



Health Insurance (General Medical Services Table) Regulation 2015

Select Legislative Instrument No. 84, 2015

made under the

Health Insurance Act 1973

Compilation No. 1

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About this compilation

This compilation

This is a compilation of the *Health Insurance (General Medical Services Table) Regulation 2015* that shows the text of the law as amended and in force on 1 September 2015 (the *compilation date*).

This compilation was prepared on 7 September 2015.

The notes at the end of this compilation (the *endnotes*) include information about amending laws and the amendment history of provisions of the compiled law.

Uncommenced amendments

The effect of uncommenced amendments is not shown in the text of the compiled law. Any uncommenced amendments affecting the law are accessible on ComLaw (www.comlaw.gov.au). The details of amendments made up to, but not commenced at, the compilation date are underlined in the endnotes. For more information on any uncommenced amendments, see the series page on ComLaw for the compiled law.

Application, saving and transitional provisions for provisions and amendments

If the operation of a provision or amendment of the compiled law is affected by an application, saving or transitional provision that is not included in this compilation, details are included in the endnotes.

Modifications

If the compiled law is modified by another law, the compiled law operates as modified but the modification does not amend the text of the law. Accordingly, this compilation does not show the text of the compiled law as modified. For more information on any modifications, see the series page on ComLaw for the compiled law.

Self-repealing provisions

If a provision of the compiled law has been repealed in accordance with a provision of the law, details are included in the endnotes.

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1 Name

This is the *Health Insurance (General Medical Services Table) Regulation 2015*.

3 Authority

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

4 Schedules

Each instrument that is specified in a Schedule to this instrument is amended or repealed as set out in the applicable items in the Schedule concerned, and any other item in a Schedule to this instrument has effect according to its terms.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 instrument 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 instrument, and includes references to certain words and expressions that are defined elsewhere in this instrument.

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
- (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 and Torres Strait Islander health practitioners;
- (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;

Schedule 1 General medical services table
Part 1 Preliminary

- (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

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- (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,

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6004, 6007 to 6016, 10905 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—services provided with non-medicare services

Items 3 to 10948 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.

1.2.7A Application of items—services provided with autologous injections of blood or blood products

An item in the table does not apply to a service mentioned in the item if the service is provided to a patient at the same time, or in connection with, an injection of blood or a blood product that is autologous.

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, 11725, 11726, 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:

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- (a) in relation to his or her speciality to the patient; and
- (b) by way of a video conferencing consultation.

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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 | 25.95 | 2.00 |
| 2 | 20 | The fee for item 3 | 46.70 | 3.30 |
| 3 | 24 | The fee for item 23 | 25.95 | 2.00 |
| 4 | 35 | The fee for item 23 | 46.70 | 3.30 |
| 5 | 37 | The fee for item 36 | 25.95 | 2.00 |
| 6 | 43 | The fee for item 36 | 46.70 | 3.30 |
| 7 | 47 | The fee for item 44 | 25.95 | 2.00 |

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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 (\$) |
|-------------|---|-------------------------|---|---|
| 8 | 51 | The fee for item 44 | 46.70 | 3.30 |
| 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 | 25.95 | 2.00 |
| 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 | 25.95 | 2.00 |
| 23 | 2506 | The fee for item 2504 | 25.95 | 2.00 |
| 24 | 2509 | The fee for item 2507 | 25.95 | 2.00 |
| 25 | 2518 | The fee for item 2517 | 25.95 | 2.00 |
| 26 | 2522 | The fee for item 2521 | 25.95 | 2.00 |
| 27 | 2526 | The fee for item 2525 | 25.95 | 2.00 |
| 28 | 2547 | The fee for item 2546 | 25.95 | 2.00 |
| 29 | 2553 | The fee for item 2552 | 25.95 | 2.00 |
| 30 | 2559 | The fee for item 2558 | 25.95 | 2.00 |

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 (\$) |
|-------------|---|-------------------------|---|---|
| 31 | 5003 | The fee for item 5000 | 25.95 | 2.00 |
| 32 | 5010 | The fee for item 5000 | 46.70 | 3.30 |
| 33 | 5023 | The fee for item 5020 | 25.95 | 2.00 |
| 34 | 5028 | The fee for item 5020 | 46.70 | 3.30 |
| 35 | 5043 | The fee for item 5040 | 25.95 | 2.00 |
| 36 | 5049 | The fee for item 5040 | 46.70 | 3.30 |
| 37 | 5063 | The fee for item 5060 | 25.95 | 2.00 |
| 38 | 5067 | The fee for item 5060 | 46.70 | 3.30 |
| 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 |

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Part 2 Services and fees

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 | 16.95 |
| 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; | 37.05 |

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 |

Schedule 1 General medical services table

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

| Item | Description | Fee (\$) |
|-------------|--|---------------------------|
| 36 | Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—each attendance | 71.70 |
| 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 | Amount under clause 2.1.1 |

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

| Item | Description | Fee (\$) |
|-------------|--|---------------------------|
| | documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient | |
| 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 | 105.55 |
| 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 |

Schedule 1 General medical services table

Part 2 Services and fees

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 |

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Part 2 Services and fees

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

| Item | Description | Fee (\$) |
|-------------|---|---------------------------|
| 54 | Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45 minutes (other than a service to which any other item applies)—each attendance, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies | 38.00 |
| 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 |

| Group A2—Other non-referred attendances to which no other item applies | | |
|---|--|---------------------------|
| Item | Description | Fee (\$) |
| 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: (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 |
| 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 | Amount under clause 2.1.1 |

Schedule 1 General medical services table

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

| Item | Description | Fee (\$) |
|-------------|--|---------------------------|
| | 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 | |
| 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 |

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| Group A3—Specialist attendances to which no other item applies | | |
|---|---|-----------------|
| Item | Description | Fee (\$) |
| 105 | Professional attendance by a specialist in the practice of his or 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 | 43.00 |
| 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 |

Group A3—Specialist attendances to which no other item applies

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| 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 (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 | 64.20 |

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 | 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 (\$) |
| | (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 | |
| 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 |

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

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| 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 attendance in a single course of treatment | 183.10 |
| 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 | 263.90 |

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

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| | the preceding 12 months by the same consultant physician | |
| 133 | <p>Professional attendance by a consultant physician in the practice 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:</p> <p>(a) a review is undertaken that covers:</p> <ul style="list-style-type: none"> (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 <p>(b) the modified consultant physician treatment and management plan is provided to the referring practitioner, which involves, if appropriate:</p> <ul style="list-style-type: none"> (i) a revised opinion on the diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and <p>(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</p> <p>(d) item 132 applied to an attendance claimed in the preceding 12 months; and</p> <p>(e) the attendance under this item is claimed by the same consultant physician who claimed item 132 or a locum tenens; and</p> <p>(f) this item has not applied more than twice in any 12 month period</p> | 132.10 |

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;
- (p) Rett's disorder.

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

| Item | Description | Fee (\$) |
|------|---|----------|
| 135 | <p>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:</p> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (i) an assessment and diagnosis of the patient's condition; (ii) a risk assessment; (iii) treatment options and decisions; (iv) if necessary—medical recommendations; | 263.90 |

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

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| | (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 |

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

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| 139 | <p>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:</p> <p>(a) undertakes a comprehensive assessment and makes a diagnosis (if appropriate, using information provided by an eligible allied health provider);</p> <p>(b) develops a treatment and management plan, which must include the following:</p> <p>(i) an assessment and diagnosis of the patient’s condition;</p> <p>(ii) a risk assessment;</p> <p>(iii) treatment options and decisions;</p> <p>(iv) if necessary—medication recommendations;</p> <p>(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;</p> <p>(other than attendance on a patient for whom payment has previously been made under this item or item 135, 137 or 289)</p> | 132.50 |

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 | <p>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:</p> <p>(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</p> <p>(b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and</p> <p>(c) during the attendance:</p> <p>(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 <i>assessment</i>); and</p> <p>(ii) the patient's various health problems and care needs are identified and prioritised (the <i>formulation</i>); and</p> <p>(iii) a detailed management plan is prepared (the <i>management plan</i>) setting out:</p> <p>(A) the prioritised list of health problems and care needs; and</p> <p>(B) short and longer term management goals; and</p> <p>(C) recommended actions or intervention strategies to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient and</p> | 452.65 |

Group A28—Geriatric medicine

| Item | Description | Fee (\$) |
|------|--|----------|
| | <ul style="list-style-type: none"> 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 | <p>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:</p> <ul style="list-style-type: none"> (a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and (b) during the attendance: <ul style="list-style-type: none"> (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, unless there has been a significant change in the patient’s clinical condition or care circumstances that requires a | 282.95 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group A28—Geriatric medicine | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | further review | |
| 145 | <p>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:</p> <p>(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</p> <p>(b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and</p> <p>(c) during the attendance:</p> <p>(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 <i>assessment</i>); and</p> <p>(ii) the patient’s various health problems and care needs are identified and prioritised (the <i>formulation</i>); and</p> <p>(iii) a detailed management plan is prepared (the <i>management plan</i>) setting out:</p> <p>(A) the prioritised list of health problems and care needs; and</p> <p>(B) short and longer term management goals; and</p> <p>(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</p> <p>(iv) the management plan is explained and discussed with the patient and, if appropriate, the patient’s family and any carers; and</p> <p>(v) the management plan is communicated in writing to the referring practitioner; and</p> <p>(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</p> | 548.85 |

Group A28—Geriatric medicine

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| | (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 | <p>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:</p> <p>(a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and</p> <p>(b) during the attendance:</p> <p style="margin-left: 20px;">(i) the patient's health status is reassessed; and</p> <p style="margin-left: 20px;">(ii) a management plan that was prepared under item 141 or 145 is reviewed and revised; and</p> <p style="margin-left: 20px;">(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</p> <p>(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</p> <p>(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</p> <p>(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</p> | 343.10 |

Schedule 1 General medical services table

Part 2 Services and fees

Group A28—Geriatric medicine

| Item | Description | Fee (\$) |
|-------------|---|------------------------------------|
| 149 | Professional attendance on a patient by a consultant physician or specialist practising in his or her specialty of geriatric medicine if: (a) the attendance is by video conference; and (b) item 141 or 143 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the physician or specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service: for which a direction made under subsection 19(2) of the Act applies | 50% of the fee for 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 | 221.50 |
| 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 | 369.15 |
| 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 | 516.65 |
| 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 | 664.55 |
| 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 | 738.40 |

Schedule 1 General medical services table
Part 2 Services and fees

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 | 117.55 |
| 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 | 123.85 |
| 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 | 150.70 |

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 | 37.05 |

Schedule 1 General medical services table
Part 2 Services and fees

Group A7—Acupuncture

| Item | Description | Fee (\$) |
|-------------|--|---------------------------|
| 195 | <p>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 the following that are clinically relevant:</p> <p>(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;</p> <p>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</p> | Amount under clause 2.1.1 |
| 197 | <p>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:</p> <p>(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;</p> <p>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</p> | 71.70 |

Group A7—Acupuncture

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| 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; (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 | 105.55 |

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: <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (i) is located both: <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; <p style="text-align: right;">for which a direction made under subsection 19(2) of the Act applies</p> | 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: <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (i) an assessment and diagnosis of the patient’s condition; | 263.90 |

Schedule 1 General medical services table
Part 2 Services and fees

| Group A8—Consultant psychiatrist attendances to which no other item applies | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| | <ul style="list-style-type: none"> (ii) a risk assessment; (iii) treatment options and decisions; (iv) if necessary—medication recommendations; <p>(c) provides a copy of the treatment and management plan to the referring practitioner;</p> <p>(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;</p> <p>(other than attendance on a patient for whom payment has previously been made under this item or item 135, 137 or 139)</p> | |
| 291 | <p>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:</p> <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (i) prepares a written diagnosis of the patient; and (ii) prepares a written management plan for the patient that: <ul style="list-style-type: none"> (A) covers the next 12 months; and (B) is appropriate to the patient’s diagnosis; and (C) comprehensively evaluates the patient’s biological, psychological and social issues; and (D) addresses the patient’s diagnostic psychiatric issues; and (E) makes management recommendations addressing the patient’s biological, psychological and social issues; and | 452.65 |

| Group A8—Consultant psychiatrist attendances to which no other item applies | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| | (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 item 293 applies has not been provided | 282.95 |
| 296 | Professional attendance of more than 45 minutes in duration by a consultant physician in the practice of his or her speciality of | 260.30 |

Schedule 1 General medical services table
Part 2 Services and fees

| Group A8—Consultant psychiatrist attendances to which no other item applies | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| | 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 | |
| 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 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 | 43.35 |

| Group A8—Consultant psychiatrist attendances to which no other item applies | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| 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 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 | 21.60 |

Schedule 1 General medical services table

Part 2 Services and fees

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

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| 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 |
| 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, | 183.65 |

| Group A8—Consultant psychiatrist attendances to which no other item applies | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| | 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 | |
| 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 of more than 75 minutes in duration at hospital | 213.15 |
| 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 | 124.65 |

Schedule 1 General medical services table

Part 2 Services and fees

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 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 | |
| 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 practitioner—each patient | 49.30 |
| 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 | 65.45 |

| Group A8—Consultant psychiatrist attendances to which no other item applies | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| | referring practitioner—each patient | |
| 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 |
| 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 | 57.20 |

Schedule 1 General medical services table

Part 2 Services and fees

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

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| | items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient | |
| 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 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 | 231.45 |
| 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 | 282.00 |

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

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| | <p>telepsychiatry consultation of more than 75 minutes in duration, if:</p> <p>(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</p> <p>(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</p> | |
| 359 | <p>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:</p> <p>(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</p> <p>(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</p> <p>(c) during the attendance, the consultant:</p> <p>(i) uses an outcome tool (if clinically appropriate); and</p> <p>(ii) carries out a mental state examination; and</p> <p>(iii) makes a psychiatric diagnosis; and</p> <p>(iv) reviews the management plan; and</p> <p>(d) within 2 weeks after the attendance, the consultant:</p> <p>(i) prepares a written diagnosis of the patient; and</p> <p>(ii) revises the management plan; and</p> <p>(iii) gives the referring practitioner a copy of the diagnosis and the revised management plan; and</p> <p>(iv) if clinically appropriate, explains the diagnosis and the revised management plan, and gives a copy, to:</p> <p>(A) the patient; and</p> <p>(B) the patient’s carer (if any), if the patient agrees; and</p> <p>(e) the patient is located in a regional, rural or remote area; and</p> <p>(f) in the preceding 12 months, a service to which item 291 applies has been performed; and</p> <p>(g) in the preceding 12 months, a service to which this item or</p> | 325.35 |

Schedule 1 General medical services table

Part 2 Services and fees

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

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| | 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 exceeded 50 attendances in a calendar year for the patient | 43.35 |
| 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 | 133.10 |

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—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 | |
| 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 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 | 213.15 |

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 |

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

| Item | Description | Fee (\$) |
|-------------|--|--|
| 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 patient to him or her by a referring practitioner—initial attendance in a single course of treatment | 85.55 |
| 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 | 50% of the fee for item 385 or 386 |

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Part 2 Services and fees

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

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| | (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 2.12—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; (e) providing appropriate preventive health care; | 42.75 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group A13—Public health physician attendances to which no other item applies | | |
|---|---|---------------------------|
| Item | Description | Fee (\$) |
| | 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 including any of the following that are clinically relevant: (a) taking a patient history; | Amount under clause 2.1.1 |

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

| 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 | |
| 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.

Schedule 1 General medical services table
Part 2 Services and fees

| 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 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: | 137.30 |

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

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| | (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 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 | 280.85 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group A21—Emergency physician attendances to which no other item applies | | |
|---|---|-----------------|
| Item | Description | Fee (\$) |
| | 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:

Schedule 1 General medical services table

Part 2 Services and fees

- (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: <ul style="list-style-type: none">(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 performed at consulting rooms—it must be necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance | 129.80 |

| Group A11—Urgent attendances after hours | | |
|---|---|-----------------|
| Item | Description | Fee (\$) |
| 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 | 153.00 |
| 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 who 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 who:
 - (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 who 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 who 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 who 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 who:
 - (i) is a refugee or humanitarian entrant, with eligibility for Medicare; and
 - (ii) 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
 - (iii) is not an in-patient of a hospital or a care recipient in a residential aged care facility;
- (h) an Australian Defence Force Post-discharge GP Health Assessment, in accordance with clause 2.16.10A, for a patient who:
 - (i) is a former member of the Permanent Forces (within the meaning of the *Defence Act 1903*) or a former member of the Reserves (within the meaning of that Act); and
 - (ii) has not already received such an assessment.

Note: The Australian Type 2 Diabetes Risk Assessment Tool could in 2015 be viewed on the Department's website (<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 and Torres Strait Islander health practitioner 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 guide called *Get Set 4 Life—habits for healthy kids*.
- Note: The *Get Set 4 Life—habits for healthy kids* guide could in 2015 be viewed on the Department's website (<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: The Australian Type 2 Diabetes Risk Assessment Tool could in 2015 be viewed on the Department's website (<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*. These documents could in 2015 be viewed on the Royal Australian College of General Practitioners' website (<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: The *Australian Immunisation Handbook* could in 2015 be viewed on the Department's website (<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.

2.16.10A Australian Defence Force Post-discharge GP Health Assessment

- (1) An Australian Defence Force Post-discharge GP Health Assessment is an assessment of:
- (a) a patient's physical and psychological health and social function; and
 - (b) whether health care, education or other assistance should be offered to the patient to improve the patient's physical or psychological health or social function.
- (2) The assessment must be performed by the patient's usual doctor.
- (3) The assessment must not be performed in conjunction with a separate consultation in relation to the patient unless the consultation is clinically necessary.
- (4) The assessment may be performed using the ADF Post-discharge GP Health Assessment Tool.

Note 1: The ADF Post-discharge GP Health Assessment Tool could in 2015 be viewed on the Department of Veterans' Affairs' At Ease website (<http://at-ease.dva.gov.au>).

Note 2: Other assessment tools mentioned in the Department of Veterans' Affairs *Mental Health Advice Book* may be relevant. The *Mental Health Advice Book* could in 2015 be viewed on the Department of Veterans' Affairs' At Ease website (<http://at-ease.dva.gov.au>).

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- (5) The assessment must include taking a history of the patient that includes the following:
- (a) the patient's service with the Australian Defence Force, including service type, years of service, field of work, number of deployments and reason for discharge;
 - (b) the patient's social history, including relationship status, number of children (if any) and current occupation;
 - (c) the patient's current medical conditions;
 - (d) whether the patient suffers from hearing loss or tinnitus;
 - (e) the patient's use of medication, including medication prescribed by another doctor and medication obtained without a prescription;
 - (f) the patient's smoking, if applicable;
 - (g) the patient's alcohol use, if applicable;
 - (h) the patient's substance use, if applicable;
 - (i) the patient's level of physical activity;
 - (j) whether the patient has bodily pain;
 - (k) whether the patient has difficulty getting to sleep or staying asleep;
 - (l) whether the patient has psychological distress;
 - (m) whether the patient has posttraumatic stress disorder;
 - (n) whether the patient is at risk of harm to self or others;
 - (o) whether the patient has anger problems;
 - (p) the patient's sexual health;
 - (q) any other health concerns the patient has.
- (6) The assessment must also include the following:
- (a) measuring the patient's height;
 - (b) weighing the patient and ascertaining, or asking the patient, whether the patient's weight has changed in the last 12 months;
 - (c) measuring the patient's waist circumference;
 - (d) taking the patient's blood pressure;
 - (e) using information gained in the course of taking the patient's history to assess whether any further assessment of the patient's health is necessary;
 - (f) either:
-

- (i) making the further assessment mentioned in paragraph (e); or
 - (ii) referring the patient to another medical practitioner who can make the further assessment;
 - (g) documenting a strategy for improving the patient's health;
 - (h) offering to give the patient a written report of the assessment that makes recommendations for treating the patient including preventive health measures.
- (7) The doctor must keep a record of the assessment.
- (8) In this clause:
- usual doctor**, in relation to a patient, means a general practitioner employed by a medical practice:
- (a) that has provided at least 50% of the primary health care required by the patient in the last 12 months; or
 - (b) that the patient anticipates will provide at least 50% of the patient's primary health care requirements in the next 12 months.

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;

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- (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

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- (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

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- (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, Aboriginal health workers 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 | 59.35 |
| 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 | 137.90 |
| 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 | 190.30 |

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| Group A14—Health assessments | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | and physical function; and (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 | 268.80 |
| 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 | 212.25 |

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; and
- (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

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- (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 management plan) | 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 |
| 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 |

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

| Item | Column 1 | Column 2 |
|-------------|---------------------------|--|
| | Items of the table | Description of patient |
| | | (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.

2.17.10A Application of items in relation to items 721, 723 and 732

The following items do not apply to a service mentioned in the item that is provided by a medical practitioner, if the service is provided on the same day for the same patient for whom the practitioner provides a service mentioned in item 721, 723 or 732:

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- (a) items 3, 4, 23, 24, 36, 37, 44, 47, 52, 53, 54, 57, 58, 59, 60 and 65;
- (b) items 597, 598, 599 and 600;
- (c) items 5000, 5003, 5020, 5023, 5040, 5043, 5060 and 5063;
- (d) items 5200, 5203, 5207, 5208, 5220, 5223, 5227 and 5228.

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 | <ul style="list-style-type: none">(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:<ul style="list-style-type: none">(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 |
|-------------|--------------------------|---|
| 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: <ul style="list-style-type: none"> (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 | 729 | (a) either: <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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 |

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

| Item | Item of the table | Circumstances |
|-------------|--------------------------|---|
| 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) | 144.25 |
| 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) | 114.30 |

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

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| 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) | 70.40 |
| 731 | Contribution by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), to: <ul style="list-style-type: none"> (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) | 70.40 |
| 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: <ul style="list-style-type: none"> (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 | 72.05 |

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

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- (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; 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) | 70.65 |
| 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) | 120.95 |

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

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| 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) | 201.65 |
| 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 items 721 to 732 apply) | 51.90 |
| 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) | 89.00 |

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

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| 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) | 148.20 |
| 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, with a multidisciplinary team of at least 3 other formal care providers of different disciplines | 278.15 |
| 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 |

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| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| 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 |
| 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 |

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

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| 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 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 | 139.10 |

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| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| 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 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) | 48.65 |

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;

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-
- (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 the patient's consent, provides relevant clinical | 154.80 |

Group A17—Domiciliary medication management review

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| | 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 | 106.00 |

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 facility where 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 | 25.95 | 2.00 |
| 2 | 2125 | The fee for item 2100 | 46.70 | 3.30 |
| 3 | 2137 | The fee for item 2126 | 25.95 | 2.00 |
| 4 | 2138 | The fee for item 2126 | 46.70 | 3.30 |
| 5 | 2147 | The fee for item 2143 | 25.95 | 2.00 |
| 6 | 2179 | The fee for item 2143 | 46.70 | 3.30 |
| 7 | 2199 | The fee for item 2195 | 25.95 | 2.00 |
| 8 | 2220 | The fee for item 2195 | 46.70 | 3.30 |

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.

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| 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: <ul style="list-style-type: none"> (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: <ul style="list-style-type: none"> (i) is located both: <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service: <ul style="list-style-type: none"> for which a direction made under subsection 19(2) of the Act applies | 22.90 |
| 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: <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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 |

Group A30—Medical Practitioner (including a general practitioner, specialist or consultant physician) video conferencing consultation

| Item | Description | Fee (\$) |
|-------------|---|----------------------------|
| 2126 | Professional attendance at consulting rooms of less than 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: <ul style="list-style-type: none"> (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: <ul style="list-style-type: none"> (i) is located both: <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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 | 49.95 |
| 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: <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (a) is participating in a video conferencing consultation with a | 96.85 |

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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: (i) is located both: | 142.50 |

Group A30—Medical Practitioner (including a general practitioner, specialist or consultant physician) video conferencing consultation

| 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 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 occasion—each patient | Amount under table 2.18A.3 |

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Part 2 Services and fees

Group A30—Medical Practitioner (including a general practitioner, specialist or consultant physician) video conferencing consultation

| Item | Description | Fee (\$) |
|-------------|--|-------------------------------|
| 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;

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- (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.

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| 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 person | | |
| 2497 | Professional attendance at consulting rooms by a general 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 | 16.95 |
| 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 | 37.05 |
| 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 | Amount under clause 2.1.1 |

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

| Item | Description | Fee (\$) |
|-------------|--|---------------------------|
| | years | |
| 2504 | 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 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 | 71.70 |
| 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; | 105.55 |

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| 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 | 37.05 |
| 2518 | Professional attendance by a general practitioner at a place | Amount |

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

| Item | Description | Fee (\$) |
|-------------|--|---------------------------|
| | 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 | 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 | 71.70 |
| 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; 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 | Amount under clause 2.1.1 |

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

| Item | Description | Fee (\$) |
|-------------|---|---------------------------|
| | 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 | 105.55 |
| 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 |

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

| Item | Description | Fee (\$) |
|--|---|---------------------------|
| 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; (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 | 37.05 |
| 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 |

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

| Item | Description | Fee (\$) |
|-------------|--|---------------------------|
| 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 | 71.70 |
| 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: (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 | Amount under clause 2.1.1 |
| 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 | 105.55 |

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

| Item | Description | Fee (\$) |
|------|---|---------------------------|
| 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 person | | |
| 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 | 38.00 |

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| Item | Description | Fee (\$) |
|---|---|---------------------------|
| | years | |
| 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 |
| 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 | 38.00 |

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

| Item | Description | Fee (\$) |
|--|---|---------------------------|
| | 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 | |
| 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 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 |
| 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 | 38.00 |

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

| Item | Description | Fee (\$) |
|-------------|---|---------------------------|
| | medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care | |
| 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 general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care | Amount under clause 2.1.1 |
| 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

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- (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 | 25.95 | 2.00 |
| 2 | 2727 | The fee for item 2725 | 25.95 | 2.00 |

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);

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- (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

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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 | 71.70 |
| 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 | 105.55 |
| 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 | 71.70 |
| 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 | 71.70 |

| Group A20—Mental health care | | |
|---|--|----------------------------|
| Item | Description | Fee (\$) |
| 2715 | 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 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient | 91.05 |
| 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 | 134.10 |
| 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 | 92.75 |
| 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 | 132.75 |

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| Group A20—Mental health care | | |
|-------------------------------------|--|----------------------------|
| Item | Description | Fee (\$) |
| 2727 | 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 40 minutes | Amount 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 |

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| 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 |

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| Group A24—Palliative and pain medicine | | |
|---|--|-----------------|
| Item | Description | Fee (\$) |
| 2974 | 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 45 minutes | 218.75 |
| 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 |

| Group A24—Palliative and pain medicine | | |
|---|---|-----------------|
| Item | Description | Fee (\$) |
| 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 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) | 218.75 |
| 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 |

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| Group A24—Palliative and pain medicine | | |
|---|---|--|
| Item | Description | Fee (\$) |
| 3014 | 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 minor attendance after the first attendance in a single course of treatment | 43.00 |
| 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 | 110.75 |

| Group A24—Palliative and pain medicine | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| | item 3028 applies) after the first in a single course of treatment | |
| 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 |

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| Group A24—Palliative and pain medicine | | |
|---|--|-----------------|
| Item | Description | Fee (\$) |
| 3062 | 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 45 minutes | 218.75 |
| 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 |

Group A24—Palliative and pain medicine

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| 3093 | 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 45 minutes, before the patient is discharged from a hospital (H) | 218.75 |

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 person in which:

- (a) information and issues relating to pregnancy are discussed; and
 - (b) the medical practitioner does not impose his or her views or values about what the person 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 person who: | 76.60 |

Group A27—Pregnancy support counselling

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| | (a) is currently pregnant; or | |
| | (b) has been pregnant in the 12 months preceding the provision of the first service to which this item or item 81000, 81005 or 81010 applies in relation to that pregnancy | |
| 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 | 29.00 |
| 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 |

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

| Item | Description | Fee (\$) |
|-------------|---|---------------------------|
| 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 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 |
| 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 | 49.00 |
| 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 | Amount under clause 2.1.1 |

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

| Item | Description | Fee (\$) |
|-------------|---|---------------------------|
| | one occasion—each patient | |
| 5028 | Professional attendance by a general practitioner (other than 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 | Amount 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 | 83.95 |

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; (c) arranging any necessary investigation; | 117.75 |

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Group A22—General practitioner after-hours 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 | |
| 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 practitioner)—each attendance | 71.00 |

Schedule 1 General medical services table

Part 2 Services and fees

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

| Item | Description | Fee (\$) |
|-------------|---|---------------------------|
| 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 residential aged care facility on one occasion—each patient | Amount under clause 2.1.1 |
| 5263 | Professional attendance (other than a service to which | Amount |

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

| Item | Description | Fee (\$) |
|-------------|---|---------------------------|
| | 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 | 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 |

Group A26—Neurosurgery attendances to which no other item applies

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| 6009 | Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to him or her—a minor attendance after the first in a single course of treatment at consulting rooms or hospital | 43.00 |
| 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 |

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Group A26—Neurosurgery attendances to which no other item applies

| Item | Description | Fee (\$) |
|-------------|---|--|
| 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 (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 6007, 6009, 6011, 6013 or 6015 |

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 logMAR (6/12) and if that corrected acuity would be | 121.65 |

Schedule 1 General medical services table

Part 2 Services and fees

Group A9—Contact lenses

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| | 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 |

Group A9—Contact lenses

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| 10816 | Attendance for the refitting of contact lenses with keratometry and testing with trial lenses and the issue of a prescription, if the patient requires a change in contact lens material or basic lens parameters, other than simple power change, because of a structural or functional change in the eye or an allergic response within 36 months after the fitting of a contact lens to which items 10801 to 10809 apply | 121.65 |

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

2.28.1 Applications of items 10940 and 10941

- (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 Subgroup 1 of Group A10 that applies to 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.

2.28.5A Limitation of item 10944

A service mentioned in item 10944 cannot be claimed on the same occasion as a service mentioned in any of items 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915, 10916 and 10918.

2.28.5B Application of items 10945 and 10946

Items 10945 and 10946 do not apply if the patient or specialist travels to a place in order for the patient to satisfy the requirement in subparagraph (c)(i) of the item that, at the time of the attendance, the patient is at least 15 kilometres by road from the specialist.

2.28.6 Meaning of old item 10900

In the items in Group A10:

old item 10900 means item 10900 of the table as it was in force at any time before its repeal by Part 1 of Schedule 1 to the *Health Insurance Legislation Amendment (Optometric Services and Other Measures) Regulation 2014*.

Schedule 1 General medical services table
Part 2 Services and fees

| Group A10—Optometric services provided by participating optometrist | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| Subgroup 1—General | | |
| 10905 | Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if the patient has been referred by another optometrist who is not associated with the optometrist to whom the patient is referred | 66.80 |
| 10907 | Professional attendance of more than 15 minutes in duration, being the first in a course of attention if the patient has attended another optometrist for an attendance to which this item or item 10905, 10910, 10911, 10912, 10913, 10914 or 10915 applies, or to which old item 10900 applied: (a) for a patient who is less than 65 years of age—within the previous 36 months; or (b) for a patient who is at least 65 years of age—within the previous 12 months | 33.45 |
| 10910 | Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if: (a) the patient is less than 65 years of age; and (b) the patient has not, within the previous 36 months, received a service to which: (i) this item or item 10905, 10907, 10912, 10913, 10914 or 10915 applies; or (ii) old item 10900 applied | 66.80 |
| 10911 | Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if: (a) the patient is at least 65 years of age; and (b) the patient has not, within the previous 12 months, received a service to which: (i) this item, or item 10905, 10907, 10910, 10912, 10913, 10914 or 10915 applies; or (ii) old item 10900 applied | 66.80 |

Group A10—Optometric services provided by participating optometrist

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| 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: (a) for a patient who is less than 65 years of age—within 36 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10913, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied; (b) for a patient who is at least 65 years of age—within 12 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10911, 10913, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied | 66.80 |
| 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: (a) for a patient who is less than 65 years of age—within 36 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10912, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied; or (b) for a patient who is at least 65 years of age—within 12 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10911, 10912, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied | 66.80 |

Schedule 1 General medical services table
Part 2 Services and fees

| Group A10—Optometric services provided by participating optometrist | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| 10914 | Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if the patient has a progressive disorder (excluding presbyopia) requiring comprehensive reassessment: (a) for a patient who is less than 65 years of age—within 36 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10912, 10913 or 10915 applies; or (ii) old item 10900 applied; or (b) for a patient who is at least 65 years of age—within 12 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10911, 10912, 10913 or 10915 applies; or (ii) old item 10900 applied | 66.80 |
| 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 | 66.80 |
| 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) | 33.45 |
| 10918 | Professional attendance, being the second or subsequent in a course of attention and being unrelated to the prescription and fitting of contact lenses (other than a service associated with a service to which item 10940 or 10941 applies) | 33.45 |
| 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: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied For patients with myopia of 5.0 dioptres or greater (spherical equivalent) in one eye | 165.80 |

| Group A10—Optometric services provided by participating optometrist | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| 10922 | <p>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:</p> <p>(a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or</p> <p>(b) old item 10900 applied</p> <p>For patients with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in one eye</p> | 165.80 |
| 10923 | <p>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:</p> <p>(a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or</p> <p>(b) old item 10900 applied</p> <p>For patients with astigmatism of 3.0 dioptres or greater in one eye</p> | 165.80 |
| 10924 | <p>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:</p> <p>(a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or</p> <p>(b) old item 10900 applied</p> <p>For 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</p> | 209.20 |
| 10925 | All professional attendances after the first, being those | 165.80 |

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| Group A10—Optometric services provided by participating optometrist | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| | <p>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:</p> <p>(a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or</p> <p>(b) old item 10900 applied</p> <p>For patients with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents)</p> | |
| 10926 | <p>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:</p> <p>(a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or</p> <p>(b) old item 10900 applied</p> <p>For patients with corrected visual acuity of 0.7 logMAR (6/30) or worse in both eyes, being patients for whom a contact lens is prescribed as part of a telescopic system</p> | 165.80 |
| 10927 | <p>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:</p> <p>(a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or</p> <p>(b) old item 10900 applied</p> <p>For 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</p> | 209.20 |
| 10928 | <p>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</p> | 165.80 |

Group A10—Optometric services provided by participating optometrist

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| | lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied For patients who, because of physical deformity, are unable to wear spectacles | |
| 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 service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied For patients who have a medical or optical condition (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10926, 10927 or 10928 applies) requiring the use of a contact lens for correction, if the condition is specified on the patient's account | 209.20 |
| 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 | 165.80 |

Schedule 1 General medical services table
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| Group A10—Optometric services provided by participating optometrist | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| 10931 | A service to which an item in Subgroup 1 of 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 | 23.30 |
| 10932 | A service to which an item in Subgroup 1 of 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 | 11.60 |
| 10933 | A service to which an item in Subgroup 1 of 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 | 7.70 |

| Group A10—Optometric services provided by participating optometrist | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| | (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 | |
| 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 item 10916, 10918, 10931, 10932 or 10933 applies | 63.75 |
| 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 | 38.45 |
| 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 | 33.45 |

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| Group A10—Optometric services provided by participating optometrist | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| 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 | 33.45 |
| 10944 | Cornea, complete removal of embedded foreign body from— not more than once on the same day by the same participating optometrist (excluding after-care) Note: If the embedded foreign body is not completely removed, this item does not apply but item 10916 may apply. | 72.15 |
| Subgroup 2—Teleheath attendance | | |
| 10945 | A professional attendance of less than 15 minutes (whether or not continuous) by a participating optometrist that requires the provision of clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and (b) is not an admitted patient; and (c) either: (i) is located within a telehealth eligible area and, at the time of the attendance, is at least 15 kilometres by road from the specialist mentioned in paragraph (a); or (ii) is a patient of an Aboriginal Medical Service, or an Aboriginal Community Controlled Health Service, for which a direction under subsection 19(2) of the Act applies | 33.45 |
| 10946 | A professional attendance of at least 15 minutes (whether or not continuous) by a participating optometrist that requires the | 66.80 |

Group A10—Optometric services provided by participating optometrist

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| | provision of clinical support to a patient who: <ul style="list-style-type: none"> (a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and (b) is not an admitted patient; and (c) either: <ul style="list-style-type: none"> (i) is located within a telehealth eligible area and, at the time of the attendance, is at least 15 kilometres by road from the specialist mentioned in paragraph (a); or (ii) is a patient of an Aboriginal Medical Service, or an Aboriginal Community Controlled Health Service, for which a direction under subsection 19(2) of the Act applies | |
| 10947 | A professional attendance (not being a service to which any other item applies) of less than 15 minutes (whether or not continuous) by a participating optometrist that requires the provision of clinical support to a patient who: <ul style="list-style-type: none"> (a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and (b) at the time of the attendance, is located at a residential aged care facility (whether or not at consulting rooms situated within the facility); and (c) is a care recipient in the facility; and (d) is not a resident of a self-contained unit; for an attendance on one occasion—each patient | 33.45 |
| 10948 | A professional attendance (not being a service to which any other item applies) of at least 15 minutes (whether or not continuous) by a participating optometrist that requires the provision of clinical support to a patient who: <ul style="list-style-type: none"> (a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and (b) at the time of the attendance, is located at a residential aged care facility (whether or not at consulting rooms situated within the facility); and | 66.80 |

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Part 2 Services and fees

Group A10—Optometric services provided by participating optometrist

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| | (c) is a care recipient in the facility; and (d) is not a resident of a self-contained unit; for an attendance on one occasion—each patient | |

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

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- (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: <ul style="list-style-type: none">(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:<ul style="list-style-type: none">(i) is located both:<ul style="list-style-type: none">(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:<ul style="list-style-type: none">(A) an Aboriginal Medical Service; or(B) an Aboriginal Community Controlled Health Service; | 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 (\$) |
|-------------|--|-----------------|
| | 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: <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (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 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: <ul style="list-style-type: none"> (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 | 24.00 |

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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 (\$) |
|-------------|--|-----------------|
| 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;

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- (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: <ol style="list-style-type: none"> (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: <ol style="list-style-type: none"> (i) this item; and (ii) the other item in the table applying to the service | 7.20 |
| 10991 | A medical service to which an item in the table (other than this item or item 10990 or 10992) applies if: <ol style="list-style-type: none"> (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: <ol style="list-style-type: none"> (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 eligible area | 10.85 |

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Group M1—Management of bulk-billed services

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| 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 unreferral 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 | 10.85 |

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:

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- (a) for an assessment for qualification as a qualified adult sleep medicine practitioner—the Advanced Training Program in Adult Sleep Medicine; or
- (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; or
- (b) for an assessment for qualification as a qualified paediatric sleep medicine practitioner—paediatric sleep medicine.

2.34.3 Application of item 11801

Item 11801 does not apply to a service mentioned in the item if the service is undertaken in association with a service mentioned in item 11800, 11810, 11820, 11823, 11830 or 11833.

| 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 |

| Group D1—Miscellaneous diagnostic procedures and investigations | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| 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, 11005, 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices | 325.70 |
| 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 |

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| Group D1—Miscellaneous diagnostic procedures and investigations | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| 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 potentials or involving multifocal multichannel objective perimetry—one or 2 studies | 113.85 |
| 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 |

| Group D1—Miscellaneous diagnostic procedures and investigations | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 | 40.85 |

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Group D1—Miscellaneous diagnostic procedures and investigations

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| | 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 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 |

| Group D1—Miscellaneous diagnostic procedures and investigations | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| 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 item in Group I1 of the diagnostic imaging services table applies | 80.10 |
| 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 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group D1—Miscellaneous diagnostic procedures and investigations | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| 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 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 | 32.85 |
| 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 |

| Group D1—Miscellaneous diagnostic procedures and investigations | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| Subgroup 4—Respiratory | | |
| 11500 | Bronchspirometry, 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; | 138.65 |

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Part 2 Services and fees

| Group D1—Miscellaneous diagnostic procedures and investigations | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| | (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 | |
| 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 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 | 61.75 |
| 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 |

| Group D1—Miscellaneous diagnostic procedures and investigations | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| 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 or 32501 applies | 75.70 |
| 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 |

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| Group D1—Miscellaneous diagnostic procedures and investigations | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 | 127.90 |

| Group D1—Miscellaneous diagnostic procedures and investigations | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| | monitoring, the second episode is regarded as a separate service | |
| 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 after each activation, including transmission, analysis, interpretation and report—payable once in any 4 week period | 51.90 |
| 11711 | Ambulatory ECG monitoring for 12 hours or more, patient activated, single or multiple event recording, utilising a memory recording device which is capable of recording for at least 30 seconds after each activation, including transmission, analysis, interpretation and report—payable once in any 4 week period | 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 | 69.75 |

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| Group D1—Miscellaneous diagnostic procedures and investigations | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| | than 1000Hz of at least 100 QRS complexes, including analysis, interpretation and report of recording by a specialist physician or consultant physician | |
| 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, 11719, 11720, 11721, 11725 or 11726 applies | 34.75 |
| 11719 | Implanted pacemaker (including cardiac resynchronisation pacemaker) remote monitoring involving reviews (without patient attendance) of arrhythmias, lead and device parameters, if at least one remote review is provided in a 12 month period Payable only once in any 12 month period | 66.86 |
| 11720 | Implanted pacemaker testing, with patient attendance, following detection of abnormality by remote monitoring involving electrocardiography, measurement of rate, width and amplitude of stimulus, including reprogramming when required, not being a service associated with a service to which item 11718 or 11721 applies | 66.86 |
| 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, 11718, 11719, 11720, 11725 or 11726 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 (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 | 34.75 |

| Group D1—Miscellaneous diagnostic procedures and investigations | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 11725 | Implanted defibrillator (including cardiac resynchronisation defibrillator) remote monitoring involving reviews (without patient attendance) of arrhythmias, lead and device parameters, if at least 2 remote reviews are provided in a 12 month period Payable only once in any 12 month period | 189.50 |
| 11726 | Implanted defibrillator testing, with patient attendance, following detection of abnormality by remote monitoring involving electrocardiography, measurement of rate, width and amplitude of stimulus, not being a service associated with a service to which item 11727 applies | 94.75 |
| 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, 11719, 11720, 11721, 11725 or 11726 applies | 94.75 |
| Subgroup 7—Gastroenterology and colorectal | | |
| 11800 | Oesophageal motility test, manometric | 174.45 |
| 11801 | Clinical assessment of gastro-oesophageal reflux disease that involves 48-hour catheter-free wireless ambulatory oesophageal pH monitoring, including administration of the device and associated endoscopy procedure for placement, analysis and interpretation of the data and all attendances for providing the service, if: (a) a catheter-based ambulatory oesophageal pH monitoring: (i) has been attempted on the patient but failed due to clinical complications; or (ii) is not clinically appropriate for the patient due to | 263.00 |

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Group D1—Miscellaneous diagnostic procedures and investigations

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| | anatomical reasons (nasopharyngeal anatomy) preventing the use of catheter-based pH monitoring; and (b) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy (Anaes.) | |
| 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 (including administration of the capsule, associated endoscopy procedure if required for placement, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if: (a) the patient to whom the service is provided: (i) has recurrent or persistent bleeding; and (ii) is anaemic or has active bleeding; and (b) an upper gastrointestinal endoscopy and a colonoscopy have been performed on the patient and have not identified the cause of the bleeding; and (c) the service has not been provided to the same patient on more than 2 occasions in the preceding 12 months; and (d) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and (e) the service is not associated with balloon enteroscopy | 2 039.20 |
| 11823 | Capsule endoscopy to conduct small bowel surveillance of a patient diagnosed with Peutz-Jeghers Syndrome, using a capsule endoscopy device approved by the Therapeutic Goods Administration (including administration of the capsule, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if: | 2 039.20 |

| Group D1—Miscellaneous diagnostic procedures and investigations | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| | (a) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and (b) the item is performed only once in any 2 year period; and (c) the service is not associated with balloon enteroscopy | |
| 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 muscles involving electromyography or measurement of pudendal and spinal nerve motor latency | 249.75 |
| 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 |

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| Group D1—Miscellaneous diagnostic procedures and investigations | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| 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 36800 applies (Anaes.) | 428.35 |
| 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 |

| Group D1—Miscellaneous diagnostic procedures and investigations | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| 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-rh (recombinant human thyroid-stimulating hormone), and arranging services to which items 61426 and 66650 apply, for the detection of recurrent well-differentiated thyroid cancer in a patient if: <ul style="list-style-type: none"> (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: <ul style="list-style-type: none"> (i) withdrawal from thyroid hormone therapy resulted in severe psychiatric disturbances when hypothyroid; or (ii) withdrawal is medically contra-indicated because the patient has: <ul style="list-style-type: none"> (A) unstable coronary artery disease; or (B) hypopituitarism; or (C) a high risk of relapse or exacerbation of a previous severe psychiatric illness; <p>—applicable once only in a 12 month period</p> | 2 392.90 |
| 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: | 588.00 |

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| Group D1—Miscellaneous diagnostic procedures and investigations | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| | <p>(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</p> <p>(b) a technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and</p> <p>(c) the patient is referred by a medical practitioner; and</p> <p>(d) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner before the investigation; and</p> <p>(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</p> <p>(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</p> <p>For any particular patient—applicable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period</p> | |
| 12207 | <p>Overnight investigation for sleep apnoea for a period of at least 8 hours in duration, for a patient aged 18 years or more, if:</p> <p>(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</p> <p>(b) a technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and</p> <p>(c) the patient is referred by a medical practitioner; and</p> <p>(d) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner before the investigation; and</p> | 588.00 |

Group D1—Miscellaneous diagnostic procedures and investigations

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| | <p>(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</p> <p>(f) interpretation and report are provided by a qualified adult sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; if it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12203 applies for the adjustment or testing, or both, of the effectiveness of a positive pressure ventilatory support device (other than nasal continuous positive airway pressure) in sleep, in a patient with severe cardio-respiratory failure, and if previous studies have demonstrated failure of continuous positive airway pressure or oxygen—each additional investigation</p> | |
| 12210 | <p>Overnight paediatric investigation for a period of at least 8 hours in duration for a patient aged 12 years or less, if:</p> <p>(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</p> <p>(b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and</p> <p>(c) the patient is referred by a medical practitioner; and</p> <p>(d) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and</p> <p>(e) polygraphic records are analysed (for assessment of sleep</p> | 701.85 |

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Part 2 Services and fees

| Group D1—Miscellaneous diagnostic procedures and investigations | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| | <p>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</p> <p>(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</p> <p>For each particular patient—applicable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period</p> | |
| 12213 | <p>Overnight paediatric investigation for a period of at least 8 hours in duration for a patient aged between 12 and 18 years, if:</p> <p>(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</p> <p>(b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and</p> <p>(c) the patient is referred by a medical practitioner; and</p> <p>(d) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and</p> <p>(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</p> <p>(f) interpretation and report are provided by a qualified sleep</p> | 632.30 |

Group D1—Miscellaneous diagnostic procedures and investigations

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| | <p>medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient</p> <p>For each particular patient—applicable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period</p> | |
| 12215 | <p>Overnight paediatric investigation for a period of at least 8 hours in duration for a patient aged 12 years or less, if:</p> <p>(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</p> <p>(b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and</p> <p>(c) the patient is referred by a medical practitioner; and</p> <p>(d) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and</p> <p>(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</p> <p>(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;</p> <p>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</p> | 701.85 |

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Part 2 Services and fees

| Group D1—Miscellaneous diagnostic procedures and investigations | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| | 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: <ul style="list-style-type: none">(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 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 | 632.30 |

Group D1—Miscellaneous diagnostic procedures and investigations

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| | is recurring hypoxia and supplemental oxygen is required— each additional investigation | |
| 12250 | <p>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:</p> <p>(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 a high probability that the patient has obstructive sleep apnoea;</p> <p>(b) the investigation takes place after the qualified sleep medicine practitioner has:</p> <p style="padding-left: 20px;">(i) confirmed the necessity for the investigation; and</p> <p style="padding-left: 20px;">(ii) communicated this confirmation to the referring medical practitioner;</p> <p>(c) during a period of sleep, the investigation involves recording a minimum of 7 physiological parameters which must include:</p> <p style="padding-left: 20px;">(i) continuous electro-encephalogram (EEG); and</p> <p style="padding-left: 20px;">(ii) continuous electro-cardiogram (ECG); and</p> <p style="padding-left: 20px;">(iii) airflow; and</p> <p style="padding-left: 20px;">(iv) thoraco-abdominal movement; and</p> <p style="padding-left: 20px;">(v) oxygen saturation; and</p> <p style="padding-left: 20px;">(vi) 2 or more of the following:</p> <p style="padding-left: 40px;">(A) electro-oculogram (EOG);</p> <p style="padding-left: 40px;">(B) chin electro-myogram (EMG);</p> <p style="padding-left: 40px;">(C) body position;</p> <p>(d) in the report on the investigation, the qualified sleep medicine practitioner uses the data specified in paragraph (c) to:</p> <p style="padding-left: 20px;">(i) analyse sleep stage, arousals and respiratory events; and</p> <p style="padding-left: 20px;">(ii) assess clinically significant alteration in heart rate;</p> <p>(e) the qualified sleep medicine practitioner:</p> <p style="padding-left: 20px;">(i) before the investigation takes place, establishes quality assurance procedures for data acquisition; and</p> <p style="padding-left: 20px;">(ii) personally analyses the data and writes the report on</p> | 335.30 |

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Part 2 Services and fees

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| | the results of the investigation; | |
| | (f) the investigation is not provided to the patient on the same occasion as a service mentioned in any of items 11000 to 11005, 11503, 11700 to 11709, 11713 and 12203 is provided to the patient | |
| | 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, the service described in item 12250.

| 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 <i>Helicobacter pylori</i> colonisation; or (b) the monitoring of the success of eradication of <i>Helicobacter pylori</i> in patients with peptic ulcer disease; (other than a service associated with a service to which item 66900 applies) | 84.65 |

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 clause 2.37.4 and items 13200 to 13209, 13215 and 13218:

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:
 - (i) if a service mentioned in item 13212, 13215 or 13221 is provided in connection with the series of treatments—on the day after the day on which the last of those services is provided; or
 - (ii) in any other case—not more than 30 days after the day mentioned in subparagraph (a)(i) or (ii).

2.37.4 Items provided as part of treatment cycle relating to assisted reproductive services not to apply

- (1) This clause applies if:
 - (a) a service to which an item (the *first item*) in Subgroup 3 of Group T1 applies is provided to a patient during a treatment cycle; and
 - (b) a service mentioned in an item (the *second item*) (other than an item in Subgroup 3 of Group T1) is provided to the patient during the same treatment cycle; and

- (c) the service mentioned in the second item is associated with the service to which the first item applies.
- (2) The second item does not apply to the service mentioned in that 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T1—Miscellaneous therapeutic procedures | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| 13025 | Hyperbaric oxygen therapy, for treatment of decompression illness, air or gas embolism, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber greater than 3 hours, including any associated attendance—per hour (or part of an hour) | 115.70 |
| 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 |
| 13206 | Assisted reproductive technologies treatment cycle using | 465.55 |

Schedule 1 General medical services table

Part 2 Services and fees

Group T1—Miscellaneous therapeutic procedures

| Item | Description | Fee (\$) |
|-------------|---|-------------------------------|
| | 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 | |
| 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 connection with a service to which item 13200, 13201 or 13206 applies (Anaes.) | 354.45 |

| Group T1—Miscellaneous therapeutic procedures | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| 13215 | Transfer of embryos or both ova and sperm to the uterus or fallopian tubes, excluding artificial insemination—only if rendered in connection with a service to which item 13200, 13201, 13206 or 13218 applies, being services rendered in one treatment cycle (Anaes.) | 111.10 |
| 13218 | Preparation of frozen or donated embryos or donated oocytes for transfer to the uterus or fallopian tubes, by any means and including quantitative estimation of hormones and all treatment counselling but excluding artificial insemination services rendered in one treatment cycle and excluding a service to which item 13200, 13201, 13202, 13203, 13206 or 13212 applies (Anaes.) | 793.55 |
| 13221 | Preparation of semen for the purpose of artificial insemination—only if rendered in connection 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| 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 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 | Transfusion of blood including collection from donor | 119.50 |
| 13706 | Transfusion 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 volume and other parameters with continuous registered nurse attendance under the supervision of a consultant physician, | 136.65 |

Group T1—Miscellaneous therapeutic procedures

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| | 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: <ul style="list-style-type: none"> (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 |

Schedule 1 General medical services table**Part 2** Services and fees

| 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, electrocardiographic monitoring, arterial sampling, bladder | 362.10 |

| Group T1—Miscellaneous therapeutic procedures | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| | 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, management by a specialist or consultant physician who is immediately available and exclusively rostered to intensive care—on the first day (H) | 153.65 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T1—Miscellaneous therapeutic procedures | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 | 85.15 |

| Group T1—Miscellaneous therapeutic procedures | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| | infusion of more than 6 hours in duration—on each day after the first in the same continuous treatment episode | |
| 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 |
| 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 | 152.50 |

Schedule 1 General medical services table**Part 2** Services and fees**Group T1—Miscellaneous therapeutic procedures**

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| | (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.) | |
| 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), 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.) | 325.75 |
| 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 | 152.50 |

| Group T1—Miscellaneous therapeutic procedures | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| | 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.) | |
| 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 <i>National Health Act 1953</i> —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 <i>National Health Act 1953</i> | 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 agents, accessing of, other than a service associated with a service to which item 13945 applies | 52.50 |
| 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 | 97.95 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T1—Miscellaneous therapeutic procedures | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| | without re-programming a programmable pump, for the management of severe chronic spasticity | |
| 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 |
| 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 15900 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, 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 | 42.55 |
| 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 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T2—Radiation oncology | | |
|------------------------------------|---|----------------------------|
| Item | Description | Fee (\$) |
| 15115 | Radiotherapy, deep or orthovoltage—attendance at which a single dose technique is applied—2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) | Amount 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 |

| Group T2—Radiation oncology | | |
|------------------------------------|---|----------------------------|
| Item | Description | Fee (\$) |
| 15230 | Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—each attendance at which treatment is given—2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)—treatment delivered to primary site (lung) | Amount under clause 2.38.1 |
| 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 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T2—Radiation oncology | | |
|------------------------------------|--|----------------------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 | Amount under clause 2.38.1 |

| Group T2—Radiation oncology | | |
|------------------------------------|--|----------------------------|
| Item | Description | Fee (\$) |
| | maximum of 5 additional fields (rotational therapy being 3 fields)—treatment delivered to primary site (breast) | |
| 15269 | Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—each attendance at which treatment is given—2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)—treatment delivered to primary site for diseases or conditions not covered by item 15260, 15263 or 15266 | Amount under 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T2—Radiation oncology | | |
|------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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, | 745.80 |

| Group T2—Radiation oncology | | |
|------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | salivary gland, axilla, subcutaneous sites), if the volume treated involves multiple planes but does not require surgical exposure and using manual afterloading 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T2—Radiation oncology | | |
|---|---|-----------------|
| Item | Description | Fee (\$) |
| 15345 | Construction and application of a radioactive mould using a sealed source having a half-life of less than 115 days including iodine, gold, iridium or tantalum to treat intracavity, intraoral or intranasal sites | 507.80 |
| 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 |

| Group T2—Radiation oncology | | |
|------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 15512 | Radiation field setting using a diagnostic x-ray unit 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 15503 applies) | 271.10 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T2—Radiation oncology | | |
|------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 | 710.55 |

| Group T2—Radiation oncology | | |
|------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | 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 | |
| 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 | 1 120.75 |

Schedule 1 General medical services table

Part 2 Services and fees

Group T2—Radiation oncology

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| | treatment plan using one or more CT image volume datasets, with: <ul style="list-style-type: none">(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 |
|-------|--|----------|

Subgroup 7—Intraoperative radiotherapy

| | | |
|-------|--|--------|
| 15900 | Breast, malignant tumour, targeted intraoperative radiotherapy, using an intrabeam device, delivered at the time of breast-conserving surgery (partial mastectomy or lumpectomy) for a patient who: <ul style="list-style-type: none">(a) is 45 years of age or over; and(b) has a T1 or small T2 (less than or equal to 3cm in diameter) primary tumour; and(c) has a histologic grade 1 or 2 tumour; and(d) has an oestrogen-receptor positive tumour; and(e) has a node negative malignancy; and(f) is suitable for wide local excision of a primary invasive ductal carcinoma that was diagnosed as unifocal on conventional examination and imaging; and(g) has no contra-indications to breast irradiation | 250.00 |
|-------|--|--------|

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 distribution of sites of bone pain | 2 442.45 |

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.

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- (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: <ul style="list-style-type: none">(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:<ul style="list-style-type: none">(i) is located both:<ul style="list-style-type: none">(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: | 50% of the fee for item 16401, 16404, 16406, 16500, 16590 or 16591 |

| Group T4—Obstetrics | | |
|----------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | (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 | |
| 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 |

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| Group T4—Obstetrics | | |
|----------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 16501 | External cephalic version for breech presentation, after 36 weeks, if no contraindication exists, in a unit with facilities for caesarean section, including pre and post version CTG, with or without tocolysis, other than a service to which items 55718 to 55728 and 55768 to 55774 apply—chargeable whether or not the version is successful and limited to a maximum of 2 ECVs per pregnancy | 140.55 |
| 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 |

| Group T4—Obstetrics | | |
|----------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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; | 1 629.35 |

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| Group T4—Obstetrics | | |
|----------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | (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; (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 |

| Group T4—Obstetrics | | |
|----------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 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 | 142.65 |
| 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 |

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| Group T4—Obstetrics | | |
|----------------------------|---|----------------------------|
| Item | Description | Fee (\$) |
| 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, 16603, 16618, 16621 and 16624 | Amount 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 |

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| Group T6—Examination by anaesthetist | | |
|---|--|-----------------|
| Item | Description | Fee (\$) |
| 17610 | Professional attendance by a medical practitioner in the practice of anaesthesia for a brief consultation involving a 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) | 43.00 |
| 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 |

| Group T6—Examination by anaesthetist | | |
|---|--|-----------------|
| Item | Description | Fee (\$) |
| 17640 | Professional attendance by a specialist anaesthetist in the practice of anaesthesia, if the patient is referred to him or 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) | 43.00 |
| 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 |

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Group T6—Examination by anaesthetist

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| 17690 | A medical service in association with an item in the range 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) | 39.55 |

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 |

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| Group T7—Regional or field nerve blocks | | |
|--|---|----------------------------|
| Item | Description | Fee (\$) |
| 18219 | Intrathecal or epidural infusion of a therapeutic substance, initial injection or commencement of, if continuous attendance by the medical practitioner extends beyond the first hour (Anaes.) | Amount under 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 |

| Group T7—Regional or field nerve blocks | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| 18236 | Trigeminal nerve, peripheral branch of, injection of an anaesthetic agent (Anaes.) | 62.50 |
| 18238 | Facial nerve, injection of an anaesthetic agent, other than a service associated with a service to which item 18240 applies | 37.65 |
| 18240 | Retrolbulbar 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 or dorsal nerve (or both), 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 |

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| Group T7—Regional or field nerve blocks | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| 18276 | Paravertebral nerves, injection of an anaesthetic agent, (multiple levels) | 124.85 |
| 18278 | Sciatic nerve, injection of an anaesthetic agent | 88.65 |
| 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 a service to which item 18354 applies (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 Supply of botulinum toxin

- (1) A service mentioned in any of items 18350 to 18379 does not include the supply of the botulinum toxin to which the service relates.
- (2) Items 18350 to 18354, 18361, 18362 and 18369 to 18379 do not apply to an injection of botulinum toxin if the botulinum toxin is not supplied under the pharmaceutical benefits scheme.

2.42A.2 Limitation of certain items

- (1) A service mentioned in item 18360 or 18365 is applicable to the first 4 treatments, not exceeding 2 for each limb, on any one day.
- (2) Items 18360, 18365, 18366 and 18368 apply only to a service provided by a specialist or consultant physician in the practice of his or her speciality.

| Group T11—Botulinum toxin | | |
|----------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 18350 | Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of hemifacial spasm in a patient who is at least 12 years of age, including all such injections on any one day | 124.85 |
| 18351 | Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport), injection of, for the treatment of hemifacial spasm in a patient who is at least 18 years of age, including all such injections on any one day | 124.85 |
| 18353 | Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of cervical dystonia (spasmodic torticollis), including all such injections on any one day | 249.75 |

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| Group T11—Botulinum toxin | | |
|----------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 18354 | Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport), injection of, for the treatment of dynamic equinus foot deformity (including equinovarus and equinovulgus) due to spasticity in an ambulant cerebral palsy patient, if: (a) the patient is at least 2 years of age; and (b) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each lower limb), including all injections per set (Anaes.) | 124.85 |
| 18360 | Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of moderate to severe focal spasticity if: (a) the patient is at least 18 years of age; and (b) the spasticity is associated with a previously diagnosed neurological disorder; and (c) the treatment is provided as: (i) second line therapy when standard treatment for the condition has failed; or (ii) an adjunct to physical therapy; and (d) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each limb), including all injections per set; and (e) the treatment is not provided on the same occasion as a service mentioned in item 18365 | 124.85 |
| 18361 | Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of moderate to severe upper limb spasticity due to cerebral palsy if: (a) the patient is at least 2 years of age; and (b) for a patient who is at least 18 years of age—before the patient turned 18, the patient had commenced treatment for the spasticity with botulinum toxin supplied under the pharmaceutical benefits scheme; and | 124.85 |

| Group T11—Botulinum toxin | | |
|----------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | (c) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set (Anaes.) | |
| 18362 | Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of severe primary axillary hyperhidrosis, including all such injections on any one day, if: (a) the patient is at least 12 years of age; and (b) the patient has been intolerant of, or has not responded to, topical aluminium chloride hexahydrate; and (c) the patient has not had treatment with botulinum toxin within the immediately preceding 4 months; and (d) if the patient has had treatment with botulinum toxin within the previous 12 months—the patient had treatment on no more than 2 separate occasions (Anaes.) | 246.70 |
| 18365 | Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of moderate to severe spasticity of the upper limb following a stroke, if: (a) the patient is at least 18 years of age; and (b) treatment is provided as: (i) second line therapy when standard treatment for the condition has failed; or (ii) an adjunct to physical therapy; and (c) the patient does not have established severe contracture in the limb that is to be treated; and (d) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set; and (e) for a patient who has received treatment on 2 previous separate occasions—the patient has responded to the | 124.85 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T11—Botulinum toxin | | |
|----------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | treatment | |
| 18366 | Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of strabismus, including all such injections on any one day and associated electromyography (Anaes.) | 156.40 |
| 18368 | Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of spasmodic dysphonia, including all such injections on any one day | 267.05 |
| 18369 | Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of unilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.) | 45.05 |
| 18370 | Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for unilateral blepharospasm in a patient who is at least 12 years of age, including all such injections on any one day (Anaes.) | 45.05 |
| 18372 | Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of bilateral blepharospasm, in a patient who is at least 12 years of age, including all such injections on any one day (Anaes.) | 124.85 |
| 18374 | Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of bilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.) | 124.85 |
| 18375 | Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), intravesical injection of, with cystoscopy, for the treatment of urinary incontinence, including all such injections on any one day, if: (a) the urinary incontinence is due to neurogenic detrusor overactivity as demonstrated by urodynamic study of a patient with: (i) multiple sclerosis; or (ii) spinal cord injury; or (iii) for a patient who is at least 18 years of age—spina bifida; and | 229.85 |

Group T11—Botulinum toxin

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| | <p>(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; and</p> <p>(c) the patient is willing and able to self-catheterise; and</p> <p>(d) the treatment is not provided on the same occasion as a service mentioned in item 104, 105, 110, 116, 119, 11900 or 11919</p> <p>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</p> <p>(H) (Anaes.)</p> | |
| 18377 | <p>Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of chronic migraine, including all injections in one day, if:</p> <p>(a) the patient is at least 18 years of age; and</p> <p>(b) the patient has experienced an inadequate response, intolerance or contraindication to at least 3 prophylactic migraine medications before commencement of treatment with botulinum toxin, as manifested by an average of 15 or more headache days per month, with at least 8 days of migraine, over a period of at least 6 months, before commencement of treatment with botulinum toxin</p> <p>For each patient—applicable not more than twice except if the patient achieves and maintains at least a 50% reduction in the number of headache days per month from baseline after 2 treatment cycles (each of 12 weeks duration)</p> | 124.85 |
| 18379 | <p>Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), intravesial injection of, with cystoscopy, for the treatment of urinary incontinence, including all such injections on any one day, if:</p> <p>(a) the urinary incontinence is due to idiopathic overactive bladder in a patient; and</p> <p>(b) the patient is at least 18 years of age; and</p> | 229.85 |

Schedule 1 General medical services table

Part 2 Services and fees

Group T11—Botulinum toxin

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| | (c) the patient has urinary incontinence that is inadequately controlled by at least 2 alternative anti-cholinergic agents, as manifested by having experienced at least 14 episodes of urinary incontinence per week before commencement of treatment with botulinum toxin; and | |
| | (d) the patient is willing and able to self-catheterise; and | |
| | (e) treatment is not provided on the same occasion as a service mentioned in item 104, 105, 110, 116, 119, 11900 or 11919 | |
| | For each patient—applicable not more than once except if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment | |
| | (H) (Anaes.) | |

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 another item in this Subgroup applies | 118.80 |

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| Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide) | | |
|---|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 20225 | Initiation of the management of anaesthesia for all cranial | 237.60 |

| Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide) | | |
|---|--|-----------------|
| Item | Description | Fee (\$) |
| | bone procedures | |
| 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 Subgroup applies | 59.40 |
| 20401 | Initiation of the management of anaesthesia for procedures | 79.20 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide) | | |
|---|---|-----------------|
| Item | Description | Fee (\$) |
| | on the breast, other than a service to which another item in this Subgroup applies | |
| 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 thoracoplasty | 198.00 |
| 20474 | Initiation of the management of anaesthesia for radical procedures on chest wall | 257.40 |

| Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide) | | |
|---|---|-----------------|
| Item | Description | Fee (\$) |
| 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 chest | 396.00 |
| 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 | 198.00 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide) | | |
|---|---|-----------------|
| Item | Description | Fee (\$) |
| | service to which another item in this Subgroup applies | |
| 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 |
| 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 |

**Group T10—Anaesthesia performed in connection with certain services
(Relative Value Guide)**

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| 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 cholecystectomy, gastrectomy, laparoscopic nephrectomy or bowel shunts | 158.40 |
| 20791 | Initiation of the management of anaesthesia for bariatric surgery in a patient with clinically severe obesity | 198.00 |

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| Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide) | | |
|---|--|-----------------|
| Item | Description | Fee (\$) |
| 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 intestinal endoscopic procedures | 79.20 |
| 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 | 99.00 |

**Group T10—Anaesthesia performed in connection with certain services
(Relative Value Guide)**

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| | on the skin, its derivatives or subcutaneous tissue of the lower posterior abdominal wall | |
| 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 |
| 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 | 118.80 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide) | | |
|---|--|-----------------|
| Item | Description | Fee (\$) |
| | extraperitoneal procedures in lower abdomen, including those on the urinary tract, other than a service to which another item in this Subgroup applies | |
| 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, other than a service to which another item in this Subgroup applies | 59.40 |
| 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 | 138.60 |

**Group T10—Anaesthesia performed in connection with certain services
(Relative Value Guide)**

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| | prostatectomy or radical vulvectomy | |
| 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 urethrocytscopy), 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, unilateral or bilateral | 79.20 |
| 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 | 158.40 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide) | | |
|---|--|-----------------|
| Item | Description | Fee (\$) |
| | amputation of penis with bilateral inguinal and iliac lymphadenectomy | |
| 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 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 of inverted uterus | 198.00 |
| 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 | 138.60 |

**Group T10—Anaesthesia performed in connection with certain services
(Relative Value Guide)**

| Item | Description | Fee (\$) |
|---------------------------------------|--|-----------------|
| | procedures in the management of post partum haemorrhage, if the blood loss is greater than 500 mls | |
| 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 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide) | | |
|---|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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, | 158.40 |

**Group T10—Anaesthesia performed in connection with certain services
(Relative Value Guide)**

| Item | Description | Fee (\$) |
|--|--|-----------------|
| | other than a service to which another item in this Subgroup applies | |
| 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 theatre of a hospital | 59.40 |
| 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 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide) | | |
|---|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 | 79.20 |

**Group T10—Anaesthesia performed in connection with certain services
(Relative Value Guide)**

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| | arthroscopic procedure of ankle joint | |
| 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 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide) | | |
|---|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 | 198.00 |

**Group T10—Anaesthesia performed in connection with certain services
(Relative Value Guide)**

| Item | Description | Fee (\$) |
|--|---|-----------------|
| | axillary-femoral bypass graft | |
| 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 tenotomy of the upper arm or elbow | 99.00 |
| 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 |

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Part 2 Services and fees

| Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide) | | |
|---|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 | 79.20 |

**Group T10—Anaesthesia performed in connection with certain services
(Relative Value Guide)**

| Item | Description | Fee (\$) |
|--|--|-----------------|
| | arthroscopic procedures of the wrist joint | |
| 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 |
| 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 | 178.20 |

Schedule 1 General medical services table

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| Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide) | | |
|---|---|-----------------|
| Item | Description | Fee (\$) |
| | total body surface | |
| 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 the area of burn involves 70% or more but less than 80% of total body surface | 376.20 |
| 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 | 99.00 |

**Group T10—Anaesthesia performed in connection with certain services
(Relative Value Guide)**

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| | procedure for discography—lumbar or thoracic | |
| 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 |
| 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 | 198.00 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide) | | |
|---|--|-----------------|
| Item | Description | Fee (\$) |
| | ablation | |
| 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 |
| 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 |

**Group T10—Anaesthesia performed in connection with certain services
(Relative Value Guide)**

| Item | Description | Fee (\$) |
|---|---|-----------------|
| 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 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 | 79.20 |
| 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 fiberoptic 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 | 59.40 |

Schedule 1 General medical services table

Part 2 Services and fees

**Group T10—Anaesthesia performed in connection with certain services
(Relative Value Guide)**

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| | 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 | |
| 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 |
| 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 |

| Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide) | | |
|---|---|-----------------|
| Item | Description | Fee (\$) |
| 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 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 | 39.60 |
| 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 or field nerve block peri-operatively performed in the induction room, theatre or recovery room, for the control of post operative pain, via the brachial plexus in conjunction with shoulder surgery | 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 | 237.60 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide) | | |
|---|---|-----------------|
| Item | Description | Fee (\$) |
| | equivalent, other than a service associated with anaesthesia to which an item in Subgroup 21 applies | |
| 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 (b) not a service associated with a service to which an item in Subgroup 21 applies | 198.00 |
| 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 | 39.60 |

**Group T10—Anaesthesia performed in connection with certain services
(Relative Value Guide)**

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| | more than 25 minutes but not more than 30 minutes | |
| 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 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide) | | |
|---|--|-----------------|
| Item | Description | Fee (\$) |
| 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 more than 2:30 hours but not more than 2:40 hours | 237.60 |
| 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 |

**Group T10—Anaesthesia performed in connection with certain services
(Relative Value Guide)**

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| 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 |
| 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 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide) | | |
|---|--|-----------------|
| Item | Description | Fee (\$) |
| 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 more than 8:00 hours but not more than 8:10 hours | 891.00 |
| 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 |

**Group T10—Anaesthesia performed in connection with certain services
(Relative Value Guide)**

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| 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 |
| 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 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide) | | |
|---|--|-----------------|
| Item | Description | Fee (\$) |
| 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 more than 13:30 hours but not more than 13:40 hours | 1 544.40 |
| 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 |

**Group T10—Anaesthesia performed in connection with certain services
(Relative Value Guide)**

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| 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 than 15:40 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 |
| 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 |

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| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| 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 more than 19:00 hours but not more than 19:10 hours | 2 197.80 |
| 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 |

**Group T10—Anaesthesia performed in connection with certain services
(Relative Value Guide)**

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| 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 |
| 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 |

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Part 2 Services and fees

| Item | Description | Fee (\$) |
|--|--|-----------------|
| 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 which is a constant threat to life (equivalent to ASA physical status indicator 4) | 39.60 |
| 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 |

**Group T10—Anaesthesia performed in connection with certain services
(Relative Value Guide)**

| Item | Description | Fee (\$) |
|-------------|--------------------|-----------------|
|-------------|--------------------|-----------------|

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 |
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| | | |
|-------|---|----------------------------|
| 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 |
|-------|---|----------------------------|

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 lymphoscintigraphy 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, 60010, 60072, 60073, 60075, 60076, 60078 or 60079 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 this Group would have applied had the procedure not been discontinued on medical grounds | Amount 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 30026 | Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, not on face or neck, small (not more than 7 cm long), superficial, other than a service to which another item in Group T4 applies (Anaes.) | 52.20 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 30048 | Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, large (more than 7 cm long), involving deeper tissue (G) (Anaes.) | 149.75 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 30075 | 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 (S) (Anaes.) | 149.75 |
| 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, 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 |
| 30103 | Sinus, excision of, involving muscle and deep tissue (S) | 183.90 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | (Anaes.) | |
| 30104 | Pre-auricular sinus, excision of, on a person 10 years of age or over (Anaes.) | 126.90 |
| 30105 | Pre-auricular sinus, excision of, on a person under 10 years of age (Anaes.) | 164.95 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 30177 | Lipectomy—radical abdominoplasty (Pitanguy type or similar) with excision of skin and subcutaneous tissue, repair of musculo-aponeurotic layer and transposition of 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.) | 985.70 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 (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.) | 63.50 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 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.) | 109.80 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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, on a person 10 years of age or over (Anaes.) (Assist.) | 397.85 |
| 30287 | Branchial cyst, removal of, on a person under 10 years of age (Anaes.) (Assist.) | 517.20 |
| 30289 | Branchial fistula, removal of, on a person 10 years of age or over (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 | 509.95 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | applies (H) (Anaes.) (Assist.) | |
| 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 |
| 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, on a person 10 years of age or over (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 |
| 30326 | Thyroglossal cyst or fistula or both, radical removal of, including thyroglossal duct and portion of hyoid bone, on a | 594.60 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | person under 10 years of age (H) (Anaes.) (Assist.) | |
| 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 |
| 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 or drainage of pancreas, on a person 10 years of age or over (H) (Anaes.) (Assist.) | 521.25 |
| 30376 | Laparotomy involving division of peritoneal adhesions (if no other intra-abdominal procedure is performed), on a person 10 years of age or over (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, on a person 10 years of age or over (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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 30390 | Laparoscopy, diagnostic, on a person 10 years of age or over, 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.) | 319.60 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | (Assist.) | |
| 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 |
| 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 | 817.10 |

General medical services table **Schedule 1**
Services and fees **Part 2**

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | item 50950 or 50952 applies (Anaes.) (Assist.) | |
| 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 |
| 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 | 526.40 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | to which item 30451 applies (Anaes.) (Assist.) | |
| 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 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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) (Anaes.) (Assist.) | 862.50 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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, caecostomy antegrade enema device (chait etc.) or stomal indwelling device, non-endoscopic insertion of, or non-endoscopic replacement of, on a person 10 years of age or over (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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 when performed), using interventional imaging techniques (H) (Anaes.) | 787.30 |
| 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 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 service to which any of items 31569 to 31581 apply (H) (Anaes.) (Assist.) | 987.50 |
| 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 | 1 071.00 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | without closure of the diaphragmatic hiatus, by laparoscopy or open operation (H) (Anaes.) (Assist.) | |
| 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 the neck or chest—one surgeon (H) (Anaes.) (Assist.) | 1 720.90 |
| 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, | 943.80 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | (abdominal and thoracic mobilisation with thoracic anastomosis)—conjoint surgery, co-surgeon (Assist.) | |
| 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 (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck)—conjoint surgery, principal surgeon (including after-care) (H) (Anaes.) (Assist.) | 1 423.15 |
| 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 | Enterostomy or colostomy, closure of (not involving resection of bowel), on a person 10 years of age or over (H) (Anaes.) (Assist.) | 595.00 |
| 30563 | Colostomy or ileostomy, refashioning of, on a person 10 years of age or over (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, on a person 10 years of age or over (H) (Anaes.) (Assist.) | 967.85 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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, on a person 10 years of age or over, other than a service to which item 30574 applies (H) (Anaes.) (Assist.) | 445.40 |
| 30572 | Laparoscopic appendicectomy, on a person 10 years of age or over (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) | 1 251.10 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | (Anaes.) (Assist.) | |
| 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 |
| 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, on a person 10 years of age or over, 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 |
| 30608 | Small intestine, resection of, with anastomosis, on a person under 10 years of age (H) (Anaes.) (Assist.) | 1 258.20 |
| 30609 | Femoral or inguinal hernia, laparoscopic repair of, other than a service associated with a service to which item 30614 applies (H) (Anaes.) (Assist.) | 464.50 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 30611 | Benign tumour of soft tissue (other than tumours of skin, cartilage and bone, simple lipomas covered by item 31345 and lipomata), removal of, by surgical excision, on a person under 10 years of age, if the specimen excised is sent for histological confirmation of diagnosis, other than a service to which another item in this Group applies (Anaes.) (Assist.) | 563.35 |
| 30614 | Femoral or inguinal hernia or infantile hydrocele, repair of, on a person 10 years of age or over, other than a service to which item 30403 or 30615 applies (H) (Anaes.) (Assist.) | 464.50 |
| 30615 | Strangulated, incarcerated or obstructed hernia, repair of, without bowel resection, on a person 10 years of age or over (H) (Anaes.) (Assist.) | 521.25 |
| 30618 | Lymph nodes of neck, selective dissection of one or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck, on a person under 10 years of age (Anaes.) (Assist.) | 522.25 |
| 30619 | Laparoscopic splenectomy, on a person under 10 years of age (H) (Anaes.) (Assist.) | 936.25 |
| 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 |
| 30622 | Caecostomy, enterostomy, colostomy, enterotomy, colotomy, cholecystostomy, gastrostomy, gastrotomy, reduction of intussusception, removal of Meckel's diverticulum, suture of perforated peptic ulcer, simple repair of ruptured viscus, reduction of volvulus, pyloroplasty or drainage of pancreas, on a person under 10 years of age (H) (Anaes.) (Assist.) | 677.65 |
| 30623 | Laparotomy involving division of peritoneal adhesions (if no other intra-abdominal procedure is performed), on a person under 10 years of age (H) (Anaes.) (Assist.) | 677.65 |
| 30626 | Laparotomy involving division of adhesions in association with another intra-abdominal procedure if the time taken to divide the adhesions is between 45 minutes and 2 hours, on a person under 10 years of age (H) (Anaes.) (Assist.) | 680.80 |

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| Item | Description | Fee (\$) |
| 30627 | Laparoscopy, diagnostic, other than a service associated with another laparoscopic procedure, on a person under 10 years of age (H) (Anaes.) | 285.95 |
| 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 |
| 30636 | Gastrostomy button, caecostomy antegrade enema device (chait etc.) or stomal indwelling device, non-endoscopic insertion of, or non-endoscopic replacement of, on a person under 10 years of age (Anaes.) | 233.15 |
| 30637 | Enterostomy or colostomy, closure of (not involving resection of bowel), on a person under 10 years of age (H) (Anaes.) (Assist.) | 773.50 |
| 30638 | Orchidectomy, simple or subcapsular, unilateral with or without insertion of testicular prosthesis (G) (H) (Anaes.) (Assist.) | 299.45 |
| 30639 | Colostomy or ileostomy, refashioning of, on a person under 10 years of age (Anaes.) (Assist.) | 773.50 |
| 30641 | Orchidectomy, simple or subcapsular, unilateral with or without insertion of testicular prosthesis (S) (H) (Anaes.) (Assist.) | 407.50 |
| 30643 | Exploration of spermatic cord, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis, on a person under 10 years of age (H) (Anaes.) (Assist.) | 677.65 |
| 30644 | Exploration of spermatic cord, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis, on a person 10 years of age or over (H) (Anaes.) (Assist.) | 521.25 |

| Group T8—Surgical operations | | |
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| Item | Description | Fee (\$) |
| 30645 | Appendicectomy, on a person under 10 years of age, other than a service to which item 30574 applies (H) (Anaes.) (Assist.) | 579.00 |
| 30646 | Laparoscopic appendicectomy, on a person under 10 years of age (H) (Anaes.) (Assist.) | 579.00 |
| 30649 | Haemorrhage, arrest of, following circumcision requiring general anaesthesia, on a person under 10 years of age (Anaes.) | 187.65 |
| 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, on a person 10 years of age or over (Anaes.) | 144.35 |
| 30666 | Paraphimosis or phimosis, reduction of, under general anaesthesia, with or without dorsal incision, other than a service associated with a service to which another item in this Group applies (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 | 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 | 1 170.00 |

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| | (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.) | |
| 30682 | Balloon enteroscopy, examination of the small bowel (anal approach), with or without biopsy, without intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding if the patient: (a) has recurrent or persistent bleeding; and (b) is anaemic or has active bleeding; and (c) has had an upper gastrointestinal endoscopy and a colonoscopy performed that did not identify the cause of the bleeding; not in association with another item in this Subgroup (other than item 30680 or 30684) (Anaes.) | 1 170.00 |
| 30684 | Balloon enteroscopy, examination of the small bowel (oral approach), with or without biopsy, with one or more of the following procedures—snare polypectomy, removal of foreign body, diathermy, heater probe, laser coagulation or argon plasma coagulation, for diagnosis and management of patients with obscure gastrointestinal bleeding if the patient: (a) has recurrent or persistent bleeding; and (b) is anaemic or has active bleeding; and (c) has had an upper gastrointestinal endoscopy and a colonoscopy performed that did not identify the cause of the bleeding; not in association with another item in this Subgroup (other than item 30682 or 30686) (Anaes.) | 1 439.85 |
| 30686 | Balloon enteroscopy, examination of the small bowel (anal approach), with or without biopsy, with one or more of the following procedures—snare polypectomy, removal of foreign body, diathermy, heater probe, laser coagulation or argon plasma coagulation, for diagnosis and management | 1 439.85 |

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| Item | Description | Fee (\$) |
| | 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.) | |
| 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 |
| 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, | 563.30 |

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| | 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.) | |
| 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 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.) | 563.30 |
| 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 | 871.30 |

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| Item | Description | Fee (\$) |
| | excised tissue, and histological examination of all excised tissue by the specialist performing the procedure—13 or more sections (Anaes.) | |
| 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 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.) | 95.45 |
| 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 | 123.10 |

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| Item | Description | Fee (\$) |
| | malignant tumour covered by any of items 31300 to 31335 (other than a service to which item 30195 applies) (Anaes.) | |
| 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 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.) | 214.55 |
| 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 | 381.30 |

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| Item | Description | Fee (\$) |
| | <p>than by shave excision); and</p> <p>(c) all of the specimens excised are sent for histological examination;</p> <p>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.)</p> | |
| 31230 | <p>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.)</p> | 168.05 |
| 31235 | <p>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:</p> <p>(a) the lesion size is not more than 10 mm in diameter; and</p> <p>(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</p> <p>(c) the specimen excised is sent for histological examination;</p> <p>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.)</p> | 143.55 |
| 31240 | <p>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</p> | 168.05 |

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| Item | Description | Fee (\$) |
| | histological examination (other than a service to which item 30195 applies) (Anaes.) | |
| 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 (c) the initial specimen removed is sent for histological examination and malignancy is confirmed (Anaes.) | 221.35 |
| 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 | 221.35 |

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| Item | Description | Fee (\$) |
| | 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.) | |
| 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 (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.) | 221.35 |
| 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 | 315.65 |

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| | (c) the removal is by surgical excision (other than shave excision) and suture; and (d) the specimen excised is sent for histological examination (Anaes.) | |
| 31262 | Basal cell carcinoma or squamous cell carcinoma, residual, removal of, from nose, eyelid, lip, ear, digit or genitalia, 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; 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 |
| 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 | 184.50 |

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| Item | Description | Fee (\$) |
| | (c) the initial specimen removed is sent for histological examination and malignancy is confirmed (Anaes.) | |
| 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 (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 |
| 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 |

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| 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: (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.) | 258.25 |
| 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 |

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| Item | Description | Fee (\$) |
| 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 |
| 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 | 299.25 |

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| Item | Description | Fee (\$) |
| | (c) the initial specimen removed is sent for histological examination and malignancy is confirmed (Anaes.) | |
| 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 (Anaes.) | 299.25 |
| 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 |

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| Item | Description | Fee (\$) |
| 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 (Anaes.) | 155.85 |
| 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 |

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| 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: (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.) | 156.40 |
| 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 |

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|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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: (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.) | 212.95 |
| 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 | 212.95 |

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|-------------------------------------|--|-----------------|
| 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 (Anaes.) | |
| 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 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.) | 245.90 |
| 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 | 245.90 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | <p>the practitioner who removed the previous carcinoma; and</p> <p>(c) the removal is by surgical excision (other than shave excision) and suture; and</p> <p>(d) the specimen excised is sent for histological examination</p> <p>(Anaes.)</p> | |
| 31293 | <p>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:</p> <p>(a) the carcinoma is more than 20 mm in diameter; and</p> <p>(b) the removal is by surgical excision (other than shave excision) and suture; and</p> <p>(c) the specimen excised is sent for histological examination and malignancy is confirmed</p> <p>(Anaes.)</p> | 245.90 |
| 31295 | <p>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:</p> <p>(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</p> <p>(b) the removal is performed by:</p> <p style="padding-left: 20px;">(i) a specialist in the practice of his or her specialty; or</p> <p style="padding-left: 20px;">(ii) a practitioner other than the practitioner who removed the previous carcinoma; and</p> <p>(c) the removal is by surgical excision and suture; and</p> <p>(d) the specimen excised is sent for histological examination and malignancy is confirmed</p> <p>(Anaes.)</p> | 292.85 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 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.) | 393.50 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 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.) | 393.50 |
| 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 | 270.55 |

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| Group T8—Surgical operations | | |
|-------------------------------------|--|----------------------------|
| Item | Description | Fee (\$) |
| | (Anaes.) | |
| 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 | 319.90 |
| | (Anaes.) | |
| 31335 | Malignant melanoma, appendageal carcinoma, malignant fibrous tumour of skin, merkel cell carcinoma of skin or Hutchinson's melanotic freckle-removal from areas of the body not covered by items 31305 and 31320, 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 | 369.00 |
| | (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 | Amount under clause 2.44.5 |
| | (Anaes.) | |
| 31345 | Lipoma, removal of, by surgical excision or liposuction, if: (a) the lesion is: | 210.95 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | (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.) | |
| 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, on a person 10 years of age or over, if the specimen excised is sent for histological confirmation of diagnosis, other than a service to which another item in this Group applies (Anaes.) (Assist.) | 433.35 |
| 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 | 502.15 |

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| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | mm in diameter (excluding tumour of the lip), excision of, if histological confirmation of malignancy has been obtained (Anaes.) (Assist.) | |
| 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, on a person 10 years of age or over (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 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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, including any associated imaging services (H) (Anaes.) (Assist.) | 357.00 |
| 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, on a person 10 years of age or over (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) | 1 169.80 |

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| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | (Anaes.) (Assist.) | |
| 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 |
| 31515 | Breast, tumour site, re-excision of, following open biopsy or incomplete excision of malignant tumour (H) (Anaes.) (Assist.) | 436.15 |
| 31516 | Breast, malignant tumour, complete local excision of, with or without frozen section histology when targeted intraoperative radiotherapy (using an intrabeam device) is performed concurrently, if the patient satisfies the requirements mentioned in paragraphs (a) to (g) of item 15900 (Anaes.) (Assist.) | 867.00 |
| 31519 | Breast, total mastectomy (H) (Anaes.) (Assist.) | 736.05 |
| 31524 | Breast, subcutaneous mastectomy (H) (Anaes.) (Assist.) | 1 040.25 |
| 31525 | Breast, mastectomy for gynecomastia, with or without liposuction (suction assisted lipolysis), not being a service associated with a service to which item 45585 applies (H) (Anaes.) (Assist.) | 520.00 |
| 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, | 595.65 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | other than a service associated with a service to which item 31539, 31545 or 31548 applies | |
| 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 a bore-enbloc stereotactic biopsy, 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 to which item 31530, 31536 or 31548 applies (H) (Anaes.) | 398.80 |
| 31542 | Breast, initial guidewire localisation of lesion, by hookwire or similar device, conducted by a qualified radiologist, using interventional imaging techniques before a bore-enbloc stereotactic biopsy, 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 a bore-enbloc stereotactic biopsy, 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, | 216.75 |

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| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | exploration and drainage of, when performed in the operating theatre of a hospital, excluding after-care (Anaes.) | |
| 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 |
| 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 |

Group T8—Surgical operations

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| 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

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- (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 | 1 299.55 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | 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.) | |
| 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 surgeon (H) (Anaes.) (Assist.) | 1 852.50 |
| 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 | 1 965.65 |

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|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | region and is 6 cm or less from the anal verge (H) (Anaes.) (Assist.) | |
| 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 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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, abdominal surgeon (including after-care) (H) (Anaes.) (Assist.) | 2 126.20 |
| 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 fiberoptic sigmoidoscopy or fiberoptic colonoscopy up to the hepatic flexure, with or without biopsy (Anaes.) | 111.35 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 32087 | Endoscopic examination of the colon up to the hepatic flexure by flexible fiberoptic sigmoidoscopy or fiberoptic 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 | Fiberoptic 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 fiberoptic 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 (Anaes.) | 469.20 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 operation) (H) (Anaes.) (Assist.) | 999.65 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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) (Anaes.) | 70.10 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 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.) | 593.55 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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—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.) | 109.80 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 recurrent veins in the same territory—one leg—including excision or injection of either tributaries or incompetent perforating veins, or both (H) (Anaes.) (Assist.) | 926.80 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 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, | 533.60 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | 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 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 re-implantation of arteries (Anaes.) (Assist.) | 2 436.50 |
| 33112 | Suprarenal abdominal aortic aneurysm, replacement by graft including re-implantation of arteries (H) (Anaes.) (Assist.) | 2 113.10 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 33145 | Ruptured thoracic aortic aneurysm, replacement by graft (H) (Anaes.) (Assist.) | 2 549.20 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 33506 | Innominate or subclavian artery, endarterectomy of, including closure by suture (H) (Anaes.) (Assist.) | 1 270.90 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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.) (Assist.) | 1 090.35 |
| 33827 | Major artery or vein of neck, repair of wound of, with restoration of continuity, by direct anastomosis (H) (Anaes.) (Assist.) | 1 278.35 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 those services to which item 32508, 32511, 32514 or 32517 applies (Anaes.) (Assist.) | 291.70 |
| 34109 | Temporal artery, biopsy of (Anaes.) (Assist.) | 338.35 |
| 34112 | Arterio-venous fistula of an extremity, dissection and ligation (H) (Anaes.) (Assist.) | 857.30 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 tumour is greater than 4 cm in maximum diameter (H) (Anaes.) (Assist.) | 1 962.65 |
| 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 | 1 188.20 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | vessel or vessels (H) (Anaes.) (Assist.) | |
| 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 access device, correction of (H) (Anaes.) (Assist.) | 1 285.75 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 34527 | Central vein catheterisation by open technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterisation, on a person 10 years of age or over (Anaes.) | 551.60 |
| 34528 | Central vein catheterisation by percutaneous technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, on a person 10 years of age or over (Anaes.) | 272.40 |
| 34529 | Central vein catheterisation by open technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterisation, on a person under 10 years of age (Anaes.) | 717.10 |
| 34530 | Central venous line, or other chemotherapy device, removal of, by open surgical procedure in the operating theatre of a hospital, on a person 10 years of age or over (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 |
| 34534 | Central vein catheterisation by percutaneous technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, on a person under 10 years of age (Anaes.) | 354.10 |
| 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 |
| 34540 | Central venous line, or other chemotherapy device, removal of, by open surgical procedure in the operating theatre of a hospital, on a person under 10 years of age (Anaes.) | 265.50 |
| 34800 | Inferior vena cava, plication, ligation, or application of caval | 812.15 |

General medical services table **Schedule 1**
Services and fees **Part 2**

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | clip (Anaes.) (Assist.) | |
| 34803 | Inferior vena cava, reconstruction of or bypass by vein or synthetic material (H) (Anaes.) (Assist.) | 1 789.85 |
| 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 | 894.75 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | sympathectomy or for previous incomplete surgical sympathectomy (H) (Anaes.) (Assist.) | |
| 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 Subgroup 11 of Group T1 or item 35319 or 35320 applies, or associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.) | 355.80 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 35319 | Peripheral arterial or venous catheterisation with administration of thrombolytic or chemotherapeutic agents, by pulse spray technique, using percutaneous approach, excluding associated radiological services or preparation, and excluding after-care (other than a service associated with a service to which an item in Subgroup 11 of Group T1 or item 35317 or 35320 applies, or associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.) | 637.80 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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.) (Assist.) | 710.30 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 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, 60010, 60072, 60073, 60075, 60076, 60078 or 60079, including aftercare (Anaes.) (Assist.) | 2 857.55 |

Subdivision D—Subgroups 4, 5 and 6 of Group T8**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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 35503 | Intra-uterine contraceptive device, introduction of, if the service is not associated with a service to which another item in this Group applies (other than a service mentioned in item 30062) (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 a premenopausal person and at least 2 cm in diameter in a postmenopausal person, by abdominal or vaginal route, using interventional imaging techniques and not associated with services provided for assisted reproductive techniques (Anaes.) | 207.85 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 35533 | Vulvoplasty or labioplasty, for repair of: (a) female genital mutilation; or (b) anomalies associated with major congenital anomalies of the uro-gynaecological tract other than a service associated with a service to which item 35536, 37836, 37050, 37842, 37851 or 43882 applies (H) (Anaes.) | 349.85 |
| 35534 | Vulvoplasty or labioplasty, for localised gigantism if it can be demonstrated that: (a) the structural abnormality is causing significant functional impairment; and (b) non-surgical treatments have failed (H) (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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 35562 | Vaginectomy, radical, for proven invasive malignancy, conjoint surgery—abdominal surgeon (including after-care) (H) (Anaes.) (Assist.) | 1 132.60 |
| 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) rectocele; (c) enterocele; 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 | 674.50 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | associated with a service to which another item in this 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 genital tract by a Hinselmann-type | 63.90 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | 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) (Anaes.) | 107.15 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 anaesthesia or under epidural or spinal (intrathecal) nerve block, including procedures to which item 35626, 35627 or | 183.00 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | 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 anaesthesia and biopsies, other than a service associated with a service to which item 35644 applies (Anaes.) | 203.65 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 lymph glands, with or without removal of uterine adnexae (H) (Anaes.) (Assist.) | 1 016.30 |
| 35673 | Hysterectomy, vaginal, (with or without uterine curettage) | 757.80 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | with salpingectomy, oophorectomy or excision of ovarian cyst, one or more, one or both sides (H) (Anaes.) (Assist.) | |
| 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 which another item in this Subgroup applies (Anaes.) | 67.50 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 35710 | Fallopscopy, 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 |
| 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 | 867.60 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | 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.) | |
| 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 operating together—ureterovesical anastomosis, including after-care (H) (Assist.) | 782.95 |
| 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 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 and any associated endoscopic procedures, complicated by previous open or laparoscopic surgery on the same kidney or ureter (H) (Anaes.) (Assist.) | 1 964.15 |
| 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 | 1 107.95 |

General medical services table **Schedule 1**
Services and fees **Part 2**

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | same skin incision, for one or 2 stones (Anaes.) (Assist.) | |
| 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 |
| 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 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 (H) (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 (H) (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, other than a service associated with a service to which any of items 36811 to 36854 apply (H) (Anaes.) | 267.65 |
| 36609 | Intestinal urinary conduit or ureterostomy, revision of (H) (Anaes.) (Assist.) | 741.50 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 waves or lasers (other than a service to which item 36645 or 36648 applies) (H) (Anaes.) | 833.10 |
| 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 | 416.45 |

Schedule 1 General medical services table
Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | bleeding (H) (Anaes.) (Assist.) | |
| 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 performed in the same collecting system to which item 36654 applies (H) (Anaes.) (Assist.) | 1 066.30 |
| 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 | 255.45 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | generator | |
| 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 adjustment of the pulse generator by a medical practitioner, to manage detrusor over-activity or non-obstructive urinary retention—each day | 125.40 |
| 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: | 334.00 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | (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.) | |
| 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 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 | 649.80 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | performed on the same ureter (H) (Anaes.) (Assist.) | |
| 36809 | Ureterscopy, 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 which item 36818, 36821, 36824, 36830 or 36833 applies (H) (Anaes.) (Assist.) | 581.30 |
| 36827 | Cystoscopy, with controlled hydro-dilatation of the bladder (Anaes.) | 229.85 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 or 18379 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 |
| 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 | 416.45 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | to which item 37011 applies or a service associated with other open bladder procedure (Anaes.) | |
| 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 | Continent catheterisation bladder stomas (for example, Mitrofanoff), 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 reconstruction (H) (Anaes.) (Assist.) | 741.50 |
| 37053 | Bladder transection and re-anastomosis to trigone (H) (Anaes.) (Assist.) | 856.70 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 applies (H) (Anaes.) | 866.45 |
| 37208 | Prostate, endoscopic non-contact (side firing) visual laser | 416.05 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | 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.) | |
| 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 radio-opaque 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 or 55603 applies (Anaes.) (Assist.) | 280.85 |
| 37220 | Prostate, radioactive seed implantation of, urological component, using transrectal ultrasound guidance, for | 1 044.20 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | 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.) | |
| 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 (Anaes.) | 558.10 |
| 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 | 1 262.15 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | 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.) | |
| 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 or 18379 applies (Anaes.) | 239.85 |
| 37340 | Urethral sling, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence—vaginal approach, other than a service associated with a service to which item 37341 applies (H) (Anaes.) (Assist.) | 425.00 |
| 37341 | Urethral sling, division or removal of, for urethral obstruction or erosion, following previous surgery for | 911.30 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | urinary incontinence—suprapubic or vaginal approach, other than a service associated with a service to which item 37340 applies (H) (Anaes.) (Assist.) | |
| 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 |
| 37393 | Priapism, decompression by glanular stab caverno-spongiosum 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 | 276.60 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | associated with sperm harvesting for IVF (Anaes.) | |
| 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, on a person 10 years of age or over (H) (Anaes.) (Assist.) | 521.25 |
| 37801 | Patent urachus, excision of, on a person under 10 years of age (H) (Anaes.) (Assist.) | 677.65 |
| 37803 | Undescended testis, orchidopexy for, on a person 10 years of age or over, other than a service to which item 37806 applies (H) (Anaes.) (Assist.) | 521.25 |
| 37804 | Undescended testis, orchidopexy for, on a person under 10 years of age, other than a service to which item 37807 | 677.65 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | applies (H) (Anaes.) (Assist.) | |
| 37806 | Undescended testis in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for, on a person 10 years of age or over (Anaes.) (Assist.) | 602.25 |
| 37807 | Undescended testis in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for, on a person under 10 years of age (Anaes.) (Assist.) | 782.95 |
| 37809 | Undescended testis, revision orchidopexy for, on a person 10 years of age or over (H) (Anaes.) (Assist.) | 602.25 |
| 37810 | Undescended testis, revision orchidopexy for, on a person under 10 years of age (H) (Anaes.) (Assist.) | 782.95 |
| 37812 | Impalpable testis, exploration of groin for, on a person 10 years of age or over, other than a service associated with a service to which any of items 37803, 37806 and 37809 apply (H) (Anaes.) (Assist.) | 556.00 |
| 37813 | Impalpable testis, exploration of groin for, on a person under 10 years of age, other than a service associated with a service to which any of items 37804, 37807 and 37810 apply (H) (Anaes.) (Assist.) | 722.80 |
| 37815 | Hypospadias, examination under anaesthesia with erection test, on a person 10 years of age or over (H) (Anaes.) | 92.75 |
| 37816 | Hypospadias, examination under anaesthesia with erection test, on a person under 10 years of age (H) (Anaes.) | 120.60 |
| 37818 | Hypospadias, glanuloplasty incorporating meatal advancement, on a person 10 years of age or over (Anaes.) (Assist.) | 491.45 |
| 37819 | Hypospadias, glanuloplasty incorporating meatal advancement, on a person under 10 years of age (Anaes.) (Assist.) | 638.90 |
| 37821 | Hypospadias, distal, one stage repair, on a person 10 years of age or over (H) (Anaes.) (Assist.) | 833.10 |
| 37822 | Hypospadias, distal, one stage repair, on a person under 10 years of age (H) (Anaes.) (Assist.) | 1 083.05 |
| 37824 | Hypospadias, proximal, one stage repair, on a person 10 years of age or over (H) (Anaes.) (Assist.) | 1 158.30 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 37825 | Hypospadias, proximal, one stage repair, on a person under 10 years of age (H) (Anaes.) (Assist.) | 1 505.80 |
| 37827 | Hypospadias, staged repair, first stage, on a person 10 years of age or over (H) (Anaes.) (Assist.) | 533.60 |
| 37828 | Hypospadias, staged repair, first stage, on a person under 10 years of age (H) (Anaes.) (Assist.) | 693.70 |
| 37830 | Hypospadias, staged repair, second stage (Anaes.) (Assist.) | 691.40 |
| 37833 | Hypospadias, repair of post-operative urethral fistula, on a person 10 years of age or over (H) (Anaes.) (Assist.) | 329.95 |
| 37834 | Hypospadias, repair of post-operative urethral fistula, on a person under 10 years of age (H) (Anaes.) (Assist.) | 428.95 |
| 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 |
| 37854 | Urethral valve, destruction of, including cystoscopy and urethroscopy (H) (Anaes.) (Assist.) | 366.45 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 item 38209 or 38213 applies (Anaes.) | 1 372.45 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 38228 | 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 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.) | 709.90 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 38240 | Selective coronary angiography—placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of 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.) | 1 064.60 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 38272 | Atrial septal defect, closure using a septal occluder or similar device by transcatheter approach (Anaes.) (Assist.) | 912.30 |
| 38273 | Patent ductus arteriosus, transcatheter closure of, including cardiac catheterisation and any imaging associated with the service (H) (Anaes.) (Assist.) | 912.30 |
| 38274 | Ventricular septal defect, transcatheter closure of, with imaging and cardiac catheterisation (H) (Anaes.) (Assist.) | 912.30 |
| 38275 | Myocardial biopsy, by cardiac catheterisation (Anaes.) | 298.20 |
| 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 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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: (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.) | 885.45 |
| 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 | 1 586.35 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | 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 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| 38365 | Permanent cardiac synchronisation device (including a cardiac synchronisation device that is capable of defibrillation), insertion, removal or replacement of, for a patient who: (a) has: (i) moderate to severe chronic heart failure (New York Heart Association (NYHA) class III or IV) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 120 ms; or (b) satisfied the requirements mentioned in paragraph (a) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode (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, for a patient who: (a) has: (i) moderate to severe chronic heart failure (New York Heart Association (NYHA) class III or IV) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 120 ms; or (b) has: (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and | 1 224.60 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | <ul style="list-style-type: none"> (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 150 ms; or <p>(c) satisfied the requirements mentioned in paragraph (a) or (b) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode</p> <p>(H) (Anaes.)</p> | |
| 38371 | <p>Permanent cardiac synchronisation device capable of defibrillation, insertion, removal or replacement of, for a patient who:</p> <p>(a) has:</p> <ul style="list-style-type: none"> (i) moderate to severe chronic heart failure (NYHA class III or IV) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 120 ms; or <p>(b) has:</p> <ul style="list-style-type: none"> (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 150 ms <p>(H) (Anaes.)</p> | 287.85 |
| 38384 | <p>Automatic defibrillator, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for, primary prevention of sudden cardiac death in:</p> <p>(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</p> <p>(b) a patient with chronic heart failure associated with mild</p> | 1 052.65 |

Schedule 1 General medical services table**Part 2** Services and fees**Group T8—Surgical operations**

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| | 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.) | |
| 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 associated with a service to which item 38213 applies (H) (Anaes.) (Assist.) | 1 052.65 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 or sternotomy (H) (Anaes.) (Assist.) | 958.40 |
| 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.) | 817.10 |

General medical services table **Schedule 1**
Services and fees **Part 2**

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | (Assist.) | |
| 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, 38503 or 38504 applies (H) (Anaes.) (Assist.) | 2 047.60 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 item 38497, 38498, 38500, 38501, 38503 or 38600 applies (H) (Anaes.) (Assist.) | 2 388.70 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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, without implantation of coronary arteries (H) (Anaes.) (Assist.) | 3 104.70 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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, for a patient who: (a) has: (i) moderate to severe chronic heart failure (New York Heart Association (NYHA) class III or IV) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 120 ms; or (b) has: (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 150 ms; or (c) satisfied the requirements mentioned in paragraph (a) or (b) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode (H) (Anaes.) (Assist.) | 1 224.60 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 conduit (H) (Anaes.) (Assist.) | 2 148.85 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (H) (Anaes.) (Assist.) | 2 134.50 |
| 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 (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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 (paracentesis), with or without diagnostic sample | 76.90 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 glycerol (Anaes.) | 443.70 |
| 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 |

Schedule 1 General medical services table
Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 of chronic intractable pain (H) (Anaes.) (Assist.) | 659.95 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 neuropathic pain or pain from refractory angina pectoris—not exceeding 4 leads (Anaes.) (Assist.) | 674.15 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 (H) (Anaes.) (Assist.) | 473.75 |
| 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) | 1 195.70 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | (Anaes.) (Assist.) | |
| 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 clearance of paranasal sinus and orbital fossa extensions, with intracranial decompression of the optic nerve, (intracranial procedure) (H) (Anaes.) (Assist.) | 3 653.60 |
| 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 | 2 565.30 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | excision (intracranial procedure), conjoint surgery, co-surgeon (H) (Assist.) | |
| 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 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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) (Anaes.) (Assist.) | 917.40 |
| 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 | 1 428.75 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | diastematomyelia (H) (Anaes.) (Assist.) | |
| 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 |
| 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 | Cranio-cervical 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 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.) | 1 053.90 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 unacceptable motor fluctuations; or (b) essential tremor or dystonia, where the patient’s symptoms cause severe disability (H) (Anaes.) (Assist.) | 340.60 |
| 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 | 255.45 |

Schedule 1 General medical services table
Part 2 Services and fees

| Group T8—Surgical operations | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| | (H) (Anaes.) (Assist.) | |
| 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 unacceptable motor fluctuations; or (b) essential tremor or dystonia where the patient’s symptoms cause severe disability (H) (Anaes.) (Assist.) | 2 022.70 |
| 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, | 82.50 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | other than by simple syringing (Anaes.) | |
| 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 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 | 1 826.75 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | (intracranial procedure)—conjoint surgery, co-surgeon (H) (Assist.) | |
| 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 |
| 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 | 186.50 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | (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 | |
| 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 |
| 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 | 109.90 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | general anaesthesia (Anaes.) | |
| 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 |
| 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, | 71.95 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | other than a service associated with a service to which another item in this Group applies (Anaes.) | |
| 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 (Anaes.) | 36.30 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 sinuscopy or fiberoptic examination of nasopharynx and larynx, one or more of these procedures, unilateral or bilateral examination of (Anaes.) | 122.85 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 | 52.20 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | (Anaes.) | |
| 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 bowel (H) (Anaes.) (Assist.) | 1 336.45 |
| 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 microlaryngoscopic techniques (H) (Anaes.) | 388.70 |
| 41870 | Injection of vocal cord by teflon, fat, collagen or gelfoam (H) (Anaes.) (Assist.) | 454.85 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 mini tracheostomy device (H) (Anaes.) | 91.05 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 integrating 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 | 883.85 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | tumour or foreign body (H) (Anaes.) (Assist.) | |
| 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 prolapse of uveal tissue—repair (H) (Anaes.) (Assist.) | 737.00 |
| 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, on a person 10 years of age or over (Anaes.) | 227.45 |
| 42574 | Dermoid, orbital, excision of (Anaes.) (Assist.) | 483.25 |
| 42575 | Tarsal cyst, extirpation of (Anaes.) | 82.75 |
| 42576 | Dermoid, periorbital, excision of, on a person under 10 years of age (Anaes.) | 295.70 |
| 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 | 631.75 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | (Anaes.) (Assist.) | |
| 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 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) | 48.30 |
| 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 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 42651 | Cornea, epithelial debridement for eliminating band keratopathy (Anaes.) | 160.80 |
| 42653 | Cornea, transplantation of (H) (Anaes.) (Assist.) | 1 307.75 |
| 42656 | Cornea, transplantation of, second and subsequent procedures (H) (Anaes.) (Assist.) | 1 669.45 |
| 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 1½ 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 1½ 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 (Anaes.) (Assist.) | 1 195.70 |
| 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 | Vitreotomy 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 |
| 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 | 300.75 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | a procedure associated with other intraocular surgery (Anaes.) | |
| 42741 | Posterior juxtасcleral 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 |
| 42743 | Anterior chamber, irrigation of blood from, as an independent procedure (Anaes.) (Assist.) | 631.75 |
| 42744 | Needle revision of glaucoma filtration bleb, following glaucoma filtering procedure (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) | 1 338.45 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | (Anaes.) (Assist.) | |
| 42779 | Detached retina, revision of scleral buckling operation for (H) (Anaes.) (Assist.) | 1 669.45 |
| 42782 | Laser trabeculoplasty, for the treatment of glaucoma—each treatment to one eye, to a maximum of 4 treatments to that eye in a 2 year period (Anaes.) (Assist.) | 451.10 |
| 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 glaucoma filtration surgery, each treatment to one eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) | 67.65 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 42801 | Episcleral radioactive plaque (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, insertion of (H) (Anaes.) (Assist.) | 1 049.70 |
| 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 | Laser peripheral iridoplasty | 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 |

Schedule 1 General medical services table

Part 2 Services and fees

| 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-ocular operations 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 |
| 42866 | Entropion or tarsal ectropion, repair of, by tightening, | 751.85 |

| Group T8—Surgical operations | | |
|---|---|-----------------|
| Item | Description | Fee (\$) |
| | shortening or repair of inferior retractors by open operation across the entire width of the eyelid (Anaes.) (Assist.) | |
| 42869 | Eyelid closure in facial nerve paralysis, insertion of foreign implant for (Anaes.) (Assist.) | 549.00 |
| 42872 | Eyebrow, elevation of, for parietic states (Anaes.) | 240.70 |
| 43021 | Photodynamic therapy, one eye, including the infusion of vertoporphin continuously through a peripheral vein, using a non-thermal laser at a wavelength of 689 nm, for the treatment of choroidal neovascularisation | 455.05 |
| 43022 | Photodynamic therapy, both eyes, including the infusion of vertoporphin continuously through a peripheral vein, using a non-thermal laser at a wavelength of 689 nm, for the treatment of choroidal neovascularisation | 546.15 |
| 43023 | Infusion of vertoporphin 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 |
| 43518 | Operation on spine or pelvic bones (for chronic osteomyelitis)—one bone (H) (Anaes.) (Assist.) | 587.60 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 43805 | Umbilical, epigastric or linea alba hernia, repair of, on a person under 10 years of age (H) (Anaes.) | 356.35 |
| 43807 | Duodenal atresia or stenosis, duodenoduodenostomy or duodenojejunosotomy 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 | Aganglioneosis Coli, 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 |
| 43831 | Acute neonatal necrotising enterocolitis, if no definitive procedure is possible, laparotomy for (H) (Anaes.) (Assist.) | 957.30 |

General medical services table **Schedule 1**
Services and fees **Part 2**

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 43832 | Branchial fistula, removal of, on a person under 10 years of age (H) (Anaes.) (Assist.) | 652.95 |
| 43834 | Bowel resection for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (H) (Anaes.) (Assist.) | 1 112.00 |
| 43835 | Strangulated, incarcerated or obstructed hernia, repair of, without bowel resection, on a person under 10 years of age (H) (Anaes.) (Assist.) | 677.65 |
| 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 |
| 43838 | Diaphragmatic hernia, congenital, repair of, by thoracic or abdominal approach, on a person under 10 years of age, not being a service to which any of items 31569 to 31581 apply (H) (Anaes.) (Assist.) | 1 244.50 |
| 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 |
| 43841 | Femoral or inguinal hernia or infantile hydrocele, repair of, on a person under 10 years of age, other than a service to which item 30403 or 43835 applies (H) (Anaes.) (Assist.) | 603.85 |
| 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 (H) (Anaes.) (Assist.) | 1 621.55 |
| 43855 | Oesophageal atresia, delayed primary anastomosis for (H) (Anaes.) (Assist.) | 1 714.35 |
| 43858 | Oesophageal atresia, cervical oesophagostomy for (H) (Anaes.) (Assist.) | 602.25 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 or exomphalos, secondary operation for, with removal of silo (H) (Anaes.) (Assist.) | 695.00 |
| 43870 | Exomphalos containing small bowel only, operation for (H) (Anaes.) (Assist.) | 972.95 |
| 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 | Eventionration, plication of diaphragm for (H) (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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 (H) (Anaes.) | 231.70 |
| 43945 | Patent vitello intestinal duct, excision of (H) (Anaes.) (Assist.) | 972.95 |
| 43948 | Umbilical granuloma, excision of, under general anaesthesia (H) (Anaes.) | 139.10 |
| 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.) | 1 297.35 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | (Assist.) | |
| 43987 | Neuroblastoma, radical excision of (H) (Anaes.) (Assist.) | 1 436.40 |
| 43990 | Aganglioneurosis Coli, 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 |
| 43993 | Aganglioneurosis Coli, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends into descending or transverse colon with or without resiting of stoma (H) (Anaes.) (Assist.) | 1 899.65 |
| 43996 | Aganglioneurosis Coli, total colectomy for total colonic aganglioneurosis with ileoanal pull-through, with or without side to side ileocolonic anastomosis (H) (Anaes.) (Assist.) | 2 131.35 |
| 43999 | Aganglioneurosis Coli, anal sphincterotomy as an independent procedure for (H) (Anaes.) (Assist.) | 266.55 |
| 44101 | Rectum, examination of, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion, on a person under 2 years of age (H) (Anaes.) (Assist.) | 334.05 |
| 44102 | Rectum, examination of, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion, on a person 2 years of age or over (H) (Anaes.) (Assist.) | 256.95 |
| 44104 | Rectal prolapse, submucosal or perirectal injection for, under general anaesthesia, on a person under 2 years of age (Anaes.) | 58.65 |
| 44105 | Rectal prolapse, submucosal or perirectal injection for, under general anaesthesia, on a person 2 years of age or over (Anaes.) | 45.10 |
| 44108 | Inguinal hernia repair at age less than 12 months (H) (Anaes.) (Assist.) | 491.45 |
| 44111 | Obstructed or strangulated inguinal hernia, repair of, at age less than 12 months, including orchidopexy when performed (Anaes.) (Assist.) | 575.65 |
| 44114 | Inguinal hernia repair at age less than 12 months when orchidopexy also required (H) (Anaes.) (Assist.) | 575.65 |
| 44130 | Lymphadenectomy, for atypical mycobacterial infection or other granulomatous disease (Anaes.) (Assist.) | 463.30 |

Group T8—Surgical operations

| Item | Description | Fee (\$) |
|-------------|---|-----------------|
| 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 |

Schedule 1 General medical services table
Part 2 Services and fees

| Group T8—Surgical operations | | |
|---|---|-----------------------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 | 396.70 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | 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.) | |
| 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 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.) | 396.70 |
| 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), | 240.70 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | large or involving deeper tissue including facial muscle or breast, excision and suture of (Anaes.) | |
| 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 |
| 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 |

General medical services table **Schedule 1**
Services and fees **Part 2**

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 burnt tissue—involving 12% or more but less than 15% of total body surface (H) (Anaes.) (Assist.) | 977.55 |
| 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 |

General medical services table **Schedule 1**
Services and fees **Part 2**

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 total body surface—conjoint surgery, co-surgeon (H) (Assist.) | 1 027.95 |
| 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 | 3 243.00 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | total body surface—conjoint surgery, principal surgeon (H) (Anaes.) (Assist.) | |
| 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 total body surface—conjoint surgery, principal surgeon (H) (Anaes.) (Assist.) | 3 712.60 |
| 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 |

General medical services table **Schedule 1**
Services and fees **Part 2**

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 burnt tissue—the whole of 5 digits of the hand (H) (Anaes.) (Assist.) | 1 353.60 |
| 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 | 2 030.35 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | techniques (H) (Anaes.) (Assist.) | |
| 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 of free flap (H) (Anaes.) (Assist.) | 1 774.70 |
| 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 mammoplasty (unilateral) with surgical repositioning of nipple (H) (Anaes.) (Assist.) | 900.45 |
| 45522 | Reduction mammoplasty (unilateral) without surgical repositioning of nipple, excluding the treatment of gynaecomastia (H) (Anaes.) (Assist.) | 631.75 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 45524 | Mammoplasty, augmentation, for significant breast asymmetry if the augmentation is limited to one breast (H) (Anaes.) (Assist.) | 741.65 |
| 45527 | Mammoplasty, augmentation, (unilateral), following mastectomy (H) (Anaes.) (Assist.) | 741.65 |
| 45528 | Mammoplasty, 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, inseting 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 | 622.55 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | surgical technique (Anaes.) (Assist.) | |
| 45546 | Nipple or areola or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple | 197.85 |
| 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 | 1 148.95 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | 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.) | |
| 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, inseting 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 | 1 909.80 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, inseting 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, 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 | 631.75 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | which item 31525 applies, if it can be demonstrated that the treatment is for Barraquer-Simon's syndrome (pathological lipodystrophy of hips, buttocks, thighs, knees or lower legs), lymphoedema or macrodystrophia lipomatosa (Anaes.) | |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 45611 | Mandible, condylectomy (H) (Anaes.) (Assist.) | 473.75 |
| 45614 | Eyelid, whole thickness reconstruction of, other than by direct suture only (Anaes.) (Assist.) | 587.60 |
| 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 for correction of nasal obstruction (Anaes.) | 511.95 |
| 45635 | Rhinoplasty, correction of bony vault only, for correction of nasal obstruction or post-traumatic deformity (other than deformity resulting from previous elective cosmetic surgery), or both (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 | 1 014.05 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | surgery), or both (H) (Anaes.) | |
| 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 significant developmental deformity (H) (Anaes.) | 1 014.05 |
| 45641 | Rhinoplasty involving nasal or septal cartilage graft, or nasal bone graft, or nasal bone and nasal cartilage graft, for correction of nasal obstruction or post-traumatic deformity (other than deformity resulting from previous elective cosmetic surgery), or both (H) (Anaes.) | 1 082.90 |
| 45644 | Rhinoplasty, total, including correction of all bony and cartilaginous elements of the external nose involving autogenous bone or cartilage graft obtained from distant donor site, including obtaining of graft For correction of nasal obstruction or post-traumatic deformity (other than deformity resulting from previous elective cosmetic surgery), or both (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, for correction of nasal obstruction, post-traumatic deformity (other than deformity resulting from previous elective cosmetic surgery) or significant developmental deformity (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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 practice of his or her specialty (H) (Anaes.) (Assist.) | 1 279.45 |
| 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 |

General medical services table **Schedule 1**
Services and fees **Part 2**

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 similar), first stage (H) (Anaes.) (Assist.) | 827.30 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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, 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.) | 1 402.70 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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, plates or pins, or any combination, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.) | 1 992.70 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 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.) | 126.90 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.) | 502.25 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 mucosal graft when performed—unilateral (Anaes.) (Assist.) | 586.50 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 service to which another item in this Subgroup applies (Anaes.) (Assist.) | 329.60 |
| 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 |

General medical services table **Schedule 1**
Services and fees **Part 2**

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 intermaxillary wiring, excluding wiring for obesity | 241.15 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 involving viscera, blood vessels or nerves, requiring open reduction involving the use of a plate | 842.25 |
| 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 associated synovectomy, tendon transfer or realignment— 3 joints (H) (Anaes.) (Assist.) | 902.55 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 distal ulna, when performed (H) (Anaes.) (Assist.) | 564.05 |
| 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 |

General medical services table **Schedule 1**
Services and fees **Part 2**

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 46366 | Dupuytren's contracture, subcutaneous fasciotomy for—each hand (Anaes.) | 127.90 |
| 46369 | Dupuytren's contracture, palmar fasciotomy for—one hand (Anaes.) | 210.60 |
| 46372 | Dupuytren's contracture, fasciotomy for, from one ray, including dissection of nerves—one hand (Anaes.) (Assist.) | 427.95 |
| 46375 | Dupuytren's contracture, fasciotomy for, from 2 rays, including dissection of nerves—one hand (Anaes.) (Assist.) | 507.70 |
| 46378 | Dupuytren's contracture, fasciotomy 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, fasciotomy for, from one ray, including dissection of nerves—operation for recurrence in that ray (Anaes.) (Assist.) | 620.60 |
| 46390 | Dupuytren's contracture, fasciotomy for, from 2 rays, including dissection of nerves—operation for recurrence in those rays (H) (Anaes.) (Assist.) | 827.50 |
| 46393 | Dupuytren's contracture, fasciotomy 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 of bone or joint and requiring soft tissue cover (H) (Anaes.) (Assist.) | 902.55 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.) | 378.40 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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, unguual 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 reduction (Anaes.) | 112.85 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 which item 47399 applies (Anaes.) | 188.20 |
| 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 | 188.20 |

Schedule 1 General medical services table
Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | reduction of (Anaes.) | |
| 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 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 | 564.85 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | external fixation (H) (Anaes.) (Assist.) | |
| 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 |
| 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 | 376.55 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | fixation, being a service associated with a service to which items 47501 to 47510 apply (H) (Anaes.) (Assist.) | |
| 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 |
| 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 | 564.85 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | fractures of, by closed reduction (H) (Anaes.) | |
| 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 intra-articular fractures of femoral condylar or tibial articular surfaces and requiring repair or reconstruction of one or more ligaments (H) (Anaes.) (Assist.) | 1 317.80 |
| 47591 | Knee joint, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar and tibial articular surfaces and requiring repair or reconstruction of | 1 600.65 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | one or more ligaments (H) (Anaes.) (Assist.) | |
| 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 (Anaes.) | 160.05 |
| 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 | 169.50 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | reduction (Anaes.) | |
| 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 |
| 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 | 1 035.55 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | closed manipulation (H) (Anaes.) (Assist.) | |
| 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.) (Assist.) | 423.75 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 (H) (Anaes.) (Assist.) | 435.65 |
| 47780 | Maxilla, treatment of fracture of, requiring open reduction and internal fixation not involving a plate (H) (Anaes.) (Assist.) | 566.35 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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, unguis 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 inserted for internal fixation purposes, removal of, in the operating theatre of a hospital—per bone (H) (Anaes.) | 141.25 |
| 47930 | Plate, rod or nail and associated wires, pins or screws, one or more of, all of which were inserted for internal fixation | 263.60 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | purposes, removal of, other than a service associated with a service to which item 47924 or 47927 applies—per bone (H) (Anaes.) (Assist.) | |
| 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 |
| 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, | 150.55 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | decompression fasciotomy of, other than a service to which another item in this Group applies (Anaes.) | |
| 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 |
| 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 | 517.80 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | internal fixation, excluding services to which item 47933 or 47936 applies (H) (Anaes.) (Assist.) | |
| 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 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 instrumentation in the presence of spinal cord involvement (H) (Anaes.) (Assist.) | 2 824.35 |
| 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 | 809.55 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | electrothermal annuloplasty (Anaes.) (Assist.) | |
| 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 (H) (Anaes.) (Assist.) | 1 082.70 |
| 48663 | Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions—one level—principal surgeon (H) (Anaes.) | 809.55 |
| 48666 | Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions—one level—assisting surgeon (H) | 489.55 |
| 48669 | Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions—more than one level (H) (Anaes.) (Assist.) | 1 459.20 |
| 48672 | Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions—more than one level—principal surgeon (H) (Anaes.) | 1 092.25 |
| 48675 | Spinal fusion (anterior interbody) to cervical, thoracic or lumbar regions—more than one level assisting surgeon (H) | 659.15 |
| 48678 | Spine, simple internal fixation of, involving one or more of | 565.45 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | facetial screw, wire loop or similar, being a service associated with a service to which items 48642 to 48675 apply (H) (Anaes.) (Assist.) | |
| 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 (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, at one level only, including removal of disc, for a patient who: (a) has not had prior spinal fusion surgery at the same lumbar level; and (b) does not have vertebral osteoporosis; and (c) has failed conservative therapy; other than a service associated with item 40300 or 40301 (Anaes.) (Assist.) | 1 793.65 |
| 48692 | Lumbar artificial intervertebral total disc replacement, at one level only, including removal of disc, for a patient who: (a) has not had prior spinal fusion surgery at the same lumbar level; and (b) does not have vertebral osteoporosis; and (c) has failed conservative therapy; other than a service associated with item 40300 or 40301—principal surgeon (Anaes.) (Assist.) | 1 208.95 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 48693 | Lumbar artificial intervertebral total disc replacement, at one level only, including removal of disc, for a patient who: (a) has not had prior spinal fusion surgery at the same lumbar level; and (b) does not have vertebral osteoporosis; and (c) has failed conservative therapy; other than a service associated with item 40300 or 40301— 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 which item 48900 applies (H) (Anaes.) (Assist.) | 564.85 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 arthroscopic procedure of the shoulder region (H) (Anaes.) (Assist.) | 611.90 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |

Schedule 1 General medical services table
Part 2 Services and fees

| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 49330 | Hip, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, including obtaining of graft (H) (Anaes.) (Assist.) | 2 165.35 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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 chondroplasty—not associated with another arthroscopic procedure of the knee region (H) (Anaes.) (Assist.) | 272.95 |
| 49559 | Knee, arthroscopic surgery of, involving chondroplasty 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 chondroplasty—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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 hallucis 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 hallucis tendon, with or without internal fixation and with or without excision of exostoses associated with the first metatarsal joint—bilateral (H) (Anaes.) (Assist.) | 1 117.75 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 item in this Group applies (Anaes.) (Assist.) | 312.30 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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; (c) allograft; (d) cementation (H) (Anaes.) (Assist.) | 611.90 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 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, affecting hips or knees, application of cast under general anaesthesia, performed in the operating theatre of a hospital (Anaes.) | 228.70 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 | 1 226.90 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | synovectomy if performed, or os calcis lengthening; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.) | |
| 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 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.) | 1 389.40 |
| 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 | 1 389.40 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | (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.) | |
| 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 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.) | 2 074.45 |
| 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 | 2 921.80 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | (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.) | |
| 50466 | Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.) | 2 921.80 |
| 50470 | Bilateral single event multilevel surgery, for a patient less than 18 years of age with cerebral palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; and | 3 705.55 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | (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.) | |
| 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 |
| 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 | 4 275.85 |

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| | (f) correction of foot instability by os calcis lengthening or subtalar fusion; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.) | |
| 50476 | Single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, for the correction of crouch gait including: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation; and (d) correction of patella alta and quadriceps insufficiency by patella tendon shortening or reconstruction; and (e) correction of tibial torsion by rotational osteotomy of the tibia with internal fixation; and (f) correction of foot instability by os calcis lengthening or subtalar fusion; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.) | 4 275.85 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 or neck of, by closed reduction of (Anaes.) | 263.60 |
| 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 | 632.65 |

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | fracture of, by internal or external fixation (H) (Anaes.) (Assist.) | |
| 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, in a hospital (Anaes.) (Assist.) | 434.70 |
| 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 | 619.35 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group T8—Surgical operations | | |
|-------------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| | adjustment or removal of segmental instrumentation used for correction of spine deformity (H) (Anaes.) (Assist.) | |
| 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 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.) | 2 185.80 |
| 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 |

| Group T8—Surgical operations | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| 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 | <p>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:</p> <ul style="list-style-type: none"> (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; <p>including any associated imaging services, other than a service associated with a service to which item 30419 or 50950 applies (Anaes.)</p> | 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 |

Schedule 1 General medical services table

Part 2 Services and fees

| 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.

Schedule 1 General medical services table
Part 2 Services and fees

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 |

Schedule 1 General medical services table
Part 2 Services and fees

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 |

| Group O3—General surgery | | |
|---------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 52018 | Foreign body in muscle, tendon or other deep tissue, removal of, as an independent procedure (Anaes.) (Assist.) | 276.80 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group O3—General surgery | | |
|---------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 52045 | Tumour, cyst (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5 mm separation between the cyst lining and tooth structure or if a tumour or cyst has been proven by positive histopathology), ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of, other than a service to which another item in Groups O3 to O9 applies, involving muscle, bone, or other deep tissue (Anaes.) | 246.50 |
| 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 |

General medical services table **Schedule 1**
Services and fees **Part 2**

| Group O3—General surgery | | |
|---------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 52060 | Muscle in the oral and maxillofacial region, excision of (Anaes.) | 189.40 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group O3—General surgery | | |
|---------------------------------|--|-----------------|
| Item | Description | Fee (\$) |
| 52096 | Orthopaedic pin or wire, insertion of, into maxilla or mandible or zygoma, as an independent procedure (Anaes.) | 112.85 |
| 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 performed (Anaes.) (Assist.) | 827.30 |

General medical services table **Schedule 1**
Services and fees **Part 2**

| Group O3—General surgery | | |
|---------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 mini tracheostomy 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 tumour in the oral and maxillofacial region, biopsy of (not including after-care) (Anaes.) | 188.20 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group O3—General surgery | | |
|---------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group O4—Plastic and reconstructive | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| 52330 | Palatal defect (oro-nasal fistula), plastic closure of, including services to which item 52300, 52303, 52306 or 52324 applies (Anaes.) (Assist.) | 781.95 |
| 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 |

| Group O4—Plastic and reconstructive | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| 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 |
| 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 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group O4—Plastic and reconstructive | | |
|--|---|-----------------|
| Item | Description | Fee (\$) |
| 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 bone or cartilage graft (Anaes.) (Assist.) | 1 279.45 |
| 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 |

General medical services table **Schedule 1**
Services and fees **Part 2**

| Group O4—Plastic and reconstructive | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| 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 similar), first stage (Anaes.) (Assist.) | 827.30 |
| 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 |

Schedule 1 General medical services table
Part 2 Services and fees

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 |

General medical services table **Schedule 1**
Services and fees **Part 2**

Group O5—Preprosthetic

| Item | Description | Fee (\$) |
|-------------|--|-----------------|
| 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 |

Schedule 1 General medical services table
Part 2 Services and fees

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 fiberoptic 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 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group O7—Ear, nose and throat | | |
|--------------------------------------|---|-----------------|
| Item | Description | Fee (\$) |
| 53060 | Cauterisation (other than by chemical means) or cauterisation by chemical means when performed under general anaesthesia or diathermy of septum or turbinates for obstruction or haemorrhage secondary to surgery (or trauma)—one or more of these procedures (including any consultation on the same occasion) other than a service associated with another operation on the nose (Anaes.) | 100.50 |
| 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 |

Schedule 1 General medical services table

Part 2 Services and fees

| Group O8—Temporomandibular joint | | |
|---|---|-----------------|
| Item | Description | Fee (\$) |
| 53226 | Temporomandibular joint, synovectomy of, other than a service to which another item in this Group applies (Anaes.) (Assist.) | 312.30 |
| 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 internal fixation involving a plate (Anaes.) (Assist.) | 718.75 |

Schedule 1 General medical services table**Part 2** Services and fees

| Group O9—Treatment of fractures | | |
|--|--|-----------------|
| Item | Description | Fee (\$) |
| 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 |

Schedule 1 General medical services table
Part 2 Services and fees

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 instrument unless otherwise indicated.

In this instrument:

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.

(G) has the meaning given by clause 1.1.5.

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.

GP management plan, for item 10997, has the meaning given by clause 2.30.1.

(H) has the meaning given by clause 1.1.6.

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: The *National Immunisation Program Schedule* could in 2015 be viewed on the Department's website (<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 instrument 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;
- (b) gamma knife surgery;
- (c) intradiscal electro thermal arthroplasty;
- (d) intravascular ultrasound, except if used in conjunction with intravascular brachytherapy;
- (e) intro-articular viscosupplementation, for the treatment of osteoarthritis of the knee;
- (f) low intensity ultrasound treatment, for the acceleration of bone fracture healing, using a bone growth stimulator;
- (g) lung volume reduction surgery, for advanced emphysema;
- (h) photodynamic therapy, for skin and mucosal cancer;
- (i) placement of artificial bowel sphincters, in the management of faecal incontinence;
- (j) selective internal radiation therapy for any condition other than hepatic metastases that are secondary to colorectal cancer;
- (k) specific mass measurement of bone alkaline phosphatase;
- (l) transmyocardial laser revascularisation;
- (m) vertebral axial decompression therapy, for chronic back pain;
- (n) autologous chondrocyte implantation and matrix-induced autologous chondrocyte implantation;
- (o) 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.

pharmaceutical benefits scheme means the scheme for the supply of pharmaceutical benefits established under Part VII of the *National Health Act 1953*.

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 given 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; or
- (b) for a referral made to a specialist who is an ophthalmologist—an optometrist; or
- (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; or
- (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; or
- (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; or
- (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 RRMA 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.

(S) has the meaning given by clause 1.1.7.

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.

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: Maps showing telehealth eligible areas could in 2015 be viewed on the Department's Medicare Benefits Schedule website (<http://www.mbsonline.gov.au>).

treatment cycle, for clause 2.37.4 and items 13200 to 13209, 13215 and 13218, 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.

Endnotes

Endnote 1—About the endnotes

Endnotes

Endnote 1—About the endnotes

The endnotes provide information about this compilation and the compiled law.

The following endnotes are included in every compilation:

Endnote 1—About the endnotes

Endnote 2—Abbreviation key

Endnote 3—Legislation history

Endnote 4—Amendment history

Endnotes about misdescribed amendments and other matters are included in a compilation only as necessary.

Abbreviation key—Endnote 2

The abbreviation key sets out abbreviations that may be used in the endnotes.

Legislation history and amendment history—Endnotes 3 and 4

Amending laws are annotated in the legislation history and amendment history.

The legislation history in endnote 3 provides information about each law that has amended (or will amend) the compiled law. The information includes commencement details for amending laws and details of any application, saving or transitional provisions that are not included in this compilation.

The amendment history in endnote 4 provides information about amendments at the provision (generally section or equivalent) level. It also includes information about any provision of the compiled law that has been repealed in accordance with a provision of the law.

Misdescribed amendments

A misdescribed amendment is an amendment that does not accurately describe the amendment to be made. If, despite the misdescription, the amendment can be given effect as intended, the amendment is incorporated into the compiled law and the abbreviation “(md)” added to the details of the amendment included in the amendment history.

If a misdescribed amendment cannot be given effect as intended, the abbreviation “(md not incorp)” is added to the details of the amendment included in the amendment history.

Endnote 2—Abbreviation key

Endnote 2—Abbreviation key

| | |
|--|--|
| A = Act | o = order(s) |
| ad = added or inserted | Ord = Ordinance |
| am = amended | orig = original |
| amdt = amendment | par = paragraph(s)/subparagraph(s) /sub-subparagraph(s) |
| c = clause(s) | pres = present |
| C[x] = Compilation No. x | prev = previous (prev...) = previously |
| Ch = Chapter(s) | Pt = Part(s) |
| def = definition(s) | r = regulation(s)/rule(s) |
| Dict = Dictionary | Reg = Regulation/Regulations |
| disallowed = disallowed by Parliament | reloc = relocated |
| Div = Division(s) | renum = renumbered |
| exp = expires/expired or ceases/ceased to have effect | rep = repealed |
| F = Federal Register of Legislative Instruments | rs = repealed and substituted |
| gaz = gazette | s = section(s)/subsection(s) |
| LI = Legislative Instrument | Sch = Schedule(s) |
| LIA = <i>Legislative Instruments Act 2003</i> | Sdiv = Subdivision(s) |
| (md) = misdescribed amendment can be given effect | SLI = Select Legislative Instrument |
| (md not incorp) = misdescribed amendment cannot be given effect | SR = Statutory Rules |
| mod = modified/modification | Sub-Ch = Sub-Chapter(s) |
| No. = Number(s) | SubPt = Subpart(s) |
| | <u>underlining</u> = whole or part not commenced or to be commenced |

Endnotes

Endnote 3—Legislation history

Endnote 3—Legislation history

| Number and year | FRLI registration | Commencement | Application, saving and transitional provisions |
|------------------------|-------------------------------|--|--|
| 84, 2015 | 19 June 2015 (F2015L00853) | 1 July 2015 (s 2) | |
| 143, 2015 | 21 Aug 2015 (F2015L01301) | Sch 1 (items 2–112): 1 Sept 2015 (s 2(1) item 1) | — |

Endnote 4—Amendment history

| Provision affected | How affected |
|---------------------------|---------------------|
| s 2 | rep LIA s 48D |
| Schedule 1 | |
| Part 1 | |
| Division 1.2 | |
| c 1.2.7 | am No 143, 2015 |
| c 1.2.8 | am No 143, 2015 |
| Part 2 | |
| Division 2.16 | |
| c 2.16.14 | am No 143, 2015 |
| Division 2.18A | |
| c 2.18A.2 | am No 143, 2015 |
| Division 2.28 | |
| c 2.28.4 | am No 143, 2015 |
| c 2.28.5A | ad No 143, 2015 |
| c 2.28.5B | ad No 143, 2015 |
| Group A10 Table | am No 143, 2015 |
| Division 2.34 | |
| c 2.34.3 | ad No 143, 2015 |
| Group D1 Table | am No 143, 2015 |
| Division 2.38 | |
| c 2.38.3 | am No 143, 2015 |
| Group T2 Table | am No 143, 2015 |
| Division 2.42 | |
| Group T7 Table | am No 143, 2015 |
| Division 2.44 | |
| Subdivision B | |
| Group T8 Table | am No 143, 2015 |
| Subdivision C | |

Endnotes

Endnote 4—Amendment history

| Provision affected | How affected |
|---------------------------|---------------------|
| Group T8 Table | am No 143, 2015 |
| Subdivision D | |
| Group T8 Table | am No 143, 2015 |
| Subdivision E | |
| Group T8 Table | am No 143, 2015 |
| Schedule 2 | rep LIA s 48C |
