Group A9: Contact lenses

2.27.1 Application of item 10809

Item 10809 does not apply if the patient's requirement for contact lenses is only for any of the following reasons:

(a) because the patient does not want to wear spectacles for reasons of appearance;

(b) because the patient wants contact lenses for work or sporting purposes;

(c) because the patient has difficulty in using, or cannot use, spectacles for psychological reasons.

Group A9—Contact lenses

Item	Description	Fee ($)
10801	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription—one service in any period of 36 months—patient with myopia of 5.0 dioptres or greater (spherical equivalent) in one eye	121.65
10802	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription—one service in any period of 36 months—patient with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in one eye	121.65
10803	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription—one service in any period of 36 months—patient with astigmatism of 3.0 dioptres or greater in one eye	121.65
10804	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription—one service in any period of 36 months—patient with irregular astigmatism in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3	121.65

Group A9—Contact lenses		
Item	**Description**	**Fee ($)**
	logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens	
10805	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription—one service in any period of 36 months—patient with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents)	121.65
10806	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription—one service in any period of 36 months—patient with corrected visual acuity of 0.7 logMAR (6/30) or worse in both eyes and for whom a contact lens is prescribed as part of a telescopic system	121.65
10807	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription—one service in any period of 36 months—patient for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by pathological mydriasis, aniridia, coloboma of the iris, pupillary malformation or distortion, significant ocular deformity or corneal opacity—whether congenital, traumatic or surgical in origin	121.65
10808	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription—one service in any period of 36 months—patient who, because of physical deformity, are unable to wear spectacles	121.65
10809	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription—one service in any period of 36 months—patient with a medical or optical condition (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10806, 10807 or 10808 applies) requiring the use of a contact lens for correction, if the condition is specified on the patient's account	121.65
10816	Attendance for the refitting of contact lenses with keratometry and testing with trial lenses and the issue of a prescription, if the	121.65

Group A9—Contact lenses		
Item	**Description**	**Fee ($)**
	patient requires a change in contact lens material or basic lens parameters, other than simple power change, because of a structural or functional change in the eye or an allergic response within 36 months after the fitting of a contact lens to which items 10801 to 10809 apply	

Division 2.28—Group A10: Optometric services provided by participating optometrist

2.28.1 Application of items 10900, 10940 and 10941

(1) A service described in item 10900 applies to a patient only if the patient has not received a service described in item 10900, 10905, 10907, 10912, 10913, 10914 or 10915 in the previous 24 months.

(2) A service described in item 10940 applies to a patient not more than twice in a 12 month period and includes a service described in item 10941.

(3) A service described in item 10941 applies to a patient not more than twice in a 12 month period and includes a service described in item 10940.

2.28.2 Application of item 10929

Item 10929 does not apply if the patient's requirement for contact lenses is only for any of the following reasons:

(a) because the patient does not want to wear spectacles for reasons of appearance;

(b) because the patient wants contact lenses for work or sporting purposes;

(c) because the patient has difficulty in using, or cannot use, spectacles for psychological reasons.

2.28.3 Limitation on items

(1) Item 10943 may only apply to a patient once in a 12 month period.

(2) Item 10942 may only apply to a patient twice in a 12 month period.

(3) Items 10921 to 10929 may only apply to a patient once in a 36 month period.

2.28.4 Application of items 10931, 10932 and 10933

(1) If item 10931, 10932 or 10933 applies, the fee mentioned in that item applies in addition to the fee mentioned in another item in the table that applies to the service.

(2) The fee charged for the following must not exceed 2 times the fee mentioned in item 10900:
  (a) the fee mentioned in item 10931, 10932 or 10933 if it is not bulk-billed;
  (b) the fee mentioned in another item in the table that applies to the service if it is not bulk-billed;
  (c) the fee charged by an optometrist for the service.

(3) In items 10931, 10932 and 10933:

bulk-billed, for a medical 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 practitioner by whom, or on whose behalf, the service is provided, his or her right to the payment of the medicare benefit; and
    (ii) the practitioner accepts the assignment in full payment of his or her fee for the service provided.

2.28.5 Limitation of item 10943

A service described in item 10943 does not apply to a service used to assess learning difficulties or learning disabilities.

Group A10—Optometric services provided by participating optometrist

Item	Description	Fee ($)
10900	Professional attendance of more than 15 minutes in duration, being the first in a course of attention	71.00
10905	Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if the patient has been	71.00

Group A10—Optometric services provided by participating optometrist		
Item	**Description**	**Fee ($)**
	referred by another optometrist who is not associated with the optometrist to whom the patient is referred	
10907	Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if the patient has attended another optometrist within the previous 24 months for an attendance to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10915 applies. The appropriate fee for the purpose of paragraph 23A(2)(c) of the Act is the fee mentioned in item 10900	35.55
10912	Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if the patient has suffered a significant change of visual function requiring comprehensive reassessment within 24 months of an initial consultation to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10915 at the same practice applies	71.00
10913	Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if the patient has new signs or symptoms, unrelated to the earlier course of attention, requiring comprehensive reassessment within 24 months of an initial consultation to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10915 at the same practice applies	71.00
10914	Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if the patient has a progressive disorder (excluding presbyopia) requiring comprehensive reassessment within 24 months of an initial consultation to which item 10900, 10905, 10907, 10912, 10913, 10914 or 10915 applies	71.00
10915	Professional attendance of more than 15 minutes in duration, being the first in a course of attention involving the examination of the eyes, with the instillation of a mydriatic, of a patient with diabetes mellitus, requiring comprehensive reassessment	71.00
10916	Professional attendance, being the first in a course of attention, of not more than 15 minutes in duration (other than a service associated with a service to which item 10931, 10932, 10933, 10940, 10941, 10942 or 10943 applies)	35.55
10918	Professional attendance, being the second or subsequent in a course of attention and being unrelated to the prescription and	35.55

Group A10—Optometric services provided by participating optometrist		
Item	**Description**	**Fee ($)**
	fitting of contact lenses (other than a service associated with a service to which item 10940 or 10941 applies)	
10921	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which item 10900, 10905, 10907, 10912, 10913, 10914, 10915 or 10916 applies—patients with myopia of 5.0 dioptres or greater (spherical equivalent) in one eye	176.15
10922	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which item 10900, 10905, 10907, 10912, 10913, 10914, 10915 or 10916 applies—patients with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in one eye	176.15
10923	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which item 10900, 10905, 10907, 10912, 10913, 10914, 10915 or 10916 applies—patients with astigmatism of 3.0 dioptres or greater in one eye	176.15
10924	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which item 10900, 10905, 10907, 10912, 10913, 10914, 10915 or 10916 applies—patients with irregular astigmatism in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3 logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens	222.30
10925	All professional attendances after the first, being those	176.15

Group A10—Optometric services provided by participating optometrist		
Item	**Description**	**Fee ($)**
	attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which item 10900, 10905, 10907, 10912, 10913, 10914, 10915 or 10916 applies—patients with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents)	
10926	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which item 10900, 10905, 10907, 10912, 10913, 10914, 10915 or 10916 applies—patients with corrected visual acuity of 0.7 logMAR (6/30) or worse in both eyes, being patients for whom a contact lens is prescribed as part of a telescopic system	176.15
10927	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which item 10900, 10905, 10907, 10912, 10913, 10914, 10915 or 10916 applies—patients for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by pathological mydriasis, aniridia, coloboma of the iris, pupillary malformation or distortion, significant ocular deformity or corneal opacity—whether congenital, traumatic or surgical in origin	222.30
10928	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which item 10900, 10905, 10907, 10912, 10913, 10914, 10915 or 10916 applies—patients who, because of physical deformity, are unable to wear spectacles	176.15
10929	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a	222.30

Group A10—Optometric services provided by participating optometrist		
Item	**Description**	**Fee ($)**
	service to which item 10900, 10905, 10907, 10912, 10913, 10914, 10915 or 10916 applies—patients who have a medical or optical condition (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10926, 10927 or 10928 applies) requiring the use of a contact lens for correction, if the condition is specified on the patient's account	
10930	All professional attendances regarded as a single service in a single course of attention involving the prescription and fitting of contact lenses if the patient meets the requirements of an item in the series 10921 to 10929 and requires a change in contact lens material or basic lens parameters, other than a simple power change, because of a structural or functional change in the eye or an allergic response within 36 months of the fitting of a contact lens covered by items 10921 to 10929	176.15
10931	A service to which an item in Group A10 applies (other than this item or item 10916, 10932, 10933, 10940 or 10941), if the service: (a) is provided: (i) during a home visit to a person; or (ii) in a residential aged care facility; or (iii) in an institution; and (b) is provided to a single patient at a single location on a single occasion; and (c) is: (i) bulk-billed for the fees for this item and another item in the table applying to the service; or (ii) not bulk-billed for the fees for this item and another item in the table applying to the service	24.75

Group A10—Optometric services provided by participating optometrist		
Item	**Description**	**Fee ($)**
10932	A service to which an item in Group A10 applies (other than this item or item 10916, 10931, 10933, 10940 or 10941), if the service: (a) is provided: (i) during a home visit to a person; or (ii) in a residential aged care facility; or (iii) in an institution; and (b) is provided to each of 2 patients at a single location on a single occasion; and (c) is: (i) bulk-billed for the fees for this item and another item in the table applying to the service; or (ii) not bulk-billed for the fees for this item and another item in the table applying to the service	12.35
10933	A service to which an item in Group A10 applies (other than this item or item 10916, 10931, 10932, 10940 or 10941), if the service: (a) is provided: (i) during a home visit to a person; or (ii) in a residential aged care facility; or (iii) in an institution; and (b) is provided to each of 3 patients at a single location on a single occasion; and (c) is: (i) bulk-billed for the fees for this item and another item in the table applying to the service; or (ii) not bulk-billed for the fees for this item and another item in the table applying to the service	8.20
10940	Full quantitative computerised perimetry (automated absolute static threshold), with bilateral assessment and report, if indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain that: (a) is not a service involving multifocal multichannel objective perimetry; and (b) is performed by an optometrist; other than a service associated with a service to which	67.75

Group A10—Optometric services provided by participating optometrist		
Item	**Description**	**Fee ($)**
	item 10916, 10918, 10931, 10932 or 10933 applies	
10941	Full quantitative computerised perimetry (automated absolute static threshold) with unilateral assessment and report, if indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain that: (a) is not a service involving multifocal multichannel objective perimetry; and (b) is performed by an optometrist; other than a service associated with a service to which item 10916, 10918 10931, 10932 or 10933 applies	40.85
10942	Testing of residual vision to provide optimum visual performance for a patient who has best corrected visual acuity of 6/15 or N.12 or worse in the better eye or a horizontal visual field of less than 120 degrees and within 10 degrees above and below the horizontal midline, involving one or more of the following: (a) spectacle correction; (b) determination of contrast sensitivity; (c) determination of glare sensitivity; (d) prescription of magnification aids; other than a service associated with a service to which item 10916, 10921, 10922, 10923, 10924, 10925, 10926, 10927, 10928, 10929 or 10930 applies	35.55
10943	Additional testing to confirm diagnosis of, or establish a treatment regime for, a significant binocular or accommodative dysfunction, in a patient aged 3 to 14 years, including assessment of one or more of the following: (a) accommodation; (b) ocular motility; (c) vergences; (d) fusional reserves; (e) cycloplegic refraction; other than a service to which item 10916, 10921, 10922, 10923, 10924, 10925, 10926, 10927, 10928, 10929 or 10930 applies	35.55

Division 2.29—Miscellaneous services

Note: Reserved for future use.

Division 2.30—Group M12: Services provided by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner

2.30.1 Definitions for item 10997

In item 10997:

GP management plan means a plan under item 721 or 732 (for coordination of a review of a GP management plan under item 721).

multidisciplinary care plan means a plan under item 729 or 731.

person with a chronic disease means a person who has a care plan under item 721, 723, 729, 731 or 732.

2.30.2 Application of item 10986

(1) For item 10986, the only health assessment that may be provided is a Healthy Kids Check, in accordance with clause 2.16.4 for a patient if the patient is:
  (a) at least 3 years old and under 5 years old; and
  (b) receiving or has received the immunisation recommended for a 4 year old child; and
  (c) not an in-patient of a hospital.

(2) Item 10986 applies only if:
  (a) the practice nurse or Aboriginal and Torres Strait Islander health practitioner providing the assessment is appropriately qualified and trained to perform the services provided; and
  (b) the medical practitioner under whose supervision the treatment is provided retains responsibility for clinical outcomes and for the health and safety of the patient.

(3) A Healthy Kids Check, in accordance with clause 2.16.4, provided under item 10986:

(a) must not be provided more than once to an eligible person; and

(b) must not be provided to a patient who has previously received a Healthy Kids Check, in accordance with clause 2.16.4, under item 701, 703, 705 or 707.

2.30.3 Restrictions on item 10986

(1) A health assessment mentioned in clause 2.30.2 must not include a health screening service.

(2) A separate consultation must not be conducted in conjunction with a health assessment unless clinically necessary.

(3) In this clause:

health screening service has the same meaning as in subsection 19(5) of the Act.

2.30.4 Application of item 10988

(1) Item 10988 applies to an immunisation provided to a person by an Aboriginal and Torres Strait Islander health practitioner only if:

(a) the Aboriginal and Torres Strait Islander health practitioner is appropriately qualified and trained to provide immunisations to persons; and

(b) the medical practitioner under whose supervision the immunisation is provided retains responsibility for the health, safety and clinical outcomes of the person.

(2) If the cost of the vaccine supplied in connection with a service described in item 10988 is not subsidised by the Commonwealth or a State, the service is taken not to include the supply of that vaccine.

2.30.5 Application of item 10989

Item 10989 applies to an Aboriginal and Torres Strait Islander health practitioner if:

(a) the health practitioner is appropriately qualified and trained to treat wounds; and

(b) a medical practitioner under whose supervision the health practitioner provides the treatment has conducted an initial assessment of the person; and

(c) the health practitioner has been instructed by the medical practitioner about the treatment of the wound; and

(d) the medical practitioner retains responsibility for the health, safety and clinical outcomes of the person.

2.30.6 Limitation of item 10983

Item 10983 does not apply if the patient or the specialist or consultant physician mentioned in paragraph (a) of the item travels to a place to satisfy the requirement in sub-subparagraph (c)(i)(B) of the item.

Group M12—Services provided by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner

Item	Description	Fee ($)
Subgroup 1—Video conferencing consultation support service provided by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner		
10983	Attendance by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner, to provide clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist, consultant physician or psychiatrist; and (b) is not an admitted patient; and (c) either: (i) is located both:	32.40

Group M12—Services provided by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner		
Item	**Description**	**Fee ($)**
	(A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist, physician or psychiatrist mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies	
Subgroup 2—Video conferencing consultation support service provided at a residential care service, on behalf of a medical practitioner		
10984	Attendance by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner, to provide clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist, consultant physician or psychiatrist; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit	32.40
Subgroup 3—Services provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner		
10986	A Healthy Kids Check in accordance with clause 2.16.4 provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner for a patient who is receiving or has received the immunisation recommended for a 4 year old child if: (a) the Healthy Kids Check is provided on behalf of, and under the supervision of, a medical practitioner (including a general practitioner, but not including a specialist or consultant physician); and (b) the patient is not an in-patient of a hospital	58.20
10987	Follow-up service, to a maximum of 10 services per patient in a	24.00

Group M12—Services provided by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner

Item	Description	Fee ($)
	calendar year, provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner, on behalf of a medical practitioner, for an Indigenous person who has received a health check if: (a) the service is provided on behalf of and under the supervision of a medical practitioner; and (b) the person is not an admitted patient of a hospital; and (c) the service is consistent with the needs identified through the health assessment	
10988	Immunisation provided to a person by an Aboriginal and Torres Strait Islander health practitioner if: (a) the immunisation is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the person is not an admitted patient of a hospital	12.00
10989	Treatment of a person's wound (other than normal aftercare) provided by an Aboriginal and Torres Strait Islander health practitioner if: (a) the treatment is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the person is not an admitted patient of a hospital	12.00
10997	Service provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner to a person with a chronic disease, to a maximum of 5 services for each patient in a calendar year, if: (a) the service is provided on behalf of and under the supervision of a medical practitioner; and (b) the person is not an admitted patient of a hospital; and (c) the person has a GP management plan, team care arrangements or multidisciplinary care plan in place and the service is consistent with the plan or arrangements	12.00

Division 2.31—Group M1: Management of bulk-billed services

2.31.1 Definitions for Division 2.31

In this Division:

ASGC means the document titled *Australian Standard Geographical Classification (ASGC) 2010*, published by the Australian Bureau of Statistics, as in force on 16 September 2010.

bulk-billed, for a medical 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 medical practitioner by whom, or on whose behalf, the service is provided, his or her right to the payment of the medicare benefit; and

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

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*.

eligible area means:

(a) a regional, rural or remote area; or

(b) Tasmania; or

(c) a geographical area included in any of the following SSD spatial units:

(i) Beaudesert Shire Part A;

(ii) Belconnen;

(iii) Darwin City;

(iv) Eastern Outer Melbourne;

(v) East Metropolitan Perth;

(vi) Frankston City;

(vii) Gosford-Wyong;
(viii) Greater Geelong City Part A;
(ix) Gungahlin-Hall;
(x) Ipswich City (Part in BSD);
(xi) Litchfield Shire;
(xii) Melton-Wyndham;
(xiii) Mornington Peninsula Shire;
(xiv) Newcastle;
(xv) North Canberra;
(xvi) Palmerston-East Arm;
(xvii) Pine Rivers Shire;
(xviii) Queanbeyan;
(xix) South Canberra;
(xx) South Eastern Outer Melbourne;
(xxi) Southern Adelaide;
(xxii) South West Metropolitan Perth;
(xxiii) Thuringowa City Part A;
(xxiv) Townsville City Part A;
(xxv) Tuggeranong;
(xxvi) Weston Creek-Stromlo;
(xxvii) Woden Valley;
(xxviii) Yarra Ranges Shire Part A; or

(d) the geographical area included in the SLA spatial unit of Palm Island (AC).

practice location, for the provision of a medical service, means the place of practice in relation to 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.

SLA means a Statistical Local Area specified in the ASGC.

SSD means a Statistical Subdivision specified in the ASGC.

unreferred service means a medical service provided to a person by, or on behalf of, a medical practitioner, being a service that has

not been referred to that practitioner by another medical practitioner or person with referring rights.

2.31.2 Application of items 10990, 10991 and 10992

(1) If the medical service described in item 10991 is provided to a person, either that item or 10990, but not both those items, applies to the service.

(2) If the medical service described in item 10992 is provided to a person, either that item or 10990, but not both those items, applies to the service.

(3) If item 10990, 10991 or 10992 applies to a medical service, the fee mentioned in that item applies in addition to the fee mentioned in another item in the table that applies to the service.

Group M1—Management of bulk-billed services

Item	Description	Fee ($)
10990	A medical service to which an item in the table (other than this item or item 10991 or 10992) applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) the other item in the table applying to the service	7.05
10991	A medical service to which an item in the table (other than this item or item 10990 or 10992) applies if: (a) the service is an unreferred service; and (b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) the other item in the table applying to the service; and (e) the service is provided at, or from, a practice location in an	10.65

Group M1—Management of bulk-billed services		
Item	**Description**	**Fee ($)**
	eligible area	
10992	A medical service to which item 597, 598, 599, 600, 5003, 5010, 5023, 5028, 5043, 5049, 5063, 5067, 5220, 5223, 5227, 5228, 5260, 5263, 5265 or 5267 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 not provided in consulting rooms; and (e) the service is provided in an eligible area; and (f) the service is provided by, or on behalf of, a medical practitioner whose practice location is not in an eligible area; and (g) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) the other item in the table applying to the service	10.65

Division 2.33—Diagnostic procedures and investigations

Note: Reserved for future use.

Division 2.34—Group D1: Miscellaneous diagnostic procedures and investigations

2.34.1 Meaning of *report*

In this Division:

report means a report prepared by a medical practitioner.

2.34.2 Meaning of *qualified sleep medicine practitioner*

(1) In items 12203, 12207, 12213 and 12217:

qualified sleep medicine practitioner means a qualified adult sleep medicine practitioner or a qualified paediatric sleep medicine practitioner.

(1A) In items 12210 and 12215:

qualified sleep medicine practitioner:

(a) means a qualified paediatric sleep medicine practitioner; and

(b) does not include a qualified adult sleep medicine practitioner.

(1AA) In item 12250:

qualified sleep medicine practitioner:

(a) means a qualified adult sleep medicine practitioner; and

(b) does not include a qualified paediatric sleep medicine practitioner.

(2) A person is a qualified adult sleep medicine practitioner or a qualified paediatric sleep medicine practitioner if:

(a) the person has been assessed by the Credentialling Subcommittee or the Appeal Committee as having had, before 1 March 1999, sufficient training and experience in the relevant field of sleep medicine to be competent in independent clinical assessment and management of patients with respiratory sleep disorders and in reporting sleep studies; or

(b) the person:

(i) has been assessed by the Credentialling Subcommittee or the Appeal Committee as having had, before 1 March 1999, substantial training or experience in adult sleep medicine, but requiring further specified training or experience in the relevant field of sleep medicine to be competent in independent clinical assessment and management of patients with respiratory sleep disorders and in reporting sleep studies; and

(ii) either:

(A) the period of 2 years immediately following that assessment has not expired; or

(B) the person has been assessed by the Credentialling Subcommittee as having satisfactorily finished the further training or gained the further experience specified for that person; or

(c) the person has attained Level I or Level II of the relevant Advanced Training Program of the Thoracic Society of Australia and New Zealand and the Australasian Sleep Association, after having completed at least 12 months core training, including clinical practice in the relevant field of sleep medicine and in reporting sleep studies; or

(d) the Advisory Committee has recognised the person, in writing, as having training equivalent to the training mentioned in paragraph (c).

(3) In this clause:

Advisory Committee means the Specialist Advisory Committee in Thoracic and Sleep Medicine of the Royal Australasian College of Physicians.

Appeal Committee means the Appeal Committee of the Royal Australasian College of Physicians.

Credentialling Subcommittee means the Credentialling Subcommittee of the Advisory Committee.

relevant Advanced Training Program means:

(a) for an assessment for qualification as a qualified adult sleep medicine practitioner—the Advanced Training Program in Adult Sleep Medicine; and

(b) for an assessment for qualification as a qualified paediatric sleep medicine practitioner—the Advanced Training Program in Paediatric Sleep Medicine.

relevant field of sleep medicine means:

(a) for an assessment for qualification as a qualified adult sleep medicine practitioner—adult sleep medicine; and

(b) for an assessment for qualification as a qualified paediatric sleep medicine practitioner—paediatric sleep medicine.

2.34.3 Application of Group D1

Items 11000 to 12217 do not apply to a service mentioned in the item if the service is provided at the same time as, or in connection with, home-based sleep studies.

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
Subgroup 1—Neurology		
11000	Electroencephalography, other than a service: (a) associated with a service to which item 11003, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices (Anaes.)	123.10
11003	Electroencephalography, prolonged recording of at least 3 hours in duration, other than a service: (a) associated with a service to which item 11000, 11004, 11005, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices	325.70
11004	Electroencephalography, ambulatory or video, prolonged recording of at least 3 hours in duration up to 24 hours in duration, recording on the first day, other than a service: (a) associated with a service to which item 11000, 11003,	325.70

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
	11005, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices	
11005	Electroencephalography, ambulatory or video, prolonged recording of at least 3 hours in duration up to 24 hours in duration, recording on each day after the first day, other than a service: (a) associated with a service to which item 11000, 11003, 11004, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices	325.70
11006	Electroencephalography, temporosphenoidal, other than a service involving quantitative topographic mapping using neurometrics or similar devices	167.00
11009	Electrocorticography	227.75
11012	Neuromuscular electrodiagnosis—conduction studies on one nerve or electromyography of one or more muscles using concentric needle electrodes or both these examinations (other than a service associated with a service to which item 11015 or 11018 applies)	112.00
11015	Neuromuscular electrodiagnosis—conduction studies on 2 or 3 nerves with or without electromyography (other than a service associated with a service to which item 11012 or 11018 applies)	149.90
11018	Neuromuscular electrodiagnosis—conduction studies on 4 or more nerves with or without electromyography or recordings from single fibres of nerves and muscles or both of these examinations (other than a service associated with a service to which item 11012 or 11015 applies)	223.95
11021	Neuromuscular electrodiagnosis—repetitive stimulation for study of neuromuscular conduction or electromyography with quantitative computerised analysis or both of these examinations	149.90
11024	Central nervous system evoked responses, investigation of, by computerised averaging techniques, other than a service involving quantitative topographic mapping of event-related	113.85

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
	potentials or involving multifocal multichannel objective perimetry—one or 2 studies	
11027	Central nervous system evoked responses, investigation of, by computerised averaging techniques, other than a service involving quantitative topographic mapping of event-related potentials or involving multifocal multichannel objective perimetry—3 or more studies	168.90
Subgroup 2—Ophthalmology		
11200	Provocative test or tests for open angle glaucoma, including water drinking	40.80
11204	Electroretinography of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards	108.25
11205	Electrooculography of one or both eyes performed according to current professional guidelines or standards	108.25
11210	Pattern electroretinography of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards	108.25
11211	Dark adaptometry of one or both eyes with a quantitative estimation of threshold in log lumens at 45 minutes of dark adaptations	108.25
11215	Retinal photography, multiple exposures, of one eye with intravenous dye injection	123.00
11218	Retinal photography, multiple exposures of both eyes with intravenous dye injection	151.95
11221	Full quantitative computerised perimetry (automated absolute static threshold), other than a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, if indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, bilateral—to a maximum of 2 examinations (including examinations to which item 11224 applies) in any 12 month period	67.75

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
11222	Full quantitative computerised perimetry (automated absolute static threshold), other than a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, with assessment and report, bilateral, if it can be demonstrated that a further examination is indicated in the same 12 month period to which item 11221 applies due to presence of one of the following conditions: (a) established glaucoma (when surgery may be required within a 6 month period) if there has been definite progression of damage over a 12 month period; (b) established neurological disease which may be progressive and if a visual field is necessary for the management of the patient; (c) monitoring for ocular disease or disease of the visual pathways which may be caused by systemic drug toxicity, if there may also be other disease such as glaucoma or neurological disease; each additional examination	67.75
11224	Full quantitative computerised perimetry (automated absolute static threshold), other than a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, if indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, unilateral—to a maximum of 2 examinations (including examinations to which item 11221 applies) in any 12 month period	40.85
11225	Full quantitative computerised perimetry (automated absolute static threshold), other than a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, with assessment and report, unilateral, if it can be demonstrated that a further examination is indicated in the same 12 month period to which item 11224 applies due to presence of one of the following conditions: (a) established glaucoma (when surgery may be required	40.85

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
	within a 6 month period) if there has been definite progression of damage over a 12 month period; (b) established neurological disease which may be progressive and if a visual field is necessary for the management of the patient; (c) monitoring for ocular disease or disease of the visual pathways which may be caused by systemic drug toxicity, if there may also be other disease such as glaucoma or neurological disease; each additional examination	
11235	Examination of the eye by impression cytology of cornea for the investigation of ocular surface dysplasia, including the collection of cells, processing and all cytological examinations and preparation of report	122.75
11237	Ocular contents, simultaneous ultrasonic echography by both unidimensional and bidimensional techniques, for the diagnosis, monitoring or measurement of choroidal and ciliary body melanomas, retinoblastoma or suspicious naevi or simulating lesions, one eye, other than a service associated with a service to which an item in Group I1 of the diagnostic imaging services table applies	81.45
11240	Orbital contents, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of one eye before lens surgery on that eye, other than a service associated with a service to which an item in Group I1 of the diagnostic imaging services table applies	81.45
11241	Orbital contents, unidimensional ultrasonic echography or partial coherence interferometry of, for bilateral eye measurement before lens surgery on both eyes, other than a service associated with a service to which an item in Group I1 of the diagnostic imaging services table applies	103.65
11242	Orbital contents, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of an eye previously measured and on which lens surgery has been performed, and if further lens surgery is contemplated in that eye, other than a service associated with a service to which an	80.10

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
	item in Group I1 of the diagnostic imaging services table applies	
11243	Orbital contents, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of a second eye if: (a) surgery for the first eye has resulted in more than one dioptre of error; or (b) more than 3 years have elapsed since the surgery for the first eye; other than a service associated with a service to which an item in Group I1 of the diagnostic imaging services table applies	80.10
11244	Orbital contents, diagnostic B-scan of, by a specialist practising in his or her specialty of ophthalmology, not being a service associated with a service to which an item in Group I1 of the diagnostic imaging services table applies	77.00
Subgroup 3—Otolaryngology		
11300	Brain stem evoked response audiometry (Anaes.)	192.45
11303	Electrocochleography, extratympanic method, one or both ears	192.45
11304	Electrocochleography, transtympanic membrane insertion technique, one or both ears	316.95
11306	Non-determinate audiometry	21.90
11309	Audiogram, air conduction	26.30
11312	Audiogram, air and bone conduction or air conduction and speech discrimination	37.15
11315	Audiogram, air and bone conduction and speech	49.20
11318	Audiogram, air and bone conduction and speech, with other cochlear tests	60.75
11321	Glycerol induced cochlear function changes assessed by a minimum of 4 air conduction and speech discrimination tests (Klockoff's test)	115.35
11324	Impedance audiogram involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of	32.85

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
	his or her specialty, if the patient is referred by a medical practitioner—other than a service associated with a service to which item 11309, 11312, 11315 or 11318 applies	
11327	Impedance audiogram involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, if the patient is referred by a medical practitioner—being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies	19.75
11330	Impedance audiogram if the patient is not referred by a medical practitioner—one examination in any 4 week period	7.90
11332	Oto-acoustic emission audiometry for the detection of permanent congenital hearing impairment, performed by or on behalf of a specialist or consultant physician, on an infant or child in circumstances in which: (a) the patient is referred to a specialist or consultant physician by a medical practitioner; and (b) the specialist or consultant physician has given an opinion that excludes middle ear pathology for the patient; and (c) the patient is at risk due to one or more of the following factors: (i) admission to a neonatal intensive care unit; (ii) family history of hearing impairment; (iii) intra-uterine or perinatal infection (either suspected or confirmed); (iv) birthweight less than 1.5 kg; (v) craniofacial deformity; (vi) birth asphyxia; (vii) chromosomal abnormality, including Down Syndrome; (viii) exchange transfusion	58.55
11333	Caloric test of labyrinth or labyrinths	44.60
11336	Simultaneous bithermal caloric test of labyrinths	44.60
11339	Electronystagmography	44.60

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
Subgroup 4—Respiratory		
11500	Bronchospirometry, including gas analysis	167.00
11503	Measurement of the: (a) mechanical or gas exchange function of the respiratory system; or (b) respiratory muscle function; or (c) ventilatory control mechanisms Various measurement parameters may be used including any of the following: (a) pressures; (b) volumes; (c) flow; (d) gas concentrations in inspired or expired air; (e) alveolar gas or blood; (f) electrical activity of muscles The tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital. Each occasion at which one or more of such tests are performed, not being a service associated with a service to which item 22018 applies	138.65
11506	Measurement of respiratory function involving a permanently recorded tracing performed before and after inhalation of bronchodilator—each occasion at which one or more such tests are performed	20.55
11509	Measurement of respiratory function involving a permanently recorded tracing and written report, performed before and after inhalation of bronchodilator, with continuous technician attendance in a laboratory equipped to perform complex respiratory function tests (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital)—each occasion at which one or more such tests are performed	35.65
11512	Continuous measurement of the relationship between flow and volume during expiration or inspiration involving a permanently recorded tracing and written report, performed	61.75

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
	before and after inhalation of bronchodilator, with continuous technician attendance in a laboratory equipped to perform complex lung function tests (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital)—each occasion at which one or more such tests are performed	
Subgroup 5—Vascular		
11600	Central venous, pulmonary arterial, systemic arterial or cardiac intracavity blood pressure monitoring by indwelling catheter—once only for each type of pressure for a patient on a calendar day, other than a service: (a) associated with the management of general anaesthesia; and (b) to which item 13876 applies	69.30
11602	Investigation of venous reflux or obstruction in one or more limbs at rest by CW Doppler or pulsed Doppler involving examination at multiple sites along each limb using intermittent limb compression or Valsalva manoeuvres, or both, to detect prograde and retrograde flow, other than a service associated with a service to which item 32500 or 32501 applies—hard copy trace and written report, the report component of which must be performed by a medical practitioner, maximum of 2 examinations in a 12 month period, not to be used in conjunction with sclerotherapy	57.75
11604	Investigation of chronic venous disease in the upper and lower extremities, one or more limbs, by plethysmography (excluding photoplethysmography)—examination, hard copy trace and written report, not being a service associated with a service to which item 32500 or 32501 applies	75.70
11605	Investigation of complex chronic lower limb reflux or obstruction, in one or more limbs, by infrared photoplethysmography, during and following exercise to determine surgical intervention or the conservative management of deep venous thrombotic disease—hard copy trace, calculation of 90% recovery time and written report, not being a service associated with a service to which item 32500	75.70

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
	or 32501 applies	
11610	Measurement of ankle—brachial indices and arterial waveform analysis, measurement of posterior tibial and dorsalis pedis (or toe) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of ankle (or toe) brachial systolic pressure indices and assessment of arterial waveforms for the evaluation of lower extremity arterial disease—examination, hard copy trace and report	63.75
11611	Measurement of wrist—brachial indices and arterial waveform analysis, measurement of radial and ulnar (or finger) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of the wrist (or finger) brachial systolic pressure indices and assessment of arterial waveforms for the evaluation of upper extremity arterial disease—examination, hard copy trace and report	63.75
11612	Exercise study for the evaluation of lower extremity arterial disease, measurement of posterior tibial and dorsalis pedis (or toe) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of ankle (or toe) brachial systolic pressure indices for the evaluation of lower extremity arterial disease at rest and following exercise using a treadmill or bicycle ergometer or other such equipment, if the exercise workload is quantifiably documented—examination and report	112.40
11614	Transcranial doppler, examination of the intracranial arterial circulation using CW Doppler or pulsed Doppler with hard copy recording of waveforms, examination and report, other than a service associated with a service to which item 55229 or 55280 of the diagnostic imaging services table applies	75.70
11615	Measurement of digital temperature, one or more digits, (unilateral or bilateral) and report, with hard copy recording of temperature before and for 10 minutes or more after cold stress testing	75.90
11627	Pulmonary artery pressure monitoring during open heart surgery, in a person under 12 years of age	228.65

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
Subgroup 6—Cardiovascular		
11700	Twelve-lead electrocardiography, tracing and report	31.25
11701	Twelve-lead electrocardiography, report only if the tracing has been forwarded to another medical practitioner, not in association with a consultation on the same occasion	15.55
11702	Twelve-lead electrocardiography, tracing only	15.55
11708	Continuous ECG recording of ambulatory patient for 12 or more hours (including resting ECG and the recording of parameters), not in association with ambulatory blood pressure monitoring, involving microprocessor based analysis equipment, interpretation and report of recordings by a specialist physician or consultant physician Not being a service to which item 11709 applies The changing of a tape or batteries does not constitute a separate service. Where a recording is analysed and reported on and a decision is made to undertake a further period of monitoring, the second episode is regarded as a separate service	127.90
11709	Continuous ECG recording (Holter) of ambulatory patient for 12 or more hours (including resting ECG and the recording of parameters), not in association with ambulatory blood pressure monitoring, utilising a system capable of superimposition and full disclosure printout of at least 12 hours of recorded ECG data, microprocessor based scanning analysis, with interpretation and report by a specialist physician or consultant physician The changing of a tape or batteries does not constitute a separate service. Where a recording is analysed and reported on and a decision is made to undertake a further period of monitoring, the second episode is regarded as a separate service	167.45
11710	Ambulatory ECG monitoring, patient activated, single or multiple event recording, utilising a looping memory recording device which is connected continuously to the patient for 12 hours or more and is capable of recording for at least 20 seconds before each activation and for 15 seconds	51.90

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
	after each activation, including transmission, analysis, interpretation and report—payable once in any 4 week period	
11711	Ambulatory ECG monitoring for 12 hours or more, patient activated, single or multiple event recording, utilising a memory recording device which is capable of recording for at least 30 seconds after each activation, including transmission, analysis, interpretation and report—payable once in any 4 week period	28.30
11712	Multi channel ECG monitoring and recording during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts) or pharmacological stress, involving the continuous attendance of a medical practitioner for not less than 20 minutes, with resting ECG, and with or without continuous blood pressure monitoring and the recording of other parameters, on premises equipped with mechanical respirator and defibrillator	152.15
11713	Signal averaged ECG recording involving not more than 300 beats, using at least 3 leads with data acquisition at not less than 1000Hz of at least 100 QRS complexes, including analysis, interpretation and report of recording by a specialist physician or consultant physician	69.75
11715	Blood dye—dilution indicator test	120.75
11718	Implanted pacemaker testing involving electrocardiography, measurement of rate, width and amplitude of stimulus, including reprogramming when required, other than a service associated with a service to which item 11700 or 11721 applies	34.75
11721	Implanted pacemaker testing of atrioventricular (AV) sequential, rate responsive, or antitachycardia pacemakers, including reprogramming when required, other than a service associated with a service to which item 11700 or 11718 applies	69.75
11722	Implanted ECG loop recording for the investigation of recurrent unexplained syncope if: (a) a diagnosis has not been achieved through all other available cardiac investigations; and	34.75

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
	(b) a neurogenic cause is not suspected; and (c) the patient to whom the service is provided does not have a structural heart defect associated with a high risk of sudden cardiac death; including reprogramming when required, retrieval of stored data, analysis, interpretation and report, other than a service to which item 38285 applies	
11724	Upright tilt table testing for the investigation of syncope of suspected cardiothoracic origin, including blood pressure monitoring, continuous ECG monitoring and the recording of the parameters, and involving an established intravenous line and the continuous attendance of a specialist or consultant physician—on premises equipped with a mechanical respirator and defibrillator	168.90
11727	Implanted defibrillator testing involving electrocardiography, assessment of pacing and sensing thresholds for pacing and defibrillation electrodes, download and interpretation of stored events and electrograms, including programming when required, other than a service associated with a service to which item 11700, 11718 or 11721 applies	94.75
Subgroup 7—Gastroenterology and colorectal		
11800	Oesophageal motility test, manometric	174.45
11810	Clinical assessment of gastro-oesophageal reflux disease involving 24-hour pH monitoring, including analysis, interpretation and report and including any associated consultation	174.45
11820	Capsule endoscopy to investigate an episode of obscure gastrointestinal bleeding, using a capsule endoscopy device approved by the Therapeutic Goods Administration (including administration of the capsule, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if: (a) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by The Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and	2 039.20

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
	(b) the patient to whom the service is provided: (i) is aged 10 years or over; and (ii) has recurrent or persistent bleeding; and (iii) is anaemic or has active bleeding; and (c) an upper gastrointestinal endoscopy and a colonoscopy have been performed on the patient and have not identified the cause of the bleeding; and (d) the service is performed within 6 months after the upper gastrointestinal endoscopy and colonoscopy; and (e) the service is not associated with double balloon enteroscopy; and (f) the service has not been provided to the same patient: (i) more than once in an episode of bleeding, being bleeding occurring within 6 months of the prerequisite upper gastrointestinal endoscopy and colonoscopy (any bleeding after that time is considered to be a new episode); or (ii) on more than 2 occasions in any 12 month period	
11823	Capsule endoscopy to conduct small bowel surveillance of a patient diagnosed with Peutz-Jeghers Syndrome, using a capsule endoscopy device approved by the Therapeutic Goods Administration (including administration of the capsule, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if: (a) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and (b) the item is performed only once in any 2 year period; and (c) the service is not associated with double balloon enteroscopy	2 039.20
11830	Diagnosis of abnormalities of the pelvic floor involving anal manometry or measurement of anorectal sensation or measurement of the rectosphincteric reflex	186.80
11833	Diagnosis of abnormalities of the pelvic floor and sphincter	249.75

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
	muscles involving electromyography or measurement of pudendal and spinal nerve motor latency	
Subgroup 8—Genito-urinary physiological investigations		
11900	Urine flow study including peak urine flow measurement, other than a service associated with a service to which item 11919 applies	27.55
11903	Cystometrography, other than a service associated with a service to which any of items 11012 to 11027, 11912, 11915, 11919, 11921 and 36800 or an item in Group I3 of the diagnostic imaging services table applies	111.10
11906	Urethral pressure profilometry, other than a service associated with a service to which any of items 11012 to 11027, 11909, 11919, 11921 and 36800 or an item in Group I3 of the diagnostic imaging services table applies	111.10
11909	Urethral pressure profilometry with simultaneous measurement of urethral sphincter electromyography, other than a service associated with a service to which item 11906, 11915, 11919, 36800 or an item in Group I3 of the diagnostic imaging services table applies	165.15
11912	Cystometrography with simultaneous measurement of rectal pressure, other than a service associated with a service to which any of items 11012 to 11027, 11903, 11915, 11919, 11921 and 36800 or an item in Group I3 of the diagnostic imaging services table applies (Anaes.)	165.15
11915	Cystometrography with simultaneous measurement of urethral sphincter electromyography, other than a service associated with a service to which any of items 11012 to 11027, 11903, 11909, 11912, 11919, 11921 and 36800 or an item in Group I3 of the diagnostic imaging services table applies (Anaes.)	165.15
11917	Cystometrography in conjunction with ultrasound of one or more components of the urinary tract, with measurement of any one or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography; including all imaging associated with cystometrography, other than a service associated with a service to which any of items 11012 to 11027, 11900 to 11915, 11919, 11921 and	428.35

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
	36800 applies (Anaes.)	
11919	Cystometrography in conjunction with contrast micturating cystourethrography, with measurement of any one or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography; including all imaging associated with cystometrography, other than a service associated with a service to which any of items 11012 to 11027, 11900 to 11917, 11921 and 36800 applies (Anaes.)	428.35
11921	Bladder washout test for localisation of urinary infection—not including bacterial counts for organisms in specimens	75.05
Subgroup 9—Allergy testing		
12000	Skin sensitivity testing for allergens, using one to 20 allergens, other than a service associated with a service to which item 12012, 12015, 12018 or 12021 applies	38.95
12003	Skin sensitivity testing for allergens, using more than 20 allergens, other than a service associated with a service to which item 12012, 12015, 12018 or 12021 applies	58.85
12012	Epicutaneous patch testing in the investigation of allergic dermatitis using less than the number of allergens included in a standard patch test battery	20.80
12015	Epicutaneous patch testing in the investigation of allergic dermatitis using all of the allergens in a standard patch test battery	62.45
12018	Epicutaneous patch testing in the investigation of allergic dermatitis using all of the allergens in a standard patch test battery and additional allergens to a total of up to and including 50 allergens	80.35
12021	Epicutaneous patch testing in the investigation of allergic dermatitis, performed by or on behalf of a specialist in the practice of his or her specialty, using more than 50 allergens	117.85
Subgroup 10—Other diagnostic procedures and investigations		
12200	Collection of specimen of sweat by iontophoresis	37.20
12201	Administration, by a specialist or consultant physician in the practice of his or her specialty, of thyrotropin alfa-rch (recombinant human thyroid-stimulating hormone), and	2 392.90

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
	arranging services to which items 61426 and 66650 apply, for the detection of recurrent well-differentiated thyroid cancer in a patient if: (a) the patient has had a total thyroidectomy and one ablative dose of radioactive iodine; and (b) the patient is maintained on thyroid hormone therapy; and (c) the patient is at risk of recurrence; and (d) on at least one previous whole body scan or serum thyroglobulin test when withdrawn from thyroid hormone therapy, the patient did not have evidence of well-differentiated thyroid cancer; and (e) either: (i) withdrawal from thyroid hormone therapy resulted in severe psychiatric disturbances when hypothyroid; or (ii) withdrawal is medically contra-indicated because the patient has: (A) unstable coronary artery disease; or (B) hypopituitarism; or (C) a high risk of relapse or exacerbation of a previous severe psychiatric illness; —applicable once only in a 12 month period	
12203	Overnight investigation for sleep apnoea for a period of at least 8 hours in duration, for a patient aged 18 years or more, if: (a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of EEG, EOG, submental EMG, anterior tibial EMG, respiratory movement, airflow, oxygen saturation and ECG are performed; and (b) a technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (c) the patient is referred by a medical practitioner; and (d) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner before the investigation; and	588.00

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
	(e) polygraphic records are analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; and (f) interpretation and report are provided by a qualified adult sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient For any particular patient—applicable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period	
12207	Overnight investigation for sleep apnoea for a period of at least 8 hours in duration, for a patient aged 18 years or more, if: (a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of EEG, EOG, submental EMG, anterior tibial EMG, respiratory movement, airflow, oxygen saturation and ECG are performed; and (b) a technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (c) the patient is referred by a medical practitioner; and (d) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner before the investigation; and (e) polygraphic records are analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; and (f) interpretation and report are provided by a qualified adult sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; if it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12203	588.00

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
	applies for the adjustment or testing, or both, of the effectiveness of a positive pressure ventilatory support device (other than nasal continuous positive airway pressure) in sleep, in a patient with severe cardio-respiratory failure, and if previous studies have demonstrated failure of continuous positive airway pressure or oxygen—each additional investigation	
12210	Overnight paediatric investigation for a period of at least 8 hours in duration for a patient aged 12 years or less, if: (a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of EEG (with a minimum of 4 EEG leads or, in selected investigations, of 6 EEG leads), EOG, submental or diaphragm EMG (or both), respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen), airflow, measurement of carbon dioxide (either end-tidal or transcutaneous), oxygen saturation and ECG are performed; and (b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (c) the patient is referred by a medical practitioner; and (d) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; and (f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient For each particular patient—applicable only in relation to each	701.85

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
	of the first 3 occasions the investigation is performed in any 12 month period	
12213	Overnight paediatric investigation for a period of at least 8 hours in duration for a patient aged between 12 and 18 years, if: (a) recordings of EEG (with a minimum of 4 EEG leads or, in selected investigations, of 6 EEG leads), EOG, submental or diaphragm EMG (or both), respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen), airflow, measurement of carbon dioxide (either end-tidal or transcutaneous), oxygen saturation and ECG are performed; and (b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (c) the patient is referred by a medical practitioner; and (d) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; and (f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient For each particular patient—applicable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period	632.30
12215	Overnight paediatric investigation for a period of at least 8 hours in duration for a patient aged 12 years or less, if: (a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of EEG	701.85

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
	(with a minimum of 4 EEG leads or, in selected investigations, of 6 EEG leads), EOG, submental or diaphragm EMG (or both), respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen), airflow, measurement of carbon dioxide (either end-tidal or transcutaneous), oxygen saturation and ECG are performed; and (b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (c) the patient is referred by a medical practitioner; and (d) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; and (f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; if it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12210 applies, for the adjustment, or testing of the effectiveness, or both, of Continuous Positive Airway Pressure (CPAP) or of the bilevel pressure support or ventilation (or both), or if supplemental oxygen is required because of recurring hypoxia—each additional investigation	
12217	Overnight paediatric investigation for a period of at least 8 hours in duration for a patient aged between 12 and 18 years, if: (a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of EEG	632.30

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
	(with a minimum of 4 EEG leads or, in selected investigations, of 6 EEG leads), EOG, submental or diaphragm EMG (or both), respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen), airflow, measurement of carbon dioxide (either end-tidal or transcutaneous), oxygen saturation and ECG are performed; and (b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (c) the patient is referred by a medical practitioner; and (d) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; and (f) interpretation and report to be provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; if it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12213 applies, for the adjustment, or testing of the effectiveness, or both, of Continuous Positive Airway Pressure (CPAP) or of the bilevel pressure support or ventilation (or both), or if there is recurring hypoxia and supplemental oxygen is required— each additional investigation	
12250	Overnight investigation for sleep apnoea for a period of at least 8 hours in duration for a patient aged 18 years or more, if all of the following requirements are met: (a) the patient has, before the overnight investigation, been referred to a qualified sleep medicine practitioner by a medical practitioner whose clinical opinion is that there is	335.30

Group D1—Miscellaneous diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
	a high probability that the patient has obstructive sleep apnoea; (b) the investigation takes place after the qualified sleep medicine practitioner has: (i) confirmed the necessity for the investigation; and (ii) communicated this confirmation to the referring medical practitioner; (c) during a period of sleep, the investigation involves recording a minimum of 7 physiological parameters which must include: (i) continuous electro-encephalogram (EEG); and (ii) continuous electro-cardiogram (ECG); and (iii) airflow; and (iv) thoraco-abdominal movement; and (v) oxygen saturation; and (vi) 2 or more of the following: (A) electro-oculogram (EOG); (B) chin electro-myogram (EMG); (C) body position; (d) in the report on the investigation, the qualified sleep medicine practitioner uses the data specified in paragraph (c) to: (i) analyse sleep stage, arousals and respiratory events; and (ii) assess clinically significant alteration in heart rate; (e) the qualified sleep medicine practitioner: (i) before the investigation takes place, establishes quality assurance procedures for data acquisition; and (ii) personally analyses the data and writes the report on the results of the investigation Payable only once in a 12 month period	

Division 2.35—Group D2: Nuclear medicine (non-imaging)

2.35.1 Application of Group D2

An item in Group D2 does not apply to a service described in the item if the service is provided at the same time as, or in connection with, home-based sleep studies.

Group D2—Nuclear medicine (non-imaging)

Item	Description	Fee ($)
12500	Blood volume estimation	216.65
12503	Erythrocyte radioactive uptake survival time test or iron kinetic test	424.75
12506	Gastrointestinal blood loss estimation involving examination of stool specimens	303.30
12509	Gastrointestinal protein loss	216.65
12512	Radioactive B12 absorption test—one isotope	105.05
12515	Radioactive B12 absorption test—2 isotopes	229.85
12518	Thyroid uptake (using probe)	105.05
12521	Perchlorate discharge study	126.65
12524	Renal function test (without imaging procedure)	158.35
12527	Renal function test (with imaging and at least 2 blood samples)	84.95
12530	Whole body count—other than a service associated with a service to which another item applies	126.65
12533	Carbon-labelled urea breath test using oral C-13 or C-14 urea, performed by a specialist or consultant physician, including the measurement of exhaled $^{13}CO_2$ or $^{14}CO_2$, for either: (a) the confirmation of Helicobactor pylori colonisation; or (b) the monitoring of the success of eradication of Helicobactor pylori in patients with peptic ulcer disease; (other than a service associated with a service to which item 66900 applies)	84.65

Division 2.36—Therapeutic procedures

2.36.1 Definition

In this Division:

medical college has the meaning given by section 3GC of the Act.

specialist trainee under the supervision of a medical practitioner means a medical practitioner who is:

(a) enrolled in and undertaking a training program with a medical college; and

(b) supervised by a medical practitioner who is present at all times while the specialist trainee provides a medical service.

2.36.2 Medical services that may be provided by medical practitioner or specialist trainee

Medical services—items

(1) A medical service set out in the following items may be provided by a medical practitioner or a specialist trainee under the supervision of a medical practitioner:

(a) items 13015 to 16018;

(b) items 16600 to 16636;

(c) items 18213 to 18298;

(d) items 20100 to 51318.

Medical services taken to be provided by supervising medical practitioner

(2) If a medical service set out in an item mentioned in paragraph (1)(a) to (d) is provided by a specialist trainee under the supervision of a medical practitioner, the medical service is taken to have been provided by the supervising medical practitioner.

Division 2.37—Group T1: Miscellaneous therapeutic procedures

2.37.1 Meaning of *comprehensive hyperbaric medicine facility*

In items 13015, 13020, 13025 and 13030:

comprehensive hyperbaric medicine facility means a separate hospital area that, on a 24-hour basis:

(a) is equipped and staffed so that it is capable of providing to a patient:
  (i) hyperbaric oxygen therapy at a treatment pressure of at least 2.8 atmospheric pressure absolute (180 kilopascal gauge pressure); and
  (ii) mechanical ventilation and invasive cardiovascular monitoring within a monoplace or multiplace chamber for the duration of the hyperbaric treatment; and

(b) is under the direction of at least one medical practitioner who is rostered, and immediately available, to the facility during the facility's ordinary working hours if the practitioner:
  (i) is a specialist with training in diving and hyperbaric medicine; or
  (ii) holds a Diploma of Diving and Hyperbaric Medicine of the South Pacific Underwater Medicine Society; and

(c) is staffed by:
  (i) at least one medical practitioner with training in diving and hyperbaric medicine who is present in the facility and immediately available at all times when patients are being treated at the facility; and
  (ii) at least one registered nurse with specific training in hyperbaric patient care to the published standards of the Hyperbaric Technicians and Nurses Association, who is present during hyperbaric oxygen therapy; and

(d) has admission and discharge policies in operation.

2.37.2 Meaning of *embryology laboratory services*

For items 13200, 13201 and 13206, ***embryology laboratory services*** includes:

(a) egg recovery from aspirated follicular fluid; and
(b) semen preparation; and
(c) insemination; and
(d) monitoring of fertilisation and embryo development; and
(e) preparation of gametes or embryos for transfer or freezing.

2.37.3 Meaning of *treatment cycle*

In items 13200 to 13209 and 13212 to 13221:

treatment cycle, for a patient, means a series of treatments for the patient that:

(a) begins:
  (i) if treatment with superovulatory drugs is given—on the day on which that treatment begins; or
  (ii) if treatment with superovulatory drugs is not given—on the first day of a menstrual cycle of the patient; and
(b) ends not more than 30 days after that day.

2.37.4 Items provided as part of treatment cycle relating to assisted reproductive services not to apply

(1) This clause applies to a service mentioned in:
  (a) an item in Subgroup 3 of Group T1; and
  (b) another item (the ***associated item***) associated with an item in Subgroup 3 of Group T1.

(2) A service provided as part of a treatment cycle to which an item in paragraph (1)(a) applies is not a medical service for the purposes of the associated item.

2.37.5 Application of items 13020 to 14245

Items 13020 to 14245 do not apply to a service mentioned in the item if the service is provided at the same time as, or in connection with, the provision of a pain pump for post-surgical pain management.

2.37.6 Limitation on item 13104

Item 13104 is not applicable to a patient more than 12 times in a 12 month period.

2.37.7 Items relating to assisted reproductive services not to apply in certain pregnancy-related circumstances

Items 13200 to 13221 do not apply to a service provided in relation to a patient's pregnancy, or intended pregnancy, that is, at the time of the service, the subject of an agreement, or arrangement, under which the patient makes provision for transfer to another person of the guardianship of, or custodial rights to, a child born as a result of the pregnancy.

2.37.8 Application of items 14227 to 14242

Items 14227 to 14242 apply to a service in relation to a patient only if:

(a) the patient has:
  (i) chronic spasticity of cerebral origin; or
  (ii) chronic spasticity caused by multiple sclerosis, spinal cord injury or spinal cord disease; and
(b) oral antispastic agents have failed or have caused the patient to experience unacceptable side effects; and
(c) an authority has been given by the Chief Executive Medicare to provide the service to the patient.

2.37.9 Application of item 14245

(1) Item 14245 applies only to a service provided by a medical practitioner who is registered by the Chief Executive Medicare to

participate in the arrangements made, under paragraph 100(1)(b) of the *National Health Act 1953*, for providing an adequate pharmaceutical service for persons requiring treatment with an immunomodulating agent.

(2) Item 14245 applies once only on any calendar day.

2.37.10 Limitation of item 13210

Item 13210 does not apply if the patient or specialist travels to a place to satisfy the requirement in sub-subparagraph (d)(i)(B) of the item.

Group T1—Miscellaneous therapeutic procedures		
Item	**Description**	**Fee**
Subgroup 1—Hyperbaric oxygen therapy		
13015	Hyperbaric oxygen therapy, for treatment of localised non-neurological soft tissue radiation injuries excluding radiation-induced soft tissue lymphoedema of the arm after treatment for breast cancer, performed in a comprehensive hyperbaric medicine facility under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of at least 1 hour 30 minutes and not more than 3 hours, including any associated attendance	$254.75
13020	Hyperbaric oxygen therapy, for treatment of decompression illness, gas gangrene, air or gas embolism, diabetic wounds (including diabetic gangrene and diabetic foot ulcers) or necrotising soft tissue infections (including necrotising fasciitis or Fournier's gangrene), or for the prevention and treatment of osteoradionecrosis, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of at least 1 hour 30 minutes and not more than 3 hours, including any associated attendance	$258.85
13025	Hyperbaric oxygen therapy, for treatment of decompression illness, air or gas embolism, performed in a comprehensive hyperbaric medicine facility, under the supervision of a	$115.70

Group T1—Miscellaneous therapeutic procedures		
Item	**Description**	**Fee**
	medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber greater than 3 hours, including any associated attendance—per hour (or part of an hour)	
13030	Hyperbaric oxygen therapy performed in a comprehensive hyperbaric medicine facility, if the medical practitioner is pressurised in the hyperbaric chamber for the purpose of providing continuous life saving emergency treatment, including any associated attendance—per hour (or part of an hour)	$163.45
Subgroup 2—Dialysis		
13100	Supervision in hospital by a medical specialist of—haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, if the total attendance time on the patient by the supervising medical specialist exceeds 45 minutes in one day	$136.65
13103	Supervision in hospital by a medical specialist of—haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, if the total attendance time on the patient by the supervising medical specialist does not exceed 45 minutes in one day	$71.20
13104	Planning and management of home dialysis (haemodialysis or peritoneal dialysis) for a patient with end-stage renal disease and supervision of the patient on self-administered dialysis, if the attendance is by a consultant physician in the practice of his or her specialty of renal medicine	$147.95
13106	Declotting of an arteriovenous shunt	$121.35
13109	Indwelling peritoneal catheter (Tenckhoff or similar) for dialysis—insertion and fixation of (Anaes.)	$227.75
13110	Tenckhoff peritoneal dialysis catheter, removal of (including catheter cuffs) (Anaes.)	$228.50
13112	Peritoneal dialysis, establishment of, by abdominal puncture and insertion of temporary catheter (including associated consultation) (Anaes.)	$136.65

Group T1—Miscellaneous therapeutic procedures		
Item	**Description**	**Fee**
Subgroup 3—Assisted reproductive services		
13200	Assisted reproductive technologies superovulated treatment cycle proceeding to oocyte retrieval, involving the use of drugs to induce superovulation and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, transfer of frozen embryos or donated embryos or ova or a service to which item 13201, 13202, 13203, 13206 or 13218 applies, being services rendered during one treatment cycle—initial cycle in a single calendar year	$3 110.75
13201	Assisted reproductive technologies superovulated treatment cycle proceeding to oocyte retrieval, involving the use of drugs to induce superovulation and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, transfer of frozen embryos or donated embryos or ova or a service to which item 13200, 13202, 13203, 13206 or 13218 applies, being services rendered during one treatment cycle—each cycle after the first in a single calendar year	$2 909.75
13202	Assisted reproductive technologies superovulated treatment cycle that is cancelled before oocyte retrieval, involving the use of drugs to induce superovulation and including quantitative estimation of hormones and ultrasound examinations, but excluding artificial insemination, transfer of frozen embryos or donated embryos or ova or a service to which item 13200, 13201, 13203, 13206 or 13218 applies, being services rendered during one treatment cycle	$465.55
13203	Ovulation monitoring services for artificial insemination, including quantitative estimation of hormones and ultrasound examinations, being services rendered during one treatment cycle but excluding a service to which item 13200, 13201, 13202, 13206, 13212, 13215 or 13218 applies	$486.75

Group T1—Miscellaneous therapeutic procedures		
Item	**Description**	**Fee**
13206	Assisted reproductive technologies treatment cycle using the natural cycle or oral medication only to induce oocyte growth and development, including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, frozen embryo transfer, donated embryos or ova or treatment involving the use of injectable drugs to induce superovulation, being services rendered during one treatment cycle—only if rendered in conjunction with a service to which item 13212 applies	$465.55
13209	Planning and management of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies or for artificial insemination payable once only during one treatment cycle	$84.70
13210	Professional attendance on a patient by a specialist practising in his or her specialty if: (a) the attendance is by video conference; and (b) item 13209 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies	50% of the fee for item 13209
13212	Oocyte retrieval for the purpose of assisted reproductive technologies—only if rendered in conjunction with a service to which item 13200, 13201 or 13206 applies (Anaes.)	$354.45
13215	Transfer of embryos or both ova and sperm to the female	$111.10

Group T1—Miscellaneous therapeutic procedures		
Item	**Description**	**Fee**
	reproductive system, excluding artificial insemination—only if rendered in conjunction with a service to which item 13200, 13201, 13206 or 13218 applies, being services rendered in one treatment cycle (Anaes.)	
13218	Preparation of frozen or donated embryos or donated oocytes for transfer to the female reproductive system, by any means and including quantitative estimation of hormones and all treatment counselling but excluding artificial insemination services rendered in one treatment cycle and excluding a service to which item 13200, 13201, 13202, 13203, 13206 or 13212 applies (Anaes.)	$793.55
13221	Preparation of semen for the purpose of artificial insemination—only if rendered in conjunction with a service to which item 13203 applies	$50.80
13251	Intracytoplasmic sperm injection for the purpose of assisted reproductive technologies, for male factor infertility, excluding a service to which item 13203 or 13218 applies	$417.95
13290	Semen, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder if required	$204.25
13292	Semen, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder if required, under general anaesthetic (H) (Anaes.)	$408.70
Subgroup 4—Paediatric and neonatal		
13300	Umbilical or scalp vein catheterisation in a neonate with or without infusion or cannulation of a vein	$56.95
13303	Umbilical artery catheterisation with or without infusion	$84.40
13306	Blood transfusion with venesection and complete replacement of blood, including collection from donor	$334.10

Group T1—Miscellaneous therapeutic procedures		
Item	**Description**	**Fee**
13309	Blood transfusion with venesection and complete replacement of blood, using blood already collected	$284.85
13312	Blood for pathology test, collection of, by femoral or external jugular vein puncture in infants	$28.45
13318	Central vein catheterisation by open exposure, in a person under 12 years of age (Anaes.)	$227.45
13319	Central vein catheterisation in a neonate via peripheral vein (Anaes.)	$227.45
Subgroup 5—Cardiovascular		
13400	Restoration of cardiac rhythm by electrical stimulation (cardioversion), other than in the course of cardiac surgery (Anaes.)	$96.80
Subgroup 6—Gastroenterology		
13500	Gastric hypothermia by closed circuit circulation of refrigerant in the absence of gastrointestinal haemorrhage	$180.30
13503	Gastric hypothermia by closed circuit circulation of refrigerant for upper gastrointestinal haemorrhage	$360.70
13506	Gastro-oesophageal balloon intubation, Minnesota, Sengstaken-Blakemore or similar, for control of bleeding from gastric oesophageal varices	$184.50
Subgroup 8—Haematology		
13700	Harvesting of homologous (including allogeneic) or autologous bone marrow for the purpose of transplantation (Anaes.)	$333.25
13703	Administration of blood including collection from donor	$119.50
13706	Administration of blood or bone marrow already collected	$83.35
13709	Collection of blood for autologous transfusion or when homologous blood is required for immediate transfusion in emergency situation	$48.45
13750	Therapeutic haemapheresis for the removal of plasma or cellular (or both) elements of blood, utilising continuous or intermittent flow techniques, including morphological tests for cell counts and viability studies, if performed; continuous monitoring of vital signs, fluid balance, blood	$136.65

Group T1—Miscellaneous therapeutic procedures		
Item	**Description**	**Fee**
	volume and other parameters with continuous registered nurse attendance under the supervision of a consultant physician, other than a service associated with a service to which item 13755 applies—each day	
13755	Donor haemapheresis for the collection of blood products for transfusion, utilising continuous or intermittent flow techniques, including morphological tests for cell counts and viability studies; continuous monitoring of vital signs, fluid balance, blood volume and other parameters; with continuous registered nurse attendance under the supervision of a consultant physician—other than a service associated with a service to which item 13750 applies—each day	$136.65
13757	Therapeutic venesection for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda	$72.95
13760	In vitro processing (and cryopreservation) of bone marrow or peripheral blood for autologous stem cell transplantation as an adjunct to high dose chemotherapy for: (a) chemosensitive intermediate or high grade non-Hodgkin's lymphoma at high risk of relapse following first line chemotherapy; or (b) Hodgkin's disease which has relapsed following, or is refractory to, chemotherapy; or (c) acute myelogenous leukaemia in first remission, if suitable genotypically matched sibling donor is not available for allogenic bone marrow transplant; or (d) multiple myeloma in remission (complete or partial) following standard dose chemotherapy; or (e) small round cell sarcomas; or (f) primitive neuroectodermal tumour; or (g) germ cell tumours which have relapsed following, or are refractory to, chemotherapy; or (h) germ cell tumours which have had an incomplete response to first line therapy; performed under the supervision of a consultant physician—each day	$762.60

Group T1—Miscellaneous therapeutic procedures		
Item	**Description**	**Fee**
Subgroup 9—Procedures associated with intensive care and cardiopulmonary support		
13815	Central vein catheterisation by percutaneous or open exposure other than a service to which item 13318 applies (Anaes.)	$85.25
13818	Right heart balloon catheter, insertion of, including pulmonary wedge pressure and cardiac output measurement (Anaes.)	$113.70
13830	Intracranial pressure, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician—each day	$75.35
13839	Arterial puncture and collection of blood for diagnostic purposes	$23.05
13842	Intra-arterial cannulation for the purpose of taking multiple arterial blood samples for blood gas analysis	$69.30
13847	Counterpulsation by intra-aortic balloon management, on first day, including initial and subsequent consultations and monitoring of parameters (Anaes.)	$156.10
13848	Counterpulsation by intra-aortic balloon-management on each day after the first, including associated consultations and monitoring of parameters	$131.05
13851	Circulatory support device, management of, on first day	$493.65
13854	Circulatory support device, management of, on each day after the first	$114.85
13857	Airway access and initiation of mechanical ventilation (other than initiation of ventilation in the context of an anaesthetic for surgery), outside of an intensive care unit, for the purpose of subsequent ventilatory support in an intensive care unit	$146.40
Subgroup 10—Management and procedures undertaken in an intensive care unit		
13870	Management of a patient in an intensive care unit by a specialist or consultant physician who is immediately available and exclusively rostered to intensive care, including initial and subsequent attendances,	$362.10

Group T1—Miscellaneous therapeutic procedures		
Item	**Description**	**Fee**
	electrocardiographic monitoring, arterial sampling, bladder catheterisation and blood sampling—management on the first day (H)	
13873	Management of a patient in an intensive care unit by a specialist or consultant physician who is immediately available and exclusively rostered to intensive care, including all attendances, electrocardiographic monitoring, arterial sampling, bladder catheterisation and blood sampling—management on each day after the first day (H)	$268.60
13876	Central venous pressure, pulmonary arterial pressure, systemic arterial pressure or cardiac intracavity pressure—once only for each type of pressure for a patient on a calendar day: (a) when managed for the patient by a specialist or consultant physician who: (i) is immediately available to care for the patient; and (ii) is exclusively rostered to intensive care; and (b) when the patient is continuously monitored by indwelling catheter in an intensive care unit (H)	$76.90
13881	Airway access and initiation of mechanical ventilation in an intensive care unit by a specialist or consultant physician to enable subsequent ventilatory support—not in association with any anaesthetic service (H)	$146.40
13882	Ventilatory support in an intensive care unit, management of a patient: (a) by: (i) invasive means; or (ii) non-invasive means, if the only alternative to non-invasive ventilatory support is invasive ventilatory support; and (b) by a specialist or consultant physician who is immediately available and exclusively rostered to intensive care; each day (H)	$115.25
13885	Continuous arterio venous or veno venous haemofiltration,	$153.65

Group T1—Miscellaneous therapeutic procedures		
Item	**Description**	**Fee**
	management by a specialist or consultant physician who is immediately available and exclusively rostered to intensive care—on the first day (H)	
13888	Continuous arterio venous or veno venous haemofiltration, management by a specialist or consultant physician who is immediately available and exclusively rostered to intensive care—on each day after the first day (H)	$76.90
Subgroup 11—Chemotherapeutic procedures		
13915	Cytotoxic chemotherapy, administration of, either by intravenous push technique (directly into a vein, or a butterfly needle, or the side-arm of an infusion) or by intravenous infusion of not more than 1 hour in duration, other than a service associated with photodynamic therapy with verteporfin or a service to administer drugs used immediately before, or during, microwave (UHF radiowave) cancer therapy—for any particular patient, once only on the same day	$65.05
13918	Cytotoxic chemotherapy, administration of, by intravenous infusion of more than 1 hour in duration but not more than 6 hours in duration—for any particular patient, once only on the same day	$97.95
13921	Cytotoxic chemotherapy, administration of, by intravenous infusion of more than 6 hours in duration—for the first day of treatment	$110.80
13924	Cytotoxic chemotherapy, administration of, by intravenous infusion of more than 6 hours in duration—on each day after the first in the same continuous treatment episode	$65.25
13927	Cytotoxic chemotherapy, administration of, either by intra-arterial push technique (directly into an artery, a butterfly needle or the side-arm of an infusion) or by intra-arterial infusion of not more than 1 hour in duration—for any particular patient, once only on the same day	$84.40
13930	Cytotoxic chemotherapy, administration of, by intra-arterial infusion of more than 1 hour in duration but not more than 6 hours in duration—for any particular patient, once only on the same day	$117.80

Group T1—Miscellaneous therapeutic procedures		
Item	**Description**	**Fee**
13933	Cytotoxic chemotherapy, administration of, by intra-arterial infusion of more than 6 hours in duration—for the first day of treatment	$130.70
13936	Cytotoxic chemotherapy, administration of, by intra-arterial infusion of more than 6 hours in duration—on each day after the first in the same continuous treatment episode	$85.15
13939	Implanted pump or reservoir, loading of, with a cytotoxic agent or agents, other than a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies	$97.95
13942	Ambulatory drug delivery device, loading of, with a cytotoxic agent or agents for the infusion of the agent or agents via the intravenous, intra-arterial or spinal routes, other than a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies	$65.25
13945	Long-term implanted drug delivery device for cytotoxic chemotherapy, accessing of	$52.50
13948	Cytotoxic agent, instillation of, into a body cavity	$65.25
Subgroup 12—Dermatology		
14050	PUVA therapy or UVB therapy administered in whole body cabinet (other than a service associated with a service to which item 14053 applies) including associated consultations other than an initial consultation	$52.75
14053	PUVA therapy or UVB therapy administered to localised body areas in a hand and foot cabinet (other than a service associated with a service to which item 14050 applies) including associated consultations other than an initial consultation	$52.75
14100	Laser photocoagulation using laser light within the wave length of 510-1064 nm in the treatment of vascular lesions of the head or neck, if abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period (Anaes.)	$152.50

Group T1—Miscellaneous therapeutic procedures		
Item	**Description**	**Fee**
14106	Laser photocoagulation using laser light within the wave length of 510-1064 nm in the treatment of port wine stains, haemangiomas of infancy, café—au—lait macules and naevi of Ota, other than melanocytic naevi (common moles), if abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period—area of treatment up to 50 cm^2 (Anaes.)	$152.50
14109	Laser photocoagulation using laser light within the wave length of 510-1064 nm in the treatment of port wine stains, haemangiomas of infancy, café—au—lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period—area of treatment more than 50 cm^2 and up to 100 cm^2 (Anaes.)	$187.35
14112	Laser photocoagulation using laser light within the wave length of 510-1064 nm in the treatment of port wine stains, haemangiomas of infancy, café-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period—area of treatment more than 100 cm^2 and up to 150 cm^2 (Anaes.)	$221.75
14115	Laser photocoagulation using laser light within the wave length of 510-1064 nm in the treatment of port wine stains, haemangiomas of infancy, café-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period—area of treatment more than 150 cm^2 and up to 250 cm^2 (Anaes.)	$256.50
14118	Laser photocoagulation using laser light within the wave length of 510-1064 nm in the treatment of port wine stains, haemangiomas of infancy, café-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles),	$325.75

Group T1—Miscellaneous therapeutic procedures		
Item	**Description**	**Fee**
	including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 apply) in any 12 month period—area of treatment more than 250 cm^2 (Anaes.)	
14124	Laser photocoagulation using laser light within the wave length of 510-1064 nm in the treatment of haemangiomas of infancy, including any associated consultation—if a seventh or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period that commences on the date of the first session (Anaes.)	$152.50
Subgroup 13—Other therapeutic procedures		
14200	Gastric lavage in the treatment of ingested poison	$59.80
14201	Poly-L-lactic acid, one or more injections of, for the initial session only, for the treatment of severe facial lipoatrophy caused by antiretroviral therapy, if prescribed in accordance with section 85 of the *National Health Act 1953*—once per patient	$236.85
14202	Poly-L-lactic acid, one or more injections of (subsequent sessions), for the continuation of treatment of severe facial lipoatrophy caused by antiretroviral therapy, if prescribed in accordance with section 85 of the *National Health Act 1953*	$119.90
14203	Hormone or living tissue implantation, by direct implantation involving incision and suture (Anaes.)	$51.15
14206	Hormone or living tissue implantation—by cannula	$35.60
14209	Intra-arterial infusion or retrograde intravenous perfusion of a sympatholytic agent	$88.70
14212	Intussusception, management of fluid or gas reduction for (Anaes.)	$185.30
14218	Implanted infusion pump, refilling of reservoir with a therapeutic agent or agents for infusion to the subarachnoid or epidural space, with or without re—programming a programmable pump, for the management of chronic intractable pain	$97.95
14221	Long—term implanted device for delivery of therapeutic	$52.50

Group T1—Miscellaneous therapeutic procedures		
Item	**Description**	**Fee**
	agents, accessing of, other than a service associated with a service to which item 13945 applies	
14224	Electroconvulsive therapy, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes.)	$70.35
14227	Implanted infusion pump, refilling of reservoir with baclofen for infusion to the subarachnoid or epidural space, with or without re-programming a programmable pump, for the management of severe chronic spasticity	$97.95
14230	Intrathecal or epidural spinal catheter, insertion or replacement of, and connection to a subcutaneous implanted infusion pump, for the management of severe chronic spasticity with baclofen (H) (Anaes.) (Assist.)	$298.05
14233	Infusion pump, subcutaneous implantation or replacement of, and: (a) connection to an intrathecal or epidural spinal catheter; and (b) filling of reservoir with baclofen; with or without programming the pump, for the management of severe chronic spasticity (H) (Anaes.) (Assist.)	$361.90
14236	All of the following: (a) infusion pump, subcutaneous implantation of; (b) intrathecal or epidural spinal catheter, insertion of; (c) connection of pump to catheter; (d) filling of reservoir with baclofen; with or without programming the pump, for the management of severe chronic spasticity (H) (Anaes.) (Assist.)	$659.95
14239	Either: (a) subcutaneously implanted infusion pump, removal of; or (b) intrathecal or epidural spinal catheter, removal or repositioning of; for the management of severe chronic spasticity (H) (Anaes.)	$159.40

Group T1—Miscellaneous therapeutic procedures		
Item	**Description**	**Fee**
14242	Subcutaneous reservoir and spinal catheter, insertion of, for the management of severe chronic spasticity (H) (Anaes.)	$473.65
14245	Immunomodulating agent, administration of, by intravenous infusion for at least 2 hours in duration	$97.95

Division 2.38—Group T2: Radiation oncology

2.38.1 Meaning of *amount under clause 2.38.1*

In an item of the table mentioned in column 1 of table 2.38.1:

amount under clause 2.38.1 means the sum of:

(a) the fee mentioned in column 2 for the item; and

(b) the amount mentioned in column 3 for each field separately treated in excess of one.

Table 2.38.1—Amount under clause 2.38.1

Item	Column 1 Item of the table	Column 2 Fee	Column 3 Amount for each field separately treated in excess of one ($)
1	15003	The fee for item 15000	17.10
2	15009	The fee for item 15006	18.55
3	15103	The fee for item 15100	18.80
4	15109	The fee for item 15106	22.70
5	15115	The fee for item 15112	47.30
6	15214	The fee for item 15211	31.90
7	15230	The fee for item 15215	37.95
8	15233	The fee for item 15218	37.95
9	15236	The fee for item 15221	37.95
10	15239	The fee for item 15224	37.95
11	15242	The fee for item 15227	37.95
12	15260	The fee for item 15245	37.95
13	15263	The fee for item 15248	37.95
14	15266	The fee for item 15251	37.95
15	15269	The fee for item 15254	37.95
16	15272	The fee for item 15257	37.95

2.38.2 Meaning of *approved site*

In item 15338:

approved site, for radiation oncology, means a site at which radiation oncology may be performed lawfully under the law of the State or Territory in which the site is located.

2.38.3 Application of Group T2

Items 15000 to 15600 do not apply to a service described in the item if the service is provided at the same time as, or in connection with, the provision of a pain pump for post-surgical pain management.

2.38.4 Application of items 15556, 15559 and 15562

A service mentioned in item 15556, 15559 or 15562 applies only if:

(a) each gross tumour target, clinical target, planning target and organ at risk specified in the prescription is rendered as a volume; and

(b) each organ at risk is nominated as a planning dose goal or constraint; and

(c) each organ at risk is specified in the prescription as a dose goal or constraint; and

(d) dose volume histograms are generated, approved and recorded with the plan; and

(e) a CT image volume dataset is required for the relevant region to be planned and treated; and

(f) the CT image is required to be suitable for the generation of quality digitally reconstructed radiographic images.

Group T2—Radiation oncology		
Item	**Description**	**Fee**
Subgroup 1—Superficial		
15000	Radiotherapy, superficial (including treatment with x-rays,	$42.55

Group T2—Radiation oncology		
Item	**Description**	**Fee**
	radium rays or other radioactive substances), other than a service to which another item in this Group applies—each attendance at which fractionated treatment is given—one field	
15003	Radiotherapy, superficial (including treatment with x-rays, radium rays or other radioactive substances), other than a service to which another item in this Group applies—each attendance at which fractionated treatment is given—2 or more fields up to a maximum of 5 additional fields	Amount under clause 2.38.1
15006	Radiotherapy, superficial—attendance at which a single dose technique is applied—one field	$94.35
15009	Radiotherapy, superficial—attendance at which a single dose technique is applied—2 or more fields up to a maximum of 5 additional fields	Amount under clause 2.38.1
15012	Radiotherapy, superficial—each attendance at which treatment is given to an eye	$53.45
Subgroup 2—Orthovoltage		
15100	Radiotherapy, deep or orthovoltage—each attendance at which fractionated treatment is given at 3 or more treatments per week—one field	$47.70
15103	Radiotherapy, deep or orthovoltage—each attendance at which fractionated treatment is given at 3 or more treatments per week—2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)	Amount under clause 2.38.1
15106	Radiotherapy, deep or orthovoltage—each attendance at which fractionated treatment is given at 2 treatments per week or less frequently—one field	$56.30
15109	Radiotherapy, deep or orthovoltage—each attendance at which fractionated treatment is given at 2 treatments per week or less frequently—2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)	Amount under clause 2.38.1
15112	Radiotherapy, deep or orthovoltage—attendance at which a single dose technique is applied—one field	$120.25
15115	Radiotherapy, deep or orthovoltage—attendance at which	Amount

Group T2—Radiation oncology		
Item	**Description**	**Fee**
	a single dose technique is applied—2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)	under clause 2.38.1
Subgroup 3—Megavoltage		
15211	Radiation oncology treatment, using cobalt unit or caesium teletherapy unit—each attendance at which treatment is given—one field	$54.70
15214	Radiation oncology treatment, using cobalt unit or caesium teletherapy unit—each attendance at which treatment is given—2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)	Amount under clause 2.38.1
15215	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—each attendance at which treatment is given—one field—treatment delivered to primary site (lung)	$59.65
15218	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—each attendance at which treatment is given—one field—treatment delivered to primary site (prostate)	$59.65
15221	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—each attendance at which treatment is given—one field—treatment delivered to primary site (breast)	$59.65
15224	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—each attendance at which treatment is given—one field—treatment delivered to primary site for diseases or conditions not covered by item 15215, 15218 or 15221	$59.65
15227	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—each attendance at which treatment is given—one field—treatment delivered to secondary site	$59.65
15230	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—each attendance at which treatment is given—2 or more fields up to a maximum of 5 additional fields	Amount under clause 2.38.1

Group T2—Radiation oncology		
Item	**Description**	**Fee**
	(rotational therapy being 3 fields)—treatment delivered to primary site (lung)	
15233	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—each attendance at which treatment is given—2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)—treatment delivered to primary site (prostate)	Amount under clause 2.38.1
15236	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—each attendance at which treatment is given—2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)—treatment delivered to primary site (breast)	Amount under clause 2.38.1
15239	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—each attendance at which treatment is given—2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)—treatment delivered to primary site for diseases or conditions not covered by item 15230, 15233 or 15236	Amount under clause 2.38.1
15242	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—each attendance at which treatment is given—2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)—treatment delivered to secondary site	Amount under clause 2.38.1
15245	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—each attendance at which treatment is given—one field—treatment delivered to primary site (lung)	$59.65
15248	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—each attendance at which treatment is given—one field—treatment delivered to primary site (prostate)	$59.65

Group T2—Radiation oncology		
Item	**Description**	**Fee**
15251	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—each attendance at which treatment is given—one field—treatment delivered to primary site (breast)	$59.65
15254	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—each attendance at which treatment is given—one field—treatment delivered to primary site for diseases or conditions not covered by item 15245, 15248 or 15251	$59.65
15257	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—each attendance at which treatment is given—one field—treatment delivered to secondary site	$59.65
15260	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—each attendance at which treatment is given—2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)—treatment delivered to primary site (lung)	Amount under clause 2.38.1
15263	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—each attendance at which treatment is given—2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)—treatment delivered to primary site (prostate)	Amount under clause 2.38.1
15266	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—each attendance at which treatment is given—2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)—treatment delivered to primary site (breast)	Amount under clause 2.38.1
15269	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least	Amount under

Group T2—Radiation oncology		
Item	**Description**	**Fee**
	10MV photons, with electron facilities—each attendance at which treatment is given—2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)—treatment delivered to primary site for diseases or conditions not covered by item 15260, 15263 or 15266	clause 2.38.1
15272	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—each attendance at which treatment is given—2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)—treatment delivered to secondary site	Amount under clause 2.38.1
Subgroup 4—Brachytherapy		
15303	Intrauterine treatment alone using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)	$357.00
15304	Intrauterine treatment alone using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)	$357.00
15307	Intrauterine treatment alone using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.)	$676.80
15308	Intrauterine treatment alone using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.)	$676.80
15311	Intravaginal treatment alone using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)	$333.20
15312	Intravaginal treatment alone using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)	$330.80
15315	Intravaginal treatment alone using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.)	$654.25

Group T2—Radiation oncology		
Item	**Description**	**Fee**
15316	Intravaginal treatment alone using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.)	$654.25
15319	Combined intrauterine and intravaginal treatment using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)	$406.05
15320	Combined intrauterine and intravaginal treatment using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)	$406.05
15323	Combined intrauterine and intravaginal treatment using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium, or tantalum using manual afterloading techniques (Anaes.)	$722.00
15324	Combined intrauterine and intravaginal treatment using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium, or tantalum using automatic afterloading techniques (Anaes.)	$722.00
15327	Implantation of a sealed radioactive source (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using manual afterloading techniques (Anaes.)	$785.45
15328	Implantation of a sealed radioactive source (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using automatic afterloading techniques (Anaes.)	$785.45
15331	Implantation of a sealed radioactive source (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), if the volume treated involves multiple planes but does not require surgical exposure and using manual afterloading	$745.80

Group T2—Radiation oncology		
Item	**Description**	**Fee**
	techniques (Anaes.)	
15332	Implantation of a sealed radioactive source (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), if the volume treated involves multiple planes but does not require surgical exposure and using automatic afterloading techniques (Anaes.)	$745.80
15335	Implantation of a sealed radioactive source (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site if the volume treated involves only a single plane but does not require surgical exposure and using manual afterloading techniques (Anaes.)	$676.80
15336	Implantation of a sealed radioactive source (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site if the volume treated involves only a single plane but does not require surgical exposure and using automatic afterloading techniques (Anaes.)	$676.80
15338	Prostate, radioactive seed implantation of, radiation oncology component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stage T1 (clinically inapparent tumour that is not palpable or visible by imaging) or clinical stage T2 (tumour confined within prostate), with a Gleason score of not more than 7 and a prostate specific antigen (PSA) of 10ng/ml or less at the time of diagnosis, if the procedure is performed by an oncologist at an approved site in association with a urologist	$935.60
15339	Removal of a sealed radioactive source under general anaesthesia, or under epidural or spinal nerve block (Anaes.)	$76.20
15342	Construction and application of a radioactive mould using a sealed source having a half-life of greater than 115 days, to treat intracavity, intraoral or intranasal site	$190.30
15345	Construction and application of a radioactive mould using a sealed source having a half-life of less than 115 days including iodine, gold, iridium or tantalum to treat	$507.80

Group T2—Radiation oncology		
Item	**Description**	**Fee**
	intracavity, intraoral or intranasal sites	
15348	Subsequent applications of radioactive mould referred to in item 15342 or 15345—each attendance	$58.40
15351	Construction with or without initial application of a radioactive mould not exceeding 5 cm in diameter to an external surface	$116.60
15354	Construction and first application of a radioactive mould more than 5 cm in diameter to an external surface	$141.50
15357	Attendance upon a patient to apply a radioactive mould constructed for application to an external surface of the patient other than an attendance which is the first attendance to apply the mould—each attendance	$40.05
Subgroup 5—Computerised planning		
15500	Radiation field setting using a simulator or isocentric x-ray or megavoltage machine or CT of a single area for treatment by a single field or parallel opposed fields (other than a service associated with a service to which item 15509 applies)	$242.65
15503	Radiation field setting using a simulator or isocentric x-ray or megavoltage machine or CT of a single area, if views in more than one plane are required for treatment by multiple fields, or of 2 areas (other than a service associated with a service to which item 15512 applies)	$311.55
15506	Radiation field setting using a simulator or isocentric x-ray or megavoltage machine or CT of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of off-axis fields or several joined fields (other than a service associated with a service to which item 15515 applies)	$465.30
15509	Radiation field setting using a diagnostic x-ray unit of a single area for treatment by a single field or parallel opposed fields (other than a service associated with a service to which item 15500 applies)	$210.30
15512	Radiation field setting using a diagnostic x-ray unit of a	$271.10

Group T2—Radiation oncology		
Item	**Description**	**Fee**
	single area, if views in more than one plane are required for treatment by multiple fields, or of 2 areas (other than a service associated with a service to which item 15503 applies)	
15513	Radiation source localisation using a simulator or x-ray machine or CT of a single area, if views in more than one plane are required, for brachytherapy treatment planning for Iodine 125 seed implantation of localised prostate cancer, being a service associated with a service to which item 15338 applies	$306.55
15515	Radiation field setting using a diagnostic x-ray unit of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of off-axis fields or several joined fields (other than a service associated with a service to which item 15506 applies)	$392.50
15518	Radiation Dosimetry by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to one area with up to 2 shielding blocks	$77.00
15521	Radiation Dosimetry by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or if wedges are used	$339.90
15524	Radiation Dosimetry by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields or tangential fields or irregularly shaped fields using multiple blocks, or off-axis fields, or several joined fields	$637.35
15527	Radiation Dosimetry by a non-CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to one area with up to 2 shielding blocks	$78.95
15530	Radiation Dosimetry by a non-CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or if wedges are used	$352.15

Group T2—Radiation oncology		
Item	**Description**	**Fee**
15533	Radiation Dosimetry by a non-CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields, or tangential fields or irregularly shaped fields using multiple blocks, or off-axis fields, or several joined fields	$667.70
15536	Brachytherapy planning, computerised Radiation Dosimetry	$266.90
15539	Brachytherapy planning, computerised radiation dosimetry for Iodine 125 seed implantation of localised prostate cancer, being a service associated with a service to which item 15338 applies	$627.30
15550	Simulation for 3 dimensional conformal radiotherapy without intravenous contrast medium if: (a) treatment set up and technique specifications are in preparation for 3 dimensional conformal radiotherapy dose planning; and (b) patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and 3 dimensional conformal radiotherapy treatment; and (c) a high-quality CT image volume dataset is required for the relevant region of interest to be planned and treated; and (d) the image set up is required to be suitable for the generation of quality digitally reconstructed radiographic images	$658.60
15553	Simulation for 3 dimensional conformal radiotherapy, including pre and post intravenous contrast medium if: (a) treatment set up and technique specifications are in preparation for 3 dimensional conformal radiotherapy dose planning; and (b) patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and 3 dimensional conformal radiotherapy treatment; and (c) a high-quality CT image volume dataset is required for	$710.55

Group T2—Radiation oncology		
Item	**Description**	**Fee**
	the relevant region of interest to be planned and treated; and (d) the image set up is required to be suitable for the generation of quality digitally reconstructed radiographic images	
15556	Dosimetry for 3 dimensional conformal radiotherapy of level one complexity if the dosimetry is for a single phase 3 dimensional conformal treatment plan using a CT image volume dataset, with one gross tumour volume or clinical target volume, one planning target volume and one organ at risk specified in the prescription	$664.40
15559	Dosimetry for 3 dimensional conformal radiotherapy of level 2 complexity if: (a) the dosimetry is for a 2 phase 3 dimensional conformal treatment plan using one or more CT image volume datasets, with at least one gross tumour volume, 2 planning target volumes and one organ at risk specified in the prescription; or (b) the dosimetry is for a single phase 3 dimensional conformal treatment plan using one or more CT image volume datasets, with at least one gross tumour volume, one planning target volume and 2 organ at risk dose goals or constraints specified in the prescription; or (c) image fusion with a secondary CT, MRI or PET image volume dataset is used to define target volumes and organs at risk as mentioned in item 15556	$866.55
15562	Dosimetry for 3 dimensional conformal radiotherapy of level 3 complexity if: (a) the dosimetry is for a 3 phase 3 dimensional conformal treatment plan using one or more CT image volume datasets, with at least one gross tumour volume, 3 planning target volumes and one organ at risk specified in the prescription; or (b) the dosimetry is for a 2 phase 3 dimensional conformal treatment plan using one or more CT image volume datasets, with:	$1 120.75

Group T2—Radiation oncology		
Item	**Description**	**Fee**
	(i) at least one gross tumour volume specified in the prescription; and (ii) 2 planning target volumes or 2 organ at risk dose goals or constraints specified in the prescription; or (c) the dosimetry is for a single phase 3 dimensional conformal treatment plan using one or more CT image volume datasets, with at least one gross tumour volume, one planning target volume and 3 organ at risk dose goals or constraints specified in the prescription; or (d) image fusion with a secondary CT, MRI or PET image volume dataset is used to define target volume and organs at risk as mentioned in item 15559	
Subgroup 6—Stereotactic radiosurgery		
15600	Stereotactic radiosurgery, including all radiation oncology consultations, planning, simulation, dosimetry and treatment	$1 702.30

Division 2.39—Group T3: Therapeutic nuclear medicine

2.39.1 Application of Group T3

An item in Group T3 does not apply to a service mentioned in the item if the service is provided at the same time as, or in connection with, the provision of a pain pump for post-surgical pain management.

Group T3—Therapeutic nuclear medicine

Item	Description	Fee ($)
16003	Intra-cavitary administration of a therapeutic dose of Yttrium 90 (not including preliminary paracentesis and other than a service to which item 35404, 35406 or 35408 applies or a service associated with selective internal radiation therapy) (Anaes.)	650.50
16006	Administration of a therapeutic dose of Iodine 131 for thyroid cancer by single dose technique	499.85
16009	Administration of a therapeutic dose of Iodine 131 for thyrotoxicosis by single dose technique	341.15
16012	Intravenous administration of a therapeutic dose of Phosphorous 32	295.15
16015	Administration of Strontium 89 for painful bony metastases from carcinoma of the prostate, if hormone therapy has failed and either: (a) the disease is poorly controlled by conventional radiotherapy; or (b) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain	4 085.70
16018	Administration of 153 Sm-lexidronam for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan), if hormonal therapy or chemotherapy have failed, and: (a) the disease is poorly controlled by conventional radiotherapy; or (b) conventional radiotherapy is inappropriate, due to the wide	2 442.45

Group T3—Therapeutic nuclear medicine		
Item	**Description**	**Fee ($)**
	distribution of sites of bone pain	

Division 2.40—Group T4: Obstetrics

2.40.1 Definitions for item 16400

In item 16400:

midwife means a person:

(a) who is registered under a law of a State or Territory as a midwife; and

(b) who is employed by, or whose services are otherwise retained by, a medical practitioner or a practice operated by a medical practitioner.

nurse means a person:

(a) who is registered under a law of a State or Territory as a registered nurse or enrolled nurse; and

(b) who is employed by, or whose services are otherwise retained by, a medical practitioner or a practice operated by a medical practitioner.

practice location has the same meaning as in clause 2.31.1.

2.40.2 Meaning of *amount under clause 2.40.2*

(1) In item 16633:

amount under clause 2.40.2, for a second or subsequent foetus, means 50% of the fee mentioned in items 16606, 16609, 16612, 16615 and 16627 for services provided in relation to the multiple pregnancy.

(2) In item 16636:

amount under clause 2.40.2, for a second or subsequent foetus, means 50% of the amount of the fee mentioned in items 16600, 16603, 16618, 16621 and 16624 for services provided in relation to the multiple pregnancy.

2.40.3 Meaning of *delivery*

For items 16515, 16519, 16522, 16527, 16590 and 16591, ***delivery*** includes:

(a) induction of labour by surgical or intravenous infusion methods; and
(b) forceps or vacuum extraction; and
(c) breech delivery; and
(d) management of multiple deliveries; and
(e) episiotomy; and
(f) repair of tears; and
(g) evacuation of the products of conception by manual removal.

2.40.4 Application of Group T4

An item in Group T4 does not apply to a service mentioned in the item if the service is provided at the same time as, or in connection with, the provision of a pain pump for post-surgical pain management.

2.40.5 Application of item 16400

(1) Item 16400 applies to an antenatal service provided to a patient by a midwife, nurse or Aboriginal and Torres Strait Islander health practitioner only if:
(a) the midwife, nurse or Aboriginal and Torres Strait Islander health practitioner has the appropriate training and skills to perform an antenatal service; and
(b) the medical practitioner under whose supervision the antenatal service is provided retains responsibility for clinical outcomes and for the health and safety of the patient; and
(c) the midwife, nurse or Aboriginal and Torres Strait Islander health practitioner complies with relevant legislative or regulatory requirements regarding the provision of the antenatal service in the State or Territory where the service is provided.

(2) Item 16400 does not apply in conjunction with another antenatal attendance item for the same patient, on the same day by the same practitioner.

(3) Item 16400 does not apply in conjunction with items 10990, 10991 or 10992.

(4) For any particular patient, item 16400 applies not more than 10 times in a 9 month period.

2.40.5A Limitation of item 16399

Item 16399 does not apply if the patient or specialist travels to a place to satisfy the requirement in sub-subparagraph (d)(i)(B) of the item.

2.40.6 Limitation of items 16590 and 16591

A service described in item 16590 or 16591 applies not more than once in a pregnancy that has progressed beyond 20 weeks.

Group T4—Obstetrics		
Item	**Description**	**Fee**
16399	Professional attendance on a patient by a specialist practising in his or her specialty of obstetrics if: (a) the attendance is by video conference; and (b) item 16401, 16404, 16406, 16500, 16590 or 16591 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service;	50% of the fee for item 16401, 16404, 16406, 16500, 16590 or 16591

Group T4—Obstetrics		
Item	**Description**	**Fee**
	for which a direction made under subsection 19(2) of the Act applies	
16400	Antenatal service provided by a midwife, nurse or an Aboriginal and Torres Strait Islander health practitioner, to a maximum of 10 services per pregnancy, if: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the service is provided at, or from, a practice location in a regional, rural or remote area; and (c) the service is not performed in conjunction with another antenatal attendance item in Group T4 for the same patient on the same day by the same practitioner; and (d) the service is not provided for an admitted patient of a hospital or approved day facility	$27.25
16401	Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics after referral of the patient to him or her—each attendance, other than a second or subsequent attendance in a single course of treatment, other than a service to which item 104 applies	$85.55
16404	Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics after referral of the patient to him or her—each attendance after the first attendance in a single course of treatment	$43.00
16406	Antenatal professional attendance, as part of a single course of treatment, at 32-36 weeks of the patient's pregnancy when the patient is referred by a participating midwife Payable only once for a pregnancy	$133.95
16500	Antenatal attendance	$47.15
16501	External cephalic version for breech presentation, after 36 weeks, if no contraindication exists, in a unit with facilities for caesarean section, including pre and post version CTG, with or without tocolysis, other than a service to which	$140.55

Group T4—Obstetrics		
Item	**Description**	**Fee**
	items 55718 to 55728 and 55768 to 55774 apply—chargeable whether or not the version is successful and limited to a maximum of 2 ECV's per pregnancy	
16502	Polyhydramnios, unstable lie, multiple pregnancy, pregnancy complicated by diabetes or anaemia, threatened premature labour treated by bed rest only or oral medication, requiring admission to hospital—each attendance that is not a routine antenatal attendance, to a maximum of one visit per day	$47.15
16504	Treatment of habitual miscarriage by injection of hormones—each injection up to a maximum of 12 injections, if the injection is not administered during a routine antenatal attendance	$47.15
16505	Threatened abortion, threatened miscarriage or hyperemesis gravidarum, requiring admission to hospital, treatment of—each attendance that is not a routine antenatal attendance	$47.15
16508	Pregnancy complicated by acute intercurrent infection, intra-uterine growth retardation, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital—each attendance that is not a routine antenatal attendance, to a maximum of one visit per day	$47.15
16509	Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of—each attendance that is not a routine antenatal attendance	$47.15
16511	Cervix, purse string ligation of (Anaes.)	$219.95
16512	Cervix, removal of purse string ligature of (Anaes.)	$63.50
16514	Antenatal cardiotocography in the management of high risk pregnancy (not during the course of the confinement)	$36.65
16515	Management of vaginal delivery as an independent procedure, if the patient's care has been transferred by another medical practitioner for management of the delivery and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the delivery (Anaes.)	$450.65

Group T4—Obstetrics		
Item	**Description**	**Fee**
16518	Management of labour, incomplete, if the patient's care has been transferred to another medical practitioner for completion of the delivery (Anaes.)	$450.65
16519	Management of labour and delivery by any means (including Caesarean section) including post-partum care for 5 days (Anaes.)	$693.95
16520	Caesarean section and post-operative care for 7 days, if the patient's care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care (Anaes.)	$811.05
16522	Management of labour and delivery, or delivery alone, (including Caesarean section), if in the course of antenatal supervision or intrapartum management, one or more, of the following conditions is present, including postnatal care for 7 days: (a) multiple pregnancy; (b) recurrent antepartum haemorrhage from 20 weeks gestation; (c) grade 2, 3 or 4 placenta praevia; (d) baby with a birth weight less than or equal to 2 500 gm; (e) pre-existing diabetes mellitus dependent on medication, or gestational diabetes requiring at least daily blood glucose monitoring; (f) trial of vaginal delivery in a patient with uterine scar, or trial of vaginal breech delivery; (g) pre-existing hypertension requiring antihypertensive medication, or pregnancy induced hypertension of at least 140/90mmHg associated with at least 1+ proteinuria on urinalysis; (h) prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress; (i) fetal distress defined by significant cardiotocograph or scalp pH abnormalities requiring immediate delivery; (j) conditions that pose a significant risk of maternal death;	$1 629.35

Group T4—Obstetrics		
Item	**Description**	**Fee**
	(Anaes.)	
16525	Management of second trimester labour, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease, other than a service to which item 35643 applies (Anaes.)	$384.35
16527	Management of vaginal delivery, if the patient's care has been transferred by a participating midwife for management of the delivery, including all attendances related to the delivery (Anaes.) Payable only once for a pregnancy	$450.65
16528	Caesarean section and post-operative care for 7 days, if the patient's care has been transferred by a participating midwife for management of the birth (Anaes.) Payable only once for a pregnancy	$811.05
16564	Evacuation of retained products of conception (placenta, membranes or mole) as a complication of confinement, with or without curettage of the uterus, as an independent procedure (Anaes.)	$218.00
16567	Management of postpartum haemorrhage by special measures such as packing of uterus, as an independent procedure (Anaes.)	$318.80
16570	Acute inversion of the uterus, vaginal correction of, as an independent procedure (Anaes.)	$416.05
16571	Cervix, repair of extensive laceration or lacerations (Anaes.)	$318.80
16573	Third degree tear, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.)	$259.80
16590	Planning and management of a pregnancy that has progressed beyond 20 weeks, if the fee does not include any amount for the management of the labour and delivery and, if the practitioner intends to undertake the delivery for the privately admitted patient, the service is not a service to which item 16591 applies	$324.10
16591	Planning and management of a pregnancy that has	$142.65

Group T4—Obstetrics		
Item	**Description**	**Fee**
	progressed beyond 20 weeks, if the fee does not include any amount for the management of the labour and delivery and, if the care of the patient will be transferred to another medical practitioner, the service is not a service to which item 16590 applies	
16600	Amniocentesis, diagnostic	$63.50
16603	Chorionic villus sampling, by any route	$121.85
16606	Fetal blood sampling, using interventional techniques from umbilical cord or foetus, including fetal neuromuscular blockade and amniocentesis (Anaes.)	$243.25
16609	Fetal intravascular blood transfusion, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling (Anaes.)	$496.00
16612	Fetal intraperitoneal blood transfusion, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling—not performed in conjunction with a service described in item 16609 (Anaes.)	$390.25
16615	Fetal intraperitoneal blood transfusion, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling—performed in conjunction with a service described in item 16609 (Anaes.)	$207.85
16618	Amniocentesis, therapeutic, when indicated because of polyhydramnios with at least 500 ml being aspirated	$207.85
16621	Amnioinfusion, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios	$207.85
16624	Fetal fluid filled cavity, drainage of	$299.10
16627	Feto-amniotic shunt, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis	$608.95
16633	Procedure on multiple pregnancies relating to items 16606, 16609, 16612, 16615 and 16627	Amount under clause 2.40.2
16636	Procedure on multiple pregnancies relating to items 16600,	Amount

Group T4—Obstetrics		
Item	**Description**	**Fee**
	16603, 16618, 16621 and 16624	under clause 2.40.2

Division 2.41—Group T6: Examination by anaesthetist

2.41.1 Application of Group T6

An item in Group T6 does not apply to a service mentioned in the item if the service is provided at the same time as, or in connection with, the provision of a pain pump for post-surgical pain management.

2.41.2 Limitation of item 17609

Item 17609 does not apply if the patient or specialist travels to a place to satisfy the requirement in sub-subparagraph (d)(i)(B) of the item.

Group T6—Examination by anaesthetist

Item	Description	Fee
17609	Professional attendance on a patient by a specialist practising in his or her specialty of anaesthesia if: (a) the attendance is by video conference; and (b) item 17610, 17615, 17620, 17625, 17640, 17645, 17650 or 17655 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies	50% of the fee for item 17610, 17615, 17620, 17640, 17645, 17650 or 17655
17610	Professional attendance by a medical practitioner in the practice of anaesthesia for a brief consultation involving a	$43.00

Group T6—Examination by anaesthetist		
Item	**Description**	**Fee**
	targeted history and limited examination, including the cardio-respiratory system, of not more than 15 minutes in duration (other than a service associated with a service to which any of items 2801 to 3000 apply)	
17615	Professional attendance by a medical practitioner in the practice of anaesthesia for a consultation on a patient undergoing advanced surgery or who has complex medical problems, involving a selective history and an extensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes, and of more than 15 minutes in duration and not more than 30 minutes in duration (other than a service associated with a service to which any of items 2801 to 3000 apply)	$85.55
17620	Professional attendance by a medical practitioner in the practice of anaesthesia for a consultation on a patient undergoing advanced surgery or who has complex medical problems involving a detailed history and comprehensive examination of multiple systems, and the formulation of a written patient management plan documented in the patient notes, and of more than 30 minutes in duration and not more than 45 minutes in duration (other than a service associated with a service to which any of items 2801 to 3000 apply)	$118.50
17625	Professional attendance by a medical practitioner in the practice of anaesthesia for a consultation on a patient undergoing advanced surgery or who has complex medical problems involving an exhaustive history and comprehensive examination of multiple systems, the formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of high complexity documented in the patient notes, and of more than 45 minutes in duration (other than a service associated with a service to which any of items 2801 to 3000 apply)	$150.90
17640	Professional attendance by a specialist anaesthetist in the practice of anaesthesia, if the patient is referred to him or	$43.00

Group T6—Examination by anaesthetist		
Item	**Description**	**Fee**
	her—a brief consultation involving a short history, a limited examination, and of not more than 15 minutes in duration (other than a service associated with a service to which any of items 2801 to 3000 apply)	
17645	Professional attendance by a specialist anaesthetist in the practice of anaesthesia, if the patient is referred to him or her—a consultation involving a selective history and examination of multiple systems, the formulation of a written patient management plan, and of more than 15 minutes in duration and not more than 30 minutes in duration (other than a service associated with a service to which any of items 2801 to 3000 apply)	$85.55
17650	Professional attendance by a specialist anaesthetist in the practice of anaesthesia, if the patient is referred to him or her—a consultation involving a detailed history and comprehensive examination of multiple systems, and the formulation of a written patient management plan, and of more than 30 minutes in duration and not more than 45 minutes in duration (other than a service associated with a service to which any of items 2801 to 3000 apply)	$118.50
17655	Professional attendance by a specialist anaesthetist in the practice of anaesthesia, if the patient is referred to him or her—a consultation involving an exhaustive history and comprehensive examination of multiple systems, and the formulation of a written patient management plan following discussion with relevant health care professionals or the patient, involving medical planning of high complexity, and of more than 45 minutes in duration (other than a service associated with a service to which any of items 2801 to 3000 apply)	$150.90
17680	Professional attendance by a medical practitioner in the practice of anaesthesia—a consultation immediately before the institution of a major regional blockade in a patient in labour, if no previous anaesthesia consultation has occurred (other than a service associated with a service to which any of items 2801 to 3000 apply)	$85.55
17690	A medical service in association with an item in the range	$39.55

Group T6—Examination by anaesthetist		
Item	**Description**	**Fee**
	17615 to 17625 if: (a) the service is provided to a patient before an admitted patient episode of care involving anaesthesia; and (b) the service is not provided to an admitted patient of a hospital or day-hospital facility; and (c) the service is not provided on the day of admission to hospital for the subsequent episode of care involving anaesthesia services; and (d) the service is of more than 15 minutes in duration; (other than a service associated with a service to which any of items 2801 to 3000 apply)	

Division 2.42—Group T7: Regional or field nerve blocks

2.42.1 Meaning of *amount under clause 2.42.1*

(1) In item 18219:

amount under clause 2.42.1 means the sum of:

(a) the fee for item 18216; and

(b) $19.00 for each additional period of 15 minutes, and part of a period of 15 minutes, of continuous attendance beyond the first hour of attendance.

(2) In item 18227:

amount under clause 2.42.1 means the sum of:

(a) the fee for item 18226; and

(b) $28.60 for each additional period of 15 minutes, and part of a period of 15 minutes, of continuous attendance beyond the first hour of attendance.

2.42.2 Application of Group T7

An item in Group T7 does not apply to a service mentioned in the item if the service is provided at the same time as, or in connection with, the provision of a pain pump for post-surgical pain management.

Group T7—Regional or field nerve blocks

Item	Description	Fee
18213	Intravenous regional anaesthesia of limb by retrograde perfusion	$88.65
18216	Intrathecal or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner (Anaes.)	$189.90
18219	Intrathecal or epidural infusion of a therapeutic substance, initial injection or commencement of, if continuous	Amount under

Group T7—Regional or field nerve blocks		
Item	**Description**	**Fee**
	attendance by the medical practitioner extends beyond the first hour (Anaes.)	clause 2.42.1
18222	Infusion of a therapeutic substance to maintain regional anaesthesia or analgesia, subsequent injection or revision of, if the period of continuous medical practitioner attendance is 15 minutes or less	$37.65
18225	Infusion of a therapeutic substance to maintain regional anaesthesia or analgesia, subsequent injection or revision of, if the period of continuous medical practitioner attendance is more than 15 minutes	$50.05
18226	Intrathecal or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner—for a patient in labour, if the service is provided between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday	$284.80
18227	Intrathecal or epidural infusion of a therapeutic substance, initial injection or commencement of, if continuous attendance by a medical practitioner extends beyond the first hour—for a patient in labour, if the service is provided between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday	Amount under clause 2.42.1
18228	Interpleural block, initial injection or commencement of infusion of a therapeutic substance	$62.50
18230	Intrathecal or epidural injection of neurolytic substance (Anaes.)	$238.45
18232	Intrathecal or epidural injection of substance other than anaesthetic, contrast or neurolytic solutions, other than a service to which another item in this Group applies (Anaes.)	$189.90
18233	Epidural injection of blood for blood patch (Anaes.)	$189.90
18234	Trigeminal nerve, primary division of, injection of an anaesthetic agent (Anaes.)	$124.85
18236	Trigeminal nerve, peripheral branch of, injection of an anaesthetic agent (Anaes.)	$62.50

Group T7—Regional or field nerve blocks		
Item	**Description**	**Fee**
18238	Facial nerve, injection of an anaesthetic agent, other than a service associated with a service to which item 18240 applies	$37.65
18240	Retrobulbar or peribulbar injection of an anaesthetic agent	$93.60
18242	Greater occipital nerve, injection of an anaesthetic agent (Anaes.)	$37.65
18244	Vagus nerve, injection of an anaesthetic agent	$100.80
18246	Glossopharyngeal nerve, injection of an anaesthetic agent	$100.80
18248	Phrenic nerve, injection of an anaesthetic agent	$88.65
18250	Spinal accessory nerve, injection of an anaesthetic agent	$62.50
18252	Cervical plexus, injection of an anaesthetic agent	$100.80
18254	Brachial plexus, injection of an anaesthetic agent	$100.80
18256	Suprascapular nerve, injection of an anaesthetic agent	$62.50
18258	Intercostal nerve (single), injection of an anaesthetic agent	$62.50
18260	Intercostal nerves (multiple), injection of an anaesthetic agent	$88.65
18262	Ilio-inguinal, iliohypogastric or genitofemoral nerves, one or more of, injection of an anaesthetic agent (Anaes.)	$62.50
18264	Pudendal nerve, injection of an anaesthetic agent	$100.80
18266	Ulnar, radial or median nerve, main trunk of, one or more of, injection of an anaesthetic agent, not being associated with a brachial plexus block	$62.50
18268	Obturator nerve, injection of an anaesthetic agent	$88.65
18270	Femoral nerve, injection of an anaesthetic agent	$88.65
18272	Saphenous, sural, popliteal or posterior tibial nerve, main trunk of, one or more of, injection of an anaesthetic agent	$62.50
18274	Paravertebral, cervical, thoracic, lumbar, sacral or coccygeal nerves, injection of an anaesthetic agent, (single vertebral level)	$88.65
18276	Paravertebral nerves, injection of an anaesthetic agent, (multiple levels)	$124.85
18278	Sciatic nerve, injection of an anaesthetic agent	$88.65

Group T7—Regional or field nerve blocks		
Item	**Description**	**Fee**
18280	Sphenopalatine ganglion, injection of an anaesthetic agent (Anaes.)	$124.85
18282	Carotid sinus, injection of an anaesthetic agent, as an independent percutaneous procedure	$100.80
18284	Stellate ganglion, injection of an anaesthetic agent (cervical sympathetic block) (Anaes.)	$147.65
18286	Lumbar or thoracic nerves, injection of an anaesthetic agent (paravertebral sympathetic block) (Anaes.)	$147.65
18288	Coeliac plexus or splanchnic nerves, injection of an anaesthetic agent (Anaes.)	$147.65
18290	Cranial nerve other than trigeminal, destruction by a neurolytic agent, other than a service associated with the injection of botulinum toxin (Anaes.)	$249.75
18292	Nerve branch, destruction by a neurolytic agent, other than a service to which another item in this Group applies or a service associated with the injection of botulinum toxin except those services to which items 18354, 18356 and 18358 apply (Anaes.)	$124.85
18294	Coeliac plexus or splanchnic nerves, destruction by a neurolytic agent (Anaes.)	$176.00
18296	Lumbar sympathetic chain, destruction by a neurolytic agent (Anaes.)	$150.55
18298	Cervical or thoracic sympathetic chain, destruction by a neurolytic agent (Anaes.)	$176.00

Division 2.42A—Group T11: Botulinum toxin

2.42A.1 Injection of botulinum toxin

(1) Items 18350 to 18375 apply to a service provided by a medical practitioner registered by the Medicare Australia CEO to participate in the arrangements made under paragraph 100(1)(b) of the *National Health Act 1953* for the purpose of providing an adequate pharmaceutical service for individuals requiring treatment with botulinum toxin.

(2) If the cost of the botulinum toxin injection supplied in connection with a service described in each of items 18350 to 18375 is not subsidised by the Commonwealth or a State, the service is taken not to include the supply of that toxin.

2.42A.2 Limitation of items 18360 and 18364

A service mentioned in item 18360 or 18364 is applicable to the first 4 treatments, not exceeding 2 for each limb, on any one day.

Group T11—Botulinum toxin

Item	Description	Fee ($)
18350	Botulinum toxin (Botox), injection of, for hemifacial spasm in a patient who is at least 12 years, including all such injections on any one day	124.85
18351	Botulinum toxin (Dysport), injection of, for hemifacial spasm in a patient who is at least 18 years, including all such injections on any one day	124.85
18352	Botulinum toxin (Botox or Dysport), injection of, for cervical dystonia (spasmodic torticollis), including all such injections on any one day	249.75
18354	Botulinum toxin (Botox or Dysport), injection of, for dynamic equinus foot deformity due to spasticity in an ambulant cerebral palsy patient who is 2 years old or older, in accordance with the supply of the drugs under the Arrangements—Botulinum Toxin Program (PB 122 of 2008)	124.85

Group T11—Botulinum toxin		
Item	**Description**	**Fee ($)**
	as in force from time to time, including all such injections on any one day for all or any of the muscles subserving one functional activity and supplied by one motor nerve—applicable to the first 2 treatments of each limb of the patient on any one day (Anaes.)	
18356	Botulinum toxin (Botox or Dysport), injection of, for dynamic equinovarus foot deformity due to spasticity in an ambulant cerebral palsy patient who is 2 years old or older, in accordance with the supply of the drugs under the Arrangements—Botulinum Toxin Program (PB 122 of 2008) as in force from time to time, including all such injections on any one day for all or any of the muscles subserving one functional activity and supplied by one motor nerve—applicable to the first 2 treatments of each limb of the patient on any one day (Anaes.)	124.85
18358	Botulinum toxin (Botox or Dysport), injection of, for dynamic equinovalgus foot deformity due to spasticity in an ambulant cerebral palsy patient who is 2 years old or older, in accordance with the supply of the drugs under the Arrangements—Botulinum Toxin Program (PB 122 of 2008) as in force from time to time, including all such injections on any one day for all or any of the muscles subserving one functional activity and supplied by one motor nerve—applicable only to the first 2 treatments of each limb of the patient on any one day (Anaes.)	124.85
18360	Botulinum toxin (Botox), injection of, for focal spasticity in adults, including all such injections for all or any of the muscles subserving one functional activity and supplied by one motor nerve	124.85
18361	Botulinum toxin (Botox), injection of, for the treatment of moderate to severe upper limb spasticity due to cerebral palsy, in a patient who is at least 2 years but less than 18 years, in association with either: (a) physiotherapy or occupational therapy or both; or (b) electrical stimulation or ultrasound for muscle localisation; including all injections for any or all of the muscles sub-serving one functional activity supplied by one motor	124.85

Group T11—Botulinum toxin		
Item	**Description**	**Fee ($)**
	nerve—with a maximum of 4 treatments per patient on any one day, and with a maximum of 2 treatments per limb (Anaes.)	
18362	Botulinum toxin (Botox), injection of, for severe primary hyperhidrosis of the axillae, including all such injections on any one day (Anaes.)	246.70
18364	Botulinum toxin (Dysport), injection of, for spasticity of the arm in adults after a stroke, including all injections for all or any of the muscles subserving one functional activity and supplied by one motor nerve	124.85
18366	Botulinum toxin (Botox), injection of, for strabismus in children and adults, including all such injections on any one day and associated electromyography (Anaes.)	156.40
18368	Botulinum toxin (Botox), injection of, for spasmodic dysphonia, including all such injections on any one day	267.05
18370	Botulinum toxin (Botox), injection of, for blepharospasm in a patient who is at least 12 years, including all such injections on any one day (Anaes.)	45.05
18371	Botulinum toxin (Dysport), injection of, for blepharospasm in a patient who is at least 18 years, including all such injections on any one day (Anaes.)	45.05
18372	Botulinum toxin (Botox), injection of, for the treatment of essential bilateral blepharospasm, in a patient who is at least 12 years of age, including all such injections on any one day (Anaes.)	124.85
18373	Botulinum toxin (Dysport), injection of, for the treatment of essential bilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.)	124.85
18375	Botulinum toxin type A (Botox), intravesical injection of, with cystoscopy, for the treatment of urinary incontinence, including all such injections on any one day, if: (a) the urinary incontinence is due to neurogenic detrusor overactivity as demonstrated by urodynamic study of a patient with:	229.85

Group T11—Botulinum toxin		
Item	**Description**	**Fee ($)**
	(i) multiple sclerosis; or (ii) spinal cord injury; or (iii) spina bifida and who is at least 18 years of age; and (b) the patient has urinary incontinence that is inadequately controlled by anti-cholinergic therapy, as manifested by having experienced at least 14 episodes of urinary incontinence per week before commencement of treatment with botulinum toxin type A; and (c) the patient is willing and able to self-catheterise; and (d) the requirements relating to botulinum toxin type A under the Pharmaceutical Benefits Scheme are complied with; and (e) treatment is not provided on the same occasion as a service described in item 104, 105, 110, 116, 119, 11900 or 11919 For each patient—applicable not more than once except if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment (H) (Anaes.)	

Division 2.43—Group T10: Anaesthesia performed in connection with certain services (Relative Value Guide)

2.43.1 Meaning of *amount under clause 2.43.1*

(1) In item 25025:

amount under clause 2.43.1 means 50% of the sum of:

(a) the fee mentioned in any of items 20100 to 21997 or 22900 for the initiation of the management of anaesthesia in association with which the anaesthesia is performed; and

(b) the fee mentioned in the item in the range 23010 to 24136 that applies to the anaesthesia; and

(c) if any of items 25000 to 25015 applies to the anaesthesia—the fee mentioned in the item; and

(d) if a service mentioned in any of items 22001 to 22051 is performed in association with the anaesthesia—the fee mentioned in the item.

(2) In item 25030:

amount under clause 2.43.1 means 50% of the sum of:

(a) the fee mentioned in the item in the range 25200 to 25205 that applies to the assistance; and

(b) the fee mentioned in the item in the range 23010 to 24136 that applies to the assistance; and

(c) if any of items 25000 to 25015 applies to the anaesthesia—the fee mentioned in the item; and

(d) if a service mentioned in any of items 22001 to 22051 is performed in association with the assistance—the fee mentioned in the item.

(3) In item 25050:

amount under clause 2.43.1 means 50% of the sum of:

(a) the fee mentioned in item 22060; and

(b) the fee mentioned in the item in the range 23010 to 24136 that applies to the perfusion; and
(c) if any of items 25000 to 25015 apply to the perfusion—the fee mentioned in the item; and
(d) if a service mentioned in any of items 22001 to 22051 or 22065 to 22075 is performed in association with the perfusion—the fee mentioned in the item.

2.43.2 Meaning of *amount under clause 2.43.2*

An ***amount under clause 2.43.2*** means the sum of:
(a) $99.00; and
(b) the fee mentioned in the item in the range 23010 to 24136 that applies to the assistance; and
(c) if any of the items 25000 to 25020 applies to the assistance—the fee mentioned in the item; and
(d) if a service mentioned in an item in the range 22001 to 22051 applies to the assistance—the fee mentioned in the item.

2.43.3 Meaning of *complex paediatric case*

In item 25205:

complex paediatric case means a case that involves one or more of the following services:
(a) invasive monitoring, either intravascular or transoesophageal;
(b) organ transplantation;
(c) craniofacial surgery;
(d) major tumour resection;
(e) separation of conjoint twins.

2.43.4 Meaning of *service time*

In Subgroups 21, 24, 25 and 26 of Group T10, ***service time*** means:
(a) for the management of anaesthesia on a patient by an anaesthetist—the period that:
(i) starts when the anaesthetist commences exclusive and continuous care of the patient for anaesthesia; and

(ii) ends when the anaesthetist places the patient safely under the supervision of other personnel; and

(b) for perfusion performed on a patient under anaesthesia—the period that:

(i) starts when the anaesthetic commences; and

(ii) ends with the closure of the chest of the patient; and

(c) for assistance given by an assistant anaesthetist in the management of anaesthesia performed on a patient—the period when the assistant anaesthetist is actively attending on the patient.

2.43.5 Application of Group T10

(1) An item in Group T10 does not apply to a service mentioned in the item if the service is provided at the same time as, or in connection with, the provision of a pain pump for post-surgical pain management.

(2) Items 20100 to 21990 (other than item 21965 or 21981), 22060, 23010 to 24136, 25200 and 25205 apply to a service only if the service is provided in connection with a service that:

(a) is a professional service within the meaning of subsection 3(1) of the Act; and

(b) is mentioned in an item that includes, in its description, "(Anaes.)".

(3) Items 22900 and 22905 apply to a service only if the service is provided in connection with a dental service (other than a dental service that is a prescribed medical service under paragraph (b) of the definition of ***professional service*** in subsection 3(1) of the Act).

(4) An item in Group T10 does not apply to a service mentioned in the item if the service is claimed in association with a service to which item 55026 or 55054 of the diagnostic imaging services table applies.

2.43.6 Application of Subgroup 21 of Group T10

(1) Items 23010 to 24136 apply to perfusion.

(2) Items 23010 to 24136 apply to assistance only as a component of item 25200 or 25205 and for the purpose of calculating the amount of fee for that item.

2.43.7 Services mentioned in Subgroups 21 to 25 of Group T10

In Subgroups 21 to 25 of Group T10:

anaesthesia means the management of anaesthesia performed in association with a service to which any of items 20100 to 21997, 22900 and 22905 applies.

assistance means assistance:

(a) in the management of anaesthesia; and

(b) to which item 25200 or 25205 applies.

perfusion means perfusion to which item 22060 applies.

2.43.8 Application of Subgroups 22 and 23 of Group T10

(1) Items 25000 to 25020 apply to anaesthesia in addition to any other item that applies to anaesthesia.

(2) Items 25000 to 25020 apply to perfusion in addition to any other item that applies to perfusion.

(3) Items 25000 to 25020 apply:

(a) to assistance only as a component of item 25200 or 25205; and

(b) for calculating the amount of fee for the item.

2.43.9 Application of Subgroups 24 and 25 of Group T10

Items 25025 to 25050 apply to anaesthesia, assistance or perfusion in addition to any other item that applies to the service.

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
Subgroup 1—Head		
20100	Initiation of the management of anaesthesia for procedures on the skin, subcutaneous tissue, muscles, salivary glands or superficial vessels of the head, including biopsy, other than a service to which another item in this Subgroup applies	$99.00
20102	Initiation of the management of anaesthesia for plastic repair of cleft lip	$118.80
20104	Initiation of the management of anaesthesia for electroconvulsive therapy	$79.20
20120	Initiation of the management of anaesthesia for procedures on external, middle or inner ear, including biopsy, other than a service to which another item in this Subgroup applies	$99.00
20124	Initiation of the management of anaesthesia for otoscopy	$79.20
20140	Initiation of the management of anaesthesia for procedures on eye, other than a service to which another item in this Subgroup applies	$99.00
20142	Initiation of the management of anaesthesia for lens surgery	$118.80
20143	Initiation of the management of anaesthesia for retinal surgery	$118.80
20144	Initiation of the management of anaesthesia for corneal transplant	$158.40
20145	Initiation of the management of anaesthesia for vitrectomy	$158.40
20146	Initiation of the management of anaesthesia for biopsy of conjunctiva	$99.00
20147	Initiation of the management of anaesthesia for squint repair	$118.80
20148	Initiation of the management of anaesthesia for ophthalmoscopy	$79.20
20160	Initiation of the management of anaesthesia for procedures on nose or accessory sinuses, other than a service to which	$118.80

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
	another item in this Subgroup applies	
20162	Initiation of the management of anaesthesia for radical surgery on the nose and accessory sinuses	$138.60
20164	Initiation of the management of anaesthesia for biopsy of soft tissue of the nose and accessory sinuses	$79.20
20170	Initiation of the management of anaesthesia for intraoral procedures, including biopsy, other than a service to which another item in this Subgroup applies	$118.80
20172	Initiation of the management of anaesthesia for repair of cleft palate	$138.60
20174	Initiation of the management of anaesthesia for excision of retropharyngeal tumour	$178.20
20176	Initiation of the management of anaesthesia for radical intraoral surgery	$198.00
20190	Initiation of the management of anaesthesia for procedures on facial bones, other than a service to which another item in this Subgroup applies	$99.00
20192	Initiation of the management of anaesthesia for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction)	$198.00
20210	Initiation of the management of anaesthesia for intracranial procedures, other than a service to which another item in this Subgroup applies	$297.00
20212	Initiation of the management of anaesthesia for subdural taps	$99.00
20214	Initiation of the management of anaesthesia for burr holes of the cranium	$178.20
20216	Initiation of the management of anaesthesia for intracranial vascular procedures, including those for aneurysms or arterio-venous abnormalities	$396.00
20220	Initiation of the management of anaesthesia for spinal fluid shunt procedures	$198.00
20222	Initiation of the management of anaesthesia for ablation of an intracranial nerve	$118.80

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
20225	Initiation of the management of anaesthesia for all cranial bone procedures	$237.60
20230	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the head or face	$237.60
Subgroup 2—Neck		
20300	Initiation of the management of anaesthesia for procedures on the skin or subcutaneous tissue of the neck, other than a service to which another item in this Subgroup applies	$99.00
20305	Initiation of the management of anaesthesia for incision and drainage of large haematoma, large abscess, cellulitis or similar lesion or epiglottitis, causing life threatening airway obstruction	$297.00
20320	Initiation of the management of anaesthesia for procedures on oesophagus, thyroid, larynx, trachea, lymphatic system, muscles, nerves or other deep tissues of the neck, other than a service to which another item in this Subgroup applies	$118.80
20321	Initiation of the management of anaesthesia for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy	$198.00
20330	Initiation of the management of anaesthesia for laser surgery to the airway (excluding nose and mouth)	$158.40
20350	Initiation of the management of anaesthesia for procedures on major vessels of neck, other than a service to which another item in this Subgroup applies	$198.00
20352	Initiation of the management of anaesthesia for simple ligation of major vessels of neck	$99.00
20355	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the neck	$237.60
Subgroup 3—Thorax		
20400	Initiation of the management of anaesthesia for procedures on the skin or subcutaneous tissue of the anterior part of the chest, other than a service to which another item in this	$59.40

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
	Subgroup applies	
20401	Initiation of the management of anaesthesia for procedures on the breast, other than a service to which another item in this Subgroup applies	$79.20
20402	Initiation of the management of anaesthesia for reconstructive procedures on breast	$99.00
20403	Initiation of the management of anaesthesia for removal of breast lump or for breast segmentectomy, if axillary node dissection is performed	$99.00
20404	Initiation of the management of anaesthesia for mastectomy	$118.80
20405	Initiation of the management of anaesthesia for reconstructive procedures on the breast using myocutaneous flaps	$158.40
20406	Initiation of the management of anaesthesia for radical or modified radical procedures on breast with internal mammary node dissection	$257.40
20410	Initiation of the management of anaesthesia for electrical conversion of arrhythmias	$99.00
20420	Initiation of the management of anaesthesia for procedures on the skin or subcutaneous tissue of the posterior part of the chest, other than a service to which another item in this Subgroup applies	$99.00
20440	Initiation of the management of anaesthesia for percutaneous bone marrow biopsy of the sternum	$79.20
20450	Initiation of the management of anaesthesia for procedures on clavicle, scapula or sternum, other than a service to which another item in this Subgroup applies	$99.00
20452	Initiation of the management of anaesthesia for radical surgery on clavicle, scapula or sternum	$118.80
20470	Initiation of the management of anaesthesia for partial rib resection, other than a service to which another item in this Subgroup applies	$118.80
20472	Initiation of the management of anaesthesia for	$198.00

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
	thoracoplasty	
20474	Initiation of the management of anaesthesia for radical procedures on chest wall	$257.40
20475	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior thorax	$198.00
Subgroup 4—Intrathoracic		
20500	Initiation of the management of anaesthesia for open procedures on the oesophagus	$297.00
20520	Initiation of the management of anaesthesia for all closed chest procedures (including rigid oesophagoscopy or bronchoscopy), other than a service to which another item in this Subgroup applies	$118.80
20522	Initiation of the management of anaesthesia for needle biopsy of pleura	$79.20
20524	Initiation of the management of anaesthesia for pneumocentesis	$79.20
20526	Initiation of the management of anaesthesia for thoracoscopy	$198.00
20528	Initiation of the management of anaesthesia for mediastinoscopy	$158.40
20540	Initiation of the management of anaesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, or mediastinum, other than a service to which another item in this Subgroup applies	$257.40
20542	Initiation of the management of anaesthesia for pulmonary decortication	$297.00
20546	Initiation of the management of anaesthesia for pulmonary resection with thoracoplasty	$297.00
20548	Initiation of the management of anaesthesia for intrathoracic repair of trauma to trachea and bronchi	$297.00
20560	Initiation of the management of anaesthesia for open procedures on the heart, pericardium or great vessels of	$396.00

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
	chest	
Subgroup 5—Spine and spinal cord		
20600	Initiation of the management of anaesthesia for procedures on cervical spine or spinal cord, or both, other than a service to which another item in this Subgroup applies	$198.00
20604	Initiation of the management of anaesthesia for posterior cervical laminectomy with the patient in the sitting position	$257.40
20620	Initiation of the management of anaesthesia for procedures on thoracic spine or spinal cord, or both, other than a service to which another item in this Subgroup applies	$198.00
20622	Initiation of the management of anaesthesia for thoracolumbar sympathectomy	$257.40
20630	Initiation of the management of anaesthesia for procedures in lumbar region, other than a service to which another item in this Subgroup applies	$158.40
20632	Initiation of the management of anaesthesia for lumbar sympathectomy	$138.60
20634	Initiation of the management of anaesthesia for chemonucleolysis	$198.00
20670	Initiation of the management of anaesthesia for extensive spine or spinal cord procedures, or both	$257.40
20680	Initiation of the management of anaesthesia for manipulation of spine when performed in the operating theatre of a hospital	$59.40
20690	Initiation of the management of anaesthesia for percutaneous spinal procedures, other than a service to which another item in this Subgroup applies	$99.00
Subgroup 6—Upper abdomen		
20700	Initiation of the management of anaesthesia for procedures on the skin or subcutaneous tissue of the upper anterior abdominal wall, other than a service to which another item in this Subgroup applies	$59.40
20702	Initiation of the management of anaesthesia for percutaneous liver biopsy	$79.20

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)

Item	Description	Fee
20703	Initiation of the management of anaesthesia for procedures on the nerves, muscles, tendons and fascia of the upper abdominal wall, other than a service to which another item in this Subgroup applies	$79.20
20704	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior upper abdomen	$198.00
20705	Initiation of the management of anaesthesia for diagnostic laparoscopy procedures	$118.80
20706	Initiation of the management of anaesthesia for laparoscopic procedures in the upper abdomen, other than a service to which another item in this Subgroup applies	$138.60
20730	Initiation of the management of anaesthesia for procedures on the skin or subcutaneous tissue of the upper posterior abdominal wall, other than a service to which another item in this Subgroup applies	$99.00
20740	Initiation of the management of anaesthesia for upper gastrointestinal endoscopic procedures	$99.00
20745	Initiation of the management of anaesthesia for upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage	$118.80
20750	Initiation of the management of anaesthesia for hernia repairs in upper abdomen, other than a service to which another item in this Subgroup applies	$79.20
20752	Initiation of the management of anaesthesia for repair of incisional hernia or wound dehiscence, or both	$118.80
20754	Initiation of the management of anaesthesia for procedures on an omphalocele	$138.60
20756	Initiation of the management of anaesthesia for transabdominal repair of diaphragmatic hernia	$178.20
20770	Initiation of the management of anaesthesia for procedures on major upper abdominal blood vessels	$297.00
20790	Initiation of the management of anaesthesia for procedures within the peritoneal cavity in upper abdomen including	$158.40

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
	cholecystectomy, gastrectomy, laparoscopic nephrectomy or bowel shunts	
20791	Initiation of the management of anaesthesia for a patient with clinically severe obesity	$198.00
20792	Initiation of the management of anaesthesia for partial hepatectomy (excluding liver biopsy)	$257.40
20793	Initiation of the management of anaesthesia for extended or trisegmental hepatectomy	$297.00
20794	Initiation of the management of anaesthesia for pancreatectomy, partial or total	$237.60
20798	Initiation of the management of anaesthesia for neuro endocrine tumour removal in the upper abdomen	$198.00
20799	Initiation of the management of anaesthesia for percutaneous procedures on an intra-abdominal organ in the upper abdomen	$118.80
Subgroup 7—Lower abdomen		
20800	Initiation of the management of anaesthesia for procedures on the skin or subcutaneous tissue of the lower anterior abdominal walls, other than a service to which another item in this Subgroup applies	$59.40
20802	Initiation of the management of anaesthesia for lipectomy of the lower abdomen	$99.00
20803	Initiation of the management of anaesthesia for procedures on the nerves, muscles, tendons and fascia of the lower abdominal wall, other than a service to which another item in this Subgroup applies	$79.20
20804	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior lower abdomen	$198.00
20805	Initiation of the management of anaesthesia for diagnostic laparoscopic procedures	$118.80
20806	Initiation of the management of anaesthesia for laparoscopic procedures in the lower abdomen	$138.60
20810	Initiation of the management of anaesthesia for lower	$79.20

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
	intestinal endoscopic procedures	
20815	Initiation of the management of anaesthesia for extracorporeal shock wave lithotripsy to urinary tract	$118.80
20820	Initiation of the management of anaesthesia for procedures on the skin, its derivatives or subcutaneous tissue of the lower posterior abdominal wall	$99.00
20830	Initiation of the management of anaesthesia for hernia repairs in lower abdomen, other than a service to which another item in this Subgroup applies	$79.20
20832	Initiation of the management of anaesthesia for repair of incisional herniae or wound dehiscence, or both, of the lower abdomen	$118.80
20840	Initiation of the management of anaesthesia for all procedures within the peritoneal cavity in lower abdomen, including appendicectomy, other than a service to which another item in this Subgroup applies	$118.80
20841	Initiation of the management of anaesthesia for bowel resection, including laparoscopic bowel resection, other than a service to which another item in this Subgroup applies	$158.40
20842	Initiation of the management of anaesthesia for amniocentesis	$79.20
20844	Initiation of the management of anaesthesia for abdominoperineal resection, including pull through procedures, ultra low anterior resection and formation of bowel reservoir	$198.00
20845	Initiation of the management of anaesthesia for radical prostatectomy	$198.00
20846	Initiation of the management of anaesthesia for radical hysterectomy	$198.00
20847	Initiation of the management of anaesthesia for ovarian malignancy	$198.00
20848	Initiation of the management of anaesthesia for pelvic exenteration	$198.00

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
20850	Initiation of the management of anaesthesia for caesarean section	$237.60
20855	Initiation of the management of anaesthesia for caesarean hysterectomy or hysterectomy within 24 hours of delivery	$297.00
20860	Initiation of the management of anaesthesia for extraperitoneal procedures in lower abdomen, including those on the urinary tract, other than a service to which another item in this Subgroup applies	$118.80
20862	Initiation of the management of anaesthesia for renal procedures, including upper one-third of ureter	$138.60
20863	Initiation of the management of anaesthesia for nephrectomy	$198.00
20864	Initiation of the management of anaesthesia for total cystectomy	$198.00
20866	Initiation of the management of anaesthesia for adrenalectomy	$198.00
20867	Initiation of the management of anaesthesia for neuro endocrine tumour removal in the lower abdomen	$198.00
20868	Initiation of the management of anaesthesia for renal transplantation (donor or recipient)	$198.00
20880	Initiation of the management of anaesthesia for procedures on major lower abdominal vessels, other than a service to which another item in this Subgroup applies	$297.00
20882	Initiation of the management of anaesthesia for inferior vena cava ligation	$198.00
20884	Initiation of the management of anaesthesia for percutaneous umbrella insertion	$99.00
20886	Initiation of the management of anaesthesia for percutaneous procedures on an intra-abdominal organ in the lower abdomen	$118.80
Subgroup 8—Perineum		
20900	Initiation of the management of anaesthesia for procedures on the skin or subcutaneous tissue of the perineum	$59.40

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
	(including biopsy of male genital system), other than a service to which another item in this Subgroup applies	
20902	Initiation of the management of anaesthesia for anorectal procedures (including endoscopy or biopsy, or both)	$79.20
20904	Initiation of the management of anaesthesia for radical perineal procedures, including radical perineal prostatectomy or radical vulvectomy	$138.60
20905	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the perineum	$198.00
20906	Initiation of the management of anaesthesia for vulvectomy	$79.20
20910	Initiation of the management of anaesthesia for transurethral procedures (including urethrocyctoscopy), other than a service to which another item in this Subgroup applies	$79.20
20911	Initiation of the management of anaesthesia for endoscopic ureteroscopic surgery including laser procedures	$99.00
20912	Initiation of the management of anaesthesia for transurethral resection of bladder tumour or tumours	$99.00
20914	Initiation of the management of anaesthesia for transurethral resection of prostate	$138.60
20916	Initiation of the management of anaesthesia for bleeding post-transurethral resection	$138.60
20920	Initiation of the management of anaesthesia for procedures on external genitalia, other than a service to which another item in this Subgroup applies	$79.20
20924	Initiation of the management of anaesthesia for procedures on undescended testis, unilateral or bilateral	$79.20
20926	Initiation of the management of anaesthesia for radical orchidectomy, inguinal approach	$79.20
20928	Initiation of the management of anaesthesia for radical orchidectomy, abdominal approach	$118.80
20930	Initiation of the management of anaesthesia for orchiopexy,	$79.20

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
	unilateral or bilateral	
20932	Initiation of the management of anaesthesia for complete amputation of penis	$79.20
20934	Initiation of the management of anaesthesia for complete amputation of penis with bilateral inguinal lymphadenectomy	$118.80
20936	Initiation of the management of anaesthesia for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy	$158.40
20938	Initiation of the management of anaesthesia for insertion of penile prosthesis	$79.20
20940	Initiation of the management of anaesthesia for per vagina and vaginal procedures (including biopsy of labia, vagina, cervix or endometrium), other than a service to which another item in this Subgroup applies	$79.20
20942	Initiation of the management of anaesthesia for vaginal procedures (including repair operations and urinary incontinence procedures)	$99.00
20943	Initiation of the management of anaesthesia for transvaginal assisted reproductive services	$79.20
20944	Initiation of the management of anaesthesia for vaginal hysterectomy	$118.80
20946	Initiation of the management of anaesthesia for vaginal delivery	$158.40
20948	Initiation of the management of anaesthesia for purse string ligation of cervix, or removal of purse string ligature, or removal of purse string ligature	$79.20
20950	Initiation of the management of anaesthesia for culdoscopy	$99.00
20952	Initiation of the management of anaesthesia for hysteroscopy	$79.20
20953	Initiation of the management of anaesthesia for endometrial ablation or resection in association with hysteroscopy	$99.00
20954	Initiation of the management of anaesthesia for correction	$198.00

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
	of inverted uterus	
20956	Initiation of the management of anaesthesia for evacuation of retained products of conception, as a complication of confinement	$79.20
20958	Initiation of the management of anaesthesia for manual removal of retained placenta or for repair of vaginal or perineal tear following delivery	$99.00
20960	Initiation of the management of anaesthesia for vaginal procedures in the management of post partum haemorrhage, if the blood loss is greater than 500 mls	$138.60
Subgroup 9—Pelvis (except hip)		
21100	Initiation of the management of anaesthesia for procedures on the skin or subcutaneous tissue of the anterior pelvic region (anterior to iliac crest), except external genitalia	$59.40
21110	Initiation of the management of anaesthesia for procedures on the skin, its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum	$99.00
21112	Initiation of the management of anaesthesia for percutaneous bone marrow biopsy of the anterior iliac crest	$79.20
21114	Initiation of the management of anaesthesia for percutaneous bone marrow biopsy of the posterior iliac crest	$99.00
21116	Initiation of the management of anaesthesia for percutaneous bone marrow harvesting from the pelvis	$118.80
21120	Initiation of the management of anaesthesia for procedures on the bony pelvis	$118.80
21130	Initiation of the management of anaesthesia for body cast application or revision, when performed in the operating theatre of a hospital	$59.40
21140	Initiation of the management of anaesthesia for interpelviabdominal (hindquarter) amputation	$297.00
21150	Initiation of the management of anaesthesia for radical procedures for tumour of the pelvis, except hindquarter amputation	$198.00

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
21155	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior pelvis	$198.00
21160	Initiation of the management of anaesthesia for closed procedures involving symphysis pubis or sacroiliac joint, when performed in the operating theatre of a hospital	$79.20
21170	Initiation of the management of anaesthesia for open procedures involving symphysis pubis or sacroiliac joint	$158.40
Subgroup 10—Upper leg (except knee)		
21195	Initiation of the management of anaesthesia for procedures on the skins or subcutaneous tissue of the upper leg	$59.40
21199	Initiation of the management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg	$79.20
21200	Initiation of the management of anaesthesia for closed procedures involving hip joint, when performed in the operating theatre of a hospital	$79.20
21202	Initiation of the management of anaesthesia for arthroscopic procedures of the hip joint	$79.20
21210	Initiation of the management of anaesthesia for open procedures involving hip joint, other than a service to which another item in this Subgroup applies	$118.80
21212	Initiation of the management of anaesthesia for hip disarticulation	$198.00
21214	Initiation of the management of anaesthesia for total hip replacement or revision	$198.00
21216	Initiation of the management of anaesthesia for bilateral total hip replacement	$277.20
21220	Initiation of the management of anaesthesia for closed procedures involving upper two-thirds of femur, when performed in the operating theatre of a hospital	$79.20
21230	Initiation of the management of anaesthesia for open procedures involving upper two-thirds of femur, other than a service to which another item in this Subgroup applies	$118.80

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
21232	Initiation of the management of anaesthesia for above knee amputation	$99.00
21234	Initiation of the management of anaesthesia for radical resection of the upper two-thirds of femur	$158.40
21260	Initiation of the management of anaesthesia for procedures involving veins of upper leg, including exploration	$79.20
21270	Initiation of the management of anaesthesia for procedures involving arteries of upper leg, including bypass graft, other than a service to which another item in this Subgroup applies	$158.40
21272	Initiation of the management of anaesthesia for femoral artery ligation	$79.20
21274	Initiation of the management of anaesthesia for femoral artery embolectomy	$118.80
21275	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the upper leg	$198.00
21280	Initiation of the management of anaesthesia for microsurgical reimplantation of upper leg	$297.00
Subgroup 11—Knee and popliteal area		
21300	Initiation of the management of anaesthesia for procedures on the skin or subcutaneous tissue of the knee or popliteal area, or both	$59.40
21321	Initiation of the management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of knee or popliteal area, or both	$79.20
21340	Initiation of the management of anaesthesia for closed procedures on lower one-third of femur, when performed in the operating theatre of a hospital	$79.20
21360	Initiation of the management of anaesthesia for open procedures on lower one-third of femur	$99.00
21380	Initiation of the management of anaesthesia for closed procedures on knee joint when performed in the operating	$59.40

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
	theatre of a hospital	
21382	Initiation of the management of anaesthesia for arthroscopic procedures of knee joint	$79.20
21390	Initiation of the management of anaesthesia for closed procedures on upper ends of tibia, fibula or patella, or any of them, when performed in the operating theatre of a hospital	$59.40
21392	Initiation of the management of anaesthesia for open procedures on upper ends of tibia, fibula or patella, or any of them	$79.20
21400	Initiation of the management of anaesthesia for open procedures on knee joint, other than a service to which another item in this Subgroup applies	$79.20
21402	Initiation of the management of anaesthesia for knee replacement	$138.60
21403	Initiation of the management of anaesthesia for bilateral knee replacement	$198.00
21404	Initiation of the management of anaesthesia for disarticulation of knee	$99.00
21420	Initiation of the management of anaesthesia for cast application, removal or repair, involving knee joint, undertaken in a hospital	$59.40
21430	Initiation of the management of anaesthesia for procedures on veins of knee or popliteal area, other than a service to which another item in this Subgroup applies	$79.20
21432	Initiation of the management of anaesthesia for repair of arteriovenous fistula of knee or popliteal area	$99.00
21440	Initiation of the management of anaesthesia for procedures on arteries of knee or popliteal area, other than a service to which another item in this Subgroup applies	$158.40
21445	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the knee or popliteal area	$198.00

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
Subgroup 12—Lower leg (below knee)		
21460	Initiation of the management of anaesthesia for procedures on the skin or subcutaneous tissue of lower leg, ankle or foot	$59.40
21461	Initiation of the management of anaesthesia for procedures on nerves, muscles, tendons or fascia of lower leg, ankle or foot, other than a service to which another item in this Subgroup applies	$79.20
21462	Initiation of the management of anaesthesia for all closed procedures on lower leg, ankle or foot	$59.40
21464	Initiation of the management of anaesthesia for arthroscopic procedure of ankle joint	$79.20
21472	Initiation of the management of anaesthesia for repair of achilles tendon	$99.00
21474	Initiation of the management of anaesthesia for gastrocnemius recession	$99.00
21480	Initiation of the management of anaesthesia for open procedures on bones of lower leg, ankle or foot, including amputation, other than a service to which another item in this Subgroup applies	$79.20
21482	Initiation of the management of anaesthesia for radical resection of bone involving lower leg, ankle or foot	$99.00
21484	Initiation of the management of anaesthesia for osteotomy or osteoplasty of tibia or fibula	$99.00
21486	Initiation of the management of anaesthesia for total ankle replacement	$138.60
21490	Initiation of the management of anaesthesia for lower leg cast application, removal or repair, undertaken in a hospital	$59.40
21500	Initiation of the management of anaesthesia for procedures on arteries of lower leg, including bypass graft, other than a service to which another item in this Subgroup applies	$158.40
21502	Initiation of the management of anaesthesia for embolectomy of the lower leg	$118.80

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
21520	Initiation of the management of anaesthesia for procedures on veins of lower leg, other than a service to which another item in this Subgroup applies	$79.20
21522	Initiation of the management of anaesthesia for venous thrombectomy of the lower leg	$99.00
21530	Initiation of the management of anaesthesia for microsurgical reimplantation of lower leg, ankle or foot	$297.00
21532	Initiation of the management of anaesthesia for microsurgical reimplantation of toe	$158.40
21535	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the lower leg	$198.00
Subgroup 13—Shoulder and axilla		
21600	Initiation of the management of anaesthesia for procedures on the skin or subcutaneous tissue of the shoulder or axilla	$59.40
21610	Initiation of the management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla, including axillary dissection	$99.00
21620	Initiation of the management of anaesthesia for closed procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint, when performed in the operating theatre of a hospital	$79.20
21622	Initiation of the management of anaesthesia for arthroscopic procedures of shoulder joint	$99.00
21630	Initiation of the management of anaesthesia for open procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint, other than a service to which another item in this Subgroup applies	$99.00
21632	Initiation of the management of anaesthesia for radical resection involving humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint	$118.80
21634	Initiation of the management of anaesthesia for shoulder disarticulation	$178.20

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
21636	Initiation of the management of anaesthesia for interthoracoscapular (forequarter) amputation	$297.00
21638	Initiation of the management of anaesthesia for total shoulder replacement	$198.00
21650	Initiation of the management of anaesthesia for procedures on arteries of shoulder or axilla, other than a service to which another item in this Subgroup applies	$158.40
21652	Initiation of the management of anaesthesia for procedures for axillary-brachial aneurysm	$198.00
21654	Initiation of the management of anaesthesia for bypass graft of arteries of shoulder or axilla	$158.40
21656	Initiation of the management of anaesthesia for axillary-femoral bypass graft	$198.00
21670	Initiation of the management of anaesthesia for procedures on veins of shoulder or axilla	$79.20
21680	Initiation of the management of anaesthesia for shoulder cast application, removal or repair, other than a service to which another item in this Subgroup applies, when undertaken in a hospital	$59.40
21682	Initiation of the management of anaesthesia for shoulder spica application, when undertaken in a hospital	$79.20
21685	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the shoulder or axilla	$198.00
Subgroup 14—Upper arm and elbow		
21700	Initiation of the management of anaesthesia for procedures on the skin or subcutaneous tissue of the upper arm or elbow	$59.40
21710	Initiation of the management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of upper arm or elbow, other than a service to which another item in this Subgroup applies	$79.20
21712	Initiation of the management of anaesthesia for open	$99.00

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
	tenotomy of the upper arm or elbow	
21714	Initiation of the management of anaesthesia for tenoplasty of the upper arm or elbow	$99.00
21716	Initiation of the management of anaesthesia for tenodesis for rupture of long tendon of biceps	$99.00
21730	Initiation of the management of anaesthesia for closed procedures on the upper arm or elbow, when performed in the operating theatre of a hospital	$59.40
21732	Initiation of the management of anaesthesia for arthroscopic procedures of elbow joint	$79.20
21740	Initiation of the management of anaesthesia for open procedures on the upper arm or elbow, other than a service to which another item in this Subgroup applies	$99.00
21756	Initiation of the management of anaesthesia for radical procedures on the upper arm or elbow	$118.80
21760	Initiation of the management of anaesthesia for total elbow replacement	$138.60
21770	Initiation of the management of anaesthesia for procedures on arteries of upper arm, other than a service to which another item in this Subgroup applies	$158.40
21772	Initiation of the management of anaesthesia for embolectomy of arteries of the upper arm	$118.80
21780	Initiation of the management of anaesthesia for procedures on veins of upper arm, other than a service to which another item in this Subgroup applies	$79.20
21785	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the upper arm or elbow	$198.00
21790	Initiation of the management of anaesthesia for microsurgical reimplantation of upper arm	$297.00
Subgroup 15—Forearm wrist and hand		
21800	Initiation of the management of anaesthesia for procedures on the skin or subcutaneous tissue of the forearm, wrist or hand	$59.40

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
21810	Initiation of the management of anaesthesia for procedures on the nerves, muscles, tendons, fascia, or bursae of the forearm, wrist or hand	$79.20
21820	Initiation of the management of anaesthesia for closed procedures on the radius, ulna, wrist, or hand bones, when performed in the operating theatre of a hospital	$59.40
21830	Initiation of the management of anaesthesia for open procedures on the radius, ulna, wrist, or hand bones, other than a service to which another item in this Subgroup applies	$79.20
21832	Initiation of the management of anaesthesia for total wrist replacement	$138.60
21834	Initiation of the management of anaesthesia for arthroscopic procedures of the wrist joint	$79.20
21840	Initiation of the management of anaesthesia for procedures on the arteries of forearm, wrist or hand, other than a service to which another item in this Subgroup applies	$158.40
21842	Initiation of the management of anaesthesia for embolectomy of artery of forearm, wrist or hand	$118.80
21850	Initiation of the management of anaesthesia for procedures on the veins of forearm, wrist or hand, other than a service to which another item in this Subgroup applies	$79.20
21860	Initiation of the management of anaesthesia for forearm, wrist, or hand cast application, removal or repair, when undertaken in a hospital	$59.40
21865	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the forearm, wrist or hand	$198.00
21870	Initiation of the management of anaesthesia for microsurgical reimplantation of forearm, wrist or hand	$297.00
21872	Initiation of the management of anaesthesia for microsurgical reimplantation of a finger	$158.40

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
Subgroup 16—Anaesthesia for burns		
21878	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves not more than 3% of total body surface	$59.40
21879	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves more than 3% but less than 10% of total body surface	$99.00
21880	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves 10% or more but less than 20% of total body surface	$138.60
21881	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves 20% or more but less than 30% of total body surface	$178.20
21882	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves 30% or more but less than 40% of total body surface	$217.80
21883	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves 40% or more but less than 50% of total body surface	$257.40
21884	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves 50% or more but less than 60% of total body surface	$297.00
21885	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves 60% or more but less than 70% of total body surface	$336.60
21886	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if	$376.20

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
	the area of burn involves 70% or more but less than 80% of total body surface	
21887	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves 80% or more of total body surface	$415.80
Subgroup 17—Anaesthesia for radiological or other diagnostic or therapeutic procedures		
21900	Initiation of the management of anaesthesia for injection procedure for hysterosalpingography	$59.40
21906	Initiation of the management of anaesthesia for injection procedure for myelography—lumbar or thoracic	$99.00
21908	Initiation of the management of anaesthesia for injection procedure for myelography—cervical	$118.80
21910	Initiation of the management of anaesthesia for injection procedure for myelography—posterior fossa	$178.20
21912	Initiation of the management of anaesthesia for injection procedure for discography—lumbar or thoracic	$99.00
21914	Initiation of the management of anaesthesia for injection procedure for discography—cervical	$118.80
21915	Initiation of the management of anaesthesia for peripheral arteriogram	$99.00
21916	Initiation of the management of anaesthesia for arteriograms—cerebral, carotid or vertebral	$99.00
21918	Initiation of the management of anaesthesia for retrograde arteriogram—brachial or femoral	$99.00
21922	Initiation of the management of anaesthesia for computerised axial tomography scanning, magnetic resonance scanning or digital subtraction angiography scanning	$138.60
21925	Initiation of the management of anaesthesia for retrograde cystography, retrograde urethrography or retrograde cystourethrography	$79.20

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
21926	Initiation of the management of anaesthesia for fluoroscopy	$99.00
21927	Initiation of the management of anaesthesia for barium enema or other opaque study of the small bowel	$99.00
21930	Initiation of the management of anaesthesia for bronchography	$118.80
21935	Initiation of the management of anaesthesia for phlebography	$99.00
21936	Initiation of the management of anaesthesia for heart—2 dimensional real time transoesophageal examination	$118.80
21939	Initiation of the management of anaesthesia for peripheral venous cannulation	$59.40
21941	Initiation of the management of anaesthesia for cardiac catheterisation (including coronary arteriography, ventriculography, cardiac mapping or insertion of automatic defibrillator or transvenous pacemaker)	$138.60
21942	Initiation of the management of anaesthesia for cardiac electrophysiological procedures including radio frequency ablation	$198.00
21943	Initiation of the management of anaesthesia for central vein catheterisation or insertion of right heart balloon catheter (via jugular, subclavian or femoral vein) by percutaneous or open exposure	$99.00
21945	Initiation of the management of anaesthesia for lumbar puncture, cisternal puncture or epidural injection	$99.00
21949	Initiation of the management of anaesthesia for harvesting of bone marrow for the purpose of transplantation	$99.00
21952	Initiation of the management of anaesthesia for muscle biopsy for malignant hyperpyrexia	$198.00
21955	Initiation of the management of anaesthesia for electroencephalography	$99.00
21959	Initiation of the management of anaesthesia for brain stem evoked response audiometry	$99.00

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
21962	Initiation of the management of anaesthesia for electrocochleography by extratympanic method or transtympanic membrane insertion method	$99.00
21965	Initiation of the management of anaesthesia as a therapeutic procedure if it can be shown that there is a clinical need for anaesthesia, not for headache of any etiology	$99.00
21969	Initiation of the management of anaesthesia during hyperbaric therapy, if the medical practitioner is not confined in the chamber (including the administration of oxygen)	$158.40
21970	Initiation of the management of anaesthesia during hyperbaric therapy, if the medical practitioner is confined in the chamber (including the administration of oxygen)	$297.00
21973	Initiation of the management of anaesthesia for brachytherapy using radioactive sealed sources	$99.00
21976	Initiation of the management of anaesthesia for therapeutic nuclear medicine	$99.00
21980	Initiation of the management of anaesthesia for radiotherapy	$99.00
21981	Anaesthetic agent allergy testing, using skin sensitivity methods on a patient with a history of anaphylactic or anaphylactoid reaction or cardiovascular collapse	$79.20
Subgroup 18—Miscellaneous		
21990	Initiation of the management of anaesthesia, being a service to which another item in this Subgroup or in Subgroups 1 to 17 or 20 would have applied if the procedure in connection with which the service is provided had not been discontinued	$59.40
21992	Initiation of the management of anaesthesia performed on a person under the age of 10 years in connection with a procedure covered by an item that does not include the word "(Anaes.)"	$79.20
21997	Initiation of the management of anaesthesia in connection	$79.20

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
	with a procedure covered by an item that does not include the word "(Anaes.)", other than a service to which item 21965 or 21992 applies, if it can be demonstrated that there is a clinical need for anaesthesia	
Subgroup 19—Therapeutic and diagnostic services performed in connection with the management of anaesthesia		
22001	Collection of blood for autologous transfusion or when homologous blood is required for immediate transfusion in an emergency situation, when performed in association with the management of anaesthesia	$59.40
22002	Administration of blood or bone marrow already collected, when performed in association with the management of anaesthesia	$79.20
22007	Endotracheal intubation with flexible fibreoptic scope associated with difficult airway, when performed in association with the management of anaesthesia	$79.20
22008	Double lumen endobronchial tube or bronchial blocker, insertion of, when performed in association with the management of anaesthesia	$79.20
22012	Central venous, pulmonary arterial, systemic arterial or cardiac intracavity blood pressure monitoring by indwelling catheter—once only for each type of pressure for a patient on a calendar day: (a) when performed in association with the management of anaesthesia for the patient; and (b) other than a service to which item 13876 applies	$59.40
22014	Central venous, pulmonary arterial, systemic arterial or cardiac intracavity blood pressure monitoring by indwelling catheter—once only for each type of pressure for a patient on a calendar day: (a) when performed in association with the management of anaesthesia for the patient; and (b) relating to another discrete operation on the same day for the patient; and (c) other than a service to which item 13876 applies	$59.40

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
22015	Right heart balloon catheter, insertion of, including pulmonary wedge pressure and cardiac output measurement, when performed in association with the management of anaesthesia	$118.80
22018	Measurement of the mechanical or gas exchange function of the respiratory system, using measurements of parameters that incorporate serial arterial blood gas analysis and include at least 2 of the following parameters: (a) pressure; (b) volume; (c) flow; (d) gas concentration in inspired or expired air; (e) alveolar gas or blood; performed in association with the management of anaesthesia, and for which a written record of the results is prepared, other than a service associated with a service to which item 11503 applies	$138.60
22020	Central vein catheterisation by percutaneous or open exposure, other than a service to which item 13318 applies, when performed in association with the management of anaesthesia	$79.20
22025	Intraarterial cannulation when performed in association with the management of anaesthesia	$79.20
22031	Intrathecal or epidural injection (initial) of a therapeutic substance, with or without insertion of a catheter, in association with anaesthesia and surgery, for post operative pain management, other than a service associated with a service to which item 22036 applies	$99.00
22036	Intrathecal or epidural injection (subsequent) of a therapeutic substance, using an in-situ catheter, in association with anaesthesia and surgery, for post operative pain, other than a service associated with a service to which item 22031 applies	$59.40
22040	Introduction of a regional or field nerve block	$39.60

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
	peri-operatively performed in the induction room, theatre or recovery room, for the control of post operative pain, via the femoral or sciatic nerves, in conjunction with hip, knee, ankle or foot surgery	
22045	Introduction of a regional or field nerve block peri-operatively performed in the induction room, theatre or recovery room, for the control of post operative pain, via the femoral and sciatic nerves, in conjunction with hip, knee, ankle or foot surgery	$59.40
22050	Introduction of a regional of field nerve block peri-operatively performed in the induction room, theatre or recovery room, for the control of post operative pain, via the brachial plexus in conjunction with shoulder surgery	$39.60
22051	Intra-operative transoesophageal echocardiography—monitoring in real time the structure and function of the heart chambers, valves and surrounding structures, including assessment of blood flow, with appropriate permanent recording during procedures on the heart, pericardium or great vessels of the chest, other than a service associated with a service to which item 55130, 55135 or 21936 applies	$178.20
22055	Perfusion of limb or organ using heart-lung machine or equivalent, other than a service associated with anaesthesia to which an item in Subgroup 21 applies	$237.60
22060	Whole body perfusion, cardiac bypass, using heart-lung machine or equivalent, other than a service associated with anaesthesia to which an item in Subgroup 21 applies	$396.00
22065	Induced controlled hypothermia—total body, that is: (a) a service to which item 22060 applies; and (b) not a service associated with anaesthesia, to which an item in Subgroup 21 applies	$99.00
22070	Cardioplegia, blood or crystalloid, administration by any route, that is: (a) a service to which item 22060 applies; and	$198.00

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
	(b) not a service associated with a service to which an item in Subgroup 21 applies	
22075	Deep hypothermic circulatory arrest, with core temperature less than 22°c, including management of retrograde cerebral perfusion (if performed), other than a service associated with anaesthesia to which an item in Subgroup 21 applies	$297.00
Subgroup 20—Management of anaesthesia in connection with a dental service		
22900	Initiation of the management by a medical practitioner of anaesthesia for extraction of tooth or teeth, with or without incision of soft tissue or removal of bone	$118.80
22905	Initiation of the management of anaesthesia for restorative dental work	$118.80
Subgroup 21—Anaesthesia, perfusion and assistance at anaesthesia (time component)		
23010	Anaesthesia, perfusion or assistance, if the service time is not more than 15 minutes	$19.80
23021	Anaesthesia, perfusion or assistance, if the service time is more than 15 minutes but not more than 20 minutes	$39.60
23022	Anaesthesia, perfusion or assistance, if the service time is more than 20 minutes but not more than 25 minutes	$39.60
23023	Anaesthesia, perfusion or assistance, if the service time is more than 25 minutes but not more than 30 minutes	$39.60
23031	Anaesthesia, perfusion or assistance, if the service time is more than 30 minutes but not more than 35 minutes	$59.40
23032	Anaesthesia, perfusion or assistance, if the service time is more than 35 minutes but not more than 40 minutes	$59.40
23033	Anaesthesia, perfusion or assistance, if the service time is more than 40 minutes but not more than 45 minutes	$59.40
23041	Anaesthesia, perfusion or assistance, if the service time is more than 45 minutes but not more than 50 minutes	$79.20
23042	Anaesthesia, perfusion or assistance, if the service time is more than 50 minutes but not more than 55 minutes	$79.20

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)

Item	Description	Fee
23043	Anaesthesia, perfusion or assistance, if the service time is more than 55 minutes but not more than 1 hour	$79.20
23051	Anaesthesia, perfusion or assistance, if the service time is more than 1:01 hours but not more than 1:05 hours	$99.00
23052	Anaesthesia, perfusion or assistance, if the service time is more than 1:05 hours but not more than 1:10 hours	$99.00
23053	Anaesthesia, perfusion or assistance, if the service time is more than 1:10 hours but not more than 1:15 hours	$99.00
23061	Anaesthesia, perfusion or assistance, if the service time is more than 1:15 hours but not more than 1:20 hours	$118.80
23062	Anaesthesia, perfusion or assistance, if the service time is more than 1:20 hours but not more than 1:25 hours	$118.80
23063	Anaesthesia, perfusion or assistance, if the service time is more than 1:25 hours but not more than 1:30 hours	$118.80
23071	Anaesthesia, perfusion or assistance, if the service time is more than 1:30 hours but not more than 1:35 hours	$138.60
23072	Anaesthesia, perfusion or assistance, if the service time is more than 1:35 hours but not more than 1:40 hours	$138.60
23073	Anaesthesia, perfusion or assistance, if the service time is more than 1:40 hours but not more than 1:45 hours	$138.60
23081	Anaesthesia, perfusion or assistance, if the service time is more than 1:45 hours but not more than 1:50 hours	$158.40
23082	Anaesthesia, perfusion or assistance, if the service time is more than 1:50 hours but not more than 1:55 hours	$158.40
23083	Anaesthesia, perfusion or assistance, if the service time is more than 1:55 hours but not more than 2:00 hours	$158.40
23091	Anaesthesia, perfusion or assistance, if the service time is more than 2:00 hours but not more than 2:10 hours	$178.20
23101	Anaesthesia, perfusion or assistance, if the service time is more than 2:10 hours but not more than 2:20 hours	$198.00
23111	Anaesthesia, perfusion or assistance, if the service time is more than 2:20 hours but not more than 2:30 hours	$217.80
23112	Anaesthesia, perfusion or assistance, if the service time is	$237.60

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
	more than 2:30 hours but not more than 2:40 hours	
23113	Anaesthesia, perfusion or assistance, if the service time is more than 2:40 hours but not more than 2:50 hours	$257.40
23114	Anaesthesia, perfusion or assistance, if the service time is more than 2:50 hours but not more than 3:00 hours	$277.20
23115	Anaesthesia, perfusion or assistance, if the service time is more than 3:00 hours but not more than 3:10 hours	$297.00
23116	Anaesthesia, perfusion or assistance, if the service time is more than 3:10 hours but not more than 3:20 hours	$316.80
23117	Anaesthesia, perfusion or assistance, if the service time is more than 3:20 hours but not more than 3:30 hours	$336.60
23118	Anaesthesia, perfusion or assistance, if the service time is more than 3:30 hours but not more than 3:40 hours	$356.40
23119	Anaesthesia, perfusion or assistance, if the service time is more than 3:40 hours but not more than 3:50 hours	$376.20
23121	Anaesthesia, perfusion or assistance, if the service time is more than 3:50 hours but not more than 4:00 hours	$396.00
23170	Anaesthesia, perfusion or assistance, if the service time is more than 4:00 hours but not more than 4:10 hours	$415.80
23180	Anaesthesia, perfusion or assistance, if the service time is more than 4:10 hours but not more than 4:20 hours	$435.60
23190	Anaesthesia, perfusion or assistance, if the service time is more than 4:20 hours but not more than 4:30 hours	$455.40
23200	Anaesthesia, perfusion or assistance, if the service time is more than 4:30 hours but not more than 4:40 hours	$475.20
23210	Anaesthesia, perfusion or assistance, if the service time is more than 4:40 hours but not more than 4:50 hours	$495.00
23220	Anaesthesia, perfusion or assistance, if the service time is more than 4:50 hours but not more than 5:00 hours	$514.80
23230	Anaesthesia, perfusion or assistance, if the service time is more than 5:00 hours but not more than 5:10 hours	$534.60
23240	Anaesthesia, perfusion or assistance, if the service time is more than 5:10 hours but not more than 5:20 hours	$554.40

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
23250	Anaesthesia, perfusion or assistance, if the service time is more than 5:20 hours but not more than 5:30 hours	$574.20
23260	Anaesthesia, perfusion or assistance, if the service time is more than 5:30 hours but not more than 5:40 hours	$594.00
23270	Anaesthesia, perfusion or assistance, if the service time is more than 5:40 hours but not more than 5:50 hours	$613.80
23280	Anaesthesia, perfusion or assistance, if the service time is more than 5:50 hours but not more than 6:00 hours	$633.60
23290	Anaesthesia, perfusion or assistance, if the service time is more than 6:00 hours but not more than 6:10 hours	$653.40
23300	Anaesthesia, perfusion or assistance, if the service time is more than 6:10 hours but not more than 6:20 hours	$673.20
23310	Anaesthesia, perfusion or assistance, if the service time is more than 6:20 hours but not more than 6:30 hours	$693.00
23320	Anaesthesia, perfusion or assistance, if the service time is more than 6:30 hours but not more than 6:40 hours	$712.80
23330	Anaesthesia, perfusion or assistance, if the service time is more than 6:40 hours but not more than 6:50 hours	$732.60
23340	Anaesthesia, perfusion or assistance, if the service time is more than 6:50 hours but not more than 7:00 hours	$752.40
23350	Anaesthesia, perfusion or assistance, if the service time is more than 7:00 hours but not more than 7:10 hours	$772.20
23360	Anaesthesia, perfusion or assistance, if the service time is more than 7:10 hours but not more than 7:20 hours	$792.00
23370	Anaesthesia, perfusion or assistance, if the service time is more than 7:20 hours but not more than 7:30 hours	$811.80
23380	Anaesthesia, perfusion or assistance, if the service time is more than 7:30 hours but not more than 7:40 hours	$831.60
23390	Anaesthesia, perfusion or assistance, if the service time is more than 7:40 hours but not more than 7:50 hours	$851.40
23400	Anaesthesia, perfusion or assistance, if the service time is more than 7:50 hours but not more than 8:00 hours	$871.20
23410	Anaesthesia, perfusion or assistance, if the service time is	$891.00

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)

Item	Description	Fee
	more than 8:00 hours but not more than 8:10 hours	
23420	Anaesthesia, perfusion or assistance, if the service time is more than 8:10 hours but not more than 8:20 hours	$910.80
23430	Anaesthesia, perfusion or assistance, if the service time is more than 8:20 hours but not more than 8:30 hours	$930.60
23440	Anaesthesia, perfusion or assistance, if the service time is more than 8:30 hours but not more than 8:40 hours	$950.40
23450	Anaesthesia, perfusion or assistance, if the service time is more than 8:40 hours but not more than 8:50 hours	$970.20
23460	Anaesthesia, perfusion or assistance, if the service time is more than 8:50 hours but not more than 9:00 hours	$990.00
23470	Anaesthesia, perfusion or assistance, if the service time is more than 9:00 hours but not more than 9:10 hours	$1 009.80
23480	Anaesthesia, perfusion or assistance, if the service time is more than 9:10 hours but not more than 9:20 hours	$1 029.60
23490	Anaesthesia, perfusion or assistance, if the service time is more than 9:20 hours but not more than 9:30 hours	$1 049.40
23500	Anaesthesia, perfusion or assistance, if the service time is more than 9:30 hours but not more than 9:40 hours	$1 069.20
23510	Anaesthesia, perfusion or assistance, if the service time is more than 9:40 hours but not more than 9:50 hours	$1 089.00
23520	Anaesthesia, perfusion or assistance, if the service time is more than 9:50 hours but not more than 10:00 hours	$1 108.80
23530	Anaesthesia, perfusion or assistance, if the service time is more than 10:00 hours but not more than 10:10 hours	$1 128.60
23540	Anaesthesia, perfusion or assistance, if the service time is more than 10:10 hours but not more than 10:20 hours	$1 148.40
23550	Anaesthesia, perfusion or assistance, if the service time is more than 10:20 hours but not more than 10:30 hours	$1 168.20
23560	Anaesthesia, perfusion or assistance, if the service time is more than 10:30 hours but not more than 10:40 hours	$1 188.00
23570	Anaesthesia, perfusion or assistance, if the service time is more than 10:40 hours but not more than 10:50 hours	$1 207.80

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
23580	Anaesthesia, perfusion or assistance, if the service time is more than 10:50 hours but not more than 11:00 hours	$1 227.60
23590	Anaesthesia, perfusion or assistance, if the service time is more than 11:00 hours but not more than 11:10 hours	$1 247.40
23600	Anaesthesia, perfusion or assistance, if the service time is more than 11:10 hours but not more than 11:20 hours	$1 267.20
23610	Anaesthesia, perfusion or assistance, if the service time is more than 11:20 hours but not more than 11:30 hours	$1 287.00
23620	Anaesthesia, perfusion or assistance, if the service time is more than 11:30 hours but not more than 11:40 hours	$1 306.80
23630	Anaesthesia, perfusion or assistance, if the service time is more than 11:40 hours but not more than 11:50 hours	$1 326.60
23640	Anaesthesia, perfusion or assistance, if the service time is more than 11:50 hours but not more than 12:00 hours	$1 346.40
23650	Anaesthesia, perfusion or assistance, if the service time is more than 12:00 hours but not more than 12:10 hours	$1 366.20
23660	Anaesthesia, perfusion or assistance, if the service time is more than 12:10 hours but not more than 12:20 hours	$1 386.00
23670	Anaesthesia, perfusion or assistance, if the service time is more than 12:20 hours but not more than 12:30 hours	$1 405.80
23680	Anaesthesia, perfusion or assistance, if the service time is more than 12:30 hours but not more than 12:40 hours	$1 425.60
23690	Anaesthesia, perfusion or assistance, if the service time is more than 12:40 hours but not more than 12:50 hours	$1 445.40
23700	Anaesthesia, perfusion or assistance, if the service time is more than 12:50 hours but not more than 13:00 hours	$1 465.20
23710	Anaesthesia, perfusion or assistance, if the service time is more than 13:00 hours but not more than 13:10 hours	$1 485.00
23720	Anaesthesia, perfusion or assistance, if the service time is more than 13:10 hours but not more than 13:20 hours	$1 504.80
23730	Anaesthesia, perfusion or assistance, if the service time is more than 13:20 hours but not more than 13:30 hours	$1 524.60
23740	Anaesthesia, perfusion or assistance, if the service time is	$1 544.40

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)

Item	Description	Fee
	more than 13:30 hours but not more than 13:40 hours	
23750	Anaesthesia, perfusion or assistance, if the service time is more than 13:40 hours but not more than 13:50 hours	$1 564.20
23760	Anaesthesia, perfusion or assistance, if the service time is more than 13:50 hours but not more than 14:00 hours	$1 584.00
23770	Anaesthesia, perfusion or assistance, if the service time is more than 14:00 hours but not more than 14:10 hours	$1 603.80
23780	Anaesthesia, perfusion or assistance, if the service time is more than 14:10 hours but not more than 14:20 hours	$1 623.60
23790	Anaesthesia, perfusion or assistance, if the service time is more than 14:20 hours but not more than 14:30 hours	$1 643.40
23800	Anaesthesia, perfusion or assistance, if the service time is more than 14:30 hours but not more than 14:40 hours	$1 663.20
23810	Anaesthesia, perfusion or assistance, if the service time is more than 14:40 hours but not more than 14:50 hours	$1 683.00
23820	Anaesthesia, perfusion or assistance, if the service time is more than 14:50 hours but not more than 15:00 hours	$1 702.80
23830	Anaesthesia, perfusion or assistance, if the service time is more than 15:00 hours but not more than 15:10 hours	$1 722.60
23840	Anaesthesia, perfusion or assistance, if the service time is more than 15:10 hours but not more than 15:20 hours	$1 742.40
23850	Anaesthesia, perfusion or assistance, if the service time is more than 15:20 hours but not more than 15:30 hours	$1 762.20
23860	Anaesthesia, perfusion or assistance, if the service time is more than 15:30 hours but not more than 15:40 hours	$1 782.00
23870	Anaesthesia, perfusion or assistance, if the service time is more than15:40 hours but not more than 15:50 hours	$1 801.80
23880	Anaesthesia, perfusion or assistance, if the service time is more than 15:50 hours but not more than 16:00 hours	$1 821.60
23890	Anaesthesia, perfusion or assistance, if the service time is more than 16:00 hours but not more than 16:10 hours	$1 841.40
23900	Anaesthesia, perfusion or assistance, if the service time is more than 16:10 hours but not more than 16:20 hours	$1 861.20

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
23910	Anaesthesia, perfusion or assistance, if the service time is more than 16:20 hours but not more than 16:30 hours	$1 881.00
23920	Anaesthesia, perfusion or assistance, if the service time is more than 16:30 hours but not more than 16:40 hours	$1 900.80
23930	Anaesthesia, perfusion or assistance, if the service time is more than 16:40 hours but not more than 16:50 hours	$1 920.60
23940	Anaesthesia, perfusion or assistance, if the service time is more than 16:50 hours but not more than 17:00 hours	$1 940.40
23950	Anaesthesia, perfusion or assistance, if the service time is more than 17:00 hours but not more than 17:10 hours	$1 960.20
23960	Anaesthesia, perfusion or assistance, if the service time is more than 17:10 hours but not more than 17:20 hours	$1 980.00
23970	Anaesthesia, perfusion or assistance, if the service time is more than 17:20 hours but not more than 17:30 hours	$1 999.80
23980	Anaesthesia, perfusion or assistance, if the service time is more than 17:30 hours but not more than 17:40 hours	$2 019.60
23990	Anaesthesia, perfusion or assistance, if the service time is more than17:40 hours but not more than 17:50 hours	$2 039.40
24100	Anaesthesia, perfusion or assistance, if the service time is more than 17:50 hours but not more than 18:00 hours	$2 059.20
24101	Anaesthesia, perfusion or assistance, if the service time is more than 18:00 hours but not more than 18:10 hours	$2 079.00
24102	Anaesthesia, perfusion or assistance, if the service time is more than 18:10 hours but not more than 18:20 hours	$2 098.80
24103	Anaesthesia, perfusion or assistance, if the service time is more than 18:20 hours but not more than 18:30 hours	$2 118.60
24104	Anaesthesia, perfusion or assistance, if the service time is more than 18:30 hours but not more than 18:40 hours	$2 138.40
24105	Anaesthesia, perfusion or assistance, if the service time is more than 18:40 hours but not more than 18:50 hours	$2 158.20
24106	Anaesthesia, perfusion or assistance, if the service time is more than 18:50 hours but not more than 19:00 hours	$2 178.00
24107	Anaesthesia, perfusion or assistance, if the service time is	$2 197.80

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)

Item	Description	Fee
	more than 19:00 hours but not more than 19:10 hours	
24108	Anaesthesia, perfusion or assistance, if the service time is more than 19:10 hours but not more than 19:20 hours	$2 217.60
24109	Anaesthesia, perfusion or assistance, if the service time is more than 19:20 hours but not more than 19:30 hours	$2 237.40
24110	Anaesthesia, perfusion or assistance, if the service time is more than 19:30 hours but not more than 19:40 hours	$2 257.20
24111	Anaesthesia, perfusion or assistance, if the service time is more than 19:40 hours but not more than 19:50 hours	$2 277.00
24112	Anaesthesia, perfusion or assistance, if the service time is more than 19:50 hours but not more than 20:00 hours	$2 296.80
24113	Anaesthesia, perfusion or assistance, if the service time is more than 20:00 hours but not more than 20:10 hours	$2 316.60
24114	Anaesthesia, perfusion or assistance, if the service time is more than 20:10 hours but not more than 20:20 hours	$2 336.40
24115	Anaesthesia, perfusion or assistance, if the service time is more than 20:20 hours but not more than 20:30 hours	$2 356.20
24116	Anaesthesia, perfusion or assistance, if the service time is more than 20:30 hours but not more than 20:40 hours	$2 376.00
24117	Anaesthesia, perfusion or assistance, if the service time is more than 20:40 hours but not more than 20:50 hours	$2 395.80
24118	Anaesthesia, perfusion or assistance, if the service time is more than 20:50 hours but not more than 21:00 hours	$2 415.60
24119	Anaesthesia, perfusion or assistance, if the service time is more than 21:00 hours but not more than 21:10 hours	$2 435.40
24120	Anaesthesia, perfusion or assistance, if the service time is more than 21:10 hours but not more than 21:20 hours	$2 455.20
24121	Anaesthesia, perfusion or assistance, if the service time is more than 21:20 hours but not more than 21:30 hours	$2 475.00
24122	Anaesthesia, perfusion or assistance, if the service time is more than 21:30 hours but not more than 21:40 hours	$2 494.80
24123	Anaesthesia, perfusion or assistance, if the service time is more than 21:40 hours but not more than 21:50 hours	$2 514.60

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
24124	Anaesthesia, perfusion or assistance, if the service time is more than 21:50 hours but not more than 22:00 hours	$2 534.40
24125	Anaesthesia, perfusion or assistance, if the service time is more than 22:00 hours but not more than 22:10 hours	$2 554.20
24126	Anaesthesia, perfusion or assistance, if the service time is more than 22:10 hours but not more than 22:20 hours	$2 574.00
24127	Anaesthesia, perfusion or assistance, if the service time is more than 22:20 hours but not more than 22:30 hours	$2 593.80
24128	Anaesthesia, perfusion or assistance, if the service time is more than 22:30 hours but not more than 22:40 hours	$2 613.60
24129	Anaesthesia, perfusion or assistance, if the service time is more than 22:40 hours but not more than 22:50 hours	$2 633.40
24130	Anaesthesia, perfusion or assistance, if the service time is more than 22:50 hours but not more than 23:00 hours	$2 653.20
24131	Anaesthesia, perfusion or assistance, if the service time is more than 23:00 hours but not more than 23:10 hours	$2 673.00
24132	Anaesthesia, perfusion or assistance, if the service time is more than 23:10 hours but not more than 23:20 hours	$2 692.80
24133	Anaesthesia, perfusion or assistance, if the service time is more than 23:20 hours but not more than 23:30 hours	$2 712.60
24134	Anaesthesia, perfusion or assistance, if the service time is more than 23:30 hours but not more than 23:40 hours	$2 732.40
24135	Anaesthesia, perfusion or assistance, if the service time is more than 23:40 hours but not more than 23:50 hours	$2 752.20
24136	Anaesthesia, perfusion or assistance, if the service time is more than 23:50 hours but not more than 24:00 hours	$2 772.00
Subgroup 22—Anaesthesia, perfusion and assistance at anaesthesia (modifying components—physical status)		
25000	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient has severe systemic disease (equivalent to ASA physical status indicator 3)	$19.80
25005	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient has severe systemic disease	$39.60

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
	which is a constant threat to life (equivalent to ASA physical status indicator 4)	
25010	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is not expected to survive for 24 hours, with or without the associated operation (equivalent to ASA physical status indicator 5)	$59.40
Subgroup 23—Anaesthesia, perfusion and assistance at anaesthesia (modifying components—other)		
25015	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient's age is less than 12 months or is 70 years or more	$19.80
25020	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient requires immediate treatment without which there would be significant threat to life or body part—other than a service associated with a service to which item 25025, 25030 or 25050 applies	$39.60
Subgroup 24—Anaesthesia and assistance at anaesthesia (after hours emergency modifier)		
25025	Anaesthesia, if the patient requires immediate treatment without which there would be significant threat to life or body part and if more than 50% of the service time occurs between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday	Amount under clause 2.43.1
25030	Assistance in the management of anaesthesia, if the patient requires immediate treatment without which there would be significant threat to life or body part and if more than 50% of the service time occurs between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday	Amount under clause 2.43.1
Subgroup 25—Perfusion (after hours emergency modifier)		
25050	Perfusion, if the patient requires immediate treatment without which there would be significant threat to life or body part and if more than 50% of the service time occurs between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday	Amount under clause 2.43.1

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Item	**Description**	**Fee**
Subgroup 26—Assistance at anaesthesia		
25200	Assistance in the management of anaesthesia requiring continuous anaesthesia on a patient in imminent danger of death requiring continuous life saving emergency treatment, to the exclusion of attendance on all other patients	Amount under clause 2.43.2
25205	Assistance in the management of elective anaesthesia, if: (a) the patient has complex airway problems; or (b) the patient is a neonate or a complex paediatric case; or (c) there is anticipated to be massive blood loss (greater than 50% of blood volume) during the procedure; or (d) the patient is critically ill, with multiple organ failure; or (e) the service time of the management of anaesthesia exceeds 6 hours and the assistance is provided to the exclusion of attendance on all other patients	Amount under clause 2.43.2

Division 2.44—Group T8: Surgical operations

Subdivision A—General

2.44.1 Meaning of *approved site*

In items 37220 and 37227:

approved site, for radiation oncology, means a site at which radiation oncology may be performed lawfully under the law of the State or Territory in which the site is located.

2.44.2 Application of Group T8

An item in Group T8 does not apply to a service mentioned in the item if the service is provided at the same time as, or in connection with, the provision of a pain pump for post-surgical pain management.

Subdivision B—Subgroup 1 of Group T8

2.44.4 Meaning of *amount under clause 2.44.4*

In item 30001:

amount under clause 2.44.4 means 50% of the fee that would normally apply for a surgical procedure if the surgical procedure had not been discontinued before completion.

2.44.5 Meaning of *amount under clause 2.44.5*

In item 31340:

amount under clause 2.44.5, for the excision of muscle, bone or cartilage in association with the excision of a malignant tumour of skin under another item, means 75% of the fee payable under that other item.

2.44.6 Meaning of *qualified surgeon*

For items 31539 and 31545, a medical practitioner is a ***qualified surgeon*** if:

(a) he or she is a specialist in the practice of his or her specialty of surgery; and

(b) the Chief Executive Medicare has received a written notice from the Royal Australasian College of Surgeons stating that the person meets the skills requirements for providing services to which the items apply.

2.44.7 Meaning of *qualified radiologist*

For item 31542, a medical practitioner is a ***qualified radiologist*** if:

(a) he or she is a specialist in the practice of his or her specialty of radiology; and

(b) the Chief Executive Medicare has received a written notice from the Royal Australian and New Zealand College of Radiologists stating that the person meets the skills requirements for providing services to which the item applies.

2.44.8 Histopathological proof of malignancy in certain cases for purposes of certain items relating to surgical procedures

For items 30196 to 30205, the requirement for histopathological proof of malignancy is satisfied if:

(a) multiple lesions are removed from a single anatomical region; and

(b) a single lesion from that region is histologically tested and proven positive for malignancy.

2.44.9 Application of items 30299 and 30300

A service described in item 30299 or 30300 applies only if pre-operative lymphoscinitigraphy is used because the patient is allergic to lymphotrophic dye.

2.44.10 Application of items 30440, 30451, 30492 and 30495

A service described in item 30440, 30451, 30492 or 30495 does not include imaging.

Note: The imaging services associated with these services are described in the diagnostic imaging services table.

2.44.11 Application of items 30688, 30690, 30692 and 30694

Item 30688, 30690, 30692 or 30694 applies to a service only if the provider makes a record of the findings of the ultrasound imaging in the patient's notes.

2.44.12 Application of item 35412

(1) Intra-operative imaging is taken to be part of the service associated with the coiling of an aneurysm and cannot be charged in addition to item 35412.

(2) Pre-operative diagnostic imaging, including aftercare, under item 60009, 60072, 60075 or 60078 of the diagnostic imaging services table may be separately claimed.

2.44.12A Application of items 31569, 31572, 31575, 31578, 31581, 31584, 31587 and 31590

(1) A service mentioned in item 31569, 31572, 31575, 31578, 31581, 31584, 31587 or 31590 may only be claimed once for a patient for the same occasion.

(2) If 2 or more services mentioned in item 31569, 31572, 31575, 31578, 31581, 31584, 31587 or 31590 are performed in conjunction on a patient on the same occasion, only one of the services may be claimed for the patient for the occasion.

Group T8—Surgical operations		
Item	**Description**	**Fee**
Subgroup 1—General		
30001	Operative procedure, being a service to which an item in	Amount

Group T8—Surgical operations		
Item	**Description**	**Fee**
	this Group would have applied had the procedure not been discontinued on medical grounds	under clause 2.44.4
30003	Localised burns, dressing of, (not involving grafting)—each attendance at which the procedure is performed, including any associated consultation	$36.30
30006	Extensive burns, dressing of, without anaesthesia (not involving grafting)—each attendance at which the procedure is performed, including any associated consultation	$46.50
30009	Localised burns, dressing of, under general anaesthesia (not involving grafting) (G) (H) (Anaes.)	$60.75
30010	Localised burns, dressing of, under general anaesthesia (not involving grafting) (S) (H) (Anaes.)	$73.90
30013	Extensive burns, dressing of, under general anaesthesia (not involving grafting) (G) (H) (Anaes.)	$130.90
30014	Extensive burns, dressing of, under general anaesthesia (not involving grafting) (S) (H) (Anaes.)	$155.40
30017	Burns, excision of, under general anaesthesia, involving not more than 10% of body surface, if grafting is not carried out during the same operation (Anaes.) (Assist.)	$326.05
30020	Burns, excision of, under general anaesthesia, involving more than 10% of body surface, if grafting is not carried out during the same operation (H) (Anaes.) (Assist.)	$635.00
30023	Wound of soft tissue, traumatic, deep or extensively contaminated, debridement of, under general anaesthesia, or regional or field nerve block, including suturing of the wound if carried out (Anaes.) (Assist.)	$326.05
30024	Wound of soft tissue, debridement of an extensively infected post-surgical incision or Fournier's gangrene, under general anaesthesia, or regional or field nerve block, including suturing of the wound if carried out (Anaes.) (Assist.)	$326.05
30026	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, small (not more than 7 cm long),	$52.20

Group T8—Surgical operations		
Item	**Description**	**Fee**
	superficial, other than a service to which another item in Group T4 applies (Anaes.)	
30029	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, small (not more than 7 cm in length), involving deeper tissue, other than a service to which another item in Group T4 applies (Anaes.)	$90.00
30032	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, small (not more than 7 cm long), superficial (Anaes.)	$82.50
30035	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, small (not more than 7 cm long), involving deeper tissue (Anaes.)	$117.55
30038	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, large (more than 7 cm long), superficial, other than a service to which another item in Group T4 applies (Anaes.)	$90.00
30041	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, large (more than 7 cm long), involving deeper tissue, other than a service to which another item in Group T4 applies (G) (Anaes.)	$144.00
30042	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, other than on face or neck, large (more than 7 cm long), involving deeper tissue, other than a service to which another item in Group T4 applies (S) (Anaes.)	$185.60
30045	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, large (more than 7 cm long), superficial (Anaes.)	$117.55
30048	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery,	$149.75

Group T8—Surgical operations		
Item	**Description**	**Fee**
	on face or neck, large (more than 7 cm long), involving deeper tissue (G) (Anaes.)	
30049	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, large (more than 7 cm long), involving deeper tissue (S) (Anaes.)	$185.60
30052	Full thickness laceration of ear, eyelid, nose or lip, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.)	$254.00
30055	Wounds, dressing of, under general anaesthesia, with or without removal of sutures, other than a service associated with a service to which another item in this Group applies (Anaes.)	$73.90
30058	Post-operative haemorrhage, control of, under general anaesthesia, as an independent procedure (Anaes.)	$144.35
30061	Superficial foreign body, removal of, (including from cornea or sclera) as an independent procedure (Anaes.)	$23.50
30062	Etonogestrel subcutaneous implant, removal of, as an independent procedure (Anaes.)	$60.75
30064	Subcutaneous foreign body, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes.)	$109.90
30067	Foreign body in muscle, tendon or other deep tissue, removal of, as an independent procedure (G) (Anaes.) (Assist.)	$223.60
30068	Foreign body in muscle, tendon or other deep tissue, removal of, as an independent procedure (S) (Anaes.) (Assist.)	$276.80
30071	Diagnostic biopsy of skin or mucous membrane, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.)	$52.20
30074	Diagnostic biopsy of lymph gland, muscle or other deep tissue or organ, as an independent procedure, if the biopsy specimen is sent for pathological examination (G) (Anaes.)	$117.55
30075	Diagnostic biopsy of lymph gland, muscle or other deep	$149.75

Group T8—Surgical operations		
Item	**Description**	**Fee**
	tissue or organ, as an independent procedure, if the biopsy specimen is sent for pathological examination (S) (Anaes.)	
30078	Diagnostic drill biopsy of lymph gland, deep tissue or organ, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.)	$48.45
30081	Diagnostic biopsy of bone marrow by trephine using an open approach, if the biopsy specimen is sent for pathological examination (Anaes.)	$109.90
30084	Diagnostic biopsy of bone marrow by trephine using a percutaneous approach with a Jamshidi needle or similar device, if the biopsy specimen is sent for pathological examination (Anaes.)	$58.80
30087	Diagnostic biopsy of bone marrow by aspiration or punch biopsy of synovial membrane, if the biopsy specimen is sent for pathological examination (Anaes.)	$29.45
30090	Diagnostic biopsy of pleura, percutaneous, if the biopsy specimen is sent for pathological examination—one or more biopsies on any one occasion (Anaes.)	$128.55
30093	Diagnostic needle biopsy of vertebra, if the biopsy specimen is sent for pathological examination (Anaes.)	$171.55
30094	Diagnostic percutaneous aspiration biopsy of deep organ using interventional techniques (but not including imaging) if the biopsy specimen is sent for pathological examination (Anaes.)	$189.40
30096	Diagnostic scalene node biopsy, by open procedure, if the specimen excised is sent for pathological examination (Anaes.)	$183.90
30097	Personal performance of a Synacthen Stimulation Test, including associated consultation, by a medical practitioner with resuscitation training and access to facilities when life support procedures can be implemented	$97.15
30099	Sinus, excision of, involving superficial tissue only (Anaes.)	$90.00
30102	Sinus, excision of, involving muscle and deep tissue (G) (Anaes.)	$149.75

Group T8—Surgical operations		
Item	**Description**	**Fee**
30103	Sinus, excision of, involving muscle and deep tissue (S) (Anaes.)	$183.90
30104	Pre-auricular sinus, excision of (Anaes.)	$126.90
30106	Ganglion or small bursa, excision of, other than a service associated with a service to which another item in this Group applies (G) (Anaes.)	$155.40
30107	Ganglion or small bursa, excision of, other than a service associated with a service to which another item in this Group applies (S) (Anaes.)	$219.95
30110	Bursa (large), including olecranon, calcaneum or patella, excision of (G) (Anaes.) (Assist.)	$284.35
30111	Bursa (large), including olecranon, calcaneum or patella, excision of (S) (Anaes.) (Assist.)	$371.50
30114	Bursa, semimembranosus (Baker's cyst), excision of (H) (Anaes.) (Assist.)	$371.50
30165	Lipectomy—transverse wedge excision of abdominal apron, other than a service associated with a service to which item 45530, 45564 or 45565 applies, or a service performed within 12 months after the end of a pregnancy of the patient (H) (Anaes.) (Assist.)	$454.85
30168	Lipectomy—wedge excision of skin and fat, other than a service associated with a service to which item 45530, 45564 or 45565 applies, or a service to which item 30165 applies—one excision (H) (Anaes.) (Assist.)	$454.85
30171	Lipectomy—wedge excision of skin and fat, other than a service associated with a service to which item 45530, 45564 or 45565 applies, or a service to which item 30165 applies—2 or more excisions (H) (Anaes.) (Assist.)	$691.75
30174	Lipectomy—subumbilical excision with undermining of skin edges and strengthening of musculo-aponeurotic wall, other than a service associated with a service to which item 45530, 45564 or 45565 applies (H) (Anaes.) (Assist.)	$691.75
30177	Lipectomy—radical abdominoplasty (Pitanguy type or similar) with excision of skin and subcutaneous tissue, repair of musculo-aponeurotic layer and transposition of	$985.70

Group T8—Surgical operations		
Item	**Description**	**Fee**
	umbilicus, other than a service associated with a service to which item 45530, 45564 or 45565 applies, or a service performed within 12 months after the end of a pregnancy of the patient (H) (Anaes.) (Assist.)	
30180	Axillary hyperhidrosis, partial excision for (Anaes.)	$136.50
30183	Axillary hyperhidrosis, total excision of sweat gland bearing area (Anaes.)	$246.50
30185	Palmar or plantar warts (10 or more), definitive removal of, excluding ablative methods alone, other than a service to which item 30186 or 30187 applies	$182.50
30186	Palmar or plantar warts (for each wart, up to a total of 9 warts), definitive removal of, excluding ablative methods alone, other than a service to which item 30185 or 30187 applies (Anaes.) Note: Section 15 of the Act provides for the reduction of the fees payable for 2 or more removals performed on the same patient on the same occasion.	$47.45
30187	Palmar or plantar warts, removal of, by carbon dioxide laser or erbium laser, requiring admission to a hospital, or when performed by a specialist in the practice of his or her specialty (5 or more warts) (Anaes.)	$256.95
30189	Warts or molluscum contagiosum (one or more), removal of, by any method (other than by chemical means), if undertaken in the operating theatre of a hospital, other than a service associated with a service to which another item in this Group applies (Anaes.)	$147.30
30190	Angiofibromas, trichoepitheliomas or other severely disfiguring tumours of the face or neck, suitable for laser excision as confirmed by specialist opinion—removal of, by serial curettage or carbon dioxide laser or erbium laser excision-ablation, including any associated resurfacing (10 or more tumours) (Anaes.)	$397.75
30192	Premalignant skin lesions (including solar keratoses), treatment of, by ablative technique (10 or more lesions) (Anaes.)	$39.55
30195	Benign neoplasm of skin, other than viral verrucae	$63.50

Group T8—Surgical operations		
Item	**Description**	**Fee**
	(common warts), seborrheic keratoses, cysts and skin tags, treatment by electrosurgical destruction, simple curettage or shave excision, or laser photocoagulation, other than a service to which item 30196, 30197, 30202, 30203 or 30205 applies (one or more lesions) (Anaes.)	
30196	Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser or erbium laser excision-ablation, including any associated cryotherapy, or diathermy, other than a service to which item 30197 applies (Anaes.)	$126.30
30197	Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser excision-ablation, including any associated cryotherapy or diathermy (10 or more lesions) (Anaes.)	$440.05
30202	Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by specialist opinion, removal of, by liquid nitrogen cryotherapy using repeat freeze-thaw cycles, other than a service to which item 30203 applies	$48.35
30203	Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by specialist opinion, removal of, by liquid nitrogen cryotherapy using repeat freeze-thaw cycles (10 or more lesions)	$170.25
30205	Malignant neoplasm of skin proven by histopathology, removal of, by liquid nitrogen cryotherapy using repeat freeze-thaw cycles if the malignant neoplasm extends into cartilage (Anaes.)	$126.30
30207	Skin lesions, multiple injections with hydrocortisone or similar preparations (Anaes.)	$44.60
30210	Keloid and other skin lesions, extensive, multiple injections of hydrocortisone or similar preparations if undertaken in the operating theatre of a hospital (Anaes.)	$162.95
30213	Telangiectases or starburst vessels on the head or neck if lesions are visible from 4 metres, diathermy or sclerosant	$109.80

Group T8—Surgical operations		
Item	**Description**	**Fee**
	injection of, including associated consultation—limited to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period—for a session of at least 20 minutes in duration (Anaes.)	
30214	Telangiectases or starburst vessels on the head or neck if lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation-session of at least 20 minutes in duration—if it can be demonstrated that a seventh or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period	$109.80
30216	Haematoma, aspiration of (Anaes.)	$27.35
30219	Haematoma, furuncle, small abscess or similar lesion not requiring admission to a hospital, incision with drainage of, excluding after-care	$27.35
30223	Large haematoma, large abscess, carbuncle, cellulitis or similar lesion, incision with drainage of, excluding after-care (H) (Anaes.)	$162.95
30224	Percutaneous drainage of deep abscess using interventional techniques—but not including imaging (Anaes.)	$237.60
30225	Abscess drainage tube, exchange of using interventional techniques—but not including imaging (Anaes.)	$267.65
30226	Muscle, excision of (limited) or fasciotomy (Anaes.)	$149.75
30229	Muscle, excision of (extensive) (Anaes.) (Assist.)	$272.95
30232	Muscle, ruptured, repair of (limited), not associated with external wound (Anaes.)	$223.60
30235	Muscle, ruptured, repair of (extensive), not associated with external wound (Anaes.) (Assist.)	$295.70
30238	Fascia, deep, repair of, for herniated muscle (Anaes.)	$149.75
30241	Bone tumour, innocent, excision of, other than a service to which another item in this Group applies (Anaes.) (Assist.)	$356.35
30244	Styloid process of temporal bone, removal of (H) (Anaes.) (Assist.)	$356.35

Group T8—Surgical operations		
Item	**Description**	**Fee**
30246	Parotid duct, repair of, using micro-surgical techniques (H) (Anaes.) (Assist.)	$689.80
30247	Parotid gland, total extirpation of (H) (Anaes.) (Assist.)	$739.35
30250	Parotid gland, total extirpation of with preservation of facial nerve (H) (Anaes.) (Assist.)	$1 251.10
30251	Recurrent parotid tumour, excision of, with preservation of facial nerve (Anaes.) (Assist.)	$1 921.75
30253	Parotid gland, superficial lobectomy of, with exposure of facial nerve (H) (Anaes.) (Assist.)	$834.05
30255	Submandibular ducts, relocation of, for surgical control of drooling (H) (Anaes.) (Assist.)	$1 110.65
30256	Submandibular gland, extirpation of (H) (Anaes.) (Assist.)	$445.40
30259	Sublingual gland, extirpation of (Anaes.)	$198.50
30262	Salivary gland, dilatation or diathermy of duct (Anaes.)	$58.80
30265	Salivary gland, removal of calculus from duct or meatotomy or marsupialisation, one or more such procedures (G) (Anaes.)	$117.55
30266	Salivary gland, removal of calculus from duct or meatotomy or marsupialisation, one or more such procedures (S) (Anaes.)	$149.75
30269	Salivary gland, repair of cutaneous fistula of (Anaes.)	$149.75
30272	Tongue, partial excision of (Anaes.) (Assist.)	$295.70
30275	Radical excision of intra-oral tumour involving resection of mandible and lymph glands of neck (commando-type operation) (H) (Anaes.) (Assist.)	$1 762.75
30278	Tongue tie, repair of, other than a service to which another item in this Group applies (Anaes.)	$46.50
30281	Tongue tie, mandibular frenulum or maxillary frenulum, repair of, in a person aged 2 years and over, under general anaesthesia (Anaes.)	$119.50
30282	Ranula or mucous cyst of mouth, removal of (G) (Anaes.)	$155.40
30283	Ranula or mucous cyst of mouth, removal of (S) (Anaes.)	$204.70
30286	Branchial cyst, removal of (Anaes.) (Assist.)	$397.85

Group T8—Surgical operations		
Item	**Description**	**Fee**
30289	Branchial fistula, removal of (H) (Anaes.) (Assist.)	$502.25
30293	Cervical oesophagostomy, or closure of cervical oesophagostomy with or without plastic repair (Anaes.) (Assist.)	$445.40
30294	Cervical oesophagectomy with tracheostomy and oesophagostomy, with or without plastic reconstruction, or laryngopharyngectomy with tracheostomy and plastic reconstruction (H) (Anaes.) (Assist.)	$1 762.75
30296	Thyroidectomy, total (H) (Anaes.) (Assist.)	$1 023.70
30297	Thyroidectomy following previous thyroid surgery (H) (Anaes.) (Assist.)	$1 023.70
30299	Sentinel lymph node biopsy, or biopsies, for breast cancer: (a) involving dissection in a level one axilla; and (b) using preoperative lymphoscintigraphy and lymphotropic dye injection; other than a service to which item 30300, 30302 or 30303 applies (H) (Anaes.) (Assist.)	$637.45
30300	Sentinel lymph node biopsy, or biopsies, for breast cancer: (a) involving dissection in a level 2 or 3 axilla; and (b) using preoperative lymphoscintigraphy and lymphotropic dye injection; other than a service to which item 30299, 30302 or 30303 applies (H) (Anaes.) (Assist.)	$764.90
30302	Sentinel lymph node biopsy, or biopsies, for breast cancer: (a) involving dissection in a level one axilla; and (b) using lymphotropic dye injection; other than a service to which item 30299, 30300 or 30303 applies (H) (Anaes.) (Assist.)	$509.95
30303	Sentinel lymph node biopsy, or biopsies, for breast cancer: (a) involving dissection in a level 2 or 3 axilla; and (b) using lymphotropic dye injection; other than a service to which item 30299, 30300 or 30302 applies (H) (Anaes.) (Assist.)	$611.85

Group T8—Surgical operations		
Item	**Description**	**Fee**
30306	Total hemithyroidectomy (H) (Anaes.) (Assist.)	$798.65
30308	Bilateral sub-total thyroidectomy (H) (Anaes.) (Assist.)	$798.65
30309	Thyroidectomy, sub-total for thyrotoxicosis (H) (Anaes.) (Assist.)	$1 023.70
30310	Thyroid, unilateral sub-total thyroidectomy or equivalent partial thyroidectomy (H) (Anaes.) (Assist.)	$457.40
30313	Thyroglossal cyst, removal of (Anaes.) (Assist.)	$272.95
30314	Thyroglossal cyst or fistula or both, radical removal of, including thyroglossal duct and portion of hyoid bone (H) (Anaes.) (Assist.)	$457.40
30315	Parathyroid operation for hyperparathyroidism (H) (Anaes.) (Assist.)	$1 139.90
30317	Cervical re-exploration for recurrent or persistent hyperparathyroidism (H) (Anaes.) (Assist.)	$1 364.90
30318	Mediastinum, exploration of, via the cervical route, for hyperparathyroidism (including thymectomy) (H) (Anaes.) (Assist.)	$907.60
30320	Mediastinum, exploration of, via mediastinotomy, for hyperparathyroidism (including thymectomy) (H) (Anaes.) (Assist.)	$1 364.90
30321	Retroperitoneal neuroendocrine tumour, removal of (H) (Anaes.) (Assist.)	$907.60
30323	Retroperitoneal neuroendocrine tumour, removal of, requiring complex and extensive dissection (H) (Anaes.) (Assist.)	$1 364.90
30324	Adrenal gland tumour, excision of (H) (Anaes.) (Assist.)	$1 364.90
30329	Lymph glands of groin, limited excision of (Anaes.)	$246.95
30330	Lymph glands of groin, radical excision of (H) (Anaes.) (Assist.)	$718.75
30332	Lymph nodes of axilla, limited excision of (sampling) (H) (Anaes.) (Assist.)	$346.75
30335	Lymph nodes of axilla, complete excision of, to level I (H) (Anaes.) (Assist.)	$866.85

Group T8—Surgical operations		
Item	**Description**	**Fee**
30336	Lymph nodes of axilla, complete excision of, to level II or III (H) (Anaes.) (Assist.)	$1 040.25
30373	Laparotomy (exploratory), including associated biopsies, if no other intra-abdominal procedure is performed (H) (Anaes.) (Assist.)	$483.25
30375	Caecostomy, enterostomy, colostomy, enterotomy, colotomy, cholecystostomy, gastrostomy, gastrotomy, reduction of intussusception, removal of Meckel's diverticulum, suture of perforated peptic ulcer, simple repair of ruptured viscus, reduction of volvulus, pyloroplasty (adult) or drainage of pancreas (H) (Anaes.) (Assist.)	$521.25
30376	Laparotomy involving division of peritoneal adhesions (if no other intra-abdominal procedure is performed) (H) (Anaes.) (Assist.)	$521.25
30378	Laparotomy involving division of adhesions in association with another intra-abdominal procedure if the time taken to divide the adhesions is between 45 minutes and 2 hours (H) (Anaes.) (Assist.)	$523.70
30379	Laparotomy with division of extensive adhesions (duration greater than 2 hours) with or without insertion of long intestinal tube (H) (Anaes.) (Assist.)	$928.15
30382	Enterocutaneous fistula, radical repair of, involving extensive dissection and resection of bowel (H) (Anaes.) (Assist.)	$1 306.90
30384	Laparotomy for grading of lymphoma, including splenectomy, liver biopsies, lymph node biopsies and oophoropexy (H) (Anaes.) (Assist.)	$1 099.40
30385	Laparotomy for control of post-operative haemorrhage, if no other procedure is performed (H) (Anaes.) (Assist.)	$563.30
30387	Laparotomy involving operation on abdominal viscera (including pelvic viscera), other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	$635.00
30388	Laparotomy for trauma involving 3 or more organs (H) (Anaes.) (Assist.)	$1 597.55

Group T8—Surgical operations		
Item	**Description**	**Fee**
30390	Laparoscopy, diagnostic, other than a service associated with another laparoscopic procedure (H) (Anaes.)	$219.95
30391	Laparoscopy, with biopsy (H) (Anaes.) (Assist.)	$284.35
30392	Radical or debulking operation for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure (H) (Anaes.) (Assist.)	$674.50
30393	Laparoscopic division of adhesions in association with another intra-abdominal procedure if the time taken to divide the adhesions exceeds 45 minutes (H) (Anaes.) (Assist.)	$523.70
30394	Laparotomy for drainage of subphrenic abscess, pelvic abscess, appendiceal abscess, ruptured appendix or for peritonitis from any cause, with or without appendicectomy (H) (Anaes.) (Assist.)	$492.85
30396	Laparotomy for gross intra peritoneal sepsis requiring debridement of fibrin, with or without removal of foreign material or enteric contents, with lavage of the entire peritoneal cavity via a major abdominal incision with or without closure of abdomen and with or without mesh or zipper insertion (H) (Anaes.) (Assist.)	$1 016.55
30397	Laparostomy, via wound previously made and left open or closed with zipper, involving change of dressings or packs, and with or without drainage of loculated collections (H) (Anaes.)	$232.35
30399	Laparostomy, final closure of wound made at previous operation, after removal of dressings or packs and removal of mesh or zipper if previously inserted (H) (Anaes.) (Assist.)	$319.60
30400	Laparotomy with insertion of portacath for administration of cytotoxic therapy including placement of reservoir (H) (Anaes.) (Assist.)	$632.50
30402	Retroperitoneal abscess, drainage of, not involving laparotomy (H) (Anaes.) (Assist.)	$464.60
30403	Ventral, incisional, or recurrent hernia or burst abdomen, repair of, with or without mesh (H) (Anaes.) (Assist.)	$521.25

Group T8—Surgical operations		
Item	**Description**	**Fee**
30405	Ventral or incisional hernia (other than recurrent inguinal or femoral hernia), repair of, requiring muscle transposition, mesh hernioplasty or resection of strangulated bowel (H) (Anaes.) (Assist.)	$914.95
30406	Paracentesis abdominis (Anaes.)	$52.20
30408	Peritoneo venous shunt, insertion of (H) (Anaes.) (Assist.)	$392.10
30409	Liver biopsy, percutaneous (Anaes.)	$174.45
30411	Liver biopsy by wedge excision when performed in association with another intra-abdominal procedure (H) (Anaes.)	$88.80
30412	Liver biopsy by core needle, when performed in conjunction with another intra-abdominal procedure (Anaes.)	$52.35
30414	Liver, subsegmental resection of, (local excision), other than for trauma (H) (Anaes.) (Assist.)	$689.80
30415	Liver, segmental resection of, other than for trauma (H) (Anaes.) (Assist.)	$1 379.50
30416	Liver cyst, laparoscopic marsupialisation of, if the size of the cyst is greater than 5 cm in diameter (H) (Anaes.) (Assist.)	$748.95
30417	Liver cysts, laparoscopic marsupialisation of 5 or more, including any cyst greater than 5 cm in diameter (H) (Anaes.) (Assist.)	$1 123.40
30418	Liver, lobectomy of, other than for trauma (H) (Anaes.) (Assist.)	$1 597.55
30419	Liver tumours, destruction of, by hepatic cryotherapy, other than a service associated with a service to which item 50950 or 50952 applies (Anaes.) (Assist.)	$817.10
30421	Liver, tri-segmental resection (extended lobectomy) of, other than for trauma (H) (Anaes.) (Assist.)	$1 996.55
30422	Liver, repair of superficial laceration of, for trauma (H) (Anaes.) (Assist.)	$675.35
30425	Liver, repair of deep multiple lacerations of, or debridement of, for trauma (H) (Anaes.) (Assist.)	$1 306.90

Group T8—Surgical operations		
Item	**Description**	**Fee**
30427	Liver, segmental resection of, for trauma (H) (Anaes.) (Assist.)	$1 560.95
30428	Liver, lobectomy of, for trauma (Anaes.) (Assist.)	$1 670.00
30430	Liver, extended lobectomy (tri-segmental resection) of, for trauma (Anaes.) (Assist.)	$2 323.30
30431	Liver abscess, open abdominal drainage of (Anaes.) (Assist.)	$521.25
30433	Liver abscess (multiple), open abdominal drainage of (H) (Anaes.) (Assist.)	$726.05
30434	Hydatid cyst of liver, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles (H) (Anaes.) (Assist.)	$588.15
30436	Hydatid cyst of liver, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles, with omentoplasty or myeloplasty (H) (Anaes.) (Assist.)	$653.45
30437	Hydatid cyst of liver, total excision of, by cysto-pericystectomy (membrane plus fibrous wall) (H) (Anaes.) (Assist.)	$813.30
30438	Hydatid cyst of liver, excision of, with drainage and excision of liver tissue (Anaes.) (Assist.)	$1 150.85
30439	Operative cholangiography or operative pancreatography or intra operative ultrasound of the biliary tract (including one or more examinations performed during the one operation) (H) (Anaes.) (Assist.)	$185.60
30440	Cholangiogram, percutaneous transhepatic, and insertion of biliary drainage tube, using interventional imaging techniques, other than a service associated with a service to which item 30451 applies (Anaes.) (Assist.)	$526.40
30441	Intra operative ultrasound for staging of intra abdominal tumours (H) (Anaes.)	$136.25
30442	Choledochoscopy in conjunction with another procedure (H) (Anaes.)	$185.60
30443	Cholecystectomy (H) (Anaes.) (Assist.)	$739.35

Group T8—Surgical operations		
Item	**Description**	**Fee**
30445	Laparoscopic cholecystectomy (H) (Anaes.) (Assist.)	$739.35
30446	Laparoscopic cholecystectomy when procedure is completed by laparotomy (H) (Anaes.) (Assist.)	$739.35
30448	Laparoscopic cholecystectomy, involving removal of common duct calculi via the cystic duct (H) (Anaes.) (Assist.)	$972.90
30449	Laparoscopic cholecystectomy with removal of common duct calculi via laparoscopic choledochotomy (H) (Anaes.) (Assist.)	$1 081.85
30450	Calculus of biliary or renal tract, extraction of, using interventional imaging techniques—other than a service associated with a service to which item 36627, 36630, 36645 or 36648 applies (Anaes.) (Assist.)	$524.40
30451	Biliary drainage tube, exchange of, using interventional imaging techniques, other than a service associated with a service to which item 30440 applies (Anaes.) (Assist.)	$267.65
30452	Choledochoscopy with balloon dilatation of a stricture or passage of stent or extraction of calculi (H) (Anaes.) (Assist.)	$377.50
30454	Choledochotomy (with or without cholecystectomy), with or without removal of calculi (H) (Anaes.) (Assist.)	$862.50
30455	Choledochotomy (with or without cholecystectomy), with removal of calculi including biliary intestinal anastomosis (H) (Anaes.) (Assist.)	$1 014.05
30457	Choledochotomy, intrahepatic, involving removal of intrahepatic bile duct calculi (Anaes.) (Assist.)	$1 379.50
30458	Transduodenal operation on sphincter of Oddi, involving one or more of, removal of calculi, sphincterotomy, sphincteroplasty, biopsy, local excision of peri-ampullary or duodenal tumour, sphincteroplasty of the pancreatic duct, pancreatic duct septoplasty, with or without choledochotomy (H) (Anaes.) (Assist.)	$1 014.05
30460	Cholecystoduodenostomy, cholecystoenterostomy, choledochojejunostomy or Roux-en-Y as a bypass procedure when no prior biliary surgery performed (H)	$862.50

Group T8—Surgical operations		
Item	**Description**	**Fee**
	(Anaes.) (Assist.)	
30461	Radical resection of porta hepatis with biliary-enteric anastomoses, other than a service associated with a service to which item 30443, 30454, 30455, 30458 or 30460 applies (H) (Anaes.) (Assist.)	$1 478.40
30463	Radical resection of common hepatic duct and right and left hepatic ducts, with 2 duct anastomoses (H) (Anaes.) (Assist.)	$1 815.20
30464	Radical resection of common hepatic duct and right and left hepatic ducts involving more than 2 anastomoses or resection of segment or major portion of segment of liver (H) (Anaes.) (Assist.)	$2 178.25
30466	Intrahepatic biliary bypass of left hepatic ductal system by Roux-en-Y loop to peripheral ductal system (H) (Anaes.) (Assist.)	$1 256.05
30467	Intrahepatic bypass of right hepatic ductal system by Roux-en-Y loop to peripheral ductal system (H) (Anaes.) (Assist.)	$1 553.70
30469	Biliary stricture, repair of, after one or more operations on the biliary tree (Anaes.) (Assist.)	$1 720.90
30472	Hepatic or common bile duct, repair of, as the primary procedure after partial or total transection of bile duct or ducts (Anaes.) (Assist.)	$929.35
30473	Oesophagoscopy (other than a service to which item 41816 or 41822 applies), gastroscopy, duodenoscopy or panendoscopy (one or more such procedures), with or without biopsy, other than a service associated with a service to which item 30476 or 30478 applies (Anaes.)	$177.10
30475	Endoscopy with balloon dilatation of gastric or gastroduodenal stricture (Anaes.)	$320.25
30476	Oesophagoscopy (other than a service to which item 41816 or 41822 applies), gastroscopy, duodenoscopy or panendoscopy (one or more such procedures), with endoscopic sclerosing injection or banding of oesophageal or gastric varices, other than a service associated with a service to which item 30473 or 30478 applies (Anaes.)	$245.55

Group T8—Surgical operations		
Item	**Description**	**Fee**
30478	Oesophagoscopy (other than a service to which item 41816, 41822 or 41825 applies), gastroscopy, duodenoscopy or panendoscopy (one or more such procedures), with one or more of the following endoscopic procedures—polypectomy, removal of foreign body, diathermy, heater probe or laser coagulation, or sclerosing injection of bleeding upper gastrointestinal lesions, other than a service associated with a service to which item 30473 or 30476 applies (Anaes.)	$245.55
30479	Endoscopy with laser therapy or argon plasma coagulation, for the treatment of neoplasia, benign vascular lesions, strictures of the gastrointestinal tract, tumorous overgrowth through or over oesophageal stents, peptic ulcers, angiodysplasia, gastric antral vascular ectasia (GAVE) or post-polypectomy bleeding, one or more of (Anaes.)	$476.10
30481	Percutaneous gastrostomy (initial procedure), including any associated imaging services (Anaes.)	$357.00
30482	Percutaneous gastrostomy (repeat procedure), including any associated imaging services (Anaes.)	$253.85
30483	Gastrostomy button, non-endoscopic insertion of, or non-endoscopic replacement of (Anaes.)	$177.05
30484	Endoscopic retrograde cholangio-pancreatography (Anaes.)	$364.90
30485	Endoscopic sphincterotomy with or without extraction of stones from common bile duct (Anaes.)	$563.30
30487	Small bowel intubation with biopsy, as an independent procedure (Anaes.)	$180.90
30488	Small bowel intubation—as an independent procedure (Anaes.)	$90.00
30490	Oesophageal prosthesis, insertion of, including endoscopy and dilatation (Anaes.)	$526.40
30491	Bile duct, endoscopic stenting of (including endoscopy and dilatation) (Anaes.)	$555.35
30492	Bile duct, percutaneous stenting of (including dilatation	$787.30

Group T8—Surgical operations		
Item	**Description**	**Fee**
	when performed), using interventional imaging techniques (H) (Anaes.)	
30493	Biliary manometry (Anaes.)	$333.20
30494	Endoscopic biliary dilatation (H) (Anaes.)	$420.50
30495	Percutaneous biliary dilatation for biliary stricture using interventional imaging techniques (H) (Anaes.)	$787.30
30496	Vagotomy, truncal or selective, with or without pyloroplasty or gastroenterostomy (Anaes.) (Assist.)	$588.15
30497	Vagotomy and antrectomy (H) (Anaes.) (Assist.)	$701.30
30499	Vagotomy, highly selective (H) (Anaes.) (Assist.)	$834.05
30500	Vagotomy, highly selective with duodenoplasty for peptic stricture (Anaes.) (Assist.)	$893.10
30502	Vagotomy, highly selective, with dilatation of pylorus (H) (Anaes.) (Assist.)	$985.70
30503	Vagotomy or antrectomy, or both, for peptic ulcer following previous operation for peptic ulcer (Anaes.) (Assist.)	$1 103.80
30505	Bleeding peptic ulcer, control of, involving suture of bleeding point or wedge excision (H) (Anaes.) (Assist.)	$551.85
30506	Bleeding peptic ulcer, control of, involving suture of bleeding point or wedge excision, and vagotomy and pyloroplasty or gastroenterostomy (H) (Anaes.) (Assist.)	$965.75
30508	Bleeding peptic ulcer, control of, involving suture of bleeding point or wedge excision, and highly selective vagotomy (H) (Anaes.) (Assist.)	$1 016.55
30509	Bleeding peptic ulcer, control of, involving gastric resection (other than wedge resection) (Anaes.) (Assist.)	$1 016.55
30515	Gastroenterostomy (including gastroduodenostomy) or enterocolostomy or enteroenterostomy, not being a service to which any of items 31569 to 31581 apply (H) (Anaes.) (Assist.)	$704.35
30517	Gastroenterostomy, pyloroplasty or gastroduodenostomy, reconstruction of (H) (Anaes.) (Assist.)	$922.20
30518	Partial gastrectomy, not being a service associated with a	$987.50

Group T8—Surgical operations		
Item	**Description**	**Fee**
	service to which any of items 31569 to 31581 apply (H) (Anaes.) (Assist.)	
30520	Gastric tumour, removal of, by local excision, other than a service to which item 30518 applies (H) (Anaes.) (Assist.)	$675.35
30521	Gastrectomy, total, for benign disease (H) (Anaes.) (Assist.)	$1 444.90
30523	Gastrectomy, sub-total radical, for carcinoma (including splenectomy when performed) (H) (Anaes.) (Assist.)	$1 510.10
30524	Gastrectomy, total radical, for carcinoma (including extended node dissection and distal pancreatectomy and splenectomy when performed) (H) (Anaes.) (Assist.)	$1 662.65
30526	Gastrectomy, total, and including lower oesophagus, performed by left thoraco-abdominal incision or opening of diaphragmatic hiatus (including splenectomy when performed) (H) (Anaes.) (Assist.)	$2 156.35
30527	Antireflux operation by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus—other than a service to which item 30601 applies (H) (Anaes.) (Assist.)	$871.30
30529	Antireflux operation by fundoplasty, with oesophagoplasty for stricture or short oesophagus (H) (Anaes.) (Assist.)	$1 306.90
30530	Antireflux operation by cardiopexy, with or without fundoplasty (H) (Anaes.) (Assist.)	$784.20
30532	Oesophagogastric myotomy (Heller's operation) via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (H) (Anaes.) (Assist.)	$900.45
30533	Oesophagogastric myotomy (Heller's operation) via abdominal or thoracic approach, with fundoplasty, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (H) (Anaes.) (Assist.)	$1 071.00
30535	Oesophagectomy with gastric reconstruction by abdominal mobilisation and thoracotomy (H) (Anaes.) (Assist.)	$1 696.65
30536	Oesophagectomy involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in	$1 720.90

Group T8—Surgical operations		
Item	**Description**	**Fee**
	the neck or chest—one surgeon (H) (Anaes.) (Assist.)	
30538	Oesophagectomy involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest—conjoint surgery, principal surgeon (including after-care) (H) (Anaes.) (Assist.)	$1 190.80
30539	Oesophagectomy involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest—conjoint surgery, co-surgeon (H) (Assist.)	$871.30
30541	Oesophagectomy, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement—one surgeon (H) (Anaes.) (Assist.)	$1 517.50
30542	Oesophagectomy, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement—conjoint surgery, principal surgeon (including after-care) (H) (Anaes.) (Assist.)	$1 031.10
30544	Oesophagectomy, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement—conjoint surgery, co-surgeon (H) (Assist.)	$755.20
30545	Oesophagectomy with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis)—one surgeon (H) (Anaes.) (Assist.)	$1 837.10
30547	Oesophagectomy with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis)—conjoint surgery, principal surgeon (including after-care) (Anaes.) (Assist.)	$1 263.35
30548	Oesophagectomy with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis)—conjoint surgery, co-surgeon (Assist.)	$943.80
30550	Oesophagectomy with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck)—one surgeon (H) (Anaes.) (Assist.)	$2 062.20
30551	Oesophagectomy with colon or jejunal replacement	$1 423.15

Group T8—Surgical operations		
Item	**Description**	**Fee**
	(abdominal and thoracic mobilisation with anastomosis of pedicle in the neck)—conjoint surgery, principal surgeon (including after-care) (H) (Anaes.) (Assist.)	
30553	Oesophagectomy with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck)—conjoint surgery, co-surgeon (Assist.)	$1 052.65
30554	Oesophagectomy with reconstruction by free jejunal graft—one surgeon (H) (Anaes.) (Assist.)	$2 294.45
30556	Oesophagectomy with reconstruction by free jejunal graft—conjoint surgery, principal surgeon (including after-care) (H) (Anaes.) (Assist.)	$1 582.80
30557	Oesophagectomy with reconstruction by free jejunal graft—conjoint surgery, co-surgeon (H) (Assist.)	$1 169.00
30559	Oesophagus, local excision for tumour of (Anaes.) (Assist.)	$849.55
30560	Oesophageal perforation, repair of, by thoracotomy (H) (Anaes.) (Assist.)	$943.80
30562	Enterosomy or colostomy, closure of—not involving resection of bowel (H) (Anaes.) (Assist.)	$595.00
30563	Colostomy or ileostomy, refashioning of (Anaes.) (Assist.)	$595.00
30564	Small bowel strictureplasty for chronic inflammatory bowel disease (H) (Anaes.) (Assist.)	$772.30
30565	Small intestine, resection of, without anastomosis (including formation of stoma) (H) (Anaes.) (Assist.)	$871.30
30566	Small intestine, resection of, with anastomosis (H) (Anaes.) (Assist.)	$967.85
30568	Intraoperative enterotomy for visualisation of the small intestine by endoscopy (H) (Anaes.) (Assist.)	$726.05
30569	Endoscopic examination of small bowel with flexible endoscope passed at laparotomy, with or without biopsies (H) (Anaes.) (Assist.)	$370.20
30571	Appendicectomy, other than a service to which item 30574 applies (H) (Anaes.) (Assist.)	$445.40

Group T8—Surgical operations		
Item	**Description**	**Fee**
30572	Laparoscopic appendicectomy (H) (Anaes.) (Assist.)	$445.40
30574	Appendicectomy, when performed in conjunction with another intra-abdominal procedure through the same incision (H) (Anaes.)	$123.25
30575	Pancreatic abscess, laparotomy and external drainage of, not requiring retro-pancreatic dissection (H) (Anaes.) (Assist.)	$512.70
30577	Pancreatic necrosectomy for pancreatic necrosis or abscess formation requiring major pancreatic or retro-pancreatic dissection, excluding after-care (H) (Anaes.) (Assist.)	$1 089.15
30578	Endocrine tumour, exploration of pancreas or duodenum, followed by local excision of pancreatic tumour (H) (Anaes.) (Assist.)	$1 147.20
30580	Endocrine tumour, exploration of pancreas or duodenum, followed by local excision of duodenal tumour (H) (Anaes.) (Assist.)	$1 045.40
30581	Endocrine tumour, exploration of pancreas or duodenum for, but no tumour found (H) (Anaes.) (Assist.)	$762.35
30583	Distal pancreatectomy (H) (Anaes.) (Assist.)	$1 194.25
30584	Pancreatico-duodenectomy, Whipple's operation, with or without preservation of pylorus (H) (Anaes.) (Assist.)	$1 762.75
30586	Pancreatic cyst-anastomosis to stomach or duodenum—by open or endoscopic means (H) (Anaes.) (Assist.)	$701.30
30587	Pancreatic cyst, anastomosis to Roux loop of jejunum (H) (Anaes.) (Assist.)	$726.05
30589	Pancreatico-jejunostomy for pancreatitis or trauma (H) (Anaes.) (Assist.)	$1 251.10
30590	Pancreatico-jejunostomy following previous pancreatic surgery (H) (Anaes.) (Assist.)	$1 379.50
30593	Pancreatectomy, near total or total (including duodenum), with or without splenectomy (Anaes.) (Assist.)	$1 887.75
30594	Pancreatectomy for pancreatitis following previously attempted drainage procedure or partial resection (H) (Anaes.) (Assist.)	$2 178.25

Group T8—Surgical operations		
Item	**Description**	**Fee**
30596	Splenorrhaphy or partial splenectomy (H) (Anaes.) (Assist.)	$897.30
30597	Splenectomy (H) (Anaes.) (Assist.)	$720.20
30599	Splenectomy, for massive spleen (weighing more than 1 500 gms) or involving thoraco-abdominal incision (H) (Anaes.) (Assist.)	$1 306.90
30600	Diaphragmatic hernia, traumatic, repair of (H) (Anaes.) (Assist.)	$777.10
30601	Diaphragmatic hernia, congenital, repair of, by thoracic or abdominal approach, not being a service to which any of items 31569 to 31581 apply (H) (Anaes.) (Assist.)	$957.30
30602	Portal hypertension, porto-caval shunt for (H) (Anaes.) (Assist.)	$1 553.70
30603	Portal hypertension, meso-caval shunt for (Anaes.) (Assist.)	$1 640.90
30605	Portal hypertension, selective spleno-renal shunt for (H) (Anaes.) (Assist.)	$1 865.95
30606	Portal hypertension, oesophageal transection via stapler or oversew of gastric varices with or without devascularisation (H) (Anaes.) (Assist.)	$1 110.80
30609	Femoral or inguinal hernia, laparoscopic repair of, other than a service associated with a service to which item 30612 or 30614 applies (H) (Anaes.) (Assist.)	$464.50
30612	Femoral or inguinal hernia or infantile hydrocele, repair of, other than a service to which item 30403 or 30615 applies (G) (H) (Anaes.) (Assist.)	$356.35
30614	Femoral or inguinal hernia or infantile hydrocele, repair of, other than a service to which item 30403 or 30615 applies (S) (H) (Anaes.) (Assist.)	$464.50
30615	Strangulated, incarcerated or obstructed hernia, repair of, without bowel resection (H) (Anaes.) (Assist.)	$521.25
30616	Umbilical, epigastric or linea alba hernia, repair of, in a person under 10 years of age (G) (H) (Anaes.)	$265.30
30617	Umbilical, epigastric or linea alba hernia, repair of, in a	$356.35

Group T8—Surgical operations		
Item	**Description**	**Fee**
	person under 10 years of age (S) (H) (Anaes.)	
30620	Umbilical, epigastric or linea alba hernia, repair of, in a person 10 years of age or over (G) (H) (Anaes.) (Assist.)	$299.45
30621	Umbilical, epigastric or linea alba hernia, repair of, in a person 10 years of age or over (S) (H) (Anaes.) (Assist.)	$407.50
30628	Hydrocele, tapping of	$35.60
30631	Hydrocele, removal of, other than a service associated with a service to which items 30638, 30641 and 30644 apply (Anaes.)	$236.65
30634	Varicocele, surgical correction of, other than a service associated with a service to which items 30638, 30641 and 30644 apply—one procedure (G) (H) (Anaes.) (Assist.)	$235.05
30635	Varicocele, surgical correction of, other than a service associated with a service to which items 30638, 30641 and 30644 apply—one procedure (S) (H) (Anaes.) (Assist.)	$291.80
30638	Orchidectomy, simple or subcapsular, unilateral with or without insertion of testicular prosthesis (G) (H) (Anaes.) (Assist.)	$299.45
30641	Orchidectomy, simple or subcapsular, unilateral with or without insertion of testicular prosthesis (S) (H) (Anaes.) (Assist.)	$407.50
30644	Exploration of spermatic cord, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis (H) (Anaes.) (Assist.)	$521.25
30653	Circumcision of the penis, on a person under 6 months of age (Anaes.)	$46.50
30656	Circumcision of the penis, on a person under 10 years of age but not less than 6 months of age (Anaes.)	$108.15
30659	Circumcision of the penis, on a person 10 years of age or over (G) (Anaes.)	$149.75
30660	Circumcision of the penis, on a person 10 years of age or over (S) (Anaes.)	$185.60
30663	Haemorrhage, arrest of, following circumcision requiring general anaesthesia (Anaes.)	$144.35

Group T8—Surgical operations		
Item	**Description**	**Fee**
30666	Paraphimosis, reduction of, under general anaesthesia, with or without dorsal incision, other than a service associated with a service to which another item in this Group applies (Anaes.)	$47.45
30672	Coccyx, excision of (H) (Anaes.) (Assist.)	$445.40
30675	Pilonidal sinus or cyst, or sacral sinus or cyst, excision of (G) (Anaes.)	$299.45
30676	Pilonidal sinus or cyst, or sacral sinus or cyst, excision of (S) (Anaes.)	$379.05
30679	Pilonidal sinus, injection of sclerosant fluid under anaesthesia (Anaes.)	$96.30
30680	Double balloon enteroscopy, examination of the small bowel (oral approach), with or without biopsy, without intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding if the patient: (a) has recurrent or persistent bleeding; and (b) is anaemic or has active bleeding; and (c) has had an upper gastrointestinal endoscopy and a colonoscopy performed that did not identify the cause of the bleeding; not in association with another item in this Subgroup (other than item 30682 or 30686) (Anaes.)	$1 170.00
30682	Double balloon enteroscopy, examination of the small bowel (anal approach), with or without biopsy, without intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding if the patient: (a) has recurrent or persistent bleeding; and (b) is anaemic or has active bleeding; and (c) has had an upper gastrointestinal endoscopy and a colonoscopy performed that did not identify the cause of the bleeding; not in association with another item in this Subgroup (other than item 30680 or 30684) (Anaes.)	$1 170.00
30684	Double balloon enteroscopy, examination of the small	$1 439.85

Group T8—Surgical operations		
Item	**Description**	**Fee**
	bowel (oral approach), with or without biopsy, with one or more of the following procedures—snare polypectomy, removal of foreign body, diathermy, heater probe or laser coagulation, for diagnosis and management of patients with obscure gastrointestinal bleeding if the patient: (a) has recurrent or persistent bleeding; and (b) is anaemic or has active bleeding; and (c) has had an upper gastrointestinal endoscopy and a colonoscopy performed that did not identify the cause of the bleeding; not in association with another item in this Subgroup (other than item 30682 or 30686) (Anaes.)	
30686	Double balloon enteroscopy, examination of the small bowel (anal approach), with or without biopsy, with one or more of the following procedures—snare polypectomy, removal of foreign body, diathermy, heater probe or laser coagulation, for diagnosis and management of patients with obscure gastrointestinal bleeding if the patient: (a) has recurrent or persistent bleeding; and (b) is anaemic or has active bleeding; and (c) has had an upper gastrointestinal endoscopy and a colonoscopy performed that did not identify the cause of the bleeding; not in association with another item in this Subgroup (other than item 30680 or 30684) (Anaes.)	$1 439.85
30687	Endoscopy with radiofrequency ablation of mucosal metaplasia for the treatment of Barrett's Oesophagus in a single course of treatment, following diagnosis of high grade dysplasia confirmed by histological examination (Anaes.)	$476.10
30688	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the staging of one or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup and other than a service associated with the routine monitoring of chronic pancreatitis (Anaes.)	$364.90

Group T8—Surgical operations		
Item	**Description**	**Fee**
30690	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, with fine needle aspiration (including aspiration of the locoregional lymph nodes if performed, for the staging of one or more of oesophageal, gastric or pancreatic cancer), not in association with another item in this Subgroup and other than a service associated with the routine monitoring of chronic pancreatitis (Anaes.)	$563.30
30692	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the diagnosis of one or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup and other than a service associated with the routine monitoring of chronic pancreatitis (Anaes.)	$364.90
30694	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, with fine needle aspiration for the diagnosis of one or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup and other than a service associated with the routine monitoring of chronic pancreatitis (Anaes.)	$563.30
30696	Endoscopic ultrasound guided fine needle aspiration biopsy or biopsies (endoscopy with ultrasound imaging) to obtain one or more specimens from either: (a) mediastinal masses; or (b) locoregional nodes to stage non-small cell lung carcinoma; other than a service associated with another item in this Subgroup or to which items 30710, 55054 apply (Anaes.)	$563.30
30710	Endobronchial ultrasound guided biopsy or biopsies (bronchoscopy with ultrasound imaging, with or without associated fluoroscopic imaging) to obtain one or more specimens by: (a) transbronchial biopsy or biopsies of peripheral lung lesions; or (b) fine needle aspirations of one or more mediastinal	$563.30

Group T8—Surgical operations		
Item	**Description**	**Fee**
	masses; or (c) fine needle aspirations of locoregional nodes to stage non-small cell lung carcinoma; other than a service associated with another item in this Subgroup or to which items 30696, 41892, 41898, or 60500 to 60509 applies (Anaes.)	
31000	Micrographically controlled serial excision of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure—6 or fewer sections (Anaes.)	$580.90
31001	Micrographically controlled serial excision of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure—7 to 12 sections (inclusive) (Anaes.)	$726.05
31002	Micrographically controlled serial excision of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure—13 or more sections (Anaes.)	$871.30
31200	Tumour (other than viral verrucae (common warts) and seborrheic keratoses), cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane, other than a service: (a) associated with a service to which item 45200, 45203 or 45206 applies; or (b) to which another item in this Group applies	$34.00
31205	Tumour (other than viral verrucae (common warts) and seborrheic keratoses), cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if: (a) the lesion size is not more than 10 mm in diameter; and (b) the removal is from cutaneous tissue, subcutaneous	$95.45

Group T8—Surgical operations		
Item	**Description**	**Fee**
	tissue or mucous membrane by surgical excision (other than by shave excision); and (c) the specimen excised is sent for histological examination; including the excision of a specimen to confirm a malignant tumour covered by any of items 31300 to 31335 (other than a service to which item 30195 applies) (Anaes.)	
31210	Tumour (other than viral verrucae (common warts) and seborrheic keratoses), cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if: (a) the lesion size is more than 10 mm but not more than 20 mm in diameter; and (b) the removal is from cutaneous tissue, subcutaneous tissue or mucous membrane by surgical excision (other than by shave excision); and (c) the specimen excised is sent for histological examination; including the excision of a specimen to confirm a malignant tumour covered by any of items 31300 to 31335 (other than a service to which item 30195 applies) (Anaes.)	$123.10
31215	Tumour (other than viral verrucae (common warts) and seborrheic keratoses), cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if: (a) the lesion size is more than 20 mm in diameter; and (b) the removal is from cutaneous tissue, subcutaneous tissue or mucous membrane by surgical excision (other than by shave excision); and (c) the specimen excised is sent for histological examination; including the excision of a specimen to confirm a malignant tumour covered by any of items 31300 to 31335 (other than a service to which item 30195 applies) (Anaes.)	$143.55
31220	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts, ulcers or scars (other than	$214.55

Group T8—Surgical operations		
Item	**Description**	**Fee**
	scars removed during the surgical approach at an operation), removal of 4 up to 10 lesions and suture, if: (a) the size of each lesion is not more 10 mm in diameter; and (b) each removal is from cutaneous tissue, subcutaneous tissue or mucous membrane by surgical excision (other than by shave excision); and (c) all of the specimens excised are sent for histological examination; including excisions to confirm a malignant tumour covered by any of items 31300 to 31335 (other than a service to which item 30195 applies) (Anaes.)	
31225	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of more than 10 lesions and suture, if: (a) the size of each lesion is not more than 10 mm in diameter; and (b) each removal is from cutaneous tissue, subcutaneous tissue or mucous membrane by surgical excision (other than by shave excision); and (c) all of the specimens excised are sent for histological examination; including excisions to confirm a malignant tumour covered by any of items 31300 to 31335 (other than a service to which item 30195 applies) (Anaes.)	$381.30
31230	Tumour (other than viral verrucae (common warts) and seborrheic keratoses), cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal by surgical excision (other than by shave excision) and suture from nose, eyelid, lip, ear, digit or genitalia, including excision to establish the diagnosis of tumours covered by items 31300 to 31335—if the specimen excised is sent for histological examination (other than a service to which item 30195 applies) (Anaes.)	$168.05
31235	Tumour (other than viral verrucae (common warts) and	$143.55

Group T8—Surgical operations		
Item	**Description**	**Fee**
	seborrheic keratoses), cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if: (a) the lesion size is not more than 10 mm in diameter; and (b) the removal is from the face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle) by surgical excision (other than by shave excision); and (c) the specimen excised is sent for histological examination; including the excision of a specimen to confirm a malignant tumour covered by any of items 31300 to 31335 (other than a service to which item 30195 applies) (Anaes.)	
31240	Tumour (other than viral verrucae (common warts) and seborrheic keratoses), cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal by surgical excision (other than by shave excision) and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), including excision to establish the diagnosis of tumours covered by items 31300 to 31335, lesion size more than 10 mm in diameter—if the specimen excised is sent for histological examination (other than a service to which item 30195 applies) (Anaes.)	$168.05
31245	Skin and subcutaneous tissue, extensive excision of, in the treatment of suppurative hydradenitis (excision from axilla, groin or natal cleft) or sycosis barbae or nuchae (excision from face or neck) (Anaes.)	$369.00
31250	Giant hairy or compound naevus, excision of an area at least 1% of body surface—if the specimen excised is sent for histological confirmation of diagnosis (Anaes.)	$369.00
31255	Basal cell carcinoma or squamous cell carcinoma (including keratocanthoma), removal of, from nose, eyelid, lip, ear, digit or genitalia, if: (a) the carcinoma is not more than 10 mm in diameter; and (b) the removal is by therapeutic surgical excision (other than shave excision) and suture; and	$221.35

Group T8—Surgical operations		
Item	**Description**	**Fee**
	(c) the initial specimen removed is sent for histological examination and malignancy is confirmed (Anaes.)	
31256	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from nose, eyelid, lip, ear, digit or genitalia, following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the previous carcinoma was not more than 10 mm in diameter; and (b) the removal is performed by the practitioner who removed the previous carcinoma; and (c) the removal is by surgical excision (other than shave excision) and suture; and (d) the specimen excised is sent for histological examination (Anaes.)	$221.35
31257	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from nose, eyelid, lip, ear, digit or genitalia, following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the previous carcinoma was not more than 10 mm in diameter; and (b) the removal is performed by a practitioner other than the practitioner who removed the previous carcinoma; and (c) the removal is by surgical excision (other than shave excision) and suture; and (d) the specimen excised is sent for histological examination (Anaes.)	$221.35
31258	Basal cell carcinoma or squamous cell carcinoma, recurrent, removal of, from nose, eyelid, lip, ear, digit or genitalia, following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the carcinoma is not more than 10 mm in diameter; and	$221.35

Group T8—Surgical operations		
Item	**Description**	**Fee**
	(b) the removal is by surgical excision (other than shave excision) and suture; and (c) the specimen excised is sent for histological examination and malignancy is confirmed; other than a service to which item 31295 applies (Anaes.)	
31260	Basal cell carcinoma or squamous cell carcinoma (including keratocanthoma), removal of, from nose, eyelid, lip, ear, digit or genitalia, if: (a) the carcinoma is more than 10 mm in diameter; and (b) the removal is by therapeutic surgical excision (other than shave excision) and suture; and (c) the initial specimen removed is sent for histological examination and malignancy is confirmed (Anaes.)	$315.65
31261	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from nose, eyelid, lip, ear, digit or genitalia, following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the previous carcinoma was more than 10 mm in diameter; and (b) the removal is performed by the practitioner who removed the previous carcinoma; and (c) the removal is by surgical excision (other than shave excision) and suture; and (d) the specimen excised is sent for histological examination (Anaes.)	$315.65
31262	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from nose, eyelid, lip, ear, digit or genitalia, following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the previous carcinoma was more than 10 mm in diameter; and (b) the removal is performed by a practitioner other than the practitioner who removed the previous carcinoma;	$315.65

Group T8—Surgical operations		
Item	**Description**	**Fee**
	and (c) the removal is by surgical excision (other than shave excision) and suture; and (d) the specimen excised is sent for histological examination (Anaes.)	
31263	Basal cell carcinoma or squamous cell carcinoma, recurrent, removal of, from nose, eyelid, lip, ear, digit or genitalia, following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the carcinoma is more than 10 mm in diameter; and (b) the removal is by surgical excision (other than shave excision) and suture; and (c) the specimen excised is sent for histological examination and malignancy is confirmed; other than a service to which item 31295 applies (Anaes.)	$315.65
31265	Basal cell carcinoma or squamous cell carcinoma (including keratocanthoma), removal of, from the face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), if: (a) the carcinoma is not more than 10 mm in diameter; and (b) the removal is by therapeutic surgical excision (other than shave excision) and suture; and (c) the initial specimen removed is sent for histological examination and malignancy is confirmed (Anaes.)	$184.50
31266	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the previous carcinoma was not more than 10 mm in diameter; and (b) the removal is performed by the practitioner who removed the previous carcinoma; and	$184.50

Group T8—Surgical operations		
Item	**Description**	**Fee**
	(c) the removal is by surgical excision (other than shave excision) and suture; and (d) the specimen excised is sent for histological examination (Anaes.)	
31267	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the previous carcinoma was not more than 10 mm in diameter; and (b) the removal is performed by a practitioner other than the practitioner who removed the previous carcinoma; and (c) the removal is by surgical excision (other than shave excision) and suture; and (d) the specimen excised is sent for histological examination (Anaes.)	$184.50
31268	Basal cell carcinoma or squamous cell carcinoma, recurrent, removal of, from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the carcinoma is not more than 10 mm in diameter; and (b) the removal is by surgical excision (other than shave excision) and suture; and (c) the specimen excised is sent for histological examination and malignancy is confirmed; other than a service to which item 31295 applies (Anaes.)	$184.50
31270	Basal cell carcinoma or squamous cell carcinoma (including keratocanthoma), removal of, from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), if:	$258.25

Group T8—Surgical operations		
Item	**Description**	**Fee**
	(a) the carcinoma is more than 10 mm and not more than 20 mm in diameter; and (b) the removal is by therapeutic surgical excision (other than shave excision) and suture; and (c) the initial specimen removed is sent for histological examination and malignancy is confirmed (Anaes.)	
31271	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the previous carcinoma was more than 10 mm and not more than 20 mm in diameter; and (b) the removal is performed by the practitioner who removed the previous carcinoma; and (c) the removal is by surgical excision (other than shave excision) and suture; and (d) the specimen excised is sent for histological examination (Anaes.)	$258.25
31272	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the previous carcinoma was more than 10 mm and not more than 20 mm in diameter; and (b) the removal is performed by a practitioner other than the practitioner who removed the previous carcinoma; and (c) the removal is by surgical excision (other than shave excision) and suture; and (d) the specimen excised is sent for histological examination (Anaes.)	$258.25

Group T8—Surgical operations		
Item	**Description**	**Fee**
31273	Basal cell carcinoma or squamous cell carcinoma, recurrent, removal of, from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the carcinoma is more than 10 mm and not more than 20 mm in diameter; and (b) the removal is by surgical excision (other than shave excision) and suture; and (c) the specimen excised is sent for histological examination and malignancy is confirmed; other than a service to which item 31295 applies (Anaes.)	$258.25
31275	Basal cell carcinoma or squamous cell carcinoma (including keratocanthoma), removal of, from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), if: (a) the carcinoma is more than 20 mm in diameter; and (b) the removal is by therapeutic surgical excision (other than shave excision) and suture; and (c) the initial specimen removed is sent for histological examination and malignancy is confirmed (Anaes.)	$299.25
31276	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the previous carcinoma was more than 20 mm in diameter; and (b) the removal is performed by the practitioner who removed the previous carcinoma; and (c) the removal is by surgical excision (other than shave excision) and suture; and (d) the specimen excised is sent for histological examination	$299.25

Group T8—Surgical operations		
Item	**Description**	**Fee**
	(Anaes.)	
31277	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the previous carcinoma was more than 20 mm in diameter; and (b) the removal is performed by a practitioner other than the practitioner who removed the previous carcinoma; and (c) the removal is by surgical excision (other than shave excision) and suture; and (d) the specimen excised is sent for histological examination (Anaes.)	$299.25
31278	Basal cell carcinoma or squamous cell carcinoma, recurrent, removal of, from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the carcinoma is more than 20 mm in diameter; and (b) the removal is by surgical excision (other than shave excision) and suture; and (c) the specimen excised is sent for histological examination and malignancy is confirmed; other than a service to which item 31295 applies (Anaes.)	$299.25
31280	Basal cell carcinoma or squamous cell carcinoma (including keratocanthoma), removal of, from an area of the body not covered by item 31255 or 31265, if: (a) the carcinoma is not more than 10 mm in diameter; and (b) the removal is by therapeutic surgical excision (other than shave excision) and suture; and (c) the initial specimen removed is sent for histological examination and malignancy is confirmed	$155.85

Group T8—Surgical operations		
Item	**Description**	**Fee**
	(Anaes.)	
31281	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from an area of the body not covered by item 31255 or 31265, following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the previous carcinoma was not more than 10 mm in diameter; and (b) the removal is performed by the practitioner who removed the previous carcinoma; and (c) the removal is by surgical excision (other than shave excision) and suture; and (d) the specimen excised is sent for histological examination (Anaes.)	$156.40
31282	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from an area of the body not covered by item 31255 or 31265, following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the previous carcinoma was not more than 10 mm in diameter; and (b) the removal is performed by a practitioner other than the practitioner who removed the previous carcinoma; and (c) the removal is by surgical excision (other than shave excision) and suture; and (d) the specimen excised is sent for histological examination (Anaes.)	$156.40
31283	Basal cell carcinoma or squamous cell carcinoma, recurrent, removal of, from an area of the body not covered by item 31255 or 31265, following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if:	$156.40

Group T8—Surgical operations		
Item	**Description**	**Fee**
	(a) the carcinoma is not more than 10 mm in diameter; and (b) the removal is by surgical excision (other than shave excision) and suture; and (c) the specimen excised is sent for histological examination and malignancy is confirmed (Anaes.)	
31285	Basal cell carcinoma or squamous cell carcinoma (including keratocanthoma), removal of, from an area of the body not covered by item 31260 or 31270, if: (a) the carcinoma is more than 10 mm and not more than 20 mm in diameter; and (b) the removal is by therapeutic surgical excision (other than by shave excision) and suture; and (c) the initial specimen removed is sent for histological examination and malignancy is confirmed (Anaes.)	$212.95
31286	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from an area of the body not covered by item 31260 or 31270, following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the previous carcinoma was more than 10 mm and not more than 20 mm in diameter; and (b) the removal is performed by the practitioner who removed the previous carcinoma; and (c) the removal is by surgical excision (other than shave excision) and suture; and (d) the specimen excised is sent for histological examination (Anaes.)	$212.95
31287	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from an area of the body not covered by item 31260 or 31270, following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if:	$212.95

Group T8—Surgical operations		
Item	**Description**	**Fee**
	(a) the previous carcinoma was more than 10 mm and not more than 20 mm in diameter; and (b) the removal is performed by a practitioner other than the practitioner who removed the previous carcinoma; and (c) the removal is by surgical excision (other than shave excision) and suture; and (d) the specimen excised is sent for histological examination (Anaes.)	
31288	Basal cell carcinoma or squamous cell carcinoma, recurrent, removal of, from an area of the body not covered by item 31260 or 31270, following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the carcinoma is more than 10 mm and not more than 20 mm in diameter; and (b) the removal is by surgical excision (other than shave excision) and suture; and (c) the specimen excised is sent for histological examination and malignancy is confirmed (Anaes.)	$212.95
31290	Basal cell carcinoma or squamous cell carcinoma (including keratocanthoma), removal of, from an area of the body not covered by item 31260 or 31275, if: (a) the carcinoma is more than 20 mm in diameter; and (b) the removal is by therapeutic surgical excision (other than shave excision) and suture; and (c) the initial specimen removed is sent for histological examination and malignancy is confirmed (Anaes.)	$245.90
31291	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from an area of the body not covered by item 31260 or 31275, following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that	$245.90

Group T8—Surgical operations		
Item	**Description**	**Fee**
	site, if: (a) the previous carcinoma was more than 20 mm in diameter; and (b) the removal is performed by the practitioner who removed the previous carcinoma; and (c) the removal is by surgical excision (other than shave excision) and suture; and (d) the specimen excised is sent for histological examination (Anaes.)	
31292	Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from an area of the body not covered by item 31260 or 31275, following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the previous carcinoma was more than 20 mm in diameter; and (b) the removal is performed by a practitioner other than the practitioner who removed the previous carcinoma; and (c) the removal is by surgical excision (other than shave excision) and suture; and (d) the specimen excised is sent for histological examination (Anaes.)	$245.90
31293	Basal cell carcinoma or squamous cell carcinoma, recurrent, removal of, from an area of the body not covered by item 31260 or 31275, following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the carcinoma is more than 20 mm in diameter; and (b) the removal is by surgical excision (other than shave excision) and suture; and (c) the specimen excised is sent for histological examination and malignancy is confirmed (Anaes.)	$245.90

Group T8—Surgical operations

Item	Description	Fee
31295	Basal cell carcinoma or squamous cell carcinoma, recurrent, removal of, from the head or neck (anterior to the sternomastoid muscles), following the removal of a previous basal cell carcinoma or squamous cell carcinoma at that site, if: (a) the previous carcinoma was treated by previous surgery, serial cautery and curettage, radiotherapy or 2 prolonged freeze and thaw cycles of liquid nitrogen therapy; and (b) the removal is performed by: (i) a specialist in the practice of his or her specialty; or (ii) a practitioner other than the practitioner who removed the previous carcinoma; and (c) the removal is by surgical excision and suture; and (d) the specimen excised is sent for histological examination and malignancy is confirmed (Anaes.)	$292.85
31300	Malignant melanoma, appendageal carcinoma, malignant fibrous tumour of skin, merkel cell carcinoma of skin or Hutchinson's melanotic freckle, removal of, from nose, eyelid, lip, ear, digit or genitalia, and suture, if: (a) the tumour size is not more than 10 mm in diameter; and (b) the removal is by definitive surgical excision (with an adequate margin and as a result, no further surgery is indicated at the site of excision); and (c) the specimen excised is sent for histological examination and malignancy is confirmed (Anaes.)	$319.90
31305	Malignant melanoma, appendageal carcinoma, malignant fibrous tumour of skin, merkel cell carcinoma of skin or Hutchinson's melanotic freckle-removal from nose, eyelid, lip, ear, digit or genitalia, tumour size more than 10 mm in diameter, and suture, if: (a) removal is by definitive surgical excision (with an	$393.50

Group T8—Surgical operations		
Item	**Description**	**Fee**
	adequate margin and as a result, no further surgery is indicated at the site of excision); and (b) the specimen excised is sent for histological examination and confirmation of malignancy has been obtained (Anaes.)	
31310	Malignant melanoma, appendageal carcinoma, malignant fibrous tumour of skin, merkel cell carcinoma of skin or Hutchinson's melanotic freckle, removal of, from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle), and suture, if: (a) the tumour size is not more than 10 mm in diameter; and (b) the removal is by definitive surgical excision (with an adequate margin and as a result, no further surgery is indicated at the site of excision); and (c) the specimen excised is sent for histological examination and malignancy is confirmed (Anaes.)	$278.65
31315	Malignant melanoma, appendageal carcinoma, malignant fibrous tumour of skin, merkel cell carcinoma of skin or Hutchinson's melanotic freckle, removal of, from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle), and suture, if: (a) the tumour size is more than 10 mm but not more than 20 mm in diameter; and (b) the removal is by definitive surgical excision (with an adequate margin and as a result, no further surgery is indicated at the site of excision); and (c) the specimen excised is sent for histological examination and malignancy is confirmed (Anaes.)	$352.50
31320	Malignant melanoma, appendageal carcinoma, malignant fibrous tumour of skin, merkel cell carcinoma of skin or Hutchinson's melanotic freckle, removal of, from face, neck (anterior to sternomastoid muscles) or lower leg (mid	$393.50

Group T8—Surgical operations		
Item	**Description**	**Fee**
	calf to ankle), and suture, if: (a) the tumour size is more than 20 mm in diameter; and (b) the removal is by definitive surgical excision (with an adequate margin and as a result, no further surgery is indicated at the site of excision); and (c) the specimen excised is sent for histological examination and malignancy is confirmed (Anaes.)	
31325	Malignant melanoma, appendageal carcinoma, malignant fibrous tumour of skin, merkel cell carcinoma of skin or Hutchinson's melanotic freckle, removal of, from an area of the body not covered by items 31300 and 31310, and suture, if: (a) the tumour size is not more than 10 mm in diameter; and (b) the removal is by definitive surgical excision (with an adequate margin and as a result, no further surgery is indicated at the site of excision); and (c) the specimen excised is sent for histological examination and malignancy is confirmed (Anaes.)	$270.55
31330	Malignant melanoma, appendageal carcinoma, malignant fibrous tumour of skin, merkel cell carcinoma of skin or Hutchinson's melanotic freckle, removal of, from an area of the body not covered by items 31305 and 31310, and suture, if: (a) the tumour size is more than 10 mm but not more than 20 mm in diameter; and (b) the removal is by definitive surgical excision (with an adequate margin and as a result, no further surgery is indicated at the site of excision); and (c) the specimen excised is sent for histological examination and malignancy is confirmed (Anaes.)	$319.90
31335	Malignant melanoma, appendageal carcinoma, malignant	$369.00

Group T8—Surgical operations		
Item	**Description**	**Fee**
	fibrous tumour of skin, merkel cell carcinoma of skin or Hutchinson's melanotic freckle-removal from areas of the body not covered by items 31305 and 31320, and suture, if: (a) the tumour size more than 20 mm in diameter; and (b) removal is by definitive surgical excision (with an adequate margin and as a result, no further surgery is indicated at the site of excision); and (c) the specimen excised is sent for histological examination and confirmation of malignancy has been obtained (Anaes.)	
31340	Muscle, bone or cartilage, excision of one or more of, if clinically indicated, and if: (a) the specimen excised is sent for histological confirmation; and (b) a malignant tumour of skin covered by any of items 31255 to 31335 is excised (Anaes.)	Amount under clause 2.44.5
31345	Lipoma, removal of, by surgical excision or liposuction, if: (a) the lesion is: (i) subcutaneous and 50 mm or more in diameter; or (ii) sub-fascial; and (b) the specimen excised is sent for histological confirmation of diagnosis (Anaes.)	$210.95
31346	Liposuction (suction assisted lipolysis) to one regional area for contour problems of abdominal, upper arm or thigh fat because of repeated insulin injections, if: (a) the lesion is subcutaneous; and (b) the lesion is 50 mm or more in diameter (Anaes.)	$210.95
31350	Benign tumour of soft tissue (other than tumours of skin, cartilage and bone, simple lipomas covered by item 31345 and lipomata), removal of, by surgical excision, if the	$433.35

Group T8—Surgical operations		
Item	**Description**	**Fee**
	specimen excised is sent for histological confirmation of diagnosis, other than a service to which another item in this Group applies (Anaes.) (Assist.)	
31355	Malignant tumour of soft tissue (other than tumours of skin or cartilage and bone), removal of, by surgical excision, if histological proof of malignancy is obtained, other than a service to which another item in this Group applies (Anaes.) (Assist.)	$714.45
31400	Malignant upper aerodigestive tract tumour (other than tumour of the lip), excision of, if: (a) the tumour is not more than 20 mm in diameter; and (b) histological confirmation of malignancy is obtained (Anaes.) (Assist.)	$261.05
31403	Malignant upper aerodigestive tract tumour (other than tumour of the lip), excision of, if: (a) the tumour is more than 20 mm but not more than 40 mm in diameter; and (b) histological confirmation of malignancy is obtained (H) (Anaes.) (Assist.)	$301.35
31406	Malignant upper aerodigestive tract tumour more than 40 mm in diameter (excluding tumour of the lip), excision of, if histological confirmation of malignancy has been obtained (Anaes.) (Assist.)	$502.15
31409	Parapharyngeal tumour, excision of, by cervical approach (H) (Anaes.) (Assist.)	$1 560.15
31412	Recurrent or persistent parapharyngeal tumour, excision of, by cervical approach (H) (Anaes.) (Assist.)	$1 921.75
31420	Lymph node of neck, biopsy of (Anaes.)	$183.90
31423	Lymph nodes of neck, selective dissection of one or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes.) (Assist.)	$401.75
31426	Lymph nodes of neck, selective dissection of 3 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (H) (Anaes.) (Assist.)	$803.45

Group T8—Surgical operations		
Item	**Description**	**Fee**
31429	Lymph nodes of neck, selective dissection of 4 lymph node levels on one side of the neck with preservation of one or more of internal jugular vein, sternocleido-mastoid muscle or spinal accessory nerve (H) (Anaes.) (Assist.)	$1 252.10
31432	Lymph nodes of neck, bilateral selective dissection of levels I, II and III (bilateral supraomohyoid dissections) (H) (Anaes.) (Assist.)	$1 339.15
31435	Lymph nodes of neck, comprehensive dissection of all 5 lymph node levels on one side of the neck (H) (Anaes.) (Assist.)	$984.30
31438	Lymph nodes of neck, comprehensive dissection of all 5 lymph node levels on one side of the neck with preservation of one or more of internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (H) (Anaes.) (Assist.)	$1 560.15
31450	Laparoscopic division of adhesions, as an independent procedure, if the time taken is 1 hour or less (H) (Anaes.) (Assist.)	$406.65
31452	Laparoscopic division of adhesions, as an independent procedure, if the time taken is more than 1 hour (H) (Anaes.) (Assist.)	$711.50
31454	Laparoscopy with drainage of pus, bile or blood, as an independent procedure (H) (Anaes.) (Assist.)	$563.30
31456	Gastroscopy and insertion of nasogastric or nasoenteral feeding tube, if blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition (H) (Anaes.)	$245.55
31458	Gastroscopy and insertion of nasogastric or nasoenteral feeding tube if: (a) blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition; and (b) the use of imaging intensification is clinically indicated (H) (Anaes.)	$294.65
31460	Percutaneous gastrostomy tube, jejunal extension to,	$357.00

Group T8—Surgical operations		
Item	**Description**	**Fee**
	including any associated imaging services (H) (Anaes.) (Assist.)	
31462	Operative feeding jejunostomy performed in conjunction with major upper gastro-intestinal resection (H) (Anaes.) (Assist.)	$521.25
31464	Antireflux operation by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopic technique—other than a service to which item 30601 applies (H) (Anaes.) (Assist.)	$871.30
31466	Antireflux operation by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, revision procedure, by laparoscopy or open operation (H) (Anaes.) (Assist.)	$1 306.95
31468	Para-oesophageal hiatus hernia, repair of, with complete reduction of hernia, resection of sac and repair of hiatus, with or without fundoplication (H) (Anaes.) (Assist.)	$1 435.85
31470	Laparoscopic splenectomy (H) (Anaes.) (Assist.)	$720.20
31472	Cholecystoduodenostomy, cholecystoenterostomy, choledochojejunostomy or Roux-en-y as a bypass procedure, if prior biliary surgery has been performed (H) (Anaes.) (Assist.)	$1 169.80
31500	Breast, benign lesion up to and including 50 mm in diameter, including simple cyst, fibroadenoma or fibrocystic disease, open surgical biopsy or excision of, with or without frozen section histology (Anaes.)	$260.05
31503	Breast, benign lesion more than 50 mm in diameter, excision of (Anaes.) (Assist.)	$346.75
31506	Breast, abnormality detected by mammography or ultrasound, if guidewire or other localisation procedure is performed, excision biopsy of (H) (Anaes.) (Assist.)	$390.10
31509	Breast, malignant tumour, open surgical biopsy of, with or without frozen section histology (Anaes.)	$346.75
31512	Breast, malignant tumour, complete local excision of, with or without frozen section histology (H) (Anaes.) (Assist.)	$650.15

Group T8—Surgical operations		
Item	**Description**	**Fee**
31515	Breast, tumour site, re-excision of, following open biopsy or incomplete excision of malignant tumour (H) (Anaes.) (Assist.)	$436.15
31518	Breast (female), total mastectomy (H) (Anaes.) (Assist.)	$736.30
31521	Breast (male), total mastectomy, other than a service associated with a service to which item 45585 applies (Anaes.) (Assist.)	$433.50
31524	Breast (female), subcutaneous mastectomy (H) (Anaes.) (Assist.)	$1 040.25
31527	Breast (male), subcutaneous mastectomy, with or without liposuction (suction assisted lipolysis), other than a service associated with a service to which item 45585 applies (Anaes.) (Assist.)	$520.20
31530	Breast, biopsy of solid tumour or tissue of, using a vacuum-assisted breast biopsy device under imaging guidance, for histological examination, if imaging has demonstrated: (a) microcalcification of lesion; or (b) impalpable lesion less than one cm in diameter; including pre-operative localisation of lesion, if performed, other than a service associated with a service to which item 31539, 31545 or 31548 applies	$595.65
31533	Fine needle aspiration of an impalpable breast lesion detected by mammography or ultrasound, imaging guided—but not including imaging (Anaes.)	$137.90
31536	Breast, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques, but not including imaging—other than a service associated with a service to which item 31539, 31542 or 31545 applies (Anaes.)	$189.40
31539	Breast, biopsy of solid tumour or tissue of, using advanced breast biopsy instrumentation (ABBI), for histological examination, conducted by a qualified surgeon, if imaging has demonstrated an impalpable lesion of less than 15 mm in diameter, other than a service associated with a service	$398.80

Group T8—Surgical operations		
Item	**Description**	**Fee**
	to which item 31530, 31536 or 31548 applies (H) (Anaes.)	
31542	Breast, initial guidewire localisation of lesion, by hookwire or similar device, conducted by a qualified radiologist, using interventional imaging techniques before advanced breast biopsy instrumentation (ABBI), including imaging—other than a service associated with a service to which item 31536 applies (Anaes.)	$196.95
31545	Breast, biopsy of solid tumour or tissue of, using advanced breast biopsy instrumentation (ABBI), for histological examination, conducted by a qualified surgeon, if imaging has demonstrated an impalpable lesion of less than 15 mm in diameter, including initial guidewire localisation of lesion, by hookwire or similar device, using interventional imaging techniques and including imaging—other than a service associated with a service to which item 31530, 31536 or 31548 applies (Anaes.)	$595.65
31548	Breast, biopsy of solid tumour or tissue of, using mechanical biopsy device, for histological examination, other than a service associated with a service to which item 31530, 31539 or 31545 applies (Anaes.)	$137.90
31551	Breast, haematoma, seroma or inflammatory condition including abscess, granulomatous mastitis or similar, exploration and drainage of, when performed in the operating theatre of a hospital, excluding after-care (Anaes.)	$216.75
31554	Breast, microdochotomy of, for benign or malignant condition (H) (Anaes.) (Assist.)	$433.50
31557	Breast central ducts, excision of, for benign condition (Anaes.) (Assist.)	$346.75
31560	Accessory breast tissue, excision of (Anaes.) (Assist.)	$346.75
31563	Inverted nipple, surgical eversion of (Anaes.)	$259.75
31566	Accessory nipple, excision of (Anaes.)	$129.95
31569	Adjustable gastric band, placement of, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (H) (Anaes.) (Assist.)	$849.55

Group T8—Surgical operations		
Item	**Description**	**Fee**
31572	Gastric bypass by Roux-en-Y including associated anastomoses, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity not being associated with a service to which item 30515 applies (H) (Anaes.) (Assist.)	$1 045.40
31575	Sleeve gastrectomy, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (H) (Anaes.) (Assist.)	$849.55
31578	Gastroplasty (excluding by gastric plication), with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (H) (Anaes.) (Assist.)	$849.55
31581	Gastric bypass by biliopancreatic diversion with or without duodenal switch including gastric restriction and anastomoses, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (H) (Anaes.) (Assist.)	$1 045.40
31584	Surgical reversal of adjustable gastric banding (removal or replacement of gastric band), gastric bypass, gastroplasty (excluding by gastric plication) or biliopancreatic diversion being services to which items 31569 to 31581 apply (H) (Anaes.) (Assist.)	$1 539.10
31587	Adjustment of gastric band as an independent procedure including any associated consultation	$97.95
31590	Adjustment of gastric band reservoir, repair, revision or replacement of (Anaes.) (Assist.)	$251.70

Subdivision C—Subgroups 2 and 3 of Group T8

2.44.13 Meaning of *foreign body* in items 35360 to 35363

For items 35360 to 35363, ***foreign body*** does not include an instrument inserted for the purpose of a service being rendered.

2.44.14 Application of items 32500 to 32517 and 35321

Items 32500 to 32517 and 35321 do not apply to the services mentioned in those items if the services are delivered by:

(a) endovenous laser treatment; or

(b) radiofrequency diathermy; or

(c) radiofrequency ablation for varicose veins.

2.44.15 Application of items 35404, 35406 and 35408

(1) Items 35404, 35406 and 35408 do not apply to selective internal radiation therapy provided in combination with systemic chemotherapy using any drugs other than 5 fluorouracil (5FU) and leucovorin.

(2) Item 35404 applies only to a service provided by a medical practitioner recognised as a specialist, or consultant physician, in the specialty of nuclear medicine or radiation oncology for the purposes of the Act.

2.44.15A Sacral nerve stimulation

Sacral nerve stimulation under items 32213 to 32218 for faecal incontinence is contraindicated in:

(a) patients under 18 years of age; and

(b) patients 18 years of age or older who:

(i) are medically unfit for surgery; or

(ii) are pregnant or planning pregnancy; or

(iii) have irritable bowel syndrome; or

(iv) have congenital anorectal malformations; or

(v) have active anal abscesses or fistulas; or

(vi) have anorectal organic bowel disease, including cancer; or

(vii) have functional effects of previous pelvic irradiation; or

(viii) have congenital or acquired malformations of the sacrum; or

(ix) have had rectal or anal surgery within the previous 12 months.

2.44.15B Artificial bowel sphincter

An artificial bowel sphincter under items 32220 and 32221 is contraindicated in:

(a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degenerative diseases or a scarred or fragile perineum; and

(b) patients who have had an adverse reaction to radiopaque solution; and

(c) patients who engage in receptive anal intercourse.

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
Subgroup 2—Colorectal		
32000	Large intestine, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (H) (Anaes.) (Assist.)	1 031.35
32003	Large intestine, resection of, with anastomosis, including right hemicolectomy (H) (Anaes.) (Assist.)	1 078.80
32004	Large intestine, sub-total colectomy (resection of right colon, transverse colon and splenic flexure) without anastomosis, other than a service associated with a service to which item 32000, 32003, 32005 or 32006 applies (H) (Anaes.) (Assist.)	1 150.35
32005	Large intestine, sub-total colectomy (resection of right colon, transverse colon and splenic flexure) with anastomosis, other than a service associated with a service to which item 32000, 32003, 32004 or 32006 applies (H) (Anaes.) (Assist.)	1 299.55
32006	Left hemicolectomy, including the descending and sigmoid colon (including formation of stoma) (H) (Anaes.) (Assist.)	1 150.35
32009	Total colectomy and ileostomy (H) (Anaes.) (Assist.)	1 364.60
32012	Total colectomy and ileo-rectal anastomosis (H) (Anaes.) (Assist.)	1 507.40
32015	Total colectomy with excision of rectum and ileostomy—one	1 852.50

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	surgeon (H) (Anaes.) (Assist.)	
32018	Total colectomy with excision of rectum and ileostomy, combined synchronous operation—abdominal resection (including after-care) (H) (Anaes.) (Assist.)	1 570.85
32021	Total colectomy with excision of rectum and ileostomy, combined synchronous operation—perineal resection (H) (Assist.)	563.30
32023	Endoscopic insertion of stent or stents for large bowel obstruction, stricture or stenosis, including colonoscopy and any image intensification, where the obstruction is due to: (a) a pre-diagnosed colorectal cancer, or cancer of an organ adjacent to the bowel; or (b) an unknown diagnosis (H) (Anaes.)	555.35
32024	Rectum, high restorative anterior resection with intraperitoneal anastomosis (of the rectum) greater than 10 cm from the anal verge—excluding resection of sigmoid colon alone, other than a service associated with a service to which item 32103, 32104 or 32106 applies (H) (Anaes.) (Assist.)	1 364.60
32025	Rectum, low restorative anterior resection with extraperitoneal anastomosis (of the rectum) less than 10 cm from the anal verge, with or without covering stoma, other than a service associated with a service to which item 32103, 32104 or 32106 applies (H) (Anaes.) (Assist.)	1 825.30
32026	Rectum, ultra low restorative resection, with or without covering stoma, if the anastomosis is sited in the anorectal region and is 6 cm or less from the anal verge (H) (Anaes.) (Assist.)	1 965.65
32028	Rectum, low or ultra low restorative resection, with peranal sutured coloanal anastomosis, with or without covering stoma (H) (Anaes.) (Assist.)	2 106.20
32029	Colonic reservoir, construction of, being a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	421.20
32030	Rectosigmoidectomy—(Hartmann's operation) (H) (Anaes.) (Assist.)	1 031.35

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
32033	Restoration of bowel following Hartmann's or similar operation, including dismantling of the stoma (H) (Anaes.) (Assist.)	1 507.40
32036	Sacrococcygeal and presacral tumour—excision of (H) (Anaes.) (Assist.)	1 911.80
32039	Rectum and anus, abdomino-perineal resection of—one surgeon (H) (Anaes.) (Assist.)	1 535.05
32042	Rectum and anus, abdomino-perineal resection of, combined synchronous operation, abdominal resection (H) (Anaes.) (Assist.)	1 293.15
32045	Rectum and anus, abdomino-perineal resection of, combined synchronous operation—perineal resection (H) (Assist.)	483.95
32046	Rectum and anus, abdomino-perineal resection of, combined synchronous operation—perineal resection if the perineal surgeon also provides assistance to the abdominal surgeon (H) (Assist.)	747.90
32047	Perineal proctectomy (H) (Anaes.) (Assist.)	871.30
32051	Total colectomy with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy—one surgeon (H) (Anaes.) (Assist.)	2 316.60
32054	Total colectomy with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy—conjoint surgery, abdominal surgeon (including after-care) (H) (Anaes.) (Assist.)	2 126.20
32057	Total colectomy with excision of rectum and ileoanal anastomosis with formation of ileal reservoir—conjoint surgery, perineal surgeon (H) (Assist.)	563.30
32060	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy—one surgeon (H) (Anaes.) (Assist.)	2 316.60
32063	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy—conjoint surgery,	2 126.20

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	abdominal surgeon (including after-care) (H) (Anaes.) (Assist.)	
32066	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy—conjoint surgery, perineal surgeon (H) (Assist.)	563.30
32069	Ileostomy reservoir, continent type, creation of, including conversion of existing ileostomy, if appropriate (H) (Anaes.)	1 713.65
32072	Sigmoidoscopic examination (with rigid sigmoidoscope), with or without biopsy	47.85
32075	Sigmoidoscopic examination (with rigid sigmoidoscope), under general anaesthesia, with or without biopsy, other than a service associated with a service to which another item in this Group applies (Anaes.)	75.05
32078	Sigmoidoscopic examination with diathermy or resection of one or more polyps, if the time taken is less than or equal to 45 minutes (Anaes.)	168.55
32081	Sigmoidoscopic examination with diathermy or resection of one or more polyps, if the time taken is greater than 45 minutes (Anaes.)	231.45
32084	Flexible fibreoptic sigmoidoscopy or fibreoptic colonoscopy up to the hepatic flexure, with or without biopsy (Anaes.)	111.35
32087	Endoscopic examination of the colon up to the hepatic flexure by flexible fibreoptic sigmoidoscopy or fibreoptic colonoscopy for the removal of one or more polyps or the treatment of radiation proctitis, angiodysplasia or post-polypectomy bleeding by argon plasma coagulation, one or more of—other than a service to which item 32078 applies (Anaes.)	204.70
32090	Fibreoptic colonoscopy—examination of colon beyond the hepatic flexure with or without biopsy (Anaes.)	334.35
32093	Endoscopic examination of the colon beyond the hepatic flexure by fibreoptic colonoscopy for the removal of one or more polyps, or the treatment of radiation proctitis, angiodysplasia or post-polypectomy bleeding by argon plasma	469.20

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	coagulation, one or more of (Anaes.)	
32094	Endoscopic dilatation of colorectal strictures including colonoscopy (H) (Anaes.)	551.85
32095	Endoscopic examination of small bowel with flexible endoscope passed by stoma, with or without biopsies (Anaes.)	127.80
32096	Rectal biopsy, full thickness, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block (H) (Anaes.) (Assist.)	256.95
32099	Rectal tumour of 5 cm or less in diameter, per anal submucosal excision of (H) (Anaes.) (Assist.)	333.20
32102	Rectal tumour of greater than 5 cm in diameter, indicated by pathological examination, per anal submucosal excision of (H) (Anaes.) (Assist.)	634.70
32103	Rectal tumour of less than 4 cm in diameter, per anal excision of, using rectoscopy incorporating either 2 dimensional or 3 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy or by local excision, other than a service associated with a service to which item 32024, 32025, 32104 or 32106 applies (H) (Anaes.) (Assist.)	772.30
32104	Rectal tumour of 4 cm or greater in diameter, per anal excision of, using rectoscopy incorporating either 2 dimensional or 3 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy or by local excision, other than a service associated with a service to which item 32024, 32025, 32103 or 32106 applies (H) (Anaes.) (Assist.)	999.65
32105	Anorectal carcinoma—per anal full thickness excision of (Anaes.) (Assist.)	483.95
32106	Anterolateral intraperitoneal rectal tumour, per anal excision of, using rectoscopy incorporating either 2 dimensional or 3 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy and if removal requires dissection within the peritoneal cavity, other than a service associated with a service to which item 32024, 32025, 32103 or 32104 applies (Anaes.) (Assist.)	1 364.60
32108	Rectal tumour, trans-sphincteric excision of (Kraske or similar	999.65

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	operation) (H) (Anaes.) (Assist.)	
32111	Rectal prolapse, Delorme procedure for (H) (Anaes.) (Assist.)	634.70
32112	Rectal prolapse, perineal recto-sigmoidectomy for (H) (Anaes.) (Assist.)	772.30
32114	Rectal stricture, per anal release of (Anaes.)	174.45
32115	Rectal stricture, dilatation of (H) (Anaes.)	126.85
32117	Rectal prolapse, abdominal rectopexy of (H) (Anaes.) (Assist.)	999.65
32120	Rectal prolapse, perineal repair of (H) (Anaes.) (Assist.)	256.95
32123	Anal stricture, anoplasty for (Anaes.) (Assist.)	333.20
32126	Anal incontinence, Parks' intersphincteric procedure for (H) (Anaes.) (Assist.)	483.95
32129	Anal sphincter, direct repair of (H) (Anaes.) (Assist.)	634.70
32131	Rectocele, transanal repair of rectocele (H) (Anaes.) (Assist.)	533.60
32132	Haemorrhoids or rectal prolapse—sclerotherapy for (Anaes.)	45.10
32135	Haemorrhoids or rectal prolapse—rubber band ligation of, with or without sclerotherapy, cryotherapy or infrared therapy for (Anaes.)	67.50
32138	Haemorrhoidectomy including excision of anal skin tags when performed (Anaes.)	367.75
32139	Haemorrhoidectomy involving third or fourth degree haemorrhoids, including excision of anal skin tags when performed (H) (Anaes.) (Assist.)	367.75
32142	Anal skin tags or anal polyps, excision of one or more of (Anaes.)	67.50
32145	Anal skin tags or anal polyps, excision of one or more of, undertaken in the operating theatre of a hospital (Anaes.)	135.05
32147	Perianal thrombosis, incision of (Anaes.)	45.10
32150	Operation for fissure-in-ano, including excision or sphincterotomy but excluding dilatation only (Anaes.) (Assist.)	256.95
32153	Anus, dilatation of, under general anaesthesia, with or without disimpaction of faeces, other than a service associated with a service to which another item in this Group applies (H)	70.10

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	(Anaes.)	
32156	Fistula-in-ano, subcutaneous, excision of (Anaes.)	131.75
32159	Anal fistula, treatment of, by excision or by insertion of a Seton, or by a combination of both procedures, involving the lower half of the anal sphincter mechanism (H) (Anaes.) (Assist.)	333.20
32162	Anal fistula, treatment of, by excision or by insertion of a Seton, or by a combination of both procedures, involving the upper half of the anal sphincter mechanism (H) (Anaes.) (Assist.)	483.95
32165	Anal fistula, repair of by mucosal flap advancement (Anaes.) (Assist.)	634.70
32166	Anal fistula—readjustment of Seton (Anaes.)	206.20
32168	Fistula wound, review of, under general or regional anaesthetic, as an independent procedure (H) (Anaes.)	131.75
32171	Anorectal examination, with or without biopsy, under general anaesthetic, other than a service associated with a service to which another item in this Group applies (H) (Anaes.)	88.80
32174	Intra-anal, perianal or ischio-rectal abscess, drainage of (excluding after-care) (Anaes.)	88.80
32175	Intra-anal, perianal or ischio-rectal abscess, draining of, performed in the operating theatre of a hospital (excluding after-care) (H) (Anaes.)	162.65
32177	Anal warts, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block), if the time taken is less than or equal to 45 minutes—other than a service associated with a service to which item 35507 or 35508 applies (H) (Anaes.)	174.25
32180	Anal warts, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block), if the time taken is greater than 45 minutes—other than a service associated with a service to which item 35507 or 35508 applies (H) (Anaes.)	256.95
32183	Intestinal sling procedure before radiotherapy (H) (Anaes.) (Assist.)	561.65

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
32186	Colonic lavage, total, intra-operative (H) (Anaes.) (Assist.)	561.65
32200	Distal muscle, devascularisation of (Anaes.) (Assist.)	295.70
32203	Anal or perineal graciloplasty (H) (Anaes.) (Assist.)	635.00
32206	Stimulator and electrodes, insertion of, following previous graciloplasty (H) (Anaes.) (Assist.)	573.70
32209	Anal or perineal graciloplasty with insertion of stimulator and electrodes (H) (Anaes.) (Assist.)	921.95
32210	Gracilis neosphincter pacemaker, replacement of (Anaes.)	255.45
32212	Ano-rectal application of formalin in the treatment of radiation proctitis, if performed in the operating theatre of a hospital, excluding after-care (Anaes.)	136.25
32213	Sacral nerve lead or leads, percutaneous placement using fluoroscopic guidance (or open placement) and intraoperative test stimulation, to manage faecal incontinence in a patient who: (a) has an anatomically intact but functionally deficient anal sphincter; and (b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months	660.95
32214	Neurostimulator or receiver, subcutaneous placement of, involving placement and connection of an extension wire to a sacral nerve electrode using fluoroscopic guidance, to manage faecal incontinence in a patient who: (a) has an anatomically intact but functionally deficient anal sphincter; and (b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months	334.00
32215	Sacral nerve electrode or electrodes, management, adjustment and electronic programming of the neurostimulator by a medical practitioner, to manage faecal incontinence—each day	125.40
32216	Sacral nerve lead or leads, percutaneous surgical repositioning of, using fluoroscopic guidance (or open surgical repositioning of) and interoperative test stimulation, to correct	593.55

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	displacement or unsatisfactory positioning, if the lead was inserted to manage faecal incontinence in a patient who: (a) has an anatomically intact but functionally deficient anal sphincter; and (b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a service to which item 32213 applies (H) (Anaes.)	
32217	Neurostimulator or receiver, removal of, if the neurostimulator or receiver was inserted to manage faecal incontinence in a patient who: (a) has an anatomically intact but functionally deficient anal sphincter; and (b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months (H) (Anaes.)	156.30
32218	Sacral nerve lead or leads, removal of, if the lead was inserted to manage faecal incontinence in a patient who: (a) has an anatomically intact but functionally deficient anal sphincter; and (b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months (H) (Anaes.)	156.30
32220	Insertion of an artificial bowel sphincter for severe faecal incontinence in the treatment of a patient for whom conservative and other less invasive forms of treatment are contraindicated or have failed (Anaes.) (Assist.)	903.90
32221	Removal or revision of an artificial bowel sphincter (with or without replacement) for severe faecal incontinence in the treatment of a patient for whom conservative and other less invasive forms of treatment are contraindicated or have failed (Anaes.) (Assist.)	903.90
Subgroup 3—Vascular		
32500	Varicose veins if varicosity measures 2.5 mm or greater in diameter, multiple injections of sclerosant using continuous compression techniques, including associated consultation—	109.80

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	one or both legs—other than a service associated with another varicose vein operation on the same leg (excluding after-care)—to a maximum of 6 treatments in a 12 month period (Anaes.)	
32501	Varicose veins if varicosity measures 2.5 mm or greater in diameter, multiple injections of sclerosant using continuous compression techniques, including associated consultation—one or both legs—other than a service associated with another varicose vein operation on the same leg (excluding after-care)—if it can be demonstrated that truncal reflux in the long or short saphenous veins has been excluded by duplex examination and that a seventh or subsequent treatment (including any treatments to which item 32500 applies) is indicated in a 12 month period	109.80
32504	Varicose veins, multiple excision of tributaries, with or without division of one or more perforating veins—one leg—other than a service associated with a service to which item 32507, 32508, 32511, 32514 or 32517 applies in relation to the same leg (Anaes.)	267.65
32507	Varicose veins, sub-fascial surgical exploration of one or more incompetent perforating veins—one leg—other than a service associated with a service to which item 32508, 32511, 32514 or 32517 applies in relation to the same leg (Anaes.) (Assist.)	533.60
32508	Varicose veins, complete dissection at the sapheno-femoral junction or sapheno-popliteal junction—one leg—with or without either ligation or stripping, or both, of the long or short saphenous vein on the same leg, for the first time, including excision or injection of either tributaries or incompetent perforating veins, or both (H) (Anaes.) (Assist.)	533.60
32511	Varicose veins, complete dissection at the sapheno-femoral junction and sapheno-popliteal junction—one leg—with or without either ligation or stripping, or both, of the long or short saphenous vein on the same leg, for the first time, including excision or injection of either tributaries or incompetent perforating veins, or both (H) (Anaes.) (Assist.)	793.30
32514	Varicose veins, ligation of the long or short saphenous vein on the same leg, with or without stripping, by re-operation for	926.80

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	recurrent veins in the same territory—one leg—including excision or injection of either tributaries or incompetent perforating veins, or both (H) (Anaes.) (Assist.)	
32517	Varicose veins, ligation of the long and short saphenous veins on the same leg, with or without stripping, by re-operation for recurrent veins in either territory—one leg—including excision or injection of either tributaries or incompetent perforating veins, or both (H) (Anaes.) (Assist.)	1 193.40
32520	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) or small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a laser probe introduced by an endovenous catheter, where it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer, including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) but not including radiofrequency diathermy or radiofrequency ablation, and not provided on the same occasion as a service described in any of items 32500, 32501, 32504 and 32507 (Anaes.)	533.60
32522	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) and small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a laser probe introduced by an endovenous catheter, where it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer, including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) but not including radiofrequency diathermy or radiofrequency ablation, and not provided on the same occasion as a service described in any of items 32500, 32501, 32504 and 32507 (Anaes.)	793.30
32523	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) or small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a radiofrequency catheter introduced by an	533.60

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	endovenous catheter, where it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer, including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both), but not including endovenous laser therapy, and not provided on the same occasion as a service described in any of items 32500, 32501, 32504 and 32507 (Anaes.)	
32526	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) and small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a radiofrequency catheter introduced by an endovenous catheter, where it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer, including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both), but not including endovenous laser therapy, and not provided on the same occasion as a service described in any of items 32500, 32501, 32504 and 32507 (Anaes.)	793.30
32700	Artery of neck, bypass using vein or synthetic material (H) (Anaes.) (Assist.)	1 436.30
32703	Internal carotid artery, transection and reanastomosis of, or resection of small length and reanastomosis of—with or without endarterectomy (H) (Assist.)	1 188.20
32708	Aortic bypass for occlusive disease using a straight non-bifurcated graft (H) (Anaes.) (Assist.)	1 421.35
32710	Aortic bypass for occlusive disease using a bifurcated graft with one or both anastomoses to the iliac arteries (H) (Anaes.) (Assist.)	1 579.30
32711	Aortic bypass for occlusive disease using a bifurcated graft with one or both anastomoses to the common femoral or profunda femoris arteries (H) (Anaes.) (Assist.)	1 737.25
32712	Ilio-femoral bypass grafting (H) (Anaes.) (Assist.)	1 255.80

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
32715	Axillary or subclavian to femoral bypass grafting to one or both femoral arteries (H) (Anaes.) (Assist.)	1 255.80
32718	Femoro-femoral or ilio-femoral cross-over bypass grafting (H) (Anaes.) (Assist.)	1 188.20
32721	Renal artery, bypass grafting to (H) (Anaes.) (Assist.)	1 887.35
32724	Renal arteries (both), bypass grafting to (H) (Anaes.) (Assist.)	2 143.10
32730	Mesenteric vessel (single), bypass grafting to (H) (Anaes.) (Assist.)	1 624.30
32733	Mesenteric vessels (multiple), bypass grafting to (H) (Anaes.) (Assist.)	1 887.35
32736	Inferior mesenteric artery, operation on, when performed in conjunction with another intra-abdominal vascular operation (H) (Anaes.) (Assist.)	413.55
32739	Femoral artery bypass grafting using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with above knee anastomosis (H) (Anaes.) (Assist.)	1 293.40
32742	Femoral artery bypass grafting using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to below knee popliteal artery (H) (Anaes.) (Assist.)	1 481.50
32745	Femoral artery bypass grafting using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to tibio peroneal trunk or tibial or peroneal artery (H) (Anaes.) (Assist.)	1 691.95
32748	Femoral artery bypass grafting using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis within 5 cm of the ankle joint (H) (Anaes.) (Assist.)	1 834.80
32751	Femoral artery bypass grafting using synthetic graft, with lower anastomosis above or below the knee (H) (Anaes.) (Assist.)	1 188.20
32754	Femoral artery bypass grafting, using a composite graft (synthetic material and vein) with lower anastomosis above or below the knee, including use of a cuff or sleeve of vein at one or both anastomoses (H) (Anaes.) (Assist.)	1 481.50

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
32757	Femoral artery sequential bypass grafting (using a vein or synthetic material) if an additional anastomosis is made to separately revascularise more than one artery—each additional artery revascularised beyond a femoral bypass (H) (Anaes.) (Assist.)	413.55
32760	Vein, harvesting of, from leg or arm for bypass or replacement graft when not performed on the limb which is the subject of the bypass or graft—each vein (H) (Anaes.) (Assist.)	406.05
32763	Arterial bypass grafting, using vein or synthetic material, other than a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	1 188.20
32766	Arterial or venous anastomosis, other than a service to which another item in this Subgroup applies, as an independent procedure (H) (Anaes.) (Assist.)	789.65
32769	Arterial or venous anastomosis other than a service to which another item in this Subgroup applies, when performed in combination with another vascular operation (including graft to graft anastomosis) (H) (Anaes.) (Assist.)	273.65
33050	Bypass grafting to replace a popliteal aneurysm using vein, including harvesting vein (when it is the ipsilateral long saphenous vein) (H) (Anaes.) (Assist.)	1 455.30
33055	Bypass grafting to replace a popliteal aneurysm using a synthetic graft (H) (Anaes.) (Assist.)	1 167.05
33070	Aneurysm in the extremities, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)	842.00
33075	Aneurysm in the neck, ligation, suture closure or excision of, without bypass grafting (H) (Anaes.) (Assist.)	1 071.05
33080	Intra-abdominal or pelvic aneurysm, ligation, suture closure or excision of, without bypass grafting (H) (Anaes.) (Assist.)	1 307.45
33100	Aneurysm of common or internal carotid artery, or both, replacement by graft of vein or synthetic material (Anaes.) (Assist.)	1 436.30
33103	Thoracic aneurysm, replacement by graft (H) (Anaes.) (Assist.)	2 015.30
33109	Thoraco-abdominal aneurysm, replacement by graft including	2 436.50

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	re-implantation of arteries (Anaes.) (Assist.)	
33112	Suprarenal abdominal aortic aneurysm, replacement by graft including re-implantation of arteries (H) (Anaes.) (Assist.)	2 113.10
33115	Infrarenal abdominal aortic aneurysm, replacement by tube graft other than a service associated with a service to which item 33116 applies (H) (Anaes.) (Assist.)	1 421.35
33116	Infrarenal abdominal aortic aneurysm[repair], replacement by tube graft using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.)	1 399.00
33118	Infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to iliac arteries (with or without excision of common iliac aneurysms) other than a service associated with a service to which item 33119 applies (H) (Anaes.) (Assist.)	1 579.30
33119	Infrarenal abdominal aortic aneurysm [repair], replacement by bifurcation graft to one or both iliac arteries using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.)	1 554.55
33121	Infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to one or both femoral arteries (with or without excision or bypass of common iliac aneurysms) (H) (Anaes.) (Assist.)	1 737.25
33124	Aneurysm of iliac artery (common, external or internal), replacement by graft—unilateral (H) (Anaes.) (Assist.)	1 210.80
33127	Aneurysms of iliac arteries (common, external or internal), replacement by graft—bilateral (Anaes.) (Assist.)	1 586.75
33130	Aneurysm of visceral artery, excision and repair by direct anastomosis or replacement by graft (H) (Anaes.) (Assist.)	1 383.65
33133	Aneurysm of visceral artery, dissection and ligation of arteries without restoration of continuity (H) (Anaes.) (Assist.)	1 037.65
33136	False aneurysm, repair of, at aortic anastomosis following previous aortic surgery (H) (Anaes.) (Assist.)	2 616.75
33139	False aneurysm, repair of, in iliac artery and restoration of arterial continuity (H) (Anaes.) (Assist.)	1 586.75
33142	False aneurysm, repair of, in femoral artery and restoration of arterial continuity (Anaes.) (Assist.)	1 481.50

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
33145	Ruptured thoracic aortic aneurysm, replacement by graft (H) (Anaes.) (Assist.)	2 549.20
33148	Ruptured thoraco-abdominal aortic aneurysm, replacement by graft (H) (Anaes.) (Assist.)	3 165.80
33151	Ruptured suprarenal abdominal aortic aneurysm, replacement by graft (H) (Anaes.) (Assist.)	3 007.90
33154	Ruptured infrarenal abdominal aortic aneurysm, replacement by tube graft (H) (Anaes.) (Assist.)	2 225.90
33157	Ruptured infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to iliac arteries (with or without excision or bypass of common iliac aneurysms) (H) (Anaes.) (Assist.)	2 481.50
33160	Ruptured infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to one or both femoral arteries (H) (Anaes.) (Assist.)	2 481.50
33163	Ruptured iliac artery aneurysm, replacement by graft (H) (Anaes.) (Assist.)	2 105.70
33166	Ruptured aneurysm of visceral artery, replacement by anastomosis or graft (Anaes.) (Assist.)	2 105.70
33169	Ruptured aneurysm of visceral artery, simple ligation of (H) (Anaes.) (Assist.)	1 639.35
33172	Aneurysm of major artery, replacement by graft, other than a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	1 278.35
33175	Ruptured aneurysm in the extremities, ligation, suture closure or excision of, without bypass grafting (H) (Anaes.) (Assist.)	1 178.10
33178	Ruptured aneurysm in the neck, ligation, suture closure or excision of, without bypass grafting (H) (Anaes.) (Assist.)	1 498.20
33181	Ruptured intra-abdominal or pelvic aneurysm, ligation, suture closure or excision of, without bypass grafting (H) (Anaes.) (Assist.)	1 831.70
33500	Artery or arteries of neck, endarterectomy of, including closure by suture (if endarterectomy of one or more arteries is undertaken through one arteriotomy incision) (H) (Anaes.) (Assist.)	1 135.40

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
33506	Innominate or subclavian artery, endarterectomy of, including closure by suture (H) (Anaes.) (Assist.)	1 270.90
33509	Aortic endarterectomy, including closure by suture, other than a service associated with another procedure on the aorta (H) (Anaes.) (Assist.)	1 421.35
33512	Aorto-iliac endarterectomy (one or both iliac arteries), including closure by suture other than a service associated with a service to which item 33515 applies (H) (Anaes.) (Assist.)	1 579.30
33515	Aorto-femoral endarterectomy (one or both femoral arteries) or bilateral ilio-femoral endarterectomy, including closure by suture, other than a service associated with a service to which item 33512 applies (H) (Anaes.) (Assist.)	1 737.25
33518	Iliac endarterectomy, including closure by suture, other than a service associated with another procedure on the iliac artery (Anaes.) (Assist.)	1 270.90
33521	Ilio-femoral endarterectomy (one side), including closure by suture (H) (Anaes.) (Assist.)	1 376.10
33524	Renal artery, endarterectomy of (H) (Anaes.) (Assist.)	1 624.30
33527	Renal arteries (both), endarterectomy of (H) (Anaes.) (Assist.)	1 887.35
33530	Coeliac or superior mesenteric artery, endarterectomy of (H) (Anaes.) (Assist.)	1 624.30
33533	Coeliac and superior mesenteric artery, endarterectomy of (H) (Anaes.) (Assist.)	1 887.35
33536	Inferior mesenteric artery, endarterectomy of, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	1 346.10
33539	Artery of extremities, endarterectomy of, including closure by suture (H) (Anaes.) (Assist.)	970.05
33542	Extended deep femoral endarterectomy, if the endarterectomy is at least 7 cm long (H) (Anaes.) (Assist.)	1 383.65
33545	Artery, vein or bypass graft, patch grafting to by vein or synthetic material if patch is less than 3 cm long (H) (Anaes.) (Assist.)	273.65

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
33548	Artery, vein or bypass graft, patch grafting to by vein or synthetic material if patch is 3 cm long or greater (H) (Anaes.) (Assist.)	556.60
33551	Vein, harvesting of from leg or arm for patch when not performed through same incision as operation (H) (Anaes.) (Assist.)	273.65
33554	Endarterectomy, in conjunction with an arterial bypass operation to prepare the site for anastomosis—each site (H) (Anaes.) (Assist.)	272.40
33800	Embolus, removal of, from artery of neck (Anaes.) (Assist.)	1 180.60
33803	Embolectomy or thrombectomy, by abdominal approach, of an artery or bypass graft of trunk (H) (Anaes.) (Assist.)	1 128.05
33806	Embolectomy or thrombectomy (including the infusion of thrombolytic or other agents) from an artery or bypass graft of extremities, or embolectomy of abdominal artery via the femoral artery, item to be claimed once per extremity, regardless of the number of incisions required to access the artery or bypass graft (Anaes.) (Assist.)	812.15
33810	Inferior vena cava or iliac vein, closed thrombectomy by catheter via the femoral vein (Anaes.) (Assist.)	592.45
33811	Inferior vena cava or iliac vein, open removal of thrombus or tumour (H) (Anaes.) (Assist.)	1 763.80
33812	Thrombus, removal of, from femoral or other similar large vein (Anaes.) (Assist.)	932.45
33815	Major artery or vein of extremity, repair of wound of, with restoration of continuity, by lateral suture (H) (Anaes.) (Assist.)	857.30
33818	Major artery or vein of extremity, repair of wound of, with restoration of continuity, by direct anastomosis (H) (Anaes.) (Assist.)	1 000.15
33821	Major artery or vein of extremity, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (H) (Anaes.) (Assist.)	1 143.00
33824	Major artery or vein of neck, repair of wound of, with restoration of continuity, by lateral suture (H) (Anaes.)	1 090.35

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	(Assist.)	
33827	Major artery or vein of neck, repair of wound of, with restoration of continuity, by direct anastomosis (H) (Anaes.) (Assist.)	1 278.35
33830	Major artery or vein of neck, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (H) (Anaes.) (Assist.)	1 466.30
33833	Major artery or vein of abdomen, repair of wound of, with restoration of continuity by lateral suture (H) (Anaes.) (Assist.)	1 331.15
33836	Major artery or vein of abdomen, repair of wound of, with restoration of continuity by direct anastomosis (H) (Anaes.) (Assist.)	1 586.75
33839	Major artery or vein of abdomen, repair of wound of, with restoration of continuity by means of interposition graft (H) (Anaes.) (Assist.)	1 857.40
33842	Artery of neck, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (H) (Anaes.) (Assist.)	917.40
33845	Laparotomy for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, if no other procedure is performed (H) (Anaes.) (Assist.)	639.20
33848	Extremity, re-operation on, for control of bleeding or thrombosis after vascular procedure, if no other procedure is performed (H) (Anaes.) (Assist.)	639.20
34100	Major artery of neck, elective ligation or exploration of, other than a service associated with another vascular procedure (H) (Anaes.) (Assist.)	707.00
34103	Great artery or great vein (including subclavian, axillary, iliac, femoral or popliteal), ligation of, or exploration of, other than a service associated with another vascular procedure except those services to which item 32508, 32511, 32514 or 32517 applies (H) (Anaes.) (Assist.)	413.55
34106	Artery or vein (including brachial, radial, ulnar or tibial), ligation of, by elective operation, or exploration of, other than a service associated with another vascular procedure except	291.70

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	those services to which item 32508, 32511, 32514 or 32517 applies (Anaes.) (Assist.)	
34109	Temporal artery, biopsy of (Anaes.) (Assist.)	338.35
34112	Arterio-venous fistula of an extremity, dissection and ligation (H) (Anaes.) (Assist.)	857.30
34115	Arterio-venous fistula of the neck, dissection and ligation (H) (Anaes.) (Assist.)	970.05
34118	Arterio-venous fistula of the abdomen, dissection and ligation (Anaes.) (Assist.)	1 383.65
34121	Arterio-venous fistula of an extremity, dissection and repair of, with restoration of continuity (H) (Anaes.) (Assist.)	1 105.35
34124	Arterio-venous fistula of the neck, dissection and repair of, with restoration of continuity (H) (Anaes.) (Assist.)	1 210.80
34127	Arterio-venous fistula of the abdomen, dissection and repair of, with restoration of continuity (H) (Anaes.) (Assist.)	1 586.75
34130	Surgically created arterio-venous fistula of an extremity, closure of (Anaes.) (Assist.)	496.30
34133	Scalenotomy (H) (Anaes.) (Assist.)	556.60
34136	First rib, resection of portion of (H) (Anaes.) (Assist.)	894.75
34139	Cervical rib, removal of, or other operation for removal of thoracic outlet compression, other than a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	894.75
34142	Coeliac artery, decompression of, for coeliac artery compression syndrome, as an independent procedure (H) (Anaes.) (Assist.)	1 105.35
34145	Popliteal artery, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (H) (Anaes.) (Assist.)	804.65
34148	Carotid associated tumour, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is 4 cm or less in maximum diameter (H) (Anaes.) (Assist.)	1 436.30
34151	Carotid associated tumour, resection of, with or without repair or reconstruction of internal or common carotid arteries, when	1 962.65

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	tumour is greater than 4 cm in maximum diameter (H) (Anaes.) (Assist.)	
34154	Recurrent carotid associated tumour, resection of, with or without repair or replacement of portion of internal or common carotid arteries (Anaes.) (Assist.)	2 338.75
34157	Neck, excision of infected bypass graft, including closure of vessel or vessels (H) (Anaes.) (Assist.)	1 188.20
34160	Aorto-duodenal fistula, repair of, by suture of aorta and repair of duodenum (H) (Anaes.) (Assist.)	2 225.90
34163	Aorto-duodenal fistula, repair of, by insertion of aortic graft and repair of duodenum (H) (Anaes.) (Assist.)	2 857.55
34166	Aorto-duodenal fistula, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo bifemoral grafting (H) (Anaes.) (Assist.)	2 857.55
34169	Infected bypass graft from trunk, excision of, including closure of arteries (H) (Anaes.) (Assist.)	1 586.75
34172	Infected axillo-femoral or femoro-femoral graft, excision of, including closure of arteries (H) (Anaes.) (Assist.)	1 293.40
34175	Infected bypass graft from extremities, excision of including closure of arteries (H) (Anaes.) (Assist.)	1 188.20
34500	Arteriovenous shunt, external, insertion of (Anaes.) (Assist.)	308.40
34503	Arteriovenous anastomosis of upper or lower limb, in conjunction with another venous or arterial operation (H) (Anaes.) (Assist.)	413.55
34506	Arteriovenous shunt, external, removal of (H) (Anaes.) (Assist.)	210.45
34509	Arteriovenous anastomosis of upper or lower limb, not in conjunction with another venous or arterial operation (H) (Anaes.) (Assist.)	977.55
34512	Arteriovenous access device, insertion of (H) (Anaes.) (Assist.)	1 075.40
34515	Arteriovenous access device, thrombectomy of (H) (Anaes.) (Assist.)	767.00
34518	Stenosis of arteriovenous fistula or prosthetic arteriovenous	1 285.75

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	access device, correction of (H) (Anaes.) (Assist.)	
34521	Intra-abdominal artery or vein, cannulation of, for infusion chemotherapy, by open operation (excluding after-care) (H) (Anaes.) (Assist.)	789.95
34524	Arterial cannulation for infusion chemotherapy by open operation, other than a service to which item 34521 applies (excluding after-care) (H) (Anaes.) (Assist.)	413.55
34527	Central vein catheterisation by open technique, using subcutaneous tunnel with pump or access port as with Hickman or Broviac catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterisation (Anaes.)	551.60
34528	Central vein catheterisation by percutaneous technique, using subcutaneous tunnel with pump or access port as with Hickman or Broviac catheter or other chemotherapy delivery device (Anaes.)	272.40
34530	Hickman or Broviac catheter, or other chemotherapy device, removal of, by open surgical procedure in the operating theatre of a hospital (Anaes.)	204.25
34533	Isolated limb perfusion, including cannulation of artery and vein at commencement of procedure, regional perfusion for chemotherapy, or other therapy, repair of arteriotomy and venotomy at conclusion of procedure (excluding after-care) (Anaes.) (Assist.)	1 240.65
34538	Central vein catheterisation by percutaneous technique, using subcutaneous tunnelled cuffed catheter or similar device, for the administration of haemodialysis or parenteral nutrition (Anaes.)	272.40
34539	Tunnelled cuffed catheter, or similar device, removal of, by open surgical procedure in the operating theatre of a hospital (Anaes.)	204.25
34800	Inferior vena cava, plication, ligation, or application of caval clip (Anaes.) (Assist.)	812.15
34803	Inferior vena cava, reconstruction of or bypass by vein or synthetic material (H) (Anaes.) (Assist.)	1 789.85

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
34806	Cross leg bypass grafting, saphenous to iliac or femoral vein (H) (Anaes.) (Assist.)	970.05
34809	Saphenous vein anastomosis to femoral or popliteal vein for femoral vein bypass (H) (Anaes.) (Assist.)	970.05
34812	Venous stenosis or occlusion, vein bypass for, using vein or synthetic material, other than a service associated with a service to which item 34806 or 34809 applies (H) (Anaes.) (Assist.)	1 173.05
34815	Vein stenosis, patch angioplasty for, (excluding vein graft stenosis)—using vein or synthetic material (H) (Anaes.) (Assist.)	970.05
34818	Venous valve, plication or repair to restore valve competency (H) (Anaes.) (Assist.)	1 067.80
34821	Vein transplant to restore valvular function (Anaes.) (Assist.)	1 451.45
34824	External stent, application of, to restore venous valve competency to superficial vein—one stent (H) (Anaes.) (Assist.)	496.30
34827	External stents, application of, to restore venous valve competency to superficial vein or veins—more than one stent (H) (Anaes.) (Assist.)	601.65
34830	External stent, application of, to restore venous valve competency to deep vein—one stent (Anaes.) (Assist.)	707.00
34833	External stents, application of, to restore venous valve competency to deep vein or veins—more than one stent (H) (Anaes.) (Assist.)	917.40
35000	Lumbar sympathectomy (Anaes.) (Assist.)	707.00
35003	Cervical or upper thoracic sympathectomy by any surgical approach (H) (Anaes.) (Assist.)	917.40
35006	Cervical or upper thoracic sympathectomy, if operation is a re-operation for previous incomplete sympathectomy by any surgical approach (H) (Anaes.) (Assist.)	1 150.55
35009	Lumbar sympathectomy, if operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (H) (Anaes.) (Assist.)	894.75

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
35012	Sacral or pre-sacral sympathectomy (H) (Anaes.) (Assist.)	707.00
35100	Ischaemic limb, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, when debridement includes muscle, tendon or bone (H) (Anaes.) (Assist.)	368.55
35103	Ischaemic limb, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (Anaes.)	234.55
35200	Operative arteriography or venography, one or more of, performed during the course of an operative procedure on an artery or vein—one site (H) (Anaes.)	171.50
35202	Major arteries or veins in the neck, abdomen or extremities, access to, as part of re-operation after prior surgery on these vessels (H) (Anaes.) (Assist.)	817.10
35300	Transluminal balloon angioplasty of one peripheral artery or vein of one limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding after-care (Anaes.) (Assist.)	515.35
35303	Transluminal balloon angioplasty of aortic arch branches, aortic visceral branches, or more than one peripheral artery or vein of one limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding after-care (Anaes.) (Assist.)	660.80
35306	Transluminal stent insertion including associated balloon dilatation for one peripheral artery or vein of one limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding after-care (Anaes.) (Assist.)	609.90

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
35307	Transluminal stent insertion, one or more stents (not drug-eluting), with or without associated balloon dilatation, for one carotid artery, percutaneous (not direct), with or without an embolic protection device, for a patient who: (a) meets the requirements for carotid endarterectomy; and (b) has medical or surgical comorbidities that cause the patient to be at high risk of perioperative complications from carotid endarterectomy; excluding associated radiological services, radiological preparation and after-care (H) (Anaes.) (Assist.)	1 121.15
35309	Transluminal stent insertion including associated balloon dilatation for visceral arteries or veins, or more than one peripheral artery or vein of one limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding after-care (Anaes.) (Assist.)	762.35
35312	Peripheral arterial atherectomy including associated balloon dilatation of one limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding after-care (H) (Anaes.) (Assist.)	864.05
35315	Peripheral laser angioplasty including associated balloon dilatation of one limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding after-care (H) (Anaes.) (Assist.)	864.05
35317	Peripheral arterial or venous catheterisation with administration of thrombolytic or chemotherapeutic agents, by continuous infusion, using percutaneous approach, excluding associated radiological services or preparation, and excluding after-care (other than a service associated with a service to which an item in Subgroup11 of Group T1 or item 35319 or 35320 applies, or associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.)	355.80
35319	Peripheral arterial or venous catheterisation with administration of thrombolytic or chemotherapeutic agents, by pulse spray technique, using percutaneous approach, excluding associated radiological services or preparation, and excluding after-care (other than a service associated with a	637.80

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	service to which an item in Subgroup 11 of Group T1 or item 35317 or 35320 applies, or associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.)	
35320	Peripheral arterial or venous catheterisation with administration of thrombolytic or chemotherapeutic agents, by open exposure, excluding associated radiological services or preparation, and excluding after-care (other than a service associated with a service to which an item in Subgroup 11 of Group T1 or item 35317 or 35319 applies, or associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.)	856.70
35321	Peripheral arterial or venous catheterisation to administer agents to occlude arteries, veins or arterio-venous fistulae or to arrest haemorrhage (but not for the treatment of uterine fibroids or varicose veins), percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding after-care (other than a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.)	813.30
35324	Angioscopy not combined with another procedure, excluding associated radiological services or preparation, and excluding after-care (H) (Anaes.) (Assist.)	304.95
35327	Angioscopy combined with another procedure, excluding associated radiological services or preparation, and excluding after-care (H) (Anaes.) (Assist.)	408.70
35330	Insertion of inferior vena caval filter, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding after-care (Anaes.) (Assist.)	515.35
35331	Retrieval of inferior vena caval filter, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (H) (Anaes.)	592.45
35360	Retrieval of foreign body in pulmonary artery, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (H) (Anaes.) (Assist.)	828.20
35361	Retrieval of foreign body in right atrium, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (H) (Anaes.)	710.30

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	(Assist.)	
35362	Retrieval of foreign body in inferior vena cava or aorta, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (H) (Anaes.) (Assist.)	592.45
35363	Retrieval of foreign body in peripheral vein or peripheral artery, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (H) (Anaes.) (Assist.)	474.65
35404	Dosimetry, handling and injection of sir-spheres for selective internal radiation therapy of hepatic metastases that are secondary to colorectal cancer and not suitable for resection or ablation (other than a service to which item 35317, 35319, 35320 or 35321 applies)—for any particular patient, payable once only (H) (Anaes.) (Assist.)	346.60
35406	Trans-femoral catheterisation of the hepatic artery to administer sir-spheres, for selective internal radiation therapy, to embolise the microvasculature of hepatic metastases, that are secondary to colorectal cancer and not suitable for resection or ablation (other than a service to which item 35317, 35319, 35320 or 35321 applies) (H) (Anaes.) (Assist.)	813.30
35408	Catheterisation of the hepatic artery via a permanently implanted hepatic artery port to administer sir-spheres, for selective internal radiation therapy, to embolise the microvasculature of hepatic metastases, that are secondary to colorectal cancer and not suitable for resection or ablation (other than a service to which item 35317, 35319, 35320 or 35321 applies) (H) (Anaes.) (Assist.)	610.10
35410	Uterine artery catheterisation with percutaneous administration of occlusive agents, for the treatment of symptomatic uterine fibroids in a patient who has been referred for uterine artery embolisation by a specialist gynaecologist, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)	813.30
35412	Intracranial aneurysm, ruptured or unruptured, endovascular occlusion with detachable coils, and assisted coiling (if	2 857.55

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	performed), with parent artery preservation, not for use with liquid embolics only, including intra-operative imaging, but in association with pre-operative diagnostic imaging under item 60009, 60072, 60075 or 60078, including aftercare (Anaes.) (Assist.)	

Subdivision D—Subgroups 4, 5 and 6 of Group T8

2.44.16 Application of items 38365, 38368 and 38654

A service described in item 38365, 38368 or 38654 applies to a patient only if:

(a) the patient:

(i) has moderate to severe chronic heart failure (New York Heart Association (NYHA) class III or IV) despite optimised medical therapy; and

(ii) has sinus rhythm; and

(iii) has a left ventricular ejection fraction of 35% or less; and

(iv) has a QRS duration of 120 milliseconds or more; or

(b) the patient satisfied the requirements mentioned in paragraph (a) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricular electrode.

2.44.17 Application of items 38470 to 38766

Items 38470 to 38766 must be performed using open exposure or minimally invasive surgery which excludes percutaneous and transcatheter techniques unless otherwise stated in the item.

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
Subgroup 4—Gynaecological		
35500	Gynaecological examination under anaesthesia, other than a service associated with a service to which another item in this Group applies (Anaes.)	81.30
35502	Intra-uterine contraceptive device, introduction of, for the control of idiopathic menorrhagia, including endometrial biopsy to exclude endometrial pathology, other than a service associated with a service to which another item in this Group applies (Anaes.)	80.15
35503	Intra-uterine contraceptive device, introduction of, other than a service associated with a service to which another item in this Group applies (Anaes.)	53.55
35506	Intra-uterine contraceptive device, removal of under general anaesthesia, other than a service associated with a service to which another item in this Group applies (Anaes.)	53.70
35507	Vulval or vaginal warts, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block), if the time taken is less than or equal to 45 minutes—other than a service associated with a service to which item 32177 or 32180 applies (H) (Anaes.)	174.45
35508	Vulval or vaginal warts, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block), if the time taken is greater than 45 minutes—other than a service associated with a service to which item 32177 or 32180 applies (H) (Anaes.) (Assist.)	256.95
35509	Hymenectomy (Anaes.)	89.45
35512	Bartholin's cyst, excision of (G) (Anaes.)	179.40
35513	Bartholin's cyst, excision of (S) (Anaes.)	221.70
35516	Bartholin's cyst or gland, marsupialisation of (G) (Anaes.)	116.35
35517	Bartholin's cyst or gland, marsupialisation of (S) (Anaes.)	146.00
35518	Ovarian cyst aspiration, for cysts of at least 4 cm in diameter in premenopausal women and at least 2 cm in diameter in postmenopausal women, by abdominal or vaginal route, using interventional imaging techniques and not associated with services provided for assisted reproductive techniques	207.85

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	(Anaes.)	
35520	Bartholin's abscess, incision of (Anaes.)	58.30
35523	Urethra or urethral caruncle, cauterisation of (Anaes.)	58.30
35526	Urethral caruncle, excision of (G) (Anaes.)	116.35
35527	Urethral caruncle, excision of (S) (Anaes.)	146.00
35530	Clitoris, amputation of, if medically indicated (H) (Anaes.) (Assist.)	269.85
35533	Vulvoplasty or labioplasty, if medically indicated, other than a service associated with a service to which item 35536 applies (Anaes.)	349.85
35536	Vulva, wide local excision of suspected malignancy or hemivulvectomy, one or both procedures (Anaes.) (Assist.)	348.45
35539	Colposcopically directed CO^2 laser therapy for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies—one anatomical site (Anaes.)	272.95
35542	Colposcopically directed CO^2 laser therapy for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies—2 or more anatomical sites (Anaes.) (Assist.)	319.60
35545	Colposcopically directed CO^2 laser therapy for condylomata, unsuccessfully treated by other methods (Anaes.)	183.60
35548	Vulvectomy, radical, for malignancy (H) (Anaes.) (Assist.)	834.05
35551	Pelvic lymph glands, excision of (radical) (H) (Anaes.) (Assist.)	683.90
35554	Vagina, dilatation of, as an independent procedure including any associated consultation (Anaes.)	43.50
35557	Vagina, removal of simple tumour—(including Gartner duct cyst) (Anaes.)	214.50
35560	Vagina, partial or complete removal of (H) (Anaes.) (Assist.)	683.90
35561	Vaginectomy, radical, for proven invasive malignancy—one surgeon (H) (Anaes.) (Assist.)	1 379.50
35562	Vaginectomy, radical, for proven invasive malignancy,	1 132.60

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	conjoint surgery—abdominal surgeon (including after-care) (H) (Anaes.) (Assist.)	
35564	Vaginectomy, radical, for proven invasive malignancy, conjoint surgery—perineal surgeon (H) (Assist.)	522.85
35565	Vaginal reconstruction for congenital absence, gynatresia or urogenital sinus (H) (Anaes.) (Assist.)	683.90
35566	Vaginal septum, excision of, for correction of double vagina (H) (Anaes.) (Assist.)	397.25
35568	Sacrospinous colpopexy for the management of upper vaginal prolapse (H) (Anaes.) (Assist.)	624.60
35569	Plastic repair to enlarge vaginal orifice (H) (Anaes.)	160.85
35570	Anterior vaginal compartment repair by vaginal approach (involving repair of urethrocele and cystocele), with or without mesh, other than a service associated with a service to which item 35573, 35577 or 35578 applies (H) (Anaes.) (Assist.)	553.85
35571	Posterior vaginal compartment repair by vaginal approach involving repair of one or more of the following: (a) perineum; (b) rectocoele; (c) enterocoele; with or without mesh, other than a service associated with a service to which item 35573, 35577 or 35578 applies (H) (Anaes.) (Assist.)	553.85
35572	Colpotomy, other than a service to which another item in this Group applies (H) (Anaes.)	123.80
35573	Anterior and posterior vaginal compartment repair by vaginal approach (involving anterior and posterior compartment defects), with or without mesh, other than a service associated with a service to which item 35577 or 35578 applies (H) (Anaes.) (Assist.)	830.90
35577	Manchester (Donald Fothergill) operation for genital prolapse, with or without mesh (H) (Anaes.) (Assist.)	674.50
35578	Le Fort operation for genital prolapse, other than a service associated with a service to which another item in this	674.50

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	Subgroup applies (H) (Anaes.) (Assist.)	
35595	Laparoscopic or abdominal pelvic floor repair involving the fixation of the uterosacral and cardinal ligaments to rectovaginal and pubocervical fascia for symptomatic upper vaginal vault prolapse (H) (Anaes.) (Assist.)	1 155.00
35596	Fistula between genital and urinary or alimentary tracts, repair of, other than a service to which item 37029, 37333 or 37336 applies (H) (Anaes.) (Assist.)	683.90
35597	Sacral colpopexy, laparoscopic or open procedure, if graft or mesh is secured to the vault, the anterior and posterior compartments and to the sacrum for correction of symptomatic upper vaginal vault prolapse (H) (Anaes.) (Assist.)	1 473.20
35599	Stress incontinence, sling operation for, with or without mesh or tape, other than a service associated with a service to which item 30405 applies (H) (Anaes.) (Assist.)	674.50
35602	Stress incontinence, combined synchronous abdomino-vaginal operation for—abdominal procedure, with or without mesh, (including after-care), other than a service associated with a service to which item 30405 applies (H) (Anaes.) (Assist.)	674.50
35605	Stress incontinence, combined synchronous abdomino-vaginal operation for—vaginal procedure, with or without mesh, (including after-care), other than a service associated with a service to which item 30405 applies (Anaes.) (Assist.)	365.95
35608	Cervix, cauterisation (other than by chemical means), ionisation, diathermy or biopsy of, with or without dilatation of cervix (Anaes.)	64.00
35611	Cervix, removal of polyp or polypi, with or without dilatation of cervix, other than a service associated with a service to which item 35608 applies (Anaes.)	64.00
35612	Cervix, residual stump, removal of, by abdominal approach (Anaes.) (Assist.)	506.00
35613	Cervix, residual stump, removal of, by vaginal approach (H) (Anaes.) (Assist.)	404.80
35614	Examination of lower female genital tract by a	63.90

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	Hinselmann-type colposcope in a patient with a previous abnormal cervical smear or a history of maternal ingestion of oestrogen or if a patient, because of suspicious signs of cancer, has been referred by another medical practitioner (Anaes.)	
35615	Vulva, biopsy of, when performed in conjunction with a service to which item 35614 applies	53.70
35616	Endometrium, endoscopic examination of and ablation of, by microwave, thermal balloon or radiofrequency electrosurgery, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage (H) (Anaes.)	449.60
35617	Cervix, cone biopsy, amputation or repair of, other than a service to which item 35577 or 35578 applies (G) (Anaes.)	173.70
35618	Cervix, cone biopsy, amputation or repair of, other than a service to which item 35577 or 35578 applies (S) (Anaes.)	218.00
35620	Endometrial biopsy if malignancy is suspected in patients with abnormal uterine bleeding or post menopausal bleeding (Anaes.)	53.35
35622	Endometrium, endoscopic ablation of, by laser or diathermy, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage, other than a service associated with a service to which item 30390 applies (H) (Anaes.)	602.45
35623	Hysteroscopic resection of myoma, or myoma and uterine septum resection (if both are performed), followed by endometrial ablation by laser or diathermy (H) (Anaes.)	819.25
35626	Hysteroscopy, including biopsy, performed by a specialist in the practice of his or her specialty, if the patient is referred to him or her for the investigation of suspected intrauterine pathology (with or without local anaesthetic), other than a service associated with a service to which item 35627 or 35630 applies	82.80
35627	Hysteroscopy with dilatation of the cervix performed in the operating theatre of a hospital—other than a service associated with a service to which item 35626 or 35630 applies (H)	107.15

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	(Anaes.)	
35630	Hysteroscopy, with endometrial biopsy, performed in the operating theatre of a hospital—other than a service associated with a service to which item 35626 or 35627 applies (Anaes.)	183.00
35633	Hysteroscopy with uterine adhesiolysis or polypectomy or tubal catheterisation (including hysteroscopy for insertion of device for sterilisation) or removal of IUD which cannot be removed by other means—one or more of (Anaes.)	218.00
35634	Hysteroscopic resection of uterine septum followed by endometrial ablation by laser or diathermy (Anaes.)	685.70
35635	Hysteroscopy involving resection of the uterine septum (H) (Anaes.)	299.45
35636	Hysteroscopy, involving resection of myoma, or resection of myoma and uterine septum (if both are performed) (H) (Anaes.)	433.00
35637	Laparoscopy, involving puncture of cysts, diathermy of endometriosis, ventrosuspension, division of adhesions or similar procedure—one or more procedures with or without biopsy—other than a service associated with another laparoscopic procedure or hysterectomy (H) (Anaes.) (Assist.)	406.65
35638	Complicated operative laparoscopy, including use of laser when required, for one or more of the following procedures—oophorectomy, ovarian cystectomy, myomectomy, salpingectomy or salpingostomy, ablation of moderate or severe endometriosis requiring more than 1 hour's operating time, or division of utero-sacral ligaments for significant dysmenorrhoea—other than a service associated with another intraperitoneal or retroperitoneal procedure except item 30393 (H) (Anaes.) (Assist.)	711.50
35639	Uterus, curettage of, with or without dilatation (including curettage for incomplete miscarriage) under general anaesthesia or under epidural or spinal (intrathecal) nerve block, including procedures to which item 35626, 35627 or 35630 applies, if performed (G) (H) (Anaes.)	134.90
35640	Uterus, curettage of, with or without dilatation (including curettage for incomplete miscarriage) under general	183.00

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	anaesthesia or under epidural or spinal (intrathecal) nerve block, including procedures to which item 35626, 35627 or 35630 applies, if performed (S) (H) (Anaes.)	
35641	Endometriosis level 4 or 5, laparoscopic resection of, involving any 2 of the following procedures: (a) resection of the pelvic side wall including dissection of endometriosis or scar tissue from the ureter; (b) resection of the Pouch of Douglas; (c) resection of an ovarian endometrioma greater than 2 cm in diameter; (d) dissection of bowel from uterus from the level of the endocervical junction or above; if the operating time exceeds 90 minutes (H) (Anaes.) (Assist.)	1 242.65
35643	Evacuation of the contents of the gravid uterus by curettage or suction curettage other than a service to which item 35639 or 35640 applies, including procedures to which item 35626, 35627 or 35630 applies, if performed (Anaes.)	218.00
35644	Cervix, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, other than a service associated with a service to which item 35639, 35640 or 35647 applies (Anaes.)	203.65
35645	Cervix, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in association with ablative therapy of additional areas of intraepithelial change in one or more sites of vagina, vulva, urethra or anus, other than a service associated with a service to which item 35649 applies (Anaes.)	318.70
35646	Cervix, colposcopy with radical diathermy of, with or without cervical biopsy, for previously confirmed intraepithelial neoplastic changes of the cervix, if performed in the operating theatre of a hospital (Anaes.)	203.65
35647	Cervix, large loop excision of transformation zone together with colposcopy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local	203.65

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	anaesthesia and biopsies, other than a service associated with a service to which item 35644 applies (Anaes.)	
35648	Cervix, large loop excision diathermy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative treatment of additional areas of intraepithelial change of one or more sites of vagina, vulva, urethra or anus, other than a service associated with a service to which item 35645 applies (Anaes.)	318.70
35649	Hysterotomy or uterine myomectomy, abdominal (H) (Anaes.) (Assist.)	536.00
35653	Hysterectomy, abdominal, sub-total or total, with or without removal of uterine adnexae (H) (Anaes.) (Assist.)	674.70
35657	Hysterectomy, vaginal, with or without uterine curettage, other than a service to which item 35673 applies (H) (Anaes.) (Assist.)	674.70
35658	Uterus (at least equivalent in size to a 10 week gravid uterus), debulking of, before vaginal removal at hysterectomy (H) (Anaes.) (Assist.)	416.05
35661	Hysterectomy, abdominal, requiring extensive retroperitoneal dissection with or without exposure of one or both ureters, for the management of severe endometriosis, pelvic inflammatory disease or benign pelvic tumours, with or without conservation of ovaries (H) (Anaes.) (Assist.)	871.30
35664	Radical hysterectomy with radical excision of pelvic lymph glands (with or without excision of uterine adnexae) for proven malignancy including excision of any one or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis if performed (H) (Anaes.) (Assist.)	1 452.20
35667	Radical hysterectomy without gland dissection (with or without excision of uterine adnexae) for proven malignancy including excision of any one or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis if performed (H) (Anaes.) (Assist.)	1 234.25
35670	Hysterectomy, abdominal, with radical excision of pelvic	1 016.30

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	lymph glands, with or without removal of uterine adnexae (H) (Anaes.) (Assist.)	
35673	Hysterectomy, vaginal, (with or without uterine curettage) with salpingectomy, oophorectomy or excision of ovarian cyst, one or more, one or both sides (H) (Anaes.) (Assist.)	757.80
35674	Ultrasound guided needling and injection of ectopic pregnancy	207.85
35676	Ectopic pregnancy, removal of (G) (H) (Anaes.) (Assist.)	425.00
35677	Ectopic pregnancy, removal of (S) (H) (Anaes.) (Assist.)	536.00
35678	Ectopic pregnancy, laparoscopic removal of (H) (Anaes.) (Assist.)	646.25
35680	Bicornuate uterus, plastic reconstruction for (Anaes.) (Assist.)	582.05
35683	Uterus, suspension or fixation of, as an independent procedure (G) (H) (Anaes.) (Assist.)	351.30
35684	Uterus, suspension or fixation of, as an independent procedure (S) (H) (Anaes.) (Assist.)	471.15
35687	Sterilisation by transection or resection of fallopian tubes, via abdominal or vaginal routes or via laparoscopy using diathermy or another method (G) (H) (Anaes.) (Assist.)	325.20
35688	Sterilisation by transection or resection of fallopian tubes, via abdominal or vaginal routes or via laparoscopy using diathermy or another method (S) (H) (Anaes.) (Assist.)	397.25
35691	Sterilisation by interruption of fallopian tubes when performed in conjunction with Caesarean section (H) (Anaes.) (Assist.)	158.70
35694	Tuboplasty (salpingostomy, salpingolysis or tubal implantation into uterus), unilateral or bilateral, one or more procedures (H) (Anaes.) (Assist.)	637.70
35697	Microsurgical tuboplasty (salpingostomy, salpingolysis or tubal implantation into uterus), unilateral or bilateral, one or more procedures (H) (Anaes.) (Assist.)	946.20
35700	Fallopian tubes, unilateral microsurgical anastomosis of, using operating microscope (H) (Anaes.) (Assist.)	730.05
35703	Hydrotubation of fallopian tubes as a non-repetitive procedure, other than a service associated with a service to	67.50

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	which another item in this Subgroup applies (Anaes.)	
35706	Rubin test for patency of fallopian tubes (Anaes.)	67.50
35709	Fallopian tubes, hydrotubation of, as a repetitive post-operative procedure (Anaes.)	43.50
35710	Falloposcopy, unilateral or bilateral, including hysteroscopy and tubal catheterisation (H) (Anaes.) (Assist.)	463.30
35712	Laparotomy, involving oophorectomy, salpingectomy, salpingo-oophorectomy, removal of ovarian, parovarian, fimbrial or broad ligament cyst—one such procedure, other than a service associated with hysterectomy (G) (H) (Anaes.) (Assist.)	362.15
35713	Laparotomy, involving oophorectomy, salpingectomy, salpingo-oophorectomy, removal of ovarian, parovarian, fimbrial or broad ligament cyst—one such procedure, other than a service associated with hysterectomy (S) (H) (Anaes.) (Assist.)	452.85
35716	Laparotomy, involving oophorectomy, salpingectomy, salpingo-oophorectomy, removal of ovarian, parovarian, fimbrial or broad ligament cyst—2 or more such procedures, unilateral or bilateral, other than a service associated with hysterectomy (G) (H) (Anaes.) (Assist.)	434.35
35717	Laparotomy, involving oophorectomy, salpingectomy, salpingo-oophorectomy, removal of ovarian, parovarian, fimbrial or broad ligament cyst—2 or more such procedures, unilateral or bilateral, other than a service associated with hysterectomy (S) (H) (Anaes.) (Assist.)	545.30
35720	Radical or debulking operation for advanced gynaecological malignancy, with or without omentectomy (H) (Anaes.) (Assist.)	674.50
35723	Retro-peritoneal lymph node biopsies from above the level of the aortic bifurcation, for staging or restaging of gynaecological malignancy (H) (Anaes.) (Assist.)	483.10
35726	Infra-colic omentectomy with multiple peritoneal biopsies for staging or restaging of gynaecological malignancy (H) (Anaes.) (Assist.)	483.10

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
35729	Ovarian transposition out of the pelvis, in conjunction with radical hysterectomy for invasive malignancy (H) (Anaes.)	217.80
35750	Laparoscopically assisted hysterectomy, including any associated laparoscopy (H) (Anaes.) (Assist.)	784.60
35753	Laparoscopically assisted hysterectomy, with one or more of the following procedures—salpingectomy, oophorectomy, excision of ovarian cyst or treatment of moderate endometriosis, one or both sides, including any associated laparoscopy (H) (Anaes.) (Assist.)	867.60
35754	Laparoscopically assisted hysterectomy which requires dissection of endometriosis, or other pathology, from the ureter, one or both sides, including any associated laparoscopy, including when performed with one or more of the following procedures—salpingectomy, oophorectomy, excision of ovarian cyst or treatment of endometriosis, other than a service to which item 35641 applies (H) (Anaes.) (Assist.)	1 091.90
35756	Laparoscopically assisted hysterectomy, when procedure is completed by open hysterectomy, including any associated laparoscopy (H) (Anaes.) (Assist.)	784.60
35759	Procedure for the control of post operative haemorrhage following gynaecological surgery, under general anaesthesia, utilising a vaginal or abdominal and vaginal approach if no other procedure is performed (H) (Anaes.) (Assist.)	563.30
Subgroup 5—Urological		
36500	Adrenal gland, excision of—partial or total (H) (Anaes.) (Assist.)	924.70
36502	Pelvic lymphadenectomy, open or laparoscopic, or both, unilateral or bilateral (H) (Anaes.) (Assist.)	683.90
36503	Renal transplant, other than a service to which item 36506 or 36509 applies (H) (Anaes.) (Assist.)	1 391.15
36506	Renal transplant, performed by vascular surgeon and urologist operating together—vascular anastomosis, including after-care (H) (Anaes.) (Assist.)	924.70
36509	Renal transplant, performed by vascular surgeon and urologist	782.95

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	operating together—ureterovesical anastomosis, including after-care (H) (Assist.)	
36516	Nephrectomy, complete (H) (Anaes.) (Assist.)	924.70
36519	Nephrectomy, complete, complicated by previous surgery on the same kidney (H) (Anaes.) (Assist.)	1 291.10
36522	Nephrectomy, partial (H) (Anaes.) (Assist.)	1 107.95
36525	Nephrectomy, partial, complicated by previous surgery on the same kidney (H) (Anaes.) (Assist.)	1 574.45
36526	Nephrectomy, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour of less than 10 cm in diameter, if performed if malignancy is clinically suspected but not confirmed by histopathological examination (Anaes.) (Assist.)	1 291.10
36527	Nephrectomy, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour of 10 cm or more in diameter, or complicated by previous open or laparoscopic surgery on the same kidney, if performed if malignancy is clinically suspected but not confirmed by histopathological examination (Anaes.) (Assist.)	1 593.40
36528	Nephrectomy, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10 cm in diameter (H) (Anaes.) (Assist.)	1 291.10
36529	Nephrectomy, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour 10 cm or more in diameter, or complicated by previous open or laparoscopic surgery on the same kidney (H) (Anaes.) (Assist.)	1 593.40
36531	Nephro-ureterectomy, complete, including associated bladder repair and any associated endoscopic procedure (H) (Anaes.) (Assist.)	1 157.85
36532	Nephro-ureterectomy, for tumour, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures (H) (Anaes.) (Assist.)	1 661.85
36533	Nephro-ureterectomy, for tumour, with or without en bloc dissection of lymph nodes, including associated bladder repair	1 964.15

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	and any associated endoscopic procedures, complicated by previous open or laparoscopic surgery on the same kidney or ureter (H) (Anaes.) (Assist.)	
36537	Kidney or perinephric area, exploration of, with or without drainage of, by open exposure, other than a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	691.40
36540	Nephrolithotomy or pyelolithotomy, or both, through the same skin incision, for one or 2 stones (Anaes.) (Assist.)	1 107.95
36543	Nephrolithotomy or pyelolithotomy, or both, extended, for staghorn stone or 3 or more stones, including one or more of the following: nephrostomy, pyelostomy, pedicle control with or without freezing, calyorrhaphy or pyeloplasty (Anaes.) (Assist.)	1 291.10
36546	Extracorporeal shock wave lithotripsy (ESWL) to urinary tract and post-treatment care for 3 days, including pre-treatment consultations, unilateral (Anaes.)	691.40
36549	Ureterolithotomy (H) (Anaes.) (Assist.)	833.10
36552	Nephrostomy or pyelostomy, open, as an independent procedure (H) (Anaes.) (Assist.)	741.50
36558	Renal cyst or cysts, excision or unroofing of (Anaes.) (Assist.)	649.80
36561	Renal biopsy (closed) (Anaes.)	172.50
36564	Pyeloplasty (plastic reconstruction of the pelvi-ureteric junction), by open exposure, laparoscopy or laparoscopic assisted techniques (H) (Anaes.) (Assist.)	924.70
36567	Pyeloplasty in a kidney that is congenitally abnormal in addition to the presence of pelvic-ureteric junction obstruction, or in a solitary kidney, by open exposure (H) (Anaes.) (Assist.)	1 016.30
36570	Pyeloplasty, complicated by previous surgery on the same kidney, by open exposure (H) (Anaes.) (Assist.)	1 291.10
36573	Divided ureter, repair of (H) (Anaes.) (Assist.)	924.70
36576	Kidney, exposure and exploration of, including repair or nephrectomy, for trauma, other than a service associated with another procedure performed on the kidney, renal pelvis or renal pedicle (H) (Anaes.) (Assist.)	1 157.85

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
36579	Ureterectomy, complete or partial, with or without associated bladder repair, other than a service associated with a service to which item 37000 applies (H) (Anaes.) (Assist.)	741.50
36585	Ureter, transplantation of, into skin (H) (Anaes.) (Assist.)	741.50
36588	Ureter, reimplantation into bladder (H) (Anaes.) (Assist.)	924.70
36591	Ureter, reimplantation into bladder with psoas hitch or Boari flap or both (H) (Anaes.) (Assist.)	1 107.95
36594	Ureter, transplantation of, into intestine (H) (Anaes.) (Assist.)	924.70
36597	Ureter, transplantation of, into another ureter (H) (Anaes.) (Assist.)	924.70
36600	Ureter, transplantation of, into isolated intestinal segment, unilateral (Anaes.) (Assist.)	1 107.95
36603	Ureters, transplantation of, into isolated intestinal segment, bilateral (H) (Anaes.) (Assist.)	1 291.10
36604	Ureteric stent, passage of through percutaneous nephrostomy tube, using interventional imaging techniques (Anaes.)	267.65
36605	Ureteric stent, insertion of, with removal of calculus from: (a) the pelvicalyceal system; or (b) ureter; or (c) the pelvicalyceal system and ureter; through a nephrostomy tube using interventional imaging techniques (H) (Anaes.)	690.70
36606	Intestinal urinary reservoir, continent, formation of, including formation of non-return valves and implantation of ureters (one or both) into reservoir (H) (Anaes.) (Assist.)	2 315.80
36607	Ureteric stent, insertion of, with balloon dilatation of: (a) the pelvicalyceal system; or (b) ureter; or (c) the pelvicalyceal system and ureter; through a nephrostomy tube using interventional imaging techniques (H) (Anaes.)	690.70
36608	Ureteric stent, exchange of, percutaneously through the ileal conduit or bladder using interventional imaging techniques,	267.65

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	other than a service associated with a service to which any of items 36811 to 36854 apply (H) (Anaes.)	
36609	Intestinal urinary conduit or ureterostomy, revision of (H) (Anaes.) (Assist.)	741.50
36612	Ureter, exploration of, with or without drainage of, as an independent procedure (H) (Anaes.) (Assist.)	649.80
36615	Ureterolysis, with or without repositioning of ureter, for obstruction of the ureter, evident either radiologically or by proximal ureteric dilatation at operation, secondary to retroperitoneal fibrosis, or similar condition (H) (Anaes.) (Assist.)	741.50
36618	Reduction ureteroplasty (H) (Anaes.) (Assist.)	649.80
36621	Closure of cutaneous ureterostomy (H) (Anaes.) (Assist.)	464.50
36624	Nephrostomy, percutaneous, using interventional imaging techniques (Anaes.) (Assist.)	558.10
36627	Nephroscopy, percutaneous, with or without any one or more of stone extraction, biopsy or diathermy, other than a service to which item 36639, 36642, 36645 or 36648 applies (H) (Anaes.)	691.40
36630	Nephroscopy, being a service to which item 36627 applies, if, after a substantial portion of the procedure has been performed, it is necessary to discontinue the operation due to bleeding (H) (Anaes.) (Assist.)	341.50
36633	Nephroscopy, percutaneous, with incision of any one or more of renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, other than a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (Anaes.) (Assist.)	741.50
36636	Nephroscopy, percutaneous, with incision of any one or more of renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, being a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (H) (Anaes.) (Assist.)	399.90
36639	Nephroscopy, percutaneous, with destruction and extraction of one or 2 stones using ultrasound or electrohydraulic shock	833.10

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	waves or lasers (other than a service to which item 36645 or 36648 applies) (H) (Anaes.)	
36642	Nephroscopy, being a service to which item 36639 applies, if, after a substantial portion of the procedure has been performed, it is necessary to discontinue the operation due to bleeding (H) (Anaes.) (Assist.)	416.45
36645	Nephroscopy, percutaneous, with removal or destruction of a stone greater than 3 cm in any dimension, or for 3 or more stones (H) (Anaes.) (Assist.)	1 066.30
36648	Nephroscopy, being a service to which item 36645 applies, if, after a substantial portion of the procedure has been performed, it is necessary to discontinue the operation (H) (Anaes.) (Assist.)	949.60
36649	Nephrostomy drainage tube, exchange of—but not including imaging (Anaes.) (Assist.)	267.65
36650	Nephrostomy tube, removal of, using interventional imaging techniques, if the ureter has been stented with a double J ureteric stent and that stent is left in place (H) (Anaes.)	149.70
36652	Pyeloscopy, retrograde, of one collecting system, with or without any one or more of, cystoscopy, ureteric meatotomy, ureteric dilatation, other than a service associated with a service to which item 36803, 36812 or 36824 applies (H) (Anaes.) (Assist.)	649.80
36654	Pyeloscopy, retrograde, of one collecting system, being a service to which item 36652 applies, plus one or more of extraction of stone from the renal pelvis or calyces, or biopsy or diathermy of the renal pelvis or calyces, other than a service associated with a service performed in the same collecting system to which item 36656 applies (H) (Anaes.) (Assist.)	833.10
36656	Pyeloscopy, retrograde, of one collecting system, being a service to which item 36652 applies, plus extraction of 2 or more stones in the renal pelvis or calyces or destruction of stone with ultrasound, electrohydraulic or kinetic lithotripsy or laser in the renal pelvis or calyces, with or without extraction of fragments, other than a service associated with a service	1 066.30

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	performed in the same collecting system to which item 36654 applies (H) (Anaes.) (Assist.)	
36658	Sacral nerve stimulation for refractory urinary incontinence or urge retention, removal of pulse generator and leads	526.40
36660	Sacral nerve stimulation for refractory urinary incontinence or urge retention, removal and replacement of pulse generator	255.45
36662	Sacral nerve stimulation for refractory urinary incontinence or urge retention, removal and replacement of leads	610.30
36663	Both: (a) percutaneous placement of sacral nerve lead or leads using fluoroscopic guidance, or open placement of sacral nerve lead or leads; and (b) intra-operative test stimulation, to manage: (i) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or (ii) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment; in a patient who is at least 18 years old (Anaes.)	660.95
36664	Both: (a) percutaneous repositioning of sacral nerve lead or leads using fluoroscopic guidance, or open repositioning of sacral nerve lead or leads; and (b) intra-operative test stimulation, to correct displacement or unsatisfactory positioning, if inserted for the management of: (i) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or (ii) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment; in a patient who is at least 18 years old—other than a service to which item 36663 applies (Anaes.)	593.55
36665	Sacral nerve electrode or electrodes, management and	125.40

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	adjustment of the pulse generator by a medical practitioner, to manage detrusor over-activity or non-obstructive urinary retention—each day	
36666	Pulse generator, subcutaneous placement of, and placement and connection of extension wire or wires to sacral nerve electrode or electrodes, for the management of: (a) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or (b) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment; in a patient who is at least 18 years old (Anaes.)	334.00
36667	Sacral nerve lead or leads, removal of, if the lead was inserted to manage: (a) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or (b) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment; in a patient who is at least 18 years old (Anaes.)	156.30
36668	Pulse generator, removal of, if the pulse generator was inserted to manage: (a) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or (b) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment; in a patient who is at least 18 years old (Anaes.)	156.30
36800	Bladder, catheterisation of, if no other procedure is performed (Anaes.)	27.60
36803	Ureteroscopy, of one ureter, with or without any one or more of cystoscopy, ureteric meatotomy, or ureteric dilatation, other than a service associated with a service to which item 36652, 36654, 36656, 36806, 36809, 36812, 36824, 36848 or 36857 applies (Anaes.) (Assist.)	466.35
36806	Ureteroscopy, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, plus one or more of extraction of stone from the ureter, or biopsy	649.80

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	or diathermy of the ureter, other than a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36809, 36824, 36848 or 36857 applies to a procedure performed on the same ureter (H) (Anaes.) (Assist.)	
36809	Ureteroscopy, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, plus destruction of stone in the ureter with ultrasound, electrohydraulic or kinetic lithotripsy or laser, with or without extraction of fragments, other than a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36806, 36824, 36848 or 36857 applies to a procedure performed on the same ureter (H) (Anaes.) (Assist.)	833.10
36811	Cystoscopy with insertion of urethral prosthesis (Anaes.)	323.40
36812	Cystoscopy with urethroscopy, with or without urethral dilatation, other than a service associated with another urological endoscopic procedure on the lower urinary tract except a service to which item 37327 applies (Anaes.)	166.70
36815	Cystoscopy, with or without urethroscopy, for the treatment of penile warts or urethral warts, other than a service associated with a service to which item 30189 applies (Anaes.)	237.90
36818	Cystoscopy, with ureteric catheterisation including fluoroscopic imaging of the upper urinary tract, unilateral or bilateral, other than a service associated with a service to which item 36824 or 36830 applies (Anaes.) (Assist.)	276.60
36821	Cystoscopy with one or more of ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or of renal pelvis, unilateral, other than a service associated with a service to which item 36824 or 36830 applies (Anaes.) (Assist.)	323.20
36824	Cystoscopy with ureteric catheterisation, unilateral or bilateral, other than a service associated with a service to which item 36818 or 36821 applies (Anaes.)	213.15
36825	Cystoscopy, with endoscopic incision of pelviureteric junction or ureteric stricture, including removal or replacement of ureteric stent, other than a service associated with a service to	581.30

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	which item 36818, 36821, 36824, 36830 or 36833 applies (H) (Anaes.) (Assist.)	
36827	Cystoscopy, with controlled hydro-dilatation of the bladder (Anaes.)	229.85
36830	Cystoscopy, with ureteric meatotomy (H) (Anaes.)	203.25
36833	Cystoscopy with removal of ureteric stent or other foreign body (Anaes.) (Assist.)	276.60
36836	Cystoscopy with biopsy of bladder, other than a service associated with a service to which item 36812, 36830, 36840, 36845, 36848, 36854, 37203, 37206, 37215, 37230 or 37233 applies (Anaes.)	229.85
36840	Cystoscopy, with resection, diathermy or visual laser destruction of bladder tumour or other lesion of the bladder, other than a service associated with a service to which item 36845 applies (Anaes.)	323.20
36842	Cystoscopy with lavage of blood clots from bladder including any associated diathermy of prostate or bladder, other than a service associated with a service to which item 36812, 36827 to 36863, 37203, 37206, 37230 or 37233 applies (H) (Anaes.) (Assist.)	325.20
36845	Cystoscopy, with diathermy, resection or visual laser destruction of multiple tumours in more than 2 quadrants of the bladder or solitary tumour greater than 2 cm in diameter (Anaes.)	691.40
36848	Cystoscopy with resection of ureterocele (H) (Anaes.)	229.85
36851	Cystoscopy with injection into bladder wall, other than a service associated with a service to which item 18375 applies (H) (Anaes.)	229.85
36854	Cystoscopy with endoscopic incision or resection of external sphincter, bladder neck or both (H) (Anaes.)	466.35
36857	Endoscopic manipulation or extraction of ureteric calculus (H) (Anaes.)	366.45
36860	Endoscopic examination of intestinal conduit or reservoir (Anaes.)	166.70
36863	Litholapaxy, with or without cystoscopy (H) (Anaes.) (Assist.)	466.35

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
37000	Bladder, partial excision of (H) (Anaes.) (Assist.)	741.50
37004	Bladder, repair of rupture (H) (Anaes.) (Assist.)	649.80
37008	Cystostomy or cystotomy, suprapubic, other than a service to which item 37011 applies or a service associated with other open bladder procedure (Anaes.)	416.45
37011	Suprapubic stab cystotomy, other than a service associated with a service to which items 37200 to 37221 apply (Anaes.)	93.35
37014	Bladder, total excision of (H) (Anaes.) (Assist.)	1 066.30
37020	Bladder diverticulum, excision or obliteration of (H) (Anaes.) (Assist.)	741.50
37023	Vesical fistula, cutaneous, operation for (H) (Anaes.)	416.45
37026	Cutaneous vesicostomy, establishment of (H) (Anaes.) (Assist.)	416.45
37029	Vesico-vaginal fistula, closure of, by abdominal approach (H) (Anaes.) (Assist.)	924.70
37038	Vesico-intestinal fistula, closure of, excluding bowel resection (H) (Anaes.) (Assist.)	691.75
37041	Bladder aspiration, by needle	46.60
37042	Bladder stress incontinence—sling procedure for, using autologous fascial sling, including harvesting of sling, with or without mesh, other than a service associated with a service to which item 30405 or 35599 applies (H) (Anaes.) (Assist.)	911.30
37043	Bladder stress incontinence, Stamey or similar type needle colposuspension, with or without mesh, other than a service associated with a service to which item 30405 or 35599 applies (H) (Anaes.) (Assist.)	674.50
37044	Bladder stress incontinence, suprapubic procedure for, eg Burch colposuspension, with or without mesh, other than a service associated with a service to which item 30405 or 35599 applies (H) (Anaes.) (Assist.)	691.75
37045	Mitrofanoff continent valve, formation of (H) (Anaes.) (Assist.)	1 428.75
37047	Bladder enlargement using intestine (H) (Anaes.) (Assist.)	1 666.05
37050	Bladder exstrophy closure, not involving sphincter	741.50

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	reconstruction (H) (Anaes.) (Assist.)	
37053	Bladder transection and re-anastomosis to trigone (H) (Anaes.) (Assist.)	856.70
37200	Prostatectomy, open (H) (Anaes.) (Assist.)	1 016.30
37201	Prostate, transurethral radio-frequency needle ablation of, with or without cystoscopy and with or without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who are not medically fit for transurethral resection of the prostate (that is, prostatectomy using diathermy or cold punch) and including a service to which item 36854, 37203, 37206, 37207, 37208, 37245, 37303, 37321 or 37324 applies (H) (Anaes.)	828.85
37202	Prostate, transurethral radio-frequency needle ablation of, with or without cystoscopy and with or without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who are not medically fit for transurethral resection of the prostate (that is prostatectomy using diathermy or cold punch) and including a service to which item 36854, 37245, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203 or 37207 which had to be discontinued for medical reasons (Anaes.)	416.05
37203	Prostatectomy (endoscopic, using diathermy or cold punch), with or without cystoscopy, and with or without urethroscopy, and including services to which item 36854, 37201, 37202, 37207, 37208, 37245, 37303, 37321 or 37324 applies (H) (Anaes.)	1 042.15
37206	Prostatectomy (endoscopic, using diathermy or cold punch), with or without cystoscopy, and with or without urethroscopy, and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203, 37207 or 37245 which had to be discontinued for medical reasons (H) (Anaes.)	558.10
37207	Prostate, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy, and with or without urethroscopy, and including services to which item 36854, 37201, 37202, 37203, 37206, 37245, 37303, 37321 or 37324	866.45

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	applies (H) (Anaes.)	
37208	Prostate, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy, and with or without urethroscopy, and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203, 37207 or 37245 which had to be discontinued for medical reasons (H) (Anaes.)	416.05
37209	Total excision (other than a service associated with a service to which item 37210 or 37211 applies) of any, or all of: (a) prostate; or (b) seminal vesicle, unilateral or bilateral; or (c) ampulla of vas, unilateral or bilateral (H) (Anaes.) (Assist.)	1 291.10
37210	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, other than a service associated with a service to which item 35551, 36502 or 37375 applies (H) (Anaes.) (Assist.)	1 593.40
37211	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, with pelvic lymphadenectomy, other than a service associated with a service to which item 35551, 36502 or 37375 applies (H) (Anaes.) (Assist.)	1 935.20
37212	Prostate, open perineal biopsy or open drainage of abscess (H) (Anaes.) (Assist.)	276.60
37215	Prostate, biopsy of, endoscopic, with or without cystoscopy (Anaes.) (Assist.)	416.45
37217	Prostate, implantation of gold fiducial markers into the prostate gland or prostate surgical bed (Anaes.)	138.30
37218	Prostate, needle biopsy of, or injection into, excluding insertion of radioopaque markers (Anaes.)	138.30
37219	Prostate, needle biopsy of, using prostatic ultrasound techniques and obtaining one or more prostatic specimens, being a service associated with a service to which item 55600	280.85

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	or 55603 applies (Anaes.) (Assist.)	
37220	Prostate, radioactive seed implantation of, urological component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stage T1 (clinically inapparent tumour that is not palpable or visible by imaging) or clinical stage T2 (tumour confined within prostate), with a Gleason score of not more than 7 and a prostate specific antigen (PSA) of 10ng/ml or less at the time of diagnosis, if the procedure is performed by a urologist at an approved site in association with a radiation oncologist, and being a service associated with a service to which item 55603 applies (H) (Anaes.)	1 044.20
37221	Prostatic abscess, endoscopic drainage of (H) (Anaes.) (Assist.)	466.35
37223	Prostatic coil, insertion of, under ultrasound control (H) (Anaes.)	206.25
37224	Prostate, diathermy or visual laser destruction of lesion of, other than a service associated with a service to which item 37201, 37202, 37203, 37206, 37207, 37208, 37215, 37230 or 37233 applies (Anaes.)	323.20
37227	Prostate, transperineal insertion of catheters for high dose rate brachytherapy using ultrasound guidance including any associated cystoscopy, if performed at an approved site, and being a service associated with a service to which item 15331 or 15332 applies	565.85
37230	Prostate, high-energy transurethral microwave thermotherapy of, with or without cystoscopy, and with or without urethroscopy, and including services to which item 36854, 37203, 37206, 37207, 37208, 37303, 37321 or 37324 applies (Anaes.)	1 042.15
37233	Prostate, high-energy transurethral microwave thermotherapy of, with or without cystoscopy, and with or without urethroscopy, and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203, 37207 or 37230 which had to be discontinued for medical reasons	558.10

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	(Anaes.)	
37245	Prostate, endoscopic enucleation of, using high powered Holmium:YAG laser and an end firing, non-contact fibre, with or without tissue morcellation, cystoscopy or urethroscopy, for the treatment of benign prostatic hyperplasia and other than a service associated with a service to which item 36854, 37201, 37202, 37203, 37206, 37207, 37208, 37303, 37321 or 37324 applies (H) (Anaes.)	1 262.15
37300	Urethral sounds, passage of, as an independent procedure (Anaes.)	46.60
37303	Urethral stricture, dilatation of (Anaes.)	74.05
37306	Urethra, repair of rupture of distal section (H) (Anaes.) (Assist.)	649.80
37309	Urethra, repair of rupture of prostatic or membranous segment (H) (Anaes.) (Assist.)	924.70
37315	Urethroscopy, as an independent procedure (Anaes.)	138.30
37318	Urethroscopy, with any one or more of biopsy, diathermy, visual laser destruction of stone or removal of foreign body or stone (Anaes.) (Assist.)	276.60
37321	Urethral meatotomy, external (Anaes.)	93.35
37324	Urethrotomy or urethrostomy, internal or external (H) (Anaes.)	229.85
37327	Urethrotomy, optical, for urethral stricture (H) (Anaes.) (Assist.)	323.20
37330	Urethrectomy, partial or complete, for removal of tumour (H) (Anaes.) (Assist.)	649.80
37333	Urethro-vaginal fistula, closure of (H) (Anaes.) (Assist.)	558.10
37336	Urethro-rectal fistula, closure of (H) (Anaes.) (Assist.)	741.50
37339	Periurethral or transurethral injection of materials for the treatment of urinary incontinence, including cystoscopy and urethroscopy, other than a service associated with a service to which item 18375 applies (Anaes.)	239.85
37340	Urethral sling, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary	425.00

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	incontinence—vaginal approach, other than a service associated with a service to which item 37341 applies (H) (Anaes.) (Assist.)	
37341	Urethral sling, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence—suprapubic or vaginal approach, other than a service associated with a service to which item 37340 applies (H) (Anaes.) (Assist.)	911.30
37342	Urethroplasty—single stage operation (H) (Anaes.) (Assist.)	833.10
37343	Urethroplasty, single stage operation, transpubic approach via separate incisions above and below the symphysis pubis, excluding laparotomy, symphysectomy and suprapubic cystotomy, with or without re-routing of the urethra around the crura (H) (Anaes.) (Assist.)	1 391.15
37345	Urethroplasty—2 stage operation—first stage (H) (Anaes.) (Assist.)	691.40
37348	Urethroplasty—2 stage operation—second stage (H) (Anaes.) (Assist.)	691.40
37351	Urethroplasty, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	276.60
37354	Hypospadias, meatotomy and hemi-circumcision (H) (Anaes.) (Assist.)	323.20
37369	Urethra, excision of prolapse of (H) (Anaes.)	186.60
37372	Urethral diverticulum, excision of (H) (Anaes.) (Assist.)	466.35
37375	Urethral sphincter, reconstruction by bladder tubularisation technique or similar procedure (H) (Anaes.) (Assist.)	1 157.85
37381	Artificial urinary sphincter, insertion of cuff, perineal approach (H) (Anaes.) (Assist.)	741.50
37384	Artificial urinary sphincter, insertion of cuff, abdominal approach (H) (Anaes.) (Assist.)	1 157.85
37387	Artificial urinary sphincter, insertion of pressure regulating balloon and pump (H) (Anaes.) (Assist.)	323.20
37390	Artificial urinary sphincter, revision or removal of, with or without replacement (H) (Anaes.) (Assist.)	924.70

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
37393	Priapism, decompression by glanular stab caverno-sospongiosum shunt or penile aspiration with or without lavage (Anaes.)	229.85
37396	Priapism, shunt operation for, other than a service to which item 37393 applies (H) (Anaes.) (Assist.)	741.50
37402	Penis, partial amputation of (H) (Anaes.) (Assist.)	466.35
37405	Penis, complete or radical amputation of (H) (Anaes.) (Assist.)	924.70
37408	Penis, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (H) (Anaes.) (Assist.)	466.35
37411	Penis, repair of avulsion (Anaes.) (Assist.)	924.70
37415	Penis, injection of, for the investigation and treatment of impotence—2 services only in a period of 36 consecutive months	46.60
37417	Penis, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting (H) (Anaes.) (Assist.)	558.10
37418	Penis, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting, involving mobilisation of the urethra (Anaes.) (Assist.)	741.50
37420	Penis, surgery to inhibit rapid penile drainage causing impotence, by ligation of veins deep to Buck's fascia including one or more deep cavernosal veins, with or without pharmacological erection test (H) (Anaes.) (Assist.)	366.45
37423	Penis, lengthening by translocation of corpora (H) (Anaes.) (Assist.)	924.70
37426	Penis, artificial erection device, insertion of, into one or both corpora (H) (Anaes.) (Assist.)	974.55
37429	Penis, artificial erection device, insertion of pump and pressure regulating reservoir (H) (Anaes.) (Assist.)	323.20
37432	Penis, artificial erection device, complete or partial revision or removal of components, with or without replacement (H) (Anaes.) (Assist.)	924.70
37435	Penis, frenuloplasty as an independent procedure (Anaes.)	93.35
37438	Scrotum, partial excision of (Anaes.) (Assist.)	276.60

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
37444	Ureterolithotomy complicated by previous surgery at the same site of the same ureter (Anaes.) (Assist.)	999.65
37601	Spermatocele or epididymal cyst, excision of, one or more of, on one side (Anaes.)	276.60
37604	Exploration of scrotal contents, with or without fixation and with or without biopsy, unilateral, other than a service associated with sperm harvesting for IVF (Anaes.)	276.60
37605	Transcutaneous sperm retrieval, unilateral, from either the testis or the epididymis, for the purposes of intracytoplasmic sperm injection, for male factor infertility, other than a service to which item 13218 applies (Anaes.)	373.45
37606	Open surgical sperm retrieval, unilateral, including the exploration of scrotal contents, with or without biopsy, for the purposes of intracytoplasmic sperm injection, for male factor infertility, performed in a hospital, other than a service to which item 13218 or 37604 applies (Anaes.)	554.55
37607	Retroperitoneal lymph node dissection, unilateral, other than a service associated with a service to which item 36528 applies (H) (Anaes.) (Assist.)	924.70
37610	Retroperitoneal lymph node dissection, unilateral, other than a service associated with a service to which item 36528 applies, following previous similar retroperitoneal dissection, retroperitoneal irradiation or chemotherapy (H) (Anaes.) (Assist.)	1 391.15
37613	Epididymectomy (Anaes.)	276.60
37616	Vasovasostomy or vasoepididymostomy, unilateral, using the operating microscope, other than a service associated with sperm harvesting for IVF (H) (Anaes.) (Assist.)	691.40
37619	Vasovasostomy or vasoepididymostomy, unilateral, other than a service associated with sperm harvesting for IVF (Anaes.) (Assist.)	276.60
37622	Vasotomy or vasectomy, unilateral or bilateral (G) (Anaes.)	193.20
37623	Vasotomy or vasectomy, unilateral or bilateral (S) (Anaes.)	229.85
37800	Patent urachus, excision of (H) (Anaes.) (Assist.)	521.25

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
37803	Undescended testis, orchidopexy for, other than a service to which item 37806 applies (H) (Anaes.) (Assist.)	521.25
37806	Undescended testis in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for (Anaes.) (Assist.)	602.25
37809	Undescended testis, revision orchidopexy for (H) (Anaes.) (Assist.)	602.25
37812	Impalpable testis, exploration of groin for, other than a service associated with a service to which items 37803 to 37809 apply (H) (Anaes.) (Assist.)	556.00
37815	Hypospadias, examination under anaesthesia with erection test (H) (Anaes.)	92.75
37818	Hypospadias, glanuloplasty incorporating meatal advancement (Anaes.) (Assist.)	491.45
37821	Hypospadias, distal, one stage repair (H) (Anaes.) (Assist.)	833.10
37824	Hypospadias, proximal, one stage repair (H) (Anaes.) (Assist.)	1 158.30
37827	Hypospadias, staged repair, first stage (H) (Anaes.) (Assist.)	533.60
37830	Hypospadias, staged repair, second stage (Anaes.) (Assist.)	691.40
37833	Hypospadias, repair of post operative urethral fistula (H) (Anaes.) (Assist.)	329.95
37836	Epispadias, staged repair, first stage (H) (Anaes.) (Assist.)	695.00
37839	Epispadias, staged repair, second stage (H) (Anaes.) (Assist.)	787.60
37842	Exstrophy of bladder or epispadias, secondary repair with bladder neck tightening, with or without ureteric reimplantation (H) (Anaes.) (Assist.)	1 529.10
37845	Ambiguous genitalia with urogenital sinus, reduction clitoroplasty, with or without endoscopy (H) (Anaes.) (Assist.)	695.00
37848	Ambiguous genitalia with urogenital sinus, reduction clitoroplasty, with endoscopy and vaginoplasty (H) (Anaes.) (Assist.)	1 251.05
37851	Congenital adrenal hyperplasia, mixed gonadal dysgenesis or similar condition, vaginoplasty for, with or without endoscopy (H) (Anaes.) (Assist.)	926.80

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
37854	Urethral valve, destruction of, including cystoscopy and urethroscopy (H) (Anaes.) (Assist.)	366.45
Subgroup 6—Cardio-Thoracic		
38200	Right heart catheterisation with any one or more of—fluoroscopy, oximetry, dye dilution curves, cardiac output measurement by any method, shunt detection or exercise stress test (Anaes.)	445.40
38203	Left heart catheterisation by percutaneous arterial puncture, arteriotomy or percutaneous left ventricular puncture with any one or more of—fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection or exercise stress test (Anaes.)	531.55
38206	Right heart catheterisation with left heart catheterisation via the right heart or by another procedure, with any one or more of—fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection or exercise stress test (Anaes.)	642.65
38209	Cardiac electrophysiological study—up to and including 3 catheter investigation of any one or more of—syncope, atrio-ventricular conduction, sinus node function or simple ventricular tachycardia studies, other than a service associated with a service to which item 38212 or 38213 applies (Anaes.)	825.15
38212	Cardiac electrophysiological study: (a) 4 or more catheter supraventricular tachycardia investigation; or (b) complex tachycardia inductions; or (c) multiple catheter mapping; or (d) acute intravenous anti-arrhythmic drug testing with pre and post drug inductions; or (e) catheter ablation to intentionally induce complete AV block; or (f) intra-operative mapping; or (g) electrophysiological services during defibrillator implantation or testing; other than a service associated with a service to which	1 372.45

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	item 38209 or 38213 applies (Anaes.)	
38213	Cardiac electrophysiological study, for follow-up testing of implanted defibrillator—other than a service associated with a service to which item 38209 or 38212 applies (Anaes.)	408.70
38215	Selective coronary angiography—placement of catheters and injection of opaque material into the native coronary arteries, other than a service associated with a service to which item 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)	354.90
38218	Selective coronary angiography—placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography, other than a service associated with a service to which item 38215, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)	532.25
38220	Selective coronary graft angiography—placement of one or more catheters and injection of opaque material into free coronary graft attached to the aorta (any number of grafts), other than a service associated with a service to which item 38215, 38218, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)	177.40
38222	Selective coronary graft angiography—placement of one or more catheters and injection of opaque material into direct internal mammary artery graft to one or more coronary arteries (irrespective of the number of grafts), other than a service associated with a service to which item 38215, 38218, 38220, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)	354.90
38225	Selective coronary angiography—placement of catheters and injection of opaque material into the native coronary arteries and placement of one or more catheters and injection of opaque material into free coronary graft attached to the aorta (irrespective of the number of grafts), other than a service associated with a service to which item 38215, 38218, 38220, 38222, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)	532.35
38228	Selective coronary angiography—placement of catheters and	709.90

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	injection of opaque material into the native coronary arteries and placement of one or more catheters and injection of opaque material into direct internal mammary artery graft to one or more coronary arteries (irrespective of the number of grafts), other than a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)	
38231	Selective coronary angiography—placement of catheters and injection of opaque material into the native coronary arteries and placement of one or more catheters and injection of opaque material into free coronary graft attached to the aorta (irrespective of the number of grafts), and placement of one or more catheters and injection of opaque material into direct internal mammary artery graft to one or more coronary arteries (irrespective of the number of grafts), other than a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38234, 38237, 38240 or 38246 applies (Anaes.)	887.25
38234	Selective coronary angiography—placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of one or more catheters and injection of opaque material into free coronary graft attached to the aorta (irrespective of the number of grafts), other than a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38237, 38240 or 38246 applies (Anaes.)	709.75
38237	Selective coronary angiography—placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of one or more catheters and injection of opaque material into direct internal mammary artery graft to one or more coronary arteries (irrespective of the number of grafts), other than a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38240 or 38246 applies (Anaes.)	887.20
38240	Selective coronary angiography—placement of catheters and injection of opaque material with right or left heart	1 064.60

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	catheterisation or both, or aortography and placement of one or more catheters and injection of opaque material into free coronary graft attached to the aorta (irrespective of the number of grafts), and placement of one or more catheters and injection of opaque material into direct internal mammary artery graft to one or more coronary arteries (irrespective of the number of grafts), other than a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237 or 38246 applies (Anaes.)	
38241	Use of a coronary pressure wire during selective coronary angiography to measure fractional flow reserve (FFR) and coronary flow reserve (CFR) in one or more intermediate coronary artery or graft lesions (stenosis of 30—70%), to determine whether revascularisation should be performed, if previous stress testing has either not been performed or the results are inconclusive (Anaes.)	469.70
38243	Placement of one or more catheters and injection of opaque material into any one or more coronary vessels or grafts before any coronary interventional procedure, other than a service associated with a service to which item 38246 applies (Anaes.)	443.60
38246	Selective coronary angiography—placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography followed by placement of catheters before any coronary interventional procedure, other than a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38243 applies (Anaes.)	887.20
38256	Temporary transvenous pacemaking electrode, insertion of (Anaes.)	267.25
38270	Balloon valvuloplasty or isolated atrial septostomy, including cardiac catheterisations before and after balloon dilatation (Anaes.) (Assist.)	912.30
38272	Atrial septal defect, closure using a septal occluder or similar device by transcatheter approach (Anaes.) (Assist.)	912.30
38275	Myocardial biopsy, by cardiac catheterisation (Anaes.)	298.20

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
38285	Implantable ECG loop recorder, insertion of, for diagnosis of primary disorder, if: (a) the patient to whom the service is provided: (i) has recurrent unexplained syncope; and (ii) does not have a structural heart defect associated with a high risk of sudden cardiac death; and (b) a diagnosis has not been achieved through all other available cardiac investigations; and (c) a neurogenic cause is not suspected; including initial programming and testing (H) (Anaes.)	192.90
38286	Implantable ECG loop recorder, removal of (H) (Anaes.)	173.75
38287	Ablation of arrhythmia circuit or focus or isolation procedure involving one atrial chamber (Anaes.) (Assist.)	2 098.45
38290	Ablation of arrhythmia circuits or foci, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (H) (Anaes.) (Assist.)	2 671.95
38293	Ventricular arrhythmia with mapping and ablation, including all associated electrophysiological studies performed on the same day (Anaes.) (Assist.)	2 868.05
38300	Transluminal balloon angioplasty of one coronary artery, percutaneous or by open exposure, excluding associated radiological services, radiological preparation and after-care (Anaes.) (Assist.)	515.35
38303	Transluminal balloon angioplasty of more than one coronary artery, percutaneous or by open exposure, excluding associated radiological services, radiological preparation and after-care (Anaes.) (Assist.)	660.80
38306	Transluminal insertion of stent or stents into one occlusional site, including associated balloon dilatation of coronary artery, percutaneous or by open exposure, excluding associated radiological services, radiological preparation and after-care (Anaes.) (Assist.)	762.35
38309	Percutaneous transluminal rotational atherectomy of one coronary artery, including balloon angioplasty without stent insertion, if:	885.45

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	(a) no lesion of the coronary artery has been stented; and (b) each lesion of the coronary artery is complex and heavily calcified; and (c) balloon angioplasty, with or without stenting, is not suitable; excluding associated radiological services, radiological preparation and after-care (Anaes.) (Assist.)	
38312	Percutaneous transluminal rotational atherectomy of one coronary artery, including balloon angioplasty with the insertion of one or more stents, if: (a) no lesion of the coronary artery has been stented; and (b) each lesion of the coronary artery is complex and heavily calcified; and (c) balloon angioplasty, with or without stenting, is not suitable; excluding associated radiological services, radiological preparation and after-care (H) (Anaes.) (Assist.)	1 132.35
38315	Percutaneous transluminal rotational atherectomy of more than one coronary artery, including balloon angioplasty without stent insertion, if: (a) no lesion of the coronary artery has been stented; and (b) each lesion of the coronary arteries is complex and heavily calcified; and (c) balloon angioplasty, with or without stenting, is not suitable; excluding associated radiological services, radiological preparation and after-care (H) (Anaes.) (Assist.)	1 215.85
38318	Percutaneous transluminal rotational atherectomy of more than one coronary artery, including balloon angioplasty, with the insertion of one or more stents, if: (a) no lesion of the coronary artery has been stented; and (b) each lesion of the coronary arteries is complex and heavily calcified; and (c) balloon angioplasty with or without stenting is not suitable; excluding associated radiological services, radiological	1 586.35

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	preparation and after-care (H) (Anaes.) (Assist.)	
38350	Single chamber permanent transvenous electrode (including cardiac electrophysiological services if used for pacemaker implantation), insertion, removal or replacement of (Anaes.)	638.65
38353	Permanent cardiac pacemaker (including cardiac electrophysiological services if used for pacemaker implantation), insertion, removal or replacement of—other than a service for the purpose of cardiac resynchronisation therapy (H) (Anaes.)	255.45
38356	Dual chamber permanent transvenous electrodes (including cardiac electrophysiological services if used for pacemaker implantation), insertion, removal or replacement of (H) (Anaes.)	837.35
38358	Extraction, by percutaneous method, of a chronically implanted transvenous pacing or defibrillator lead, if the lead has been in place for more than 6 months, and requires removal: (a) with locking stylets, snares or extraction sheaths; and (b) in a facility where cardiac surgery is available; being a service associated with item 61109 or 60509 (H) (Anaes.) (Assist.)	2 868.05
38359	Pericardium, paracentesis of (excluding after-care) (Anaes.)	133.55
38362	Intra-aortic balloon pump, percutaneous insertion of (H) (Anaes.)	384.95
38365	Permanent cardiac synchronisation device (including a cardiac synchronisation device that is capable of defibrillation), insertion, removal or replacement of (H) (Anaes.)	255.45
38368	Permanent transvenous left ventricular electrode, insertion, removal or replacement of through the coronary sinus, for the purpose of cardiac resynchronisation therapy, including right heart catheterisation and any associated venogram of left ventricular veins—other than a service associated with a service to which item 35200 or 38200 applies (H) (Anaes.)	1 224.60
38371	Permanent cardiac syncronisation device capable of defibrillation, insertion, removal or replacement of, for a	287.85

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	patient who has moderate to severe chronic heart failure (NYHA class III or IV) despite optimised medical therapy and who meets all of the following criteria: (a) sinus rhythm; (b) a left ventricular ejection fraction of less than or equal to 35%; (c) a QRS duration greater than or equal to 120 ms; (H) (Anaes.)	
38384	Automatic defibrillator, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for, primary prevention of sudden cardiac death in: (a) a patient with a left ventricular ejection fraction of less than or equal to 30% at least one month after a myocardial infarct despite optimised medical therapy; or (b) a patient with chronic heart failure associated with mild to moderate symptoms (NYHA II and III) and a left ventricular ejection fraction less than or equal to 35% despite optimised medical therapy; other than a service associated with a service to which item 38213 applies (H) (Anaes.) (Assist.)	1 052.65
38387	Automatic defibrillation generator (other than a defibrillator capable of cardiac resynchronisation therapy), insertion or replacement of, for primary prevention of sudden cardiac death in: (a) a patient with a left ventricular ejection fraction of less than or equal to 30% at least one month after a myocardial infarct despite optimised medical therapy; or (b) a patient with chronic heart failure associated with mild to moderate symptoms (NYHA II and III) and a left ventricular ejection fraction less than or equal to 35% despite optimised medical therapy; other than a service associated with a service to which item 38213 applies (H) (Anaes.) (Assist.)	287.85
38390	Automatic defibrillator, insertion of patches or transvenous endocardial defibrillation electrodes for, other than for primary prevention for tachycardia arrhythmias or a service	1 052.65

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	associated with a service to which item 38213 applies (H) (Anaes.) (Assist.)	
38393	Automatic defibrillator generator (other than a defibrillator capable of cardiac resynchronisation therapy), insertion or replacement of, other than for primary prevention for tachycardia arrhythmias or a service associated with a service to which item 38213 applies (H) (Anaes.) (Assist.)	287.85
38415	Empyema, radical operation for, involving resection of rib (Anaes.) (Assist.)	399.35
38418	Thoracotomy, exploratory, with or without biopsy (H) (Anaes.) (Assist.)	958.40
38421	Thoracotomy, with pulmonary decortication (H) (Anaes.) (Assist.)	1 532.00
38424	Thoracotomy, with pleurectomy or pleurodesis, or enucleation of hydatid cysts (H) (Anaes.) (Assist.)	958.40
38427	Thoracoplasty (complete)—3 or more ribs (H) (Anaes.) (Assist.)	1 183.40
38430	Thoracoplasty (in stages)—each stage (H) (Anaes.) (Assist.)	609.90
38436	Thoracoscopy, with or without division of pleural adhesions, including insertion of intercostal catheter, if necessary, with or without biopsy (H) (Anaes.)	249.75
38438	Pneumonectomy or lobectomy or segmentectomy other than a service associated with a service to which item 38418 applies (H) (Anaes.) (Assist.)	1 532.00
38440	Lung, wedge resection of (H) (Anaes.) (Assist.)	1 147.20
38441	Radical lobectomy or pneumonectomy including resection of chest wall, diaphragm, pericardium, or formal mediastinal node dissection (H) (Anaes.) (Assist.)	1 815.20
38446	Thoracotomy or sternotomy, for removal of thymus or mediastinal tumour (H) (Anaes.) (Assist.)	1 183.40
38447	Pericardiectomy via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (H) (Anaes.) (Assist.)	1 532.00
38448	Mediastinum, cervical exploration of, with or without biopsy (H) (Anaes.) (Assist.)	363.05

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
38449	Pericardiectomy via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass (H) (Anaes.) (Assist.)	2 143.20
38450	Pericardium, transthoracic open surgical drainage of (H) (Anaes.) (Assist.)	856.65
38452	Pericardium, sub-xyphoid open surgical drainage of (H) (Anaes.) (Assist.)	573.70
38453	Tracheal excision and repair without cardiopulmonary bypass (H) (Anaes.) (Assist.)	1 720.90
38455	Tracheal excision and repair of, with cardiopulmonary bypass (H) (Anaes.) (Assist.)	2 327.70
38456	Intrathoracic operation on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than one of those organs, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	1 532.00
38457	Pectus excavatum or pectus carinatum, repair or radical correction of (H) (Anaes.) (Assist.)	1 430.25
38458	Pectus excavatum, repair of, with implantation of subcutaneous prosthesis (H) (Anaes.) (Assist.)	762.35
38460	Sternal wires or wires, removal of (H) (Anaes.)	275.40
38462	Sternotomy wound, debridement of, not involving reopening of the mediastinum (H) (Anaes.)	326.45
38464	Sternotomy wound, debridement of, involving curettage of infected bone with or without removal of wires but not involving reopening of the mediastinum (H) (Anaes.)	354.80
38466	Sternum, re-operation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring (H) (Anaes.) (Assist.)	958.00
38468	Sternum and mediastinum, re-operation for infection of, involving muscle advancement flaps or greater omentum (H) (Anaes.) (Assist.)	1 476.15
38469	Sternum and mediastinum, re-operation for infection of, involving muscle advancement flaps and greater omentum (H) (Anaes.) (Assist.)	1 720.90
38470	Permanent myocardial electrode, insertion of, by thoracotomy	958.40

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	or sternotomy (H) (Anaes.) (Assist.)	
38473	Permanent pacemaker electrode, insertion by open surgical approach (H) (Anaes.) (Assist.)	573.70
38475	Valve annuloplasty without insertion of ring, other than a service associated with a service to which item 38480 or 38481 applies (H) (Anaes.) (Assist.)	831.75
38477	Valve annuloplasty with insertion of ring other than a service to which item 38478 applies (H) (Anaes.) (Assist.)	2 003.35
38478	Valve annuloplasty with insertion of ring performed in conjunction with item 38480 or 38481 (H) (Anaes.) (Assist.)	970.40
38480	Valve repair, one leaflet (H) (Anaes.) (Assist.)	2 003.35
38481	Valve repair, 2 or more leaflets (H) (Anaes.) (Assist.)	2 280.65
38483	Aortic valve leaflet or leaflets, decalcification of, other than a service to which item 38475, 38477, 38480, 38481, 38488 or 38489 applies (H) (Anaes.) (Assist.)	1 720.90
38485	Mitral annulus, reconstruction of, after decalcification, when performed in association with valve surgery (H) (Anaes.) (Assist.)	817.10
38487	Mitral valve, open valvotomy of (H) (Anaes.) (Assist.)	1 720.90
38488	Valve replacement with bioprosthesis or mechanical prosthesis (H) (Anaes.) (Assist.)	1 909.60
38489	Valve replacement with allograft (subcoronary or cylindrical implant), or unstented xenograft (H) (Anaes.) (Assist.)	2 271.05
38490	Sub-valvular structures, reconstruction and re-implantation of, associated with mitral and tricuspid valve replacement (H) (Anaes.) (Assist.)	554.55
38493	Operative management of acute infective endocarditis, in association with heart valve surgery (H) (Anaes.) (Assist.)	1 957.60
38496	Artery harvesting (other than internal mammary), for coronary artery bypass (H) (Anaes.) (Assist.)	623.95
38497	Coronary artery bypass with cardiopulmonary bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material if performed, other than a service associated with a service to which item 38498, 38500, 38501,	2 047.60

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	38503 or 38504 applies (H) (Anaes.) (Assist.)	
38498	Coronary artery bypass with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material if performed, either by a median sternotomy or other minimally invasive technique, and if a stand-by perfusionist is present, other than a service associated with a service to which item 38497, 38500, 38501, 38503, 38504 or 38600 applies (H) (Anaes.) (Assist.)	2 047.60
38500	Coronary artery bypass with cardiopulmonary bypass, using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material if performed, other than a service associated with a service to which item 38497, 38498, 38501, 38503 or 38504 applies (H) (Anaes.) (Assist.)	2 200.00
38501	Coronary artery bypass with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material if performed, either by a median sternotomy or other minimally invasive technique, and if a stand-by perfusionist is present, other than a service associated with a service to which item 38497, 38498, 38500, 38503, 38504 or 38600 applies (H) (Anaes.) (Assist.)	2 200.00
38503	Coronary artery bypass with cardiopulmonary bypass, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material if performed, other than a service associated with a service to which item 38497, 38498, 38500, 38501 or 38504 applies (H) (Anaes.) (Assist.)	2 388.70
38504	Coronary artery bypass with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material if performed, either by a median sternotomy or other minimally invasive technique, and if a stand-by perfusionist is present, other than a service associated with a service to which	2 388.70

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	item 38497, 38498, 38500, 38501, 38503 or 38600 applies (H) (Anaes.) (Assist.)	
38505	Coronary endarterectomy, by open operation, including repair with one or more patch grafts, each vessel (H) (Anaes.) (Assist.)	277.25
38506	Left ventricular aneurysm, plication of (H) (Anaes.) (Assist.)	1 626.25
38507	Left ventricular aneurysm resection with primary repair (H) (Anaes.) (Assist.)	1 909.20
38508	Left ventricular aneurysm resection with patch reconstruction of the left ventricle (H) (Anaes.) (Assist.)	2 388.70
38509	Ischaemic ventricular septal rupture, repair of (H) (Anaes.) (Assist.)	2 388.70
38512	Division of accessory pathway, isolation procedure, procedure on atrioventricular node or perinodal tissues involving one atrial chamber only (H) (Anaes.) (Assist.)	2 098.45
38515	Division of accessory pathway, isolation procedure, procedure on atrioventricular node or perinodal tissues involving both atrial chambers and including curative surgery for atrial fibrillation (H) (Anaes.) (Assist.)	2 671.95
38518	Ventricular arrhythmia with mapping and muscle ablation, with or without aneurysmeotomy (H) (Anaes.) (Assist.)	2 868.05
38550	Ascending thoracic aorta, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (H) (Anaes.) (Assist.)	2 146.15
38553	Ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (H) (Anaes.) (Assist.)	2 719.75
38556	Ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (H) (Anaes.) (Assist.)	3 104.70
38559	Aortic arch and ascending thoracic aorta, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (H) (Anaes.) (Assist.)	2 531.00
38562	Aortic arch and ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair,	3 104.70

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	without implantation of coronary arteries (H) (Anaes.) (Assist.)	
38565	Aortic arch and ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (H) (Anaes.) (Assist.)	3 482.25
38568	Descending thoracic aorta, repair or replacement of, without shunt or cardiopulmonary bypass, by open exposure, percutaneous or endovascular means (H) (Anaes.) (Assist.)	1 862.95
38571	Descending thoracic aorta, repair or replacement of, using shunt or cardiopulmonary bypass (H) (Anaes.) (Assist.)	2 051.75
38572	Operative management of acute rupture or dissection, in conjunction with procedures on the thoracic aorta (H) (Anaes.) (Assist.)	1 987.05
38577	Cannulation for, and supervision and monitoring of, the administration of retrograde cerebral perfusion during deep hypothermic arrest (H) (Assist.)	554.55
38588	Cannulation of the coronary sinus for, and supervision of, the retrograde administration of blood or crystalloid for cardioplegia, including pressure monitoring (H) (Assist.)	416.05
38600	Central cannulation for cardiopulmonary bypass excluding post-operative management, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	1 532.00
38603	Peripheral cannulation for cardiopulmonary bypass excluding post-operative management (H) (Anaes.) (Assist.)	958.40
38609	Intra-aortic balloon pump, insertion of, by arteriotomy (H) (Anaes.) (Assist.)	479.15
38612	Intra-aortic balloon pump, removal of, with closure of artery by direct suture (Anaes.) (Assist.)	537.10
38613	Intra-aortic balloon pump, removal of, with closure of artery by patch graft (H) (Anaes.) (Assist.)	674.05
38615	Left or right ventricular assist device, insertion of (H) (Anaes.) (Assist.)	1 532.00
38618	Left and right ventricular assist device, insertion of (H) (Anaes.) (Assist.)	1 909.60

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
38621	Left or right ventricular assist device, removal of, as an independent procedure (H) (Anaes.) (Assist.)	762.35
38624	Left and right ventricular assist device, removal of, as an independent procedure (H) (Anaes.) (Assist.)	856.65
38627	Extra-corporeal membrane oxygenation, bypass or ventricular assist device cannulae, adjustment and re-positioning of, by open operation, in patients supported by these devices (H) (Anaes.) (Assist.)	669.60
38637	Patent diseased coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of (H) (Anaes.) (Assist.)	554.55
38640	Re-operation via median sternotomy, for any procedure, including any divisions of adhesions if the time taken to divide the adhesions is 45 minutes or less (H) (Anaes.) (Assist.)	958.40
38643	Thoracotomy or sternotomy involving division of adhesions if the time taken to divide the adhesions exceeds 45 minutes (H) (Anaes.) (Assist.)	1 067.40
38647	Thoracotomy or sternotomy involving division of extensive adhesions if the time taken to divide the adhesions exceeds 2 hours (H) (Anaes.) (Assist.)	2 134.50
38650	Myomectomy or myotomy for hypertrophic obstructive cardiomyopathy (H) (Anaes.) (Assist.)	1 909.60
38653	Open heart surgery, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	1 909.60
38654	Permanent left ventricular electrode, insertion, removal or replacement of via open thoracotomy, for the purpose of cardiac resynchronisation therapy (H) (Anaes.) (Assist.)	1 224.60
38656	Thoracotomy or median sternotomy for post-operative bleeding (H) (Anaes.) (Assist.)	958.40
38670	Cardiac tumour, excision of, involving the wall of the atrium or inter-atrial septum, without patch or conduit reconstruction (H) (Anaes.) (Assist.)	1 909.20
38673	Cardiac tumour, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or	2 148.85

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	conduit (H) (Anaes.) (Assist.)	
38677	Cardiac tumour arising from ventricular myocardium, partial thickness excision of (H) (Anaes.) (Assist.)	2 010.35
38680	Cardiac tumour arising from ventricular myocardium, full thickness excision of including repair or reconstruction (Anaes.) (Assist.)	2 384.55
38700	Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease (H) (Anaes.) (Assist.)	1 067.40
38703	Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease (H) (Anaes.) (Assist.)	1 924.10
38706	Aorta, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (H) (Anaes.) (Assist.)	1 822.40
38709	Aorta, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (H) (Anaes.) (Assist.)	2 134.50
38712	Aortic interruption, repair of, for congenital heart disease (H) (Anaes.) (Assist.)	2 563.15
38715	Main pulmonary artery, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease (H) (Anaes.) (Assist.)	1 706.30
38718	Main pulmonary artery, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (H) (Anaes.) (Assist.)	2 134.50
38721	Vena cava, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (H) (Anaes.) (Assist.)	1 495.80
38724	Vena cava, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (H) (Anaes.) (Assist.)	2 134.50
38727	Intrathoracic vessels, anastomosis or repair of, without cardiopulmonary bypass, other than a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (H) (Anaes.) (Assist.)	1 495.80
38730	Intrathoracic vessels, anastomosis or repair of, with cardiopulmonary bypass, other than a service to which	2 134.50

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (H) (Anaes.) (Assist.)	
38733	Systemic pulmonary or cavo-pulmonary shunt, creation of, without cardiopulmonary bypass, for congenital heart disease (H) (Anaes.) (Assist.)	1 495.80
38736	Systemic pulmonary or cavo-pulmonary shunt, creation of, with cardiopulmonary bypass, for congenital heart disease (H) (Anaes.) (Assist.)	2 134.50
38739	Atrial septectomy, with or without cardiopulmonary bypass, for congenital heart disease (H) (Anaes.) (Assist.)	1 924.10
38742	Atrial septal defect, closure by open exposure and direct suture or patch, for congenital heart disease (H) (Anaes.) (Assist.)	1 924.10
38745	Intra-atrial baffle, insertion of, for congenital heart disease (H) (Anaes.) (Assist.)	2 134.50
38748	Ventricular septectomy, for congenital heart disease (H) (Anaes.) (Assist.)	2 134.50
38751	Ventricular septal defect, closure by direct suture or patch, for congenital heart disease (H) (Anaes.) (Assist.)	2 134.50
38754	Intraventricular baffle or conduit, insertion of, for congenital heart disease (H) (Anaes.) (Assist.)	2 671.95
38757	Extracardiac conduit, insertion of, for congenital heart disease (H) (Anaes.) (Assist.)	2 134.50
38760	Extracardiac conduit, replacement of, for congenital heart disease (H) (Anaes.) (Assist.)	2 134.50
38763	Ventricular myectomy, for relief of ventricular obstruction, right or left, for congenital heart disease (H) (Anaes.) (Assist.)	2 134.50
38766	Ventricular augmentation, right or left, for congenital heart disease (H) (Anaes.) (Assist.)	2 134.50
38800	Thoracic cavity, aspiration of, for diagnostic purposes, other than a service associated with a service to which item 38803 applies	38.50
38803	Thoracic cavity, aspiration of, with therapeutic drainage	76.90

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	(paracentesis), with or without diagnostic sample	
38806	Intercostal drain, insertion of, not involving resection of rib (excluding after-care) (Anaes.)	133.55
38809	Intercostal drain, insertion of, with pleurodesis and not involving resection of rib (excluding after-care) (Anaes.)	164.55
38812	Percutaneous needle biopsy of lung (Anaes.)	209.15

Subdivision E—Subgroups 7 to 11 of Group T8

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
Subgroup 7—Neurosurgical		
39000	Lumbar puncture (Anaes.)	75.30
39003	Cisternal puncture (Anaes.)	85.65
39006	Ventricular puncture (not including burr-hole) (Anaes.)	159.40
39009	Subdural haemorrhage, tap for, each tap (H) (Anaes.)	59.35
39012	Burr-hole, single, preparatory to ventricular puncture or for inspection purpose—other than a service to which another item applies (H) (Anaes.)	237.60
39013	Injection under image intensification with one or more of contrast media, local anaesthetic or corticosteroid into one or more zygo-apophyseal or costo-transverse joints or one or more primary posterior rami of spinal nerves (Anaes.)	109.15
39015	Ventricular reservoir, external ventricular drain or intracranial pressure monitoring device, insertion of—including burr-hole (excluding after-care) (H) (Anaes.) (Assist.)	376.00
39018	Cerebrospinal fluid reservoir, insertion of (H) (Anaes.) (Assist.)	376.00
39100	Injection of primary branch of trigeminal nerve with alcohol, cortisone, phenol, or similar substance (Anaes.)	237.60
39106	Neurectomy, intracranial, for trigeminal neuralgia (H) (Anaes.) (Assist.)	1 188.20
39109	Trigeminal gangliotomy by radiofrequency, balloon or	443.70

Group T8—Surgical operations

Item	Description	Fee ($)
	glycerol (Anaes.)	
39112	Cranial nerve, intracranial decompression of, using microsurgical techniques (H) (Anaes.) (Assist.)	1 541.50
39115	Percutaneous neurotomy of posterior divisions (or rami) of spinal nerves by any method, including any associated spinal, epidural or regional nerve block (payable once only in a 30 day period) (Anaes.)	75.30
39118	Percutaneous neurotomy for facet joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.) (Assist.)	297.85
39121	Percutaneous cordotomy (Anaes.) (Assist.)	631.75
39124	Cordotomy or myelotomy, partial or total laminectomy for, or operation for dorsal root entry zone (Drez) lesion (H) (Anaes.) (Assist.)	1 616.80
39125	Intrathecal or epidural spinal catheter, insertion or replacement of, and connection to a subcutaneous implanted infusion pump, for the management of chronic intractable pain (H) (Anaes.) (Assist.)	298.05
39126	All of the following: (a) infusion pump, subcutaneous implantation or replacement of; (b) connection of the pump to an intrathecal or epidural spinal catheter; (c) filling of reservoir with a therapeutic agent or agents; with or without programming the pump, for the management of chronic intractable pain (H) (Anaes.) (Assist.)	361.90
39127	Subcutaneous reservoir and spinal catheter, insertion of, for the management of chronic intractable pain (H) (Anaes.)	473.65
39128	All of the following: (a) infusion pump, subcutaneous implantation of; (b) intrathecal or epidural spinal catheter, insertion of; (c) connection of pump to catheter; (d) filling of reservoir with a therapeutic agent or agents; with or without programming the pump, for the management	659.95

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	of chronic intractable pain (H) (Anaes.) (Assist.)	
39130	Epidural lead, percutaneous placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris—to a maximum of 4 leads (H) (Anaes.)	674.15
39131	Epidural or peripheral nerve electrodes, management, adjustment, and electronic programming of, by a medical practitioner, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris—each day	127.80
39133	Either: (a) subcutaneously implanted infusion pump, removal of; or (b) intrathecal or epidural spinal catheter, removal or repositioning of; for the management of chronic intractable pain (H) (Anaes.)	159.40
39134	Neurostimulator or receiver, subcutaneous placement of, including placement and connection of extension wires to epidural or peripheral nerve electrodes, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris (H) (Anaes.) (Assist.)	340.60
39135	Neurostimulator or receiver that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, removal of, performed in the operating theatre of a hospital (Anaes.)	159.40
39136	Epidural or peripheral nerve lead that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, removal of, performed in the operating theatre of a hospital (Anaes.)	159.40
39137	Epidural or peripheral nerve lead that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, surgical repositioning of, to correct displacement or unsatisfactory positioning, including intraoperative test stimulation, other than a service to which item 39130, 39138 or 39139 applies (Anaes.)	605.35
39138	Peripheral nerve lead, surgical placement of, including intraoperative test stimulation, for chronic intractable	674.15

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	neuropathic pain or pain from refractory angina pectoris—not exceeding 4 leads (Anaes.) (Assist.)	
39139	Epidural lead, surgical placement of one or more of by partial or total laminectomy, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris—to a maximum of 4 leads (H) (Anaes.) (Assist.)	905.10
39140	Epidural catheter, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (Anaes.)	292.85
39300	Cutaneous nerve (including digital nerve), primary repair of, using microsurgical techniques (H) (Anaes.) (Assist.)	353.35
39303	Cutaneous nerve (including digital nerve), secondary repair of, using microsurgical techniques (H) (Anaes.) (Assist.)	466.10
39306	Nerve trunk, primary repair of, using microsurgical techniques (H) (Anaes.) (Assist.)	676.80
39309	Nerve trunk, secondary repair of, using microsurgical techniques (H) (Anaes.) (Assist.)	714.35
39312	Nerve trunk, internal (interfascicular), neurolysis of, using microsurgical techniques (H) (Anaes.) (Assist.)	398.55
39315	Nerve trunk, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgical techniques (H) (Anaes.) (Assist.)	1 030.20
39318	Cutaneous nerve (including digital nerve), nerve graft to, using microsurgical techniques (H) (Anaes.) (Assist.)	639.20
39321	Nerve, transposition of (H) (Anaes.) (Assist.)	473.65
39323	Percutaneous neurotomy by cryotherapy or radiofrequency lesion generator, other than a service to which another item applies (Anaes.) (Assist.)	276.80
39324	Neurectomy, neurotomy or removal of tumour from superficial peripheral nerve, by open operation (Anaes.) (Assist.)	276.80
39327	Neurectomy, neurotomy or removal of tumour from deep peripheral or cranial nerve, by open operation, other than a service to which item 41575, 41576, 41578 or 41579 applies	473.75

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	(H) (Anaes.) (Assist.)	
39330	Neurolysis by open operation without transposition, other than a service associated with a service to which item 39312 applies (H) (Anaes.) (Assist.)	276.80
39331	Carpal tunnel release (division of transverse carpal ligament), by any method (Anaes.)	276.80
39333	Brachial plexus, exploration of, other than a service to which another item in this Group applies (Anaes.) (Assist.)	398.55
39500	Vestibular nerve, section of, via posterior fossa (H) (Anaes.) (Assist.)	1 270.90
39503	Facio-hypoglossal nerve or facio-accessory nerve, anastomosis of (H) (Anaes.) (Assist.)	955.00
39600	Intracranial haemorrhage, burr-hole craniotomy for—including burr-holes (H) (Anaes.) (Assist.)	473.65
39603	Intracranial haemorrhage, osteoplastic craniotomy or extensive craniectomy and removal of haematoma (H) (Anaes.) (Assist.)	1 195.70
39606	Fractured skull, depressed or comminuted, operation for (H) (Anaes.) (Assist.)	797.10
39609	Fractured skull, compound, without dural penetration, operation for (H) (Anaes.) (Assist.)	955.00
39612	Fractured skull, compound, depressed or complicated, with dural penetration and brain laceration, operation for (H) (Anaes.) (Assist.)	1 120.45
39615	Fractured skull with rhinorrhoea or otorrhoea, cranioplasty and repair of (H) (Anaes.) (Assist.)	1 195.70
39640	Tumour involving anterior cranial fossa, removal of, involving craniotomy, radical excision of the skull base, and dural repair (H) (Anaes.) (Assist.)	3 031.65
39642	Tumour involving anterior cranial fossa, removal of, involving frontal craniotomy with lateral rhinotomy for clearance of paranasal sinus extension, (intracranial procedure) (H) (Anaes.) (Assist.)	3 187.25
39646	Tumour involving anterior cranial fossa, removal of, involving frontal craniotomy with lateral rhinotomy and radical	3 653.60

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	clearance of paranasal sinus and orbital fossa extensions, with intracranial decompression of the optic nerve, (intracranial procedure) (H) (Anaes.) (Assist.)	
39650	Tumour involving middle cranial fossa and infra-temporal fossa, removal of, craniotomy and radical or sub-total radical excision, with division and reconstruction of zygomatic arch, (intracranial procedure) (H) (Anaes.) (Assist.)	2 642.95
39653	Petro-clival and clival tumour, removal of, by supra and infratentorial approaches for radical or sub-total radical excision (intracranial procedure), other than a service to which item 39654 or 39656 applies (H) (Anaes.) (Assist.)	4 703.15
39654	Petro-clival and clival tumour, removal of, by supra and infratentorial approaches for radical or sub-total radical excision (intracranial procedure), conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	3 420.50
39656	Petro-clival and clival tumour, removal of, by supra and infratentorial approaches for radical or sub-total radical excision (intracranial procedure), conjoint surgery, co-surgeon (H) (Assist.)	2 565.30
39658	Tumour involving the clivus, radical or sub-total radical excision of, involving transoral or transmaxillary approach (H) (Anaes.) (Assist.)	3 031.65
39660	Tumour or vascular lesion of cavernous sinus, radical excision of, involving craniotomy with or without intracranial carotid artery exposure (H) (Anaes.) (Assist.)	3 031.65
39662	Tumour or vascular lesion of foramen magnum, radical excision of, via transcondylar or far lateral suboccipital approach (H) (Anaes.) (Assist.)	3 031.65
39700	Skull tumour, benign or malignant, excision of, excluding cranioplasty (H) (Anaes.) (Assist.)	556.60
39703	Intracranial tumour, cyst or other brain tissue, burr-hole and biopsy of, or drainage of, or both (H) (Anaes.) (Assist.)	519.00
39706	Intracranial tumour, biopsy or decompression of via osteoplastic flap or biopsy and decompression of via osteoplastic flap (H) (Anaes.) (Assist.)	1 112.85

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
39709	Craniotomy for removal of glioma, metastatic carcinoma or another tumour in cerebrum, cerebellum or brain stem—other than a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	1 586.75
39712	Craniotomy for removal of meningioma, pinealoma, cranio-pharyngioma, intraventricular tumour or another intracranial tumour—other than a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	2 865.00
39715	Pituitary tumour, removal of, by transcranial or transphenoidal approach (H) (Anaes.) (Assist.)	1 985.30
39718	Arachnoidal cyst, craniotomy for (H) (Anaes.) (Assist.)	872.30
39721	Craniotomy, involving osteoplastic flap, for re-opening post-operatively for haemorrhage, swelling, etc (H) (Anaes.) (Assist.)	797.10
39800	Aneurysm, clipping or reinforcement of sac (H) (Anaes.) (Assist.)	2 857.55
39803	Intracranial arteriovenous malformation, excision of (H) (Anaes.) (Assist.)	2 857.55
39806	Aneurysm, or arteriovenous malformation, intracranial proximal artery clipping of (H) (Anaes.) (Assist.)	1 285.75
39812	Intracranial aneurysm or arteriovenous fistula, ligation of cervical vessel or vessels (H) (Anaes.) (Assist.)	631.75
39815	Carotid-cavernous fistula, obliteration of—combined cervical and intracranial procedure (Anaes.) (Assist.)	1 827.25
39818	Extracranial to intracranial bypass using superficial temporal artery (H) (Anaes.) (Assist.)	1 827.25
39821	Extracranial to intracranial bypass using saphenous vein graft (H) (Anaes.) (Assist.)	2 169.75
39900	Intracranial infection, drainage of, via burr-hole—including burr-hole (H) (Anaes.) (Assist.)	519.00
39903	Intracranial abscess, excision of (H) (Anaes.) (Assist.)	1 586.75
39906	Osteomyelitis of skull or removal of infected bone flap, craniectomy for (H) (Anaes.) (Assist.)	797.10
40000	Ventriculo-cisternostomy (Torkildsen's operation) (H)	917.40

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	(Anaes.) (Assist.)	
40003	Cranial or cisternal shunt diversion, insertion of (H) (Anaes.) (Assist.)	917.40
40006	Lumbar shunt diversion, insertion of (H) (Anaes.) (Assist.)	721.95
40009	Cranial, cisternal or lumbar shunt, revision or removal of (H) (Anaes.) (Assist.)	526.40
40012	Third ventriculostomy (open or endoscopic) with or without endoscopic septum pellucidotomy (H) (Anaes.) (Assist.)	1 030.20
40015	Subtemporal decompression (H) (Anaes.) (Assist.)	638.65
40018	Lumbar cerebrospinal fluid drain, insertion of (Anaes.)	159.40
40100	Meningocele, excision and closure of (H) (Anaes.) (Assist.)	691.75
40103	Myelomeningocele, excision and closure of, including skin flaps or Z plasty, if performed (H) (Anaes.) (Assist.)	1 015.25
40106	Arnold-Chiari malformation, decompression of (H) (Anaes.) (Assist.)	1 030.20
40109	Encephalocoele, excision and closure of (H) (Anaes.) (Assist.)	1 112.85
40112	Tethered cord, release of, including lipomeningocele or diastematomyelia (H) (Anaes.) (Assist.)	1 428.75
40115	Craniostenosis, operation for—single suture (H) (Anaes.) (Assist.)	721.95
40118	Craniostenosis, operation for—more than one suture (H) (Anaes.) (Assist.)	955.00
40300	Intervertebral disc or discs, partial or total laminectomy for removal of (H) (Anaes.) (Assist.)	955.00
40301	Intervertebral disc or discs, microsurgical partial or total discectomy of (H) (Anaes.) (Assist.)	958.00
40303	Recurrent disc lesion or spinal stenosis, or both, partial or total laminectomy for—one level (H) (Anaes.) (Assist.)	1 090.35
40306	Spinal stenosis, partial or total laminectomy for, involving more than one vertebral interspace (disc level) (H) (Anaes.) (Assist.)	1 436.30
40309	Extradural tumour or abscess, partial or total laminectomy for (H) (Anaes.) (Assist.)	1 090.35

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
40312	Intradural lesion, partial or total laminectomy for, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	1 466.30
40315	Craniocervical junction lesion, transoral approach for (H) (Anaes.) (Assist.)	1 586.75
40316	Odontoid screw fixation (H) (Anaes.) (Assist.)	2 079.75
40318	Intramedullary tumour or arteriovenous malformation, partial or total laminectomy and radical excision of (H) (Anaes.) (Assist.)	1 985.30
40321	Posterior spinal fusion, other than a service to which items 40324 and 40327 apply (H) (Anaes.) (Assist.)	1 090.35
40324	Partial or total laminectomy followed by posterior fusion, performed by neurosurgeon and orthopaedic surgeon operating together—laminectomy, including after-care (H) (Anaes.) (Assist.)	639.20
40327	Partial or total laminectomy followed by posterior fusion, performed by neurosurgeon and orthopaedic surgeon operating together—posterior fusion, including after-care (H) (Assist.)	639.20
40330	Spinal rhizolysis involving exposure of spinal nerve roots—for lateral recess, exit foraminal stenosis, adhesive radiculopathy or extensive epidural fibrosis, at one or more levels—with or without partial or total laminectomy (H) (Anaes.) (Assist.)	955.00
40331	Cervical decompression of spinal cord with or without involvement of nerve roots, without fusion, one level, by any approach, other than a service to which item 40330 applies (H) (Anaes.) (Assist.)	955.00
40332	Cervical decompression of spinal cord with or without involvement of nerve roots, including anterior fusion, one level, other than a service to which item 40330 applies (H) (Anaes.) (Assist.)	1 558.30
40333	Cervical partial or total discectomy (anterior), without fusion (H) (Anaes.) (Assist.)	797.10
40334	Cervical decompression of spinal cord with or without	1 053.90

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	involvement of nerve roots, without fusion, more than one level, by any approach, other than a service to which item 40330 applies (H) (Anaes.) (Assist.)	
40335	Cervical decompression of spinal cord with or without involvement of nerve roots, including anterior fusion, more than one level, by any approach, other than a service to which item 40330 applies (H) (Anaes.) (Assist.)	1 935.60
40336	Intradiscal injection of chymopapain (discase)—one disc (H) (Anaes.) (Assist.)	315.90
40339	Hydromyelia, plugging of obex for, with or without duroplasty (H) (Anaes.) (Assist.)	1 586.75
40342	Hydromyelia, craniotomy and partial or total laminectomy for, with cavity packing and CSF shunt (H) (Anaes.) (Assist.)	1 466.30
40345	Thoracic decompression of spinal cord with or without involvement of nerve roots, via pedicle or costotransversectomy (H) (Anaes.) (Assist.)	1 365.00
40348	Thoracic decompression of spinal cord via thoracotomy with vertebrectomy, not including stabilisation procedure (H) (Anaes.) (Assist.)	1 733.10
40351	Thoraco-lumbar or high lumbar anterior decompression of spinal cord, not including stabilisation procedure (H) (Anaes.) (Assist.)	1 733.10
40600	Cranioplasty, reconstructive (H) (Anaes.) (Assist.)	955.00
40700	Corpus callosum, anterior section of, for epilepsy (H) (Anaes.) (Assist.)	1 744.65
40703	Corticectomy, topectomy or partial lobectomy for epilepsy (H) (Anaes.) (Assist.)	1 466.30
40706	Hemispherectomy for intractable epilepsy (Anaes.) (Assist.)	2 143.10
40709	Burr-hole placement of intracranial depth or surface electrodes (H) (Anaes.) (Assist.)	519.00
40712	Intracranial electrode placement via craniotomy (H) (Anaes.) (Assist.)	1 045.20
40800	Stereotactic anatomical localisation, as an independent procedure (Anaes.) (Assist.)	638.65

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
40801	Functional stereotactic procedure, including computer assisted anatomical localisation, physiological localisation and lesion production in the basal ganglia, brain stem or deep white matter tracts, other than a service associated with deep brain stimulation for Parkinson's disease, essential tremor or dystonia (H) (Anaes.) (Assist.)	1 745.80
40803	Intracranial stereotactic procedure by any method, other than a service to which item 40800 or 40801 applies (Anaes.) (Assist.)	1 195.70
40850	Deep brain stimulation (unilateral) functional stereotactic procedure, including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes for the treatment of: (a) Parkinson's disease, where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or (b) essential tremor or dystonia, where the patient's symptoms cause severe disability (H) (Anaes.) (Assist.)	2 264.45
40851	Deep brain stimulation (bilateral) functional stereotactic procedure, including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes for the treatment of: (a) Parkinson's disease, where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or (b) essential tremor or dystonia, where the patient's symptoms cause severe disability (H) (Anaes.) (Assist.)	3 963.00
40852	Deep brain stimulation (unilateral) subcutaneous placement of neuro-stimulator receiver or pulse generator for the treatment of: (a) Parkinson's disease, where the patient's response to medical therapy is not sustained and is accompanied by	340.60

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	unacceptable motor fluctuations; or (b) essential tremor or dystonia, where the patient's symptoms cause severe disability (H) (Anaes.) (Assist.)	
40854	Deep brain stimulation (unilateral) revision or removal of brain electrode for the treatment of: (a) Parkinson's disease, where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or (b) essential tremor or dystonia, where the patient's symptoms cause severe disability (H) (Anaes.) (Assist.)	526.40
40856	Deep brain stimulation (unilateral) removal or replacement of neurostimulator receiver or pulse generator for the treatment of: (a) Parkinson's disease, where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or (b) essential tremor or dystonia, where the patient's symptoms cause severe disability (H) (Anaes.) (Assist.)	255.45
40858	Deep brain stimulation (unilateral) placement, removal or replacement of extension lead for the treatment of: (a) Parkinson's disease, where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or (b) essential tremor or dystonia, where the patient's symptoms cause severe disability (H) (Anaes.) (Assist.)	526.40
40860	Deep brain stimulation (unilateral) target localisation incorporating anatomical and physiological techniques, including intra-operative clinical evaluation, for the insertion of a single neurostimulation wire for the treatment of: (a) Parkinson's disease, where the patient's response to medical therapy is not sustained and is accompanied by	2 022.70

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	unacceptable motor fluctuations; or (b) essential tremor or dystonia where the patient's symptoms cause severe disability (H) (Anaes.) (Assist.)	
40862	Deep brain stimulation (unilateral) electronic analysis and programming of neurostimulator pulse generator for the treatment of: (a) Parkinson's disease, where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or (b) essential tremor or dystonia, where the patient's symptoms cause severe disability (Anaes.)	189.70
40903	Neuroendoscopy, for inspection of an intraventricular lesion, with or without biopsy including burr-hole (H) (Anaes.) (Assist.)	554.55
40905	Craniotomy, performed in association with items 45767, 45776, 45782 and 45785 for the correction of craniofacial abnormalities (Anaes.)	601.70
Subgroup 8—ear, nose and throat		
41500	Ear, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.)	82.50
41503	Ear, removal of foreign body in, involving incision of external auditory canal (Anaes.)	238.80
41506	Aural polyp, removal of (Anaes.)	144.00
41509	External auditory meatus, surgical removal of keratosis obturans from, other than a service to which another item in this Group applies (Anaes.)	162.95
41512	Meatoplasty involving removal of cartilage or bone or both cartilage and bone, other than a service to which item 41515 applies (H) (Anaes.) (Assist.)	585.90
41515	Meatoplasty involving removal of cartilage or bone or both cartilage and bone, being a service associated with a service to which item 41530, 41548, 41560 or 41563 applies (H) (Anaes.) (Assist.)	384.55

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
41518	External auditory meatus, removal of exostoses in (H) (Anaes.) (Assist.)	928.75
41521	Correction of auditory canal stenosis, including meatoplasty, with or without grafting (H) (Anaes.) (Assist.)	988.85
41524	Reconstruction of external auditory canal, being a service associated with a service to which items 41557, 41560 and 41563 apply (H) (Anaes.) (Assist.)	285.70
41527	Myringoplasty, trans-canal approach (Rosen incision) (H) (Anaes.) (Assist.)	587.60
41530	Myringoplasty, post-aural or endaural approach with or without mastoid inspection (H) (Anaes.)	957.30
41533	Atticotomy without reconstruction of the bony defect, with or without myringoplasty (H) (Anaes.) (Assist.)	1 144.30
41536	Atticotomy with reconstruction of the bony defect with or without myringoplasty (H) (Anaes.) (Assist.)	1 281.70
41539	Ossicular chain reconstruction (H) (Anaes.) (Assist.)	1 089.90
41542	Ossicular chain reconstruction and myringoplasty (H) (Anaes.) (Assist.)	1 194.25
41545	Mastoidectomy (cortical) (H) (Anaes.) (Assist.)	521.25
41548	Obliteration of the mastoid cavity (H) (Anaes.) (Assist.)	691.75
41551	Mastoidectomy, intact wall technique, with myringoplasty (H) (Anaes.) (Assist.)	1 593.05
41554	Mastoidectomy, intact wall technique, with myringoplasty and ossicular chain reconstruction (H) (Anaes.) (Assist.)	1 876.95
41557	Mastoidectomy (radical or modified radical) (H) (Anaes.) (Assist.)	1 089.90
41560	Mastoidectomy (radical or modified radical) and myringoplasty (H) (Anaes.)	1 194.25
41563	Mastoidectomy (radical or modified radical), myringoplasty and ossicular chain reconstruction (H) (Anaes.) (Assist.)	1 478.40
41564	Mastoidectomy (radical or modified radical), obliteration of the mastoid cavity, blind sac closure of external auditory canal and obliteration of eustachian tube (H) (Anaes.) (Assist.)	1 911.80

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
41566	Revision of mastoidectomy (radical, modified radical or intact wall), including myringoplasty (H) (Anaes.) (Assist.)	1 089.90
41569	Decompression of facial nerve in its mastoid portion (H) (Anaes.) (Assist.)	1 194.25
41572	Labyrinthotomy or destruction of labyrinth (H) (Anaes.) (Assist.)	1 033.20
41575	Cerebello-pontine angle tumour, removal of by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approach—transmastoid, translabyrinthine or retromastoid procedure (including after-care) (H) (Anaes.) (Assist.)	2 435.70
41576	Cerebello-pontine angle tumour, removal of, by transmastoid, translabyrinthine or retromastoid approach (intracranial procedure) (including after-care) other than a service to which item 41578 or 41579 applies (H) (Anaes.) (Assist.)	3 653.60
41578	Cerebello-pontine angle tumour, removal of, by transmastoid, translabyrinthine or retromastoid approach (intracranial procedure)—conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	2 435.70
41579	Cerebello-pontine angle tumour, removal of, by transmastoid, translabyrinthine or retromastoid approach (intracranial procedure)—conjoint surgery, co-surgeon (H) (Assist.)	1 826.75
41581	Tumour involving infra-emporal fossa, removal of, involving craniotomy and radical excision of (H) (Anaes.) (Assist.)	2 801.55
41584	Partial temporal bone resection for removal of tumour involving mastoidectomy with or without decompression of facial nerve (H) (Anaes.) (Assist.)	1 922.65
41587	Total temporal bone resection for removal of tumour (H) (Anaes.) (Assist.)	2 618.60
41590	Endolymphatic sac, transmastoid decompression with or without drainage of (H) (Anaes.) (Assist.)	1 194.25
41593	Translabyrinthine vestibular nerve section (H) (Anaes.) (Assist.)	1 556.50
41596	Retrolabyrinthine vestibular nerve section or cochlear nerve section, or both (H) (Anaes.) (Assist.)	1 739.50

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
41599	Internal auditory meatus, exploration by middle cranial fossa approach with cranial nerve decompression (H) (Anaes.) (Assist.)	1 739.50
41603	Osseo-integration procedure—implantation of titanium fixture for use with implantable bone conduction hearing system device, in a patient: (a) with a permanent or long term hearing loss; and (b) unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and (c) with bone conduction thresholds that accord with recognised surgical criteria for the implantable bone conduction hearing system devices; other than a service associated with a service to which item 41554, 45794 or 45797 applies	503.85
41604	Osseo-integration procedure—fixation of transcutaneous abutment implantation of titanium fixture for use with implantable bone conduction hearing system device, in a patient: (a) with a permanent or long term hearing loss; and (b) unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and (c) with bone conduction thresholds that accord with recognised surgical criteria for the implantable bone conduction hearing system devices; other than a service associated with a service to which item 41554, 45794 or 45797 applies	186.50
41608	Stapedectomy (H) (Anaes.) (Assist.)	1 089.90
41611	Stapes mobilisation (H) (Anaes.) (Assist.)	701.30
41614	Round window surgery including repair of cochleotomy (Anaes.) (Assist.)	1 089.90
41615	Oval window surgery, including repair of fistula, other than a service associated with a service to which another item in this Group applies (Anaes.) (Assist.)	1 089.90
41617	Cochlear implant, insertion of, including mastoidectomy (H) (Anaes.) (Assist.)	1 895.20

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
41620	Glomus tumour, transtympanic removal of (H) (Anaes.) (Assist.)	824.55
41623	Glomus tumour, transmastoid removal of, including mastoidectomy (H) (Anaes.) (Assist.)	1 194.25
41626	Abscess or inflammation of middle ear, operation for (excluding after-care) (Anaes.)	144.00
41629	Middle ear, exploration of (H) (Anaes.) (Assist.)	521.25
41632	Middle ear, insertion of tube for drainage of (including myringotomy) (Anaes.)	238.80
41635	Clearance of middle ear for granuloma, cholesteatoma and polyp, one or more, with or without myringoplasty (Anaes.) (Assist.)	1 144.30
41638	Clearance of middle ear for granuloma, cholesteatoma and polyp, one or more, with or without myringoplasty with ossicular chain reconstruction (H) (Anaes.) (Assist.)	1 428.35
41641	Perforation of tympanum, cauterisation or diathermy of (Anaes.)	47.45
41644	Excision of rim of eardrum perforation, other than a service associated with myringoplasty (Anaes.)	142.80
41647	Ear toilet requiring use of operating microscope and microinspection of tympanic membrane with or without general anaesthesia (Anaes.)	109.90
41650	Tympanic membrane, microinspection of one or both ears under general anaesthesia, other than a service associated with a service to which another item in this Group applies (Anaes.)	109.90
41653	Examination of nasal cavity or post-nasal space or nasal cavity and post-nasal space, under general anaesthesia, other than a service associated with a service to which another item in this Group applies (Anaes.)	71.95
41656	Nasal haemorrhage, posterior, arrest of, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding after-care) (Anaes.)	122.85
41659	Nose, removal of foreign body in, other than by simple probing (Anaes.)	77.55

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
41662	Nasal polyp or polypi (simple), removal of	82.50
41665	Nasal polyp or polypi, removal of (G) (H) (Anaes.)	172.50
41668	Nasal polyp or polypi, removal of (S) (H) (Anaes.)	219.95
41671	Nasal septum, septoplasty, submucous resection or closure of septal perforation (H) (Anaes.)	483.25
41672	Nasal septum, reconstruction of (H) (Anaes.) (Assist.)	602.85
41674	Cauterisation (other than by chemical means) or cauterisation by chemical means when performed under general anaesthesia or diathermy of septum, turbinates or pharynx—one or more of these procedures (including any consultation on the same occasion) other than a service associated with another operation on the nose (Anaes.)	100.50
41677	Nasal haemorrhage, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.)	90.00
41680	Cryotherapy to nose in the treatment of nasal haemorrhage (Anaes.)	162.95
41683	Division of nasal adhesions, with or without stenting other than a service associated with another operation on the nose and not performed during the post-operative period of a nasal operation (Anaes.)	117.20
41686	Dislocation of turbinate or turbinates, one or both sides, other than a service associated with a service to which another item in this Group applies (Anaes.)	71.95
41689	Turbinectomy or turbinectomies, partial or total, unilateral (H) (Anaes.)	136.50
41692	Turbinates, submucous resection of, unilateral (H) (Anaes.)	178.05
41695	Nasal turbinates, cryotherapy to (Anaes.)	100.00
41698	Maxillary antrum, proof puncture and lavage of (Anaes.)	32.55
41701	Maxillary antrum, proof puncture and lavage of—under general anaesthesia, other than a service associated with a service to which another item in this Group applies (H) (Anaes.)	91.90
41704	Maxillary antrum, lavage of—each attendance at which the procedure is performed, including any associated consultation	36.30

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	(Anaes.)	
41707	Maxillary artery, transantral ligation of (H) (Anaes.) (Assist.)	448.55
41710	Antrostomy (radical) (H) (Anaes.) (Assist.)	521.25
41713	Antrostomy (radical) with transantral ethmoidectomy or transantral vidian neurectomy (H) (Anaes.) (Assist.)	606.50
41716	Antrum, intranasal operation on or removal of foreign body from (H) (Anaes.) (Assist.)	295.70
41719	Antrum, drainage of, through tooth socket (Anaes.)	117.55
41722	Oro-antral fistula, plastic closure of (Anaes.) (Assist.)	587.60
41725	Ethmoidal artery or arteries, transorbital ligation of (unilateral) (H) (Anaes.) (Assist.)	448.55
41728	Lateral rhinotomy with removal of tumour (H) (Anaes.) (Assist.)	897.30
41729	Dermoid of nose, excision of, with intranasal extension (H) (Anaes.) (Assist.)	568.65
41731	Fronto-nasal ethmoidectomy by external approach with or without sphenoidectomy (H) (Anaes.) (Assist.)	777.10
41734	Radical fronto-ethmoidectomy with osteoplastic flap (H) (Anaes.) (Assist.)	1 014.05
41737	Frontal sinus, or ethmoidal sinuses on the one side, intranasal operation on (H) (Anaes.) (Assist.)	483.25
41740	Frontal sinus, catheterisation of (H) (Anaes.)	58.80
41743	Frontal sinus, trephine of (H) (Anaes.) (Assist.)	337.45
41746	Frontal sinus, radical obliteration of (Anaes.) (Assist.)	777.10
41749	Ethmoidal sinuses, external operation on (H) (Anaes.) (Assist.)	606.50
41752	Sphenoidal sinus, intranasal operation on (H) (Anaes.) (Assist.)	295.70
41755	Eustachian tube, catheterisation of (Anaes.)	46.50
41758	Division of pharyngeal adhesions (Anaes.)	117.55
41761	Post nasal space, direct examination of, with or without biopsy (Anaes.)	122.85
41764	Nasendoscopy or sinoscopy or fibreoptic examination of	122.85

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	nasopharynx and larynx, one or more of these procedures, unilateral or bilateral examination of (Anaes.)	
41767	Nasopharyngeal angiofibroma, removal of (Anaes.) (Assist.)	737.00
41770	Pharyngeal pouch, removal of, with or without cricopharyngeal myotomy (H) (Anaes.) (Assist.)	701.30
41773	Pharyngeal pouch, endoscopic resection of (Dohlman's operation) (H) (Anaes.) (Assist.)	587.60
41776	Cricopharyngeal myotomy with or without inversion of pharyngeal pouch (H) (Anaes.) (Assist.)	585.90
41779	Pharyngotomy (lateral), with or without total excision of tongue (H) (Anaes.) (Assist.)	701.30
41782	Partial pharyngectomy via pharyngotomy (Anaes.) (Assist.)	952.10
41785	Partial pharyngectomy via pharyngotomy with partial or total glossectomy (H) (Anaes.) (Assist.)	1 181.15
41786	Uvulopalatopharyngoplasty, with or without tonsillectomy, by any means (H) (Anaes.) (Assist.)	737.00
41787	Uvulectomy and partial palatectomy with laser incision of the palate, with or without tonsillectomy, one or more stages, including any revision procedures within 12 months (Anaes.) (Assist.)	568.65
41788	Tonsils or tonsils and adenoids, removal of, in a person aged less than 12 years (G) (H) (Anaes.)	219.95
41789	Tonsils or tonsils and adenoids, removal of, in a person aged less than 12 years (S) (H) (Anaes.)	295.70
41792	Tonsils or tonsils and adenoids, removal of, in a person 12 years of age or over (G) (H) (Anaes.)	276.80
41793	Tonsils or tonsils and adenoids, removal of, in a person 12 years of age or over (S) (H) (Anaes.)	371.50
41796	Tonsils or tonsils and adenoids, arrest of haemorrhage requiring general anaesthesia, following removal of (G) (H) (Anaes.)	113.70
41797	Tonsils or tonsils and adenoids, arrest of haemorrhage requiring general anaesthesia, following removal of (S) (H) (Anaes.)	144.00

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
41800	Adenoids, removal of (G) (H) (Anaes.)	117.55
41801	Adenoids, removal of (S) (H) (Anaes.)	162.95
41804	Lingual tonsil or lateral pharyngeal bands, removal of (H) (Anaes.)	90.00
41807	Peritonsillar abscess (quinsy), incision of (Anaes.)	70.10
41810	Uvulotomy or uvulectomy (Anaes.)	35.60
41813	Vallecular or pharyngeal cysts, removal of (H) (Anaes.) (Assist.)	356.35
41816	Oesophagoscopy (with rigid oesophagoscope) (Anaes.)	185.60
41819	Dilatation of stricture of upper gastro-intestinal tract using bougie or balloon over endoscopically inserted guidewire, including endoscopy with flexible or rigid endoscope (Anaes.)	348.95
41820	Dilatation of stricture of upper gastro-intestinal tract using bougie or balloon over endoscopically inserted guidewire, including endoscopy with flexible or rigid endoscope, if the use of imaging intensification is clinically indicated (Anaes.)	418.75
41822	Oesophagoscopy (with rigid oesophagoscope) with biopsy (H) (Anaes.)	238.80
41825	Oesophagoscopy (with rigid oesophagoscope) with removal of foreign body (H) (Anaes.) (Assist.)	356.35
41828	Oesophageal stricture, dilatation of, without oesophagoscopy (Anaes.)	52.20
41831	Oesophagus, endoscopic pneumatic dilatation of (Anaes.) (Assist.)	357.00
41832	Oesophagus, balloon dilatation of, using interventional imaging techniques (Anaes.)	228.50
41834	Laryngectomy (total) (H) (Anaes.) (Assist.)	1 289.15
41837	Vertical hemi-laryngectomy including tracheostomy (H) (Anaes.) (Assist.)	1 236.05
41840	Supraglottic laryngectomy including tracheostomy (H) (Anaes.) (Assist.)	1 519.80
41843	Laryngopharyngectomy or primary restoration of alimentary continuity after laryngopharyngectomy using stomach or	1 336.45

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	bowel (H) (Anaes.) (Assist.)	
41846	Larynx, direct examination of the supraglottic, glottic and subglottic regions, other than a service associated with another procedure on the larynx or with the administration of a general anaesthetic (Anaes.)	185.60
41849	Larynx, direct examination of, with biopsy (H) (Anaes.) (Assist.)	272.90
41852	Larynx, direct examination of, with removal of tumour (H) (Anaes.) (Assist.)	295.70
41855	Microlaryngoscopy (H) (Anaes.) (Assist.)	288.20
41858	Microlaryngoscopy with removal of juvenile papillomata (H) (Anaes.) (Assist.)	494.15
41861	Microlaryngoscopy with removal of benign lesions of the larynx by laser surgery (H) (Anaes.) (Assist.)	604.30
41864	Microlaryngoscopy with removal of tumour (H) (Anaes.) (Assist.)	407.50
41867	Microlaryngoscopy with arytenoidectomy (H) (Anaes.) (Assist.)	613.40
41868	Laryngeal web, division of, using microlarygoscopic techniques (H) (Anaes.)	388.70
41870	Injection of vocal cord by teflon, fat, collagen or gelfoam (H) (Anaes.) (Assist.)	454.85
41873	Larynx, fractured, operation for (Anaes.) (Assist.)	587.60
41876	Larynx, external operation on, or laryngofissure, with or without cordectomy (Anaes.) (Assist.)	587.60
41879	Laryngoplasty or tracheoplasty, including tracheostomy (H) (Anaes.) (Assist.)	952.10
41880	Tracheostomy by a percutaneous technique using sequential dilatation or partial splitting method to allow insertion of a cuffed tracheostomy tube (H) (Anaes.)	254.15
41881	Tracheostomy by open exposure of the trachea, including separation of the strap muscles or division of the thyroid isthmus, if performed (H) (Anaes.) (Assist.)	401.75
41884	Cricothyrostomy by direct stab or Seldinger technique, using	91.05

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	Minitrach or similar device (H) (Anaes.)	
41885	Trache-oesophageal fistula, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (Anaes.) (Assist.)	287.90
41886	Trachea, removal of foreign body in (Anaes.)	178.05
41889	Bronchoscopy, as an independent procedure (Anaes.)	178.05
41892	Bronchoscopy with one or more endobronchial biopsies or other diagnostic or therapeutic procedures (Anaes.)	235.05
41895	Bronchus, removal of foreign body in (H) (Anaes.) (Assist.)	367.75
41898	Fibreoptic bronchoscopy with one or more transbronchial lung biopsies, with or without bronchial or broncho-alveolar lavage, with or without the use of interventional imaging (Anaes.) (Assist.)	256.95
41901	Endoscopic laser resection of endobronchial tumours for relief of obstruction including any associated endoscopic procedures (H) (Anaes.) (Assist.)	604.30
41904	Bronchoscopy with dilatation of tracheal stricture (Anaes.)	246.50
41905	Trachea or bronchus, dilatation of stricture and endoscopic insertion of stent (H) (Anaes.) (Assist.)	453.35
41907	Nasal septum button, insertion of (Anaes.)	122.85
41910	Duct of major salivary gland, transposition of (H) (Anaes.) (Assist.)	390.25
Subgroup 9—Ophthalmology		
42503	Ophthalmological examination under general anaesthesia, other than a service associated with a service to which another item in this Group applies (H) (Anaes.)	102.50
42506	Eye, enucleation of, with or without sphere implant (Anaes.) (Assist.)	481.25
42509	Eye, enucleation of, with insertion of integrated implant (H) (Anaes.) (Assist.)	609.05
42510	Eye, enucleation of, with insertion of hydroxy apatite implant or similar coralline implant (H) (Anaes.) (Assist.)	702.05
42512	Globe, evisceration of (Anaes.) (Assist.)	481.25

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
42515	Globe, evisceration of, and insertion of intrascleral ball or cartilage (H) (Anaes.) (Assist.)	609.05
42518	Anophthalmic orbit, insertion of cartilage or artificial implant as a delayed procedure, or removal of implant from socket, or placement of a motility intergrating peg by drilling into existing orbital implant (H) (Anaes.) (Assist.)	353.35
42521	Anophthalmic socket, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (H) (Anaes.) (Assist.)	1 203.20
42524	Orbit, skin graft to, as a delayed procedure (Anaes.)	204.60
42527	Contracted socket, reconstruction including mucous membrane grafting and stent mould (H) (Anaes.) (Assist.)	406.05
42530	Orbit, exploration with or without biopsy, requiring removal of bone (H) (Anaes.) (Assist.)	631.75
42533	Orbit, exploration of, with drainage or biopsy not requiring removal of bone (H) (Anaes.) (Assist.)	406.05
42536	Orbit, exenteration of, with or without skin graft and with or without temporalis muscle transplant (H) (Anaes.) (Assist.)	834.60
42539	Orbit, exploration of, with removal of tumour or foreign body, requiring removal of bone (H) (Anaes.) (Assist.)	1 188.20
42542	Orbit, exploration of anterior aspect with removal of tumour or foreign body (H) (Anaes.) (Assist.)	503.85
42543	Orbit, exploration of retrobulbar aspect with removal of tumour or foreign body (H) (Anaes.) (Assist.)	883.85
42545	Orbit, decompression of, for dysthyroid eye disease, by fenestration of 2 or more walls, or by the removal of intraorbital peribulbar and retrobulbar fat from each quadrant of the orbit, one eye (H) (Anaes.) (Assist.)	1 278.35
42548	Optic nerve meninges, incision of (H) (Anaes.) (Assist.)	759.40
42551	Eye, penetrating wound or rupture of, not involving intraocular structures—repair involving suture of cornea or sclera, or both, other than a service to which item 42632 applies (Anaes.) (Assist.)	631.75
42554	Eye, penetrating wound or rupture of, with incarceration or	737.00

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	prolapse of uveal tissue—repair (H) (Anaes.) (Assist.)	
42557	Eye, penetrating wound or rupture of, with incarceration of lens or vitreous—repair (H) (Anaes.) (Assist.)	1 030.20
42563	Intraocular foreign body, removal from anterior segment (Anaes.) (Assist.)	519.00
42569	Intraocular foreign body, removal from posterior segment (H) (Anaes.) (Assist.)	1 030.20
42572	Orbital abscess or cyst, drainage of (Anaes.)	117.35
42573	Dermoid, periorbital, excision of (Anaes.)	227.45
42574	Dermoid, orbital, excision of (Anaes.) (Assist.)	483.25
42575	Tarsal cyst, extirpation of (Anaes.)	82.75
42581	Ectropion or entropion, tarsal cauterisation of (Anaes.)	117.35
42584	Tarsorrhaphy (Anaes.) (Assist.)	276.80
42587	Trichiasis, treatment of by cryotherapy, laser or electrolysis—each eyelid (Anaes.)	51.95
42590	Canthoplasty, medial or lateral (Anaes.) (Assist.)	338.35
42593	Lacrimal gland, excision of palpebral lobe (H) (Anaes.)	204.60
42596	Lacrimal sac, excision of, or operation on (Anaes.) (Assist.)	503.85
42599	Lacrimal canalicular system, establishment of patency by closed operation using silicone tubes or similar, one eye (Anaes.) (Assist.)	631.75
42602	Lacrimal canalicular system, establishment of patency by open operation, one eye (Anaes.) (Assist.)	631.75
42605	Lacrimal canaliculus, immediate repair of (Anaes.) (Assist.)	466.10
42608	Lacrimal drainage by insertion of glass tube, as an independent procedure (Anaes.) (Assist.)	300.75
42610	Nasolacrimal tube (unilateral), removal or replacement of, or lacrimal passages, probing for obstruction, unilateral, with or without lavage—under general anaesthesia (Anaes.)	96.25
42611	Nasolacrimal tube (bilateral), removal or replacement of, or lacrimal passages, probing for obstruction, bilateral, with or without lavage—under general anaesthesia (Anaes.)	144.35
42614	Nasolacrimal tube (unilateral), removal or replacement of, or	48.30

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	lacrimal passages, probing to establish patency of, or probing for obstruction (or both), unilateral, including lavage, other than a service associated with a service to which item 42610 applies (excluding after-care)	
42615	Nasolacrimal tube (bilateral), removal or replacement of, or lacrimal passages, probing for obstruction, bilateral, including lavage, other than a service associated with a service to which item 42611 applies (excluding after-care)	72.25
42617	Punctum snip operation (Anaes.)	136.95
42620	Punctum, occlusion of, by use of a plug (Anaes.)	52.65
42621	Punctum, temporary occlusion of, by use of electrical cautery (Anaes.)	52.65
42622	Punctum, permanent occlusion of, by use of electrical cautery (Anaes.)	82.75
42623	Dacryocystorhinostomy (H) (Anaes.) (Assist.)	699.45
42626	Dacryocystorhinostomy if a previous dacryocystorhinostomy has been performed (Anaes.) (Assist.)	1 128.05
42629	Conjunctivorhinostomy including dacryocystorhinostomy and fashioning of conjunctival flaps (H) (Anaes.) (Assist.)	849.70
42632	Conjunctival peritomy or repair of corneal laceration by conjunctival flap (Anaes.)	117.35
42635	Corneal perforations, sealing of, with tissue adhesive (Anaes.) (Assist.)	300.75
42638	Conjunctival graft over cornea (Anaes.) (Assist.)	376.00
42641	Autoconjunctival transplant, or mucous membrane graft (Anaes.) (Assist.)	488.75
42644	Cornea or sclera, complete removal of embedded foreign body from—not more than once on the same day by the same practitioner (excluding after-care) (Anaes.)	72.15
42647	Corneal scars, removal of, by partial keratectomy, other than a service associated with a service to which item 42686 applies (Anaes.)	204.60
42650	Cornea, epithelial debridement for corneal ulcer or corneal erosion (excluding after-care) (Anaes.)	72.15

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
42651	Cornea, epithelial debridement for eliminating band keratopathy (Anaes.)	160.80
42653	Cornea, transplantation of, full thickness (H) (Anaes.) (Assist.)	1 338.45
42656	Cornea, transplantation of, second and subsequent procedures (H) (Anaes.) (Assist.)	1 669.45
42659	Cornea, transplantation of, superficial or lamellar (Anaes.) (Assist.)	902.30
42662	Sclera, transplantation of, full thickness, including collection of donor material (H) (Anaes.) (Assist.)	902.30
42665	Sclera, transplantation of, superficial or lamellar, including collection of donor material (Anaes.) (Assist.)	601.65
42667	Running corneal suture, manipulation of, performed within 4 months of corneal grafting, to reduce astigmatism, if a reduction of 2 dioptres of astigmatism is obtained, including any associated consultation	141.95
42668	Corneal sutures, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or operating microscope (Anaes.)	75.30
42672	Corneal incisions, to correct corneal astigmatism of more than $1^1/_2$ diopters following anterior segment surgery, including appropriate measurements and calculations, performed as an independent procedure (Anaes.) (Assist.)	902.30
42673	Additional corneal incisions, to correct corneal astigmatism of more than $1^1/_2$ diopters, including appropriate measurements and calculations, performed in conjunction with other anterior segment surgery (Anaes.) (Assist.)	451.10
42676	Conjunctiva, biopsy of, as an independent procedure	115.70
42677	Conjunctiva, cautery of, including treatment of pannus—each attendance at which treatment is given including any associated consultation (Anaes.)	60.95
42680	Conjunctiva, cryotherapy to, for melanotic lesions or similar using CO^2 or N^{20} (Anaes.)	300.75
42683	Conjunctival cysts, removal of (H) (Anaes.)	120.35

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
42686	Pterygium, removal of (Anaes.)	273.65
42689	Pinguecula, removal of, other than a service associated with the fitting of contact lenses (Anaes.)	117.35
42692	Limbic tumour, removal of, excluding Pterygium (Anaes.) (Assist.)	276.80
42695	Limbic tumour, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Anaes.) (Assist.)	451.10
42698	Lens extraction, excluding surgery performed to correct a refractive error, other than anisometropia that exceeds 3 dioptres and develops after the removal of cataract in the first eye (Anaes.)	594.75
42701	Intraocular lens, insertion of, excluding surgery performed to correct a refractive error, other than anisometropia that exceeds 3 dioptres and develops after the removal of cataract in the first eye (Anaes.)	331.70
42702	Lens extraction and insertion of intraocular lens, excluding surgery performed to correct a refractive error, other than anisometropia that exceeds 3 dioptres and develops after the removal of cataract in the first eye (Anaes.)	760.65
42703	Intraocular lens or iris prosthesis, insertion of, into the posterior chamber with fixation to the iris or sclera (Anaes.) (Assist.)	572.05
42704	Intraocular lens, removal or repositioning of by open operation—other than a service associated with a service to which item 42701 applies (Anaes.)	466.10
42707	Intraocular lens, removal of and replacement with a different lens, excluding surgery performed to correct a refractive error, other than anisometropia that exceeds 3 dioptres and develops after the removal of cataract in the first eye (Anaes.)	797.10
42710	Intraocular lens, removal of, and replacement with a lens inserted into the posterior chamber and fixated to the iris or sclera (Anaes.) (Assist.)	902.30
42713	Iris suturing, McCannell technique or similar, for fixation of intraocular lens or repair of iris defect (Anaes.) (Assist.)	376.00
42716	Cataract, juvenile, removal of, including subsequent needlings	1 195.70

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	(Anaes.) (Assist.)	
42719	Either or both of the following, via a limbal approach by any method: (a) removal of capsular or lens material; (b) removal of vitreous; other than a service associated with a service to which item 42698, 42702, 42716, 42725 or 42731 applies (Anaes.) (Assist.)	519.00
42725	Vitrectomy via pars plana sclerotomy, including one or more of the following: (a) removal of vitreous; (b) division of vitreous bands; (c) removal of epiretinal membranes (H) (Anaes.) (Assist.)	1 338.45
42731	Limbal or pars plana lensectomy combined with vitrectomy, other than a service associated with item 42698, 42702, 42719 or 42725 (H) (Anaes.) (Assist.)	1 519.00
42734	Capsulotomy, other than by laser (Anaes.) (Assist.)	300.75
42737	Needling of posterior capsule (Anaes.) (Assist.)	300.75
42738	Paracentesis of anterior chamber or vitreous cavity, or both, for the injection of therapeutic substances, or the removal of aqueous or vitreous humours for diagnostic or therapeutic purposes, one or more of, as an independent procedure	300.75
42739	Paracentesis of anterior chamber or vitreous cavity, or both, for the injection of therapeutic substances, or the removal of aqueous or vitreous humours for diagnostic or therapeutic purposes, one or more of, as an independent procedure, for a patient requiring anaesthetic services (Anaes.)	300.75
42740	Intravitreal injection of therapeutic substances, or the removal of vitreous humour for diagnostic purposes, one or more of, as a procedure associated with other intraocular surgery (Anaes.)	300.75
42741	Posterior juxtascleral depot injection of a therapeutic substance, for the treatment of subfoveal choroidal neovascularisation due to age-related macular degeneration, one or more of (Anaes.)	300.75

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
42743	Anterior chamber, irrigation of blood from, as an independent procedure (Anaes.) (Assist.)	631.75
42744	Needling to drain an encysted bleb, following trabeculectomy (Anaes.)	300.55
42746	Glaucoma, filtering operation for, if conservative therapies have failed, are likely to fail, or are contraindicated (H) (Anaes.) (Assist.)	955.00
42749	Glaucoma, filtering operation for, if previous filtering operation has been performed (H) (Anaes.) (Assist.)	1 195.70
42752	Glaucoma, insertion of drainage device incorporating an extraocular reservoir for, such as a Molteno device (H) (Anaes.) (Assist.)	1 338.45
42755	Glaucoma, removal of drainage device incorporating an extraocular reservoir for, such as a Molteno device (H) (Anaes.) (Assist.)	165.45
42758	Goniotomy (H) (Anaes.) (Assist.)	699.45
42761	Division of anterior or posterior synechiae, as an independent procedure, other than by laser (Anaes.) (Assist.)	519.00
42764	Iridectomy (including excision of tumour of iris) or iridotomy, as an independent procedure, other than by laser (Anaes.) (Assist.)	519.00
42767	Tumour, involving ciliary body or ciliary body and iris, excision of (H) (Anaes.) (Assist.)	1 090.35
42770	Cyclodestructive procedures for the treatment of intractable glaucoma, treatment to one eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.)	294.80
42773	Detached retina, pneumatic retinopexy for, other than a service associated with a service to which item 42776 applies (Anaes.) (Assist.)	902.30
42776	Detached retina, buckling or resection operation for (H) (Anaes.) (Assist.)	1 338.45
42779	Detached retina, revision of scleral buckling operation for (H) (Anaes.) (Assist.)	1 669.45
42782	Laser trabeculoplasty, for the treatment of glaucoma—each	451.10

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	treatment to one eye, to a maximum of 4 treatments to that eye in a 2 year period (Anaes.) (Assist.)	
42783	Laser trabeculoplasty, for the treatment of glaucoma—each treatment to one eye—if it can be demonstrated that a fifth or subsequent treatment to that eye (including any treatments to which item 42782 applies) is indicated in a 2 year period (Anaes.) (Assist.)	451.10
42785	Laser iridotomy—each treatment episode to one eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.)	353.35
42786	Laser iridotomy—each treatment episode to one eye—if it can be demonstrated that a third or subsequent treatment to that eye (including any treatments to which item 42785 applies) is indicated in a 2 year period (Anaes.) (Assist.)	353.35
42788	Laser capsulotomy—each treatment episode to one eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.)	353.35
42789	Laser capsulotomy—each treatment episode to one eye—if it can be demonstrated that a third or subsequent treatment to that eye (including any treatments to which item 42788 applies) is indicated in a 2 year period (Anaes.) (Assist.)	353.35
42791	Laser vitreolysis or corticolysis of lens material or fibrinolysis—each treatment to one eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.)	353.35
42792	Laser vitreolysis or corticolysis of lens material or fibrinolysis—each treatment to one eye—if it can be demonstrated that a third or subsequent treatment to that eye (including any treatments to which item 42791 applies) is indicated in a 2 year period (Anaes.) (Assist.)	353.35
42794	Division of suture by laser following trabeculoplasty, each treatment to one eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.)	67.65
42797	Laser coagulation of corneal or scleral blood vessels—each treatment to one eye, to a maximum of 4 treatments to that eye in a 2 year period (Anaes.)	67.65
42801	Episcleral radioactive plaque (Ruthenium 106 or Iodine 125),	1 049.70

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	for the treatment of choroidal melanomas, insertion of (H) (Anaes.) (Assist.)	
42802	Episcleral radioactive plaque (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, removal of (H) (Anaes.) (Assist.)	524.70
42805	Tantalum markers, surgical insertion to the sclera to localise the tumour base and to assist in planning radiotherapy of choroidal melanomas—one or more (Anaes.)	586.50
42806	Iris tumour, laser photocoagulation of (Anaes.) (Assist.)	353.35
42807	Photomydriasis, laser	355.80
42808	Photoiridosyneresis, laser	355.80
42809	Retina, photocoagulation of, other than a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.)	451.10
42810	Phototherapeutic keratectomy, by laser, for corneal scarring or disease, excluding surgery for refractive error (Anaes.)	567.70
42811	Transpupillary thermotherapy, for choroidal and retinal tumours or vascular malformations (Anaes.)	451.10
42812	Removal of scleral buckling material, from an eye having undergone previous scleral buckling surgery (Anaes.)	165.45
42815	Vitreous cavity, removal of silicone oil or other liquid vitreous substitutes from, during a procedure other than that in which the vitreous substitute is inserted (H) (Anaes.) (Assist.)	631.75
42818	Retina, cryotherapy to, as an independent procedure, or when performed in association with item 42770 or 42809 (Anaes.)	586.50
42821	Ocular transillumination, for the diagnosis and measurement of intraocular tumours (Anaes.)	90.35
42824	Retrobulbar injection of alcohol or other drug, as an independent procedure	69.90
42833	Squint, operation for, on one or both eyes, the operation involving a total of one or 2 muscles on a patient aged 15 years or over (H) (Anaes.) (Assist.)	586.50
42836	Squint, operation for, on one or both eyes, the operation involving a total of one or 2 muscles: (a) on a patient aged 14 years or under; or	729.45

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	(b) if the patient has had previous squint, retinal or extra ocular operations on the eye or eyes; or (c) on a patient with concurrent thyroid eye disease (H) (Anaes.) (Assist.)	
42839	Squint, operation for, on one or both eyes, the operation involving a total of 3 or more muscles on a patient aged 15 years or over (H) (Anaes.) (Assist.)	699.45
42842	Squint, operation for, on one or both eyes, the operation involving a total of 3 or more muscles: (a) on a patient aged 14 years or under; or (b) if the patient has had previous squint, retinal or extra ocular operations on the eye or eyes; or (c) on a patient with concurrent thyroid eye disease (H) (Anaes.) (Assist.)	872.30
42845	Readjustment of adjustable sutures, one or both eyes, as an independent procedure following an operation for correction of squint (Anaes.)	189.40
42848	Squint, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 15 years or over (H) (Anaes.) (Assist.)	699.45
42851	Squint, muscle transplant for (Hummelsheim type, or similar operation) on a patient who: (a) is aged 14 years or under; or (b) has had previous squint, retinal or extra ocularoperations on his or her eye or eyes; or (c) has concurrent thyroid eye disease (H) (Anaes.) (Assist.)	872.30
42854	Ruptured medial palpebral ligament or ruptured extra-ocular muscle, repair of (Anaes.) (Assist.)	406.05
42857	Resuturing of wound following intraocular procedures with or without excision of prolapsed iris (Anaes.) (Assist.)	406.05
42860	Eyelid (upper or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid retractors (Anaes.) (Assist.)	902.30
42863	Eyelid, recession of (Anaes.) (Assist.)	774.55

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
42866	Entropion or tarsal ectropion, repair of, by tightening, shortening or repair of inferior retractors by open operation across the entire width of the eyelid (Anaes.) (Assist.)	751.85
42869	Eyelid closure in facial nerve paralysis, insertion of foreign implant for (Anaes.) (Assist.)	549.00
42872	Eyebrow, elevation of, for paretic states (Anaes.)	240.70
43021	Photodynamic therapy, one eye, including the infusion of vertoporfin continuously through a peripheral vein, using a non-thermal laser at a wavwelength of 689 nm, for the treatment of choroidal neovascularisation	455.05
43022	Photodynamic therapy, both eyes, including the infusion of vertoporfin continuously through a peripheral vein, using a non-thermal laser at a wavwelength of 689 nm, for the treatment of choroidal neovascularisation	546.15
43023	Infusion of vertoporfin for discontinued photodynamic therapy, if a session of therapy that would have been provided under item 43021 or 43022 has been discontinued on medical grounds	88.50
Subgroup 10—Operations for osteomyelitis		
43500	Operation on phalanx (for acute osteomyelitis) (H) (Anaes.)	123.35
43503	Operation on sternum, clavicle, rib, ulna, radius, carpus, tibia, fibula, tarsus, skull, mandible or maxilla (other than alveolar margins) (for acute osteomyelitis)—one bone (H) (Anaes.)	204.70
43506	Operation on humerus or femur (for acute osteomyelitis)—one bone (H) (Anaes.) (Assist.)	356.35
43509	Operation on spine or pelvic bones (for acute osteomyelitis)—one bone (H) (Anaes.) (Assist.)	356.35
43512	Operation on scapula, sternum, clavicle, rib, ulna, radius, metacarpus, carpus, phalanx, tibia, fibula, metatarsus, tarsus, mandible or maxilla (other than alveolar margins) (for chronic osteomyelitis)—one bone or any combination of adjoining bones (H) (Anaes.) (Assist.)	356.35
43515	Operation on humerus or femur (for chronic osteomyelitis)—one bone (Anaes.) (Assist.)	356.35

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
43518	Operation on spine or pelvic bones (for chronic osteomyelitis)—one bone (H) (Anaes.) (Assist.)	587.60
43521	Operation on skull (for chronic osteomyelitis) (H) (Anaes.) (Assist.)	464.50
43524	Operation on any combination of adjoining bones, being bones referred to in item 43515, 43518 or 43521 (for chronic osteomyelitis) (Anaes.) (Assist.)	587.60
Subgroup 11—Paediatric		
43801	Intestinal malrotation with or without volvulus, laparotomy for, not involving bowel resection (H) (Anaes.) (Assist.)	957.30
43804	Intestinal malrotation with or without volvulus, laparotomy for, with bowel resection and anastomosis, with or without formation of stoma (H) (Anaes.) (Assist.)	1 019.25
43807	Duodenal atresia or stenosis, duodenoduodenostomy or duodenojejunostomy for (H) (Anaes.) (Assist.)	1 112.00
43810	Jejunal atresia, bowel resection and anastomosis for, with or without tapering (H) (Anaes.) (Assist.)	1 297.35
43813	Meconium ileus, laparotomy for, complicated by one or more of associated volvulus, atresia, intestinal perforation with or without meconium peritonitis (H) (Anaes.) (Assist.)	1 297.35
43816	Ileal atresia, colonic atresia or meconium ileus other than a service associated with a service to which item 43813 applies, laparotomy for (H) (Anaes.) (Assist.)	1 204.60
43819	Hirschsprung's disease, laparotomy for, with or without frozen section biopsies and formation of stoma (H) (Anaes.) (Assist.)	972.95
43822	Anorectal malformation, laparotomy and colostomy for (H) (Anaes.) (Assist.)	972.95
43825	Neonatal alimentary obstruction, laparotomy for, other than a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	1 112.00
43828	Acute neonatal necrotising enterocolitis, laparotomy for, with resection, including any anastomoses or stoma formation (H) (Anaes.) (Assist.)	1 228.55

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
43831	Acute neonatal necrotising enterocolitis, if no definitive procedure is possible, laparotomy for (H) (Anaes.) (Assist.)	957.30
43834	Bowel resection for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (H) (Anaes.) (Assist.)	1 112.00
43837	Congenital diaphragmatic hernia, repair by thoracic or abdominal approach, with diagnosis confirmed in the first 24 hours of life (H) (Anaes.) (Assist.)	1 389.90
43840	Congenital diaphragmatic hernia, repair by thoracic or abdominal approach, diagnosed after the first day of life and before 20 days of age (H) (Anaes.) (Assist.)	1 204.60
43843	Oesophageal atresia (with or without repair of tracheo-oesophageal fistula), complete correction of, other than a service to which item 43846 applies (H) (Anaes.) (Assist.)	1 853.35
43846	Oesophageal atresia (with or without repair of tracheo-oesophageal fistula), complete correction of, in infant of birth weight less than 1 500 gms (H) (Anaes.) (Assist.)	1 992.30
43849	Oesophageal atresia, gastrostomy for (H) (Anaes.) (Assist.)	509.65
43852	Oesophageal atresia, thoracotomy for, and division of tracheo-oesophageal fistula without anastomosis (Anaes.) (Assist.)	1 621.55
43855	Oesophageal atresia, delayed primary anastomosis for (H) (Anaes.) (Assist.)	1 714.35
43858	Oesophageal atresia, cervical oesophagostomy for (Anaes.) (Assist.)	602.25
43861	Congenital cystadenomatoid malformation or congenital lobar emphysema, thoracotomy and lung resection for (H) (Anaes.) (Assist.)	1 668.05
43864	Gastroschisis, operation for (H) (Anaes.) (Assist.)	1 251.05
43867	Gastroschisis, secondary operation for, with removal of silo and closure of abdominal wall (H) (Anaes.) (Assist.)	695.00
43870	Exomphalos containing small bowel only, operation for (H) (Anaes.) (Assist.)	972.95

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
43873	Exomphalos containing small bowel and other viscera, operation for (H) (Anaes.) (Assist.)	1 297.35
43876	Sacrococcygeal teratoma, excision of, by posterior approach (H) (Anaes.) (Assist.)	1 112.00
43879	Sacrococcygeal teratoma, excision of, by combined posterior and abdominal approach (H) (Anaes.) (Assist.)	1 297.35
43882	Cloacal exstrophy, operation for (Anaes.) (Assist.)	1 668.05
43900	Tracheo-oesophageal fistula without atresia, division and repair of (H) (Anaes.) (Assist.)	1 112.00
43903	Oesophageal atresia or corrosive oesophageal stricture, oesophageal replacement for, utilising gastric tube, jejunum or colon (H) (Anaes.) (Assist.)	1 853.35
43906	Oesophagus, resection of congenital, anastomic or corrosive stricture and anastomosis, other than a service to which item 43903 applies (H) (Anaes.) (Assist.)	1 621.55
43909	Tracheomalacia, aortopexy for (H) (Anaes.) (Assist.)	1 621.55
43912	Thoracotomy and excision of one or more of bronchogenic or enterogenous cyst or mediastinal teratoma (H) (Anaes.) (Assist.)	1 532.00
43915	Eventration, plication of diaphragm for (Anaes.) (Assist.)	1 158.30
43930	Hypertrophic pyloric stenosis, pyloromyotomy for (H) (Anaes.) (Assist.)	445.40
43933	Idiopathic intussusception, laparotomy and manipulative reduction of (H) (Anaes.) (Assist.)	521.40
43936	Intussusception, laparotomy and resection with anastomosis (H) (Anaes.) (Assist.)	972.95
43939	Ventral hernia following neonatal closure of exomphalos or gastroschisis, repair of (H) (Anaes.) (Assist.)	741.30
43942	Abdominal wall vitello intestinal remnant, excision of (Anaes.)	231.70
43945	Patent vitello intestinal duct, excision of (H) (Anaes.) (Assist.)	972.95
43948	Umbilical granuloma, excision of, under general anaesthesia (Anaes.)	139.10

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
43951	Gastro-oesophageal reflux with or without hiatus hernia, laparotomy and fundoplication for, without gastrostomy (H) (Anaes.) (Assist.)	871.30
43954	Gastro-oesophageal reflux with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (H) (Anaes.) (Assist.)	1 065.75
43957	Gastro-oesophageal reflux, laparotomy and fundoplication for, with or without hiatus hernia, in child with neurological disease, with gastrostomy (H) (Anaes.) (Assist.)	1 158.30
43960	Anorectal malformation, perineal anoplasty of (H) (Anaes.) (Assist.)	407.50
43963	Anorectal malformation, posterior sagittal anorectoplasty of (H) (Anaes.) (Assist.)	1 621.55
43966	Anorectal malformation, posterior sagittal anorectoplasty of, with laparotomy (H) (Anaes.) (Assist.)	1 853.35
43969	Persistent cloaca, total correction of, with genital repair using posterior sagittal approach, with or without laparotomy (H) (Anaes.) (Assist.)	2 548.35
43972	Choledochal cyst, resection of, with one duct anastomosis (H) (Anaes.) (Assist.)	1 853.35
43975	Choledochal cyst, resection of, with 2 duct anastomoses (H) (Anaes.) (Assist.)	2 177.70
43978	Biliary atresia, portoenterostomy for (H) (Anaes.) (Assist.)	1 853.35
43981	Nephroblastoma, neuroblastoma or other malignant tumour, laparotomy (exploratory), including associated biopsies, if no other intra-abdominal procedure is performed (H) (Anaes.) (Assist.)	509.65
43984	Nephroblastoma, radical nephrectomy for (H) (Anaes.) (Assist.)	1 297.35
43987	Neuroblastoma, radical excision of (H) (Anaes.) (Assist.)	1 436.40
43990	Hirschsprung's disease, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends to sigmoid colon (H) (Anaes.) (Assist.)	1 760.75

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
43993	Hirschsprung's disease, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends into descending or transverse colon with or without resiting of stoma (Anaes.) (Assist.)	1 899.65
43996	Hirschsprung's disease, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or without side to side ileocolonic anastomosis (Anaes.) (Assist.)	2 131.35
43999	Hirschsprung's disease, anal sphincterotomy as an independent procedure for (H) (Anaes.) (Assist.)	266.55
44102	Rectum, examination of, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (H) (Anaes.) (Assist.)	256.95
44105	Rectal prolapse, submucosal or perirectal injection for, under general anaesthesia (Anaes.)	45.10
44108	Inguinal hernia repair at age less than 3 months (H) (Anaes.) (Assist.)	491.45
44111	Obstructed or strangulated inguinal hernia, repair of, at age less than 3 months, including orchidopexy when performed (Anaes.) (Assist.)	575.65
44114	Inguinal hernia repair at age less than 3 months when orchidopexy also required (H) (Anaes.) (Assist.)	575.65
44130	Lymphadenectomy, for atypical mycobacterial infection or other granulomatous disease (Anaes.) (Assist.)	463.30
44133	Torticollis, open division of sternomastoid muscle for (H) (Anaes.) (Assist.)	367.75
44136	Ingrown toe nail, operation for, under general anaesthesia (Anaes.)	169.50

Subdivision F—Subgroups 12 and 13

2.44.18 Meaning of *amount under clause 2.44.18*

In item 44376:

amount under clause 2.44.18 means an amount equal to 75% of the fee mentioned for the item relating to an original amputation (any of items 44325 to 44373) of the body part for which the reamputation is performed.

2.44.19 Meaning of *maxilla*

In items 45720 to 45752, ***maxilla*** includes the zygoma.

Group T8—Surgical operations		
Item	**Description**	**Fee**
Subgroup 12—Amputations		
44325	Hand, midcarpal or transmetacarpal, amputation of (Anaes.) (Assist.)	$295.70
44328	Hand, forearm or through arm, amputation of (H) (Anaes.) (Assist.)	$356.35
44331	Amputation at shoulder (H) (Anaes.) (Assist.)	$587.60
44334	Interscapulothoracic amputation (Anaes.) (Assist.)	$1 194.25
44338	one digit of foot, amputation of (Anaes.)	$144.00
44342	2 digits of one foot, amputation of (H) (Anaes.)	$219.95
44346	3 digits of one foot, amputation of (H) (Anaes.) (Assist.)	$254.00
44350	4 digits of one foot, amputation of (H) (Anaes.) (Assist.)	$288.20
44354	5 digits of one foot, amputation of (H) (Anaes.) (Assist.)	$329.80
44358	Toe, including metatarsal or part of metatarsal—each toe, amputation of (H) (Anaes.)	$183.90
44359	One or more toes of one foot, amputation of, including if performed, excision of one or more metatarsal bones of the foot, performed for diabetic or other microvascular disease, excluding after-care (H) (Anaes.) (Assist.)	$263.95
44361	Foot at ankle (Syme, Pirogoff types), amputation of (H) (Anaes.) (Assist.)	$356.35
44364	Foot, midtarsal or transmetatarsal, amputation of (H) (Anaes.) (Assist.)	$295.70
44367	Amputation through thigh, at knee or below knee (H) (Anaes.) (Assist.)	$521.95

Group T8—Surgical operations		
Item	**Description**	**Fee**
44370	Amputation at hip (H) (Anaes.) (Assist.)	$720.20
44373	Hindquarter, amputation of (Anaes.) (Assist.)	$1 478.40
44376	Amputation stump, re-amputation of, to provide adequate skin and muscle cover (Anaes.) (Assist.)	Amount under clause 2.44.18
Subgroup 13—Plastic and reconstructive surgery		
45000	Single stage local muscle flap repair, on eyelid, nose, lip, neck, hand, thumb, finger or genitals (Anaes.)	$541.35
45003	Single stage local myocutaneous flap repair to one defect, simple and small (Anaes.)	$601.65
45006	Single stage large myocutaneous flap repair to one defect (pectoralis major, latissimus dorsi, or similar large muscle) (H) (Anaes.) (Assist.)	$1 037.65
45009	Single stage local muscle flap repair to one defect, simple and small (H) (Anaes.) (Assist.)	$379.05
45012	Single stage large muscle flap repair to one defect (pectoralis major, gastrocnemius, gracilis or similar large muscle) (H) (Anaes.) (Assist.)	$635.00
45015	Muscle or myocutaneous flap, delay of (H) (Anaes.)	$300.75
45018	Dermis, dermofat or fascia graft (excluding transfer of fat by injection) (Anaes.) (Assist.)	$473.65
45019	Full face chemical peel for severely sun-damaged skin, if it can be demonstrated that the damage affects 75% of the facial skin surface area involving photodamage (dermatoheliosis) typically consisting of solar keratoses, solar lentigines, freckling, yellowing and leathering of the skin, when at least medium depth peeling agents are used, performed in the operating theatre of a hospital by a specialist in the practice of his or her specialty (H) (Anaes.)	$396.70
45020	Full face chemical peel for severe chloasma or melasma refractory to all other treatments, if it can be demonstrated that the chloasma or melasma affects 75% of the facial skin surface area involving diffuse pigmentation visible at a distance of 4 metres, when at least medium depth peeling agents are used, performed	$396.70

Group T8—Surgical operations		
Item	**Description**	**Fee**
	in the operating theatre of a hospital by a specialist in the practice of his or her specialty—one session only in a 12 month period (Anaes.)	
45021	Abrasive therapy for severely disfiguring scarring resulting from trauma, burns or acne—limited to one aesthetic area (Anaes.)	$177.35
45024	Abrasive therapy for severely disfiguring scarring resulting from trauma, burns or acne—more than one aesthetic area (Anaes.)	$398.55
45025	Carbon dioxide laser or erbium laser resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne (not including fractional laser therapy)—limited to one aesthetic area (Anaes.)	$177.35
45026	Carbon dioxide laser or erbium laser resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne (not including fractional laser therapy)—more than one aesthetic area (Anaes.)	$398.55
45027	Angioma, cauterisation of or injection into, if undertaken in the operating theatre of a hospital (Anaes.)	$120.35
45030	Angioma (haemangioma or lymphangioma or both) of skin and subcutaneous tissue (excluding facial muscle or breast) or mucous surface, small, excision and suture of (Anaes.)	$129.25
45033	Angioma (haemangioma or lymphangioma or both), large or involving deeper tissue including facial muscle or breast, excision and suture of (Anaes.)	$240.70
45035	Angioma (haemangioma or lymphangioma or both) large and deep, involving muscles or nerves, excision of (H) (Anaes.) (Assist.)	$702.05
45036	Angioma (haemangioma or lymphangioma or both) of neck, deep, excision of (H) (Anaes.) (Assist.)	$1 128.05
45039	Arteriovenous malformation (3 cm or less) of superficial tissue, excision of (Anaes.)	$240.70
45042	Arteriovenous malformation, (greater than 3 cm), excision of (Anaes.) (Assist.)	$308.40

Group T8—Surgical operations		
Item	**Description**	**Fee**
45045	Arteriovenous malformation on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.)	$308.40
45048	Lymphoedematous tissue or lymphangiectasis, of lower leg and foot, or thigh, or upper arm, or forearm and hand, major excision of (H) (Anaes.) (Assist.)	$774.55
45051	Contour reconstruction for pathological deformity, insertion of foreign implant (non biological but excluding injection of liquid or semisolid material) by open operation (H) (Anaes.) (Assist.)	$473.75
45054	Limb or chest, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (H) (Anaes.) (Assist.)	$246.10
45200	Single stage local flap, if indicated to repair one defect, simple and small, excluding flap for male pattern baldness and excluding H-flap or double advancement flap (Anaes.)	$284.35
45203	Single stage local flap, if indicated to repair one defect, complicated or large, excluding flap for male pattern baldness and excluding H-flap or double advancement flap (Anaes.) (Assist.)	$406.05
45206	Single stage local flap if indicated to repair one defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals and excluding H-flap or double advancement flap (Anaes.)	$383.55
45207	H-flap or double advancement flap if indicated to repair one defect, on eyelid, eyebrow or forehead (Anaes.)	$383.55
45209	Direct flap repair (cross arm, abdominal or similar), first stage (Anaes.) (Assist.)	$473.75
45212	Direct flap repair (cross arm, abdominal or similar), second stage (Anaes.)	$235.05
45215	Direct flap repair, cross leg, first stage (H) (Anaes.) (Assist.)	$1 014.05
45218	Direct flap repair, cross leg, second stage (H) (Anaes.) (Assist.)	$454.85

Group T8—Surgical operations		
Item	**Description**	**Fee**
45221	Direct flap repair, small (cross finger or similar), first stage (Anaes.)	$261.55
45224	Direct flap repair, small (cross finger or similar), second stage (Anaes.)	$117.55
45227	Indirect flap or tubed pedicle, formation of (Anaes.) (Assist.)	$445.40
45230	Direct or indirect flap or tubed pedicle, delay of (Anaes.)	$222.75
45233	Indirect flap or tubed pedicle, preparation of intermediate or final site and attachment to the site (Anaes.) (Assist.)	$473.75
45236	Indirect flap or tubed pedicle, spreading of pedicle, as a separate procedure (H) (Anaes.)	$371.50
45239	Direct, indirect or local flap, revision of, by incision and suture, other than a service to which item 45240 applies (Anaes.)	$261.55
45240	Direct, indirect or local flap, revision of, by liposuction, other than a service to which item 45239, 45497, 45498 or 45499 applies (Anaes.)	$261.55
45400	Free grafting (split skin) of a granulating area, small (Anaes.)	$204.70
45403	Free grafting (split skin) of a granulating area, extensive (Anaes.) (Assist.)	$407.50
45406	Free grafting (split skin) to burns, including excision of burnt tissue—involving not more than 3% of total body surface (Anaes.) (Assist.)	$451.10
45409	Free grafting (split skin) to burns, including excision of burnt tissue—involving 3% or more but less than 6% of total body surface (H) (Anaes.) (Assist.)	$601.65
45412	Free grafting (split skin) to burns, including excision of burnt tissue—involving 6% or more but less than 9% of total body surface (H) (Anaes.) (Assist.)	$827.30
45415	Free grafting (split skin) to burns, including excision of burnt tissue—involving 9% or more but less than 12% of total body surface (H) (Anaes.) (Assist.)	$902.30
45418	Free grafting (split skin) to burns, including excision of	$977.55

Group T8—Surgical operations		
Item	**Description**	**Fee**
	burnt tissue—involving 12% or more but less than 15% of total body surface (H) (Anaes.) (Assist.)	
45439	Free grafting (split skin) to one defect, including elective dissection, small (Anaes.)	$284.35
45442	Free grafting (split skin) to one defect, including elective dissection, extensive (Anaes.) (Assist.)	$586.50
45445	Free grafting (split skin) as inlay graft to one defect including elective dissection using a mould (including insertion of and removal of mould) (Anaes.) (Assist.)	$556.60
45448	Free grafting (split skin) to one defect, including elective dissection on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, other than a service to which item 45442 or 45445 applies (Anaes.)	$376.00
45451	Free grafting (full thickness) to one defect, excluding grafts for male pattern baldness (Anaes.) (Assist.)	$473.75
45460	Free grafting (split skin) to burns, including excision of burnt tissue, involving 15% or more but less than 20% of total body surface—one surgeon (H) (Anaes.) (Assist.)	$1 253.30
45461	Free grafting (split skin) to burns, including excision of burnt tissue, involving 15% or more but less than 20% of total body surface—conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	$893.25
45462	Free grafting (split skin) to burns, including excision of burnt tissue, involving 15% or more but less than 20% of total body surface—conjoint surgery, co-surgeon (H) (Assist.)	$674.05
45464	Free grafting (split skin) to burns, including excision of burnt tissue, involving 20% or more but less than 30% of total body surface—one surgeon (H) (Anaes.) (Assist.)	$1 913.10
45465	Free grafting (split skin) to burns, including excision of burnt tissue, involving 20% or more but less than 30% of total body surface—conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	$1 363.00
45466	Free grafting (split skin) to burns, including excision of burnt tissue, involving 20% or more but less than 30% of	$1 027.95

Group T8—Surgical operations		
Item	**Description**	**Fee**
	total body surface—conjoint surgery, co-surgeon (H) (Assist.)	
45468	Free grafting (split skin) to burns, including excision of burnt tissue, involving 30% or more but less than 40% of total body surface—conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	$1 832.65
45469	Free grafting (split skin) to burns, including excision of burnt tissue, involving 30% or more but less than 40% of total body surface—conjoint surgery, co-surgeon (H) (Assist.)	$1 382.70
45471	Free grafting (split skin) to burns, including excision of burnt tissue, involving 40% or more but less than 50% of total body surface—conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	$2 303.65
45472	Free grafting (split skin) to burns, including excision of burnt tissue, involving 40% or more but less than 50% of total body surface—conjoint surgery, co-surgeon (H) (Assist.)	$1 737.60
45474	Free grafting (split skin) to burns, including excision of burnt tissue, involving 50% or more but less than 60% of total body surface—conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	$2 773.30
45475	Free grafting (split skin) to burns, including excision of burnt tissue, involving 50% or more but less than 60% of total body surface—conjoint surgery, co-surgeon (H) (Assist.)	$2 092.45
45477	Free grafting (split skin) to burns, including excision of burnt tissue, involving 60% or more but less than 70% of total body surface—conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	$3 243.00
45478	Free grafting (split skin) to burns, including excision of burnt tissue, involving 60% or more but less than 70% of total body surface—conjoint surgery, co-surgeon (H) (Assist.)	$2 446.05
45480	Free grafting (split skin) to burns, including excision of burnt tissue, involving 70% or more but less than 80% of	$3 712.60

Group T8—Surgical operations		
Item	**Description**	**Fee**
	total body surface—conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	
45481	Free grafting (split skin) to burns, including excision of burnt tissue, involving 70% or more but less than 80% of total body surface—conjoint surgery, co-surgeon (H) (Assist.)	$2 801.10
45483	Free grafting (split skin) to burns, including excision of burnt tissue, involving 80% or more of total body surface—conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	$4 229.95
45484	Free grafting (split skin) to burns, including excision of burnt tissue, involving 80% or more of total body surface—conjoint surgery, co-surgeon (H) (Assist.)	$3 191.50
45485	Free grafting (split skin) to burns, including excision of burnt tissue—upper eyelid, nose, lip, ear or palm of the hand (H) (Anaes.) (Assist.)	$527.70
45486	Free grafting (split skin) to burns, including excision of burnt tissue—forehead, cheek, anterior aspect of the neck, chin, plantar aspect of the foot, heel or genitalia (H) (Anaes.) (Assist.)	$451.10
45487	Free grafting (split skin) to burns, including excision of burnt tissue—whole of toe (Anaes.) (Assist.)	$406.05
45488	Free grafting (split skin) to burns, including excision of burnt tissue—the whole of one digit of the hand (H) (Anaes.) (Assist.)	$451.10
45489	Free grafting (split skin) to burns, including excision of burnt tissue—the whole of 2 digits of the hand (H) (Anaes.) (Assist.)	$676.80
45490	Free grafting (split skin) to burns, including excision of burnt tissue—the whole of 3 digits of the hand (H) (Anaes.) (Assist.)	$902.50
45491	Free grafting (split skin) to burns, including excision of burnt tissue—the whole of 4 digits of the hand (H) (Anaes.) (Assist.)	$1 128.05
45492	Free grafting (split skin) to burns, including excision of	$1 353.60

Group T8—Surgical operations		
Item	**Description**	**Fee**
	burnt tissue—the whole of 5 digits of the hand (H) (Anaes.) (Assist.)	
45493	Free grafting (split skin) to burns, including excision of burnt tissue—portion of digit of hand (H) (Anaes.) (Assist.)	$406.05
45494	Free grafting (split skin) to burns, including excision of burnt tissue—whole of face (excluding ears) (H) (Anaes.) (Assist.)	$1 638.70
45496	Flap, free tissue transfer using microvascular techniques—revision of, by open operation (H) (Anaes.)	$416.05
45497	Flap, free tissue transfer using microvascular techniques or any breast reconstruction—complete revision of, by liposuction (H) (Anaes.)	$324.95
45498	Flap, free tissue transfer using microvascular techniques or any breast reconstruction—staged revision of, by liposuction (first stage) (H) (Anaes.)	$261.55
45499	Flap, free tissue transfer using microvascular techniques or any breast reconstruction—staged revision of, by liposuction (second stage) (H) (Anaes.)	$195.00
45500	Microvascular repair using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (H) (Anaes.) (Assist.)	$1 090.35
45501	Microvascular anastomosis of artery using microsurgical techniques, for re-implantation of limb or digit (H) (Anaes.) (Assist.)	$1 774.70
45502	Microvascular anastomosis of vein using microsurgical techniques, for re-implantation of limb or digit (H) (Anaes.) (Assist.)	$1 774.70
45503	Micro-arterial or micro-venous graft using microsurgical techniques (H) (Anaes.) (Assist.)	$2 030.35
45504	Microvascular anastomosis of artery using microsurgical techniques, for free transfer of tissue including setting in of free flap (H) (Anaes.) (Assist.)	$1 774.70
45505	Microvascular anastomosis of vein using microsurgical techniques, for free transfer of tissue including setting in	$1 774.70

Group T8—Surgical operations		
Item	**Description**	**Fee**
	of free flap (H) (Anaes.) (Assist.)	
45506	Scar, of face or neck, not more than 3 cm in length, revision of, if: (a) undertaken in the operating theatre of a hospital; or (b) performed by a specialist in the practice of his or her specialty (Anaes.)	$219.95
45512	Scar, of face or neck, more than 3 cm in length, revision of, if: (a) undertaken in the operating theatre of a hospital; or (b) performed by a specialist in the practice of his or her specialty (Anaes.)	$295.70
45515	Scar, other than on face or neck, not more than 7 cm in length, revision of, as an independent procedure, if: (a) undertaken in the operating theatre of a hospital; or (b) performed by a specialist in the practice of his or her specialty (Anaes.)	$186.50
45518	Scar, other than on face or neck, more than 7 cm in length, revision of, as an independent procedure, if: (a) undertaken in the operating theatre of a hospital; or (b) performed by a specialist in the practice of his or her speciality (Anaes.)	$225.70
45519	Extensive burn scars of skin (more than 1% of body surface area), excision of, for correction of scar contracture (H) (Anaes.) (Assist.)	$429.05
45520	Reduction mammaplasty (unilateral) with surgical repositioning of nipple (H) (Anaes.) (Assist.)	$900.45
45522	Reduction mammaplasty (unilateral) without surgical repositioning of nipple, excluding the treatment of gynaecomastia (H) (Anaes.) (Assist.)	$631.75
45524	Mammaplasty, augmentation, for significant breast asymmetry if the augmentation is limited to one breast (H) (Anaes.) (Assist.)	$741.65
45527	Mammaplasty, augmentation, (unilateral), following mastectomy (H) (Anaes.) (Assist.)	$741.65

Group T8—Surgical operations		
Item	**Description**	**Fee**
45528	Mammaplasty, augmentation, bilateral, other than a service to which item 45527 applies, if it can be demonstrated that surgery is indicated because of malformation of breast tissue (excluding hypomastia), or disease or trauma of the breast (other than trauma resulting from previous elective cosmetic surgery) (H) (Anaes.) (Assist.)	$1 112.35
45530	Breast reconstruction (unilateral), using a latissimus dorsi or other large muscle or myocutaneous flap, including repair of secondary skin defect, if required, excluding repair of muscular aponeurotic layer, other than a service associated with a service to which item 30165, 30168, 30171, 30174 or 30177 applies (H) (Anaes.) (Assist.)	$1 099.40
45533	Breast reconstruction using breast sharing technique (first stage) including breast reduction, transfer of complex skin and breast tissue flap, split skin graft to pedicle of flap and other similar procedures (H) (Anaes.) (Assist.)	$1 245.10
45536	Breast reconstruction using breast sharing technique (second stage) including division of pedicle, insetting of breast flap, with closure of donor site or other similar procedure (H) (Anaes.) (Assist.)	$457.85
45539	Breast reconstruction (unilateral), following mastectomy, using tissue expansion—insertion of tissue expansion unit and all attendances for subsequent expansion injections (H) (Anaes.) (Assist.)	$1 071.20
45542	Breast reconstruction (unilateral), following mastectomy, using tissue expansion—removal of tissue expansion unit and insertion of permanent prosthesis (H) (Anaes.) (Assist.)	$613.40
45545	Nipple or areola or both, reconstruction of, by any surgical technique (Anaes.) (Assist.)	$622.55
45546	Nipple or areola or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple	$197.85

Group T8—Surgical operations		
Item	**Description**	**Fee**
45548	Breast prosthesis, removal of, as an independent procedure (Anaes.)	$276.80
45551	Breast prosthesis, removal of, with excision of fibrous capsule (H) (Anaes.) (Assist.)	$443.70
45552	Breast prosthesis, removal of, with excision of fibrous capsule and replacement of prosthesis (Anaes.) (Assist.)	$638.65
45553	Breast prosthesis, removal of and replacement with another prosthesis, following medical complications (such as rupture, migration of prosthetic material, or capsule formation) (Anaes.) (Assist.)	$638.65
45554	Breast prosthesis, removal and replacement with another prosthesis, following medical complications (such as rupture, migration of prosthetic material, or capsule formation), if new pocket is formed, including excision of fibrous capsule (Anaes.) (Assist.)	$699.45
45555	Silicone breast prosthesis, removal of and replacement with prosthesis other than silicone gel prosthesis (H) (Anaes.) (Assist.)	$638.65
45556	Breast ptosis, correction of (unilateral), to match the position of the contralateral breast (H) (Anaes.) (Assist.)	$766.05
45557	Breast ptosis, correction by mastopexy of (unilateral), following pregnancy and lactation, when performed not less than one year, and not more than 7 years, after the end of the most recent pregnancy of the patient, and if it can be demonstrated that the nipple is inferior to the infra-mammary groove, other than a service associated with a service to which item 45522 applies (H) (Anaes.) (Assist.)	$766.05
45558	Breast ptosis, correction by mastopexy of (bilateral), following pregnancy and lactation, when performed not less than one year, and not more than 7 years, after the end of the most recent pregnancy of the patient, and if it can be demonstrated that the nipple is inferior to the infra-mammary groove, other than a service associated with a service to which item 45522 applies (H) (Anaes.) (Assist.)	$1 148.95

Group T8—Surgical operations		
Item	**Description**	**Fee**
45559	Tuberous, tubular or constricted breast, if it can be demonstrated, correction of by simultaneous mastopexy and augmentation of (unilateral) (Anaes.) (Assist.)	$1 136.80
45560	Hair transplantation for the treatment of alopecia of congenital or traumatic origin or due to disease, excluding male pattern baldness, other than a service to which another item in this Group applies (Anaes.)	$473.65
45561	Microvascular anastomosis of artery or vein using microsurgical techniques, for supercharging of pedicled flaps (H) (Anaes.) (Assist.)	$1 774.70
45562	Free transfer of tissue involving raising of tissue on vascular or neurovascular pedicle, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.)	$1 099.40
45563	Neurovascular island flap, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.)	$1 099.40
45564	Free transfer of tissue reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, other than a service associated with a service to which item 30165, 30168, 30171, 30174, 30177, 45501, 45502, 45504, 45505 or 45562 applies—conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.)	$2 546.30
45565	Free transfer of tissue reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of	$1 909.80

Group T8—Surgical operations		
Item	**Description**	**Fee**
	secondary cutaneous defect if performed, other than a service associated with a service to which item 30165, 30168, 30171, 30174, 30177, 45501, 45502, 45504, 45505 or 45562 applies—conjoint surgery, conjoint specialist surgeon (H) (Assist.)	
45566	Tissue expansion other than a service to which item 45539 or 45542 applies—insertion of tissue expansion unit and all attendances for subsequent expansion injections (H) (Anaes.) (Assist.)	$1 071.20
45568	Tissue expander, removal of, with complete excision of fibrous capsule (H) (Anaes.) (Assist.)	$443.70
45569	Closure of abdomen with reconstruction of umbilicus, with or without lipectomy, being a service associated with items 45562, 45530, 45564 or 45565 (H) (Anaes.) (Assist.)	$677.60
45570	Closure of abdomen, repair of musculoaponeurotic layer, being a service associated with item 45569 (Anaes.) (Assist.)	$914.95
45572	Intra-operative tissue expansion performed during an operation when combined with a service to which another item in Group T8 applies including expansion injections and excluding treatment of male pattern baldness (Anaes.)	$291.70
45575	Facial nerve paralysis, free fascia graft for (Anaes.) (Assist.)	$720.20
45578	Facial nerve paralysis, muscle transfer for (H) (Anaes.) (Assist.)	$834.05
45581	Facial nerve palsy, excision of tissue for (Anaes.)	$276.80
45584	Liposuction (suction assisted lipolysis) to one regional area (thigh, buttock, or similar), for treatment of post-traumatic pseudolipoma (Anaes.)	$631.75
45585	Liposuction (suction assisted lipolysis) to one regional area, other than a service associated with a service to which item 31521 or 31527 applies, if it can be demonstrated that the treatment is for Barraquer-Simon's syndrome (pathological lipodystrophy of hips, buttocks,	$631.75

Group T8—Surgical operations		
Item	**Description**	**Fee**
	thighs, knees or lower legs), lymphoedema or macrodystrophia lipomatosa (Anaes.)	
45586	Liposuction (suction assisted lipolysis) for reduction of a buffalo hump, if it can be demonstrated that the buffalo hump is secondary to an endocrine disorder or pharmacological treatment of a medical condition (H) (Anaes.)	$631.75
45587	Meloplasty for correction of facial asymmetry due to soft tissue abnormality if the meloplasty is limited to one side of the face (Anaes.) (Assist.)	$890.85
45588	Meloplasty (excluding browlifts and chinlift platysmaplasties), bilateral, if it can be demonstrated that surgery is indicated because of congenital conditions, disease or trauma (other than trauma resulting from previous elective cosmetic surgery) (H) (Anaes.) (Assist.)	$1 336.40
45590	Orbital cavity, reconstruction of a wall or floor, with or without foreign implant (H) (Anaes.) (Assist.)	$483.25
45593	Orbital cavity, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (H) (Anaes.) (Assist.)	$567.65
45596	Maxilla, total resection of (H) (Anaes.) (Assist.)	$900.45
45597	Maxilla, total resection of both maxillae (H) (Anaes.) (Assist.)	$1 205.40
45599	Mandible, total resection of both sides, including condylectomies, if performed (Anaes.) (Assist.)	$936.55
45602	Mandible, including lower border, or maxilla, sub-total resection of (H) (Anaes.) (Assist.)	$699.45
45605	Mandible or maxilla, segmental resection of, for tumours or cysts (H) (Anaes.) (Assist.)	$587.60
45608	Mandible, hemi-mandibular reconstruction with bone graft, other than a service associated with a service to which item 45599 applies (H) (Anaes.) (Assist.)	$827.30
45611	Mandible, condylectomy (H) (Anaes.) (Assist.)	$473.75
45614	Eyelid, whole thickness reconstruction of, other than by	$587.60

Group T8—Surgical operations		
Item	**Description**	**Fee**
	direct suture only (Anaes.) (Assist.)	
45617	Upper eyelid, reduction of, for skin redundancy obscuring vision (as evidenced by upper eyelid skin resting on lashes on straight ahead gaze), herniation of orbital fat in exophthalmos, facial nerve palsy or post-traumatic scarring, or the restoration of symmetry of contralateral upper eyelid in respect of one of these conditions (Anaes.)	$235.05
45620	Lower eyelid, reduction of, for herniation of orbital fat in exophthalmos, facial nerve palsy or post-traumatic scarring, or, in respect of one of these conditions, the restoration of symmetry of the contralateral lower eyelid (Anaes.)	$326.05
45623	Ptosis of eyelid (unilateral), correction of (Anaes.) (Assist.)	$723.05
45624	Ptosis of eyelid, correction of, if previous ptosis surgery has been performed on that side (Anaes.) (Assist.)	$937.40
45625	Ptosis of eyelid, correction of eyelid height by revision of levator sutures within one week of primary repair by levator resection or advancement, performed in the operating theatre of a hospital (H) (Anaes.)	$187.55
45626	Ectropion or entropion, correction of (unilateral) (Anaes.)	$326.05
45629	Symblepharon, grafting for (Anaes.) (Assist.)	$473.75
45632	Rhinoplasty, correction of lateral or alar cartilages (Anaes.)	$511.95
45635	Rhinoplasty, correction of bony vault only (Anaes.)	$587.60
45638	Rhinoplasty, total, including correction of all bony and cartilaginous elements of the external nose, for correction of nasal obstruction or post-traumatic deformity (other than deformity resulting from previous elective cosmetic surgery), or both (H) (Anaes.)	$1 014.05
45639	Rhinoplasty, total, including correction of all bony and cartilaginous elements of the external nose, if it can be demonstrated that there is a need for correction of	$1 014.05

Group T8—Surgical operations		
Item	**Description**	**Fee**
	significant developmental deformity (H) (Anaes.)	
45641	Rhinoplasty involving nasal or septal cartilage graft, or nasal bone graft, or nasal bone and nasal cartilage graft (H) (Anaes.)	$1 082.90
45644	Rhinoplasty involving autogenous bone or cartilage graft obtained from distant donor site, including obtaining of graft (H) (Anaes.) (Assist.)	$1 279.45
45645	Choanal atresia, repair of by puncture and dilatation (H) (Anaes.)	$223.60
45646	Choanal atresia, correction by open operation with bone removal (Anaes.) (Assist.)	$900.45
45647	Face, contour restoration of one region, using autogenous bone or cartilage graft (other than a service to which item 45644 applies) (H) (Anaes.) (Assist.)	$1 279.45
45650	Rhinoplasty, secondary revision of (Anaes.)	$147.80
45652	Rhinophyma, carbon dioxide laser or erbium laser excision—ablation of (Anaes.)	$356.35
45653	Rhinophyma, shaving of (Anaes.)	$356.35
45656	Composite graft (chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (Anaes.) (Assist.)	$502.25
45659	Lop ear, bat ear or similar deformity, correction of (Anaes.)	$521.25
45660	External ear, complex total reconstruction of, using multiple costal cartilage grafts to form a framework, including the harvesting and sculpturing of the cartilage and its insertion, for congenital absence, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage)—performed by a specialist in the practice of his or her specialty (H) (Anaes.) (Assist.)	$2 878.75
45661	External ear, complex total reconstruction of, elevation of costal cartilage framework using cartilage previously stored in abdominal wall, including the use of local skin and fascia flaps and full thickness skin graft to cover cartilage (second stage)—performed by a specialist in the	$1 279.45

Group T8—Surgical operations		
Item	**Description**	**Fee**
	practice of his or her specialty (H) (Anaes.) (Assist.)	
45662	Congenital atresia, reconstruction of external auditory canal (H) (Anaes.) (Assist.)	$701.30
45665	Lip, eyelid or ear, full thickness wedge excision of, with repair by direct sutures (Anaes.)	$326.05
45668	Vermilionectomy, by surgical excision (Anaes.)	$326.05
45669	Vermilionectomy, using carbon dioxide laser or erbium laser excision—ablation (Anaes.)	$326.05
45671	Lip or eyelid reconstruction using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.)	$834.05
45674	Lip or eyelid reconstruction using full thickness flap (Abbe or similar), second stage (Anaes.)	$242.55
45675	Macrocheilia or macroglossia, operation for (H) (Anaes.) (Assist.)	$483.25
45676	Macrostomia, operation for (H) (Anaes.) (Assist.)	$575.30
45677	Cleft lip, unilateral—primary repair, one stage, without anterior palate repair (H) (Anaes.) (Assist.)	$541.35
45680	Cleft lip, unilateral—primary repair, one stage, with anterior palate repair (H) (Anaes.) (Assist.)	$676.80
45683	Cleft lip, bilateral—primary repair, one stage, without anterior palate repair (H) (Anaes.) (Assist.)	$751.85
45686	Cleft lip, bilateral—primary repair, one stage, with anterior palate repair (H) (Anaes.) (Assist.)	$887.50
45689	Cleft lip, lip adhesion procedure, unilateral or bilateral (H) (Anaes.) (Assist.)	$261.75
45692	Cleft lip, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.)	$300.75
45695	Cleft lip, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (H) (Anaes.) (Assist.)	$488.75
45698	Cleft lip, primary columella lengthening procedure, bilateral (H) (Anaes.)	$458.75
45701	Cleft lip reconstruction using full thickness flap (Abbe or	$827.30

Group T8—Surgical operations		
Item	**Description**	**Fee**
	similar), first stage (H) (Anaes.) (Assist.)	
45704	Cleft lip reconstruction using full thickness flap (Abbe or similar), second stage (Anaes.)	$300.75
45707	Cleft palate, primary repair (H) (Anaes.) (Assist.)	$781.95
45710	Cleft palate, secondary repair, closure of fistula using local flaps (H) (Anaes.)	$488.75
45713	Cleft palate, secondary repair, lengthening procedure (H) (Anaes.) (Assist.)	$556.60
45714	Oro-nasal fistula, plastic closure of, including services to which item 45200, 45203 or 45239 applies (H) (Anaes.) (Assist.)	$781.95
45716	Velo-pharyngeal incompetence, pharyngeal flap for, or pharyngoplasty for (H) (Anaes.)	$781.95
45720	Mandible or maxilla, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site, excluding services to which item 47933 or 47936 applies (Anaes.) (Assist.)	$966.80
45723	Mandible or maxilla, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	$1 090.35
45726	Mandible or maxilla, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	$1 232.05
45729	Mandible or maxilla, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	$1 383.65
45731	Mandible or maxilla, osteotomies or osteectomies of,	$1 402.70

Group T8—Surgical operations		
Item	**Description**	**Fee**
	involving 3 or more such procedures on the one jaw, including transposition of nerves and vessels and bone grafts taken from the same site, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	
45732	Mandible or maxilla, osteotomies or osteectomies of, involving 3 or more such procedures on the one jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	$1 579.20
45735	Mandible and maxilla, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	$1 611.05
45738	Mandible and maxilla, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	$1 812.40
45741	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of one jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	$1 772.30
45744	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of one jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws,	$1 992.70

Group T8—Surgical operations		
Item	**Description**	**Fee**
	plates or pins, or any combination, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	
45747	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty (when performed) and transposition of nerves and vessels and bone grafts taken from the same site, excluding services to which item 47933 or 47936 applies (Anaes.) (Assist.)	$1 933.55
45752	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	$2 165.75
45753	Midfacial osteotomies—Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	$2 178.60
45754	Midfacial osteotomies—Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (H) (Anaes.) (Assist.)	$2 611.60
45755	Temporo-mandibular partial or total meniscectomy (Anaes.) (Assist.)	$367.75
45758	Temporo-mandibular joint, arthroplasty (H) (Anaes.) (Assist.)	$658.05
45761	Genioplasty, including transposition of nerves and vessels and bone grafts taken from the same site (H) (Anaes.) (Assist.)	$748.65

Group T8—Surgical operations		
Item	**Description**	**Fee**
45767	Hypertelorism, correction of, intra-cranial (Anaes.) (Assist.)	$2 511.65
45770	Hypertelorism, correction of, sub-cranial (H) (Anaes.) (Assist.)	$1 923.90
45773	Treacher Collins Syndrome, periorbital correction of, with rib and iliac bone grafts (Anaes.) (Assist.)	$1 753.40
45776	Orbital dystopia (unilateral), correction of, with total repositioning of one orbit, intra-cranial (H) (Anaes.) (Assist.)	$1 753.40
45779	Orbital dystopia (unilateral), correction of, with total repositioning of one orbit, extra-cranial (H) (Anaes.) (Assist.)	$1 289.15
45782	Fronto-orbital advancement, unilateral (Anaes.) (Assist.)	$985.70
45785	Cranial vault reconstruction for oxycephaly, brachycephaly, turricephaly or similar condition—(bilateral fronto-orbital advancement) (H) (Anaes.) (Assist.)	$1 668.10
45788	Glenoid fossa, zygomatic arch and temporal bone, reconstruction of, (Obwegeser technique) (H) (Anaes.) (Assist.)	$1 649.10
45791	Absent condyle and ascending ramus in hemifacial microsomia, construction of, not including harvesting of graft material (H) (Anaes.) (Assist.)	$890.85
45794	Osseo-integration procedure—extra-oral, implantation of titanium fixture, not for implantable bone conduction hearing system device (Anaes.)	$503.85
45797	Osseo-integration procedure, fixation of transcutaneous abutment, not for implantable bone conduction hearing system device (Anaes.)	$186.50
45799	Aspiration biopsy of one or more jaw cysts as an independent procedure to obtain material for diagnostic purposes, other than a service associated with an operative procedure on the same day (Anaes.)	$29.45
45801	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), in the oral	$126.90

Group T8—Surgical operations		
Item	**Description**	**Fee**
	and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, if the removal is by surgical excision and suture, other than a service to which item 45803 applies (Anaes.)	
45803	Tumour, cyst, ulcers or scar (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, if the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Anaes.) (Assist.)	$326.05
45805	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.)	$172.50
45807	Tumour, cyst (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5 mm separation between the cyst lining and tooth structure or if a tumour or cyst has been proven by positive histopathology), ulcer or scar (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, removal of, other than a service to which another item in this Subgroup applies, involving muscle, bone, or other deep tissue (Anaes.)	$246.50
45809	Tumour or deep cyst (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5 mm separation between the cyst lining and tooth structure or if a tumour or cyst has been proven by positive histopathology), in the oral and maxillofacial region, removal of, requiring wide excision, other than a service to which another item in this Subgroup applies (Anaes.) (Assist.)	$371.50
45811	Tumour, in the oral and maxillofacial region, removal of,	$502.25

Group T8—Surgical operations		
Item	**Description**	**Fee**
	from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.)	
45813	Tumour, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.)	$587.60
45815	Operation on mandible or maxilla (other than alveolar margins) for chronic osteomyelitis—one bone or in combination with adjoining bones (Anaes.) (Assist.)	$356.35
45817	Operation on skull for osteomyelitis (Anaes.) (Assist.)	$464.50
45819	Operation on any combination of adjoining bones in the oral and maxillofacial region, being bones referred to in item 45817 (Anaes.) (Assist.)	$587.55
45821	Bone growth stimulator in the oral and maxillofacial region, insertion of (Anaes.) (Assist.)	$380.80
45823	Arch bars, one or more, that were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia, if undertaken in the operating theatre of a hospital (Anaes.)	$108.90
45825	Mandibular or palatal exostosis, excision of (Anaes.) (Assist.)	$338.35
45827	Mylohyoid ridge, reduction of (Anaes.) (Assist.)	$323.40
45829	Maxillary tuberosity, reduction of (Anaes.)	$246.70
45831	Papillary hyperplasia of the palate, removal of—less than 5 lesions (Anaes.) (Assist.)	$323.40
45833	Papillary hyperplasia of the palate, removal of—5 to 20 lesions (Anaes.) (Assist.)	$406.05
45835	Papillary hyperplasia of the palate, removal of—more than 20 lesions (Anaes.) (Assist.)	$503.85
45837	Vestibuloplasty, submucosal or open, including excision of muscle and skin or mucosal graft when performed—unilateral or bilateral (Anaes.) (Assist.)	$586.50
45839	Floor of mouth lowering (Obwegeser or similar procedure), including excision of muscle and skin or	$586.50

Group T8—Surgical operations		
Item	**Description**	**Fee**
	mucosal graft when performed—unilateral (Anaes.) (Assist.)	
45841	Alveolar ridge augmentation with bone or alloplast or both—unilateral (Anaes.) (Assist.)	$473.65
45843	Alveolar ridge augmentation—unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region (Anaes.) (Assist.)	$290.50
45845	Osseo-integration procedure—intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.)	$503.85
45847	Osseo-integration procedure—fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.)	$186.50
45849	Maxillary sinus, bone graft to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), unilateral (Anaes.) (Assist.)	$580.90
45851	Temporomandibular joint, manipulation of, performed in the operating theatre of a hospital, other than a service associated with a service to which another item in this Subgroup applies (Anaes.)	$142.95
45853	Absent condyle and ascending ramus in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.)	$890.85
45855	Temporomandibular joint, arthroscopy of, with or without biopsy, other than a service associated with another arthroscopic procedure of that joint (Anaes.) (Assist.)	$408.70
45857	Temporomandibular joint, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions—one or more of such procedures, other than a service associated with another arthroscopic procedure of the temporomandibular joint (Anaes.) (Assist.)	$653.80
45859	Temporomandibular joint, arthrotomy of, other than a	$329.60

Group T8—Surgical operations		
Item	**Description**	**Fee**
	service to which another item in this Subgroup applies (Anaes.) (Assist.)	
45861	Temporomandibular joint, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.)	$872.30
45863	Temporomandibular joint, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.)	$967.00
45865	Arthrocentesis, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.)	$290.50
45867	Temporomandibular joint, synovectomy of, other than a service to which another item in this Subgroup applies (Anaes.) (Assist.)	$312.30
45869	Temporomandibular joint, open surgical exploration of, with or without meniscus or capsular surgery, including partial or total meniscectomy when performed, with or without microsurgical techniques (Anaes.) (Assist.)	$1 188.20
45871	Temporomandibular joint, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.)	$1 338.45
45873	Temporomandibular joint, surgery of, involving procedures to which item 45863, 45867, 45869 or 45871 applies and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Anaes.) (Assist.)	$1 504.05
45875	Temporomandibular joint, stabilisation of, involving one or more of: repair of capsule, repair of ligament or internal fixation, other than a service to which another item in this Subgroup applies (Anaes.) (Assist.)	$470.70
45877	Temporomandibular joint, arthrodesis of, with synovectomy if performed, other than a service to which another item in this Subgroup applies (Anaes.) (Assist.)	$470.70
45879	Temporomandibular joint or joints, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.)	$312.30

Group T8—Surgical operations		
Item	**Description**	**Fee**
45882	Treatment of a premalignant lesion of the oral mucosa using cryotherapy, diathermy or carbon dioxide laser	$43.00
45885	Ligation of a facial, mandibular or lingual artery or vein, or artery and vein	$443.70
45888	Removal of a deep foreign body using interventional imaging techniques	$413.55
45891	Repair to one defect using temporalis muscle by a single stage local flap	$602.45
45894	Free grafting of a granulating area (mucosa or split skin)	$204.70
45897	Grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation, a unilateral alveolar cleft (congenital)	$1 069.10
45900	Fixation of the mandible by intermaxillay wiring, excluding wiring for obesity	$241.15
45939	Cryosurgery of the peripheral branches of the trigeminal nerve for pain relief	$447.10
45945	Treatment of a dislocation of the mandible requiring open reduction	$118.70
45975	Treatment of a fracture of the unilateral or bilateral maxilla, not requiring splinting	$129.20
45978	Treatment of a fracture of the mandible, not requiring splinting	$157.85
45981	Treatment of the zygomatic bone, not requiring surgical reduction	$85.65
45984	Treatment of a complicated fracture of the maxilla involving viscera, blood vessels or nerves, requiring open reduction not involving the use of a plate	$616.65
45987	Treatment of a complicated fracture of the mandible involving viscera, blood vessels or nerves, requiring open reduction not involving the use of a plate	$616.65
45990	Treatment of a complicated fracture of the maxilla including viscera, blood vessels or nerves, requiring open reduction involving the use of a plate	$842.25
45993	Treatment of a complicated fracture of the mandible	$842.25

Group T8—Surgical operations		
Item	**Description**	**Fee**
	involving viscera, blood vessels or nerves, requiring open reduction involving the use of a plate	
45996	Treatment of a closed fracture of the mandible involving a joint surface	$238.80

Subdivision G—Subgroup 14

2.44.20 Items 46300 to 46534 apply only in certain circumstances

Items 46300 to 46534 apply only to a service provided in the course of an operation on a hand or hands.

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
Subgroup 14—Hand surgery		
46300	Interphalangeal joint or metacarpophalangeal joint, arthrodesis of, with synovectomy if performed (H) (Anaes.) (Assist.)	338.40
46303	Carpometacarpal joint, arthrodesis of, with synovectomy if performed (H) (Anaes.) (Assist.)	376.10
46306	Interphalangeal joint or metacarpophalangeal joint—interposition arthroplasty of and including tendon transfers or realignment on the one ray (H) (Anaes.) (Assist.)	526.50
46307	Interphalangeal joint or metacarpophalangeal joint—volar plate arthroplasty for traumatic deformity including tendon transfers or realignment on the one ray (H) (Anaes.) (Assist.)	526.50
46309	Interphalangeal joint or metacarpophalangeal joint, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment—one joint (H) (Anaes.) (Assist.)	526.50
46312	Interphalangeal joint or metacarpophalangeal joint, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment—2 joints (H) (Anaes.) (Assist.)	676.95
46315	Interphalangeal joint or metacarpophalangeal joint, total replacement arthroplasty or hemiarthroplasty of, including	902.55

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	associated synovectomy, tendon transfer or realignment—3 joints (H) (Anaes.) (Assist.)	
46318	Interphalangeal joint or metacarpophalangeal joint, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment—4 joints (H) (Anaes.) (Assist.)	1 128.25
46321	Interphalangeal joint or metacarpophalangeal joint, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment—5 or more joints (H) (Anaes.) (Assist.)	1 353.90
46324	Carpal bone replacement arthroplasty including associated tendon transfer or realignment when performed (H) (Anaes.) (Assist.)	807.35
46325	Carpal bone replacement or resection arthroplasty using adjacent tendon or other soft tissue including associated tendon transfer or realignment when performed (H) (Anaes.) (Assist.)	842.50
46327	Interphalangeal joint or metacarpophalangeal joint, arthrotomy of (Anaes.)	203.15
46330	Interphalangeal joint or metacarpophalangeal joint, ligamentous or capsular repair, with or without arthrotomy(H) (Anaes.) (Assist.)	346.10
46333	Interphalangeal joint or metacarpophalangeal joint, ligamentous repair of, using free tissue graft or implant (H) (Anaes.) (Assist.)	564.05
46336	Interphalangeal joint or metacarpophalangeal joint, synovectomy, capsulectomy or debridement of, other than a service associated with another procedure related to that joint (Anaes.) (Assist.)	263.30
46339	Extensor tendons or flexor tendons of hand or wrist, synovectomy of (Anaes.) (Assist.)	466.20
46342	Distal radioulnar joint or carpometacarpal joint or joints, synovectomy of (H) (Anaes.) (Assist.)	466.20
46345	Distal radioulnar joint, reconstruction or stabilisation of, including fusion, or ligamentous arthroplasty and excision of	564.05

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	distal ulna, when performed (H) (Anaes.) (Assist.)	
46348	Digit, synovectomy of flexor tendon or tendons—one digit (Anaes.)	244.45
46351	Digit, synovectomy of flexor tendon or tendons—2 digits (H) (Anaes.) (Assist.)	364.80
46354	Digit, synovectomy of flexor tendon or tendons—3 digits (H) (Anaes.) (Assist.)	488.85
46357	Digit, synovectomy of flexor tendon or tendons—4 digits (H) (Anaes.) (Assist.)	609.20
46360	Digit, synovectomy of flexor tendon or tendons—5 digits (H) (Anaes.) (Assist.)	733.35
46363	Tendon sheath of hand or wrist, open operation on, for stenosing tenovaginitis (Anaes.)	210.60
46366	Dupuytren's contracture, subcutaneous fasciotomy for—each hand (Anaes.)	127.90
46369	Dupuytren's contracture, palmar fasciectomy for—one hand (Anaes.)	210.60
46372	Dupuytren's contracture, fasciectomy for, from one ray, including dissection of nerves—one hand (Anaes.) (Assist.)	427.95
46375	Dupuytren's contracture, fasciectomy for, from 2 rays, including dissection of nerves—one hand (Anaes.) (Assist.)	507.70
46378	Dupuytren's contracture, fasciectomy for, from 3 or more rays, including dissection of nerves—one hand (H) (Anaes.) (Assist.)	676.95
46381	Interphalangeal joint, joint capsule release when performed in conjunction with operation for Dupuytren's contracture—each procedure (H) (Anaes.) (Assist.)	300.80
46384	Z plasty (or similar local flap procedure) when performed in conjunction with operation for Dupuytren's contracture—one such procedure (H) (Anaes.) (Assist.)	300.80
46387	Dupuytren's contracture, fasciectomy for, from one ray, including dissection of nerves—operation for recurrence in that ray (Anaes.) (Assist.)	620.60
46390	Dupuytren's contracture, fasciectomy for, from 2 rays,	827.50

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	including dissection of nerves—operation for recurrence in those rays (H) (Anaes.) (Assist.)	
46393	Dupuytren's contracture, fasciectomy for, from 3 or more rays, including dissection of nerves—operation for recurrence in those rays (H) (Anaes.) (Assist.)	959.00
46396	Phalanx or metacarpal of the hand, osteotomy or osteectomy of, excluding services to which item 47933 or 47936 applies (Anaes.) (Assist.)	329.60
46399	Phalanx or metacarpal of the hand, osteotomy of, with internal fixation (H) (Anaes.) (Assist.)	517.80
46402	Phalanx or metacarpal, bone grafting of, for pseudarthrosis (non-union), including obtaining of graft material (H) (Anaes.) (Assist.)	517.80
46405	Phalanx or metacarpal, bone grafting of, for pseudarthrosis (non-union), involving internal fixation and including obtaining of graft material (H) (Anaes.) (Assist.)	631.90
46408	Tendon, reconstruction of, by tendon graft (H) (Anaes.) (Assist.)	692.00
46411	Flexor tendon pulley, reconstruction of, by graft (H) (Anaes.) (Assist.)	406.15
46414	Artificial tendon prosthesis, insertion of, in preparation for tendon grafting (Anaes.) (Assist.)	526.40
46417	Tendon transfer for restoration of hand function, each transfer (H) (Anaes.) (Assist.)	488.85
46420	Extensor tendon of hand or wrist, primary repair of, each tendon (Anaes.)	204.60
46423	Extensor tendon of hand or wrist, secondary repair of, each tendon (Anaes.) (Assist.)	327.15
46426	Flexor tendon of hand or wrist, primary repair of, proximal to A1 pulley, each tendon (H) (Anaes.) (Assist.)	338.40
46429	Flexor tendon of hand or wrist, secondary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.)	413.65
46432	Flexor tendon of hand, primary repair of, distal to A1 pulley, each tendon (H) (Anaes.) (Assist.)	451.35

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
46435	Flexor tendon of hand, secondary repair of, distal to A1 pulley, each tendon (H) (Anaes.) (Assist.)	526.50
46438	Mallet finger, closed pin fixation of (Anaes.)	135.45
46441	Mallet finger, open repair of, including pin fixation when performed (Anaes.) (Assist.)	327.15
46442	Mallet finger with intra-articular fracture involving more than one-third of base of terminal phalanx—open reduction (H) (Anaes.) (Assist.)	280.85
46444	Boutonniere deformity without joint contracture, reconstruction of (H) (Anaes.) (Assist.)	488.85
46447	Boutonniere deformity with joint contracture, reconstruction of (H) (Anaes.) (Assist.)	609.20
46450	Extensor tendon, tenolysis of, following tendon injury, repair or graft (H) (Anaes.)	225.70
46453	Flexor tendon, tenolysis of, following tendon injury, repair or graft (H) (Anaes.) (Assist.)	376.10
46456	Finger, percutaneous tenotomy of (Anaes.)	97.80
46459	Operation for osteomyelitis on distal phalanx (Anaes.)	188.05
46462	Operation for osteomyelitis on middle or proximal phalanx, metacarpal or carpus (Anaes.) (Assist.)	300.80
46464	Amputation of a supernumerary complete digit (Anaes.)	225.70
46465	Amputation of single digit, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.)	225.70
46468	Amputation of 2 digits, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (H) (Anaes.) (Assist.)	394.90
46471	Amputation of 3 digits, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.)	564.05
46474	Amputation of 4 digits, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (H) (Anaes.) (Assist.)	733.35
46477	Amputation of 5 digits, proximal to nail bed, involving section	902.55

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	of bone or joint and requiring soft tissue cover (H) (Anaes.) (Assist.)	
46480	Amputation of single digit, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover, including metacarpal (Anaes.) (Assist.)	376.10
46483	Revision of amputation stump to provide adequate soft tissue cover (Anaes.) (Assist.)	300.80
46486	Nail bed, accurate reconstruction of nail bed laceration using magnification, undertaken in the operating theatre of a hospital (Anaes.)	225.70
46489	Nail bed, secondary exploration and accurate repair of nail bed deformity using magnification, undertaken in the operating theatre of a hospital (Anaes.) (Assist.)	263.30
46492	Contracture of digits of hand, flexor or extensor, correction of, involving tissues deeper than skin and subcutaneous tissue (H) (Anaes.) (Assist.)	361.05
46494	Ganglion of hand, excision of, other than a service associated with a service to which another item in this Group applies (Anaes.)	219.95
46495	Ganglion or mucous cyst of distal digit, excision of, other than a service associated with a service to which item 30106 or 30107 applies (Anaes.)	203.15
46498	Ganglion of flexor tendon sheath, excision of, other than a service associated with a service to which item 30106 or 30107 applies (Anaes.)	219.95
46500	Ganglion of dorsal wrist joint, excision of, other than a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.)	263.30
46501	Ganglion of volar wrist joint, excision of, other than a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.)	329.20
46502	Recurrent ganglion of dorsal wrist joint, excision of, other than a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.)	302.95
46503	Recurrent ganglion of volar wrist joint, excision of, other than	378.40

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.)	
46504	Neurovascular island flap, for pulp innervation (Anaes.) (Assist.)	1 105.55
46507	Digit or ray, transposition or transfer of, on vascular pedicle, complete procedure (H) (Anaes.) (Assist.)	1 286.20
46510	Macrodactyly, surgical reduction of enlarged elements—each digit (H) (Anaes.) (Assist.)	351.00
46513	Digital nail of finger or thumb, removal of, other than a service to which item 46516 applies (Anaes.)	56.50
46516	Digital nail of finger or thumb, removal of, in the operating theatre of a hospital (Anaes.)	112.85
46519	Middle palmar, thenar or hypothenar spaces of hand, drainage of (excluding after-care) (Anaes.)	141.25
46522	Flexor tendon sheath of finger or thumb—open operation and drainage for infection (H) (Anaes.) (Assist.)	421.20
46525	Pulp space infection, paronychia of hand, incision for, when performed in an operating theatre of a hospital, other than a service to which another item in this Group applies (excluding after-care) (Anaes.)	56.50
46528	Ingrowing nail of finger or thumb, wedge resection for, including removal of segment of nail, ungual fold and portion of the nail bed (Anaes.)	169.50
46531	Ingrowing nail of finger or thumb, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes.)	85.15
46534	Nail plate injury or deformity, radical excision of nail germinal matrix (Anaes.)	235.50

Subdivision H—Subgroup 15

2.44.21 Limitation of item 50303

A service described in item 50303 is applicable once in any 12 month period for each limb.

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
Subgroup 15—Orthopaedic		
47000	Mandible, treatment of dislocation of, by closed reduction (Anaes.)	70.65
47003	Clavicle, treatment of dislocation of, by closed reduction (Anaes.)	84.80
47006	Clavicle, treatment of dislocation of, by open reduction (Anaes.)	170.25
47009	Shoulder, treatment of dislocation of, requiring general anaesthesia, other than a service to which item 47012 applies (Anaes.)	169.50
47012	Shoulder, treatment of dislocation of, requiring general anaesthesia, open reduction (H) (Anaes.) (Assist.)	338.85
47015	Shoulder, treatment of dislocation of, not requiring general anaesthesia	84.80
47018	Elbow, treatment of dislocation of, by closed reduction (Anaes.)	197.60
47021	Elbow, treatment of dislocation of, by open reduction (H) (Anaes.) (Assist.)	263.60
47024	Radioulnar joint, distal or proximal, treatment of dislocation of, by closed reduction, other than a service associated with fracture or dislocation in the same region (Anaes.)	197.60
47027	Radioulnar joint, distal or proximal, treatment of dislocation of, by open reduction, other than a service associated with fracture or dislocation in the same region (H) (Anaes.) (Assist.)	263.60
47030	Carpus, or carpus on radius and ulna, or carpometacarpal joint, treatment of dislocation of, by closed reduction (Anaes.)	197.60
47033	Carpus, or carpus on radius and ulna, or carpometacarpal joint, treatment of dislocation of, by open reduction (Anaes.) (Assist.)	263.60
47036	Interphalangeal joint, treatment of dislocation of, by closed reduction (Anaes.)	84.80
47039	Interphalangeal joint, treatment of dislocation of, by open	112.85

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	reduction (Anaes.)	
47042	Metacarpophalangeal joint, treatment of dislocation of, by closed reduction (Anaes.)	112.85
47045	Metacarpophalangeal joint, treatment of dislocation of, by open reduction (Anaes.)	150.75
47048	Hip, treatment of dislocation of, by closed reduction (Anaes.)	324.80
47051	Hip, treatment of dislocation of, by open reduction (H) (Anaes.) (Assist.)	432.95
47054	Knee, treatment of dislocation of, by closed reduction (Anaes.) (Assist.)	324.80
47057	Patella, treatment of dislocation of, by closed reduction (Anaes.)	127.00
47060	Patella, treatment of dislocation of, by open reduction (Anaes.)	169.50
47063	Ankle or tarsus, treatment of dislocation of, by closed reduction (Anaes.)	254.20
47066	Ankle or tarsus, treatment of dislocation of, by open reduction (H) (Anaes.) (Assist.)	338.85
47069	Toe, treatment of dislocation of, by closed reduction (Anaes.)	70.65
47072	Toe, treatment of dislocation of, by open reduction (Anaes.)	94.00
47300	Distal phalanx of finger or thumb, treatment of fracture of, by closed reduction, including percutaneous fixation, if used (Anaes.)	84.80
47303	Distal phalanx of finger or thumb, treatment of intra-articular fracture of, by closed reduction (Anaes.)	98.90
47306	Distal phalanx of finger or thumb, treatment of fracture of, by open reduction (Anaes.)	112.85
47309	Distal phalanx of finger or thumb, treatment of intra-articular fracture of, by open reduction (Anaes.)	141.25
47312	Middle phalanx of finger, treatment of fracture of, by closed reduction (Anaes.)	127.00
47315	Middle phalanx of finger, treatment of intra-articular fracture of, by closed reduction (Anaes.)	145.95

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
47318	Middle phalanx of finger, treatment of fracture of, by open reduction (Anaes.)	169.50
47321	Middle phalanx of finger, treatment of intra-articular fracture of, by open reduction (H) (Anaes.)	211.75
47324	Proximal phalanx of finger or thumb, treatment of fracture of, by closed reduction (Anaes.)	169.50
47327	Proximal phalanx of finger or thumb, treatment of intra-articular fracture of, by closed reduction (Anaes.)	197.60
47330	Proximal phalanx of finger or thumb, treatment of fracture of, by open reduction (Anaes.)	226.00
47333	Proximal phalanx of finger or thumb, treatment of intra-articular fracture of, by open reduction (H) (Anaes.) (Assist.)	282.35
47336	Metacarpal, treatment of fracture of, by closed reduction (Anaes.)	169.50
47339	Metacarpal, treatment of intra-articular fracture of, by closed reduction (Anaes.)	197.60
47342	Metacarpal, treatment of fracture of, by open reduction (Anaes.)	226.00
47345	Metacarpal, treatment of intra-articular fracture of, by open reduction (H) (Anaes.) (Assist.)	282.35
47348	Carpus (excluding scaphoid), treatment of fracture of, other than a service to which item 47351 applies (Anaes.)	94.00
47351	Carpus (excluding scaphoid), treatment of fracture of, by open reduction (Anaes.)	235.50
47354	Carpal scaphoid, treatment of fracture of, other than a service to which item 47357 applies (Anaes.)	169.50
47357	Carpal scaphoid, treatment of fracture of, by open reduction (Anaes.) (Assist.)	376.55
47360	Radius or ulna, distal end of, treatment of fracture of, by cast immobilisation, other than a service to which item 47363 or 47366 applies (Anaes.)	131.85
47363	Radius or ulna, distal end of, treatment of fracture of, by closed reduction (Anaes.)	197.60

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
47366	Radius or ulna, distal end of, treatment of fracture of, by open reduction (Anaes.) (Assist.)	263.60
47369	Radius, distal end of, treatment of Colles', Smith's or Barton's fracture of, by cast immobilisation, other than a service to which item 47372 or 47375 applies (Anaes.)	169.50
47372	Radius, distal end of, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.)	282.35
47375	Radius, distal end of, treatment of Colles', Smith's or Barton's fracture, by open reduction (H) (Anaes.) (Assist.)	376.55
47378	Radius or ulna, shaft of, treatment of fracture of, by cast immobilisation, other than a service to which item 47381, 47384, 47385 or 47386 applies (Anaes.)	169.50
47381	Radius or ulna, shaft of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.)	254.20
47384	Radius or ulna, shaft of, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.)	338.85
47385	Radius or ulna, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction undertaken in the operating theatre of a hospital (Anaes.) (Assist.)	291.75
47386	Radius or ulna, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by open reduction or internal fixation (H) (Anaes.) (Assist.)	470.70
47387	Radius and ulna, shafts of, treatment of fracture of, by cast immobilisation, other than a service to which item 47390 or 47393 applies (Anaes.) (Assist.)	272.95
47390	Radius and ulna, shafts of, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (H) (Anaes.)	409.55
47393	Radius and ulna, shafts of, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.)	546.00
47396	Olecranon, treatment of fracture of, other than a service to	188.20

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	which item 47399 applies (Anaes.)	
47399	Olecranon, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.)	376.55
47402	Olecranon, treatment of fracture of, involving excision of olecranon fragment and reimplantation of tendon (Anaes.) (Assist.)	282.35
47405	Radius, treatment of fracture of head or neck of, closed reduction of (Anaes.)	188.20
47408	Radius, treatment of fracture of head or neck of, open reduction of, including internal fixation and excision, if performed (H) (Anaes.) (Assist.)	376.55
47411	Humerus, treatment of fracture of tuberosity of, other than a service to which item 47417 applies (Anaes.)	112.85
47414	Humerus, treatment of fracture of tuberosity of, by open reduction (Anaes.)	226.00
47417	Humerus, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.)	263.60
47420	Humerus, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by open reduction (H) (Anaes.) (Assist.)	517.80
47423	Humerus, proximal, treatment of fracture of, other than a service to which item 47426, 47429 or 47432 applies (Anaes.)	216.50
47426	Humerus, proximal, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.)	324.80
47429	Humerus, proximal, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.)	432.95
47432	Humerus, proximal, treatment of intra-articular fracture of, by open reduction (H) (Anaes.) (Assist.)	541.30
47435	Humerus, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.)	414.25
47438	Humerus, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (H) (Anaes.) (Assist.)	659.15

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
47441	Humerus, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction (H) (Anaes.) (Assist.)	823.75
47444	Humerus, shaft of, treatment of fracture of, other than a service to which item 47447 or 47450 applies (Anaes.)	226.00
47447	Humerus, shaft of, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (H) (Anaes.)	338.85
47450	Humerus, shaft of, treatment of fracture of, by internal or external (H) (Anaes.) (Assist.)	451.95
47451	Humerus, shaft of, treatment of fracture of, by intramedullary fixation (H) (Anaes.) (Assist.)	544.80
47453	Humerus, distal, (supracondylar or condylar), treatment of fracture of, other than a service to which item 47456 or 47459 applies (Anaes.) (Assist.)	263.60
47456	Humerus, distal (supracondylar or condylar), treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.)	395.50
47459	Humerus, distal (supracondylar or condylar), treatment of fracture of, by open reduction, undertaken in the operating theatre of a hospital (H) (Anaes.) (Assist.)	527.25
47462	Clavicle, treatment of fracture of, other than a service to which item 47465 applies (Anaes.)	112.85
47465	Clavicle, treatment of fracture of, by open reduction (Anaes.) (Assist.)	226.00
47466	Sternum, treatment of fracture of, other than a service to which item 47467 applies (Anaes.)	112.85
47467	Sternum, treatment of fracture of, by open reduction (H) (Anaes.)	226.00
47468	Scapula, neck or glenoid region of, treatment of fracture of, by open reduction (Anaes.) (Assist.)	432.95
47471	Ribs (one or more), treatment of fracture of—each attendance	43.00
47474	Pelvic ring, treatment of fracture of, not involving disruption of pelvic ring or acetabulum	188.20

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
47477	Pelvic ring, treatment of fracture of, with disruption of pelvic ring or acetabulum	235.50
47480	Pelvic ring, treatment of fracture of, requiring traction (H) (Anaes.) (Assist.)	470.70
47483	Pelvic ring, treatment of fracture of, requiring control by external fixation (H) (Anaes.) (Assist.)	564.85
47486	Pelvic ring, treatment of fracture of, by open reduction and involving internal fixation of anterior segment, including diastasis of pubic symphysis (H) (Anaes.) (Assist.)	941.45
47489	Pelvic ring, treatment of fracture of, by open reduction and involving internal fixation of posterior segment (including sacro-iliac joint), with or without fixation of anterior segment (H) (Anaes.) (Assist.)	1 412.20
47492	Acetabulum, treatment of fracture of, and associated dislocation of hip (Anaes.)	235.50
47495	Acetabulum, treatment of fracture of, and associated dislocation of hip, requiring traction (Anaes.) (Assist.)	470.70
47498	Acetabulum, treatment of fracture of, and associated dislocation of hip, requiring internal fixation, with or without traction (H) (Anaes.) (Assist.)	706.05
47501	Acetabulum, treatment of single column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	941.45
47504	Acetabulum, treatment of T-shape fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, excluding services to which item 47933 or 47936 applies (Anaes.) (Assist.)	1 412.20
47507	Acetabulum, treatment of transverse fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	1 412.20

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
47510	Acetabulum, treatment of double column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	1 412.20
47513	Sacro-iliac joint disruption, treatment of, requiring internal fixation, being a service associated with a service to which items 47501 to 47510 apply (H) (Anaes.) (Assist.)	376.55
47516	Femur, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.)	432.95
47519	Femur, treatment of trochanteric or subcapital fracture of, by internal fixation (H) (Anaes.) (Assist.)	866.20
47522	Femur, treatment of subcapital fracture of, by hemi-arthroplasty (H) (Anaes.) (Assist.)	753.25
47525	Femur, treatment of fracture of, for slipped capital femoral epiphysis (H) (Anaes.) (Assist.)	866.20
47528	Femur, treatment of fracture of, by internal fixation or external fixation (H) (Anaes.) (Assist.)	753.25
47531	Femur, treatment of fracture of shaft, by intramedullary fixation and cross fixation (H) (Anaes.) (Assist.)	960.25
47534	Femur, condylar region of, treatment of intra-articular (T-shaped condylar) fracture of, requiring internal fixation, with or without internal fixation of one or more osteochondral fragments (H) (Anaes.) (Assist.)	1 082.70
47537	Femur, condylar region of, treatment of fracture of, requiring internal fixation of one or more osteochondral fragments, other than a service associated with a service to which item 47534 applies (Anaes.) (Assist.)	432.95
47540	Hip spica or shoulder spica, application of, as an independent procedure (Anaes.)	216.50
47543	Tibia, plateau of, treatment of medial or lateral fracture of, other than a service to which item 47546 or 47549 applies (Anaes.)	226.00
47546	Tibia, plateau of, treatment of medial or lateral fracture of, by closed reduction (Anaes.)	338.85

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
47549	Tibia, plateau of, treatment of medial or lateral fracture of, by open reduction (H) (Anaes.) (Assist.)	451.95
47552	Tibia, plateau of, treatment of both medial and lateral fractures of, other than a service to which item 47555 or 47558 applies (Anaes.) (Assist.)	376.55
47555	Tibia, plateau of, treatment of both medial and lateral fractures of, by closed reduction (H) (Anaes.)	564.85
47558	Tibia, plateau of, treatment of both medial and lateral fractures of, by open reduction (H) (Anaes.) (Assist.)	753.25
47561	Tibia, shaft of, treatment of fracture of, by cast immobilisation, other than a service to which item 47564, 47567, 47570 or 47573 applies (Anaes.)	272.95
47564	Tibia, shaft of, treatment of fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.)	409.55
47565	Tibia, shaft of, treatment of fracture of, by internal fixation or external fixation (H) (Anaes.) (Assist.)	712.40
47566	Tibia, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (H) (Anaes.) (Assist.)	908.05
47567	Tibia, shaft of, treatment of intra-articular fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) (Assist.)	475.35
47570	Tibia, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (Anaes.) (Assist.)	546.00
47573	Tibia, shaft of, treatment of intra-articular fracture of, by open reduction, with or without treatment of fibular fracture (H) (Anaes.) (Assist.)	682.55
47576	Fibula, treatment of fracture of (Anaes.)	112.85
47579	Patella, treatment of fracture of, other than a service to which item 47582 or 47585 applies (Anaes.)	160.05
47582	Patella, treatment of fracture of, by excision of patella or pole with reattachment of tendon (H) (Anaes.) (Assist.)	329.60
47585	Patella, treatment of fracture of, by internal fixation (H) (Anaes.) (Assist.)	423.75
47588	Knee joint, treatment of fracture of, by internal fixation of	1 317.80

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	intra-articular fractures of femoral condylar or tibial articular surfaces and requiring repair or reconstruction of one or more ligaments (H) (Anaes.) (Assist.)	
47591	Knee joint, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar and tibial articular surfaces and requiring repair or reconstruction of one or more ligaments (H) (Anaes.) (Assist.)	1 600.65
47594	Ankle joint, treatment of fracture of, other than a service to which item 47597 applies (Anaes.)	216.50
47597	Ankle joint, treatment of fracture of, by closed reduction (Anaes.)	324.80
47600	Ankle joint, treatment of fracture of, by internal fixation of one of malleolus, fibula or diastasis (H) (Anaes.) (Assist.)	432.95
47603	Ankle joint, treatment of fracture of, by internal fixation of more than one of malleolus, fibula or diastasis (H) (Anaes.) (Assist.)	564.85
47606	Calcaneum or talus, treatment of fracture of, other than a service to which item 47609, 47612, 47615 or 47618 applies, with or without dislocation (Anaes.)	235.50
47609	Calcaneum or talus, treatment of fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.)	353.05
47612	Calcaneum or talus, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.)	409.55
47615	Calcaneum or talus, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.)	470.70
47618	Calcaneum or talus, treatment of intra-articular fracture of, by open reduction, with or without dislocation (H) (Anaes.) (Assist.)	588.45
47621	Tarso-metatarsal, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.)	409.55
47624	Tarso-metatarsal, treatment of fracture of, by open reduction, with or without dislocation (H) (Anaes.) (Assist.)	564.85
47627	Tarsus (excluding calcaneum or talus), treatment of fracture of	160.05

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	(Anaes.)	
47630	Tarsus (excluding calcaneum or talus), treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.)	338.85
47633	Metatarsal, one of, treatment of fracture of (Anaes.)	112.85
47636	Metatarsal, one of, treatment of fracture of, by closed reduction (Anaes.)	169.50
47639	Metatarsal, one of, treatment of fracture of, by open reduction (Anaes.)	226.00
47642	Metatarsals, 2 of, treatment of fracture of (Anaes.)	150.75
47645	Metatarsals, 2 of, treatment of fracture of, by closed reduction (Anaes.)	226.00
47648	Metatarsals, 2 of, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.)	301.05
47651	Metatarsals, 3 or more of, treatment of fracture of (Anaes.)	235.50
47654	Metatarsals, 3 or more of, treatment of fracture of, by closed reduction (Anaes.) (Assist.)	353.05
47657	Metatarsals, 3 or more of, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.)	470.70
47663	Phalanx of great toe, treatment of fracture of, by closed reduction (Anaes.)	141.25
47666	Phalanx of great toe, treatment of fracture of, by open reduction (Anaes.)	235.50
47672	Phalanx of toe (other than great toe), one of, treatment of fracture of, by open reduction (Anaes.)	112.85
47678	Phalanx of toe (other than great toe), more than one of, treatment of fracture of, by open reduction (Anaes.)	169.50
47681	Spine (excluding sacrum), treatment of fracture of transverse process, vertebral body, or posterior elements—each attendance	43.00
47684	Spine, treatment of fracture, dislocation or fracture-dislocation, without spinal cord involvement, by means of immobilisation by calipers or halo (Anaes.) (Assist.)	753.25

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
47687	Spine, treatment of fracture, dislocation or fracture-dislocation, with spinal cord involvement, by means of immobilisation by calipers or halo, requiring not more than 14 days post-operative care (H) (Assist.)	1 317.80
47690	Spine, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, by means of immobilisation by calipers or halo, requiring reduction by closed manipulation (H) (Anaes.) (Assist.)	1 035.55
47693	Spine, treatment of fracture, dislocation or fracture-dislocation, with cord involvement, by means of immobilisation by calipers or halo, requiring reduction by closed manipulation and not more than 14 days post-operative care (H) (Assist.)	1 317.80
47696	Spine, reduction of fracture or dislocation of, without cord involvement, undertaken in the operating theatre of a hospital (Anaes.) (Assist.)	376.55
47699	Spine, treatment of fracture, dislocation or fracture-dislocation without cord involvement requiring open reduction with or without internal fixation (H) (Anaes.) (Assist.)	1 506.45
47702	Spine, treatment of fracture, dislocation or fracture-dislocation with cord involvement requiring open reduction with or without internal fixation, including up to 14 days post-operative care (H) (Anaes.) (Assist.)	1 882.95
47703	Skull, treatment of fracture of, each attendance	43.00
47705	Skull callipers, insertion of, as an independent procedure (H) (Anaes.) (Assist.)	282.35
47708	Plaster jacket, application of, as an independent procedure (Anaes.)	216.50
47711	Halo, application of, as an independent procedure (H) (Anaes.) (Assist.)	320.15
47714	Halo, application of, in addition to spinal fusion for scoliosis, or other conditions (H) (Anaes.)	240.05
47717	Halo-thoracic traction—application of both halo and thoracic jacket (H) (Anaes.) (Assist.)	423.75
47720	Halo-femoral traction, as an independent procedure (Anaes.)	423.75

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	(Assist.)	
47723	Halo-femoral traction in conjunction with a major spine operation (Anaes.) (Assist.)	423.75
47726	Bone graft, harvesting of, via separate incision, in conjunction with another service, autogenous, small quantity (H) (Anaes.)	141.25
47729	Bone graft, harvesting of, via separate incision, in conjunction with another service, autogenous, large quantity (H) (Anaes.)	235.50
47732	Vascularised pedicle bone graft, harvesting of, in conjunction with another service (H) (Anaes.) (Assist.)	376.55
47735	Nasal bones, treatment of fracture of, other than a service to which item 47738 or 47741 applies—each attendance	43.05
47738	Nasal bones, treatment of fracture of, by reduction (Anaes.)	235.50
47741	Nasal bones, treatment of fracture of, by open reduction involving osteotomies (H) (Anaes.) (Assist.)	480.35
47753	Maxilla, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (H) (Anaes.) (Assist.)	406.65
47756	Mandible, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (H) (Anaes.) (Assist.)	406.65
47762	Zygomatic bone, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.)	238.80
47765	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at one site (H) (Anaes.) (Assist.)	392.10
47768	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (H) (Anaes.) (Assist.)	480.35
47771	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (H) (Anaes.) (Assist.)	551.85
47774	Maxilla, treatment of fracture of, requiring open operation (H) (Anaes.) (Assist.)	435.65
47777	Mandible, treatment of fracture of, requiring open reduction	435.65

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	(H) (Anaes.) (Assist.)	
47780	Maxilla, treatment of fracture of, requiring open reduction and internal fixation not involving a plate (H) (Anaes.) (Assist.)	566.35
47783	Mandible, treatment of fracture of, requiring open reduction and internal fixation not involving a plate (Anaes.) (Assist.)	566.35
47786	Maxilla, treatment of fracture of, requiring open reduction and internal fixation involving a plate (H) (Anaes.) (Assist.)	718.75
47789	Mandible, treatment of fracture of, requiring open reduction and internal fixation involving a plate (H) (Anaes.) (Assist.)	718.75
47900	Bone cyst, injection into or aspiration of (Anaes.)	169.50
47903	Epicondylitis, open operation for (Anaes.)	235.50
47904	Digital nail of toe, removal of, other than a service to which item 47906 applies (Anaes.)	56.50
47906	Digital nail of toe, removal of, in the operating theatre of a hospital (Anaes.)	112.85
47912	Pulp space infection, paronychia of foot, incision for, other than a service to which another item in this Group applies (excluding after-care) (Anaes.)	56.50
47915	Ingrowing nail of toe, wedge resection for, with removal of segment of nail, ungual fold and portion of the nail bed (Anaes.)	169.50
47916	Ingrowing nail of toe, partial resection of nail, with destruction of nail matrix by phenolisation, electrocautery, laser, sodium hydroxide or acid but not including excision of nail bed (Anaes.)	85.15
47918	Ingrowing toenail, radical excision of nailbed (Anaes.)	235.50
47920	Bone growth stimulator, insertion of (H) (Anaes.) (Assist.)	380.80
47921	Orthopaedic pin or wire, insertion of, as an independent procedure (Anaes.)	112.85
47924	Buried wire, pin or screw, one or more of, which were inserted for internal fixation purposes, removal of requiring incision and suture, other than a service to which item 47927 or 47930 applies—per bone (Anaes.)	37.65
47927	Buried wire, pin or screw, one or more of, which were	141.25

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	inserted for internal fixation purposes, removal of, in the operating theatre of a hospital—per bone (H) (Anaes.)	
47930	Plate, rod or nail and associated wires, pins or screws, one or more of, all of which were inserted for internal fixation purposes, removal of, other than a service associated with a service to which item 47924 or 47927 applies—per bone (H) (Anaes.) (Assist.)	263.60
47933	Small exostosis (not more than 20 mm of growth above bone), excision of, or simple removal of bunion and any associated bursa, other than a service associated with a service for removal of bursa (Anaes.)	207.00
47936	Large exostosis (greater than 20 mm growth above bone), excision of (H) (Anaes.) (Assist.)	254.20
47948	External fixation, removal of, in the operating theatre of a hospital (H) (Anaes.)	160.05
47951	External fixation, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.)	188.20
47954	Tendon, repair of, as an independent procedure (Anaes.) (Assist.)	376.55
47957	Tendon, large, lengthening of, as an independent procedure (H) (Anaes.) (Assist.)	282.35
47960	Tenotomy, subcutaneous, other than a service to which another item in this Group applies (Anaes.)	131.85
47963	Tenotomy, open, with or without tenoplasty, other than a service to which another item in this Group applies (Anaes.)	216.50
47966	Tendon or ligament transfer, as an independent procedure (H) (Anaes.) (Assist.)	432.95
47969	Tenosynovectomy, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	263.60
47972	Tendon sheath, open operation for teno-vaginitis, other than a service to which another item in this Group applies (H) (Anaes.)	210.60
47975	Forearm or calf, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (H) (Anaes.) (Assist.)	369.15

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
47978	Forearm or calf, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue (H) (Anaes.)	224.20
47981	Forearm, calf or interosseous muscle space of hand, decompression fasciotomy of, other than a service to which another item in this Group applies (Anaes.)	150.55
47982	Forage (Drill decompression), of neck or head of femur, or both (H) (Anaes.) (Assist.)	364.90
48200	Femur, bone graft to (H) (Anaes.) (Assist.)	753.25
48203	Femur, bone graft to, with internal fixation (H) (Anaes.) (Assist.)	913.25
48206	Tibia, bone graft to (H) (Anaes.) (Assist.)	565.45
48209	Tibia, bone graft to, with internal fixation (H) (Anaes.) (Assist.)	724.95
48212	Humerus, bone graft to (H) (Anaes.) (Assist.)	565.45
48215	Humerus, bone graft to, with internal fixation (H) (Anaes.) (Assist.)	724.95
48218	Radius or ulna, bone graft to (H) (Anaes.) (Assist.)	565.45
48221	Radius and ulna, bone graft to, with internal fixation of one or both bones (H) (Anaes.) (Assist.)	753.25
48224	Radius or ulna, bone graft to (H) (Anaes.) (Assist.)	376.55
48227	Radius or ulna, bone graft to, with internal fixation of one or both bones (H) (Anaes.) (Assist.)	489.55
48230	Scaphoid, bone graft to, for non-union (H) (Anaes.) (Assist.)	423.75
48233	Scaphoid, bone graft to, for non-union, with internal fixation (H) (Anaes.) (Assist.)	611.90
48236	Scaphoid, bone graft to, for mal-union, including osteotomy, bone graft and internal fixation (H) (Anaes.) (Assist.)	800.20
48239	Bone graft, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	442.45
48242	Bone graft, with internal fixation, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	611.90

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
48400	Phalanx, metatarsal, accessory bone or sesamoid bone, osteotomy or osteectomy of, excluding services to which item 49848 or 49851 applies, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	329.60
48403	Phalanx or metatarsal, osteotomy or osteectomy of, with internal fixation, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	517.80
48406	Fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, osteotomy or osteectomy of, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	329.60
48409	Fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, osteotomy or osteectomy, with internal fixation, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	517.80
48412	Humerus, osteotomy or osteectomy of, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	630.65
48415	Humerus, osteotomy or osteectomy of, with internal fixation, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	800.20
48418	Tibia, osteotomy or osteectomy of, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	630.65
48421	Tibia, osteotomy or osteectomy of, with internal fixation, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	800.20
48424	Femur or pelvis, osteotomy or osteectomy of, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	753.25
48427	Femur or pelvis, osteotomy or osteectomy of, with internal fixation, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	913.25
48500	Femur, epiphysiodesis of (H) (Anaes.) (Assist.)	329.60
48503	Tibia and fibula, epiphysiodesis of (H) (Anaes.) (Assist.)	329.60
48506	Femur, tibia and fibula, epiphysiodesis of (H) (Anaes.) (Assist.)	489.55

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
48509	Epiphysiodesis, staple arrest of hemi-epiphysis (H) (Anaes.)	235.50
48512	Epiphysiolysis, operation to prevent closure of plate (H) (Anaes.) (Assist.)	894.40
48600	Spine, manipulation of, performed in the operating theatre of a hospital (H) (Anaes.)	94.00
48603	Spine, manipulation of, under epidural anaesthesia, with or without steroid injection, if the manipulation and the administration of the epidural anaesthetic are performed by the same medical practitioner in the operating theatre of a hospital, other than a service associated with a service to which item 48600 or 50115 applies (Anaes.)	141.25
48606	Scoliosis or Kyphosis, spinal fusion for (without instrumentation) (H) (Anaes.) (Assist.)	1 317.80
48612	Scoliosis, spinal fusion for, using segmental instrumentation (C D, Zielke, Luque, or similar) (H) (Anaes.) (Assist.)	2 447.85
48613	Scoliosis or Kyphosis, spinal fusion for, using segmental instrumentation, reconstruction using separate anterior and posterior approaches (H) (Anaes.) (Assist.)	3 481.80
48615	Scoliosis, re-exploration for, involving adjustment or removal of instrumentation or simple bone grafting procedure (H) (Anaes.) (Assist.)	442.45
48618	Scoliosis, revision of failed scoliosis surgery, involving more than one of multiple osteotomy, fusion or instrumentation (H) (Anaes.) (Assist.)	2 447.85
48621	Scoliosis, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke, or similar)—not more than 4 levels (H) (Anaes.) (Assist.)	1 600.65
48624	Scoliosis, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar)—more than 4 levels (H) (Anaes.) (Assist.)	1 977.20
48627	Scoliosis, spinal fusion for, combined with segmental instrumentation (C D, Zielke or similar) down to and including pelvis (H) (Anaes.) (Assist.)	2 541.85
48630	Scoliosis, requiring anterior decompression of spinal cord with resection of vertebrae including bone graft and	2 824.35

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	instrumentation in the presence of spinal cord involvement (H) (Anaes.) (Assist.)	
48632	Scoliosis, congenital, vertebral resection and fusion for (H) (Anaes.) (Assist.)	1 561.30
48636	Percutaneous lumbar partial or total discectomy, one or more levels, other than a service associated with intradiscal electrothermal annuloplasty (Anaes.) (Assist.)	809.55
48639	Vertebral body, total or sub-total excision of, including bone grafting or other form of fixation (H) (Anaes.) (Assist.)	1 365.00
48640	Vertebral body, disease of, excision and spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (H) (Anaes.) (Assist.)	3 481.80
48642	Spine, posterior, bone graft to, other than a service to which item 48648 or 48651 applies—one or 2 levels (H) (Anaes.) (Assist.)	800.20
48645	Spine, posterior, bone graft to, other than a service to which item 48648 or 48651 applies—more than 2 levels (H) (Anaes.) (Assist.)	1 082.70
48648	Spine, bone graft to, (postero-lateral fusion)—one or 2 levels (H) (Anaes.) (Assist.)	1 082.70
48651	Spine, bone graft to, (postero-lateral fusion)—more than 2 levels (H) (Anaes.) (Assist.)	1 506.45
48654	Spinal fusion (posterior interbody), with partial or total laminectomy—one level (H) (Anaes.) (Assist.)	1 082.70
48657	Spinal fusion (posterior interbody), with partial or total laminectomy—more than one level (H) (Anaes.) (Assist.)	1 506.45
48660	Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions—one level, other than a service associated with artificial intervertebral total disc replacement (H) (Anaes.) (Assist.)	1 082.70
48663	Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions—one level (if an assisting surgeon performs the approach)—principal surgeon (H) (Anaes.) (Assist.)	809.55
48666	Spinal fusion (anterior interbody) to cervical, thoracic or	489.55

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	lumbar regions—one level (if an assisting surgeon performs the approach)—assisting surgeon (H) (Assist.)	
48669	Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions—more than one level, other than a service associated with artificial intervertebral total disc replacement (H) (Anaes.) (Assist.)	1 459.20
48672	Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions—more than one level (if an assisting surgeon performs the approach)—principal surgeon (H) (Anaes.) (Assist.)	1 092.25
48675	Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions—more than one level (if an assisting surgeon performs the approach)—assisting surgeon (H) (Assist.)	659.15
48678	Spine, simple internal fixation of, involving one or more of facetal screw, wire loop or similar, being a service associated with a service to which items 48642 to 48675 apply (H) (Anaes.) (Assist.)	565.45
48681	Spine, non-segmental internal fixation of (Harrington or similar), other than for scoliosis, being a service associated with a service to which any one of items 48642 to 48675 applies (H) (Anaes.) (Assist.)	941.45
48684	Spine, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which any one of items 48642 to 48675 applies—one or 2 levels, other than a service associated with artificial intervertebral total disc replacement (H) (Anaes.) (Assist.)	941.45
48687	Spine, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply—3 or 4 levels (H) (Anaes.) (Assist.)	1 317.80
48690	Spine, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply—more than 4 levels (H) (Anaes.) (Assist.)	1 506.45
48691	Lumbar artificial intervertebral total disc replacement including removal of disc, one level, in a patient with single-level intralumbar disc disease in the absence of vertebral osteoporosis and prior spinal fusion at the same	1 793.65

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	lumbar level who has failed conservative therapy, with fluoroscopy (Anaes.) (Assist.)	
48692	Lumbar artificial intervertebral total disc replacement including removal of disc, one level, in a patient with single-level intralumbar disc disease in the absence of vertebral osteoporosis and prior spinal fusion at the same lumbar level who has failed conservative therapy, with fluoroscopy (if an assisting surgeon performs the approach)—principal surgeon (Anaes.) (Assist.)	1 208.95
48693	Lumbar artificial intervertebral total disc replacement including removal of disc, one level, in a patient with single-level intralumbar disc disease in the absence of vertebral osteoporosis and prior spinal fusion at the same lumbar level who has failed conservative therapy, (if an assisting surgeon performs the approach)—assisting surgeon (Anaes.) (Assist.)	584.70
48694	Cervical artificial intervertebral total disc replacement, at one level only, including removal of disc, for a patient who: (a) has not had prior spinal surgery at the same cervical level; and (b) is skeletally mature; and (c) has symptomatic degenerative disc disease with radiculopathy; and (d) does not have vertebral osteoporosis; and (e) has failed conservative therapy; other than a service associated with item 40300 or 40301 (H) (Anaes.) (Assist.)	1 082.70
48900	Shoulder, excision of coraco-acromial ligament or removal of calcium deposit from cuff or both (Anaes.) (Assist.)	282.35
48903	Shoulder, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination (H) (Anaes.) (Assist.)	564.85
48906	Shoulder, repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff, or both—other than a service associated with a service to	564.85

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	which item 48900 applies (H) (Anaes.) (Assist.)	
48909	Shoulder, repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination, other than a service associated with a service to which item 48903 applies (H) (Anaes.) (Assist.)	753.25
48912	Shoulder, arthrotomy of (Anaes.) (Assist.)	329.60
48915	Shoulder, hemi-arthroplasty of (H) (Anaes.) (Assist.)	753.25
48918	Shoulder, total replacement arthroplasty of, including any associated rotator cuff repair (H) (Anaes.) (Assist.)	1 506.45
48921	Shoulder, total replacement arthroplasty, revision of (H) (Anaes.) (Assist.)	1 553.40
48924	Shoulder, total replacement arthroplasty, revision of, requiring bone graft to scapula or humerus, or both (H) (Anaes.) (Assist.)	1 788.85
48927	Shoulder prosthesis, removal of (H) (Anaes.) (Assist.)	367.05
48930	Shoulder, stabilisation procedure for recurrent anterior or posterior dislocation (H) (Anaes.) (Assist.)	753.25
48933	Shoulder, stabilisation procedure for multi-directional instability, anterior or posterior (or both) repair when performed (H) (Anaes.) (Assist.)	988.55
48936	Shoulder, synovectomy of, as an independent procedure (H) (Anaes.) (Assist.)	753.25
48939	Shoulder, arthrodesis of, with synovectomy if performed (H) (Anaes.) (Assist.)	1 082.70
48942	Shoulder, arthrodesis of, with synovectomy if performed, with removal of prosthesis, requiring bone grafting or internal fixation (H) (Anaes.) (Assist.)	1 412.20
48945	Shoulder, diagnostic arthroscopy of (including biopsy)—other than a service associated with another arthroscopic procedure of the shoulder region (H) (Anaes.) (Assist.)	272.95
48948	Shoulder, arthroscopic surgery of, involving any one or more of: removal of loose bodies; decompression of calcium deposit; debridement of labrum, synovium or rotator cuff; or chondroplasty—other than a service associated with another	611.90

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	arthroscopic procedure of the shoulder region (H) (Anaes.) (Assist.)	
48951	Shoulder, arthroscopic division of coraco-acromial ligament including acromioplasty—other than a service associated with another arthroscopic procedure of the shoulder region (H) (Anaes.) (Assist.)	894.40
48954	Shoulder, arthroscopic total synovectomy of, including release of contracture when performed—other than a service associated with another arthroscopic procedure of the shoulder region (H) (Anaes.) (Assist.)	941.45
48957	Shoulder, arthroscopic stabilisation of, for recurrent instability including labral repair or reattachment when performed—other than a service associated with another arthroscopic procedure of the shoulder region (H) (Anaes.) (Assist.)	1 082.70
48960	Shoulder, reconstruction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by separate approach when performed—other than a service associated with another procedure of the shoulder region (H) (Anaes.) (Assist.)	941.45
49100	Elbow, arthrotomy of, involving one or more of lavage, removal of loose body or division of contracture (H) (Anaes.) (Assist.)	329.60
49103	Elbow, ligamentous stabilisation of (H) (Anaes.) (Assist.)	706.05
49106	Elbow, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)	941.45
49109	Elbow, total synovectomy of (H) (Anaes.) (Assist.)	706.05
49112	Elbow, silastic or other replacement of radial head (H) (Anaes.) (Assist.)	706.05
49115	Elbow, total joint replacement of (H) (Anaes.) (Assist.)	1 129.65
49116	Elbow, total replacement arthroplasty of, revision procedure, including removal of prosthesis (H) (Anaes.) (Assist.)	1 491.15
49117	Elbow, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (H) (Anaes.) (Assist.)	1 789.35

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
49118	Elbow, diagnostic arthroscopy of, including biopsy and lavage, other than a service associated with another arthroscopic procedure of the elbow (H) (Anaes.) (Assist.)	272.95
49121	Elbow, arthroscopic surgery involving any one or more of: drilling of defect; removal of loose body; release of contracture or adhesions; chondroplasty; or osteoplasty—other than a service associated with another arthroscopic procedure of the elbow (H) (Anaes.) (Assist.)	611.90
49200	Wrist, arthrodesis of, with synovectomy if performed, with or without bone graft and internal fixation of the radiocarpal joint (H) (Anaes.) (Assist.)	818.95
49203	Wrist, limited arthrodesis of the intercarpal joint, with synovectomy if performed, with or without bone graft (H) (Anaes.) (Assist.)	611.90
49206	Wrist, proximal carpectomy of, including styloidectomy when performed (H) (Anaes.) (Assist.)	564.85
49209	Wrist, total replacement arthroplasty of (H) (Anaes.) (Assist.)	753.25
49210	Wrist, total replacement arthroplasty of, revision procedure, including removal of prosthesis (H) (Anaes.) (Assist.)	994.30
49211	Wrist, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (H) (Anaes.) (Assist.)	1 193.15
49212	Wrist, arthrotomy of (H) (Anaes.)	235.50
49215	Wrist, reconstruction of, including repair of single or multiple ligaments or capsules, including associated arthrotomy (H) (Anaes.) (Assist.)	649.70
49218	Wrist, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy)—other than a service associated with another arthroscopic procedure of the wrist joint (H) (Anaes.) (Assist.)	272.95
49221	Wrist, arthroscopic surgery of, involving any one or more of: drilling of defect; removal of loose body, release of adhesions; local synovectomy; or debridement of one area—other than a service associated with another arthroscopic procedure of the wrist joint (H) (Anaes.) (Assist.)	611.90

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
49224	Wrist, arthroscopic debridement of: 2 or more distinct areas; or osteoplasty including excision of the distal ulna; or total synovectomy, other than a service associated with another arthroscopic procedure of the wrist (H) (Anaes.) (Assist.)	706.05
49227	Wrist, arthroscopic pinning of osteochondral fragment or stabilisation procedure for ligamentous disruption—other than a service associated with another arthroscopic procedure of the wrist joint (H) (Anaes.) (Assist.)	706.05
49300	Sacro-iliac joint—arthrodesis of (H) (Anaes.) (Assist.)	521.25
49303	Hip, arthrotomy of, including lavage, drainage or biopsy when performed (H) (Anaes.) (Assist.)	546.00
49306	Hip-arthrodesis of, with synovectomy if performed (H) (Anaes.) (Assist.)	1 082.70
49309	Hip, arthrectomy or excision arthroplasty of, including removal of prosthesis (Austin Moore or similar (non cement)) (H) (Anaes.) (Assist.)	753.25
49312	Hip, arthrectomy or excision arthroplasty of, including removal of prosthesis (cemented, porous coated or similar) (H) (Anaes.) (Assist.)	941.45
49315	Hip, arthroplasty of, unipolar or bipolar (H) (Anaes.) (Assist.)	847.35
49318	Hip, total replacement arthroplasty of, including minor bone grafting (H) (Anaes.) (Assist.)	1 317.80
49319	Hip, total replacement arthroplasty of, including associated minor grafting, if performed—bilateral (H) (Anaes.) (Assist.)	2 315.30
49321	Hip, total replacement arthroplasty of, including major bone grafting, including obtaining of graft (H) (Anaes.) (Assist.)	1 600.65
49324	Hip, total replacement arthroplasty of, revision procedure including removal of prosthesis (H) (Anaes.) (Assist.)	1 882.95
49327	Hip, total replacement arthroplasty of, revision procedure requiring bone grafting to acetabulum, including obtaining of graft (H) (Anaes.) (Assist.)	2 165.35
49330	Hip, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, including obtaining of graft (H) (Anaes.) (Assist.)	2 165.35

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
49333	Hip, total replacement arthroplasty of, revision procedure requiring bone grafting to both acetabulum and femur, including obtaining of graft (H) (Anaes.) (Assist.)	2 447.85
49336	Hip, treatment of a fracture of the femur if revision total hip replacement is required as part of the treatment of the fracture (not including intra-operative fracture), being a service associated with a service to which items 49324 to 49333 apply (H) (Anaes.) (Assist.)	357.70
49339	Hip, revision total replacement of, requiring anatomic specific allograft of proximal femur greater than 5 cm in length (H) (Anaes.) (Assist.)	2 777.30
49342	Hip, revision total replacement of, requiring anatomic specific allograft of acetabulum (H) (Anaes.) (Assist.)	2 777.30
49345	Hip, revision total replacement of, requiring anatomic specific allograft of both femur and acetabulum (H) (Anaes.) (Assist.)	3 295.10
49346	Hip, revision arthroplasty with replacement of acetabular liner or ceramic head, not requiring removal of femoral component or acetabular shell (H) (Anaes.) (Assist.)	847.35
49360	Hip, diagnostic arthroscopy of, other than a service associated with another arthroscopic procedure of the hip (H) (Anaes.) (Assist.)	343.95
49363	Hip, diagnostic arthroscopy of, with synovial biopsy, other than a service associated with another arthroscopic procedure of the hip (H) (Anaes.) (Assist.)	414.20
49366	Hip, arthroscopic surgery of, other than a service associated with another arthroscopic procedure of the hip (H) (Anaes.) (Assist.)	611.90
49500	Knee, arthrotomy of, involving one or more of; capsular release, biopsy or lavage, or removal of loose body or foreign body (H) (Anaes.) (Assist.)	376.55
49503	Knee, partial or total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patello-femoral stabilisation or single transfer of ligament or tendon (other than a service to which another item in this Group applies)—any one procedure (H) (Anaes.) (Assist.)	489.55

Group T8—Surgical operations

Item	Description	Fee ($)
49506	Knee, partial or total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patello-femoral stabilisation or single transfer of ligament or tendon (other than a service to which another item in this Group applies)—any 2 or more procedures (H) (Anaes.) (Assist.)	734.40
49509	Knee, total synovectomy or arthrodesis with synovectomy if performed (H) (Anaes.) (Assist.)	753.25
49512	Knee, arthrodesis of, with synovectomy if performed, with removal of prosthesis (H) (Anaes.) (Assist.)	1 082.70
49515	Knee, removal of prosthesis, cemented or uncemented, including associated cement, as the first stage of a 2 stage procedure (H) (Anaes.) (Assist.)	847.35
49517	Knee, hemiarthroplasty of (H) (Anaes.) (Assist.)	1 206.35
49518	Knee, total replacement arthroplasty of (H) (Anaes.) (Assist.)	1 317.80
49519	Knee, total replacement arthroplasty of, including associated minor grafting, if performed—bilateral (H) (Anaes.) (Assist.)	2 315.30
49521	Knee, total replacement arthroplasty of, requiring major bone grafting to femur or tibia, including obtaining of graft (H) (Anaes.) (Assist.)	1 600.65
49524	Knee, total replacement arthroplasty of, requiring major bone grafting to femur and tibia, including obtaining of graft (H) (Anaes.) (Assist.)	1 882.95
49527	Knee, total replacement arthroplasty of, revision procedure, including removal of prosthesis (H) (Anaes.) (Assist.)	1 600.65
49530	Knee, total replacement arthroplasty of, revision procedure, requiring bone grafting to femur or tibia, including obtaining of graft and including removal of prosthesis (H) (Anaes.) (Assist.)	1 977.20
49533	Knee, total replacement arthroplasty of, revision procedure, requiring bone grafting to both femur and tibia, including obtaining of graft and including removal of prosthesis (H) (Anaes.) (Assist.)	2 259.65
49534	Knee, patello-femoral joint of, total replacement arthroplasty as a primary procedure (H) (Anaes.) (Assist.)	449.55

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
49536	Knee, repair or reconstruction of, for chronic instability (open or arthroscopic, or both) involving either cruciate or collateral ligaments, including notchplasty when performed, other than a service associated with another arthroscopic procedure of the knee (H) (Anaes.) (Assist.)	941.45
49539	Knee, reconstructive surgery of cruciate ligament or ligaments (open or arthroscopic, or both), including notchplasty when performed and surgery to other internal derangements, other than a service to which another item in this Group applies or a service associated with another arthroscopic procedure of the knee (H) (Anaes.) (Assist.)	941.45
49542	Knee, reconstructive surgery of cruciate ligament or ligaments (open or arthroscopic, or both), including notchplasty, meniscus repair, extracapsular procedure and debridement when performed, other than a service associated with another arthroscopic procedure of the knee (H) (Anaes.) (Assist.)	1 317.80
49545	Knee, revision arthrodesis of, with synovectomy if performed (H) (Anaes.) (Assist.)	753.25
49548	Knee, revision of patello-femoral stabilisation (H) (Anaes.) (Assist.)	941.45
49551	Knee, revision of procedures to which item 49536, 49539 or 49542 applies (H) (Anaes.) (Assist.)	1 317.80
49554	Knee, revision of total replacement of, by anatomic specific allograft of tibia or femur (H) (Anaes.) (Assist.)	1 882.95
49557	Knee, diagnostic arthroscopy of (including biopsy, simple trimming of meniscal margin or plica)—other than a service associated with: (a) autologous chondrocyte implantation; or (b) matrix-induced autologous chondrocyte implantation; or (c) another arthroscopic procedure of the knee region (H) (Anaes.) (Assist.)	272.95
49558	Knee, arthroscopic surgery of, involving one or more of debridement, osteoplasty or chrondroplasty—not associated with another arthroscopic procedure of the knee region (H) (Anaes.) (Assist.)	272.95

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
49559	Knee, arthroscopic surgery of, involving chrondroplasty requiring multiple drilling or carbon fibre (or similar) implant, including any associated debridement or osteoplasty—not associated with another arthroscopic procedure of the knee region (H) (Anaes.) (Assist.)	408.70
49560	Knee, arthroscopic surgery of, involving one or more of partial or total meniscectomy, removal of loose body or lateral release—other than a service associated with another arthroscopic procedure of the knee region (H) (Anaes.) (Assist.)	551.60
49561	Knee, arthroscopic surgery of, involving one or more of partial or total meniscectomy, removal of loose body or lateral release, if the procedure includes associated debridement, osteoplasty or chrondroplasty—not associated with another arthroscopic procedure of the knee region (H) (Anaes.) (Assist.)	674.00
49562	Knee, arthroscopic surgery of, involving one or more of partial or total meniscectomy, removal of loose body or lateral release, if the procedure includes chondroplasty requiring multiple drilling or carbon fibre (or similar) implant and associated debridement or osteoplasty—not associated with another arthroscopic procedure of the knee region (H) (Anaes.) (Assist.)	735.50
49563	Knee, arthroscopic surgery of, involving one or more of: (a) meniscus repair; or (b) osteochondral graft; or (c) chondral graft —excluding autologous chondrocyte implantation or matrix-induced autologous chondrocyte implantation and not associated with another arthroscopic procedure of the knee region (H) (Anaes.) (Assist.)	796.70
49564	Knee, patello-femoral stabilisation of, combined arthroscopic and open procedure, including lateral release, medial capsulorrhaphy and tendon transfer, other than a service associated with another arthroscopic procedure of the knee (H) (Anaes.) (Assist.)	919.05

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
49566	Knee, arthroscopic total synovectomy of, other than a service associated with another arthroscopic procedure of the knee (H) (Anaes.) (Assist.)	753.25
49569	Knee, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (H) (Anaes.) (Assist.)	753.25
49700	Ankle, diagnostic arthroscopy of, including biopsy (H) (Anaes.) (Assist.)	272.95
49703	Ankle, arthroscopic surgery of (H) (Anaes.) (Assist.)	611.90
49706	Ankle, arthrotomy of, involving one or more of: lavage, removal of loose body or division of contracture (H) (Anaes.) (Assist.)	329.60
49709	Ankle, ligamentous stabilisation of (H) (Anaes.) (Assist.)	706.05
49712	Ankle, arthrodesis of, with synovectomy if performed (H) (Anaes.) (Assist.)	753.25
49715	Ankle, total joint replacement of (H) (Anaes.) (Assist.)	1 129.65
49716	Ankle, total replacement arthroplasty of, revision procedure, including removal of prosthesis (H) (Anaes.) (Assist.)	1 491.15
49717	Ankle, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (H) (Anaes.) (Assist.)	1 789.35
49718	Ankle, Achilles' tendon or other major tendon, repair of (H) (Anaes.) (Assist.)	376.55
49721	Ankle, Achilles' tendon rupture managed by non-operative treatment	235.50
49724	Ankle, Achilles' tendon, secondary repair or reconstruction of (H) (Anaes.) (Assist.)	659.15
49727	Ankle, Achilles' tendon, operation for lengthening (H) (Anaes.) (Assist.)	282.35
49728	Ankle, lengthening of the gastrocnemius aponeurosis and soleus fascia, for the correction of equinus deformity in children with cerebral palsy (H) (Anaes.) (Assist.)	564.70
49800	Foot, flexor or extensor tendon, primary repair of (Anaes.)	131.85
49803	Foot, flexor or extensor tendon, secondary repair of (Anaes.)	169.50

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
49806	Foot, subcutaneous tenotomy of, one or more tendons (Anaes.)	131.85
49809	Foot, open tenotomy of, with or without tenoplasty (H) (Anaes.)	216.50
49812	Foot, tendon or ligament transplantation of, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	432.95
49815	Foot, triple arthrodesis of, with synovectomy if performed (H) (Anaes.) (Assist.)	753.25
49818	Foot, excision of calcaneal spur (H) (Anaes.) (Assist.)	272.95
49821	Foot, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure)—unilateral (H) (Anaes.) (Assist.)	432.95
49824	Foot, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure)—bilateral (H) (Anaes.) (Assist.)	757.95
49827	Foot, correction of hallux valgus by transfer of adductor hallucis tendon—unilateral (H) (Anaes.) (Assist.)	470.70
49830	Foot, correction of hallux valgus by transfer of adductor hallucis tendon—bilateral (H) (Anaes.) (Assist.)	823.75
49833	Foot, correction of hallus valgus by osteotomy of first metatarsal with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint—unilateral (H) (Anaes.) (Assist.)	517.80
49836	Foot, correction of hallus valgus by osteotomy of first metatarsal with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint—bilateral (H) (Anaes.) (Assist.)	894.40
49837	Foot, correction of hallus valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, with or without internal fixation and with or without excision of exostoses associated with the first metatarsal joint—unilateral (H) (Anaes.) (Assist.)	647.25
49838	Foot, correction of hallus valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, with or	1 117.75

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	without internal fixation and with or without excision of exostoses associated with the first metatarsal joint—bilateral (H) (Anaes.) (Assist.)	
49839	Foot, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty—unilateral (H) (Anaes.) (Assist.)	517.80
49842	Foot, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty—bilateral (H) (Anaes.) (Assist.)	894.40
49845	Foot, arthrodesis of, first metatarso-phalangeal joint, with synovectomy if performed (H) (Anaes.) (Assist.)	470.70
49848	Foot, correction of claw or hammer toe (Anaes.)	160.05
49851	Foot, correction of claw or hammer toe with internal fixation (H) (Anaes.)	207.00
49854	Foot, radical plantar fasciotomy or fasciectomy of (H) (Anaes.) (Assist.)	376.55
49857	Foot, metatarso-phalangeal joint replacement (H) (Anaes.) (Assist.)	348.35
49860	Foot, synovectomy of metatarso-phalangeal joint, single joint (H) (Anaes.) (Assist.)	282.35
49863	Foot, synovectomy of metatarso-phalangeal joint, 2 or more joints (H) (Anaes.) (Assist.)	423.75
49866	Foot, neurectomy for plantar or digital neuritis (Morton's or Bett's syndrome) (H) (Anaes.) (Assist.)	301.05
49878	Talipes equinovarus, calcaneo valgus or metatarsus varus, treatment by cast, splint or manipulation—each attendance (Anaes.)	56.50
50100	Joint, diagnostic arthroscopy of (including biopsy), other than a service to which another item in this Group applies and other than a service associated with another arthroscopic procedure (Anaes.) (Assist.)	272.95
50102	Joint, arthroscopic surgery of, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	611.90
50103	Joint, arthrotomy of, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	329.60
50104	Joint, synovectomy of, other than a service to which another	312.30

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	item in this Group applies (Anaes.) (Assist.)	
50106	Joint, stabilisation of, involving one or more of: repair of capsule, repair of ligament or internal fixation, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	470.70
50109	Joint, arthrodesis of, other than a service to which another item in this Group applies, with synovectomy if performed (H) (Anaes.) (Assist.)	470.70
50112	Cicatricial flexion or extension contraction of joint, correction of, involving tissues deeper than skin and subcutaneous tissue, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	361.05
50115	Joint or joints, manipulation of, performed in the operating theatre of a hospital, other than a service associated with a service to which another item in this Group applies (Anaes.)	142.95
50118	Subtalar joint, arthrodesis of, with synovectomy if performed (H) (Anaes.) (Assist.)	432.95
50121	Greater trochanter, transplantation of ileopsoas tendon to (H) (Anaes.) (Assist.)	847.35
50127	Joint or joints, arthroplasty of, by any technique other than a service to which another item applies (H) (Anaes.) (Assist.)	702.50
50130	Joint or joints, application of external fixator to, other than for treatment of fractures (H) (Anaes.) (Assist.)	312.30
50200	Aggressive or potentially malignant bone or deep soft tissue tumour, biopsy of (not including after-care) (Anaes.)	188.20
50201	Aggressive or potentially malignant bone or deep soft tissue tumour involving neurovascular structures, open biopsy of (not including after-care) (Anaes.) (Assist.)	329.50
50203	Bone or malignant deep soft tissue tumour, lesional or marginal excision of (Anaes.) (Assist.)	414.25
50206	Bone tumour, lesional or marginal excision of, combined with any one of the following: (a) liquid nitrogen freezing; (b) autograft;	611.90

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	(c) allograft; (d) cementation (H) (Anaes.) (Assist.)	
50209	Bone tumour, lesional or marginal excision of, combined with any 2 or more of the following: (a) liquid nitrogen freezing; (b) autograft; (c) allograft; (d) cementation (H) (Anaes.) (Assist.)	753.25
50212	Malignant or aggressive soft tissue tumour affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, without reconstruction (H) (Anaes.) (Assist.)	1 647.55
50215	Malignant or aggressive soft tissue tumour affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, with intercalary reconstruction (prosthesis, allograft or autograft) (H) (Anaes.) (Assist.)	2 071.20
50218	Malignant tumour of long bone, enbloc resection of, with replacement or arthrodesis of adjacent joint, with synovectomy if performed (H) (Anaes.) (Assist.)	2 730.30
50221	Malignant or aggressive soft tissue tumour of pelvis, sacrum or spine; or scapula and shoulder, enbloc resection of (H) (Anaes.) (Assist.)	2 541.85
50224	Malignant or aggressive soft tissue tumour of pelvis, sacrum or spine; or scapula and shoulder, enbloc resection of, with reconstruction by prosthesis, allograft or autograft (Anaes.) (Assist.)	2 824.35
50227	Malignant bone tumour, enbloc resection of, with massive anatomic specific allograft or autograft, with or without prosthetic replacement (H) (Anaes.) (Assist.)	3 295.10
50230	Benign tumour, resection of, requiring anatomic specific allograft, with or without internal fixation (H) (Anaes.) (Assist.)	1 694.60

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
50233	Malignant tumour, amputation for, hemipelvectomy or interscapulo-thoracic (H) (Anaes.) (Assist.)	2 165.35
50236	Malignant tumour, amputation for, hip disarticulation, shoulder disarticulation or proximal third femur (H) (Anaes.) (Assist.)	1 694.60
50239	Malignant tumour, amputation for, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	1 129.65
50300	Joint deformity, slow correction of, using ring fixator or similar device, including all associated attendances—payable only once in any 12 month period (H) (Anaes.) (Assist.)	1 157.70
50303	Limb lengthening, not more than 5 cm, by gradual distraction, applying an external fixator or intra medullary device in the operating theatre of a hospital (H) (Anaes.) (Assist.)	1 580.60
50306	Limb lengthening, if: (a) the lengthening is bipolar; or (b) bone transport is carried out; or (c) the fixator is extended to correct an adjacent joint deformity; or (d) the lengthening is more than 5cm (Anaes.) (Assist.)	2 467.90
50309	Ring fixator or similar device, adjustment of, with or without insertion or removal of fixation pins, performed under general anaesthesia in the operating theatre of a hospital, other than a service to which item 50303 or 50306 applies (H) (Anaes.) (Assist.)	305.05
50312	Ankle, synovectomy of, by arthroscopic or other means—not associated with another arthroscopic procedure of the ankle (H) (Anaes.) (Assist.)	700.10
50315	Talipes equinovarus, posterior release of (H) (Anaes.) (Assist.)	693.30
50318	Talipes equinovarus, medial release of (H) (Anaes.) (Assist.)	693.30
50321	Talipes equinovarus, combined postero-medial release of (H) (Anaes.) (Assist.)	928.85

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
50324	Talipes equinovarus, combined postero-medial release of, revision procedure (H) (Anaes.) (Assist.)	1 324.15
50327	Talipes equinovarus, bilateral procedures (H) (Anaes.) (Assist.)	1 615.15
50330	Talipes equinovarus, or talus, vertical congenital—post operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital, other than a service to which item 50315, 50318, 50321, 50324 or 50327 applies (Anaes.)	228.70
50333	Tarsal coalition, excision of, with interposition of muscle, fat graft or similar graft (H) (Anaes.) (Assist.)	616.85
50336	Talus, vertical, congenital, combined anterior and posterior reconstruction (H) (Anaes.) (Assist.)	922.05
50339	Foot and ankle, tibialis anterior tendon (split or whole) transfer to lateral column (H) (Anaes.) (Assist.)	561.55
50342	Foot and ankle, tibialis or tibialis posterior tendon transfer, through the interosseous membrane to anterior or posterior aspect of foot (H) (Anaes.) (Assist.)	651.60
50345	Hyperextension deformity of toe, release incorporating V-Y plasty of skin, lengthening of extensor tendons and release of capsule contracture (H) (Anaes.) (Assist.)	346.65
50348	Knee, deformity of, post-operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital (Anaes.)	228.70
50349	Hip, congenital dislocation of, treatment of, by closed reduction (Anaes.) (Assist.)	320.15
50351	Hip, developmental dislocation of, open reduction of (H) (Anaes.) (Assist.)	1 597.25
50352	Hip, congenital dislocation of, treatment of, involving supervision of splint, harness or cast—each attendance (Anaes.)	56.50
50353	Hip spica, initial application of, for congenital dislocation of hip (excluding after-care) (H) (Anaes.) (Assist.)	354.80
50354	Tibia, pseudarthrosis of, congenital, resection and internal fixation (Anaes.) (Assist.)	1 310.15

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
50357	Knee, leg or thigh, rectus femoris tendon transfer or medial or lateral hamstring tendon transfer (H) (Anaes.) (Assist.)	561.55
50360	Knee, leg or thigh, combined medial and lateral hamstring tendon transfer (H) (Anaes.) (Assist.)	651.60
50363	Knee, contracture of, posterior release involving multiple tendon lengthening or tenotomies, unilateral (H) (Anaes.) (Assist.)	499.05
50366	Knee, contracture of, posterior release involving multiple tendon lengthening or tenotomies, bilateral (H) (Anaes.) (Assist.)	873.45
50369	Knee, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, unilateral (H) (Anaes.) (Assist.)	651.60
50372	Knee, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, bilateral (H) (Anaes.) (Assist.)	1 143.80
50375	Hip, contracture of, medial release, involving lengthening of, or division of, the adductors and psoas with or without division of the obturator nerve, unilateral (H) (Anaes.) (Assist.)	499.05
50378	Hip, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, bilateral (H) (Anaes.) (Assist.)	873.45
50381	Hip, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, unilateral (H) (Anaes.) (Assist.)	651.60
50384	Hip, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, bilateral (H) (Anaes.) (Assist.)	1 143.80
50387	Hip, iliopsoas tendon transfer to greater trochanter, or transfer of abdominal musculature to greater trochanter, or transfer or adductors to ischium (H) (Anaes.) (Assist.)	651.60
50390	Perthes, cerebral palsy, or other neuromuscular conditions,	228.70

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	affecting hips or knees, application of cast under general anaesthesia, performed in the operating theatre of a hospital (Anaes.)	
50393	Pelvis, bone graft or shelf procedures for acetabular dysplasia (H) (Anaes.) (Assist.)	845.60
50394	Acetabular dysplasia, treatment of, by multiple peri-acetabular osteotomy, including internal fixation, if performed (H) (Anaes.) (Assist.)	2 777.30
50396	Hand, congenital abnormalities or duplication of digits, amputation or splitting of phalanx or phalanges, with ligament or joint reconstruction (H) (Anaes.) (Assist.)	464.55
50399	Forearm, radial aplasia or dysplasia (radial club hand), centralisation or radialisation of (H) (Anaes.) (Assist.)	922.05
50402	Torticollis, bipolar release of sternocleidomastoid muscle and associated soft tissue (H) (Anaes.) (Assist.)	422.95
50405	Elbow, flexorplasty, or tendon transfer to restore elbow function (H) (Anaes.) (Assist.)	575.40
50408	Shoulder, congenital or developmental dislocation, open reduction of (H) (Anaes.) (Assist.)	998.25
50411	Lower limb deficiency, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion (Anaes.) (Assist.)	1 310.15
50414	Lower limb deficiency, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion and rotationplasty (Anaes.) (Assist.)	1 767.60
50417	Lower limb deficiency, treatment of congenital deficiency of the tibia by reconstruction of the knee, involving transfer of fibula or tibia, and repair of quadriceps mechanism (Anaes.) (Assist.)	1 310.15
50420	Patella, congenital dislocation of, reconstruction of the quadriceps (H) (Anaes.) (Assist.)	1 081.35
50423	Tibia, fibula or both, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (Anaes.) (Assist.)	998.25
50426	Diaphyseal aclasia, removal of lesion or lesions from bone—one approach (H) (Anaes.) (Assist.)	464.55

Group T8—Surgical operations

Item	Description	Fee ($)
50450	Unilateral single event multilevel surgery, for a patient less than 18 years of age with hemiplegic cerebral palsy, comprising 3 or more of the following: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; (b) correction of muscle imbalance by transfer of a tendon or tendons; (c) correction of femoral torsion by rotational osteotomy of the femur; (d) correction of tibial torsion by rotational osteotomy of the tibia; (e) correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis with synovectomy if performed, or os calcis lengthening; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)	1 226.90
50451	Unilateral single event multilevel surgery, for a patient less than 18 years of age with hemiplegic cerebral palsy, comprising 3 or more of the following: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; (b) correction of muscle imbalance by transfer of a tendon or tendons; (c) correction of femoral torsion by rotational osteotomy of the femur; (d) correction of tibial torsion by rotational osteotomy of the tibia; (e) correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis with synovectomy if performed, or os calcis lengthening; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)	1 226.90
50455	Bilateral single event multilevel surgery, for a patient less than	1 389.40

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	18 years of age with diplegic cerebral palsy, that comprises: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)	
50456	Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)	1 389.40
50460	Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises bilateral soft tissue surgery and bilateral femoral osteotomies, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of torsional abnormality of the femur by rotational osteotomy and internal fixation; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)	2 074.45
50461	Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises bilateral soft tissue surgery and bilateral femoral osteotomies, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional	2 074.45

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of torsional abnormality of the femur by rotational osteotomy and internal fixation; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)	
50465	Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)	2 921.80
50466	Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation;	2 921.80

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)	
50470	Bilateral single event multilevel surgery, for a patient less than 18 years of age with cerebral palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; and (e) correction of bilateral pes valgus by os calcis lengthening or subtalar fusion; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)	3 705.55
50471	Bilateral single event multilevel surgery, for a patient less than 18 years of age with cerebral palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; and (e) correction of bilateral pes valgus by os calcis lengthening or subtalar fusion; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)	3 705.55

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
50475	Single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, for the correction of crouch gait, including: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation; and (d) correction of patella alta and quadriceps insufficiency by patella tendon shortening or reconstruction; and (e) correction of tibial torsion by rotational osteotomy of the tibia with internal fixation; and (f) correction of foot instability by os calcis lengthening or subtalar fusion; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)	4 275.85
50476	Single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, for the correction of crouch gait including: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; (b) correction of muscle imbalance by transfer of a tendon or tendons; (c) correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation; (d) correction of patella alta and quadriceps insufficiency by patella tendon shortening or reconstruction; (e) correction of tibial torsion by rotational osteotomy of the tibia with internal fixation; (f) correction of foot instability by os calcis lengthening or subtalar fusion;	4 275.85

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)	
50500	Radius or ulna, distal end of, with open growth plate, treatment of fracture of, by closed reduction (Anaes.)	276.65
50504	Radius or ulna, distal end of, with open growth plate, treatment of fracture of, by open reduction (Anaes.) (Assist.)	369.05
50508	Radius, distal end of, with open growth plate, treatment of Colles', Smith's or Barton's fracture of, by closed reduction (Anaes.)	395.25
50512	Radius, distal end of, with open growth plate, treatment of Colles', Smith's or Barton's fracture of, by open reduction (H) (Anaes.) (Assist.)	527.30
50516	Radius or ulna, shaft of, with open growth plate, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.)	355.85
50520	Radius or ulna, shaft of, with open growth plate, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.)	474.40
50524	Radius or ulna, shaft of, with open growth plate, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction undertaken in the operating theatre of a hospital (Anaes.) (Assist.)	408.50
50528	Radius or ulna, shaft of, with open growth plate, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by reduction with or without internal fixation by open or percutaneous means (H) (Anaes.) (Assist.)	659.00
50532	Radius and ulna, shafts of, with open growth plates, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (H) (Anaes.)	573.40
50536	Radius and ulna, shafts of, with open growth plates, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.)	764.40
50540	Olecranon, with open growth plate, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.)	527.30
50544	Radius, with open growth plate, treatment of fracture of head	263.60

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	or neck of, by closed reduction of (Anaes.)	
50548	Radius, with open growth plate, treatment of fracture of head or neck of, by reduction with or without internal fixation by open or percutaneous means (H) (Anaes.) (Assist.)	527.30
50552	Humerus, proximal, with open growth plate, treatment of fracture of, by closed reduction, undertaken in the operating theatre, neonatal unit or nursery of a hospital (Anaes.)	454.75
50556	Humerus, proximal, with open growth plate, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.)	606.20
50560	Humerus, shaft of, with open growth plate, treatment of fracture of, by closed reduction, undertaken in the operating theatre, neonatal unit or nursery of a hospital (H) (Anaes.)	474.40
50564	Humerus, shaft of, with open growth plate, treatment of fracture of, by internal or external fixation (H) (Anaes.) (Assist.)	632.65
50568	Humerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.)	553.60
50572	Humerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means, undertaken in the operating theatre of a hospital (H) (Anaes.) (Assist.)	738.10
50576	Femur, with open growth plate, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.)	606.20
50580	Tibia, with open growth plate, plateau or condyles, medial or lateral, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (H) (Anaes.) (Assist.)	632.65
50584	Tibia, distal, with open growth plate, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (H) (Anaes.) (Assist.)	606.20
50588	Tibia and fibula, with open growth plates, treatment of fracture of, by internal fixation (H) (Anaes.) (Assist.)	790.70
50600	Scoliosis or kyphosis, in a child, manipulation of deformity and application of a localiser cast, under general anaesthesia,	434.70

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	in a hospital (Anaes.) (Assist.)	
50604	Scoliosis or kyphosis, in a child or adolescent, spinal fusion for (without instrumentation) (H) (Anaes.) (Assist.)	1 845.05
50608	Scoliosis or kyphosis, in a child or adolescent, treatment by segmental instrumentation and fusion of the spine, other than a service to which any of items 48642 to 48675 apply (H) (Anaes.) (Assist.)	3 426.95
50612	Scoliosis or kyphosis, in a child or adolescent, with spinal deformity, treatment by segmental instrumentation, utilising separate anterior and posterior approaches, other than a service to which any of items 48642 to 48675 apply (H) (Anaes.) (Assist.)	4 874.50
50616	Scoliosis, in a child or adolescent, re-exploration for adjustment or removal of segmental instrumentation used for correction of spine deformity (H) (Anaes.) (Assist.)	619.35
50620	Scoliosis, in a child or adolescent, revision of failed scoliosis surgery, involving more than one of osteotomy, fusion, removal of instrumentation or instrumentation, other than a service to which any of items 48642 to 48675 apply (H) (Anaes.) (Assist.)	3 426.95
50624	Scoliosis, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar)—not more than 4 levels (H) (Anaes.) (Assist.)	3 426.95
50628	Scoliosis, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar)—more than 4 levels (H) (Anaes.) (Assist.)	4 233.20
50632	Scoliosis or kyphosis, in a child or adolescent, requiring segmental instrumentation and fusion of the spine down to and including the pelvis or sacrum, other than a service to which any of items 48642 to 48675 apply (H) (Anaes.) (Assist.)	3 558.65
50636	Scoliosis, in a child or adolescent, requiring anterior decompression of the spinal cord with vertebral resection and instrumentation in the presence of spinal cord involvement, other than a service to which any of items 48642 to 48675 apply (H) (Anaes.) (Assist.)	3 954.10
50640	Scoliosis, in a child or adolescent, congenital, resection and	2 185.80

Group T8—Surgical operations		
Item	**Description**	**Fee ($)**
	fusion of abnormal vertebra via an anterior or posterior approach, other than a service to which any of items 48642 to 48675 apply (H) (Anaes.) (Assist.)	
50644	Spine, bone graft to, for a child or adolescent, associated with surgery for correction of scoliosis or kyphosis or both (H) (Anaes.) (Assist.)	2 108.95
50650	Hip dysplasia or dislocation, in a child, examination, manipulation and arthrography of the hip under anaesthesia (Anaes.)	414.75
50654	Hip dysplasia or dislocation, in a child, application or reapplication of a hip spica, including examination of the hip (H) (Assist.) (Anaes.)	496.65
50658	Hip dysplasia or dislocation, in a child, examination and manipulation of the hip under anaesthesia (Anaes.)	197.75
Subgroup 16—Radiofrequency ablation		
50950	Nonresectable hepatocellular carcinoma, destruction of, by percutaneous radiofrequency ablation, including any associated imaging services, other than a service associated with a service to which item 30419 or 50952 applies (Anaes.)	817.10
50952	Nonresectable hepatocellular carcinoma, destruction of, by open or laparoscopic radiofrequency ablation, if a multi-disciplinary team has assessed that percutaneous radiofrequency ablation cannot be performed or is not practical because of one or more of the following clinical circumstances: (a) percutaneous access cannot be achieved; (b) vital organs or tissues are at risk of damage from the percutaneous radiofrequency ablation procedure; (c) resection of one part of the liver is possible, however there is at least one primary liver tumour in a nonresectable section of the liver that is suitable for radiofrequency ablation; including any associated imaging services, other than a service associated with a service to which item 30419 or 50950 applies (Anaes.)	817.10

Division 2.45—Group T9: Assistance at operations

2.45.1 Meaning of *amount under clause 2.45.1*

In item 51303:

amount under clause 2.45.1, for assistance at an operation or series of operations, means 20% of the sum of the fees payable under the Act for the services provided at that operation, or series of operations, by the practitioner to whom the assistance was given.

2.45.2 Meaning of *amount under clause 2.45.2*

In item 51309:

amount under clause 2.45.2, for assistance at a series or combination of operations, means:

(a) 20% of the sum of the fees payable under the Act for the services provided at those operations by the practitioner to whom the assistance was given; or

(b) for the caesarean section component of the operations—the fee mentioned in item 16520.

2.45.3 Meaning of *amount under clause 2.45.3*

In item 51312:

amount under clause 2.45.3, for assistance at a procedure, means 20% of the sum of the fees payable under the Act for the services provided at that procedure by the practitioner to whom the assistance was given.

2.45.4 Meaning of *previous significant surgical complication*

In item 51318:

previous significant surgical complication means:

(a) vitreous loss; or

(b) rupture of posterior capsule; or
(c) loss of nuclear material into the vitreous; or
(d) intraocular haemorrhage; or
(e) intraocular infection (endophthalmitis); or
(f) cystoid macular oedema; or
(g) corneal decompensation; or
(h) retinal detachment.

2.45.5 Application of Group T9

Items 51300 to 51318 do not apply to a service described in the item if the service is provided at the same time as, or in connection with, the provision of a pain pump for post-surgical pain management.

2.45.6 Assistance at operations

Items 51300 to 51318 apply only to assistance rendered by a medical practitioner other than:

(a) the practitioner performing the operation; or
(b) the anaesthetist administering the anaesthetic in connection with the operation, if any; or
(c) the assistant anaesthetist, if any.

Group T9—Assistance at operations

Item	Description	Fee
51300	Assistance at any operation mentioned in an item in Group T8 that includes "(Assist.)" for which the fee does not exceed $558.30 or at a series or combination of operations mentioned in an item in Group T8 that include "(Assist.)" for which the aggregate fee does not exceed $558.30	$86.30
51303	Assistance at any operation mentioned in an item in Group T8 that includes "(Assist.)" for which the fee exceeds $558.30 or at a series or combination of operations mentioned in an item in Group T8 that include "(Assist.)" for which the aggregate fee exceeds $558.30	Amount under clause 2.45.1
51306	Assistance at a delivery involving Caesarean section	$124.65

Group T9—Assistance at operations		
Item	**Description**	**Fee**
51309	Assistance at a series or combination of operations that include "(Assist.)" and assistance at a delivery involving Caesarean section	Amount under clause 2.45.2
51312	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615, 16627 and 16633	Amount under clause 2.45.3
51315	Assistance at cataract and intraocular lens surgery covered by item 42698, 42701, 42702, 42704 or 42707, when performed in association with services covered by item 42551 to 42569, 42653, 42656, 42725, 42746, 42749, 42752, 42776 or 42779	$272.40
51318	Assistance at cataract and intraocular lens surgery, if patient has: (a) total loss of vision, including no potential for central vision, in the fellow eye; or (b) previous significant surgical complication in the fellow eye; or (c) pseudo exfoliation, subluxed lens, iridodonesis, phacodonesis, retinal detachment, corneal scarring, pre-existing uveitis, bound down miosed pupil, nanophthalmos, spherophakia, Marfan's syndrome, homocysteinuria or previous blunt trauma causing intraocular damage	$179.75

Division 2.46—Oral and Maxillofacial services

2.46.1 Application of Groups O1 to O11

Items 51700 to 53706 apply only to a service provided in the course of dental practice by a dental practitioner approved by the Minister before 1 November 2004 for the definition of ***professional service*** in subsection 3(1) of the Act.

Division 2.47—Group O1: Consultations

Group O1—Consultations		
Item	**Description**	**Fee ($)**
51700	Professional attendance (other than a second or subsequent attendance in a single course of treatment) by an approved dental practitioner in the practice of oral and maxillofacial surgery, at consulting rooms, hospital or residential aged care facility if the patient is referred to him or her	85.55
51703	Professional attendance by an approved dental practitioner in the practice of oral and maxillofacial surgery, each attendance after the first in a single course of treatment at consulting rooms, hospital or residential aged care facility if the patient is referred to him or her	43.00

Division 2.48—Group O2: Assistance at operation

2.48.1 Meaning of *amount under clause 2.48.1*

In item 51803:

amount under clause 2.48.1, for assistance at an operation or series of operations, means an amount equal to 20% of the sum of the fees payable under the Act for the services provided at that operation, or series of operations, by the practitioner to whom the assistance was given.

2.48.2 Assistance at operations

Items 51800 and 51803 apply only to assistance rendered by an approved dental practitioner other than:

(a) the practitioner performing the operation; or

(b) the anaesthetist administering the anaesthetic in connection with the operation, if any; or

(c) the assistant anaesthetist, if any.

Group O2—Assistance at operation

Item	Description	Fee
51800	Assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery at any operation mentioned in an item that includes "(Assist.)" for which the fee does not exceed $558.30 or at a series or combination of operations mentioned in an item in Groups O3 to O9 that include "(Assist.)" for which the aggregate fee does not exceed $558.30	$86.30
51803	Assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery at any operation mentioned in an item that includes "(Assist.)" for which the fee exceeds $558.30 or at a series or combination of operations mentioned in an item that include "(Assist.)" if the aggregate fee exceeds $558.30	Amount under clause 2.48.1

Division 2.49—Group O3: General surgery

Group O3—General surgery		
Item	**Description**	**Fee ($)**
51900	Wound of soft tissue in the oral and maxillofacial region, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.)	326.05
51902	Wounds of the oral and maxillofacial region, dressing of, under general anaesthesia, with or without removal of sutures, other than a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.)	73.90
51904	Lipectomy—wedge excision of skin or fat—one excision (Anaes.) (Assist.)	454.85
51906	Lipectomy—wedge excision of skin or fat—2 or more excisions (Anaes.) (Assist.)	691.75
52000	Skin and subcutaneous tissue or mucous membrane, repair of recent wound of, on face or neck, small (not more than 7 cm long), superficial (Anaes.)	82.50
52003	Skin and subcutaneous tissue or mucous membrane, repair of recent wound of, on face or neck, small (not more than 7 cm long), involving deeper tissue (Anaes.)	117.55
52006	Skin and subcutaneous tissue or mucous membrane, repair of recent wound of, on face or neck, large (more than 7 cm long), superficial (Anaes.)	117.55
52009	Skin and subcutaneous tissue or mucous membrane, repair of recent wound of, on face or neck, large (more than 7 cm long), involving deeper tissue (Anaes.)	185.60
52010	Full thickness laceration of ear, eyelid, nose or lip, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.)	254.00
52012	Superficial foreign body, removal of, as an independent procedure (Anaes.)	23.50
52015	Subcutaneous foreign body, removal of, requiring incision and suture, as an independent procedure (Anaes.)	109.90
52018	Foreign body in muscle, tendon or other deep tissue, removal	276.80

Group O3—General surgery		
Item	**Description**	**Fee ($)**
	of, as an independent procedure (Anaes.) (Assist.)	
52021	Aspiration biopsy of one or more jaw cysts as an independent procedure to obtain material for diagnostic purposes and other than a service associated with an operative procedure on the same day (Anaes.)	29.45
52024	Biopsy of skin or mucous membrane, as an independent procedure (Anaes.)	52.20
52025	Lymph node of neck, biopsy of (Anaes.)	183.90
52027	Biopsy of lymph gland, muscle or other deep tissue or organ, as an independent procedure and other than a service to which item 52025 applies (Anaes.)	149.75
52030	Sinus, excision of, involving superficial tissue only (Anaes.)	90.00
52033	Sinus, excision of, involving muscle and deep tissue (Anaes.)	183.90
52034	Premalignant lesions of the oral mucous, treatment by cryotherapy, diathermy or carbon dioxide laser	43.00
52035	Endoscopic laser therapy for neoplasia and benign vascular lesions of the oral cavity (Anaes.)	476.10
52036	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, if the removal is by surgical excision and suture, other than a service to which item 52039 applies (Anaes.)	126.90
52039	Tumours, cysts, ulcers or scars (other than a scar removed during the surgical approach at an operation), up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, if the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Anaes.) (Assist.)	326.05
52042	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.)	172.50
52045	Tumour, cyst (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological	246.50

Group O3—General surgery		
Item	**Description**	**Fee ($)**
	examination that there is a minimum of 5 mm separation between the cyst lining and tooth structure or if a tumour or cyst has been proven by positive histopathology), ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of, other than a service to which another item in Groups O3 to O9 applies, involving muscle, bone, or other deep tissue (Anaes.)	
52048	Tumour or deep cyst (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5 mm separation between the cyst lining and tooth structure or if a tumour or cyst has been proven by positive histopathology), removal of, requiring wide excision, other than a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.)	371.50
52051	Tumour, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.)	502.25
52054	Tumour, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.)	587.60
52055	Haematoma, small abscess or cellulitis in the oral and maxillofacial region, not requiring admission to a hospital, incision with drainage of (excluding after-care)	27.35
52056	Haematoma in the oral and maxillofacial region, aspiration of (Anaes.)	27.35
52057	Large haematoma, large abscess, carbuncle, cellulitis or similar lesion in the oral and maxillofacial region, incision with drainage of (excluding after-care) (H) (Anaes.)	162.95
52058	Percutaneous drainage of deep abscess in the oral and maxillofacial region, using interventional imaging techniques—but not including imaging (Anaes.)	237.60
52059	Abscess in the oral and maxillofacial region drainage tube, exchange of using interventional imaging techniques—but not including imaging (Anaes.)	267.65
52060	Muscle in the oral and maxillofacial region, excision of	189.40

Group O3—General surgery		
Item	**Description**	**Fee ($)**
	(Anaes.)	
52061	Muscle, in the oral and maxillofacial region, ruptured, repair of (limited), not associated with external wound (Anaes.)	223.60
52062	Muscle, in the oral and maxillofacial region, ruptured, repair of (extensive), not associated with external wound (Anaes.) (Assist.)	295.70
52063	Bone tumour in the oral and maxillofacial region, innocent, excision of, other than a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.)	356.35
52064	Bone cyst in the oral and maxillofacial region, injection into or aspiration of (Anaes.)	169.50
52066	Submandibular gland, extirpation of (Anaes.) (Assist.)	445.40
52069	Sublingual gland, extirpation of (Anaes.)	198.50
52072	Salivary gland, dilatation or diathermy of duct (Anaes.)	58.80
52073	Salivary gland, repair of cutaneous fistula of (Anaes.)	149.75
52075	Salivary gland, removal of calculus from duct or meatotomy or marsupialisation, one or more such procedures (Anaes.)	149.75
52078	Tongue, partial excision of (Anaes.) (Assist.)	295.70
52081	Tongue tie, division or excision of frenulum (Anaes.)	46.50
52084	Tongue tie, mandibular frenulum or maxillary frenulum, division or excision of frenulum, in a person aged not less than 2 years (Anaes.)	119.50
52087	Ranula or mucous cyst of mouth, removal of (Anaes.)	204.70
52090	Operation on mandible or maxilla (other than alveolar margins) for chronic osteomyelitis—one bone or in combination with adjoining bones (Anaes.) (Assist.)	356.35
52092	Operation on skull for osteomyelitis (Anaes.) (Assist.)	464.50
52094	Operation on any combination of adjoining bones in the oral and maxillofacial region, being bones referred to in item 52092 (Anaes.) (Assist.)	587.55
52095	Bone growth stimulator in the oral and maxillofacial region, insertion of (Anaes.) (Assist.)	380.80
52096	Orthopaedic pin or wire, insertion of, into maxilla or mandible	112.85

Group O3—General surgery		
Item	**Description**	**Fee ($)**
	or zygoma, as an independent procedure (Anaes.)	
52097	External fixation in the oral and maxillofacial region, removal of, in the operating theatre of a hospital (Anaes.)	160.05
52098	External fixation in the oral and maxillofacial region, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.)	188.20
52099	Buried wire, pin or screw, one or more, which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, per bone, other than a service associated with a service to which item 52102 or 52105 applies (Anaes.)	141.25
52102	Buried wire, pin or screw, one or more, which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, if undertaken in the operating theatre of a hospital, per bone (Anaes.)	141.25
52105	Plate, one or more of, and associated screw and wire which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, per bone, other than a service associated with a service to which item 52099 or 52102 applies (Anaes.) (Assist.)	263.60
52106	Arch bars, one or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia if undertaken in the operating theatre of a hospital (Anaes.)	108.90
52108	Lip, full thickness wedge excision of, with repair by direct sutures (Anaes.) (Assist.)	326.05
52111	Vermilionectomy (Anaes.) (Assist.)	326.05
52114	Mandible or maxilla, segmental resection of, for tumours or cysts (Anaes.) (Assist.)	587.60
52117	Mandible, including lower border, or maxilla, sub-total resection of (Anaes.) (Assist.)	699.45
52120	Mandible, hemimandiblectomy of, including condylectomy, if	827.30

Group O3—General surgery		
Item	**Description**	**Fee ($)**
	performed (Anaes.) (Assist.)	
52122	Mandible, hemi-mandibular reconstruction of, or maxilla reconstruction of, with bone graft, plate, tray or alloplast, other than a service associated with a service to which item 52123 applies (Anaes.) (Assist.)	827.30
52123	Mandible, total resection of both sides, including condylectomies if performed (Anaes.) (Assist.)	936.55
52126	Maxilla, total resection of (Anaes.) (Assist.)	900.45
52129	Maxilla, total resection of both maxillae (Anaes.) (Assist.)	1 205.40
52130	Bone graft in the oral and maxillofacial region, other than a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.)	442.45
52131	Bone graft with internal fixation, in the oral and maxillofacial region, other than a service to which another item in the range 51900 to 52186, or the range 52303 to 53460, applies (Anaes.) (Assist.)	611.90
52132	Tracheostomy (Anaes.)	248.95
52133	Cricothyrostomy by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.)	91.05
52135	Post-operative or post-nasal haemorrhage, or both, control of, if undertaken in the operating theatre of a hospital (Anaes.)	144.35
52138	Maxillary artery, ligation of (Anaes.) (Assist.)	448.55
52141	Facial, mandibular or lingual artery or vein or artery and vein, ligation of, other than a service to which item 52138 applies (Anaes.) (Assist.)	443.70
52144	Foreign body, deep, removal of using interventional imaging techniques (Anaes.) (Assist.)	413.55
52147	Duct of major salivary gland, transposition of (Anaes.) (Assist.)	390.25
52148	Parotid duct, repair of, using micro-surgical techniques (Anaes.) (Assist.)	689.80
52158	Submandibular ducts, relocation of, for surgical control of drooling (Anaes.) (Assist.)	1 110.65
52180	Aggressive or potentially malignant bone or deep soft tissue	188.20

Group O3—General surgery		
Item	**Description**	**Fee ($)**
	tumour in the oral and maxillofacial region, biopsy of (not including after-care) (Anaes.)	
52182	Bone or malignant deep soft tissue tumour in the oral and maxillofacial region, lesional or marginal excision of (Anaes.) (Assist.)	414.25
52184	Bone tumour in the oral and maxillofacial region, lesional or marginal excision of, combined with any one of liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.)	611.90
52186	Bone tumour in the oral and maxillofacial region, lesional or marginal excision of, combined with any 2 or more of liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.)	753.25

Division 2.50—Group O4: Plastic and reconstructive

2.50.1 Meaning of *maxilla*

In items 52342 to 52375, ***maxilla*** includes the zygoma.

Group O4—Plastic and reconstructive		
Item	**Description**	**Fee ($)**
52300	Single-stage local flap, where indicated, repair to one defect, with skin or mucosa (Anaes.) (Assist.)	284.35
52303	Single-stage local flap, if indicated, repair to one defect, with buccal pad of fat (Anaes.) (Assist.)	406.05
52306	Single-stage local flap, if indicated, repair to one defect, using temporalis muscle (Anaes.) (Assist.)	602.45
52309	Free grafting (mucosa or split skin) of a granulating area (Anaes.)	204.70
52312	Free grafting (mucosa, split skin or connective tissue) to one defect, including elective dissection (Anaes.) (Assist.)	284.35
52315	Free grafting, full thickness, to one defect (mucosa or skin) (Anaes.) (Assist.)	473.75
52318	Bone graft, harvesting of, via separate incision, being a service associated with a service to which another item in Groups O3 to O9 applies—Autogenous, small quantity (Anaes.)	141.25
52319	Bone graft, harvesting of, via separate incision, being a service associated with a service to which another item in Groups O3 to O9 applies—Autogenous, large quantity (Anaes.)	235.50
52321	Foreign implant (non-biological), insertion of, for contour reconstruction of pathological deformity, other than a service associated with a service to which item 52624 applies (Anaes.) (Assist.)	473.75
52324	Direct flap repair, using tongue, first stage (Anaes.) (Assist.)	473.75
52327	Direct flap repair, using tongue, second stage (Anaes.)	235.05
52330	Palatal defect (oro-nasal fistula), plastic closure of, including	781.95

Group O4—Plastic and reconstructive		
Item	**Description**	**Fee ($)**
	services to which item 52300, 52303, 52306 or 52324 applies (Anaes.) (Assist.)	
52333	Cleft palate, primary repair (Anaes.) (Assist.)	781.95
52336	Cleft palate, secondary repair, closure of fistula using local flaps (Anaes.) (Assist.)	488.75
52337	Alveolar cleft (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes.) (Assist.)	1 069.10
52339	Cleft palate, secondary repair, lengthening procedure (Anaes.) (Assist.)	556.60
52342	Mandible or maxilla, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (H) (Anaes.) (Assist.)	966.80
52345	Mandible or maxilla, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (H) (Anaes.) (Assist.)	1 090.35
52348	Mandible or maxilla, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (H) (Anaes.) (Assist.)	1 232.05
52351	Mandible or maxilla, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (H) (Anaes.) (Assist.)	1 383.65
52354	Mandible or maxilla, osteotomies or osteectomies of, involving 3 or more such procedures on the one jaw, including transposition of nerves and vessels and bone grafts taken from the same site (H) (Anaes.) (Assist.)	1 402.70
52357	Mandible or maxilla, osteotomies or osteectomies of, involving 3 or more such procedures on the one jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (H) (Anaes.) (Assist.)	1 579.20

Group O4—Plastic and reconstructive		
Item	**Description**	**Fee ($)**
52360	Mandible and maxilla, osteotomies or osteectomies of, involving 2 such procedures of each jaw including transposition of nerves and vessels and bone grafts taken from the same site (H) (Anaes.) (Assist.)	1 611.05
52363	Mandible and maxilla, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (H) (Anaes.) (Assist.)	1 812.40
52366	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of one jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (H) (Anaes.) (Assist.)	1 772.30
52369	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of one jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (H) (Anaes.)) (Assist.)	1 992.70
52372	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (H) (Anaes.) (Assist.)	1 933.55
52375	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (H) (Anaes.) (Assist.)	2 165.75
52378	Genioplasty including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	748.65
52379	Face, contour reconstruction of one region, using autogenous	1 279.45

Group O4—Plastic and reconstructive		
Item	**Description**	**Fee ($)**
	bone or cartilage graft (Anaes.) (Assist.)	
52380	Midfacial osteotomies—Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	2 178.60
52382	Midfacial osteotomies—Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.)	2 611.60
52420	Mandible, fixation by intermaxillary wiring, excluding wiring for obesity	241.15
52424	Dermis, dermofat or fascia graft (excluding transfer of fat by injection) in the oral and maxillofacial region (Anaes.) (Assist.)	473.65
52430	Microvascular repair of the oral and maxillofacial region using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.)	1 090.35
52440	Cleft lip, unilateral—primary repair, one stage, without anterior palate repair (Anaes.) (Assist.)	541.35
52442	Cleft lip, unilateral—primary repair, one stage, with anterior palate repair (Anaes.) (Assist.)	676.80
52444	Cleft lip, bilateral—primary repair, one stage, without anterior palate repair (Anaes.) (Assist.)	751.85
52446	Cleft lip, bilateral—primary repair, one stage, with anterior palate repair (Anaes.) (Assist.)	887.50
52450	Cleft lip, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.)	300.75
52452	Cleft lip, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.)	488.75
52456	Cleft lip reconstruction using full thickness flap (Abbe or	827.30

Group O4—Plastic and reconstructive		
Item	**Description**	**Fee ($)**
	similar), first stage (Anaes.) (Assist.)	
52458	Cleft lip reconstruction using full thickness flap (Abbe or similar), second stage (Anaes.)	300.75
52460	Velo-pharyngeal incompetence, pharyngeal flap for, or pharyngoplasty for (Anaes.)	781.95
52480	Composite graft (chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (Anaes.) (Assist.)	502.25
52482	Macrocheilia or macroglossia, operation for (Anaes.) (Assist.)	483.25
52484	Macrostomia, operation for (Anaes.) (Assist.)	575.30

Division 2.51—Group O5: Preprosthetic

Group O5—Preprosthetic		
Item	**Description**	**Fee ($)**
52600	Mandibular or palatal exostosis, excision of (Anaes.) (Assist.)	338.35
52603	Mylohyoid ridge, reduction of (Anaes.) (Assist.)	323.40
52606	Maxillary tuberosity, reduction of (Anaes.)	246.70
52609	Papillary hyperplasia of the palate, removal of—less than 5 lesions (Anaes.) (Assist.)	323.40
52612	Papillary hyperplasia of the palate, removal of—5 to 20 lesions (Anaes.) (Assist.)	406.05
52615	Papillary hyperplasia of the palate, removal of—more than 20 lesions (Anaes.) (Assist.)	503.85
52618	Vestibuloplasty, submucosal or open, including excision of muscle and skin or mucosal graft when performed—unilateral or bilateral (Anaes.) (Assist.)	586.50
52621	Floor of mouth lowering (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed—unilateral (Anaes.) (Assist.)	586.50
52624	Alveolar ridge augmentation with bone or alloplast or both—unilateral (Anaes.) (Assist.)	473.65
52626	Alveolar ridge augmentation—unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.)	290.50
52627	Osseo-integration procedure—extra oral implantation of titanium fixture (Anaes.) (Assist.)	503.85
52630	Osseo-integration procedure—fixation of transcutaneous abutment (Anaes.)	186.50
52633	Osseo-integration procedure—intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.)	503.85
52636	Osseo-integration procedure—fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.)	186.50

Division 2.52—Group O6: Neurosurgical

Group O6—Neurosurgical		
Item	**Description**	**Fee ($)**
52800	Neurolysis by open operation, without transposition, other than a service associated with a service to which item 52803 applies (Anaes.) (Assist.)	276.80
52803	Nerve trunk, internal (interfascicular), neurolysis of, using microsurgical techniques (Anaes.) (Assist.)	398.55
52806	Neurectomy, neurotomy or removal of tumour from superficial peripheral nerve (Anaes.) (Assist.)	276.80
52809	Neurectomy, neurotomy or removal of tumour from deep peripheral nerve (Anaes.) (Assist.)	473.75
52812	Nerve trunk, primary repair of, using microsurgical techniques (Anaes.) (Assist.)	676.80
52815	Nerve trunk, secondary repair of, using microsurgical techniques (Anaes.) (Assist.)	714.35
52818	Nerve, transposition of (Anaes.) (Assist.)	473.75
52821	Nerve graft to nerve trunk (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.) (Assist.)	1 030.20
52824	Peripheral branches of the trigeminal nerve, cryosurgery of, for pain relief (Anaes.) (Assist.)	443.70
52826	Injection of primary branch of trigeminal nerve with alcohol, cortisone, phenol, or similar substance (Anaes.)	237.60
52828	Cutaneous nerve, primary repair of, using microsurgical techniques (Anaes.) (Assist.)	353.35
52830	Cutaneous nerve, secondary repair of, using microsurgical techniques (Anaes.) (Assist.)	466.10
52832	Cutaneous nerve, nerve graft to, using microsurgical techniques (Anaes.) (Assist.)	639.20

Division 2.53—Group O7: Ear, nose and throat

Group O7—Ear, nose and throat		
Item	**Description**	**Fee ($)**
53000	Maxillary antrum, proof puncture and lavage of (Anaes.)	32.55
53003	Maxillary antrum, proof puncture and lavage of, under general anaesthesia, other than a service associated with a service to which another item in Groups O3 to O9 applies (H) (Anaes.)	91.90
53004	Maxillary antrum, lavage of—each attendance at which the procedure is performed, including any associated consultation (Anaes.)	35.60
53006	Antrostomy (radical) (Anaes.) (Assist.)	521.25
53009	Antrum, intranasal operation on or removal of foreign body from (Anaes.) (Assist.)	295.70
53012	Antrum, drainage of, through tooth socket (Anaes.)	117.55
53015	Oro-antral fistula, plastic closure of (Anaes.) (Assist.)	587.60
53016	Nasal septum, septoplasty, submucous resection or closure of septal perforation (Anaes.) (Assist.)	483.25
53017	Nasal septum, reconstruction of (Anaes.) (Assist.)	602.85
53019	Maxillary sinus, bone graft to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), unilateral (Anaes.) (Assist.)	580.90
53052	Post-nasal space, direct examination of, with or without biopsy (Anaes.)	122.85
53054	Nasendoscopy or sinoscopy or fibreoptic examination of nasopharynx—one or more of these procedures (Anaes.)	122.85
53056	Examination of nasal cavity or post-nasal space, or nasal cavity and post-nasal space, under general anaesthesia, other than a service associated with a service to which another item in this Group applies (Anaes.)	71.95
53058	Nasal haemorrhage, posterior, arrest of, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding after-care) (Anaes.)	122.85
53060	Cauterisation (other than by chemical means) or cauterisation by chemical means when performed under general anaesthesia	100.50

Group O7—Ear, nose and throat		
Item	**Description**	**Fee ($)**
	or diathermy of septum or turbinates for obstruction or haemorrhage secondary to surgery (or trauma)—one or more of these procedures (including any consultation on the same occasion) other than a service associated with another operation on the nose (Anaes.)	
53062	Post-surgical nasal haemorrhage, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.)	90.00
53064	Cryotherapy to nose in the treatment of nasal haemorrhage (Anaes.)	162.95
53068	Turbinectomy or turbinectomies, partial or total, unilateral (Anaes.)	136.50
53070	Turbinates, submucous resection of, unilateral (Anaes.)	178.05

Division 2.54—Group O8: Temporomandibular joint

Group O8—Temporomandibular joint		
Item	**Description**	**Fee ($)**
53200	Mandible, treatment of a dislocation of, not requiring open reduction (Anaes.)	70.65
53203	Mandible, treatment of a dislocation of, requiring open reduction (Anaes.)	118.70
53206	Temporomandibular joint, manipulation of, performed in the operating theatre of a hospital, other than a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.)	142.95
53209	Glenoid fossa, zygomatic arch and temporal bone, reconstruction of (Obwegeser technique) (Anaes.) (Assist.)	1 649.10
53212	Absent condyle and ascending ramus in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.)	890.85
53215	Temporomandibular joint, arthroscopy of, with or without biopsy, other than a service associated with another arthroscopic procedure of that joint (Anaes.) (Assist.)	408.70
53218	Temporomandibular joint, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions—one or more of such procedures (Anaes.) (Assist.)	653.80
53220	Temporomandibular joint, arthrotomy of, other than a service to which another item in this Group applies (Anaes.) (Assist.)	329.60
53221	Temporomandibular joint, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.)	872.30
53224	Temporomandibular joint, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.)	967.00
53225	Arthrocentesis, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space (Anaes.) (Assist.)	290.50
53226	Temporomandibular joint, synovectomy of, other than a service to which another item in this Group applies (Anaes.) (Assist.)	312.30

Group O8—Temporomandibular joint		
Item	**Description**	**Fee ($)**
53227	Temporomandibular joint, open surgical exploration of, with or without meniscus or capsular surgery, including meniscectomy when performed, with or without microsurgical techniques (Anaes.) (Assist.)	1 188.20
53230	Temporomandibular joint, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.)	1 338.45
53233	Temporomandibular joint, surgery of, involving procedures to which item 53224, 53226, 53227 or 53230 applies and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Anaes.) (Assist.)	1 504.05
53236	Temporomandibular joint, stabilisation of, involving one or more of: repair of capsule, repair of ligament or internal fixation, other than a service to which another item in this Group applies (Anaes.) (Assist.)	470.70
53239	Temporomandibular joint, arthrodesis of, other than a service to which another item in this Group applies (Anaes.) (Assist.)	470.70
53242	Temporomandibular joint or joints, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.)	312.30

Division 2.55—Group O9: Treatment of fractures

Group O9—Treatment of fractures		
Item	**Description**	**Fee ($)**
53400	Maxilla, unilateral or bilateral, treatment of fracture of, not requiring splinting	129.20
53403	Mandible, treatment of fracture of, not requiring splinting	157.85
53406	Maxilla, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.)	406.65
53409	Mandible, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.)	406.65
53410	Zygomatic bone, treatment of fracture of, not requiring surgical reduction	85.65
53411	Zygomatic bone, treatment of fracture of, requiring surgical reduction, by temporal, intra-oral or other approach (Anaes.)	238.80
53412	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at one site (Anaes.) (Assist.)	392.10
53413	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.)	480.35
53414	Zygomatic bone, treatment of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.)	551.85
53415	Maxilla, treatment of fracture of, requiring open reduction (Anaes.) (Assist.)	435.65
53416	Mandible, treatment of fracture of, requiring open reduction (Anaes.) (Assist.)	435.65
53418	Maxilla, treatment of fracture of, requiring open reduction and internal fixation not involving a plate (Anaes.) (Assist.)	566.35
53419	Mandible, treatment of fracture of, requiring open reduction and internal fixation not involving a plate (Anaes.) (Assist.)	566.35
53422	Maxilla, treatment of fracture of, requiring open reduction and	718.75

Group O9—Treatment of fractures		
Item	**Description**	**Fee ($)**
	internal fixation involving a plate (Anaes.) (Assist.)	
53423	Mandible, treatment of fracture of, requiring open reduction and internal fixation involving a plate (Anaes.) (Assist.)	718.75
53424	Maxilla, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving a plate (Anaes.) (Assist.)	616.65
53425	Mandible, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving a plate (Anaes.) (Assist.)	616.65
53427	Maxilla, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of a plate (Anaes.) (Assist.)	842.25
53429	Mandible, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of a plate (Anaes.) (Assist.)	842.25
53439	Mandible, treatment of a closed fracture of, involving a joint surface (Anaes.)	238.80
53453	Orbital cavity, reconstruction of a wall or floor with or without foreign implant (Anaes.) (Assist.)	483.25
53455	Orbital cavity, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.)	567.65
53458	Nasal bones, treatment of fracture of, other than a service to which item 53459 or 53460 applies	43.05
53459	Nasal bones, treatment of fracture of, by reduction (Anaes.)	235.50
53460	Nasal bones, treatment of fractures of, by open reduction involving osteotomies (Anaes.) (Assist.)	480.35

Division 2.56—Group O10: Diagnostic procedures and investigations

Group O10—Diagnostic procedures and investigations		
Item	**Description**	**Fee ($)**
53600	Skin sensitivity testing for allergens to anaesthetics and materials used in oral and maxillofacial surgery, using one to 20 allergens	38.95

Division 2.57—Group O11: Regional or field nerve blocks

Group O11—Regional or field nerve blocks		
Item	**Description**	**Fee ($)**
53700	Trigeminal nerve, primary division of, injection of an anaesthetic agent	124.85
53702	Trigeminal nerve, peripheral branch of, injection of an anaesthetic agent	62.50
53704	Facial nerve, injection of an anaesthetic agent	37.65
53706	Nerve branch in the oral and maxillofacial region, destruction by a neurolytic agent, other than a service to which another item in this Group applies	124.85

Part 3—Dictionary

Note: All references in the Dictionary to a provision are references to a provision in this Schedule of this regulation unless otherwise indicated.

In this regulation:

(G) has the meaning given by clause 1.1.5.

(H) has the meaning given by clause 1.1.6.

(S) has the meaning given by clause 1.1.7.

Aboriginal and Torres Strait Islander health practitioner means a person:

(a) who is registered under a law of a State or Territory as an Aboriginal and Torres Strait Islander health practitioner; and

(b) who is employed by, or whose services are otherwise retained by, a medical practitioner in a general practice or a health service to which a direction made under subsection 19(2) of the Act applies.

aboriginal health worker means a person:

(a) who holds a Certificate III in Aboriginal or Torres Strait Islander Health Worker Primary Health Care (Clinical) or other appropriate qualification; and

(b) who is engaged by a medical practitioner in a general practice or a health service to which a direction made under subsection 19(2) of the Act applies.

ACRRM means the Australian College of Rural and Remote Medicine.

Act means the *Health Insurance Act 1973*.

after-hours period means any of the following:

(a) a public holiday;

(b) a Sunday;

(c) before 8 am, or after 12 noon, on a Saturday;

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

amount under clause 2.1.1 has the meaning given by clause 2.1.1.

amount under clause 2.20.2 has the meaning given by clause 2.20.2.

amount under clause 2.38.1 has the meaning given by clause 2.38.1.

amount under clause 2.40.2 has the meaning given by clause 2.40.2.

amount under clause 2.42.1 has the meaning given by clause 2.42.1.

amount under clause 2.43.1 has the meaning given by clause 2.43.1.

amount under clause 2.43.2 has the meaning given by clause 2.43.2.

amount under clause 2.44.4 has the meaning given by clause 2.44.4.

amount under clause 2.44.5 has the meaning given by clause 2.44.5.

amount under clause 2.44.18 has the meaning given by clause 2.44.18.

amount under clause 2.45.1 has the meaning given by clause 2.45.1.

amount under clause 2.45.2 has the meaning given by clause 2.45.2.

amount under clause 2.45.3 has the meaning given by clause 2.45.3.

amount under clause 2.48.1 has the meaning given by clause 2.48.1.

approved site:

(a) for item 15338—has the meaning given by clause 2.38.2; and

(b) for items 37220 and 37227—has the meaning given by clause 2.44.1.

ASGC, for Division 2.31, has the meaning given by clause 2.31.1.

associated medical practitioner:

(a) for item 732—has the meaning given by clause 2.17.2; and

(b) for item 2712—has the meaning given by clause 2.20.5.

bulk-billed:

(a) for items 10931, 10932 and 10933—has the meaning given by subclause 2.28.4(3); and

(b) for Division 2.31—has the meaning given by clause 2.31.1.

care recipient means a person receiving residential care under section 21-2 of the *Aged Care Act 1997*.

case conference team, for item 880, has the meaning given by clause 2.17.17.

closed reduction means treatment of a dislocation or fracture by non-operative reduction, including the use of percutaneous fixation, or external splintage by cast or splints.

Commonwealth concession card holder, for Division 2.31, has the meaning given by clause 2.31.1.

community case conference means a case conference for community based patients.

completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus has the meaning given by clause 2.19.1.

completes the minimum requirements of the Asthma Cycle of Care has the meaning given by clause 2.19.2.

complex paediatric case, for item 25205, has the meaning given by clause 2.43.3.

comprehensive hyperbaric medicine facility, for items 13015, 13020, 13025 and 13030, has the meaning given by clause 2.37.1.

contribute to a multidisciplinary care plan, for items 729 and 731, has the meaning given by clause 2.17.3.

coordinating, for item 880, has the meaning given by clause 2.17.16.

coordinating a review of team care arrangements, for item 732, has the meaning given by clause 2.17.5.

coordinating the development of team care arrangements, for item 723, has the meaning given by clause 2.17.4.

delivery, for items 16515, 16519, 16522, 16527, 16590 and 16591, has the meaning given by clause 2.40.3.

eligible allied health provider:

(a) for items 135, 137 and 139—has the meaning given by clause 2.5A.1; and

(b) for item 289—has the meaning given by clause 2.10.5.

eligible area, for Division 2.31, has the meaning given by clause 2.31.1.

eligible disability has the meaning given by clause 2.5A.2.

eligible non-vocationally recognised medical practitioner has the meaning given by clause 1.1.1.

embryology laboratory services, for items 13200, 13201 and 13206, has the meaning given by clause 2.37.2.

family carer, of a patient, includes a person if the person is:

(a) a relative or friend of the patient; and

(b) providing care to the patient other than for payment.

focussed psychological strategies has the meaning given by clause 2.20.1.

foreign body, for items 35360 and 35363, has the meaning given by clause 2.44.13.

general intensive care unit means a separate hospital area that:

(a) is equipped and staffed so that it is capable of providing to a patient:
  (i) mechanical ventilation for a period of several days; and
  (ii) invasive cardiovascular monitoring; and
(b) is supported by:
  (i) during normal working hours—at least one specialist, or consultant physician, in the specialty of intensive care, who is immediately available, and exclusively rostered, to that area; and
  (ii) at all times—at least one registered medical practitioner who is present in the hospital and immediately available to that area; and
  (iii) at least 18 hours each day—at least one registered nurse; and
(c) has admission and discharge policies in operation.

general practice means a business, consisting of one or more medical practitioners, that provides a general practice of medical services.

general practitioner has the meaning given by clause 1.1.1A.

GPET means the body registered under the *Corporations Act 2001* as General Practice Education and Training Limited (ACN 095 433 140).

GP management plan, for item 10997, has the meaning given by clause 2.30.1.

immunisation means the administration of a registered vaccine to a person for any purpose other than as part of a mass immunisation of persons.

immunisation recommended for a 4 year old child means the immunisation recommended for a 4 year old child by the National Immunisation Program Schedule as in effect on 1 July 2013.

Note: In 2013, the National Immunisation Program Schedule was accessible at http://www.immunise.health.gov.au.

institution means a place (other than a hospital or residential aged care facility) at which residential accommodation or day care is, or both residential accommodation and day care are, made available to:

(a) disadvantaged children; or
(b) juvenile offenders; or
(c) aged persons; or
(d) chronically ill psychiatric patients; or
(e) homeless persons; or
(f) unemployed persons; or
(g) persons suffering from alcoholism; or
(h) persons addicted to drugs; or
(i) physically or intellectually disabled persons.

intensive care unit means a general intensive care unit or a neo-natal intensive care unit.

item means:

(a) an item mentioned, by number, in column 1 of:
  (i) Part 2; or
  (ii) Part 2 of the diagnostic imaging services table; or
  (iii) Part 2 of the pathology services table; and
(b) in a reference immediately followed by a number—the item so numbered.

Note: Because of the determination about allied health services under subsection 3C(1) of the Act, certain health services are treated as if there were an item for the service mentioned in the table. A note is included at the end of a provision of this regulation if an item mentioned in the provision is that kind of item: see subclause 2.20.3(2) for an example.

living in a community setting, for item 900, has the meaning given by clause 2.18.1.

maxilla:

(a) for items 45720 to 45752—has the meaning given by clause 2.44.19; and
(b) for items 52342 to 52375—has the meaning given by clause 2.50.1.

mental disorder, for Division 2.20, has the meaning given by clause 2.20.1.

minor attendance, for an attendance on a patient by a consultant physician, means an attendance that:

(a) is a second or subsequent attendance on the patient, in the course of a single course of treatment by the consultant physician, during which it is not necessary for the consultant physician to carry out a physical examination of the patient; and
(b) does not result in a substantial alteration to the treatment of the patient.

multidisciplinary care plan:

(a) for items 729 and 731—has the meaning given by clause 2.17.6; and
(b) for item 10997—has the meaning given by clause 2.30.1.

multidisciplinary case conference has the meaning given by clause 1.1.2.

multidisciplinary case conference in a residential aged care facility, for items 735, 739, 743, 747, 750 and 758, has the meaning given by clause 2.17.13.

multidisciplinary case conference team has the meaning given by clause 1.1.3.

multidisciplinary discharge case conference, for items 735, 739, 743, 747, 750 and 758, has the meaning given by clause 2.17.12.

neo-natal intensive care unit means a separate hospital area that:

(a) is equipped and staffed so that it is capable of providing to a patient who is a newly born child:
    (i) mechanical ventilation for a period of several days; and

(ii) invasive cardiovascular monitoring; and

(b) is supported by:

(i) during normal working hours—at least one consultant physician in paediatric medicine who is immediately available, and exclusively rostered, to that area; and

(ii) at all times—at least one registered medical practitioner who is present in the hospital and immediately available to that area; and

(iii) at least 18 hours each day—at least one registered nurse; and

(c) has admission and discharge policies in operation.

non-directive pregnancy support counselling, for item 4001, has the meaning given by clause 2.22.1.

non-medicare service means any of the following:

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

(c) gamma knife surgery;

(d) intradiscal electro thermal arthroplasty;

(e) intravascular ultrasound, except if used in conjunction with intravascular brachytherapy;

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

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

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

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

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

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

(l) specific mass measurement of bone alkaline phosphatise;

(m) transmyocardial laser revascularisation;

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

(o) autologous chondrocyte implantation and matrix-induced autologous chondrocyte implantation;
(p) vertebroplasty.

open reduction means treatment of a dislocation or fracture by either:
(a) operative exposure, including the use of any internal or external fixation; or
(b) non-operative (closed) reduction using intra-medullary fixation or external fixation.

organise and coordinate:
(a) for items 735, 739, 743, 820, 822, 823, 825, 826, 828, 830, 832, 834, 835, 837, 838, 855, 857, 858, 861, 864 and 866—has the meaning given by clause 2.17.14; and
(b) for items mentioned in Subgroups 2 and 4 of Group A24—has the meaning given by clause 2.21.1.

outcome measurement tool, for Division 2.20, has the meaning given by clause 2.20.1.

participate:
(a) for items 747, 750, 758, 825, 826, 828, 835, 837 and 838—has the meaning given by clause 2.17.15; and
(b) for items 2958, 2972, 2974, 2992, 2996, 3000, 3051, 3055, 3062, 3083, 3088 and 3093—has the meaning given by clause 2.21.2.

participating in a video conferencing consultation has the meaning given by clause 1.2.9.

patient's medical condition requires urgent treatment, for items 597 to 600, has the meaning given by clause 2.15.1.

patient's usual medical practitioner means a medical practitioner:
(a) who has provided the majority of services to the patient in the past 12 months; or
(b) who is likely to provide the majority of services to the patient in the following 12 months; or
(c) located at a medical practice that:

(i) has provided the majority of services to the patient in the past 12 months; or
(ii) is likely to provide the majority of services to the patient in the next 12 months.

person with a chronic disease, for item 10997, has the meaning given by clause 2.30.1.

practice location has the meaning given by clause 2.31.1.

practice nurse means a registered or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice or by a health service to which a direction made under subsection 19(2) of the Act applies.

preparation of a GP mental health treatment plan has the meaning given by clause 2.20.3.

preparing a GP management plan, for item 721, has the meaning given by clause 2.17.7.

previous significant surgical complication, for item 51318, has the meaning givne by clause 2.45.4.

problem focussed history, for items 501, 503 and 507, has the meaning given by clause 2.14.2.

qualified medical acupuncturist has the meaning given by clause 2.9.1.

qualified radiologist, for item 31542, has the meaning given by clause 2.44.7.

qualified sleep medicine practitioner:
(a) for items 12203, 12207, 12213 and 12217—has the meaning given by subclause 2.34.2(1); and
(b) for items 12210 and 122015—has the meaning given by subclause 2.34.2(1A); and
(c) for item 12250—has the meaning given by subclause 2.34.2(1AA).

qualified surgeon, for items 31539 and 31545, has the meaning given by clause 2.44.6.

RACGP means the Royal Australian College of General Practitioners.

recognised emergency department, for Division 2.14, has the meaning given by clause 2.14.1.

referral means referral by a referring practitioner.

referring practitioner, for the referral of a patient, means:

(a) for all referrals—a medical practitioner; and

(b) for a referral made to a specialist who is an ophthalmologist—an optometrist; and

(c) for a referral that arises out of a dental service provided by a dental practitioner and that is made to a specialist (but not a consultant physician)—a dental practitioner; and

(d) for a referral that arises out of a dental service provided by a dental practitioner who is approved by the Minister for the purposes of paragraph (b) of the definition of ***professional service*** in subsection 3(1) of the Act and that is made to a consultant physician—a dental practitioner; and

(e) for a referral made to a specialist in the specialty of obstetrics or paediatrics (however described) that arises out of a midwifery service provided by a participating midwife—a participating midwife; and

(f) for a referral made to a specialist or consultant physician that arises out of a nurse practitioner service provided by a participating nurse practitioner—a participating nurse practitioner.

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

registered vaccine means a vaccine that is included in the part of the Australian Register of Therapeutic Goods for registered goods, being the Register maintained under section 9A of the *Therapeutic Goods Act 1989*.

Report, for Division 2.34, has the meaning given by clause 2.34.1.

residential aged care facility means a facility where residential care (within the meaning given by section 41-3 of the *Aged Care Act 1997*) is provided.

residential care service has the meaning given by clause 1 of Schedule 1 to the *Aged Care Act 1997*.

residential medication management review, for item 903, has the meaning given by clause 2.18.2.

responsible person, for items 597 to 600, has the meaning given by clause 2.15.2.

reviewing a GP management plan, for item 732, has the meaning given by clause 2.17.8.

review of a GP mental health treatment plan has the meaning given by clause 2.20.4.

risk assessment:

(a) for items 135, 137 and 139—has the meaning given by clause 2.5A.1; and

(b) for item 289—has the meaning given by clause 2.10.5.

Rural, Remote and Metropolitan Areas Classification means the document so titled, as in force on 1 January 2001, setting out certain categories of areas in Australia that have been determined by the Department by reference to population size and remoteness of locality on the basis of 1991 census data published by the Australian Bureau of Statistics in 1994.

service time, for an item in subgroups 21, 24, 25 and 26 of Group T10, has the meaning given by clause 2.43.4.

single course of treatment has the meaning given by clause 1.1.4.

SLA, for Division 2.31, has the meaning given by clause 2.31.1.

specialist trainee under the supervision of a medical practitioner, for Division 2.36, has the meaning given by clause 2.36.1.

SSD, for Division 2.31, has the meaning given by clause 2.31.1.

team care arrangements means a plan under item 723 or 732 (for a review of team care arrangements under item 723).

telehealth eligible area means an area classified as a telehealth eligible area by the Minister.

Note: In 2013, maps showing telehealth eligible areas was accessible at http://www.mbsonline.gov.au.

treatment cycle, for items 13200 to 13209 and 13212 to 13221, has the meaning given by clause 2.37.3.

unreferred service, for Division 2.31, has the meaning given by clause 2.31.1.

unsociable hours means the period starting at 11 pm and ending at 7 am on any day.

Schedule 2—Repeals

Health Insurance (General Medical Services Table) Regulation 2012

1 The whole of the regulation

Repeal the regulation.