Health Insurance (General Medical Services Table) Regulations 2021

I, General the Honourable David Hurley AC DSC (Retd), Governor-General of the Commonwealth of Australia, acting with the advice of the Federal Executive Council, make the following regulations.

Dated 27 May 2021

David Hurley
Governor-General

By His Excellency's Command

Greg Hunt
Minister for Health and Aged Care

Contents

1 Name

This instrument is the *Health Insurance (General Medical Services Table) Regulations 2021*.

2 Commencement

(1) Each provision of this instrument specified in column 1 of the table commences, or is taken to have commenced, in accordance with column 2 of the table. Any other statement in column 2 has effect according to its terms.

Commencement information

Column 1	Column 2	Column 3
Provisions	**Commencement**	**Date/Details**
1. The whole of this instrument	1 July 2021.	1 July 2021

Note: This table relates only to the provisions of this instrument as originally made. It will not be amended to deal with any later amendments of this instrument.

(2) Any information in column 3 of the table is not part of this instrument. Information may be inserted in this column, or information in it may be edited, in any published version of this instrument.

3 Authority

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

4 General medical services table

For the purposes of subsection 4(1) of the *Health Insurance Act 1973*, Schedule 1 is prescribed as a table of medical services.

5 Schedules

Each instrument that is specified in Schedule 2 to this instrument is amended or repealed as set out in the applicable items in that Schedule, and any other item in that Schedule has effect according to its terms.

Schedule 1—General medical services table

Note: See section 4.

Part 1—Preliminary

Division 1.1—Interpretation

1.1.1 Dictionary

The Dictionary in Part 7 defines certain words and expressions that are used in this Schedule, and includes references to certain words and expressions that are defined elsewhere in this Schedule.

1.1.2 Meaning of eligible non-vocationally recognised medical practitioner

(1) In this Schedule:

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; 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; 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.

(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.

1.1.3 General practitioners

For the purposes of paragraph (b) of the definition of ***general practitioner*** in subsection 3(1) of the Act, the following medical practitioners are specified:

(a) a medical practitioner who is undertaking a placement in general practice that is approved by the Royal Australian College of General Practitioners (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;

(b) an eligible non-vocationally recognised medical practitioner;

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

(d) a medical practitioner who is undertaking a placement in general practice that is approved by the Australian College of Rural and Remote Medicine (the ***ACRRM***):
  (i) as part of a training program for general practice leading to the award of Fellowship of the ACRRM; or
  (ii) as part of another training program recognised by the ACRRM as being of an equivalent standard.

Note: For other medical practitioners who are general practitioners, see the definition of ***general practitioner*** in subsection 3(1) of the Act and section 16 of the *Health Insurance Regulations 2018*.

1.1.4 Meaning of multidisciplinary case conference

In this Schedule:

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.

1.1.5 Meaning of multidisciplinary case conference team

(1) In this Schedule, a ***multidisciplinary case conference team*** for a patient:
  (a) includes a medical practitioner; and
  (b) either:
    (i) for items 735 to 758, 825 to 828, 855 to 858, 6029 to 6042 and 6064 to 6075—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 an unpaid 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;
(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 the purposes of 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.

1.1.6 Meaning of single course of treatment

(1) Use this clause for items 104 to 131, 133, 384 to 388, 2799, 2801 to 2840, 3003, 3005 to 3028, 6004, 6007 to 6015, 6018, 6019, 6024, 6025, 6026, 6051, 6052, 6058, 6059, 6060, 6062, 6063, 16401, 16404, 16406, 51700 and 51703.

(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 section 102 of the *Health Insurance Regulations 2018* 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.

Note: Division 4 of Part 11 of the *Health Insurance Regulations 2018* prescribes the manner in which patients are to be referred when an item in this Schedule specifies a service that is to be rendered by a specialist or consultant physician to a patient who has been referred.

1.1.7 Meaning of symbol (H)

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

1.1.8 References in this Schedule to items include items determined under section 3C of the Act

A reference in this Schedule to an item includes a reference to an item relating to a health service that, under a determination in force under subsection 3C(1) of the Act, is treated as if there were an item in the table that relates to the service.

Division 1.2—General application provisions

1.2.1 Application

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

Clause 1.2.2

1.2.2 Restrictions on certain items—attendances by specialists and consultant physicians without referrals

(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, 6018 to 6028, 6051 to 6063, 13210, 16399, 16401, 16404, 16407, 16408, 16508, 16509, 16533, 16534, 17609, 17640 to 17655, 90260, 90261, 90262, 90263, 90266, 90267, 90268 and 90269.

(2) The item does not apply to an attendance on a patient by a specialist or consultant physician if:

(a) the attendance forms part of a single course of treatment for the patient; and

(b) the attendance is after the end of the period of validity (under section 102 of the *Health Insurance Regulations 2018*) of the referral that was valid for the initial attendance on the patient by the specialist or consultant physician in the single course of treatment; and

(c) the attendance is not within the period of validity (under section 102 of the *Health Insurance Regulations 2018*) of a later referral.

Note: Division 4 of Part 11 of the *Health Insurance Regulations 2018* prescribes the manner in which patients are to be referred when an item in this Schedule specifies a service that is to be rendered by a specialist or consultant physician to a patient who has been referred.

1.2.3 Restrictions on certain items—attendances by specialist radiologists in conjunction with certain diagnostic imaging services

(1) Use this clause for items 52, 53, 54, 57, 104 and 105.

(2) The item does not apply to an attendance on a patient by a specialist in the specialty of diagnostic radiology if the attendance is in association with a service to which any of the following items of the diagnostic imaging services table applies:

(a) an item in Subgroup 6 of Group I1;

(b) an item in any of Subgroups 1 to 7 of Group I3;

(c) items 58900 and 58903 in Subgroup 8 of Group I3;

(d) item 59103 in Subgroup 9 of Group I3.

1.2.4 Restrictions on certain items—attendances by specialists and consultant physicians on same day as they perform certain surgical operations

(1) Use this clause for items 105, 116, 119, 386, 2806, 2814, 3010, 3014, 6009 to 6015, 6019, 6052 and 16404.

(2) The item does not apply to a service if:

(a) the service is an attendance on a patient by a specialist or a consultant physician on the same day as the day on which an operation is performed on the patient by the specialist or consultant physician; and

(b) the operation is a service to which an item in Group T8 applies; and

(c) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $309.35 or more.

1.2.5 Professional attendance services—matters included

(1) Use this clause for items 3 to 338, 348 to 389, 410 to 417, 585 to 600, 900, 903, 2497 to 2840, 3003, 3005 to 3028, 5000 to 5267, 6004, 6007 to 6016, 6018 to 6026, 6051 to 6063, 13210, 13899, 16399, 16401, 16404, 16406, 16407, 16508, 16509, 16533, 16534, 17609 to 17690, 90020 to 90096 and 90250 to 90282.

(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 65, 5000 to 5267 and 90020 to 90096; and

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

1.2.6 Personal attendance by medical practitioners generally—application and matters included

(1) Use this clause for items 3 to 149, 173 to 338, 348 to 417, 585 to 600, 2100 to 2478, 2497 to 2840, 3003, 3005 to 3028, 35570, 35571, 35573, 35577, 35581, 35582, 35585, 4001 to 6016, 6018 to 6024, 6051 to 6058, 6062, 6063, 10801 to 10816, 11012 to 11021, 11304, 11600, 11627, 11705, 11724, 11731, 11921 to 12004, 12201, 13030 to 13104, 13106 to 13110, 13209, 13210, 13290 to 13700, 13815 to 13899, 14100 to 14124, 14203 to 14212, 14224, 14255 to 14288, 15600, 16003 to 16512, 16515 to 51318, 90020 to 90096 and 90250 to 90282.

(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, 2461, 2463, 2464, 2465, 2471, 2472, 2475, 2478, 2799, 2820, 3003, 3015, 6004, 6016, 6025, 6026, 6059, 6060, 13210, 16399, 17609, 90262, 90263, 90268, 90269, 90279, 90280, 90281 and 90282.

1.2.7 Personal attendance by medical practitioners—application and matters included

(1) Use this clause for items 3 to 723, 732, 900 to 6016, 6018 to 6024, 6028, 6051 to 6058, 6062, 6063, 10801 to 10816, 11012 to 11021, 11304, 11600, 11627, 11705, 11724, 11728, 11731, 11820, 11823, 11921, 12000, 12003, 12004, 12201, 13030 to 13104, 13106 to 13110, 13209, 13210, 13290 to 13700, 13815 to 13899, 14100 to 14124, 14203 to 14212, 14224, 14255 to 14288, 15600, 16003 to 16512, 16515 to 51318, 90020 to 90096 and 90250 to 90282.

(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, 2461, 2463, 2464, 2465, 2471, 2472, 2475, 2478, 2799, 2820, 3003, 3015, 6004, 6016, 6025, 6026, 6059, 6060, 13210, 16399, 17609, 90262, 90263, 90268, 90269, 90279, 90280, 90281 and 90282.

1.2.8 Restriction on items—services provided with non-medicare services

Items 3 to 10816, 90020 to 90096 and 90250 to 90282 do not apply to a service described in the item if the service is provided at the same time as, or in connection with, a non-medicare service.

1.2.9 Restrictions on items—services rendered in certain circumstances or for certain purposes

An item in this Schedule does not apply to a service described in the item if the service is rendered in any of the following circumstances:

(a) the service is rendered in relation to the provision of chelation therapy, in the form of the intravenous administration of ethylenediamine tetra-acetic acid or any of its salts, otherwise than for the treatment of heavy-metal poisoning;

(b) the service is rendered in association with the injection of human chorionic gonadotrophin in the management of obesity;

(c) the service is rendered in relation to the use of hyperbaric oxygen therapy in the treatment of multiple sclerosis;

(d) the service is rendered for the purpose of, or in relation to, the removal of tattoos;

(e) the service is rendered for the purposes of, or in relation to, the removal from a cadaver of kidneys for transplantation;

(f) the service is rendered to a patient of a hospital for the purposes of, or in relation to:

(i) the transplantation of a thoracic or abdominal organ, other than a kidney, or of part of an organ of that kind; or

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

(g) the service is rendered for the purpose of administering microwave (UHF radiowave) cancer therapy, including the intravenous injection of drugs used immediately before or during the therapy;

(h) the service is rendered to a patient at the same time as, or in connection with, an injection of blood or a blood product that is autologous.

1.2.10 Restriction on items—services provided with harvesting, storage, in vitro processing or injection of non-haematopoietic stem cells

An item in this Schedule does not apply to a service described in the item if the service is provided to a patient at the same time as, or in connection with, the harvesting, storage, in vitro processing or injection of non-haematopoietic stem cells.

1.2.11 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, 11009, 11024, 11027, 11200, 11203, 11204, 11205, 11210, 11211, 11215, 11218, 11221, 11224, 11235, 11237, 11240, 11241, 11242, 11243, 11244, 11300, 11303, 11306, 11309, 11312, 11315, 11318, 11324, 11327, 11330, 11332, 11333, 11336, 11339, 11503, 11505, 11506, 11507, 11508, 11512, 11602, 11604, 11605, 11610, 11611, 11612, 11614, 11615, 11704, 11707, 11713, 11714, 11715, 11716, 11717, 11718, 11721, 11723, 11725, 11726, 11727, 11729, 11730, 11735, 11800, 11810, 11830, 11833, 11900, 11903, 11906, 11909, 11912, 11915, 11919, 12012, 12017, 12021, 12022, 12024, 12200, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217, 12250 to 12272, 12500 to 12527, 13015, 13020, 13025, 13200 to 13203, 13206, 13212, 13215, 13218, 13221, 13703, 13706, 13750, 13755, 13757, 13760, 14050, 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.

1.2.12 Restriction on items—services involving video conferences between patients and medical practitioners separated by at least 15 km

If it is a condition of a service, in an item, involving a video conference between a patient and a medical practitioner that the patient and practitioner be at least 15 km by road from one another, the item does not apply if the patient or the practitioner travels to ensure that the condition is met.

Note: This clause has effect whether the condition is set out in the item or not.

1.2.13 Restriction on items—attendances on same day as electrocardiogram services are performed

(1) An item in Part 2 of this Schedule does not apply to a service (the ***attendance service***) provided by a specialist or consultant physician to a patient on a day if an electrocardiogram service to which item 11716, 11717, 11723, 11729 or 11735 applies is provided by the specialist or consultant physician to the patient on the same day.

(2) Subclause (1) does not apply if:
  (a) the patient has been referred to the specialist or consultant physician; or
  (b) the patient is being provided with ongoing care by the specialist or consultant physician; or
  (c) both of the following apply:
    (i) another medical practitioner has requested the electrocardiogram service;
    (ii) the attendance service is provided at the same time as, or after, the electrocardiogram service and is required because there is an urgent clinical need to make decisions about the patient's care as a result of the electrocardiogram service.

1.2.14 Restriction on items—attendances on same day as echocardiogram services or myocardial perfusion study services are performed

(1) An item in Part 2 of this Schedule does not apply to a service (the ***attendance service***) provided to a patient on a day if either of the following is provided to the patient on the same day:
  (a) an echocardiogram service to which item 55126, 55127, 55128, 55129, 55132, 55133, 55134, 55137, 55141, 55143, 55145 or 55146 applies;
  (b) a myocardial perfusion study service to which item 61321, 61324, 61325, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 or 61414 applies.

(2) Subclause (1) does not apply if:

(a) both:
  (i) the attendance service is provided after another service is provided to the patient; and
  (ii) clinical management decisions are made about the patient during that other service; or

(b) the decision to perform the echocardiogram service or the myocardial perfusion study service on the same day is made as a result of a clinical assessment of the patient during the attendance service.

Part 2—Attendances

Division 2.1—Preliminary

2.1.1 Meaning of amount under clause 2.1.1

In an item of this Schedule 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 Items of this Schedule	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	27.40	2.15
2	24	The fee for item 23	27.40	2.15
3	37	The fee for item 36	27.40	2.15
4	47	The fee for item 44	27.40	2.15
5	58	$8.50	15.50	0.70
6	59, 2610, 2631, 2673	$16.00	17.50	0.70
7	60, 2613, 2633, 2675	$35.50	15.50	0.70
8	65, 2616, 2635, 2677	$57.50	15.50	0.70
9	195	The fee for item 193	27.00	2.10
10	414	The fee for item 410	26.90	2.10
11	415	The fee for item 411	26.90	2.10
12	416	The fee for item 412	26.90	2.10
13	417	The fee for item 413	26.90	2.10
14	2503	The fee for item 2501	27.00	2.10
15	2506	The fee for item 2504	27.00	2.10
16	2509	The fee for item 2507	27.00	2.10
17	2518	The fee for item 2517	27.00	2.10
18	2522	The fee for item 2521	27.00	2.10

Table 2.1.1—Amount under clause 2.1.1

Item	Column 1 Items of this Schedule	Column 2 Fee	Column 3 Amount if not more than 6 patients (to be divided by the number of patients) ($)	Column 4 Amount if more than 6 patients ($)
19	2526	The fee for item 2525	27.00	2.10
20	2547	The fee for item 2546	27.00	2.10
21	2553	The fee for item 2552	27.00	2.10
22	2559	The fee for item 2558	27.00	2.10
23	5003	The fee for item 5000	27.00	2.10
24	5010	The fee for item 5000	48.60	3.45
25	5023	The fee for item 5020	27.00	2.10
26	5028	The fee for item 5020	48.60	3.45
27	5043	The fee for item 5040	27.00	2.10
28	5049	The fee for item 5040	48.60	3.45
29	5063	The fee for item 5060	27.00	2.10
30	5067	The fee for item 5060	48.60	3.45
31	5220	$18.50	15.50	0.70
32	5223	$26.00	17.50	0.70
33	5227	$45.50	15.50	0.70
34	5228	$67.50	15.50	0.70
35	5260	$18.50	27.95	1.25
36	5263	$26.00	31.55	1.25
37	5265	$45.50	27.95	1.25
38	5267	$67.50	27.95	1.25
39	90272	The fee for item 90271	27.00	2.10
40	90274	The fee for item 90273	27.00	2.10
41	90276	The fee for item 90275	21.60	1.70
42	90278	The fee for item 90277	21.60	1.70

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

2.2.1 Items in Group A1

This clause sets out items in Group A1.

Clause 2.2.1

Group A1—General practitioner attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **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	17.90
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 this Schedule applies) that requires a short patient history and, if necessary, limited examination and management—an attendance on one or more patients at one place on one occasion—each patient	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 this Schedule 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	39.10
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 this Schedule 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
36	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	75.75
37	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which	Amount under

Group A1—General practitioner attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	another item in this Schedule applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one place on one occasion—each patient	clause 2.1.1
44	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	111.50
47	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in this Schedule applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one place on one occasion—each patient	Amount under clause 2.1.1

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

2.3.1 Items in Group A2

This clause sets out items in Group A2.

Clause 2.3.1

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
52	Professional attendance at consulting rooms lasting not more than 5 minutes (other than a service to which any other item applies) by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	11.00
53	Professional attendance at consulting rooms lasting more than 5 minutes, but not more than 25 minutes (other than a service to which any other item applies) by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	21.00
54	Professional attendance at consulting rooms lasting more than 25 minutes, but not more than 45 minutes (other than a service to which any other item applies) by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	38.00
57	Professional attendance at consulting rooms lasting more than 45 minutes (other than a service to which any other item applies) by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	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 this Schedule applies), lasting not more than 5 minutes—an attendance on one or more patients at one place on one occasion—each patient, by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	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 this Schedule applies) lasting more than 5 minutes, but not more than 25 minutes—an attendance on one or more patients at one place on one occasion—each patient, by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	Amount under clause 2.1.1
60	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in this Schedule applies) lasting more than 25 minutes, but not more than 45 minutes—an attendance on one or more patients at one place on one occasion—each patient, by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	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 this Schedule applies) lasting more than 45 minutes—an attendance on one or more patients at one place on one occasion—each patient, by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	Amount under clause 2.1.1

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

2.4.1 Items in Group A3

This clause sets out items in Group A3.

Group A3—Specialist attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
99	Professional attendance on a patient by a specialist practising in the specialist's 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 km by road from the specialist; or (ii) is a care recipient in a residential aged care facility; 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 the specialist's specialty after referral of the patient to the specialist—initial attendance in a single course of treatment, other than a service to which item 106, 109 or 16401 applies	90.35
105	Professional attendance by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist—an attendance after the initial attendance in a single course of treatment, if that attendance is at consulting rooms or hospital, other than a service to which item 16404 applies	45.40
106	Professional attendance by a specialist in the practice of the specialist's specialty of ophthalmology and following referral of the patient to the specialist—an initial attendance 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)	74.95
107	Professional attendance by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist—an initial attendance, if that attendance is at a place other than consulting rooms or hospital	132.60
108	Professional attendance by a specialist in the practice of the specialist's	83.95

Clause 2.4.1

Group A3—Specialist attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	specialty following referral of the patient to the specialist—an attendance after the initial attendance in a single course of treatment, if that attendance is at a place other than consulting rooms or hospital	
109	Professional attendance by a specialist in the practice of the specialist's specialty of ophthalmology following referral of the patient to the specialist—an initial attendance 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)	203.65
111	Professional attendance at consulting rooms or in hospital by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist by a referring practitioner—an attendance after the initial attendance in a single course of treatment, if: (a) during the attendance, the specialist determines the need to perform an operation on the patient that had not otherwise been scheduled; and (b) the specialist subsequently performs the operation on the patient, on the same day; and (c) the operation is a service to which an item in Group T8 applies; and (d) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $312.15 or more For any particular patient, once only on the same day	45.40
113	Initial professional attendance lasting 10 minutes or less on a patient by a specialist in the practice of the specialist's 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 km by road from the specialist; or (ii) is a care recipient in a residential aged care facility; 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	67.80
115	Professional attendance at consulting rooms or in hospital on a day by a medical practitioner (the ***attending practitioner***) who is a specialist or consultant physician in the practice of the attending practitioner's specialty after referral of the patient to the attending practitioner by a referring practitioner—an attendance after the initial attendance in a single course of treatment, if:	45.40

Group A3—Specialist attendances to which no other item applies		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(a) the attending practitioner performs a scheduled operation on the patient on the same day; and (b) the operation is a service to which an item in Group T8 applies; and (c) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $312.15 or more; and (d) the attendance is unrelated to the scheduled operation; and (e) it is considered a clinical risk to defer the attendance to a later day For any particular patient, once only on the same day	

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

2.5.1 Items in Group A4

This clause sets out items in Group A4.

Group A4—Consultant physician (other than psychiatry) attendances to which no other item applies		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
110	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner—initial attendance in a single course of treatment	159.35
112	Professional attendance on a patient by a consultant physician practising in the consultant physician's 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 km by road from the physician; or (ii) is a care recipient in a residential aged care facility; 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 110, 116, 119, 132 or 133
114	Initial professional attendance lasting 10 minutes or less on a patient by	119.55

Clause 2.5.1

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	a consultant physician practising in the consultant physician's 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 km by road from the physician; or (ii) is a care recipient in a residential aged care facility; 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	
116	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner—an attendance (other than a service to which item 119 applies) after the initial attendance in a single course of treatment	79.75
117	Professional attendance at consulting rooms or in hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner—an attendance after the initial attendance in a single course of treatment, if: (a) the attendance is not a minor attendance; and (b) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and (c) the consultant physician subsequently performs the operation on the patient, on the same day; and (d) the operation is a service to which an item in Group T8 applies; and (e) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $312.15 or more For any particular patient, once only on the same day	79.75
119	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner—minor attendance	45.40
120	Professional attendance at consulting rooms or in hospital by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the	45.40

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	consultant physician by a referring practitioner—minor attendance, if: (a) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and (b) the consultant physician subsequently performs the operation on the patient, on the same day; and (c) the operation is a service to which an item in Group T8 applies; and (d) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $312.15 or more For any particular patient, once only on the same day	
122	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner—initial attendance in a single course of treatment	193.35
128	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner—an attendance (other than a service to which item 131 applies) after the initial attendance in a single course of treatment	116.95
131	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner—minor attendance	84.25
132	Professional attendance by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) lasting at least 45 minutes for an initial assessment of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders) following referral of the patient to the consultant physician by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) a consultant physician treatment and management plan of significant complexity is prepared and provided to the referring practitioner, which involves: (i) an opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) medication recommendations; and (c) an attendance on the patient to which item 110, 116 or 119 applies	278.75

Clause 2.6.1

Group A4—Consultant physician (other than psychiatry) attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	did not take place on the same day by the same consultant physician; and (d) this item has not applied to an attendance on the patient in the preceding 12 months by the same consultant physician	
133	Professional attendance by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) lasting at least 20 minutes after the initial attendance in a single course of treatment for a review of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders) if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified consultant physician treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on the diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient to which item 110, 116 or 119 applies did not take place on the same day by the same consultant physician; and (d) item 132 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same consultant physician who claimed item 132 or a locum tenens; and (f) this item has not applied more than twice in any 12 month period	139.55

Division 2.6—Group A29: Early intervention services for children with autism, pervasive developmental disorder or disability

2.6.1 Meaning of eligible disability

In this Schedule:

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.

2.6.2 Meaning of risk assessment

In items 135, 137 and 139:

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.

2.6.3 Items in Group A29

This clause sets out items in Group A29.

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
135	Professional attendance lasting at least 45 minutes at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty of paediatrics, following referral of the patient to the consultant by a referring practitioner, for assessment, diagnosis and preparation of a treatment and management plan for a patient aged under 13 years with autism or another pervasive developmental disorder, if the consultant paediatrician does all of the following: (a) undertakes a comprehensive assessment and makes a diagnosis (if appropriate, using information provided by an eligible allied health	278.75

Clause 2.6.3

Group A29—Early intervention services for children with autism, pervasive developmental disorder or disability		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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—medical recommendations; (c) provides a copy of the treatment and management plan to: (i) the referring practitioner; and (ii) one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 137, 139 or 289)	
137	Professional attendance lasting at least 45 minutes at consulting rooms or hospital, by a specialist or consultant physician (not including a general practitioner) following referral of the patient to the specialist or consultant physician by a referring practitioner, for 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)	278.75
139	Professional attendance lasting at least 45 minutes 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: (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;	139.95

Group A29—Early intervention services for children with autism, pervasive developmental disorder or disability		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(iii) treatment options and decisions; (iv) if necessary—medication recommendations; (c) provides a copy of the treatment and management plan to one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 137 or 289)	

Division 2.7—Group A28: Geriatric medicine

2.7.1 Items in Group A28

This clause sets out items in Group A28.

Group A28—Geriatric medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
141	Professional attendance lasting more than 60 minutes at consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine, if: (a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and (c) during the attendance: (i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail using appropriately validated assessment tools if indicated (the ***assessment***); and (ii) the patient's various health problems and care needs are identified and prioritised (the ***formulation***); and (iii) a detailed management plan is prepared (the ***management plan***) setting out: (A) the prioritised list of health problems and care needs; and (B) short and longer term management goals; and (C) recommended actions or intervention strategies to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient and the patient's family and carers; and (iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers;	478.05

Clause 2.7.1

Group A28—Geriatric medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	and (v) the management plan is communicated in writing to the referring practitioner; and (d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (e) an attendance to which this item or item 145 applies has not been provided to the patient by the same practitioner in the preceding 12 months	
143	Professional attendance lasting more than 30 minutes at consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under item 141 or 145, if: (a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and (b) during the attendance: (i) the patient's health status is reassessed; and (ii) a management plan prepared under item 141 or 145 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116 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 further review	298.85
145	Professional attendance lasting more than 60 minutes at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine, if: (a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and (c) during the attendance: (i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail utilising appropriately validated assessment tools if indicated (the ***assessment***); and (ii) the patient's various health problems and care needs are identified and prioritised (the ***formulation***); and	579.65

Group A28—Geriatric medicine

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(iii) a detailed management plan is prepared (the ***management plan***) setting out: (A) the prioritised list of health problems and care needs; and (B) short and longer term management goals; and (C) recommended actions or intervention strategies, to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient, the patient's family and any carers; and (iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and (v) the management plan is communicated in writing to the referring practitioner; and (d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (e) an attendance to which this item or item 141 applies has not been provided to the patient by the same practitioner in the preceding 12 months	
147	Professional attendance lasting more than 30 minutes at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under items 141 or 145, if: (a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and (b) during the attendance: (i) the patient's health status is reassessed; and (ii) a management plan that was prepared under item 141 or 145 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and (e) an attendance to which this item or 143 applies has not been provided by the same practitioner in the preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review	362.35
149	Professional attendance on a patient by a consultant physician or specialist practising in the consultant physician's or specialist's specialty of geriatric medicine if: (a) the attendance is by video conference; and	50% of the fee for item 141 or 143

Clause 2.8.1

Group A28—Geriatric medicine		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(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 km by road from the physician or specialist; or (ii) is a care recipient in a residential aged care facility; 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 2.8—Group A5: Prolonged attendances to which no other item applies

2.8.1 Restrictions on items in Group A5

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

(2) If the personal attendance is provided by one or more general practitioners, specialists or consultant physicians concurrently, each general practitioner, specialist or consultant physician 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.

2.8.2 Items in Group A5

This clause sets out items in Group A5.

Group A5—Prolonged attendances to which no other item applies		
Column 1	**Column 2**	**Column 3**
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	230.50
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	384.15
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	537.55

Group A5—Prolonged attendances to which no other item applies		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	patient in imminent danger of death	
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	691.50
164	Professional attendance for a period of 5 hours or more (other than a service to which another item applies) on a patient in imminent danger of death	768.30

Division 2.9—Group A6: Group therapy

2.9.1 Items in Group A6

This clause sets out items in Group A6.

Group A6—Group therapy		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
170	Professional attendance for the purpose of group therapy lasting at least 1 hour given under the direct continuous supervision of a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of the consultant physician's specialty of psychiatry) involving members of a family and persons with close personal relationships with that family—each group of 2 patients	122.35
171	Professional attendance for the purpose of group therapy lasting at least 1 hour given under the direct continuous supervision of a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of the consultant physician's specialty of psychiatry) involving members of a family and persons with close personal relationships with that family—each group of 3 patients	128.90
172	Professional attendance for the purpose of group therapy lasting at least 1 hour given under the direct continuous supervision of a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of the consultant physician's specialty of psychiatry) involving members of a family and persons with close personal relationships with that family—each group of 4 or more patients	156.80

Clause 2.10.1

Division 2.10—Group A7: Acupuncture and non-specialist practitioner items

2.10.1 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.

2.10.2 Items in Group A7

This clause sets out items in Group A7.

Group A7—Acupuncture and non-specialist practitioner items		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 1—Acupuncture		
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	38.55
195	Professional attendance by a general practitioner who is a qualified medical acupuncturist, on one or more patients at a hospital, lasting less than 20 minutes and including any of 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,	Amount under clause 2.1.1

Group A7—Acupuncture and non-specialist practitioner items		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	
197	Professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	74.60
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	109.85

Division 2.11—Group A8: Consultant psychiatrist attendances to which no other item applies

2.11.1 Restriction on timing of services in items 291, 293 and 359

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

Clause 2.11.2

2.11.2 Restriction on 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.

2.11.3 Restriction on items 353 to 361—location of patient

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

2.11.4 Meaning of risk assessment

In item 289:

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.

2.11.5 Items in Group A8

This clause sets out items in Group A8.

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
288	Professional attendance on a patient by a consultant physician practising in the consultant physician's specialty of psychiatry if: (a) the attendance is by video conference; and (b) item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 348, 350 or 352 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 km by road from the physician; or (ii) is a care recipient in a residential aged care facility; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies	50% of the fee for item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 348, 350 or 352
289	Professional attendance lasting at least 45 minutes at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant physician by a referring practitioner, for 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 physician does all of the following:	278.75

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(a) undertakes a comprehensive assessment and makes a diagnosis (if appropriate, using information provided by an eligible allied health provider); (b) develops a treatment and management plan which must include the following: (i) an assessment and diagnosis of the patient's condition; (ii) a risk assessment; (iii) treatment options and decisions; (iv) if necessary—medication recommendations; (c) provides a copy of the treatment and management plan to the referring practitioner; (d) provides a copy of the treatment and management plan to one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 137 or 139)	
291	Professional attendance lasting more than 45 minutes at consulting rooms by a consultant physician in the practice of the consultant physician's specialty of psychiatry, if: (a) the attendance follows referral of the patient to the consultant for an assessment or management by a medical practitioner in general practice (including a general practitioner, but not a specialist or consultant physician) or a participating nurse practitioner; and (b) during the attendance, the consultant: (i) uses an outcome tool (if clinically appropriate); and (ii) carries out a mental state examination; and (iii) makes a psychiatric diagnosis; and (c) the consultant decides that it is clinically appropriate for the patient to be managed by the referring practitioner without ongoing treatment by the consultant; and (d) within 2 weeks after the attendance, the consultant: (i) prepares a written diagnosis of the patient; and (ii) prepares a written management plan for the patient that: (A) covers the next 12 months; and (B) is appropriate to the patient's diagnosis; and (C) comprehensively evaluates the patient's biological, psychological and social issues; and (D) addresses the patient's diagnostic psychiatric issues; and (E) makes management recommendations addressing the patient's biological, psychological and social issues; and (iii) gives the referring practitioner a copy of the diagnosis and the management plan; and (iv) if clinically appropriate, explains the diagnosis and management plan, and a gives a copy, to: (A) the patient; and	478.05

Clause 2.11.5

Group A8—Consultant psychiatrist attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(B) the patient's carer (if any), if the patient agrees	
293	Professional attendance lasting more than 30 minutes, but not more than 45 minutes, at consulting rooms by a consultant physician in the practice of the consultant physician's specialty of psychiatry, if: (a) the patient is being managed by a medical practitioner or a participating nurse practitioner in accordance with a management plan prepared by the consultant in accordance with item 291; 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 359 applies has not been provided	298.85
296	Professional attendance lasting more than 45 minutes by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance at consulting rooms if the patient: (a) is a new patient for this consultant physician; or (b) has not received a professional attendance from this consultant physician in the preceding 24 months; other than attendance on a patient in relation to whom this item, 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	274.95
297	Professional attendance lasting more than 45 minutes by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance at hospital if the patient: (a) is a new patient for this consultant physician; or (b) has not received a professional attendance from this consultant physician in the preceding 24 months;	274.95

Group A8—Consultant psychiatrist attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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)	
299	Professional attendance lasting more than 45 minutes by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance at a place other than consulting rooms or a hospital if the patient: (a) is a new patient for this consultant physician; or (b) has not received a professional attendance from this consultant physician in the preceding 24 months; other than attendance on a patient in relation to whom this item, 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	328.75
300	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting not more than 15 minutes at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	45.75
302	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 15 minutes, but not more than 30 minutes, at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	91.30
304	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 30 minutes, but not more than 45 minutes, at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	140.55
306	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 45 minutes, but not more than 75 minutes, at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	194.00
308	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral	225.10

Clause 2.11.5

Group A8—Consultant psychiatrist attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 75 minutes at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	
310	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting not more than 15 minutes at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient	22.80
312	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 15 minutes, but not more than 30 minutes, at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient	45.75
314	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 30 minutes, but not more than 45 minutes, at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient	70.45
316	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 45 minutes, but not more than 75 minutes, at consulting rooms, if that 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	97.10
318	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 75 minutes at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient	112.60
319	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 45 minutes at consulting rooms, if the patient has:	194.00

Group A8—Consultant psychiatrist attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) been diagnosed as suffering severe personality disorder, anorexia nervosa, bulimia nervosa, dysthymic disorder, substance-related disorder, somatoform disorder or a pervasive development disorder; and (b) for patients 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 the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting not more than 15 minutes at hospital	45.75
322	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 15 minutes, but not more than 30 minutes, at hospital	91.30
324	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 30 minutes, but not more than 45 minutes, at hospital	140.55
326	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 45 minutes, but not more than 75 minutes, at hospital	194.00
328	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 75 minutes at hospital	225.10
330	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting not more than 15 minutes if that attendance is at a place other than consulting rooms or hospital	84.05
332	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 15 minutes, but not more than 30 minutes, if that attendance is at a place other than consulting rooms or hospital	131.60
334	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—	191.80

Clause 2.11.5

Group A8—Consultant psychiatrist attendances to which no other item applies		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	an attendance lasting more than 30 minutes, but not more than 45 minutes, if that attendance is at a place other than consulting rooms or hospital	
336	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 45 minutes, but not more than 75 minutes, if that attendance is at a place other than consulting rooms or hospital	232.05
338	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 75 minutes if that attendance is at a place other than consulting rooms or hospital	263.55
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) lasting at least 1 hour given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry, involving a group of 2 to 9 unrelated patients or a family group of more than 3 patients, each of whom is referred to the consultant physician by a referring practitioner—each patient	52.05
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) lasting at least 1 hour given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry, involving a family group of 3 patients, each of whom is referred to the consultant physician by a referring practitioner—each patient	69.10
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) lasting at least 1 hour given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry, involving a family group of 2 patients, each of whom is referred to the consultant physician by a referring practitioner—each patient	102.20
348	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant physician by a referring practitioner, involving an interview of a person other than the patient lasting at least 20 minutes, but less than 45 minutes, in the course of initial diagnostic evaluation of a patient	133.85
350	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant physician by a referring practitioner, involving an interview of a person other than the patient lasting not	184.80

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	less than 45 minutes, in the course of initial diagnostic evaluation of a patient	
352	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant physician by a referring practitioner, involving an interview of a person other than the patient lasting at least 20 minutes, 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	133.85
353	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—a telepsychiatry consultation lasting not more than 15 minutes, 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	60.45
355	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—a telepsychiatry consultation lasting more than 15 minutes, but not more than 30 minutes, 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	120.85
356	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—a telepsychiatry consultation lasting more than 30 minutes, but not more than 45 minutes, 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	177.20
357	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—a telepsychiatry consultation lasting more than 45 minutes, but not more than 75 minutes, 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	244.45

Clause 2.11.5

Group A8—Consultant psychiatrist attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	calendar year for the patient; and (b) that attendance and another attendance to which any of items 296 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient	
358	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—a telepsychiatry consultation lasting more than 75 minutes, 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	297.85
359	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry—a telepsychiatry consultation lasting more than 30 minutes, but not more than 45 minutes, 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 physician in accordance with item 291; and (b) the attendance follows referral of the patient to the consultant physician for review of the management plan by the referring practitioner managing the patient; and (c) during the attendance, the consultant physician: (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 physician: (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) the patient is located in a regional, rural or remote area; and (f) in the preceding 12 months, a service to which item 291 applies has been performed; and (g) in the preceding 12 months, a service to which this item or item 293 applies has not been performed	343.65
361	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—a telepsychiatry consultation lasting more than 45 minutes, if the	316.10

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	patient: (a) either: (i) is a new patient for this consultant physician; or (ii) has not received a professional attendance from this consultant physician 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	
364	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—a face-to-face consultation lasting not more than 15 minutes, 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	45.75
366	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—a face-to-face consultation lasting more than 15 minutes, but not more than 30 minutes, 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	91.30
367	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—a face-to-face consultation lasting more than 30 minutes, but not more than 45 minutes, 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	140.55
369	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—a face-to-face consultation lasting more than 45 minutes, but not more than 75 minutes, 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	194.15

Clause 2.12.1

Group A8—Consultant psychiatrist attendances to which no other item applies		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	attendances in a calendar year for the patient	
370	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—a face-to-face consultation lasting more than 75 minutes, 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	225.10

Division 2.12—Group A12: Consultant occupational physician attendances to which no other item applies

2.12.1 Restrictions on items in Group A12—attendances by consultant occupational physicians

Items 384 to 389 apply to an attendance by a consultant occupational physician 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.

2.12.2 Items in Group A12

This clause sets out items in Group A12.

Group A12—Consultant occupational physician attendances to which no other item applies		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
384	Initial professional attendance lasting 10 minutes or less on a patient by a consultant occupational physician practising in the consultant occupational physician's 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:	67.80

Group A12—Consultant occupational physician attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 km by road from the physician; or (ii) is a care recipient in a residential aged care facility; 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	
385	Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine following referral of the patient to the consultant occupational physician by a referring practitioner—initial attendance in a single course of treatment	90.35
386	Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine following referral of the patient to the consultant occupational physician by a referring practitioner—an attendance after the initial attendance in a single course of treatment	45.40
387	Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine following referral of the patient to the consultant occupational physician by a referring practitioner—initial attendance in a single course of treatment	132.60
388	Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine following referral of the patient to the consultant occupational physician by a referring practitioner—an attendance after the initial attendance in a single course of treatment	83.95
389	Professional attendance on a patient by a consultant occupational physician practising in the consultant occupational physician's 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 km by road from	50% of the fee for item 385 or 386

Clause 2.13.1

Group A12—Consultant occupational physician attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	the physician; or (ii) is a care recipient in a residential aged care facility; 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 2.13—Group A13: Public health physician attendances to which no other item applies

2.13.1 Restrictions on items in Group A13—attendances by 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.

2.13.2 Items in Group A13

This clause sets out items in Group A13.

Group A13—Public health physician attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
410	Professional attendance at consulting rooms by a public health physician in the practice of the public health physician's specialty of public health medicine—attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management	20.65
411	Professional attendance by a public health physician in the practice of the public health physician's 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;	45.15

Group A13—Public health physician attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	
412	Professional attendance by a public health physician in the practice of the public health physician's 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	87.35
413	Professional attendance by a public health physician in the practice of the public health physician's 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	128.60
414	Professional attendance at other than consulting rooms by a public health physician in the practice of the public health physician's specialty of public health medicine—attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management	Amount under clause 2.1.1
415	Professional attendance by a public health physician in the practice of the public health physician's specialty of public health medicine at other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	Amount under clause 2.1.1
416	Professional attendance by a public health physician in the practice of the public health physician's specialty of public health medicine at other than consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history;	Amount under clause 2.1.1

Clause 2.14.1

Group A13—Public health physician attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **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	
417	Professional attendance by a public health physician in the practice of the public health physician's specialty of public health medicine at other than consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	Amount under clause 2.1.1

Division 2.14—Group A11: Urgent attendances after—hours

2.14.1 Meaning of patient's medical condition requires urgent assessment

(1) A ***patient's medical condition requires urgent assessment*** if:

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

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

(2) For the purposes of 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.

2.14.2 Restrictions on items in Group A11

(1) Items 585 to 600 do not apply to a service provided by a medical practitioner if:

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

(b) the practitioner:

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

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

(2) Items 585 to 600 do not apply to a professional attendance requested by:

(a) the attending medical practitioner; or
(b) an employee of the attending medical practitioner; or
(c) 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
(d) a call centre; or
(e) a reception service.

(3) Also, item 585, 588, 591, 599 or 600 applies to a service only if the practitioner keeps a record of the assessment of the patient.

2.14.4 Restrictions on items in Group A11—practitioners

(1) Item 585 does not apply to a service described in the item that is provided by an eligible non-vocationally recognised medical practitioner registered under the After Hours Other Medical Practitioners Program (within the meaning of subclause 1.1.2(2)) who provides the service through a medical deputising service.

(2) Each of items 588 and 591 apply to a service described in the item only if the service is rendered by:
(a) a medical practitioner other than a general practitioner; or
(b) an eligible non-vocationally recognised medical practitioner registered under the After Hours Other Medical Practitioners Program (within the meaning of subclause 1.1.2(2)) who provides the service through a medical deputising service.

2.14.5 Items in Group A11

This clause sets out items in Group A11.

Group A11—Urgent attendances after hours

Column 1 Item	Column 2 Description	Column 3 Fee ($)
585	Professional attendance by a general practitioner on one patient on one occasion in an after-hours period outside unsociable hours if: (a) the attendance is requested by or on behalf of the patient in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	135.10
588	Professional attendance by a medical practitioner on one patient on one occasion in an after-hours period outside unsociable hours if: (a) the attendance is requested by or on behalf of the patient in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) the attendance is in an after-hours rural area; and (d) if the attendance is at consulting rooms—it is necessary for the	135.10

Clause 2.15.1

Group A11—Urgent attendances after hours		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	practitioner to return to, and specially open, the consulting rooms for the attendance	
591	Professional attendance by a medical practitioner on one patient on one occasion in an after-hours period outside unsociable hours if: (a) the attendance is requested by or on behalf of the patient in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) the attendance is not in an after-hours rural area; and (d) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	93.65
594	Professional attendance by a medical practitioner—each additional patient at an attendance that qualifies for item 585, 588 or 591 in relation to the first patient	43.65
599	Professional attendance by a general practitioner on one patient on one occasion in unsociable hours if: (a) the attendance is requested by or on behalf of the patient in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	159.20
600	Professional attendance by a medical practitioner (other than a general practitioner) on one patient on one occasion in unsociable hours if: (a) the attendance is requested by or on behalf of the patient in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	127.25

Division 2.15—Group A14: Health assessments

2.15.1 Restrictions on items in Group A14

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

2.15.2 Types of health assessments

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

(a) a Type 2 Diabetes Risk Evaluation, in accordance with clause 2.15.4, 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;

(b) a 45 year old Health Assessment, in accordance with clause 2.15.5, 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;

(c) an Older Person's Health Assessment, in accordance with clause 2.15.6, 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;

(d) a Comprehensive Medical Assessment, in accordance with clause 2.15.7, for a patient who is a care recipient in a residential aged care facility;

(e) a health assessment, in accordance with clause 2.15.8, 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;

(f) a health assessment, in accordance with clause 2.15.9, 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;

(g) an Australian Defence Force Post-Discharge GP Health Assessment, in accordance with clause 2.15.10, 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.

(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.

Clause 2.15.3

2.15.3 Application of item 715

(1) Item 715 applies to the following health assessments:

(a) an Aboriginal and Torres Strait Islander child health assessment, in accordance with clause 2.15.11, for a patient if the patient is:

(i) under 15 years old; and

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

(b) an Aboriginal and Torres Strait Islander adult health assessment, in accordance with clause 2.15.12, for a patient if the patient is:

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

(ii) 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 2.15.13, for a patient if the patient is:

(i) at least 55 years old; and

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

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

2.15.4 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.

(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

(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.

2.15.5 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 general 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 general 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.

2.15.6 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 general 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.

2.15.7 Comprehensive Medical Assessment for care recipient in a residential aged care facility

(1) A Comprehensive Medical Assessment of a care recipient in 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 general 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.

2.15.8 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);
  (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 general 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 general 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.

2.15.9 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 general 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.

2.15.10 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*, as existing on 1 July 2020.

Note 1: The *ADF Post-discharge GP Health Assessment Tool* could in 2021 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 2021 be viewed on the Department of Veterans' Affairs' At Ease website (http://at-ease.dva.gov.au).

(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.

2.15.11 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 general practitioner; and
(b) taking the patient's history, including the following:
(i) mother's pregnancy history;
(ii) birth and neo-natal history;
(iii) breastfeeding history;
(iv) weaning, food access and dietary history;
(v) physical activity engaged in;
(vi) previous presentations, hospital admissions and medication use;
(vii) relevant family medical history;
(viii) immunisation status;
(ix) vision and hearing (including neo-natal hearing screening);
(x) development (including achievement of age-appropriate milestones);

(xi) family relationships, social circumstances and whether the patient 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 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).

2.15.12 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 general practitioner; and

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

(i) current health problems and risk factors;

(ii) relevant family medical history;

(iii) medication use (including medication obtained without prescription or from other doctors);

(iv) immunisation status, by reference to the appropriate current age and sex immunisation schedule;

(v) sexual and reproductive health;

(vi) physical activity, nutrition and alcohol, tobacco or other substance use;

(vii) hearing loss;

(viii) mood (including incidence of depression and risk of self-harm);

(ix) family relationships and whether the patient is a carer, or is cared for by another person;

(x) vision; and

(c) examination of the patient, including the following:

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

(ii) measurement of height and weight to calculate the patient's body mass index and, if indicated, measurement of waist circumference for central obesity;

(iii) oral examination (including gums and dentition);

(iv) ear and hearing examination (including otoscopy and, if indicated, a whisper test);

(v) urinalysis (by dipstick) for proteinuria;

(vi) eye examination; and

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

(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).

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

(3) An Aboriginal and Torres Strait Islander Older Person's Health Assessment must also include:
(a) keeping a record of the health assessment; and
(b) offering the patient a written report on the health assessment, with recommendations on matters covered by the health assessment; and
(c) offering the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

2.15.14 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.

Clause 2.15.15

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

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

(5) For the purposes of subclause (4), assistance may include activities associated with:
  (a) information collection; and
  (b) at the direction of the general 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.

2.15.15 Items in Group A14

This clause sets out items in Group A14.

Group A14—Health assessments

Column 1 Item	Column 2 Description	Column 3 Fee ($)
701	Professional attendance by a general 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	61.75
703	Professional attendance by a general 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	143.50
705	Professional attendance by a general practitioner (other than a specialist or consultant physician) to perform a long health assessment, lasting at least 45 minutes but less than 60 minutes, including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition and physical function; and (c) initiating interventions and referrals as indicated; and	198.00

Group A14—Health assessments		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(d) providing a basic preventive health care management plan for the patient	
707	Professional attendance by a general 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	279.70
715	Professional attendance by a general 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	220.85

Division 2.16—Group A15: GP management plans, team care arrangements and multidisciplinary care plans and case conferences

Subdivision A—General

2.16.1 Restrictions on items 729 to 866—services by certain 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.

Clause 2.16.2

Subdivision B—Subgroup 1 of Group A15

2.16.2 Meaning of associated general practitioner

In item 732:

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

2.16.3 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.

2.16.4 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 general 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 (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 an unpaid carer of the patient.

2.16.5 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 general 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:

(i) paragraph (b) of the definition of ***coordinating the development of team care arrangements*** in subclause 2.16.4(1); and

(ii) paragraph (a) of the definition of ***preparing a GP management plan*** in clause 2.16.7;

as applicable; and

(b) if different arrangements need to be made—makes amendments to the plan, or to the document mentioned in paragraph (b) of the definition of ***coordinating the development of team care arrangements*** in subclause 2.16.4(1), 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 an unpaid carer of the patient.

2.16.6 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 general 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 general 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 an unpaid carer of the patient.

2.16.7 Meaning of preparing a GP management plan

In item 721:

preparing a GP management plan, for a patient, means a process by which a general 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.

2.16.8 Meaning of reviewing a GP management plan

In item 732:

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

(a) reviews the matters mentioned in paragraph (a) of the definition of ***preparing a GP management plan*** in clause 2.16.7; and
(b) if different arrangements need to be made—makes amendments to the plan that:
  (i) state the new arrangements; and
  (ii) provide for a further review of the amended plan by a date stated in the plan; and
(c) explains to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in the review; and
(d) records the patient's agreement to the review of the plan; and
(e) if amendments are made to the plan:
  (i) offers a copy of the amended plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
  (ii) adds a copy of the amended plan to the patient's medical records.

2.16.9 Restrictions on items 721, 723, 729, 731 and 732—services for certain patients

(1) An item of this Schedule mentioned in column 1 of table 2.16.9 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 2.16.9.

Table 2.16.9—Application of items 721, 723, 729, 731 and 732

Item	Column 1 Items of this Schedule	Column 2 Description of patient
1	721 and 732 (if the service is for preparing a GP management plan or	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

Clause 2.16.10

Table 2.16.9—Application of items 721, 723, 729, 731 and 732

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

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

2.16.10 Restrictions on items 721, 723 and 732

Items 721, 723 and 732 apply only to a service provided in the course of personal attendance by a single general practitioner on a single patient.

2.16.11 Restrictions on other items—services provided on same day as services in items 721, 723 and 732

The following items do not apply to a service described in the item that is provided by a general practitioner, if the service is provided on the same day for the same patient for whom the practitioner provides a service described in item 721, 723 or 732:
(a) items 3, 4, 23, 24, 36, 37, 44, 47, 52, 53, 54, 57, 58, 59, 60 and 65;
(b) items 585, 588, 591, 594, 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.

2.16.12 Conditions relating to timing of services in items 721, 723, 729, 731 and 732 if exceptional circumstances do not exist

(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 2.16.12.

Table 2.16.12—Conditions relating to timing of services in items 721, 723, 729, 731 and 732

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

Clause 2.16.13

Table 2.16.12—Conditions relating to timing of services in items 721, 723, 729, 731 and 732

Item	Column 1 Item of this Schedule	Column 2 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.

2.16.13 Items in Subgroup 1 of Group A15

This clause sets out items in Subgroup 1 of Group A15.

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
Subgroup 1—GP management plans, team care arrangements and multidisciplinary care plans		
721	Attendance by a general practitioner (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)	150.10
723	Attendance by a general practitioner (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)	118.95
729	Contribution by a general practitioner (not including a specialist or consultant physician), to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 735 to 758 apply)	73.25
731	Contribution by a general practitioner (not including a specialist or consultant physician), to: (a) a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan	73.25

Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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)	
732	Attendance by a general practitioner (not including a specialist or consultant physician) to review or coordinate a review of: (a) a GP management plan prepared by a general practitioner (or an associated general practitioner) to which item 721 applies; or (b) team care arrangements which have been coordinated by the general practitioner (or an associated general practitioner) to which item 723 applies	74.95

Subdivision C—Subgroup 2 of Group A15

2.16.14 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.

2.16.15 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 1.1.4 and putting a copy of that record in the patient's medical records;
(g) offering the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees), and giving each other member of the team, a summary of the conference;

(h) discussing the outcomes of the conference with the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees).

2.16.16 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 the definition of ***multidisciplinary case conference*** in clause 1.1.4 and putting a copy of that record in the patient's medical records.

2.16.17 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.

2.16.18 Meaning of case conference team

In item 880:

case conference team:

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

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

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

Example: For the purposes of 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.

2.16.19 Restrictions on item 880—certain patients

(1) Item 880 applies if the attendance is on a patient who:

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

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

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

(i) geriatric evaluation and management;

(ii) 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.

2.16.20 Items in Subgroup 2 of Group A15

This clause sets out items in Subgroup 2 of Group A15.

Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 2—Case conferences		
735	Attendance by a general practitioner (not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference carried out for a care recipient in a	73.55

Clause 2.16.20

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	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)	
739	Attendance by a general practitioner (not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference carried out for a care recipient in a residential 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)	125.85
743	Attendance by a general practitioner (not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference carried out for a care recipient in a residential 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)	209.80
747	Attendance by a general practitioner (not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference carried out for a care recipient in a residential 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)	54.05
750	Attendance by a general practitioner (not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference carried out for a care recipient in a residential 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	92.60

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	apply)	
758	Attendance by a general practitioner (not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference carried out for a care recipient in a residential 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)	154.20
820	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	146.90
822	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	220.45
823	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	293.70
825	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	105.50
826	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	168.25
828	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team	231.05
830	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise	146.90

Clause 2.16.20

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	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	
832	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	220.45
834	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	293.70
835	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	105.50
837	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	168.25
838	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	231.05
855	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	146.90
857	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	220.45
858	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at	293.70

Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	least 45 minutes, with the multidisciplinary case conference team	
861	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	146.90
864	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	220.45
866	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	293.70
871	Attendance by a general practitioner, specialist or consultant physician, as a member of a case conference team, to lead and coordinate a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 3 other medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers	84.80
872	Attendance by a general practitioner, specialist or consultant physician, as a member of a case conference team, to participate in a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 4 medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers	39.50
880	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of geriatric or rehabilitation medicine, as a member of a case conference team, to coordinate a case conference of at least 10 minutes but less than 30 minutes—for any particular patient, one attendance only in a 7 day period (other than attendance on the same day as an attendance for which item 832, 834, 835, 837 or 838 was applicable in relation to the patient) (H)	51.40

Division 2.17—Group A17: Domiciliary and residential medication management reviews

2.17.1 Meaning of living in a community setting

In item 900:

living in a community setting: 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.

2.17.2 Meaning of residential medication management review

(1) In item 903:

residential medication management review means a collaborative service provided by a general practitioner and a pharmacist to review the medication management needs of a care recipient in a residential aged care facility.

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

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

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

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

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

(i) the findings of the review; and

(ii) medication management strategies; and

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

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

(3) A general 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 general practitioner agree that issues arising out of the review should be considered in a case conference.

2.17.3 Restrictions on items 900 and 903

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

2.17.4 Items in Group A17

This clause sets out items in Group A17.

Group A17—Domiciliary and residential medication management reviews

Column 1 Item	Column 2 Description	Column 3 Fee ($)
900	Participation by a general practitioner (not including a specialist or consultant physician) in a Domiciliary Medication Management Review (***DMMR***) for a patient living in a community setting, in which the general practitioner, with the patient's consent: (a) assesses the patient as: (i) having a chronic medical condition or a complex medication regimen; and (ii) not having their therapeutic goals met; and (b) following that assessment: (i) refers the patient to a community pharmacy or an accredited pharmacist for the DMMR; and (ii) provides relevant clinical information required for the DMMR; and (c) discusses with the reviewing pharmacist the results of the DMMR including suggested medication management strategies; and (d) develops a written medication management plan following discussion with the patient; and (e) provides the written medication management plan to a community pharmacy chosen by the patient For any particular patient—applicable not more than once in each 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR	161.10
903	Participation by a general practitioner (not including a specialist or consultant physician) in a residential medication management review (***RMMR***) for a patient who is a care recipient in a residential 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	110.30

Division 2.18—Group A30: Medical practitioner video conferencing consultation

2.18.1 Restrictions on items in Subgroups 1 and 2 of Group A30—services provided in association with certain other services

(1) An item in Subgroup 1 or 2 of Group A30 applies if:

(a) the service described in the item is provided in association with a service described in an item mentioned in subclause (2); and
(b) no other service described in an item in Group A30 is provided to the patient on the same occasion; and
(c) the medical practitioner providing clinical support to the patient is a general practitioner, specialist or consultant physician.

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

2.18.2 Location of attendance in 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 aged care facility where the patient is a care recipient.

2.18.3 Meaning of amount under clause 2.18.3

An ***amount under clause 2.18.3***, for an item mentioned in column 1 of table 2.18.3, means the sum of:

(a) the fee for the item mentioned in column 2 of that 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 that 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 that table.

Table 2.18.3—Amount under clause 2.18.3

Item	Column 1 Item of this Schedule	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	27.00	2.10
2	2125	The fee for item 2100	48.60	3.45
3	2137	The fee for item 2126	27.00	2.10
4	2138	The fee for item 2126	48.60	3.45
5	2147	The fee for item 2143	27.00	2.10
6	2179	The fee for item 2143	48.60	3.45
7	2199	The fee for item 2195	27.00	2.10
8	2220	The fee for	48.60	3.45

Table 2.18.3—Amount under clause 2.18.3				
Item	**Column 1** **Item of this Schedule**	**Column 2** **Fee**	**Column 3** **Amount if not more than 6 patients (to be divided by the number of patients) ($)**	**Column 4** **Amount per patient if more than 6 patients ($)**
		item 2195		

2.18.4 Restrictions on items in Subgroups 5 and 6 of Group A30 (video conferencing consultation attendances for patients in rural and remote areas)

An item in Subgroup 5 or 6 of Group A30 applies to a professional attendance on a patient by a medical practitioner only if:

(a) the patient is not an admitted patient; and

(b) the patient is located within a Modified Monash 6 area or a Modified Monash 7 area; and

(c) at the time of the attendance, the patient and the medical practitioner are at least 15 km by road from each other; and

(d) the patient has received 3 face-to-face professional attendances from that practitioner in the preceding 12 months.

2.18.5 Items in Group A30

This clause sets out items in Group A30.

Group A30—Medical practitioner video conferencing consultation		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 1—Video conferencing consultation attendance at consulting rooms, home visit or other institution		
2100	Professional attendance at consulting rooms lasting at least 5 minutes (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 km 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	23.80

Clause 2.18.5

Group A30—Medical practitioner video conferencing consultation		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
2122	Professional attendance not in consulting rooms lasting at least 5 minutes (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 aged care facility; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance—at least 15 km 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 clause 2.18.3
2126	Professional attendance at consulting rooms lasting less than 20 minutes (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 km 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	51.95
2137	Professional attendance not in consulting rooms lasting less than 20 minutes (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 aged care facility; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance—at least 15 km 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 clause 2.18.3
2143	Professional attendance at consulting rooms lasting at least 20 minutes (whether or not continuous) by a medical practitioner providing clinical support to a patient who:	100.80

Group A30—Medical practitioner video conferencing consultation

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 km 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 lasting at least 20 minutes (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 aged care facility; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance—at least 15 km 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 clause 2.18.3
2195	Professional attendance at consulting rooms lasting at least 40 minutes (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 km 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	148.25
2199	Professional attendance not in consulting rooms lasting at least 40 minutes (whether or not continuous) by a medical practitioner providing clinical support to a patient who:	Amount under clause 2.18.3

Clause 2.18.5

Group A30—Medical practitioner video conferencing consultation		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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 aged care facility; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance—at least 15 km 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	
Subgroup 2—Video conferencing consultation attendance at a residential aged care facility		
2125	Professional attendance lasting at least 5 minutes (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 aged care facility; 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 clause 2.18.3
2138	Professional attendance lasting less than 20 minutes (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 aged care facility; 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 clause 2.18.3
2179	Professional attendance lasting at least 20 minutes (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 aged care facility; 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 clause 2.18.3
2220	Professional attendance lasting at least 40 minutes (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 aged care facility; and	Amount under clause 2.18.3

Group A30—Medical practitioner video conferencing consultation		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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	
Subgroup 5—General practitioner video conferencing consultation attendance for patients in rural and remote areas		
2461	Professional attendance by video conference 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	17.90
2463	Professional attendance by video conference by a general practitioner, lasting less than 20 minutes, including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	39.10
2464	Professional attendance by video conference by a general practitioner, lasting at least 20 minutes but less than 40 minutes, including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	75.75
2465	Professional attendance by video conference by a general practitioner, lasting at least 40 minutes, including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	111.50
Subgroup 6—Other non-referred video conferencing consultation attendance for patients in rural and remote areas		
2471	Professional attendance by video conference lasting not more than 5 minutes by a medical practitioner who is not a general practitioner	11.25
2472	Professional attendance by video conference lasting more than 5 minutes, but not more than 25 minutes, by a medical practitioner who is not a general practitioner	21.50

Clause 2.19.1

Group A30—Medical practitioner video conferencing consultation		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
2475	Professional attendance by video conference lasting more than 25 minutes, but not more than 45 minutes, by a medical practitioner who is not a general practitioner	38.90
2478	Professional attendance by video conference lasting more than 45 minutes by a medical practitioner who is not a general practitioner	62.45

Division 2.19—Groups A18 and A19 (Attendances associated with Practice Incentive Program payments)

2.19.1 Restrictions on items in Subgroup 2 of Groups A18 and A19—timing

(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 described in that Subgroup.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(n) 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	Column 1 Patient's condition	Column 2 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 Restrictions on items in Subgroup 3 of Groups A18 and A19—timing

(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 described 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.

2.19.3 Items in Group A18

This clause sets out items in Group A18.

Group A18—General practitioner attendances associated with Practice Incentives Program (PIP) payments		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 1—Collection of a cervical screening specimen from an unscreened or significantly underscreened patient		
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 specimen for a cervical screening service is collected from the patient; if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years.	17.60
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 specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years	38.55
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 specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a	Amount under clause 2.1.1

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	cervical screening service or a cervical smear service in the last 4 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 specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years	74.60
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 specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service 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; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years	109.85
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:	Amount under clause 2.1.1

Clause 2.19.3

Group A18—General practitioner attendances associated with Practice Incentives Program (PIP) payments		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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 specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years	
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	38.55
2518	Professional attendance by a general practitioner at a place other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus	Amount under clause 2.1.1
2521	Professional attendance by a general practitioner at consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation,	74.60

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus	
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 diabetes mellitus	Amount under clause 2.1.1
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	109.85
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

Clause 2.19.3

Group A18—General practitioner attendances associated with Practice Incentives Program (PIP) payments		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 3—Completion of the minimum requirements 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	38.55
2547	Professional attendance by a general practitioner at a place other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care	Amount under clause 2.1.1
2552	Professional attendance by a general practitioner at consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care	74.60
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;	Amount under clause 2.1.1

Group A18—General practitioner attendances associated with Practice Incentives Program (PIP) payments		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care	
2558	Professional attendance by a general practitioner at consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care	109.85
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

2.19.4 Items in Group A19

This clause sets out items in Group A19.

Group A19—Other non-referred attendances associated with Practice Incentives Program (PIP) payments to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 1—Collection of a cervical screening specimen from an unscreened or significantly underscreened patient		
2598	Professional attendance at consulting rooms lasting less than 5 minutes by a medical practitioner who practices in general practice (other than a general practitioner) at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service	11.00

Clause 2.19.4

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	in the last 4 years	
2600	Professional attendance at consulting rooms lasting more than 5 minutes, but not more than 25 minutes, by a medical practitioner who practises in general practice (other than a general practitioner), at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years	21.00
2603	Professional attendance at consulting rooms lasting more than 25 minutes, but not more than 45 minutes, by a medical practitioner who practises in general practice (other than a general practitioner), at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years	38.00
2606	Professional attendance at consulting rooms lasting more than 45 minutes by a medical practitioner who practises in general practice (other than a general practitioner), at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years	61.00
2610	Professional attendance at a place other than consulting rooms lasting more than 5 minutes, but not more than 25 minutes, by a medical practitioner who practises in general practice (other than a general practitioner), at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years	Amount under clause 2.1.1
2613	Professional attendance at a place other than consulting rooms lasting more than 25 minutes, but not more than 45 minutes, by a medical practitioner who practises in general practice (other than a general practitioner), at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years	Amount under clause 2.1.1
2616	Professional attendance at a place other than consulting rooms lasting more than 45 minutes by a medical practitioner who practises in general practice (other than a general practitioner), at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years	Amount under clause 2.1.1

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
Subgroup 2—Completion of a cycle of care for patients with established diabetes mellitus		
2620	Professional attendance at consulting rooms lasting more than 5 minutes, but not more than 25 minutes, 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 lasting more than 25 minutes, but not more than 45 minutes, by a medical practitioner who practises in general practice (other than a general practitioner), that completes the requirements for a cycle of care of a patient with established diabetes mellitus	38.00
2624	Professional attendance at consulting rooms lasting more than 45 minutes 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 lasting more than 5 minutes, but not more than 25 minutes, 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 lasting more than 25 minutes, but not more than 45 minutes, 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 lasting more than 45 minutes 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 minimum requirements of the Asthma Cycle of Care		
2664	Professional attendance at consulting rooms lasting more than 5 minutes, but not more than 25 minutes, 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 lasting more than 25 minutes, but not more than 45 minutes, by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care	38.00
2668	Professional attendance at consulting rooms lasting more than 45 minutes 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 lasting	Amount under

Clause 2.20.1

Group A19—Other non-referred attendances associated with Practice Incentives Program (PIP) payments to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	more than 5 minutes, but not more than 25 minutes, 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	clause 2.1.1
2675	Professional attendance at a place other than consulting rooms lasting more than 25 minutes, but not more than 45 minutes, 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 lasting more than 45 minutes 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 Schedule:

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;
(f) eye movement desensitisation and reprocessing.

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

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

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

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

2.20.2 Meaning of amount under clause 2.20.2

In items 2723 and 2727:

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

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

(b) either:

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

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

Table 2.20.2—Amount under clause 2.20.2

Item	Column 1 Item of this Schedule	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	27.00	2.10
2	2727	The fee for item 2725	27.00	2.10

2.20.3 Meaning of preparation of a GP mental health treatment plan

(1) In this Schedule:

preparation of a GP mental health treatment plan, for a patient, means each of the following:

(a) preparation of a written plan by a general 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 (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 general 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

In this Schedule:

review of a GP mental health treatment plan means a process by which a general practitioner:
(a) reviews the matters mentioned in paragraph (a) of the definition of ***preparation of a GP mental health treatment plan*** in subclause 2.20.3(1); 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 (a)(i) of the definition of ***preparation of a GP mental health treatment plan*** in subclause 2.20.3(1) (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 general practitioner

In item 2712:

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

2.20.6 Restrictions on items in Subgroup 1 of Group A20 (GP mental health treatment plans)

Patients provided with certain services

(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 general practitioner on a single patient.

Timing of certain services

(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.

Item 2712

(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 items 2700, 2701, 2715 and 2717;

(b) 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).

Item 2713

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

Items 2715 and 2717—practitioner training

(8) Items 2715 and 2717 apply only if the general practitioner providing the service has successfully completed mental health skills training.

Definition

(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 Restrictions on items in Subgroup 2 of Group A20 (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 general practitioner:
(i) whose name is entered in the register maintained by the Chief Executive Medicare under section 33 of the *Human Services (Medicare) Regulations 2017*; and
(ii) who is identified in the register as a medical 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 is provided to a patient who has already been provided, in the calendar year, with 10 other services to which any of the items in Subgroup 2, or items 80000 to 80015, 80100 to 80115, 80125 to 80140 or 80150 to 80165 apply.

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

2.20.8 Items in Group A20

This clause sets out items in Group A20.

Group A20—Mental health care		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 1—GP mental health treatment plans		
2700	Professional attendance, by a general practitioner who has not undertaken mental health skills training (and not including a specialist or consultant physician), lasting at least 20 minutes, but less than 40 minutes, for the preparation of a GP mental health treatment plan for a patient	74.60
2701	Professional attendance, by a general practitioner who has not undertaken mental health skills training (and not including a specialist or consultant physician), lasting at least 40 minutes for the preparation of a GP mental health treatment plan for a patient	109.85
2712	Professional attendance by a general practitioner (not including a specialist or consultant physician) to review a GP mental health treatment plan which the general practitioner, or an associated general practitioner has prepared, or to review a Psychiatrist Assessment and Management Plan	74.60
2713	Professional attendance at consulting rooms by a general practitioner (not including a specialist or consultant physician) in relation to a mental disorder and lasting at least 20 minutes, 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	74.60
2715	Professional attendance, by a general practitioner who has undertaken mental health skills training (but not including a specialist or consultant physician), lasting at least 20 minutes, but less than 40 minutes, for the preparation of a GP mental health treatment plan for a patient	94.75
2717	Professional attendance, by a general practitioner who has undertaken mental health skills training (but not including a specialist or consultant physician), lasting at least 40 minutes for the preparation of a GP mental health treatment plan for a patient	139.55
Subgroup 2—Focussed psychological strategies		
2721	Professional attendance at consulting rooms by a general practitioner (not including a specialist or a consultant physician), for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes	96.50
2723	Professional attendance at a place other than consulting rooms by a general practitioner (not including a specialist or a consultant physician), for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements	Amount under clause 2.20.2

Clause 2.21.1

Group A20—Mental health care		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	for provision of this service, and lasting at least 30 minutes, but less than 40 minutes	
2725	Professional attendance at consulting rooms by a general practitioner (not including a specialist or a consultant physician), for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes	138.10
2727	Professional attendance at a place other than consulting rooms by a general practitioner (not including a specialist or a consultant physician), for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes	Amount under clause 2.20.2
2729	Professional attendance at consulting rooms, by a general practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, to provide focussed psychological strategies for assessed mental disorders, if: (a) the attendance is by video conference and lasts at least 30 minutes but less than 40 minutes; and (b) the patient is not an admitted patient; and (c) the patient is located within a Modified Monash 4, 5, 6 or 7 area and, at the time of the attendance, is at least 15 kilometres by road from the general practitioner	96.50
2731	Professional attendance at consulting rooms, by a general practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, to provide focussed psychological strategies for assessed mental disorders, if: (a) the attendance is by video conference and lasts at least 40 minutes; and (b) the patient is not an admitted patient; and (c) the patient is located within a Modified Monash 4, 5, 6 or 7 area and, at the time of the attendance, is at least 15 kilometres by road from the general practitioner	138.10

Division 2.21—Group A24: Palliative and pain medicine

2.21.1 Meaning of organise and coordinate

In the items 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 1.1.4 and putting a copy of that record in the patient's medical records;
(g) offering the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees), and giving each other member of the team, a summary of the conference;
(h) discussing the outcomes of the conference with the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees).

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 1.1.4 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 Restrictions on items in Subgroups 2 and 4 of Group A24—timing

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

2.21.4 Items in Group A24

This clause sets out items in Group A24.

Clause 2.21.4

Group A24—Palliative and pain medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 1—Pain medicine attendances		
2799	Initial professional attendance lasting 10 minutes or less on a patient by a specialist or consultant physician practising in the specialist's or consultant physician's 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 km by road from the specialist or physician; or (ii) is a care recipient in a residential aged care facility; 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	119.55
2801	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—initial attendance in a single course of treatment	159.35
2806	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—an attendance (other than a service to which item 2814 applies) after the initial attendance in a single course of treatment	79.75
2814	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—minor attendance	45.40
2820	Professional attendance on a patient by a specialist or consultant physician practising in the specialist's or consultant physician's 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 km by road	50% of the fee for item 2801, 2806 or 2814

Group A24—Palliative and pain medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	from the specialist or physician; or (ii) is a care recipient in a residential aged care facility; 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	
2824	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—initial attendance in a single course of treatment	193.35
2832	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—an attendance (other than a service to which item 2840 applies) after the initial attendance in a single course of treatment	116.95
2840	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—minor attendance	84.25
Subgroup 2—Pain medicine case conferences		
2946	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes	146.90
2949	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes	220.45
2954	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 45 minutes	293.70
2958	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes	105.50
2972	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as	168.25

Clause 2.21.4

Group A24—Palliative and pain medicine		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	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	
2974	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes	231.05
2978	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	146.90
2984	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	220.45
2988	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H)	293.70
2992	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	105.50
2996	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	168.25
3000	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H)	231.05
Subgroup 3—Palliative medicine attendances		
3003	Initial professional attendance lasting 10 minutes or less on a patient by a specialist or consultant physician practising in the specialist's or consultant physician's specialty of palliative medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and	119.55

Group A24—Palliative and pain medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 km by road from the specialist or physician; or (ii) is a care recipient in a residential aged care facility; 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	
3005	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—initial attendance in a single course of treatment	159.35
3010	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—an attendance (other than a service to which item 3014 applies) after the initial attendance in a single course of treatment	79.75
3014	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—minor attendance	45.40
3015	Professional attendance on a patient by a specialist or consultant physician practising in the specialist's or consultant physician's 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 km by road from the specialist or physician; or (ii) is a care recipient in a residential aged care facility; 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

Clause 2.21.4

Group A24—Palliative and pain medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
3018	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—initial attendance in a single course of treatment	193.35
3023	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—an attendance (other than a service to which item 3028 applies) after the initial attendance in a single course of treatment	116.95
3028	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—minor attendance	84.25
Subgroup 4—Palliative medicine case conferences		
3032	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes	146.90
3040	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes	220.45
3044	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 45 minutes	293.70
3051	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes	105.50
3055	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	168.25

Group A24—Palliative and pain medicine

Column 1 Item	Column 2 Description	Column 3 Fee ($)
3062	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes	231.05
3069	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	146.90
3074	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	220.45
3078	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H)	293.70
3083	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	105.50
3088	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	168.25
3093	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H)	231.05

Clause 2.22.1

Division 2.22—Group A27: Pregnancy support counselling

2.22.1 Restrictions on item 4001

(1) A service to which item 4001 applies must not be provided by a general 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 general practitioner to a patient in which:

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

(b) the general practitioner does not impose the general practitioner's views or values about what the patient 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.

2.22.2 Items in Group A27

This clause sets out items in Group A27.

Group A27—Pregnancy support counselling

Column 1 Item	Column 2 Description	Column 3 Fee ($)
4001	Professional attendance lasting at least 20 minutes at consulting rooms by a general practitioner (not including a specialist or consultant physician) who is registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service for the purpose of providing non-directive pregnancy support counselling to a patient who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item or item 81000, 81005 or 81010 applies in relation to that pregnancy Note: For items 81000, 81005 and 81010, see the determination about allied health services under subsection 3C(1) of the Act.	79.70

Division 2.23—Group A21: Professional attendances at recognised emergency departments of private hospitals

2.23.1 Items in Group A21

This clause sets out items in Group A21.

Group A21—Professional attendances at recognised emergency departments of private hospitals		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
5001	Professional attendance, on a patient at least 4 years old but under 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of ordinary complexity	61.05
5004	Professional attendance, on a patient under 4 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of ordinary complexity	102.50
5011	Professional attendance, on a patient at least 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of ordinary complexity	102.50
5012	Professional attendance, on a patient at least 4 years old but under 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of complexity that is more than ordinary but is not high	160.70
5013	Professional attendance, on a patient under 4 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of complexity that is more than ordinary but is not high	202.15
5014	Professional attendance, on a patient at least 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of complexity that is more than ordinary but is not high	202.15
5016	Professional attendance, on a patient at least 4 years old but under 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of high complexity	271.25
5017	Professional attendance, on a patient under 4 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of high complexity	312.80
5019	Professional attendance, on a patient at least 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of high complexity	312.80

Clause 2.23.1

Group A21—Professional attendances at recognised emergency departments of private hospitals		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
5021	Professional attendance, on a patient at least 4 years old but under 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of ordinary complexity	45.75
5022	Professional attendance, on a patient under 4 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of ordinary complexity	76.90
5027	Professional attendance, on a patient at least 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of ordinary complexity	76.90
5030	Professional attendance, on a patient at least 4 years old but under 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of complexity that is more than ordinary but is not high	120.45
5031	Professional attendance, on a patient under 4 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of complexity that is more than ordinary but is not high	151.60
5032	Professional attendance, on a patient at least 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of complexity that is more than ordinary but is not high	151.60
5033	Professional attendance, on a patient at least 4 years old but under 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of high complexity	203.45
5035	Professional attendance, on a patient under 4 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of high complexity	234.60
5036	Professional attendance, on a patient at least 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of high complexity	234.60

Group A21—Professional attendances at recognised emergency departments of private hospitals

Column 1 Item	Column 2 Description	Column 3 Fee ($)
5039	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine for preparation of goals of care by the specialist for a gravely ill patient lacking current goals of care if: (a) the specialist takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the initial attendance by the specialist for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is in conjunction with, or after, an attendance on the patient by the specialist that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019	148.25
5041	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine for preparation of goals of care by the specialist for a gravely ill patient lacking current goals of care if: (a) the specialist takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the initial attendance by the specialist for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is not in conjunction with, or after, an attendance on the patient by the specialist that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019; and (d) the attendance is for at least 60 minutes	278.75
5042	Professional attendance at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) for preparation of goals of care by the practitioner for a gravely ill patient lacking current goals of care if: (a) the practitioner takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the initial attendance by the practitioner for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is in conjunction with, or after, an attendance on the patient by the practitioner that is described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036	111.25
5044	Professional attendance at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) for preparation of goals of care by the practitioner for a gravely ill patient lacking current goals of care if: (a) the practitioner takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the initial attendance by the practitioner for the	209.00

Clause 2.24.1

Group A21—Professional attendances at recognised emergency departments of private hospitals		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is not in conjunction with, or after, an attendance on the patient by the practitioner that is described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (d) the attendance is for at least 60 minutes	

Division 2.24—Group A22: General practitioner after-hours attendances to which no other item applies

2.24.1 Restrictions on items in Group A22—timing

(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.

2.24.2 Items in Group A22

This clause sets out items in Group A22.

Group A22—General practitioner after-hours attendances to which no other item applies		
Column 1	**Column 2**	**Column 3**
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	30.15
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 this Schedule applies) that requires a short patient history and, if necessary, limited examination and management—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1
5010	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained	Amount under clause 2.1.1

Group A22—General practitioner after-hours attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	unit, by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	
5020	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule 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	51.00
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 this Schedule applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1
5028	Professional attendance by a general practitioner (other than a service to which another item in this Schedule applies), on care recipients in a residential aged care 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 this Schedule applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history;	87.40

Clause 2.24.2

Group A22—General practitioner after-hours attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **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	
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 this Schedule applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1
5049	Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item in this Schedule applies, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	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 this Schedule applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	122.55
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 this Schedule applies), lasting at least 40 minutes and including any of the following that are	Amount under clause 2.1.1

Group A22—General practitioner after-hours attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
5067	Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item in this Schedule applies, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1

Division 2.25—Group A23: Other non-referred after-hours attendances to which no other item applies

2.25.1 Restrictions on items in Group A23—timing

(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.

2.25.2 Items in Group A23

This clause sets out items in Group A23.

Clause 2.25.2

Group A23—Other non-referred after-hours attendances to which no other item applies		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
5200	Professional attendance at consulting rooms lasting not more than 5 minutes (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)	21.00
5203	Professional attendance at consulting rooms lasting more than 5 minutes, but not more than 25 minutes, (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)	31.00
5207	Professional attendance at consulting rooms lasting more than 25 minutes, but not more than 45 minutes, (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)	48.00
5208	Professional attendance at consulting rooms lasting more than 45 minutes (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)	71.00
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 this Schedule 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 this Schedule 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 this Schedule 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 this Schedule 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 a care recipient in the facility who is not a resident of a self-contained unit, lasting not more than 5 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
5263	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care	Amount under clause 2.1.1

Group A23—Other non-referred after-hours attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	recipient in the facility who is not a resident of a self-contained unit, lasting more than 5 minutes, but not more than 25 minutes, 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	
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 a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 25 minutes, but not more than 45 minutes, 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 a care recipient in the facility who is not a resident of a self-contained unit, lasting 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

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

2.26.1 Items in Group A26

This clause sets out items in Group A26.

Group A26—Neurosurgery attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
6004	Initial professional attendance lasting 10 minutes or less on a patient by a specialist practising in the specialist's 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 km by road from the specialist; or (ii) is a care recipient in a residential aged care facility; or (iii) is a patient of: (A) an Aboriginal Medical Service; or	102.65

Clause 2.26.1

Group A26—Neurosurgery attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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	
6007	Professional attendance by a specialist practising in the specialist's specialty of neurosurgery following referral of the patient to the specialist—an initial attendance in a single course of treatment at consulting rooms or hospital	136.85
6009	Professional attendance by a specialist practising in the specialist's specialty of neurosurgery following referral of the patient to the specialist—minor attendance at consulting rooms or hospital	45.40
6011	Professional attendance by a specialist practising in the specialist's specialty of neurosurgery following referral of the patient to the specialist—an attendance after the initial attendance 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 lasting more than 15 minutes, but not more than 30 minutes, at consulting rooms or hospital	90.35
6013	Professional attendance by a specialist practising in the specialist's specialty of neurosurgery following referral of the patient to the specialist—an attendance after the initial attendance 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 lasting more than 30 minutes, but not more than 45 minutes, at consulting rooms or hospital	125.15
6015	Professional attendance by a specialist practising in the specialist's specialty of neurosurgery following referral of the patient to the specialist—an attendance after the initial attendance 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 lasting more than 45 minutes at consulting rooms or hospital	159.35
6016	Professional attendance on a patient by a specialist practising in the specialist's 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 km by road from the specialist; or (ii) is a care recipient in a residential aged care facility; or (iii) is a patient of:	50% of the fee for item 6007, 6009, 6011, 6013 or 6015

Group A26—Neurosurgery attendances to which no other item applies		
Column 1	**Column 2**	**Column 3**
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	

Division 2.27—Group A31: Addiction medicine

2.27.1 Meaning of organise and coordinate

In items 6029 to 6042:

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 1.1.4 and putting a copy of that record in the patient's medical records;
(g) offering the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees), and giving each other member of the team, a summary of the conference;
(h) discussing the outcomes of the conference with the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees).

2.27.2 Meaning of participate

In items 6035 to 6042:

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 activities mentioned in the definition of ***multidisciplinary case conference*** in clause 1.1.4 and putting a copy of that record in the patient's medical records.

2.27.3 Restrictions on item 6028

Item 6028 applies only to a service provided in the course of a personal attendance by a single addiction medicine specialist.

2.27.4 Items in Group A31

This clause sets out items in Group A31.

Group A31—Addiction medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 1—Addiction medicine attendances		
6018	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty following referral of the patient to the addiction medicine specialist by a referring practitioner, if the attendance: (a) includes a comprehensive assessment; and (b) is the first or only time in a single course of treatment that a comprehensive assessment is provided	159.35
6019	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty following referral of the patient to the addiction medicine specialist by a referring practitioner, if the attendance is a patient assessment: (a) before or after a comprehensive assessment under item 6018 in a single course of treatment; or (b) that follows an initial assessment under item 6023 in a single course of treatment; or (c) that follows a review under item 6024 in a single course of treatment	79.75
6023	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to the addiction medicine specialist by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) a comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) an addiction medicine specialist treatment and management plan of significant complexity that includes the following is prepared and provided to the referring practitioner: (i) an opinion on diagnosis and risk assessment; (ii) treatment options and decisions;	278.75

Group A31—Addiction medicine

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(iii) medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6018 or 6019 applies did not take place on the same day by the same addiction medicine specialist; and (d) neither this item nor item 132 has applied to an attendance on the patient in the preceding 12 months by the same addiction medicine specialist	
6024	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty of at least 20 minutes, after the initial attendance in a single course of treatment for a review of a patient with at least 2 morbidities if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified addiction medicine specialist treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6018 or 6019 applies did not take place on the same day by the same addiction medicine specialist; and (d) item 6023 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same addiction medicine specialist who claimed item 6023 or by a locum tenens; and (f) this item has not applied more than twice in any 12 month period	139.55
6025	Initial professional attendance of 10 minutes or less, on a patient by an addiction medicine specialist in the practice of the addiction medicine specialist's 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 km by road from the addiction medicine specialist; or (ii) is a care recipient in a residential aged care facility; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service;	119.55

Clause 2.27.4

Group A31—Addiction medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
6026	Professional attendance on a patient by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 6018 or 6019 and lasting more than 10 minutes; or (ii) provided with item 6023 or 6024; 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 km by road from the addiction medicine specialist; or (ii) is a care recipient in a residential aged care facility; 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 6018, 6019, 6023 or 6024
Subgroup 2—Group therapy		
6028	Group therapy (including any associated consultation with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hour, given under the continuous direct supervision of an addiction medicine specialist in the practice of the addiction medicine specialist's specialty for a group of 2 to 9 unrelated patients, or a family group of more than 2 patients, each of whom is referred to the addiction medicine specialist by a referring practitioner—for each patient	52.05
Subgroup 3—Addiction medicine case conferences		
6029	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of less than 15 minutes, with the multidisciplinary case conference team	45.10
6031	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	79.75
6032	Attendance by an addiction medicine specialist in the practice of the	119.65

Group A31—Addiction medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	
6034	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate the multidisciplinary case conference of at least 45 minutes, with the multidisciplinary case conference team	159.35
6035	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of less than 15 minutes, with the multidisciplinary case conference team	36.05
6037	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	63.80
6038	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	95.70
6042	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team	127.50

Division 2.28—Group A32: Sexual health medicine

2.28.1 Meaning of organise and coordinate

In items 6064 to 6075:

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 1.1.4 and putting a copy of that record in the patient's medical records;
(g) offering the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees), and giving each other member of the team, a summary of the conference;
(h) discussing the outcomes of the conference with the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees).

2.28.2 Meaning of participate

In items 6071 to 6075:

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 activities mentioned in the definition of ***multidisciplinary case conference*** in clause 1.1.4 and putting a copy of that record in the patient's medical records.

2.28.3 Items in Group A32

This clause sets out items in Group A32.

Group A32—Sexual health medicine		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
Subgroup 1—Sexual health medicine attendances		
6051	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner, if the attendance: (a) includes a comprehensive assessment; and	159.35

Group A32—Sexual health medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(b) is the first or only time in a single course of treatment that a comprehensive assessment is provided	
6052	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner, if the attendance is a patient assessment: (a) before or after a comprehensive assessment under item 6051 in a single course of treatment; or (b) that follows an initial assessment under item 6057 in a single course of treatment; or (c) that follows a review under item 6058 in a single course of treatment	79.75
6057	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to the sexual health medicine specialist by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) a comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) a sexual health medicine specialist treatment and management plan of significant complexity that includes the following is prepared and provided to the referring practitioner: (i) an opinion on diagnosis and risk assessment; (ii) treatment options and decisions; (iii) medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6051 or 6052 applies did not take place on the same day by the same sexual health medicine specialist; and (d) neither this item nor item 132 has applied to an attendance on the patient in the preceding 12 months by the same sexual health medicine specialist	278.75
6058	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty of at least 20 minutes, after the initial attendance in a single course of treatment for a review of a patient with at least 2 morbidities if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified sexual health medicine specialist treatment and	139.55

Clause 2.28.3

Group A32—Sexual health medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient, being an attendance to which item 104, 105, 110, 116, 119, 132, 133, 6051 or 6052 applies did not take place on the same day by the same sexual health medicine specialist; and (d) item 6057 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same sexual health medicine specialist who claimed item 6057 or by a locum tenens; and (f) this item has not applied more than twice in any 12 month period	
6059	Initial professional attendance of 10 minutes or less, on a patient by a sexual health medicine specialist in the practice of the sexual health medicine specialist's 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 km by road from the sexual health medicine specialist; or (ii) is a care recipient in a residential aged care facility; 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	119.55
6060	Professional attendance on a patient by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 6051 or 6052 and lasting more than 10 minutes; or (ii) provided with item 6057 or 6058; 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 km by road from the sexual health medicine specialist; or	50% of the fee for item 6051, 6052, 6057 or 6058

Group A32—Sexual health medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(ii) is a care recipient in a residential aged care facility; 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	
Subgroup 2—Home visits		
6062	Professional attendance at a place other than consulting rooms or a hospital by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner—initial attendance in a single course of treatment	193.35
6063	Professional attendance at a place other than consulting rooms or a hospital by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner—an attendance after the attendance under item 6062 in a single course of treatment	116.95
Subgroup 3—Sexual health medicine case conferences		
6064	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of less than 15 minutes, with the multidisciplinary case conference team	45.10
6065	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	79.75
6067	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	119.65
6068	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 45 minutes, with the multidisciplinary case conference team	159.35
6071	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of	36.05

Clause 2.29.1

Group A32—Sexual health medicine		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	less than 15 minutes, with the multidisciplinary case conference team	
6072	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	63.80
6074	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	95.70
6075	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team	127.50

Division 2.29—Group A9: Contact lenses

2.29.1 Restrictions on 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.

2.29.2 Items in Group A9

This clause sets out items in Group A9.

Group A9—Contact lenses		
Column 1	**Column 2**	**Column 3**
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	128.50

Group A9—Contact lenses

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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	128.50
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	128.50
10804	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription—one service in any period of 36 months—patient with irregular astigmatism in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3 logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens	128.50
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)	128.50
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	128.50
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	128.50
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	128.50
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	128.50

Clause 2.30.1

Group A9—Contact lenses		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	contact lens for correction, if the condition is specified on the patient's account	
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	128.50

Division 2.30—Group A35: Non-referred attendance at a residential aged care facility

2.30.1 Fee in relation to the first patient during each attendance at a residential aged care facility

(1) For the first patient attended during one attendance by a general practitioner at one residential aged care facility on one occasion, the fee for the medical service described in whichever of items 90020, 90035, 90043 or 90051 applies is the amount listed in the item plus $57.25.

(2) For the first patient attended during one attendance by a medical practitioner at one residential aged care facility on one occasion, the fee for the medical service described in whichever of items 90092, 90093, 90095 or 90096 applies is the amount listed in the item plus $41.60.

2.30.2 Items in Group A35

This clause sets out items in Group A35.

Group A35—Non-referred attendance at a residential aged care facility		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
90020	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (subject to clause 2.30.1)	17.90
90035	Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item applies, lasting less than 20 minutes and including any of the	39.10

	following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (subject to clause 2.30.1)	
90043	Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item applies, lasting at least 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 (subject to clause 2.30.1)	75.75
90051	Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item applies, lasting at least 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 (subject to clause 2.30.1)	111.50
90092	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting not more than 5 minutes—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (subject to clause 2.30.1), by a medical practitioner who is not a general practitioner	8.50
90093	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a	16.00

	care recipient in the facility who is not a resident of a self-contained unit, lasting more than 5 minutes, but not more than 25 minutes—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (subject to clause 2.30.1), by a medical practitioner who is not a general practitioner	
90095	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 25 minutes, but not more than 45 minutes—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (subject to clause 2.30.1), by a medical practitioner who is not a general practitioner	35.50
90096	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 45 minutes—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (subject to clause 2.30.1), by a medical practitioner who is not a general practitioner	57.50

Division 2.31—Group A36: Eating disorder services

2.31.1 Application of items in Group A36

Eligible patients

(1) Subject to this clause, the items in Group A36 apply to a service provided to a patient (an ***eligible patient***) covered by clause 2.31.2.

Preparation of eating disorder treatment and management plans

(2) The items in Subgroup 1 apply to a service provided to an eligible patient by a medical practitioner (other than a specialist or consultant physician) only if:
  (a) the service includes the preparation of a plan for the patient in accordance with clause 2.31.3; and
  (b) during the attendance, a copy of the plan and suitable education about the patient's eating disorder is given to the patient and, if authorised by the patient, the patient's carer.

(3) The items in Subgroup 2 apply to a service provided to an eligible patient by a consultant physician only if:
  (a) the service includes the preparation of a plan for the patient in accordance with the requirements in clause 2.31.3; and
  (b) for a service provided by a consultant psychiatrist—during the attendance, the consultant uses an outcome tool (if clinically appropriate) and carries out a mental state examination; and

(c) for a service provided by a consultant paediatrician—during the attendance, the consultant undertakes an assessment of the patient that includes:
  (i) a comprehensive history (including a psychosocial history and medication review); and
  (ii) a comprehensive multi-organ system assessment or a detailed single-organ system assessment; and
(d) within 2 weeks of the attendance, a copy of the plan is given to:
  (i) the referring practitioner; and
  (ii) if clinically appropriate—the patient and, if authorised by the patient, the patient's carer.

Review of eating disorder treatment and management plans

(4) The items in Subgroup 3 apply to a service provided to an eligible patient by a medical practitioner (other than a specialist or consultant physician) only if:
(a) the service includes a review of an eating disorder treatment and management plan in accordance with clause 2.31.4; and
(b) during the attendance, a copy of the plan and suitable education about the patient's eating disorder is given to the patient and, if authorised by the patient, the patient's carer.

(5) The items in Subgroup 3 apply to a service provided to an eligible patient by a consultant physician only if:
(a) the service includes a review of an eating disorder treatment and management plan in accordance with clause 2.31.4; and
(b) for a service provided by a consultant psychiatrist—during the attendance, the consultant uses an outcome tool (if clinically appropriate) and carries out a mental state examination; and
(c) for a service provided by a consultant paediatrician—during the attendance, the consultant undertakes an assessment of the patient that includes:
  (i) a comprehensive history (including a psychosocial history and medication review); and
  (ii) a comprehensive multi-organ system assessment or a detailed single-organ system assessment; and
(d) within 2 weeks of the attendance, a copy of the plan is given to:
  (i) the referring practitioner; and
  (ii) if clinically appropriate—the patient and, if authorised by the patient, the patient's carer.

Providing treatments under eating disorder treatment and management plans

(6) The items in Subgroup 4 apply to a service only if the service:
(a) is provided by a medical practitioner covered by clause 2.31.5; and
(b) is clinically indicated by an eating disorder treatment and management plan; and
(c) is provided using at least one mental health care management strategy covered by clause 2.31.6.

Clause 2.31.2

2.31.2 Eating disorder services—patients

(1) For the purposes of clause 2.31.1, a patient is covered by this clause if:
  (a) the patient has a clinical diagnosis of anorexia nervosa; or
  (b) both:
    (i) the patient has a clinical diagnosis of bulimia nervosa, a binge-eating disorder or other specified feeding or eating disorder; and
    (ii) subclause (2) applies to the patient.

(2) This subclause applies to a patient if:
  (a) the patient has been assessed as having an eating disorder classified as severe based on clinical screening tool results; and
  (b) the patient's condition is characterised by:
    (i) rapid weight loss; or
    (ii) frequent binge eating or inappropriate compensatory behaviour, as manifested by 3 or more occurrences per week; and
  (c) at least 2 of the following apply to the patient:
    (i) the patient is clinically underweight, with a body weight of less than 85% of the expected weight of the patient, and the weight loss is directly attributable to the eating disorder;
    (ii) the patient is currently at risk, or has a high risk, of medical complications due to eating disorder behaviours and symptoms;
    (iii) serious comorbid medical or psychological conditions are significantly impacting on the patient's physical or psychological health and ability to function;
    (iv) the patient has been admitted to a hospital for an eating disorder in the previous 12 months;
    (v) the patient has had an inadequate treatment response to evidence based eating disorder treatment over the previous 6 months despite actively and consistently participating in the treatment.

2.31.3 Eating disorder services—requirements for eating disorder treatment and management plan

For the purposes of clause 2.31.1, a plan for the treatment and management of a patient's eating disorder must:
  (a) be in writing; and
  (b) include the following:
    (i) an opinion on the diagnosis of the patient's eating disorder;
    (ii) treatment options and recommendations to manage the patient's condition for 12 months commencing on the day the plan is prepared;
    (iii) an outline of the options for the referral of the patient to allied health professionals for mental health and dietetic services, and to specialists, as appropriate;
    (iv) if the plan is prepared by a consultant psychiatrist—a comprehensive evaluation of the patient's biological, psychological and social issues, and management recommendations addressing those issues;
    (v) if the plan is prepared by a consultant paediatrician—a comprehensive history of the patient (including a psychosocial history and medication

review) and a comprehensive multi-organ system assessment or a detailed single-organ system assessment; and

(c) be expressed to expire at the end of the period mentioned in subparagraph (b)(ii).

2.31.4 Eating disorder services—requirements for review of eating disorder treatment and management plan

(1) For the purposes of clause 2.31.1, a review of an eating disorder treatment and management plan for a patient must include a review of the treatment efficacy of treatments provided under the plan, including by discussing with the patient whether the treatments are meeting the patient's needs.

(2) In conducting the review, the reviewing practitioner must:

(a) if the treatment options in the plan are to be continued—modify the plan, in writing, to include the recommendation that the treatment options are to be continued; and

(b) if the treatment options in the plan are to be revised—modify the plan, in writing, to include the recommendation that the treatment options are to be revised and the revised treatment options.

(3) If the review is conducted by a medical practitioner (other than a specialist or consultant physician), and the practitioner considers that it is appropriate for a consultant physician to review the plan, the practitioner must refer the patient to the consultant physician for the review of the plan.

2.31.5 Eating disorder services—medical practitioners for providing treatments

For the purposes of clause 2.31.1, a medical practitioner is covered by this clause if:

(a) the practitioner's name is entered in the register maintained by the Chief Executive Medicare under section 33 of the *Human Services (Medicare) Regulations 2017*; and

(b) the practitioner is identified in the register as a medical practitioner who can provide services to which items in Subgroup 2 of Group A20, and items 283, 285, 286, 287, 371 and 372, apply; and

(c) the practitioner meets any training and skills requirements determined by the General Practice Mental Health Standards Collaboration for providing those services.

Note 1: Section 33 of the *Human Services (Medicare) Regulations 2017* provides for the Chief Executive Medicare to establish and maintain a register of medical practitioners who may provide focused psychological strategies under the initiative known as the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) Initiative.

Note 2: For items 285, 286, 287, 371 and 372, see the determination about other medical practitioners under subsection 3C(1) of the Act.

Clause 2.31.6

2.31.6 Eating disorder services—mental health care management strategies for use in providing treatments

For the purposes of clause 2.31.1, the following mental health care management strategies are covered by this clause:

(a) family based treatment (including whole family, parent based, parent only or separated therapy);
(b) adolescent focused therapy;
(c) cognitive behavioural therapy;
(d) specialist supportive clinical management;
(e) Maudsley model of anorexia treatment in adults;
(f) interpersonal therapy for bulimia nervosa or binge-eating disorder;
(g) dialectical behavioural therapy for bulimia nervosa or binge-eating disorder;
(h) focal psychodynamic therapy.

2.31.7 Restrictions on items in Group A36—general

Items do not apply to services provided to admitted patients

(1) An item in Group A36 does not apply to an attendance on an admitted patient.

Limit on number of plans that can be prepared for a patient each year

(2) An item in Subgroup 1 or 2 of Group A36 does not apply to a service that is provided to a patient who has already been provided, in the previous 12 months, with:
(a) another service to which an item in Subgroup 1 or 2 of Group A36 applies; or
(b) a service to which an item in Subgroup 21 to 24 of Group A40 applies.

Items do not apply to services provided in association with certain other services

(3) An item in Subgroup 1 of Group A36 does not apply to a service performed in association with a service to which item 279, 235 to 244, 735 to 758, 2713, 92115, 92121, 92127 or 92133 applies.

(4) Items 90261 and 90263 do not apply to a service performed in association with a service to which item 110, 116, 119, 132, 133, 91824, 91825, 91826, 91834, 91835, 91836, 92422, 92423, 92431 or 92432 applies.

(5) An item in Subgroup 3 of Group A36 does not apply to a service performed in association with a service to which item 279, 2713, 92115, 92121, 92127 or 92133 applies.

2.31.8 Restrictions on items in Group A36—attendance by video conference

(1) Items 90262, 90263, 90268 and 90269 apply to a service provided to a patient by video conference only if the patient:

(a) is located within a telehealth eligible area and, at the time of the attendance, is at least 15 kilometres by road from the medical practitioner providing the service; or
(b) is a care recipient in a residential aged care facility; or
(c) is a patient of:
(i) an Aboriginal Medical Service; or
(ii) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the Act applies.

(2) Items 90279, 90280, 90281 and 90282 apply to a service provided to a patient by video conference only if the patient is located within a Modified Monash 4, 5, 6 or 7 area and, at the time of the attendance, is at least 15 kilometres by road from the medical practitioner providing the service.

2.31.9 Restriction on items in Group A36—limitation on number of services providing treatments under a plan

(1) An item in Subgroup 4 of Group A36 does not apply to a service providing a treatment to a patient under an eating disorder treatment and management plan if:
(a) the service is provided more than 12 months after the plan is prepared; or
(b) the patient has already been provided with 40 services under the plan; or
(c) the service is provided after the patient has already been provided with 10 services under the plan but before a recommendation by a reviewing practitioner is given that additional services should be provided under the plan; or
(d) the service is provided after the patient has already been provided with 20 services under the plan but before recommendations that additional services should be provided under the plan are given by each of the following:
(i) a medical practitioner (other than a specialist or consultant physician);
(ii) a consultant physician; or
(e) the service is provided after the patient has already been provided with 30 services under the plan but before a recommendation is given by a reviewing practitioner that additional services should be provided.

(2) A reviewing practitioner may recommend that additional services be provided under a plan only if:
(a) the recommendation is made as part of a service to which an item in Subgroup 3 of Group A36 or Subgroup 25 or 26 of Group A40 applies; and
(b) the service is provided:
(i) for the purposes of paragraph (1)(c)—after the patient has been provided with 10 services under the plan; and
(ii) for the purposes of paragraph (1)(d)—after the patient has been provided with 20 services under the plan; and
(iii) for the purposes of paragraph (1)(e)—after the patient has been provided with 30 services under the plan; and
(c) the practitioner records the recommendation in the patient's records.

Clause 2.31.10

(3) For the purposes of this clause, in counting the services providing treatments under a plan, only count the services to which any of the following apply:
  (a) items 283, 285, 286, 287, 371 and 372;
  (b) items 2721, 2723, 2725 and 2727;
  (c) items in Groups M6, M7 and M16 other than items 82350 and 82351;
  (d) items 90271, 90272, 90273, 90274, 90275, 90276, 90277, 90278, 90279, 90280, 90281 and 90282;
  (e) items 91166, 91167, 91169, 91170, 91172, 91173, 91175, 91176, 91181 to 91188, 91818, 91819, 91820, 91821, 91842, 91843, 91844, 91845, 92182, 92184, 92186, 92188, 92194, 92196, 92198, 92200, 93076, 93079, 93084. 93087, 93092, 93095, 93100, 93103, 93110, 93113, 93118, 93121, 93126, 93129, 93134 and 93137.

2.31.10 Items in Group A36

This clause sets out items in Group A36.

Group A36—Eating disorders		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
Subgroup 1—Preparation of eating disorder treatment and management plans: general practitioners and non-specialist medical practitioners		
90250	Professional attendance by a general practitioner to prepare an eating disorder treatment and management plan, lasting at least 20 minutes but less than 40 minutes	74.60
90251	Professional attendance by a general practitioner to prepare an eating disorder treatment and management plan, lasting at least 40 minutes	109.85
90252	Professional attendance by a general practitioner to prepare an eating disorder treatment and management plan, lasting at least 20 minutes but less than 40 minutes, if the practitioner has successfully completed mental health skills training	94.75
90253	Professional attendance by a general practitioner to prepare an eating disorder treatment and management plan, lasting at least 40 minutes, if the practitioner has successfully completed mental health skills training	139.55
90254	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to prepare an eating disorder treatment and management plan, lasting at least 20 minutes but less than 40 minutes	59.70
90255	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to prepare an eating disorder treatment and management plan, lasting at least 40 minutes	87.90
90256	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to prepare an eating disorder treatment and management plan, lasting at least 20 minutes but less than 40 minutes, if the practitioner has successfully completed mental health skills training	75.80
90257	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to prepare an eating disorder treatment and management plan, lasting at least 40 minutes, if the	111.65

Group A36—Eating disorders		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	practitioner has successfully completed mental health skills training	
Subgroup 2—Preparation of eating disorder treatment and management plans: consultant physicians		
90260	Professional attendance at consulting rooms by a consultant physician in the practice of the physician's specialty of psychiatry to prepare an eating disorder treatment and management plan, if: (a) the patient is referred; and (b) the attendance lasts at least 45 minutes	478.05
90261	Professional attendance at consulting rooms by a consultant physician in the practice of the physician's specialty of paediatrics to prepare an eating disorder treatment and management plan, if: (a) the patient is referred; and (b) the attendance lasts at least 45 minutes	278.75
90262	Professional attendance by a consultant physician in the practice of the physician's specialty of psychiatry to prepare an eating disorder treatment and management plan, if: (a) the patient is referred; and (b) the attendance is by video conference and lasts at least 45 minutes	478.05
90263	Professional attendance by a consultant physician in the practice of the physician's specialty of paediatrics to prepare an eating disorder treatment and management plan, if: (a) the patient is referred; and (b) the attendance is by video conference and lasts at least 45 minutes	278.75
Subgroup 3—Review of eating disorder treatment and management plans		
90264	Professional attendance by a general practitioner to review an eating disorder treatment and management plan	74.60
90265	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to review an eating disorder treatment and management plan	59.70
90266	Professional attendance at consulting rooms by a consultant physician in the practice of the physician's specialty of psychiatry to review an eating disorder treatment and management plan, if: (a) the patient is referred; and (b) the attendance lasts at least 30 minutes	298.85
90267	Professional attendance at consulting rooms by a consultant physician in the practice of the physician's specialty of paediatrics to review an eating disorder treatment and management plan, if: (a) the patient is referred; and (b) the attendance lasts at least 20 minutes	139.55
90268	Professional attendance by a consultant physician in the practice of the physician's specialty of psychiatry to review an eating disorder treatment and management plan, if: (a) the patient is referred; and (b) the attendance is by video conference and lasts at least 30 minutes	298.85

Clause 2.31.10

Group A36—Eating disorders		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
90269	Professional attendance by a consultant physician in the practice of the physician's specialty of paediatrics to review an eating disorder treatment and management plan, if: (a) the patient is referred; and (b) the attendance is by video conference and lasts at least 20 minutes	139.55
Subgroup 4—Providing treatments under eating disorder treatment and management plans		
90271	Professional attendance at consulting rooms by a general practitioner to provide treatment under an eating disorder treatment and management plan, lasting at least 30 minutes but less than 40 minutes	96.50
90272	Professional attendance at a place other than consulting rooms by a general practitioner to provide treatment under an eating disorder treatment and management plan, lasting at least 30 minutes but less than 40 minutes	Amount under clause 2.1.1
90273	Professional attendance at consulting rooms by a general practitioner to provide treatment under an eating disorder treatment and management plan, lasting at least 40 minutes	138.10
90274	Professional attendance at a place other than consulting rooms by a general practitioner to provide treatment under an eating disorder treatment and management plan, lasting at least 40 minutes	Amount under clause 2.1.1
90275	Professional attendance at consulting rooms by a medical practitioner (other than a general practitioner, specialist or consultant physician) to provide treatment under an eating disorder treatment and management plan, lasting at least 30 minutes but less than 40 minutes	77.20
90276	Professional attendance at a place other than consulting rooms by a medical practitioner (other than a general practitioner, specialist or consultant physician) to provide treatment under an eating disorder treatment and management plan, lasting at least 30 minutes but less than 40 minutes	Amount under clause 2.1.1
90277	Professional attendance at consulting rooms by a medical practitioner (other than a general practitioner, specialist or consultant physician) to provide treatment under an eating disorder treatment and management plan, lasting at least 40 minutes	110.50
90278	Professional attendance at a place other than consulting rooms by a medical practitioner (other than a general practitioner, specialist or consultant physician) to provide treatment under an eating disorder treatment and management plan, lasting at least 40 minutes	Amount under clause 2.1.1
90279	Professional attendance at consulting rooms by a general practitioner to provide treatment under an eating disorder treatment and management plan, lasting at least 30 minutes but less than 40 minutes, if the attendance is by video conference	96.50
90280	Professional attendance at consulting rooms by a general practitioner to provide treatment under an eating disorder treatment and management plan, lasting at least 40 minutes, if the attendance is by video conference	138.10
90281	Professional attendance at consulting rooms by a medical practitioner (other than a general practitioner, specialist or consultant physician) to provide treatment under an eating disorder treatment and management plan, lasting at least 30 minutes but less than 40 minutes, if the attendance is by video conference	77.20

Group A36—Eating disorders

Column 1 Item	Column 2 Description	Column 3 Fee ($)
90282	Professional attendance at consulting rooms by a medical practitioner (other than a general practitioner, specialist or consultant physician) to provide treatment under an eating disorder treatment and management plan, lasting at least 40 minutes, if the attendance is by video conference	110.50

Part 3—Miscellaneous services

Division 3.1—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

3.1.1 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.

3.1.2 Restrictions on 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.

3.1.3 Restrictions on item 10989

Item 10989 applies to an Aboriginal and Torres Strait Islander health practitioner if:
  (a) the health practitioner is appropriately qualified and trained to treat wounds; and
  (b) a medical practitioner under whose supervision the health practitioner provides the treatment has conducted an initial assessment of the person; and
  (c) the health practitioner has been instructed by the medical practitioner about the treatment of the wound; and
  (d) the medical practitioner retains responsibility for the health, safety and clinical outcomes of the person.

3.1.4 Items in Group M12

This clause sets out items in Group M12.

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		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 1—Video conferencing consultation support service provided by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner		
10983	Attendance by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner, to provide clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist, consultant physician or psychiatrist; and (b) is not an admitted patient; and (c) either: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 km by road from the specialist, physician or psychiatrist mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies	33.70
Subgroup 2—Video conferencing consultation support service provided at a residential aged care facility on behalf of a medical practitioner		
10984	Attendance by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner, to provide clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist, consultant physician or psychiatrist; and (b) is a care recipient in a residential aged care facility; and (c) is not a resident of a self-contained unit	33.70
Subgroup 3—Services provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner		
10987	Follow-up service, to a maximum of 10 services per patient in a calendar year, provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner, on behalf of a medical practitioner, for an Indigenous person who has received a health check if: (a) the service is provided on behalf of and under the supervision of a medical practitioner; and (b) the person is not an admitted patient of a hospital; and	24.95

Clause 3.2.1

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		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(c) the service is consistent with the needs identified through the health assessment	
10988	Immunisation provided to a person by an Aboriginal and Torres Strait Islander health practitioner if: (a) the immunisation is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the person is not an admitted patient of a hospital	12.50
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	12.50
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 the person 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	12.50

Division 3.2—Group M1: Management of bulk-billed services

3.2.1 Definitions

In this Division:

ASGC means the July 2011 edition of the *Australian Standard Geographical Classification (ASGC)* (ABS catalogue number 1216.0), published by the Australian Statistician, as existing on 1 July 2020.

bulk-billed: a medical service is ***bulk-billed*** if:

(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, the person's right to the payment of the medicare benefit; and

(ii) the medical practitioner accepts the assignment in full payment of the medical practitioner's fee for the service provided.

concessional beneficiary has the same meaning as in Part VII of the *National Health Act 1953*.

designated area means the following:

(a) a regional, rural or remote area;
(b) Tasmania;
(c) a geographical area included in any of the following SSD spatial units:
  (i) Beaudesert Shire Part A;
  (ii) Belconnen;
  (iii) Darwin City;
  (iv) Eastern Outer Melbourne;
  (v) East Metropolitan Perth;
  (vi) Frankston City;
  (vii) Gosford-Wyong;
  (viii) Greater Geelong City Part A;
  (ix) Gungahlin-Hall;
  (x) Ipswich City (Part in BSD);
  (xi) Litchfield Shire;
  (xii) Melton-Wyndham;
  (xiii) Mornington Peninsula Shire;
  (xiv) Newcastle;
  (xv) North Canberra;
  (xvi) Palmerston-East Arm;
  (xvii) Pine Rivers Shire;
  (xviii) Queanbeyan;
  (xix) South Canberra;
  (xx) South Eastern Outer Melbourne;
  (xxi) Southern Adelaide;
  (xxii) South West Metropolitan Perth;
  (xxiii) Thuringowa City Part A;
  (xxiv) Townsville City Part A;
  (xxv) Tuggeranong;
  (xxvi) Weston Creek-Stromlo;
  (xxvii) Woden Valley;
  (xxviii) Yarra Ranges Shire Part A;
(d) the geographical area included in the SLA spatial unit of Palm Island (AC).

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 by, or on behalf of, a medical practitioner to a patient who has not been referred to the practitioner for the service.

3.2.2 Restrictions on items 10990, 10991 and 10992

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

Clause 3.2.3

(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 this Schedule that applies to the service.

3.2.3 Items in Group M1

This clause sets out items in Group M1.

Group M1—Management of bulk-billed services

Column 1 Item	Column 2 Description	Column 3 Fee ($)
10990	A medical service to which an item in this Schedule (other than this item or item 10991 or 10992) applies if: (a) the service is an unreferred service; and (b) the service is provided to a patient who is under the age of 16 or is a concessional beneficiary; and (c) the patient is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) the other item in this Schedule applying to the service	7.65
10991	A medical service to which an item in this Schedule (other than this item or item 10990 or 10992) applies if: (a) the service is an unreferred service; and (b) the service is provided to a patient who is under the age of 16 or is a concessional beneficiary; and (c) the patient is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) the other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in: (i) a Modified Monash 2 area; or (ii) a Modified Monash 3 area; or (iii) a Modified Monash 4 area; or (iv) a Modified Monash 5 area; or (v) a Modified Monash 6 area; or (vi) a Modified Monash 7 area	11.60
10992	A medical service to which: (a) item 585, 588, 591, 594, 599, 600, 5003, 5010, 5023, 5028, 5043, 5049, 5063, 5067, 5220, 5223, 5227, 5228, 5260, 5263, 5265 or 5267 applies; or (b) item 761, 763, 766, 769, 772, 776, 788 or 789 of a Schedule (within the meaning of the *Health Insurance (Section 3C General Medical Services – Other Medical Practitioner) Determination 2018*) applies; if: (c) the service is an unreferred service; and (d) the service is provided to a patient who is under the age of 16 or is a concessional beneficiary; and (e) the patient is not an admitted patient of a hospital; and	11.60

Group M1—Management of bulk-billed services

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(f) the service is not provided in consulting rooms; and (g) the service is provided in a designated area; and (h) the service is provided by, or on behalf of, a medical practitioner whose practice location is not in a designated area; and (i) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) the other item mentioned in paragraph (a) or (b) applying to the service	

Part 4—Diagnostic procedures and investigations

Division 4.1—Group D1: Miscellaneous diagnostic procedures and investigations

4.1.1 Meaning of report

In this Division:

report means a report prepared by a medical practitioner.

4.1.2 Meaning of qualified adult sleep medicine practitioner, qualified paediatric sleep medicine practitioner and qualified sleep medicine practitioner

(1) In this Schedule:

qualified adult sleep medicine practitioner means a person who meets the conditions in one of subclauses (2), (3), (4) and (5) relating to:

(a) the field (the ***relevant field***) of adult sleep medicine; or

(b) the training program (the ***relevant training program***) of the Thoracic Society of Australia and New Zealand and the Australasian Sleep Association known as the Advanced Training Program in Adult Sleep Medicine.

qualified paediatric sleep medicine practitioner means a person who meets the conditions in one of subclauses (2), (3), (4) and (5) relating to:

(a) the field (the ***relevant field***) of paediatric sleep medicine; or

(b) the training program (the ***relevant training program***) of the Thoracic Society of Australia and New Zealand and the Australasian Sleep Association known as the Advanced Training Program in Paediatric Sleep Medicine.

qualified sleep medicine practitioner means a qualified adult sleep medicine practitioner or a qualified paediatric sleep medicine practitioner.

RACP Advisory Committee means the Specialist Advisory Committee in Thoracic and Sleep Medicine of the Royal Australasian College of Physicians.

RACP Appeal Committee means the Appeal Committee of the Royal Australasian College of Physicians.

RACP Credentialling Subcommittee means the Credentialling Subcommittee of the RACP Advisory Committee.

Conditions for being a qualified sleep medicine practitioner

(2) A person meets the conditions in this subclause if the person has been assessed by the RACP Credentialling Subcommittee or the RACP Appeal Committee as having had, before 1 March 1999, sufficient training and experience in the relevant field to be competent in:

(a) independent clinical assessment and management of patients with respiratory sleep disorders; and
(b) reporting sleep studies.

(3) A person meets the conditions in this subclause if:
(a) the person has been assessed by the RACP Credentialling Subcommittee or the RACP Appeal Committee as having had, before 1 March 1999, substantial training or experience in sleep medicine, but requiring further specified training or experience in the relevant field to be competent in:
(i) independent clinical assessment and management of patients with respiratory sleep disorders; and
(ii) reporting sleep studies; and
(b) either:
(i) the person has been assessed by the RACP Credentialling Subcommittee as having satisfactorily finished the further specified training or gained the further specified experience; or
(ii) where an assessment mentioned in paragraph (a) has been carried out, less than 2 years has passed since the assessment.

(4) A person meets the conditions in this subclause if the person has attained Level I or Level II of the relevant training program after completing at least 12 months core training, including clinical practice in the relevant field and in reporting sleep studies.

(5) A person meets the conditions in this subclause if the RACP Advisory Committee has recognised the person, in writing, as having training equivalent to the training mentioned in subclause (4).

4.1.3 Restriction on item 11801—service provided in association with other services

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

4.1.3A Restriction on items 11704, 11705 and 11723—services to include formal reports

(1) Items 11704, 11705 and 11723 apply to a service only if:
(a) the formal report required for the service complies with subclause (2); and
(b) a copy of the formal report is provided to the requesting practitioner.

(2) The formal report must:
(a) be in writing; and
(b) include an interpretation of the trace, including the indicators for the investigation; and
(c) include comments on the significance of:
(i) the trace findings; and
(ii) the relationship of the trace findings to clinical decision making for the patient in the clinical context; and

(d) if appropriate—include a copy of the trace and any measurements taken or automatically generated; and

(e) for item 11705—be a report of a trace from a twelve-lead electrocardiography for the patient:

(i) provided with the request by the requesting practitioner; and

(ii) that has not previously been reported on.

4.1.3B Restriction on item 11714—services to include clinical notes

(1) Item 11714 applies to a service only if:

(a) the clinical note required for the service complies with subclause (2); and

(b) if appropriate, a copy of the clinical note is provided to the requesting practitioner.

(2) The clinical note must include:

(a) comments on the significance of:

(i) the trace findings; and

(ii) the relationship of the trace findings to clinical decision making for the patient in the clinical context; and

(b) an interpretation that is not based solely on measurements or diagnoses automatically generated from the trace.

4.1.3C Restriction on items 11704 and 11705—financial relationship

Items 11704 and 11705 apply to a service only if the medical practitioner providing the service does not have a financial relationship with the medical practitioner who has requested the service.

4.1.3D Restrictions on items 11729 and 11730—patient limitations

(1) Items 11729 and 11730 apply to a service provided to a patient only if:

(a) the patient's body habitus, or other physical condition, is suitable for exercise stress testing or pharmacological induced stress testing; and

(b) the patient can complete the exercise sufficiently, or respond adequately to pharmacological induced stress, for the required measurements to be taken.

(2) Despite subclause (1), item 11729 does not apply to a service if:

(a) the patient is asymptomatic and has a normal cardiac examination; or

(b) the service is to monitor a patient who has a known cardiac disease, but the absence of symptom evolution suggests the disease has not progressed; or

(c) the patient has an abnormal resting electrocardiography result which would prevent the interpretation of results.

(3) Despite subclause (1), item 11730 does not apply to a service if the patient is asymptomatic and has a normal cardiac examination.

4.1.3E Restriction on items 11729 and 11730—safety requirements

(1) Items 11729 and 11730 apply to a service provided to a patient only if:

(a) the service is performed on premises equipped with resuscitation equipment, including a defibrillator; and
(b) a person trained in the matters mentioned in subclause (2) and cardiopulmonary resuscitation is in continuous personal attendance during the monitoring and recording; and
(c) at the time the service is performed, a second person trained in cardiopulmonary resuscitation is located at the premises and is immediately available to respond if required; and
(d) at least one of the persons mentioned in paragraphs (b) and (c) is a medical practitioner.

(2) For the purposes of paragraph (1)(b), the matters are:
(a) how to safely perform exercise or pharmacological stress monitoring and recording; and
(b) how to recognise the symptoms and signs of cardiac disease.

4.1.3F Restriction on certain items—patients receiving hospital treatment or hospital-substitute treatment

Items 11704, 11707, 11714, 11716, 11717, 11723 and 11735 do not apply to a service provided to a patient if the patient is being provided with the service as part of an episode of:
(a) hospital treatment; or
(b) hospital-substitute treatment in respect of which the patient chooses to receive a benefit from a private health insurer.

4.1.3G Restriction on certain items—other services on the same day

(1) Item 11704 does not apply to a service if the specialist or consultant physician providing the service provides to the patient, on the same day, another service to which another item in Part 2 (attendances) applies.

(2) Item 11705 does not apply to a service if the specialist or consultant physician providing the service provides to the patient, on the same day, another service to which another item in Part 2 (attendances) applies, unless there has been a significant change in the patient's clinical condition or care circumstances that necessitates the providing of the service.

4.1.4 Restrictions on items 12306 to 12322

(1) Items 12306 to 12322 apply to a service for a patient only as set out in this clause.

(2) The items apply to a service that is provided by a specialist or consultant physician to whom the patient has been referred by another medical practitioner.

(3) The items also apply to a service that is provided as follows:
(a) a person (the ***radiation licence holder***) who holds a radiation licence under a law of a State or Territory performs the service (other than interpretation and reporting) under the supervision of a specialist or consultant physician;

(b) the specialist or consultant physician performs the interpretation and reporting for the service;
(c) the radiation licence authorises the radiation licence holder to undertake the activities involved in performing the service (other than interpretation and reporting);
(d) the patient has been referred to the specialist or consultant physician by another medical practitioner;
(e) for items 12320 and 12322—if the service is performed using quantitative computed tomography:
(i) the radiation licence holder is registered as a medical radiation practitioner under a law of a State or Territory; and
(ii) the specialist or consultant physician is available to monitor and influence the conduct and diagnostic quality of the examination and, if necessary, to attend on the patient personally.

4.1.5 Items in Group D1

This clause sets out items in Group D1.

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 1—Neurology		
11000	Electroencephalography, other than a service: (a) associated with a service to which item 11003 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices (Anaes.)	128.10
11003	Electroencephalography, prolonged recording lasting at least 3 hours, that requires multi-channel recording using: (a) for a service not associated with a service to which an item in Group T8 applies—standard 10-20 electrode placement; or (b) for a service associated with a service to which an item in Group T8 applies—either standard 10-20 electrode placement or a different electrode placement and number of recorded channels; other than a service: (c) associated with a service to which item 11000, 11004 or 11005 applies; or (d) involving quantitative topographic mapping using neurometrics or similar devices	338.85
11004	Electroencephalography, ambulatory or video, prolonged recording lasting at least 3 hours and up to 24 hours, that requires multi-channel recording using standard 10-20 electrode placement, first day, other than a service: (a) associated with a service to which item 11000, 11003 or 11005 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices	338.85
11005	Electroencephalography, ambulatory or video, prolonged recording	338.85

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	lasting at least 3 hours and up to 24 hours, that requires multi-channel recording using standard 10-20 electrode placement, each day after the first day, other than a service: (a) associated with a service to which item 11000, 11003 or 11004 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices	
11009	Electrocorticography	338.85
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)	116.55
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)	156.00
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)	233.05
11021	Neuromuscular electrodiagnosis—repetitive stimulation for study of neuromuscular conduction or electromyography with quantitative computerised analysis or both of these examinations	156.00
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	118.45
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	175.70
Subgroup 2—Ophthalmology		
11200	Provocative test or tests for open angle glaucoma, including water drinking	42.45
11204	Electroretinography of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards, performed by or on behalf of a specialist or consultant physician in the practice of the specialist's or consultant physician's speciality	112.65
11205	Electrooculography of one or both eyes performed according to current professional guidelines or standards, performed by or on behalf of a specialist or consultant physician in the practice of the specialist's or consultant physician's speciality	112.65
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	112.65

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
11211	Dark adaptometry of one or both eyes with a quantitative estimation of threshold in log lumens at 45 minutes of dark adaptations	112.65
11215	Retinal angiography, multiple exposures, of one eye with intravenous dye injection	127.95
11218	Retinal angiography, multiple exposures of both eyes with intravenous dye injection	158.10
11219	Optical coherence tomography for diagnosis of an ocular condition for the treatment of which there is a medication that is: (a) listed on the pharmaceutical benefits scheme; and (b) indicated for intraocular administration Applicable only once in any 12 month period	41.60
11220	Optical coherence tomography, to a maximum of one service per eye per lifetime, for the assessment of the need for treatment following provision of pharmaceutical benefits scheme-subsidised ocriplasmin	41.60
11221	Full quantitative computerised perimetry (automated absolute static threshold), other than a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of the specialist's specialty, if indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, bilateral—to a maximum of 3 examinations (including examinations to which item 11224 applies) in any 12 month period	70.55
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 the specialist's specialty, if indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, unilateral—to a maximum of 3 examinations (including examinations to which item 11221 applies) in any 12 month period	42.50
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 a report	127.70
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	84.75
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	84.75
11241	Orbital contents, unidimensional ultrasonic echography or partial	107.85

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
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	83.35
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	83.35
11244	Orbital contents, diagnostic B-scan of, by a specialist practising in the specialist's 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	80.10
Subgroup 3—Otolaryngology		
11300	Brain stem evoked response audiometry (Anaes.)	200.30
11303	Electrocochleography, extratympanic method, one or both ears	200.30
11304	Electrocochleography, transtympanic membrane insertion technique, one or both ears	329.80
11306	Non-determinate audiometry	22.80
11309	Audiogram, air conduction	27.35
11312	Audiogram, air and bone conduction or air conduction and speech discrimination	38.65
11315	Audiogram, air and bone conduction and speech	51.20
11318	Audiogram, air and bone conduction and speech, with other cochlear tests	63.20
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 the specialist's 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	34.20
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 the specialist's 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	20.55
11330	Impedance audiogram if the patient is not referred by a medical practitioner—one examination in any 4 week period	8.20

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **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	60.95
11333	Caloric test of labyrinth or labyrinths	46.40
11336	Simultaneous bithermal caloric test of labyrinths	46.40
11339	Electronystagmography	46.40
Subgroup 4—Respiratory		
11503	Complex measurement of properties of the respiratory system, including the lungs and respiratory muscles, that is performed: (a) in a respiratory laboratory; and (b) under the supervision of a consultant respiratory physician who is responsible for staff training, supervision, quality assurance and the issuing of written reports on tests performed; and (c) using any of the following tests: (i) measurement of absolute lung volumes by any method; (ii) measurement of carbon monoxide diffusing capacity by any method; (iii) measurement of airway or pulmonary resistance by any method; (iv) inhalation provocation testing, including pre-provocation spirometry and the construction of a dose response curve, using a recognised direct or indirect bronchoprovocation agent and post-bronchodilator spirometry; (v) provocation testing involving sequential measurement of lung function at baseline and after exposure to specific sensitising agents, including drugs, or occupational asthma triggers; (vi) spirometry performed before and after simple exercise testing undertaken as a provocation test for the investigation of asthma, in premises equipped with resuscitation equipment and personnel trained in Advanced Life Support; (vii) measurement of the strength of inspiratory and expiratory muscles at multiple lung volumes; (viii) simulated altitude test involving exposure to hypoxic gas	144.25

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	mixtures and oxygen saturation at rest and/or during exercise with or without an observation of the effect of supplemental oxygen; (ix) calculation of pulmonary or cardiac shunt by measurement of arterial oxygen partial pressure and haemoglobin concentration following the breathing of an inspired oxygen concentration of 100% for 15 minutes or greater; (x) if the measurement is for the purpose of determining eligibility for pulmonary arterial hypertension medications subsidised under the Pharmaceutical Benefits Scheme or eligibility for the provision of portable oxygen—functional exercise test by any method (including 6 minute walk test and shuttle walk test); each occasion at which one or more tests are performed Not applicable to a service performed in association with a spirometry or sleep study service to which item 11505, 11506, 11507, 11508, 11512, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Not applicable to a service to which item 11507 applies	
11505	Measurement of spirometry, that: (a) involves a permanently recorded tracing, performed before and after inhalation of a bronchodilator; and (b) is performed to confirm diagnosis of: (i) asthma; or (ii) chronic obstructive pulmonary disease (COPD); or (iii) another cause of airflow limitation; each occasion at which 3 or more recordings are made Applicable only once in any 12 month period	42.80
11506	Measurement of spirometry, that: (a) involves a permanently recorded tracing, performed before and after inhalation of a bronchodilator; and (b) is performed to: (i) confirm diagnosis of chronic obstructive pulmonary disease (COPD); or (ii) assess acute exacerbations of asthma; or (iii) monitor asthma and COPD; or (iv) assess other causes of obstructive lung disease or the presence of restrictive lung disease; each occasion at which recordings are made	21.40
11507	Measurement of spirometry: (a) that includes continuous measurement of the relationship between flow and volume during expiration or during expiration and inspiration, performed before and after inhalation of a bronchodilator; and (b) fractional exhaled nitric oxide (FeNO) concentration in exhaled breath;	104.30

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	if: (c) the measurement is performed: (i) under the supervision of a specialist or consultant physician; and (ii) with continuous attendance by a respiratory scientist; and (iii) in a respiratory laboratory equipped to perform complex lung function tests; and (d) a permanently recorded tracing and written report is provided; and (e) 3 or more spirometry recordings are performed unless difficult to achieve for clinical reasons; each occasion at which one or more such tests are performed Not applicable to a service associated with a service to which item 11503 or 11512 applies	
11508	Maximal symptom-limited incremental exercise test using a calibrated cycle ergometer or treadmill, if: (a) the test is performed for the evaluation of: (i) breathlessness of uncertain cause from tests performed at rest; or (ii) breathlessness out of proportion with impairment due to known conditions; or (iii) functional status and prognosis in a patient with significant cardiac or pulmonary disease for whom complex procedures such as organ transplantation are considered; or (iv) anaesthetic and perioperative risks in a patient undergoing major surgery who is assessed as substantially above average risk after standard evaluation; and (b) the test has been requested by a specialist or consultant physician following professional attendance on the patient by the specialist or consultant physician; and (c) a respiratory scientist and a medical practitioner are in constant attendance during the test; and (d) the test is performed in a respiratory laboratory equipped with airway management and defibrillator equipment; and (e) there is continuous measurement of at least the following: (i) work rate; (ii) pulse oximetry; (iii) respired oxygen and carbon dioxide partial pressures and respired volumes; (iv) ECG; (v) heart rate and blood pressure; and (f) interpretation and preparation of a permanent report is provided by a consultant respiratory physician who is also responsible for the supervision of technical staff and quality assurance	302.60
11512	Measurement of spirometry: (a) that includes continuous measurement of the relationship between flow and volume during expiration or during expiration and inspiration, performed before and after inhalation of a	64.25

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	bronchodilator; and (b) that is performed with a respiratory scientist in continuous attendance; and (c) that is performed in a respiratory laboratory equipped to perform complex lung function tests; and (d) that is performed under the supervision of a consultant physician practising respiratory medicine who is responsible for staff training, supervision, quality assurance and the issuing of written reports; and (e) for which a permanently recorded tracing and written report is provided; and (f) for which 3 or more spirometry recordings are performed; each occasion at which one or more such tests are performed Not applicable for a service associated with a service to which item 11503 or 11507 applies	
Subgroup 5—Vascular		
11600	Central venous, pulmonary arterial, systemic arterial or cardiac intracavity blood pressure monitoring by indwelling catheter—once per day for each type of pressure for a patient, other than a service: (a) associated with the management of general anaesthesia; and (b) to which item 13876 applies	72.10
11602	Investigation of venous reflux or obstruction in one or more limbs at rest by CW Doppler or pulsed Doppler involving examination at multiple sites along each limb using intermittent limb compression or Valsalva manoeuvres, or both, to detect prograde and retrograde flow, other than a service associated with a service to which item 32500 applies—hard copy trace and written report, the report component of which must be performed by a medical practitioner, maximum of 2 examinations in a 12 month period, not to be used in conjunction with sclerotherapy	60.10
11604	Investigation of chronic venous disease in the upper and lower extremities, one or more limbs, by plethysmography (excluding photoplethysmography)—examination, hard copy trace and written report, not being a service associated with a service to which item 32500 applies	78.75
11605	Investigation of complex chronic lower limb reflux or obstruction, in one or more limbs, by infrared photoplethysmography, during and following exercise to determine surgical intervention or the conservative management of deep venous thrombotic disease—hard copy trace, calculation of 90% recovery time and written report, not being a service associated with a service to which item 32500 applies	78.75
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	66.30
11611	Measurement of wrist—brachial indices and arterial waveform analysis,	66.30

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
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	116.95
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	78.75
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	78.95
11627	Pulmonary artery pressure monitoring during open heart surgery, in a patient under 12 years of age	237.90
Subgroup 6—Cardiovascular		
11704	Twelve-lead electrocardiography, trace and formal report, by a specialist or a consultant physician, if the service: (a) is requested by a requesting practitioner; and (b) is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies	32.55
11705	Twelve-lead electrocardiography, formal report only, by a specialist or a consultant physician, if the service: (a) is requested by a requesting practitioner; and (b) is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable not more than twice on the same day	19.15
11707	Twelve-lead electrocardiography, trace only, by a medical practitioner, if: (a) the trace: (i) is required to inform clinical decision making; and (ii) is reviewed in a clinically appropriate timeframe to identify potentially serious or life-threatening abnormalities; and (iii) does not need to be fully interpreted or reported on; and (b) the service is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable not more than twice on the same day	19.15

Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
11713	Signal averaged ECG recording involving not more than 300 beats, using at least 3 leads with data acquisition at not less than 1000Hz of at least 100 QRS complexes, including analysis, interpretation and report of recording by a specialist physician or consultant physician	72.55
11714	Twelve-lead electrocardiography, trace and clinical note, by a specialist or consultant physician, if the service is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable not more than twice on the same day	25.20
11715	Blood dye—dilution indicator test	125.65
11716	Continuous ambulatory electrocardiogram recording for 12 or more hours, by a specialist or consultant physician, if the service: (a) is indicated for the evaluation of any of the following: (i) syncope; (ii) pre-syncopal episodes; (iii) palpitations where episodes are occurring more than once a week; (iv) another asymptomatic arrhythmia is suspected with an expected frequency of greater than once a week; (v) surveillance following cardiac surgical procedures that have an established risk of causing dysrhythmia; and (b) utilises a system capable of superimposition and full disclosure printout of at least 12 hours of recorded electrocardiogram data (including resting electrocardiogram and the recording of parameters) and microprocessor based scanning analysis; and (c) includes interpretation and report; and (d) is not provided in association with ambulatory blood pressure monitoring; and (e) is not associated with a service to which item 11704, 11705, 11707, 11714, 11717, 11723, 11735, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable only once in any 4 week period	174.30
11717	Ambulatory electrocardiogram monitoring, by a specialist or consultant physician, if the service: (a) utilises a patient activated, single or multiple event memory recording device that: (i) is connected continuously to the patient for between 7 and 30 days; and (ii) is capable of recording for at least 20 seconds prior to each activation and for 15 seconds after each activation; and (b) includes transmission, analysis, interpretation and reporting (including the indication for the investigation); and (c) is for the investigation of recurrent episodes of: (i) unexplained syncope; or (ii) palpitation; or (iii) other symptoms where a cardiac rhythm disturbance is suspected and where infrequent episodes have occurred; and	102.40

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Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(d) is not associated with a service to which item 11716, 11723, 11735, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable only once in any 3 month period	
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 11719, 11720, 11721, 11725 or 11726 applies	36.15
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 Applicable once in any 12 month period	69.50
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	69.50
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 11718, 11719, 11720, 11725 or 11726 applies	72.55
11723	Ambulatory electrocardiogram monitoring, by a specialist or consultant physician, if the service: (a) utilises a patient activated, single or multiple event recording, on a memory recording device that: (i) is connected continuously to the patient for up to 7 days; and (ii) is capable of recording for at least 20 seconds prior to each activation and for 15 seconds after each activation; and (b) includes transmission, analysis, interpretation and formal report (including the indication for the investigation); and (c) is for the investigation of recurrent episodes of: (i) unexplained syncope; or (ii) palpitation; or (iii) other symptoms where a cardiac rhythm disturbance is suspected and where infrequent episodes have occurred; and (d) is not associated with a service to which item 11716, 11717, 11735, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable only once in any 3 month period	54.05
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	175.70

Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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 Applicable once in any 12 month period	197.20
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	98.60
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 11718, 11719, 11720, 11721, 11725 or 11726 applies	98.60
11728	Implanted loop recording for the investigation of atrial fibrillation if the patient to whom the service is provided has been diagnosed as having had an embolic stroke of undetermined source, including reprogramming when required, retrieval of stored data, analysis, interpretation and report, other than a service to which item 38288 applies For any particular patient—applicable not more than 4 times in any 12 months	36.15
11729	Multi channel electrocardiogram monitoring and recording during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts) or pharmacological stress, if: (a) the patient is 17 years or more; and (b) the patient: (i) has symptoms consistent with cardiac ischemia; or (ii) has other cardiac disease which may be exacerbated by exercise; or (iii) has a first degree relative with suspected heritable arrhythmia; and (c) the monitoring and recording: (i) is not less than 20 minutes; and (ii) includes resting electrocardiogram; and (d) a written report is produced by a medical practitioner that includes interpretation of the monitoring and recording data, commenting on the significance of the data, and the relationship of the data to clinical decision making for the patient in the clinical context; and (e) the service is not a service: (i) provided on the same occasion as a service to which item 11704, 11705, 11707 or 11714 applies; or (ii) performed within 24 months of a service to which item 55141, 55143, 55145, 55146, 61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 or 61414 applies Applicable only once in any 24 month period	158.35

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
11730	Multi channel electrocardiogram monitoring and recording during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts), if: (a) the patient is less than 17 years; and (b) the patient: (i) has symptoms consistent with cardiac ischemia; or (ii) has other cardiac disease which may be exacerbated by exercise; or (iii) has a first degree relative with suspected heritable arrhythmia; and (c) the monitoring and recording: (i) is not less than 20 minutes in duration; and (ii) includes resting electrocardiogram; and (d) a written report is produced by a medical practitioner that includes interpretation of the monitoring and recording data, commenting on the significance of the data, and the relationship of the data to clinical decision making for the patient in the clinical context; and (e) the service is not a service: (i) provided on the same occasion as a service to which item 11704, 11705, 11707 or 11714 applies; or (ii) performed within 24 months of a service to which item 55141, 55143, 55145, 55146, 61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 or 61414 applies Applicable only once in any 24 month period	158.35
11731	Implanted electrocardiogram loop recording, by a medical practitioner, including reprogramming (if required), retrieval of stored data, analysis, interpretation and report, if the service is: (a) an investigation for a patient with: (i) cryptogenic stroke; or (ii) recurrent unexplained syncope; and (b) not a service to which item 38285 applies Applicable only once in any 4 week period	36.15
11735	Continuous ambulatory electrocardiogram recording for 7 days, by a specialist or consultant physician, if the service: (a) utilises intelligent microprocessor based monitoring, with patient triggered recording and symptom reporting capability, real time analysis of electrocardiograms and alerts and daily or live data uploads; and (b) is for the investigation of: (i) episodes of suspected intermittent cardiac arrhythmia or episodes of syncope; or (ii) suspected intermittent cardiac arrhythmia in a patient who has had a previous cerebrovascular accident, is at risk of cerebrovascular accident or has had one or more previous transient ischemic attacks; and (c) includes interpretation and report; and (d) is not a service:	133.10

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(i) provided in association with ambulatory blood pressure monitoring; or (ii) associated with a service to which item 11716, 11717, 11723, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable not more than 4 times in any 12 month period	
Subgroup 7—Gastroenterology and colorectal		
11800	Oesophageal motility test, manometric	181.50
11801	Clinical assessment of gastro-oesophageal reflux disease that involves 48-hour catheter-free wireless ambulatory oesophageal pH monitoring, including administration of the device and associated endoscopy procedure for placement, analysis and interpretation of the data and all attendances for providing the service, if: (a) a catheter-based ambulatory oesophageal pH monitoring: (i) has been attempted on the patient but failed due to clinical complications; or (ii) is not clinically appropriate for the patient due to anatomical reasons (nasopharyngeal anatomy) preventing the use of catheter-based pH monitoring; and (b) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy (Anaes.)	273.65
11810	Clinical assessment of gastro-oesophageal reflux disease involving 24-hour pH monitoring, including analysis, interpretation and report and including any associated consultation	181.50
11820	Capsule endoscopy to investigate an episode of obscure gastrointestinal bleeding, using a capsule endoscopy device (including administration of the capsule, associated endoscopy procedure if required for placement, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if: (a) the service is provided to a patient who: (i) has overt gastrointestinal bleeding; or (ii) has gastrointestinal bleeding that is recurrent or persistent, and iron deficiency anaemia that is not due to coeliac disease, and, if the patient also has menorrhagia, has had the menorrhagia considered and managed; and (b) an upper gastrointestinal endoscopy and a colonoscopy have been performed on the patient and have not identified the cause of the bleeding; and (c) the service has not been provided to the same patient on more than 2 occasions in the preceding 12 months; and (d) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and (e) the service is not associated with a service to which item 30680, 30682, 30684 or 30686 applies	1,279.15
11823	Capsule endoscopy to conduct small bowel surveillance of a patient	1,279.15

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	diagnosed with Peutz-Jeghers Syndrome, using a capsule endoscopy device approved by the Therapeutic Goods Administration (including administration of the capsule, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if: (a) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and (b) the item is performed only once in any 2 year period; and (c) the service is not associated with balloon enteroscopy	
11830	Diagnosis of abnormalities of the pelvic floor involving anal manometry or measurement of anorectal sensation or measurement of the rectosphincteric reflex	194.40
11833	Diagnosis of abnormalities of the pelvic floor and sphincter muscles involving electromyography or measurement of pudendal and spinal nerve motor latency	259.85
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	28.65
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	115.65
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	115.65
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	171.85
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.)	171.85
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.)	171.85
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	445.75

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	36800 applies (Anaes.)	
11919	Cystometrography in conjunction with contrast micturating cystourethrography, with measurement of any one or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography, being a service associated with a service to which item 60506 or 60509 applies, other than a service associated with a service to which any of items 11012 to 11027, 11900 to 11917, 11921 and 36800 applies (Anaes.)	445.75
11921	Bladder washout test for localisation of urinary infection—not including bacterial counts for organisms in specimens	78.10
Subgroup 9—Allergy testing		
12000	Skin prick testing for aeroallergens by a specialist or consultant physician in the practice of the specialist or consultant physician's specialty, including all allergens tested on the same day, not being a service associated with a service to which item 12001, 12002, 12005, 12012, 12017, 12021, 12022 or 12024 applies	40.50
12001	Skin prick testing for aeroallergens, including all allergens tested on the same day, not being a service associated with a service to which item 12000, 12002, 12005, 12012, 12017, 12021, 12022 or 12024 applies Applicable only once in any 12 month period	40.50
12002	Repeat skin prick testing of a patient for aeroallergens, including all allergens tested on the same day, if: (a) further testing for aeroallergens is indicated in the same 12 month period to which item 12001 applies to a service for the patient; and (b) the service is not associated with a service to which item 12000, 12001, 12005, 12012, 12017, 12021, 12022 or 12024 applies Applicable only once in any 12 month period	40.50
12003	Skin prick testing for food and latex allergens, including all allergens tested on the same day, not being a service associated with a service to which item 12012, 12017, 12021, 12022 or 12024 applies	40.50
12004	Skin testing for medication allergens (antibiotics or non-general anaesthetics agents) and venoms (including prick testing and intradermal testing with a number of dilutions), including all allergens tested on the same day, not being a service associated with a service to which item 12012, 12017, 12021, 12022 or 12024 applies	61.25
12005	Skin testing: (a) performed by or on behalf of a specialist or consultant physician in the practice of the specialist's or consultant physician's specialty; and (b) for agents used in the perioperative period (including prick testing and intradermal testing with a number of dilutions), to investigate anaphylaxis in a patient with a history of prior anaphylactic reaction or cardiovascular collapse associated with the administration of an anaesthetic; and (c) including all allergens tested on the same day; and	82.40

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(d) not being a service associated with a service to which item 12000, 12001, 12002, 12003, 12012, 12017, 12021, 12022 or 12024 applies	
12012	Epicutaneous patch testing in the investigation of allergic dermatitis using not more than 25 allergens	21.65
12017	Epicutaneous patch testing in the investigation of allergic dermatitis using more than 25 allergens but not more than 50 allergens	73.10
12021	Epicutaneous patch testing in the investigation of allergic dermatitis, performed by or on behalf of a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty, using more than 50 allergens but not more than 75 allergens	120.15
12022	Epicutaneous patch testing in the investigation of allergic dermatitis, performed by or on behalf of a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty, using more than 75 allergens but not more than 100 allergens	141.10
12024	Epicutaneous patch testing in the investigation of allergic dermatitis, performed by or on behalf of a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty, using more than 100 allergens	160.75
Subgroup 10—Other diagnostic procedures and investigations		
12200	Collection of specimen of sweat by iontophoresis	38.70
12201	Administration, by a specialist or consultant physician in the practice of the specialist's or consultant physician's specialty, of thyrotropin alfa-rch (recombinant human thyroid-stimulating hormone), and arranging services to which items 61426 and 66650 apply, for the detection of recurrent well-differentiated thyroid cancer in a patient if: (a) the patient has had a total thyroidectomy and one ablative dose of radioactive iodine; and (b) the patient is maintained on thyroid hormone therapy; and (c) the patient is at risk of recurrence; and (d) on at least one previous whole body scan or serum thyroglobulin test when withdrawn from thyroid hormone therapy, the patient did not have evidence of well-differentiated thyroid cancer; and (e) either: (i) withdrawal from thyroid hormone therapy resulted in severe psychiatric disturbances when hypothyroid; or (ii) withdrawal is medically contra-indicated because the patient has: (A) unstable coronary artery disease; or (B) hypopituitarism; or (C) a high risk of relapse or exacerbation of a previous severe psychiatric illness Applicable once only in a 12 month period	2,489.85
12203	Overnight diagnostic assessment of sleep, for at least 8 hours, for a patient aged 18 years or more, to confirm diagnosis of a sleep disorder, if: (a) either:	611.80

Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(i) the patient has been referred by a medical practitioner to a qualified adult sleep medicine practitioner or a consultant respiratory physician who has determined that the patient has a high probability for symptomatic, moderate to severe obstructive sleep apnoea based on clinical screening tool results; or (ii) following professional attendance on the patient (either face-to-face or by video conference) by a qualified adult sleep medicine practitioner or a consultant respiratory physician, the qualified adult sleep medicine practitioner or consultant respiratory physician determines that assessment is necessary to confirm the diagnosis of a sleep disorder; and (b) the overnight diagnostic assessment is performed to investigate: (i) suspected obstructive sleep apnoea syndrome where the patient is assessed as not suitable for an unattended sleep study; or (ii) suspected central sleep apnoea syndrome; or (iii) suspected sleep hypoventilation syndrome; or (iv) suspected sleep-related breathing disorders in association with non-respiratory co-morbid conditions including heart failure, significant cardiac arrhythmias, neurological disease, acromegaly or hypothyroidism; or (v) unexplained hypersomnolence which is not attributed to inadequate sleep hygiene or environmental factors; or (vi) suspected parasomnia or seizure disorder where clinical diagnosis cannot be established on clinical features alone (including associated atypical features, vigilance behaviours or failure to respond to conventional therapy); or (vii) suspected sleep related movement disorder, where the diagnosis of restless legs syndrome is not evident on clinical assessment; and (c) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (d) there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and	

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the overnight diagnostic assessment is not provided to the patient on the same occasion that a service described in any of items 11000 to 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient Applicable only once in any 12 month period	
12204	Overnight assessment of positive airway pressure, for at least 8 hours, for a patient aged 18 years or more, if: (a) the necessity for an intervention sleep study is determined by a qualified adult sleep medicine practitioner or consultant respiratory physician where a diagnosis of a sleep-related breathing disorder has been made; and (b) the patient has not undergone positive airway pressure therapy in the previous 6 months; and (c) following professional attendance on the patient by a qualified adult sleep medicine practitioner or a consultant respiratory physician (either face-to-face or by video conference), the qualified adult sleep medicine practitioner or consultant respiratory physician establishes that the sleep-related breathing disorder is responsible for the patient's symptoms; and (d) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (e) there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement; (ix) position; and (f) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (g) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and	611.80

Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(h) the overnight assessment is not provided to the patient on the same occasion that a service described in any of items 11000 to 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient Applicable only once in any 12 month period	
12205	Follow-up study for a patient aged 18 years or more with a sleep-related breathing disorder, following professional attendance on the patient by a qualified adult sleep medicine practitioner or consultant respiratory physician, if: (a) any of the following subparagraphs applies: (i) there has been a recurrence of symptoms not explained by known or identifiable factors such as inadequate usage of treatment, sleep duration or significant recent illness; (ii) there has been a significant change in weight or changes in co-morbid conditions that could affect sleep-related breathing disorders, and other means of assessing treatment efficacy (including review of data stored by a therapy device used by the patient) are unavailable or have been equivocal; (iii) the patient has undergone a therapeutic intervention (including, but not limited to, positive airway pressure, upper airway surgery, positional therapy, appropriate oral appliance, weight loss of more than 10% in the previous 6 months or oxygen therapy), and there is either clinical evidence of sub-optimal response or uncertainty about control of sleep-disordered breathing; and (b) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (c) there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (d) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (e) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and	611.80

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(f) the follow-up study is not provided to the patient on the same occasion that a service described in any of items 11000 to 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient Applicable only once in any 12 month period	
12207	Overnight investigation, for a patient aged 18 years or more, for a sleep-related breathing disorder, following professional attendance by a qualified adult sleep medicine practitioner or a consultant respiratory physician (either face-to-face or by video conference), if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner before the investigation; and (c) there is continuous monitoring and recording, in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (d) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the investigation is not provided to the patient on the same occasion that a service described in any of items 11000 to 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient; and (h) previous studies have demonstrated failure of continuous positive airway pressure or oxygen; and (i) if the patient has severe respiratory failure—a further investigation is indicated in the same 12 month period to which items 12204 and 12205 apply to a service for the patient, for the adjustment or testing, or both, of the effectiveness of a positive pressure ventilatory support device (other than continuous positive airway pressure) in sleep Applicable only once in any 12 month period	611.80

Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
12208	Overnight investigation for sleep apnoea for at least 8 hours, for a patient aged 18 years or more, if: (a) a qualified adult sleep medicine practitioner or consultant respiratory physician has determined that the investigation is necessary to confirm the diagnosis of a sleep disorder; and (b) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (c) there is continuous monitoring and recording, in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (d) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (e) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (f) a further investigation is indicated in the same 12 month period to which item 12203 applies to a service for the patient because insufficient sleep was acquired, as evidenced by a sleep efficiency of 25% or less, during the previous investigation to which that item applied; and (g) the investigation is not provided to the patient on the same occasion that a service described in any of items 11000 to 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient Applicable only once in any 12 month period	611.80
12210	Overnight paediatric investigation, for at least 8 hours, for a patient less than 12 years of age, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG;	730.30

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and (d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and report are provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and (g) the investigation is not provided to the patient on the same occasion that a service to which item 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient For each particular patient—applicable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period	
12213	Overnight paediatric investigation, for at least 8 hours, for a patient aged at least 12 years but less than 18 years, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or	657.90

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	transcutaneous); and (d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and (g) the investigation is not provided to the patient on the same occasion that a service to which item 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient For each particular patient—applicable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period	
12215	Overnight paediatric investigation, for at least 8 hours, for a patient less than 12 years of age, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and (d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of	730.30

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and report are provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and (g) a further investigation is indicated in the same 12 month period to which item 12210 applies to a service for the patient, for a patient using Continuous Positive Airway Pressure (CPAP) or non-invasive or invasive ventilation, or supplemental oxygen, in either or both of the following circumstances: (i) there is ongoing hypoxia or hypoventilation on the third study to which item 12210 applied for the patient, and further titration of respiratory support is needed to optimise therapy; (ii) there is clear and significant change in clinical status (for example lung function or functional status) or an intervening treatment that may affect ventilation in the period since the third study to which item 12210 applied for the patient, and repeat study is therefore required to determine the need for or the adequacy of respiratory support; and (h) the investigation is not provided to the patient on the same occasion that a service to which item 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient Applicable only once in the same 12 month period to which item 12210 applies	
12217	Overnight paediatric investigation for at least 8 hours for a patient aged at least 12 years but less than 18 years, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and (d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and	657.90

Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and (g) a further investigation is indicated in the same 12 month period to which item 12213 applies to a service for the patient, for a patient using Continuous Positive Airway Pressure (CPAP) or non-invasive or invasive ventilation, or supplemental oxygen, in either or both of the following circumstances: (i) there is ongoing hypoxia or hypoventilation on the third study to which item 12213 applied for the patient, and further titration is needed to optimise therapy; (ii) there is clear and significant change in clinical status (for example lung function or functional status) or an intervening treatment that may affect ventilation in the period since the third study to which item 12213 applied for the patient, and repeat study is therefore required to determine the need for or the adequacy of respiratory support; and (h) the investigation is not provided to the patient on the same occasion that a service to which item 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient Applicable only once in the same 12 month period to which item 12213 applies	
12250	Overnight investigation of sleep for at least 8 hours of a patient aged 18 years or more to confirm diagnosis of obstructive sleep apnoea, if: (a) either: (i) the patient has been referred by a medical practitioner to a qualified adult sleep medicine practitioner or a consultant respiratory physician who has determined that the patient has a high probability for symptomatic, moderate to severe obstructive sleep apnoea based on clinical screening tool results; or (ii) following professional attendance on the patient (either face-to-face or by video conference) by a qualified adult sleep medicine practitioner or a consultant respiratory physician, the qualified adult sleep medicine practitioner or consultant respiratory physician determines that investigation is necessary to confirm the diagnosis of obstructive sleep apnoea; and (b) during a period of sleep, there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures:	348.85

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(i) airflow; (ii) continuous EMG; (iii) continuous ECG; (iv) continuous EEG; (v) EOG; (vi) oxygen saturation; (vii) respiratory effort; and (c) the investigation is performed under the supervision of a qualified adult sleep medicine practitioner; and (d) either: (i) the equipment is applied to the patient by a sleep technician; or (ii) if this is not possible—the reason it is not possible for the sleep technician to apply the equipment to the patient is documented and the patient is given instructions on how to apply the equipment by a sleep technician supported by written instructions; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events and cardiac abnormalities) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the investigation is not provided to the patient on the same occasion that a service described in any of items 11000 to 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 and 12203 is provided to the patient Applicable only once in any 12 month period	
12254	Multiple sleep latency test for the assessment of unexplained hypersomnolence in a patient aged 18 years or more, if: (a) a qualified adult sleep medicine practitioner or neurologist determines that testing is necessary to confirm the diagnosis of a central disorder of hypersomnolence or to determine whether the eligibility criteria under the pharmaceutical benefits scheme for drugs relevant to treat that condition are met; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring and recording, in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen);	950.70

Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(ix) position; and (c) immediately following the overnight assessment, a daytime assessment is performed where at least 4 nap periods are conducted, during which there is continuous recording of EMG, ECG, EEG and EOG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12203, 12204, 12205, 12208, 12250 or 12258 is provided to the patient Applicable only once in a 12 month period	
12258	Maintenance of wakefulness test for the assessment of the ability to maintain wakefulness in a patient aged 18 years or more, if: (a) a qualified adult sleep medicine practitioner or neurologist determines that testing is necessary to objectively confirm the ability to maintain wakefulness; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring and recording, in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (c) immediately following the overnight assessment, a daytime assessment is performed where at least 4 wakefulness trials are conducted, during which there is continuous recording of EMG, ECG, EEG and EOG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring	950.70

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12203, 12204, 12205, 12208, 12250 or 12254 is provided to the patient Applicable only once in a 12 month period	
12261	Multiple sleep latency test for the assessment of unexplained hypersomnolence in a patient aged at least 12 years but less than 18 years, if: (a) a qualified sleep medicine practitioner determines that testing is necessary to confirm the diagnosis of a central disorder of hypersomnolence or to determine whether the eligibility criteria under the pharmaceutical benefits scheme for drugs relevant to treat that condition are met; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and (c) immediately following the overnight assessment, a daytime assessment is performed where at least 4 nap periods are conducted, during which there is continuous recording of EMG, ECG, EEG and EOG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a	996.85

Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12213, 12217 or 12265 is provided to the patient Applicable only once in a 12 month period	
12265	Maintenance of wakefulness test for the assessment of the ability to maintain wakefulness in a patient aged at least 12 years but less than 18 years, if: (a) a qualified sleep medicine practitioner determines that testing to objectively confirm the ability to maintain wakefulness is necessary; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and (c) immediately following the overnight assessment, a daytime assessment is performed where at least 4 wakefulness trials are conducted, during which there is continuous recording of EMG, ECG, EEG and EOG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12213, 12217 or 12261 is provided to the patient	996.85

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	Applicable only once in a 12 month period	
12268	Multiple sleep latency test for the assessment of unexplained hypersomnolence for a patient less than 12 years of age, if: (a) a qualified paediatric sleep medicine practitioner determines that testing is necessary to confirm the diagnosis of a central disorder of hypersomnolence or to determine whether the eligibility criteria under the pharmaceutical benefits scheme for drugs relevant to treat that condition are met; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and (c) immediately following the overnight assessment, a daytime assessment is performed where at least 4 nap periods are conducted, during which there is continuous recording of EMG, ECG, EEG and EOG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified paediatric sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12210, 12215 or 12272 is provided to the patient Applicable only once in a 12 month period	1,069.20
12272	Maintenance of wakefulness test for the assessment of the ability to maintain wakefulness for a patient less than 12 years of age, if: (a) a qualified paediatric sleep medicine practitioner determines that	1,069.20

Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	testing to objectively confirm the ability to maintain wakefulness is necessary; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and (c) immediately following the overnight assessment, a daytime assessment is performed where at least 4 wakefulness trials are conducted, during which there is continuous recording of EMG, ECG, EEG and EOG; and (d) a sleep technician is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified paediatric sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12210, 12215 or 12268 is provided to the patient Applicable only once in a 12 month period	
12306	Bone densitometry, using dual energy X-ray absorptiometry, involving the measurement of 2 or more sites (including interpretation and reporting), for: (a) confirmation of a presumptive diagnosis of low bone mineral density made on the basis of one or more fractures occurring after minimal trauma; or (b) monitoring of low bone mineral density proven by bone densitometry at least 12 months previously; other than a service associated with a service to which item 12312, 12315 or 12321 applies	106.55

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	For any particular patient, once only in a 24 month period	
12312	Bone densitometry, using dual energy X-ray absorptiometry, involving the measurement of 2 or more sites (including interpretation and reporting) for diagnosis and monitoring of bone loss associated with one or more of the following: (a) prolonged glucocorticoid therapy; (b) any condition associated with excess glucocorticoid secretion; (c) male hypogonadism; (d) female hypogonadism lasting more than 6 months before the age of 45; other than a service associated with a service to which item 12306, 12315 or 12321 applies For any particular patient, once only in a 12 month period	106.55
12315	Bone densitometry, using dual energy X-ray absorptiometry, involving the measurement of 2 or more sites (including interpretation and reporting) for diagnosis and monitoring of bone loss associated with one or more of the following conditions: (a) primary hyperparathyroidism; (b) chronic liver disease; (c) chronic renal disease; (d) any proven malabsorptive disorder; (e) rheumatoid arthritis; (f) any condition associated with thyroxine excess; other than a service associated with a service to which item 12306, 12312 or 12321 applies For any particular patient, once only in a 24 month period	106.55
12320	Bone densitometry, using dual energy X-ray absorptiometry or quantitative computed tomography, involving the measurement of 2 or more sites (including interpretation and reporting) for the measurement of bone mineral density, if: (a) the patient is 70 years of age or over; and (b) either: (i) the patient has not previously had bone densitometry; or (ii) the t-score for the patient's bone mineral density is -1.5 or more; other than a service associated with a service to which item 12306, 12312, 12315, 12321 or 12322 applies For any particular patient, once only in a 5 year period	106.55
12321	Bone densitometry, using dual energy X-ray absorptiometry, involving the measurement of 2 or more sites at least 12 months after a significant change in therapy (including interpretation and reporting), for: (a) established low bone mineral density; or (b) confirming a presumptive diagnosis of low bone mineral density made on the basis of one or more fractures occurring after minimal	106.55

Group D1—Miscellaneous diagnostic procedures and investigations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	trauma; other than a service associated with a service to which item 12306, 12312 or 12315 applies For any particular patient, once only in a 12 month period	
12322	Bone densitometry, using dual energy X-ray absorptiometry or quantitative computed tomography, involving the measurement of 2 or more sites (including interpretation and reporting) for measurement of bone mineral density, if: (a) the patient is 70 years of age or over; and (b) the t-score for the patient's bone mineral density is less than -1.5 but more than -2.5; other than a service associated with a service to which item 12306, 12312, 12315, 12320 or 12321 applies For any particular patient, once only in a 2 year period	106.55
12325	Assessment of visual acuity and bilateral retinal photography with a non-mydriatic retinal camera, including analysis and reporting of the images for initial or repeat assessment for presence or absence of diabetic retinopathy, in a patient with medically diagnosed diabetes, if: (a) the patient is of Aboriginal and Torres Strait Islander descent; and (b) the assessment is performed by the medical practitioner (other than an optometrist or ophthalmologist) providing the primary glycaemic management of the patient's diabetes; and (c) this item and item 12326 have not applied to the patient in the preceding 12 months; and (d) the patient does not have: (i) an existing diagnosis of diabetic retinopathy; or (ii) visual acuity of less than 6/12 in either eye; or (iii) a difference of more than 2 lines of vision between the 2 eyes at the time of presentation	52.00
12326	Assessment of visual acuity and bilateral retinal photography with a non-mydriatic retinal camera, including analysis and reporting of the images for initial or repeat assessment for presence or absence of diabetic retinopathy, in a patient with medically diagnosed diabetes, if: (a) the assessment is performed by the medical practitioner (other than an optometrist or ophthalmologist) providing the primary glycaemic management of the patient's diabetes; and (b) this item and item 12325 have not applied to the patient in the preceding 24 months; and (c) the patient does not have: (i) an existing diagnosis of diabetic retinopathy; or (ii) visual acuity of less than 6/12 in either eye; or (iii) a difference of more than 2 lines of vision between the 2 eyes at the time of presentation	52.00

Clause 4.2.1

Division 4.2—Group D2: Nuclear medicine (non-imaging)

4.2.1 Restriction on items in Group D2—services connected with services in item 12250

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.

4.2.2 Items in Group D2

This clause sets out items in Group D2.

Group D2—Nuclear medicine (non-imaging)

Column 1 Item	Column 2 Description	Column 3 Fee ($)
12500	Blood volume estimation	225.40
12524	Renal function test (without imaging procedure)	164.75
12527	Renal function test (with imaging and at least 2 blood samples)	88.40
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 $13CO^2$ or $14CO^2$, for either: (a) the confirmation of *Helicobacter pylori* colonisation; or (b) the monitoring of the success of eradication of *Helicobacter pylori* in patients with peptic ulcer disease; (other than a service associated with a service to which item 66900 applies)	88.10

Part 5—Therapeutic procedures

Division 5.1—Preliminary

5.1.1 Restriction on items in this Part—services connected with provision of pain pump for post-surgical pain management

An item in Group T1, T2, T3, T4, T6, T7, T8, T9 or T10 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 provision of a pain pump for post-surgical pain management.

Division 5.2—Group T1: Miscellaneous therapeutic procedures

5.2.1 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.

5.2.2 Meaning of embryology laboratory services

In 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.

5.2.3 Meaning of treatment cycle

In clause 5.2.4 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 described 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).

5.2.4 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 described 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 described 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 described in that item.

5.2.5 Restriction on item 13104—timing

Item 13104 does not apply to a patient more than 12 times in a 12 month period.

5.2.6 Restriction on items relating to assisted reproductive services—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.

5.2.7 Restrictions on items 14227 to 14237—patients

Items 14227 to 14237 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.

5.2.8 Restrictions on item 14245—practitioner and timing

(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 per day.

5.2.9 Restriction on item 13899—other services performed on the same day

Item 13899 does not apply to professional attendance by a specialist on a day for preparation of goals of care for a patient if, on that day, the specialist performs a service for the patient that is described in item 13870 or 13873.

5.2.10 Items in Group T1

This clause sets out items in Group T1.

Group T1—Miscellaneous therapeutic procedures		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **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	265.10
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	269.35

Clause 5.2.10

Group T1—Miscellaneous therapeutic procedures		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	the hyperbaric chamber of at least 1 hour 30 minutes and not more than 3 hours, including any associated attendance	
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)	120.35
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)	170.05
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	142.20
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	74.10
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 the consultant physician's specialty of renal medicine	153.90
13105	Haemodialysis for a patient with end-stage renal disease if: (a) the service is provided by a registered nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner; and (b) the service is supervised by the medical practitioner (either in person or remotely); and (c) the patient's care is managed by a nephrologist; and (d) the patient is treated or reviewed by the nephrologist every 3 to 6 months (either in person or remotely); and (e) the patient is not an admitted patient of a hospital; and (f) the service is provided in a Modified Monash 7 area	615.95
13106	Declotting of an arteriovenous shunt	126.30
13109	Indwelling peritoneal catheter (Tenckhoff or similar) for dialysis—insertion and fixation of (Anaes.)	236.95
13110	Indwelling peritoneal catheter (Tenckhoff or similar) for dialysis—removal of (including catheter cuffs) (Anaes.)	237.75
Subgroup 3—Assisted reproductive services		
13200	Assisted reproductive technologies superovulated treatment cycle	3,236.75

Group T1—Miscellaneous therapeutic procedures

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	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	
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	3,027.65
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	484.40
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	506.45
13206	Assisted reproductive technologies treatment cycle using the natural cycle or oral medication only to induce oocyte growth and development, including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, frozen embryo transfer, donated embryos or ova or treatment involving the use of injectable drugs to induce superovulation, being services rendered during one treatment cycle—only if rendered in conjunction with a service to which item 13212 applies	484.40
13209	Planning and management of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies or for artificial insemination—applicable once during a treatment cycle	88.15
13210	Professional attendance on a patient by a specialist practising in the specialist's 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:	50% of the fee for item 13209

Clause 5.2.10

Group T1—Miscellaneous therapeutic procedures		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 km by road from the specialist; or (ii) is a care recipient in a residential aged care facility; 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	
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.)	368.80
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.)	115.65
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.)	825.70
13221	Preparation of semen for the purpose of artificial insemination—only if rendered in connection with a service to which item 13203 applies	52.80
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	434.90
13260	Processing and initial cryopreservation (not including storage) of semen for fertility preservation treatment before or after completion of gonadotoxic treatment for malignant or non-malignant conditions, in a post-pubertal male in Tanner stages II–V, up to 60 years old, who is referred by a specialist or consultant physician—applicable to not more than 2 semen collection cycles	431.80
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	212.50
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.)	425.30
Subgroup 4—Paediatric and neonatal		
13300	Umbilical or scalp vein catheterisation in a neonate with or without infusion or cannulation of a vein	59.25
13303	Umbilical artery catheterisation with or without infusion	87.85

Group T1—Miscellaneous therapeutic procedures

Column 1 Item	Column 2 Description	Column 3 Fee ($)
13306	Blood transfusion with venesection and complete replacement of blood, including collection from donor	347.65
13309	Blood transfusion with venesection and complete replacement of blood, using blood already collected	296.40
13312	Blood for pathology test, collection of, by femoral or external jugular vein puncture in infants	29.60
13318	Central vein catheterisation by open exposure, in a patient under 12 years of age (Anaes.)	236.65
13319	Central vein catheterisation in a neonate via peripheral vein (Anaes.)	236.65
Subgroup 5—Cardiovascular		
13400	Restoration of cardiac rhythm by electrical stimulation (cardioversion), other than in the course of cardiac surgery (Anaes.)	100.75
Subgroup 6—Gastroenterology		
13506	Gastro-oesophageal balloon intubation for control of bleeding from gastric oesophageal varices	191.95
Subgroup 8—Haematology		
13700	Harvesting of homologous (including allogeneic) or autologous bone marrow for the purpose of transplantation (Anaes.)	346.80
13703	Transfusion of blood including collection from donor, when used for intra-operative normovolaemic haemodilution	124.30
13706	Transfusion of blood or bone marrow already collected	86.70
13750	Therapeutic haemapheresis for the removal of plasma or cellular (or both) elements of blood, utilising continuous or intermittent flow techniques, including morphological tests for cell counts and viability studies, if performed; continuous monitoring of vital signs, fluid balance, blood volume and other parameters with continuous registered nurse attendance under the supervision of a consultant physician, other than a service associated with a service to which item 13755 applies—each day	142.20
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	142.20
13757	Therapeutic venesection for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda	75.90
13760	In vitro processing with cryopreservation of bone marrow or peripheral blood, for autologous stem cell transplantation for a patient receiving high-dose chemotherapy for management of: (a) aggressive malignancy; or (b) malignancy that has proven refractory to prior treatment	793.50

Clause 5.2.10

Group T1—Miscellaneous therapeutic procedures		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 9—Procedures associated with intensive care and cardiopulmonary support		
13815	Central vein catheterisation, including under ultrasound guidance where clinically appropriate, by percutaneous or open exposure, other than a service to which item 13318 applies (Anaes.)	118.25
13818	Right heart balloon catheter, insertion of, including pulmonary wedge pressure and cardiac output measurement (Anaes.)	118.30
13830	Intracranial pressure, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician—each day	78.40
13832	Peripheral cannulation, including under ultrasound guidance where clinically appropriate, for veno-arterial cardiopulmonary extracorporeal life support	917.50
13834	Veno–arterial cardiopulmonary extracorporeal life support, management of—the first day	513.65
13835	Veno–arterial cardiopulmonary extracorporeal life support, management of—each day after the first	119.50
13837	Veno-venous pulmonary extracorporeal life support, management of—the first day	513.65
13838	Veno-venous pulmonary extracorporeal life support, management of—each day after the first	119.50
13839	Arterial puncture and collection of blood for diagnostic purposes	23.95
13840	Peripheral cannulation, including under ultrasound guidance where clinically appropriate, for veno-venous pulmonary extracorporeal life support	614.70
13842	Intra-arterial cannulation, including under ultrasound guidance where clinically appropriate, for the purpose of intra-arterial pressure monitoring or arterial blood sampling (or both)	97.35
13848	Counterpulsation by intra-aortic balloon-management, including associated consultations and monitoring of parameters by means of full haemodynamic assessment and management on several occasions on a day—each day	162.45
13851	Ventricular assist device, management of, for a patient admitted to an intensive care unit for implantation of the device or for complications arising from implantation or management of the device—first day	513.65
13854	Ventricular assist device, management of, for a patient admitted to an intensive care unit, including management of complications arising from implantation or management of the device—each day after the first day	119.50
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	152.35
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	376.75

Group T1—Miscellaneous therapeutic procedures		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	rostered to intensive care, including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling, bladder catheterisation and blood sampling—management on the first day (H)	
13873	Management of a patient in an intensive care unit by a specialist or consultant physician who is immediately available and exclusively rostered to intensive care, including all attendances, electrocardiographic monitoring, arterial sampling, bladder catheterisation and blood sampling—management on each day after the first day (H)	279.50
13876	Central venous pressure, pulmonary arterial pressure, systemic arterial pressure or cardiac intracavity pressure—once per day for each type of pressure for a patient: (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)	80.00
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)	152.35
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)	119.90
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)	159.90
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)	80.00
Subgroup 10A—Preparation of goals of care by intensive care specialist outside intensive care unit		
13899	Professional attendance outside an intensive care unit for at least 60 minutes spent in preparation of goals of care for a gravely ill patient lacking current goals of care, by a specialist in the specialty of intensive care who takes overall responsibility for the preparation of the goals of care for the patient	278.75

Clause 5.2.10

Group T1—Miscellaneous therapeutic procedures		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 11—Chemotherapeutic procedures		
13950	Parenteral administration of one or more antineoplastic agents, including agents used in cytotoxic chemotherapy or monoclonal antibody therapy but not agents used in anti-resorptive bone therapy or hormonal therapy, by or on behalf of a specialist or consultant physician—attendance for one or more episodes of administration	112.40
Subgroup 12—Dermatology		
14050	UVA or UVB phototherapy administered in a whole body cabinet or hand and foot cabinet including associated consultations other than the initial consultation, if treatment is initiated and supervised by a specialist in the specialty of dermatology Applicable not more than 150 times in a 12 month period	54.90
14100	Laser photocoagulation using laser radiation in the treatment of vascular abnormalities of the head or neck, including any associated consultation, if: (a) the abnormality is visible from 3 metres; and (b) photographic evidence demonstrating the need for this service is documented in the patient notes; to a maximum of 4 sessions (including any sessions to which this item or any of items 14106 to 14118 apply) in any 12 month period (Anaes.)	158.65
14106	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), if the abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12 month period—area of treatment less than 150 cm^2 (Anaes.)	166.65
14115	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12 month period—area of treatment 150 cm^2 to 300 cm^2 (Anaes.)	266.90
14118	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14115 apply) in any 12 month period—area of treatment more than 300 cm^2 (Anaes.)	338.90
14124	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, if: (a) a seventh or subsequent session (including any sessions to which this item or any of items 14100 to 14118 apply) is indicated in a 12	158.65

Group T1—Miscellaneous therapeutic procedures		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	month period commencing on the day of the first session; and (b) photographic evidence demonstrating the need for this service is documented in the patient notes (Anaes.)	
Subgroup 13—Miscellaneous therapeutic procedures		
14201	Poly-L-lactic acid, one or more injections of, for the initial session only, for the treatment of severe facial lipoatrophy caused by antiretroviral therapy, if prescribed in accordance with section 85 of the *National Health Act 1953*—once per patient	246.45
14202	Poly-L-lactic acid, one or more injections of (subsequent sessions), for the continuation of treatment of severe facial lipoatrophy caused by antiretroviral therapy, if prescribed in accordance with section 85 of the *National Health Act 1953*	124.75
14203	Hormone or living tissue implantation, by direct implantation involving incision and suture (Anaes.)	53.20
14206	Hormone or living tissue implantation—by cannula	37.05
14209	Intra-arterial infusion or retrograde intravenous perfusion of a sympatholytic agent	92.25
14212	Intussusception, management of fluid or gas reduction for (Anaes.)	192.75
14218	Implanted infusion pump, refilling of reservoir with a therapeutic agent or agents for infusion to the subarachnoid or epidural space, with or without reprogramming a programmable pump, for the management of chronic intractable pain	101.90
14221	Long—term implanted device for delivery of therapeutic agents, accessing of, other than a service associated with a service to which item 13950 applies	54.65
14224	Electroconvulsive therapy, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes.)	73.20
14227	Implanted infusion pump, refilling of reservoir with baclofen for infusion to the subarachnoid or epidural space, with or without reprogramming a programmable pump, for the management of severe chronic spasticity	101.90
14234	Infusion pump or components of an infusion pump, removal or replacement of, and connection to intrathecal or epidural catheter, and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (H) (Anaes.)	376.55
14237	Infusion pump or components of an infusion pump, subcutaneous implantation of, and intrathecal or epidural spinal catheter insertion, and connection of pump to catheter, and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (H) (Anaes.)	686.65
14245	Immunomodulating agent, administration of, by intravenous infusion lasting at least 2 hours	101.90

Clause 5.2.10

Group T1—Miscellaneous therapeutic procedures		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 14—Management and procedures undertaken in emergency department		
14255	Resuscitation of a patient provided for at least 30 minutes but less than 1 hour, by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.)	154.40
14256	Resuscitation of a patient provided for at least 1 hour but less than 2 hours, by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.)	296.90
14257	Resuscitation of a patient provided for at least 2 hours, by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.)	591.25
14258	Resuscitation of a patient provided for at least 30 minutes but less than 1 hour, by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)	115.85
14259	Resuscitation of a patient provided for at least 1 hour but less than 2 hours, by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)	222.70
14260	Resuscitation of a patient provided for at least 2 hours, by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)	443.45
14263	Minor procedure on a patient by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.)	54.35
14264	Procedure (except a minor procedure) on a patient by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.)	122.35
14265	Minor procedure on a patient by a medical practitioner (except a	40.75

Group T1—Miscellaneous therapeutic procedures

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)	
14266	Procedure (except a minor procedure) on a patient by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (Anaes.)	91.75
14270	Management, without aftercare, of all fractures and dislocations suffered by a patient that: (a) is provided by a specialist in the practice of the specialist's specialty of emergency medicine in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019; and (b) occurs at a recognised emergency department of a private hospital (Anaes.)	137.15
14272	Management, without aftercare, of all fractures and dislocations suffered by a patient that: (a) is provided by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) in conjunction with an attendance on the patient by the practitioner described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (b) occurs at a recognised emergency department of a private hospital (Anaes.)	102.90
14277	Application of chemical or physical restraint of a patient by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital	154.40
14278	Application of chemical or physical restraint of a patient by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital	115.85
14280	Anaesthesia (whether general anaesthesia or not) of a patient that: (a) is managed by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies	154.40
14283	Anaesthesia (whether general anaesthesia or not) of a patient that: (a) is managed by a medical practitioner (except a specialist in the	115.85

Clause 5.3.1

Group T1—Miscellaneous therapeutic procedures		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies	
14285	Emergent intubation, airway management or both of a patient that: (a) is managed by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies	154.40
14288	Emergent intubation, airway management or both of a patient that: (a) is managed by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies	115.85

Division 5.3—Group T2: Radiation oncology

5.3.1 Meaning of amount under clause 5.3.1

In an item of this Schedule mentioned in column 1 of table 5.3.1:

amount under clause 5.3.1 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 5.3.1—Amount under clause 5.3.1

Item	Column 1 Item of this Schedule	Column 2 Fee	Column 3 Amount for each field separately treated in excess of one ($)
1	15003	The fee for item 15000	17.75

Table 5.3.1—Amount under clause 5.3.1

Item	Column 1 Item of this Schedule	Column 2 Fee	Column 3 Amount for each field separately treated in excess of one ($)
2	15009	The fee for item 15006	19.30
3	15103	The fee for item 15100	19.55
4	15109	The fee for item 15106	23.60
5	15115	The fee for item 15112	49.20
6	15214	The fee for item 15211	33.20
7	15230	The fee for item 15215	39.50
8	15233	The fee for item 15218	39.50
9	15236	The fee for item 15221	39.50
10	15239	The fee for item 15224	39.50
11	15242	The fee for item 15227	39.50
12	15260	The fee for item 15245	39.50
13	15263	The fee for item 15248	39.50
14	15266	The fee for item 15251	39.50
15	15269	The fee for item 15254	39.50
16	15272	The fee for item 15257	39.50

5.3.2 Restrictions on items 15215 to 15272—services provided to implement intensity-modulated radiation therapy dosimetry plans

Items 15215 to 15272 do not apply to a service if the service is provided to implement an intensity-modulated radiation therapy dosimetry plan prepared in accordance with item 15565.

5.3.3 Restrictions on items 15556, 15559 and 15562

A service described 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.

5.3.4 Items in Group T2

This clause sets out items in Group T2.

Clause 5.3.4

Group T2—Radiation oncology		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **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—attendance at which fractionated treatment is given—one field	44.30
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—attendance at which fractionated treatment is given—2 or more fields up to a maximum of 5 additional fields	Amount under clause 5.3.1
15006	Radiotherapy, superficial—attendance at which a single dose technique is applied—one field	98.20
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 5.3.1
15012	Radiotherapy, superficial—attendance at which treatment is given to an eye	55.60
Subgroup 2—Orthovoltage		
15100	Radiotherapy, deep or orthovoltage—attendance at which fractionated treatment is given at 3 or more treatments per week—one field	49.65
15103	Radiotherapy, deep or orthovoltage—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 5.3.1
15106	Radiotherapy, deep or orthovoltage—attendance at which fractionated treatment is given at 2 treatments per week or less frequently—one field	58.55
15109	Radiotherapy, deep or orthovoltage—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 5.3.1
15112	Radiotherapy, deep or orthovoltage—attendance at which a single dose technique is applied—one field	125.10
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 5.3.1
Subgroup 3—Megavoltage		
15211	Radiation oncology treatment, using cobalt unit or caesium teletherapy unit—attendance at which treatment is given—one field	56.95
15214	Radiation oncology treatment, using cobalt unit or caesium teletherapy unit—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 5.3.1
15215	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—attendance at which treatment is given—one field—treatment delivered to primary site	62.05

Group T2—Radiation oncology

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(lung)	
15218	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—attendance at which treatment is given—one field—treatment delivered to primary site (prostate)	62.05
15221	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—attendance at which treatment is given—one field—treatment delivered to primary site (breast)	62.05
15224	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—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	62.05
15227	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—attendance at which treatment is given—one field—treatment delivered to secondary site	62.05
15230	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—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 5.3.1
15233	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—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 5.3.1
15236	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—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 5.3.1
15239	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—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 5.3.1
15242	Radiation oncology treatment, using a single photon energy linear accelerator, with or without electron facilities—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 5.3.1
15245	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—attendance at which treatment is given—one field—treatment delivered to primary site (lung)	62.05
15248	Radiation oncology treatment, using a dual photon energy linear	62.05

Clause 5.3.4

Group T2—Radiation oncology		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—attendance at which treatment is given—one field—treatment delivered to primary site (prostate)	
15251	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—attendance at which treatment is given—one field—treatment delivered to primary site (breast)	62.05
15254	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—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	62.05
15257	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—attendance at which treatment is given—one field—treatment delivered to secondary site	62.05
15260	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—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 5.3.1
15263	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—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 5.3.1
15266	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—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 5.3.1
15269	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—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 5.3.1
15272	Radiation oncology treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities—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 5.3.1
15275	Radiation oncology treatment, with image-guided radiation therapy imaging, undertaken: (a) to implement an intensity-modulated radiation therapy dosimetry plan prepared in accordance with item 15565; and (b) utilising an intensity-modulated treatment delivery mode (delivered	190.35

Group T2—Radiation oncology		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	by a fixed or dynamic gantry linear accelerator or by a helical non C-arm based linear accelerator) Applicable once for each treatment	
Subgroup 4—Brachytherapy		
15303	Intrauterine treatment alone using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)	371.45
15304	Intrauterine treatment alone using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)	371.45
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.)	704.25
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.)	704.25
15311	Intravaginal treatment alone using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)	346.75
15312	Intravaginal treatment alone using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)	344.20
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.)	680.70
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.)	680.70
15319	Combined intrauterine and intravaginal treatment using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)	422.50
15320	Combined intrauterine and intravaginal treatment using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)	422.50
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.)	751.25
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.)	751.25
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	817.25

Clause 5.3.4

Group T2—Radiation oncology

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	techniques (Anaes.)	
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.)	817.25
15331	Implantation of a sealed radioactive source (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), if the volume treated involves multiple planes but does not require surgical exposure and using manual afterloading techniques (Anaes.)	776.00
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.)	776.00
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.)	704.25
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.)	704.25
15338	Prostate, radioactive seed implantation of, radiation oncology component, using transrectal ultrasound guidance: (a) for a patient with: (i) localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate); and (ii) a Gleason score of less than or equal to 7 (Grade Group 1 to Grade Group 3); and (iii) a prostate specific antigen (PSA) of not more than 10ng/ml at the time of diagnosis; and (b) performed by an oncologist at an approved site in association with a urologist; and (c) being a service associated with: (i) services to which items 37220 and 55603 apply; and (ii) a service to which item 60506 or 60509 applies	973.50
15339	Removal of a sealed radioactive source under general anaesthesia, or under epidural or spinal nerve block (Anaes.)	79.25
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	198.00

Group T2—Radiation oncology		
Column 1	**Column 2**	**Column 3**
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	528.35
15348	Subsequent applications of radioactive mould referred to in item 15342 or 15345—each attendance	60.80
15351	Construction with or without initial application of a radioactive mould not exceeding 5 cm in diameter to an external surface	121.35
15354	Construction and initial application of a radioactive mould more than 5 cm in diameter to an external surface	147.20
15357	Application of a radioactive mould constructed for application to an external surface of the patient other than the initial application of the mould	41.65
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)	252.50
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)	324.20
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)	484.15
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)	218.80
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)	282.10
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	318.95
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)	408.45
15518	Radiation dosimetry by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel	80.10

Clause 5.3.4

Group T2—Radiation oncology

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	opposed fields to one area with up to 2 shielding blocks	
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	353.70
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	663.15
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	82.15
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	366.40
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	694.80
15536	Brachytherapy planning, computerised Radiation Dosimetry	277.70
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	652.70
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	685.30
15553	Simulation for 3 dimensional conformal radiotherapy, including pre and post intravenous contrast medium if: (a) treatment set up and technique specifications are in preparation for 3 dimensional conformal radiotherapy dose planning; and (b) patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and 3 dimensional conformal radiotherapy treatment; and (c) a high-quality CT image volume dataset is required for the relevant region of interest to be planned and treated; and	739.35

Group T2—Radiation oncology

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(d) the image set up is required to be suitable for the generation of quality digitally reconstructed radiographic images	
15555	Simulation for intensity-modulated radiation therapy, with or without intravenous contrast medium, if: (a) treatment set-up and technique specifications are in preparation for intensity-modulated radiation therapy dose planning; and (b) patient set-up and immobilisation techniques are suitable for reliable CT image volume data acquisition and intensity-modulated radiation therapy; and (c) a high-quality CT image volume dataset is acquired for the relevant region of interest to be planned and treated; and (d) the image set is suitable for the generation of quality digitally reconstructed radiographic images	739.35
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	691.35
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	901.65
15562	Dosimetry for 3 dimensional conformal radiotherapy of level 3 complexity if: (a) the dosimetry is for a 3 phase 3 dimensional conformal treatment plan using one or more CT image volume datasets, with at least one gross tumour volume, 3 planning target volumes and one organ at risk specified in the prescription; or (b) the dosimetry is for a 2 phase 3 dimensional conformal treatment plan using one or more CT image volume datasets, with: (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	1,166.20

Group T2—Radiation oncology		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
15565	Preparation of an intensity-modulated radiation therapy dosimetry plan, which uses one or more CT image volume datasets, if: (a) in preparing the intensity-modulated radiation therapy dosimetry plan: (i) the differential between target dose and normal tissue dose is maximised, based on a review and assessment by a radiation oncologist; and (ii) all gross tumour targets, clinical targets, planning targets and organs at risk are rendered as volumes as defined in the prescription; and (iii) organs at risk are nominated as planning dose goals or constraints and the prescription specifies the organs at risk as dose goals or constraints; and (iv) dose calculations and dose volume histograms are generated in an inverse planned process, using a specialised calculation algorithm, with prescription and plan details approved and recorded in the plan; and (v) a CT image volume dataset is used for the relevant region to be planned and treated; and (vi) the CT images are suitable for the generation of quality digitally reconstructed radiographic images; and (b) the final intensity-modulated radiation therapy dosimetry plan is validated by the radiation therapist and the medical physicist, using robust quality assurance processes that include: (i) determination of the accuracy of the dose fluence delivered by the multi-leaf collimator and gantry position (static or dynamic); and (ii) ensuring that the plan is deliverable, data transfer is acceptable and validation checks are completed on a linear accelerator; and (iii) validating the accuracy of the derived intensity-modulated radiation therapy dosimetry plan; and (c) the final intensity-modulated radiation therapy dosimetry plan is approved by the radiation oncologist prior to delivery	3,448.10
Subgroup 6—Stereotactic radiosurgery		
15600	Stereotactic radiosurgery, including all radiation oncology consultations, planning, simulation, dosimetry and treatment	1,771.30
Subgroup 7—Radiation oncology treatment verification		
15700	Radiation oncology treatment verification with single projection acquisition (with single or double exposures), if: (a) the service is prescribed and reviewed by a radiation oncologist; and (b) the service is not associated with item 15705 or 15710;	47.85

Group T2—Radiation oncology

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	—each attendance at which treatment is verified	
15705	Radiation oncology treatment verification with multiple projection acquisition, if: (a) the service is prescribed and reviewed by a radiation oncologist; and (b) the service is not associated with item 15700 or item 15710; —each attendance at which treatment involving 3 fields or more is verified	79.70
15710	Radiation oncology treatment verification with volumetric acquisition, if: (a) the service is prescribed and reviewed by a radiation oncologist; and (b) the service is not associated with item 15700 or item 15705; —each attendance at which treatment involving 3 fields or more is verified	79.70
15715	Radiation oncology treatment verification of planar or volumetric image-guided radiation therapy for intensity-modulated radiation therapy, involving the use of at least 2 planar image views or projections or 1 volumetric image set to facilitate a 3-dimensional adjustment to radiation treatment field positioning, if: (a) the treatment technique is classified as intensity-modulated radiation therapy; and (b) the margins applied to volumes (clinical target volume or planning target volume) are tailored or reduced to minimise treatment related exposure of healthy or normal tissues; and (c) the decisions made using acquired images are based on action algorithms and are given effect immediately prior to or during treatment delivery by qualified and trained staff considering complex competing factors and using software-driven modelling programs; and (d) the radiation treatment field positioning requires accuracy levels of less than 5mm (curative cases) or up to 10mm (palliative cases) to ensure accurate dose delivery to the target; and (e) the image decisions and actions are documented in the patient's record; and (f) the radiation oncologist is responsible for supervising the process, including specifying the type and frequency of imaging, tolerance and action levels to be incorporated in the process, reviewing the trend analysis and any reports and relevant images during the treatment course and specifying action protocols as required; and (g) when treatment adjustments are inadequate to satisfy treatment protocol requirements, replanning is required; and (h) the imaging infrastructure (hardware and software) is linked to the treatment unit and networked to an image database, enabling both on-line and off-line reviews	79.70

Clause 5.4.1

Group T2—Radiation oncology		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
Subgroup 8—Brachytherapy planning and verification		
15800	Brachytherapy treatment verification—once for each attendance	100.20
15850	Radiation source localisation using a simulator, x-ray machine, CT or ultrasound of a single area, if views in more than one plane are required, for brachytherapy treatment planning, not being a service to which item 15513 applies.	207.60
Subgroup 10—Intraoperative radiotherapy		
15900	Breast, malignant tumour, targeted intraoperative radiation therapy, using an Intrabeam® or Xoft® Axxent® device, delivered at the time of breast-conserving surgery (partial mastectomy or lumpectomy) for a patient who: (a) is 45 years of age or over; and (b) has a T1 or small T2 (less than or equal to 3cm in diameter) primary tumour; and (c) has a histologic grade 1 or 2 tumour; and (d) has an oestrogen-receptor positive tumour; and (e) has a node negative malignancy; and (f) is suitable for wide local excision of a primary invasive ductal carcinoma that was diagnosed as unifocal on conventional examination and imaging; and (g) has no contra-indications to breast irradiation Applicable only once per breast per lifetime (H)	260.10

Division 5.4—Group T3: Therapeutic nuclear medicine

5.4.1 Items in Group T3

This clause sets out items in Group T3.

Group T3—Therapeutic nuclear medicine		
Column 1	**Column 2**	**Column 3**
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.)	676.85
16006	Administration of a therapeutic dose of Iodine 131 for thyroid cancer by single dose technique	520.10
16009	Administration of a therapeutic dose of Iodine 131 for thyrotoxicosis by single dose technique	354.95
16012	Intravenous administration of a therapeutic dose of Phosphorous 32	307.10
16015	Administration of Strontium 89 for painful bony metastases from carcinoma of the prostate, if hormone therapy has failed and either:	4,251.20

Group T3—Therapeutic nuclear medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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	
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	2,541.40

Division 5.5—Group T4: Obstetrics

5.5.1 Definitions for item 16400

In item 16400:

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.

5.5.2 Meaning of practice midwife in items 16400 and 16408

In items 16400 and 16408:

practice midwife means a midwife who is employed by, or whose services are otherwise retained by, a medical practitioner or a practice operated by a medical practitioner.

5.5.3 Restrictions on item 16400—provider and timing

(1) Item 16400 applies to an antenatal service provided to a patient by a practice midwife, nurse or Aboriginal and Torres Strait Islander health practitioner only if:

(a) the practice 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 practice 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.

Clause 5.5.4

(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.

5.5.4 Items in Group T4

This clause sets out items in Group T4.

Group T4—Obstetrics

Column 1 Item	Column 2 Description	Column 3 Fee ($)
16399	Professional attendance on a patient by a specialist practising in the specialist's specialty of obstetrics if: (a) the attendance is by video conference; and (b) item 16401, 16404, 16406, 16500, 16590 or 16591 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 km by road from the specialist; or (ii) is a care recipient in a residential aged care facility; 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 16401, 16404, 16406, 16500, 16590 or 16591
16400	Antenatal service provided by a practice midwife, nurse or an Aboriginal and Torres Strait Islander health practitioner, applicable 10 times for a pregnancy, if: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the service is provided at, or from, a practice location in a regional, rural or remote area; and (c) the service is not performed in conjunction with another antenatal attendance item in Group T4 for the same patient on the same day by the same practitioner; and (d) the service is not provided for an admitted patient of a hospital or approved day facility	28.35
16401	Professional attendance at consulting rooms or a hospital by a specialist in the practice of the specialist's specialty of obstetrics after referral of the patient to the specialist—initial attendance in a single course of treatment	89.00
16404	Professional attendance at consulting rooms or a hospital by a specialist in the practice of the specialist's specialty of obstetrics	44.75

Group T4—Obstetrics

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	after referral of the patient to the specialist—an attendance after the initial attendance in a single course of treatment	
16406	Antenatal professional attendance by an obstetrician or general practitioner, as part of a single course of treatment when the patient is referred by a participating midwife Applicable once for a pregnancy	139.40
16407	Postnatal professional attendance (other than a service to which any other item applies) if the attendance: (a) is by an obstetrician or general practitioner; and (b) is in hospital or at consulting rooms; and (c) is between 4 and 8 weeks after the birth; and (d) lasts at least 20 minutes; and (e) includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (f) is for a pregnancy in relation to which a service to which item 82140 applies is not provided Applicable once for a pregnancy	74.60
16408	Postnatal attendance (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which any other item applies) if the attendance: (a) is by: (i) a practice midwife (on behalf of and under the supervision of the medical practitioner who attended the birth); or (ii) an obstetrician; or (iii) a general practitioner; and (b) is between 1 week and 4 weeks after the birth; and (c) lasts at least 20 minutes; and (d) is for a patient who was privately admitted for the birth; and (e) is for a pregnancy in relation to which a service to which item 82130, 82135 or 82140 applies is not provided Applicable once for a pregnancy	55.55
16500	Antenatal attendance	49.05
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	146.25
16502	Polyhydramnios, unstable lie, multiple pregnancy, pregnancy complicated by diabetes or anaemia, threatened premature labour treated by bed rest only or oral medication, requiring admission to hospital—a professional attendance that is not a routine antenatal attendance, applicable once per day	49.05
16505	Threatened abortion, threatened miscarriage or hyperemesis gravidarum, requiring admission to hospital, treatment of—an	49.05

Clause 5.5.4

Group T4—Obstetrics

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	attendance that is not a routine antenatal attendance	
16508	Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital—professional attendance (other than a service to which item 16533 applies) that is not a routine antenatal attendance, applicable once per day	49.05
16509	Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of—professional attendance (other than a service to which item 16534 applies) that is not a routine antenatal attendance	49.05
16511	Cervix, purse string ligation of (Anaes.)	228.85
16512	Cervix, removal of purse string ligature of (Anaes.)	66.05
16514	Antenatal cardiotocography in the management of high risk pregnancy (not during the course of the confinement)	38.15
16515	Management of vaginal birth as an independent procedure, if the patient's care has been transferred by another medical practitioner for management of the birth and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the birth (Anaes.)	656.40
16518	Management of labour, incomplete, if the patient's care has been transferred to another medical practitioner for completion of the birth (Anaes.)	468.90
16519	Management of labour and birth by any means (including Caesarean section) including post-partum care for 5 days (Anaes.)	722.10
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.)	656.40
16522	Management of labour and birth, or birth alone, (including caesarean section), on or after 23 weeks gestation, if in the course of antenatal supervision or intrapartum management one or more of the following conditions is present, including postnatal care for 7 days: (a) fetal loss; (b) multiple pregnancy; (c) antepartum haemorrhage that is: (i) of greater than 200 ml; or (ii) associated with disseminated intravascular coagulation; (d) placenta praevia on ultrasound in the third trimester with the placenta within 2 cm of the internal cervical os; (e) baby with a birth weight less than or equal to 2,500 g; (f) trial of vaginal birth in a patient with uterine scar if there has been a planned vaginal birth after caesarean section; (g) trial of vaginal breech birth if there has been a planned vaginal breech birth; (h) prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress as evidenced by cervical	1,695.35

Group T4—Obstetrics

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	dilatation at less than 1 cm/hr in the active phase of labour (after 3 cm cervical dilatation and effacement until full dilatation of the cervix); (i) acute fetal compromise evidenced by: (i) scalp pH less than 7.15; or (ii) scalp lactate greater than 4.0; (j) acute fetal compromise evidenced by at least one of the following significant cardiotocograph abnormalities: (i) prolonged bradycardia (less than 100 bpm for more than 2 minutes); (ii) absent baseline variability (less than 3 bpm); (iii) sinusoidal pattern; (iv) complicated variable decelerations with reduced (3 to 5 bpm) or absent baseline variability; (v) late decelerations; (k) pregnancy induced hypertension of at least 140/90 mm Hg associated with: (i) at least 2+ proteinuria on urinalysis; or (ii) protein-creatinine ratio greater than 30 mg/mmol; or (iii) platelet count less than 150 x 10^9/L; or (iv) uric acid greater than 0.36 mmol/L; (l) gestational diabetes mellitus requiring at least daily blood glucose monitoring; (m) mental health disorder (whether arising prior to pregnancy, during pregnancy or postpartum) that is demonstrated by: (i) the patient requiring hospitalisation; or (ii) the patient receiving ongoing care by a psychologist or psychiatrist to treat the symptoms of a mental health disorder; or (iii) the patient having a GP mental health treatment plan; or (iv) the patient having a management plan prepared in accordance with item 291; (n) disclosure or evidence of domestic violence; (o) any of the following conditions either diagnosed pre-pregnancy or evident at the first antenatal visit before 20 weeks gestation: (i) pre-existing hypertension requiring antihypertensive medication prior to pregnancy; (ii) cardiac disease (co-managed with a specialist physician and with echocardiographic evidence of myocardial dysfunction); (iii) previous renal or liver transplant; (iv) renal dialysis; (v) chronic liver disease with documented oesophageal varices; (vi) renal insufficiency in early pregnancy (serum creatinine greater than 110 mmol/L); (vii) neurological disorder that confines the patient to a wheelchair throughout pregnancy; (viii) maternal height of less than 148 cm;	

Clause 5.5.4

Group T4—Obstetrics		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(ix) a body mass index greater than or equal to 40; (x) pre-existing diabetes mellitus on medication prior to pregnancy; (xi) thyrotoxicosis requiring medication; (xii) previous thrombosis or thromboembolism requiring anticoagulant therapy through pregnancy and the early puerperium; (xiii) thrombocytopenia with platelet count of less than 100,000 prior to 20 weeks gestation; (xiv) HIV, hepatitis B or hepatitis C carrier status positive; (xv) red cell or platelet iso-immunisation; (xvi) cancer with metastatic disease; (xvii) illicit drug misuse during pregnancy (H) (Anaes.)	
16527	Management of vaginal birth, if the patient's care has been transferred by a participating midwife for management of the birth, including all attendances related to the birth (Anaes.) Applicable once for a pregnancy	656.40
16528	Caesarean section and post-operative care for 7 days, if the patient's care has been transferred by a participating midwife for management of the birth (Anaes.) Applicable once for a pregnancy	656.40
16530	Management of pregnancy loss, from 14 weeks to 15 weeks and 6 days gestation, other than a service to which item 16531, 35640 or 35643 applies (Anaes.)	399.90
16531	Management of pregnancy loss, from 16 weeks to 22 weeks and 6 days gestation, other than a service to which item 16530, 35640 or 35643 applies (Anaes.) (H)	799.85
16533	Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital—each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, applicable 3 times for a pregnancy (H)	109.85
16534	Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of—each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, applicable 3 times for a pregnancy (H)	109.85
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.)	226.80
16567	Management of postpartum haemorrhage by special measures such as packing of uterus, as an independent procedure (Anaes.)	331.70
16570	Acute inversion of the uterus, vaginal correction of, as an independent procedure (Anaes.)	432.90
16571	Cervix, repair of extensive laceration or lacerations (Anaes.)	331.70
16573	Third degree tear, involving anal sphincter muscles and rectal	270.30

Group T4—Obstetrics

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	mucosa, repair of, as an independent procedure (Anaes.)	
16590	Planning and management, by a practitioner, of a pregnancy if: (a) the practitioner intends to take primary responsibility for management of the pregnancy and any complications, and to be available for the birth; and (b) the patient intends to be privately admitted for the birth; and (c) the pregnancy has progressed beyond 28 weeks gestation; and (d) the practitioner has maternity privileges at a hospital or birth centre; and (e) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (f) a service to which item 16591 applies is not provided in relation to the same pregnancy Applicable once for a pregnancy	387.85
16591	Planning and management, by a practitioner, of a pregnancy if: (a) the pregnancy has progressed beyond 28 weeks gestation; and (b) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (c) a service to which item 16590 applies is not provided in relation to the same pregnancy Applicable once for a pregnancy	148.40
16600	Amniocentesis, diagnostic	66.05
16603	Chorionic villus sampling, by any route	126.80
16606	Fetal blood sampling, using interventional techniques from umbilical cord or fetus, including fetal neuromuscular blockade and amniocentesis (Anaes.)	253.10
16609	Fetal intravascular blood transfusion, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling (Anaes.)	516.10
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.)	406.05
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.)	216.30
16618	Amniocentesis, therapeutic, when indicated because of polyhydramnios with at least 500 ml being aspirated	216.30
16621	Amnioinfusion, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios	216.30
16624	Fetal fluid filled cavity, drainage of	311.25

Clause 5.6.1

Group T4—Obstetrics		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
16627	Feto-amniotic shunt, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis	633.65

Division 5.6—Group T6: Examination by anaesthetist

5.6.1 Items in Group T6

This clause sets out items in Group T6.

Group T6—Examination by anaesthetist		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
17609	Professional attendance on a patient by a specialist practising in the specialist's 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 km by road from the specialist; or (ii) is a care recipient in a residential aged care facility; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies	50% of the fee for item 17610, 17615, 17620, 17640, 17645, 17650 or 17655
17610	Professional attendance by a medical practitioner in the practice of anaesthesia for a brief consultation involving a targeted history and limited examination, including the cardio-respiratory system, lasting not more than 15 minutes (other than a service associated with a service to which any of items 2801 to 3000 apply)	45.40
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 lasting more than 15 minutes, but not more than 30 minutes, (other than a service associated with a service to which any of items 2801 to 3000 apply)	90.35
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	125.15

Group T6—Examination by anaesthetist

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	history and comprehensive examination of multiple systems, and the formulation of a written patient management plan documented in the patient notes, and lasting more than 30 minutes, but not more than 45 minutes, (other than a service associated with a service to which any of items 2801 to 3000 apply)	
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 lasting more than 45 minutes (other than a service associated with a service to which any of items 2801 to 3000 apply)	159.35
17640	Professional attendance by a specialist anaesthetist in the practice of anaesthesia, if the patient is referred to the specialist anaesthetist—a brief consultation involving a short history, a limited examination, and lasting not more than 15 minutes (other than a service associated with a service to which any of items 2801 to 3000 apply)	45.40
17645	Professional attendance by a specialist anaesthetist in the practice of anaesthesia, if the patient is referred to the specialist anaesthetist—a consultation involving a selective history and examination of multiple systems, the formulation of a written patient management plan, and lasting more than 15 minutes, but not more than 30 minutes, (other than a service associated with a service to which any of items 2801 to 3000 apply)	90.35
17650	Professional attendance by a specialist anaesthetist in the practice of anaesthesia, if the patient is referred to the specialist anaesthetist—a consultation involving a detailed history and comprehensive examination of multiple systems, and the formulation of a written patient management plan, and lasting more than 30 minutes, but not more than 45 minutes, (other than a service associated with a service to which any of items 2801 to 3000 apply)	125.15
17655	Professional attendance by a specialist anaesthetist in the practice of anaesthesia, if the patient is referred to the specialist anaesthetist—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 lasting more than 45 minutes (other than a service associated with a service to which any of items 2801 to 3000 apply)	159.35
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)	90.35
17690	A medical service in association with an item in the range 17615 to	41.75

Clause 5.7.1

Group T6—Examination by anaesthetist		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	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 lasts more than 15 minutes; (other than a service associated with a service to which any of items 2801 to 3000 apply)	

Division 5.7—Group T7: Regional or field nerve blocks

5.7.1 Meaning of amount under clause 5.7.1

(1) In item 18219:

amount under clause 5.7.1 means the sum of:

(a) the fee for item 18216; and

(b) $19.80 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 5.7.1 means the sum of:

(a) the fee for item 18226; and

(b) $29.75 for each additional period of 15 minutes, and part of a period of 15 minutes, of continuous attendance beyond the first hour of attendance.

5.7.2 Items in Group T7

This clause sets out items in Group T7.

Group T7—Regional or field nerve blocks		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
18213	Intravenous regional anaesthesia of limb by retrograde perfusion	92.20
18216	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner (Anaes.)	197.60
18219	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, if continuous attendance by the medical practitioner extends beyond the	Amount under clause 5.7.1

Group T7—Regional or field nerve blocks

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	first hour (Anaes.)	
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	39.15
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	52.05
18226	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner—for a patient in labour, if the service is provided between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday	296.35
18227	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, if continuous attendance by a medical practitioner extends beyond the first hour—for a patient in labour, if the service is provided between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday	Amount under clause 5.7.1
18228	Interpleural block, initial injection or commencement of infusion of a therapeutic substance	65.05
18230	Intrathecal or epidural injection of neurolytic substance (Anaes.)	248.10
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.)	197.60
18233	Epidural injection of blood for blood patch (Anaes.)	197.60
18234	Trigeminal nerve, primary division of, injection of an anaesthetic agent (Anaes.)	129.90
18236	Trigeminal nerve, peripheral branch of, injection of an anaesthetic agent (Anaes.)	65.05
18238	Facial nerve, injection of an anaesthetic agent, other than a service associated with a service to which item 18240 applies	39.15
18240	Retrobulbar or peribulbar injection of an anaesthetic agent	97.40
18242	Greater occipital nerve, injection of an anaesthetic agent (Anaes.)	39.15
18244	Vagus nerve, injection of an anaesthetic agent	104.90
18248	Phrenic nerve, injection of an anaesthetic agent	92.20
18250	Spinal accessory nerve, injection of an anaesthetic agent	65.05
18252	Cervical plexus, injection of an anaesthetic agent	104.90
18254	Brachial plexus, injection of an anaesthetic agent	104.90
18256	Suprascapular nerve, injection of an anaesthetic agent	65.05
18258	Intercostal nerve (single), injection of an anaesthetic agent	65.05
18260	Intercostal nerves (multiple), injection of an anaesthetic agent	92.20
18262	Ilio-inguinal, iliohypogastric or genitofemoral nerves, one or more of, injections of an anaesthetic agent (Anaes.)	65.05

Clause 5.8.1

Group T7—Regional or field nerve blocks

Column 1 Item	Column 2 Description	Column 3 Fee ($)
18264	Pudendal nerve or dorsal nerve (or both), injection of an anaesthetic agent	104.90
18266	Ulnar, radial or median nerve, main trunk of, one or more of, injections of an anaesthetic agent, not being associated with a brachial plexus block	65.05
18268	Obturator nerve, injection of an anaesthetic agent	92.20
18270	Femoral nerve, injection of an anaesthetic agent	92.20
18272	Saphenous, sural, popliteal or posterior tibial nerve, main trunk of, one or more of, injections of an anaesthetic agent	65.05
18274	Paravertebral, cervical, thoracic, lumbar, sacral or coccygeal nerves, injection of an anaesthetic agent, (single vertebral level)	92.20
18276	Paravertebral nerves, injection of an anaesthetic agent, (multiple levels)	129.90
18278	Sciatic nerve, injection of an anaesthetic agent	92.20
18280	Sphenopalatine ganglion, injection of an anaesthetic agent (Anaes.)	129.90
18282	Carotid sinus, injection of an anaesthetic agent, as an independent percutaneous procedure	104.90
18284	Stellate ganglion, injection of an anaesthetic agent (cervical sympathetic block) (Anaes.)	153.60
18286	Lumbar or thoracic nerves, injection of an anaesthetic agent (paravertebral sympathetic block) (Anaes.)	153.60
18288	Coeliac plexus or splanchnic nerves, injection of an anaesthetic agent (Anaes.)	153.60
18290	Cranial nerve other than trigeminal, destruction by a neurolytic agent, other than a service associated with the injection of botulinum toxin (Anaes.)	259.85
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.)	129.90
18294	Coeliac plexus or splanchnic nerves, destruction by a neurolytic agent (Anaes.)	183.15
18296	Lumbar sympathetic chain, destruction by a neurolytic agent (Anaes.)	156.65
18297	Assistance at the administration of an epidural blood patch (a service to which item 18233 applies) by another medical practitioner	61.75
18298	Cervical or thoracic sympathetic chain, destruction by a neurolytic agent (Anaes.)	183.15

Division 5.8—Group T11: Botulinum toxin

5.8.1 Group T11 services do not include supply of botulinum toxin

A service described in any of items 18350 to 18379 does not include the supply of the botulinum toxin to which the service relates.

5.8.2 Restrictions on items in Group T11

(1) Items 18350 to 18354, 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) A service described in item 18360 is applicable to the first 4 treatments, not exceeding 2 for each limb, on any one day.

(3) Items 18360, 18366 and 18368 apply only to a service provided by a specialist or consultant physician in the practice of the specialist's or consultant physician's speciality.

5.8.3 Items in Group T11

This clause sets out items in Group T11.

Group T11—Botulinum toxin

Column 1 Item	Column 2 Description	Column 3 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	129.90
18351	Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport), injection of, for the treatment of hemifacial spasm in a patient who is at least 18 years of age, including all such injections on any one day	129.90
18353	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of cervical dystonia (spasmodic torticollis), including all such injections on any one day	259.85
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.)	129.90

Clause 5.8.3

Group T11—Botulinum toxin

Column 1 Item	Column 2 Description	Column 3 Fee ($)
18360	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin Haemagglutinin Complex (Dysport), injection of, for the treatment of moderate to severe focal spasticity if: (a) the patient is at least 18 years of age; and (b) the spasticity is associated with a previously diagnosed neurological disorder; and (c) 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	129.90
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.)	256.70
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.)	162.75
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	277.85
18369	Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of unilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.)	46.85
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.)	46.85
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.)	129.90
18374	Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the	129.90

Group T11—Botulinum toxin

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	treatment of bilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.)	
18375	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: (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 (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 (c) the patient is willing and able to self-catheterise; and (d) the treatment is not provided on the same occasion as a service described in item 104, 105, 110, 116, 119, 11900 or 11919 Applicable only once unless 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.)	239.20
18377	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of chronic migraine, including all injections in one day, if: (a) the patient is at least 18 years of age; and (b) the patient has experienced an inadequate response, intolerance or contraindication to at least 3 prophylactic migraine medications before commencement of treatment with botulinum toxin, as manifested by an average of 15 or more headache days per month, with at least 8 days of migraine, over a period of at least 6 months, before commencement of treatment with botulinum toxin Applicable not more than twice unless the patient achieves and maintains at least a 50% reduction in the number of headache days per month from baseline after 2 cycles of treatment (each of 12 weeks)	129.90
18379	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: (a) the urinary incontinence is due to idiopathic overactive bladder in a patient; and (b) the patient is at least 18 years of age; and (c) the patient has urinary incontinence that is inadequately controlled by at least 2 alternative anti-cholinergic agents, as manifested by having experienced at least 14 episodes of urinary incontinence per week before commencement of treatment with botulinum toxin; and (d) the patient is willing and able to self-catheterise; and	239.20

Clause 5.9.1

Group T11—Botulinum toxin		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(e) treatment is not provided on the same occasion as a service described in item 104, 105, 110, 116, 119, 11900 or 11919 Applicable only once unless 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 5.9—Group T10: Anaesthesia performed in connection with certain services (Relative Value Guide)

5.9.1 Meaning of amount under clause 5.9.1

(1) In item 25025:

amount under clause 5.9.1 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 25014 applies to the anaesthesia—the fee mentioned in the item; and

(d) if a service described in any of items 22002 to 22051 is performed in association with the anaesthesia—the fee mentioned in the item.

(2) In item 25030:

amount under clause 5.9.1 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 25014 applies to the anaesthesia—the fee mentioned in the item; and

(d) if a service described in any of items 22002 to 22051 is performed in association with the assistance—the fee mentioned in the item.

(3) In item 25050:

amount under clause 5.9.1 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 25014 apply to the perfusion—the fee mentioned in the item; and

(d) if a service described in any of items 22002 to 22051 or 22065 to 22075 is performed in association with the perfusion—the fee mentioned in the item.

5.9.2 Meaning of amount under clause 5.9.2

In items 25200 and 25205:

amount under clause 5.9.2 means the sum of:

(a) $103.00; 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 described in an item in the range 22002 to 22051 applies to the assistance—the fee mentioned in the item.

5.9.3 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.

5.9.4 Restrictions on items in Group T10

Items applying only to services connected with services described using "(Anaes.)"

(1) Items 20100 to 21990 (other than item 21965), 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.)".

Items 22900 and 22905 applying only to services connected with dental services

(2) 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).

Services associated with certain diagnostic imaging services

(3) An item in Group T10 does not apply to a service described 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.

5.9.5 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.

5.9.6 Meaning of anaesthesia, assistance and perfusion 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.

5.9.7 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.

5.9.8 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.

5.9.9 Items in Group T10

This clause sets out items in Group T10.

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **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	103.00
20102	Initiation of the management of anaesthesia for plastic repair of cleft lip	123.60
20104	Initiation of the management of anaesthesia for electroconvulsive therapy	82.40
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	103.00
20124	Initiation of the management of anaesthesia for otoscopy	82.40
20140	Initiation of the management of anaesthesia for procedures on eye, other than a service to which another item in this Subgroup applies	103.00
20142	Initiation of the management of anaesthesia for lens surgery	103.00
20143	Initiation of the management of anaesthesia for retinal surgery	123.60
20144	Initiation of the management of anaesthesia for corneal transplant	144.20
20145	Initiation of the management of anaesthesia for vitrectomy	144.20
20146	Initiation of the management of anaesthesia for biopsy of conjunctiva	103.00
20147	Initiation of the management of anaesthesia for squint repair	123.60
20148	Initiation of the management of anaesthesia for ophthalmoscopy	82.40
20160	Initiation of the management of anaesthesia for intranasal procedures on nose or accessory sinuses, other than a service to which another item in this Subgroup applies	123.60
20162	Initiation of the management of anaesthesia for intranasal surgery for malignancy or for intranasal ablation	144.20
20164	Initiation of the management of anaesthesia for biopsy of soft tissue of the nose and accessory sinuses	82.40
20170	Initiation of the management of anaesthesia for intraoral procedures, including biopsy, other than a service to which another item in this Subgroup applies	123.60
20172	Initiation of the management of anaesthesia for repair of cleft palate	144.20
20174	Initiation of the management of anaesthesia for excision of retropharyngeal tumour	185.40
20176	Initiation of the management of anaesthesia for radical intraoral surgery	206.00
20190	Initiation of the management of anaesthesia for procedures on facial bones, other than a service to which another item in this Subgroup applies	103.00

Clause 5.9.9

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
20192	Initiation of the management of anaesthesia for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction)	206.00
20210	Initiation of the management of anaesthesia for intracranial procedures, other than a service to which another item in this Subgroup applies	309.00
20212	Initiation of the management of anaesthesia for subdural taps	103.00
20214	Initiation of the management of anaesthesia for burr holes of the cranium	185.40
20216	Initiation of the management of anaesthesia for intracranial vascular procedures, including those for aneurysms or arterio-venous abnormalities	412.00
20220	Initiation of the management of anaesthesia for spinal fluid shunt procedures	206.00
20222	Initiation of the management of anaesthesia for ablation of an intracranial nerve	123.60
20225	Initiation of the management of anaesthesia for all cranial bone procedures	247.20
20230	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the head or face	247.20
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	103.00
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	309.00
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	123.60
20321	Initiation of the management of anaesthesia for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy	206.00
20330	Initiation of the management of anaesthesia for laser surgery to the airway (excluding nose and mouth)	164.80
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	206.00
20352	Initiation of the management of anaesthesia for simple ligation of major vessels of neck	103.00
20355	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the neck	247.20
Subgroup 3—Thorax		
20400	Initiation of the management of anaesthesia for procedures on the skin	61.80

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	or subcutaneous tissue of the anterior part of the chest, other than a service to which another item in this Subgroup applies	
20401	Initiation of the management of anaesthesia for procedures on the breast, other than a service to which another item in this Subgroup applies	82.40
20402	Initiation of the management of anaesthesia for reconstructive procedures on breast	103.00
20403	Initiation of the management of anaesthesia for removal of breast lump or for breast segmentectomy, if axillary node dissection is performed	103.00
20404	Initiation of the management of anaesthesia for mastectomy	123.60
20405	Initiation of the management of anaesthesia for reconstructive procedures on the breast using myocutaneous flaps	164.80
20406	Initiation of the management of anaesthesia for radical or modified radical procedures on breast with internal mammary node dissection	267.80
20410	Initiation of the management of anaesthesia for electrical conversion of arrhythmias	82.40
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	103.00
20440	Initiation of the management of anaesthesia for percutaneous bone marrow biopsy of the sternum	82.40
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	103.00
20452	Initiation of the management of anaesthesia for radical surgery on clavicle, scapula or sternum	123.60
20470	Initiation of the management of anaesthesia for partial rib resection, other than a service to which another item in this Subgroup applies	123.60
20472	Initiation of the management of anaesthesia for thoracoplasty	206.00
20474	Initiation of the management of anaesthesia for radical procedures on chest wall	267.80
20475	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior thorax	206.00
Subgroup 4—Intrathoracic		
20500	Initiation of the management of anaesthesia for open procedures on the oesophagus	309.00
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	123.60
20522	Initiation of the management of anaesthesia for needle biopsy of pleura	82.40
20524	Initiation of the management of anaesthesia for pneumocentesis	82.40
20526	Initiation of the management of anaesthesia for thoracoscopy	206.00
20528	Initiation of the management of anaesthesia for mediastinoscopy	164.80

Clause 5.9.9

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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	267.80
20542	Initiation of the management of anaesthesia for pulmonary decortication	309.00
20546	Initiation of the management of anaesthesia for pulmonary resection with thoracoplasty	309.00
20548	Initiation of the management of anaesthesia for intrathoracic repair of trauma to trachea and bronchi	309.00
20560	Initiation of the management of anaesthesia for: (a) open procedures on the heart, pericardium or great vessels of the chest; or (b) percutaneous insertion of a valvular prosthesis	412.00
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 service to which another item in this Subgroup applies	206.00
20604	Initiation of the management of anaesthesia for posterior cervical laminectomy with the patient in the sitting position	267.80
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	206.00
20622	Initiation of the management of anaesthesia for thoracolumbar sympathectomy	267.80
20630	Initiation of the management of anaesthesia for procedures in lumbar region, other than a service to which another item in this Subgroup applies	164.80
20632	Initiation of the management of anaesthesia for lumbar sympathectomy	144.20
20634	Initiation of the management of anaesthesia for chemonucleolysis	206.00
20670	Initiation of the management of anaesthesia for extensive spine or spinal cord procedures, or both	267.80
20680	Initiation of the management of anaesthesia for manipulation of spine when performed in the operating theatre of a hospital	61.80
20690	Initiation of the management of anaesthesia for percutaneous spinal procedures, other than a service to which another item in this Subgroup applies	103.00
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	61.80
20702	Initiation of the management of anaesthesia for percutaneous liver biopsy	82.40
20703	Initiation of the management of anaesthesia for procedures on the nerves, muscles, tendons and fascia of the upper abdominal wall, other	82.40

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	than a service to which another item in this Subgroup applies	
20704	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior upper abdomen	206.00
20706	Initiation of the management of anaesthesia for laparoscopic procedures in the upper abdomen, including laparoscopic cholecystectomy, other than a service to which another item in this Subgroup applies	144.20
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	103.00
20740	Initiation of the management of anaesthesia for upper gastrointestinal endoscopic procedures	103.00
20745	Initiation of the management of anaesthesia for either or both of the following: (a) upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage; (b) endoscopic retrograde cholangiopancreatography	144.20
20750	Initiation of the management of anaesthesia for hernia repairs to the upper abdominal wall, other than a service to which another item in this Subgroup applies	103.00
20752	Initiation of the management of anaesthesia for repair of incisional hernia or wound dehiscence, or both	123.60
20754	Initiation of the management of anaesthesia for procedures on an omphalocele	144.20
20756	Initiation of the management of anaesthesia for transabdominal repair of diaphragmatic hernia	185.40
20770	Initiation of the management of anaesthesia for procedures on major upper abdominal blood vessels	309.00
20790	Initiation of the management of anaesthesia for procedures within the peritoneal cavity in the upper abdomen, including any of the following: (a) open cholecystectomy; (b) gastrectomy; (c) laparoscopic assisted nephrectomy; (d) bowel shunts	164.80
20791	Initiation of the management of anaesthesia for bariatric surgery in a patient with clinically severe obesity	206.00
20792	Initiation of the management of anaesthesia for partial hepatectomy (excluding liver biopsy)	267.80
20793	Initiation of the management of anaesthesia for extended or trisegmental hepatectomy	309.00
20794	Initiation of the management of anaesthesia for pancreatectomy, partial or total	247.20
20798	Initiation of the management of anaesthesia for neuro endocrine tumour removal in the upper abdomen	206.00

Clause 5.9.9

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
20799	Initiation of the management of anaesthesia for percutaneous procedures on an intra-abdominal organ in the upper abdomen	123.60
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	61.80
20802	Initiation of the management of anaesthesia for lipectomy of the lower abdomen	103.00
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	82.40
20804	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior lower abdomen	206.00
20806	Initiation of the management of anaesthesia for laparoscopic procedures in the lower abdomen	144.20
20810	Initiation of the management of anaesthesia for lower intestinal endoscopic procedures	82.40
20815	Initiation of the management of anaesthesia for extracorporeal shock wave lithotripsy to urinary tract	123.60
20820	Initiation of the management of anaesthesia for procedures on the skin, its derivatives or subcutaneous tissue of the lower posterior abdominal wall	103.00
20830	Initiation of the management of anaesthesia for hernia repairs in lower abdomen, other than a service to which another item in this Subgroup applies	82.40
20832	Initiation of the management of anaesthesia for repair of incisional herniae or wound dehiscence, or both, of the lower abdomen	123.60
20840	Initiation of the management of anaesthesia for all open procedures within the peritoneal cavity in the lower abdomen, including appendicectomy, other than a service to which another item in this Subgroup applies	123.60
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	164.80
20842	Initiation of the management of anaesthesia for amniocentesis	82.40
20844	Initiation of the management of anaesthesia for abdominoperineal resection, including pull through procedures, ultra low anterior resection and formation of bowel reservoir	206.00
20845	Initiation of the management of anaesthesia for radical prostatectomy	206.00
20846	Initiation of the management of anaesthesia for radical hysterectomy	206.00
20847	Initiation of the management of anaesthesia for ovarian malignancy	206.00
20848	Initiation of the management of anaesthesia for pelvic exenteration	206.00
20850	Initiation of the management of anaesthesia for caesarean section	247.20

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
20855	Initiation of the management of anaesthesia for caesarean hysterectomy or hysterectomy within 24 hours of birth	309.00
20860	Initiation of the management of anaesthesia for extraperitoneal procedures in lower abdomen, including those on the urinary tract, other than a service to which another item in this Subgroup applies	123.60
20862	Initiation of the management of anaesthesia for renal procedures, including upper one-third of ureter	144.20
20863	Initiation of the management of anaesthesia for nephrectomy	206.00
20864	Initiation of the management of anaesthesia for total cystectomy	206.00
20866	Initiation of the management of anaesthesia for adrenalectomy	206.00
20867	Initiation of the management of anaesthesia for neuro endocrine tumour removal in the lower abdomen	206.00
20868	Initiation of the management of anaesthesia for renal transplantation (donor or recipient)	206.00
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	309.00
20882	Initiation of the management of anaesthesia for inferior vena cava ligation	206.00
20884	Initiation of the management of anaesthesia for percutaneous umbrella insertion	103.00
20886	Initiation of the management of anaesthesia for percutaneous procedures on an intra-abdominal organ in the lower abdomen	123.60
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	61.80
20902	Initiation of the management of anaesthesia for anorectal procedures (including surgical haemorrhoidectomy, but not banding of haemorrhoids)	82.40
20904	Initiation of the management of anaesthesia for radical perineal procedures, including radical perineal prostatectomy or radical vulvectomy	144.20
20905	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the perineum	206.00
20906	Initiation of the management of anaesthesia for vulvectomy	82.40
20910	Initiation of the management of anaesthesia for transurethral procedures (including urethrocystoscopy), other than a service to which another item in this Subgroup applies	82.40
20911	Initiation of the management of anaesthesia for endoscopic ureteroscopic surgery including laser procedures	103.00
20912	Initiation of the management of anaesthesia for transurethral resection of bladder tumour or tumours	103.00

Clause 5.9.9

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
20914	Initiation of the management of anaesthesia for transurethral resection of prostate	144.20
20916	Initiation of the management of anaesthesia for bleeding post-transurethral resection	144.20
20920	Initiation of the management of anaesthesia for procedures on external genitalia, other than a service to which another item in this Subgroup applies	82.40
20924	Initiation of the management of anaesthesia for procedures on undescended testis, unilateral or bilateral	82.40
20926	Initiation of the management of anaesthesia for radical orchidectomy, inguinal approach	82.40
20928	Initiation of the management of anaesthesia for radical orchidectomy, abdominal approach	123.60
20930	Initiation of the management of anaesthesia for orchiopexy, unilateral or bilateral	82.40
20932	Initiation of the management of anaesthesia for complete amputation of penis	82.40
20934	Initiation of the management of anaesthesia for complete amputation of penis with bilateral inguinal lymphadenectomy	123.60
20936	Initiation of the management of anaesthesia for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy	164.80
20938	Initiation of the management of anaesthesia for insertion of penile prosthesis	82.40
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	82.40
20942	Initiation of the management of anaesthesia for vaginal procedures (including repair operations and urinary incontinence procedures)	103.00
20943	Initiation of the management of anaesthesia for transvaginal assisted reproductive services	82.40
20944	Initiation of the management of anaesthesia for vaginal hysterectomy	123.60
20946	Initiation of the management of anaesthesia for vaginal birth	164.80
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	82.40
20950	Initiation of the management of anaesthesia for culdoscopy	103.00
20952	Initiation of the management of anaesthesia for hysteroscopy	82.40
20954	Initiation of the management of anaesthesia for correction of inverted uterus	206.00
20956	Initiation of the management of anaesthesia for evacuation of retained products of conception, as a complication of confinement	82.40
20958	Initiation of the management of anaesthesia for manual removal of retained placenta or for repair of vaginal or perineal tear following birth	103.00

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
20960	Initiation of the management of anaesthesia for vaginal procedures in the management of post-partum haemorrhage, if the blood loss is greater than 500 ml	144.20
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	61.80
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	103.00
21112	Initiation of the management of anaesthesia for percutaneous bone marrow biopsy of the anterior iliac crest	82.40
21114	Initiation of the management of anaesthesia for percutaneous bone marrow biopsy of the posterior iliac crest	103.00
21116	Initiation of the management of anaesthesia for percutaneous bone marrow harvesting from the pelvis	123.60
21120	Initiation of the management of anaesthesia for procedures on the bony pelvis	123.60
21130	Initiation of the management of anaesthesia for body cast application or revision, when performed in the operating theatre of a hospital	61.80
21140	Initiation of the management of anaesthesia for interpelviabdominal (hindquarter) amputation	309.00
21150	Initiation of the management of anaesthesia for radical procedures for tumour of the pelvis, except hindquarter amputation	206.00
21155	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior pelvis	206.00
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	82.40
21170	Initiation of the management of anaesthesia for open procedures involving symphysis pubis or sacroiliac joint	164.80
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	61.80
21199	Initiation of the management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg	82.40
21200	Initiation of the management of anaesthesia for closed procedures involving hip joint, when performed in the operating theatre of a hospital	82.40
21202	Initiation of the management of anaesthesia for arthroscopic procedures of the hip joint	82.40
21210	Initiation of the management of anaesthesia for open procedures involving hip joint, other than a service to which another item in this	123.60

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Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	Subgroup applies	
21212	Initiation of the management of anaesthesia for hip disarticulation	206.00
21214	Initiation of the management of anaesthesia for total hip replacement or revision	206.00
21216	Initiation of the management of anaesthesia for bilateral total hip replacement	288.40
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	82.40
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	123.60
21232	Initiation of the management of anaesthesia for above knee amputation	103.00
21234	Initiation of the management of anaesthesia for radical resection of the upper two-thirds of femur	164.80
21260	Initiation of the management of anaesthesia for procedures involving veins of upper leg, including exploration	82.40
21270	Initiation of the management of anaesthesia for procedures involving arteries of upper leg, including bypass graft, other than a service to which another item in this Subgroup applies	164.80
21272	Initiation of the management of anaesthesia for femoral artery ligation	82.40
21274	Initiation of the management of anaesthesia for femoral artery embolectomy	123.60
21275	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the upper leg	206.00
21280	Initiation of the management of anaesthesia for microsurgical reimplantation of upper leg	309.00
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	61.80
21321	Initiation of the management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of knee or popliteal area, or both	82.40
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	82.40
21360	Initiation of the management of anaesthesia for open procedures on lower one-third of femur	103.00
21380	Initiation of the management of anaesthesia for closed procedures on knee joint when performed in the operating theatre of a hospital	61.80
21382	Initiation of the management of anaesthesia for arthroscopic procedures of knee joint	82.40
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	61.80

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	the operating theatre of a hospital	
21392	Initiation of the management of anaesthesia for open procedures on upper ends of tibia, fibula or patella, or any of them	82.40
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	82.40
21402	Initiation of the management of anaesthesia for knee replacement	144.20
21403	Initiation of the management of anaesthesia for bilateral knee replacement	206.00
21404	Initiation of the management of anaesthesia for disarticulation of knee	103.00
21420	Initiation of the management of anaesthesia for cast application, removal or repair, involving knee joint, undertaken in a hospital	61.80
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	82.40
21432	Initiation of the management of anaesthesia for repair of arteriovenous fistula of knee or popliteal area	103.00
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	164.80
21445	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the knee or popliteal area	206.00
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	61.80
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	82.40
21462	Initiation of the management of anaesthesia for all closed procedures on lower leg, ankle or foot	61.80
21464	Initiation of the management of anaesthesia for arthroscopic procedure of ankle joint	82.40
21472	Initiation of the management of anaesthesia for repair of Achilles tendon	103.00
21474	Initiation of the management of anaesthesia for gastrocnemius recession	103.00
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	82.40
21482	Initiation of the management of anaesthesia for radical resection of bone involving lower leg, ankle or foot	103.00
21484	Initiation of the management of anaesthesia for osteotomy or osteoplasty of tibia or fibula	103.00
21486	Initiation of the management of anaesthesia for total ankle replacement	144.20
21490	Initiation of the management of anaesthesia for lower leg cast application, removal or repair, undertaken in a hospital	61.80

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Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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	164.80
21502	Initiation of the management of anaesthesia for embolectomy of the lower leg	123.60
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	82.40
21522	Initiation of the management of anaesthesia for venous thrombectomy of the lower leg	103.00
21530	Initiation of the management of anaesthesia for microsurgical reimplantation of lower leg, ankle or foot	309.00
21532	Initiation of the management of anaesthesia for microsurgical reimplantation of toe	164.80
21535	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the lower leg	206.00
Subgroup 13—Shoulder and axilla		
21600	Initiation of the management of anaesthesia for procedures on the skin or subcutaneous tissue of the shoulder or axilla	61.80
21610	Initiation of the management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla, including axillary dissection	103.00
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	82.40
21622	Initiation of the management of anaesthesia for arthroscopic procedures of shoulder joint	103.00
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	103.00
21632	Initiation of the management of anaesthesia for radical resection involving humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint	123.60
21634	Initiation of the management of anaesthesia for shoulder disarticulation	185.40
21636	Initiation of the management of anaesthesia for interthoracoscapular (forequarter) amputation	309.00
21638	Initiation of the management of anaesthesia for total shoulder replacement	206.00
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	164.80
21652	Initiation of the management of anaesthesia for procedures for	206.00

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	axillary-brachial aneurysm	
21654	Initiation of the management of anaesthesia for bypass graft of arteries of shoulder or axilla	164.80
21656	Initiation of the management of anaesthesia for axillary-femoral bypass graft	206.00
21670	Initiation of the management of anaesthesia for procedures on veins of shoulder or axilla	82.40
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	61.80
21682	Initiation of the management of anaesthesia for shoulder spica application, when undertaken in a hospital	82.40
21685	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the shoulder or axilla	206.00
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	61.80
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	82.40
21712	Initiation of the management of anaesthesia for open tenotomy of the upper arm or elbow	103.00
21714	Initiation of the management of anaesthesia for tenoplasty of the upper arm or elbow	103.00
21716	Initiation of the management of anaesthesia for tenodesis for rupture of long tendon of biceps	103.00
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	61.80
21732	Initiation of the management of anaesthesia for arthroscopic procedures of elbow joint	82.40
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	103.00
21756	Initiation of the management of anaesthesia for radical procedures on the upper arm or elbow	123.60
21760	Initiation of the management of anaesthesia for total elbow replacement	144.20
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	164.80
21772	Initiation of the management of anaesthesia for embolectomy of arteries of the upper arm	123.60
21780	Initiation of the management of anaesthesia for procedures on veins of	82.40

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Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	upper arm, other than a service to which another item in this Subgroup applies	
21785	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the upper arm or elbow	206.00
21790	Initiation of the management of anaesthesia for microsurgical reimplantation of upper arm	309.00
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	61.80
21810	Initiation of the management of anaesthesia for procedures on the nerves, muscles, tendons, fascia, or bursae of the forearm, wrist or hand	82.40
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	61.80
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	82.40
21832	Initiation of the management of anaesthesia for total wrist replacement	144.20
21834	Initiation of the management of anaesthesia for arthroscopic procedures of the wrist joint	82.40
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	164.80
21842	Initiation of the management of anaesthesia for embolectomy of artery of forearm, wrist or hand	123.60
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	82.40
21860	Initiation of the management of anaesthesia for forearm, wrist, or hand cast application, removal or repair, when undertaken in a hospital	61.80
21865	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the forearm, wrist or hand	206.00
21870	Initiation of the management of anaesthesia for microsurgical reimplantation of forearm, wrist or hand	309.00
21872	Initiation of the management of anaesthesia for microsurgical reimplantation of a finger	164.80
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	61.80
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	103.00

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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	144.20
21881	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves 20% or more but less than 30% of total body surface	185.40
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	226.60
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	267.80
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	309.00
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	350.20
21886	Initiation of the management of anaesthesia for excision or debridement of burns, with or without skin grafting, if the area of burn involves 70% or more but less than 80% of total body surface	391.40
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	432.60
Subgroup 17—Anaesthesia for radiological or other diagnostic or therapeutic procedures		
21900	Initiation of the management of anaesthesia for injection procedure for hysterosalpingography	61.80
21906	Initiation of the management of anaesthesia for injection procedure for myelography—lumbar or thoracic	103.00
21908	Initiation of the management of anaesthesia for injection procedure for myelography—cervical	123.60
21910	Initiation of the management of anaesthesia for injection procedure for myelography—posterior fossa	185.40
21912	Initiation of the management of anaesthesia for injection procedure for discography—lumbar or thoracic	103.00
21914	Initiation of the management of anaesthesia for injection procedure for discography—cervical	123.60
21915	Initiation of the management of anaesthesia for peripheral arteriogram	103.00
21916	Initiation of the management of anaesthesia for arteriograms—cerebral, carotid or vertebral	103.00
21918	Initiation of the management of anaesthesia for retrograde arteriogram—brachial or femoral	103.00
21922	Initiation of the management of anaesthesia for computerised axial	123.60

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Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	tomography scanning, magnetic resonance scanning or digital subtraction angiography scanning	
21925	Initiation of the management of anaesthesia for retrograde cystography, retrograde urethrography or retrograde cystourethrography	82.40
21926	Initiation of the management of anaesthesia for fluoroscopy	82.40
21930	Initiation of the management of anaesthesia for bronchography	123.60
21935	Initiation of the management of anaesthesia for phlebography	103.00
21936	Initiation of the management of anaesthesia for heart—2 dimensional real time transoesophageal examination	103.00
21939	Initiation of the management of anaesthesia for peripheral venous cannulation	61.80
21941	Initiation of the management of anaesthesia for cardiac catheterisation (including coronary arteriography, ventriculography, cardiac mapping or insertion of automatic defibrillator or transvenous pacemaker)	144.20
21942	Initiation of the management of anaesthesia for cardiac electrophysiological procedures including radio frequency ablation	206.00
21943	Initiation of the management of anaesthesia for central vein catheterisation or insertion of right heart balloon catheter (via jugular, subclavian or femoral vein) by percutaneous or open exposure	103.00
21945	Initiation of the management of anaesthesia for lumbar puncture, cisternal puncture or epidural injection	103.00
21949	Initiation of the management of anaesthesia for harvesting of bone marrow for the purpose of transplantation	103.00
21952	Initiation of the management of anaesthesia for diagnostic muscle biopsy to assess for malignant hyperpyrexia	82.40
21955	Initiation of the management of anaesthesia for electroencephalography	103.00
21959	Initiation of the management of anaesthesia for brain stem evoked response audiometry	103.00
21962	Initiation of the management of anaesthesia for electrocochleography by extratympanic method or transtympanic membrane insertion method	103.00
21965	Initiation of the management of anaesthesia as a therapeutic procedure if there is a clinical need for anaesthesia, not for headache of any etiology	103.00
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)	164.80
21970	Initiation of the management of anaesthesia during hyperbaric therapy, if the medical practitioner is confined in the chamber (including the administration of oxygen)	309.00
21973	Initiation of the management of anaesthesia for brachytherapy using radioactive sealed sources	103.00
21976	Initiation of the management of anaesthesia for therapeutic nuclear medicine	103.00
21980	Initiation of the management of anaesthesia for radiotherapy	103.00

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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	61.80
21992	Initiation of the management of anaesthesia performed on a patient under the age of 10 years in connection with a procedure covered by an item that does not include the word "(Anaes.)"	82.40
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 there is a clinical need for anaesthesia	82.40
Subgroup 19—Therapeutic and diagnostic services performed in connection with the management of anaesthesia		
22002	Administration of homologous blood or bone marrow already collected, when performed in association with the management of anaesthesia	82.40
22007	Endotracheal intubation with flexible fibreoptic scope associated with difficult airway, when performed in association with the management of anaesthesia	82.40
22008	Double lumen endobronchial tube or bronchial blocker, insertion of, when performed in association with the management of anaesthesia	82.40
22012	Monitoring that: (a) is of one of the following types of blood pressure: (i) central venous blood pressure; (ii) pulmonary arterial blood pressure; (iii) systemic arterial blood pressure; (iv) cardiac intracavity blood pressure; and (b) is conducted by indwelling catheter; and (c) is performed in association with the administration of anaesthesia for a procedure and not as a service to which item 13876 applies; and (d) is performed, on a day, on a patient who: (i) is categorised as having a high risk of complications; or (ii) during the procedure develops either complications or a high risk of complications; and (e) has not previously been performed in those circumstances on the day on the patient for that type of blood pressure	61.80
22014	Monitoring that: (a) is of one of the following types of blood pressure: (i) central venous blood pressure; (ii) pulmonary arterial blood pressure; (iii) systemic arterial blood pressure; (iv) cardiac intracavity blood pressure; and (b) is conducted by indwelling catheter; and (c) is performed in association with the administration of anaesthesia for a procedure (the ***current procedure***) and not as a service to which	61.80

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Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	item 13876 applies; and (d) is performed, on a day, on a patient: (i) who is categorised as having a high risk of complications or develops during the current procedure either complications or a high risk of complications; and (ii) for whom monitoring of that type of blood pressure to which item 22012 applies has already been performed on the day in association with the administration of anaesthesia for another discrete procedure; and (e) has not previously been performed in association with the current procedure for that type of blood pressure	
22015	Right heart balloon catheter, insertion of, including pulmonary wedge pressure and cardiac output measurement, when performed in association with the management of anaesthesia	123.60
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	82.40
22025	Intra-arterial cannulation when performed in association with the management of anaesthesia for a procedure for a patient who: (a) is categorised as having a high risk of complications; or (b) develops a high risk of complications during the procedure	82.40
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	103.00
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	61.80
22041	Introduction of a plexus or nerve block proximal to the lower leg or forearm, perioperatively performed in the induction room, theatre or recovery room, for post-operative pain management	41.20
22042	Introduction of a regional or field nerve block performed via retrobulbar, peribulbar or sub-Tenon's block injection of an anaesthetic agent, or other complex eye block, when administered by an anaesthetist perioperatively	20.60
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	185.40
22055	Perfusion of limb or organ using heart-lung machine or equivalent, other than a service associated with anaesthesia to which an item in Subgroup 21 applies	247.20

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
22060	Whole body perfusion, cardiac bypass, if the heart-lung machine or equivalent is continuously operated by a medical perfusionist, other than a service associated with anaesthesia to which an item in Subgroup 21 applies	618.00
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	103.00
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	309.00
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	123.60
22905	Initiation of the management of anaesthesia for restorative dental work	123.60
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	20.60
23025	Anaesthesia, perfusion or assistance, if the service time is more than 15 minutes but not more than 30 minutes	41.20
23035	Anaesthesia, perfusion or assistance, if the service time is more than 30 minutes but not more than 45 minutes	61.80
23045	Anaesthesia, perfusion or assistance, if the service time is more than 45 minutes but not more than 1 hour	82.40
23055	Anaesthesia, perfusion or assistance, if the service time is more than 1 hour but not more than 1:15 hours	103.00
23065	Anaesthesia, perfusion or assistance, if the service time is more than 1:15 hours but not more than 1:30 hours	123.60
23075	Anaesthesia, perfusion or assistance, if the service time is more than 1:30 hours but not more than 1:45 hours	144.20
23085	Anaesthesia, perfusion or assistance, if the service time is more than 1:45 hours but not more than 2:00 hours	164.80
23091	Anaesthesia, perfusion or assistance, if the service time is more than 2:00 hours but not more than 2:10 hours	185.40
23101	Anaesthesia, perfusion or assistance, if the service time is more than 2:10 hours but not more than 2:20 hours	206.00
23111	Anaesthesia, perfusion or assistance, if the service time is more than 2:20 hours but not more than 2:30 hours	226.60
23112	Anaesthesia, perfusion or assistance, if the service time is more than 2:30 hours but not more than 2:40 hours	247.20
23113	Anaesthesia, perfusion or assistance, if the service time is more than	267.80

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Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	2:40 hours but not more than 2:50 hours	
23114	Anaesthesia, perfusion or assistance, if the service time is more than 2:50 hours but not more than 3:00 hours	288.40
23115	Anaesthesia, perfusion or assistance, if the service time is more than 3:00 hours but not more than 3:10 hours	309.00
23116	Anaesthesia, perfusion or assistance, if the service time is more than 3:10 hours but not more than 3:20 hours	329.60
23117	Anaesthesia, perfusion or assistance, if the service time is more than 3:20 hours but not more than 3:30 hours	350.20
23118	Anaesthesia, perfusion or assistance, if the service time is more than 3:30 hours but not more than 3:40 hours	370.80
23119	Anaesthesia, perfusion or assistance, if the service time is more than 3:40 hours but not more than 3:50 hours	391.40
23121	Anaesthesia, perfusion or assistance, if the service time is more than 3:50 hours but not more than 4:00 hours	412.00
23170	Anaesthesia, perfusion or assistance, if the service time is more than 4:00 hours but not more than 4:10 hours	432.60
23180	Anaesthesia, perfusion or assistance, if the service time is more than 4:10 hours but not more than 4:20 hours	453.20
23190	Anaesthesia, perfusion or assistance, if the service time is more than 4:20 hours but not more than 4:30 hours	473.80
23200	Anaesthesia, perfusion or assistance, if the service time is more than 4:30 hours but not more than 4:40 hours	494.40
23210	Anaesthesia, perfusion or assistance, if the service time is more than 4:40 hours but not more than 4:50 hours	515.00
23220	Anaesthesia, perfusion or assistance, if the service time is more than 4:50 hours but not more than 5:00 hours	535.60
23230	Anaesthesia, perfusion or assistance, if the service time is more than 5:00 hours but not more than 5:10 hours	556.20
23240	Anaesthesia, perfusion or assistance, if the service time is more than 5:10 hours but not more than 5:20 hours	576.80
23250	Anaesthesia, perfusion or assistance, if the service time is more than 5:20 hours but not more than 5:30 hours	597.40
23260	Anaesthesia, perfusion or assistance, if the service time is more than 5:30 hours but not more than 5:40 hours	618.00
23270	Anaesthesia, perfusion or assistance, if the service time is more than 5:40 hours but not more than 5:50 hours	638.60
23280	Anaesthesia, perfusion or assistance, if the service time is more than 5:50 hours but not more than 6:00 hours	659.20
23290	Anaesthesia, perfusion or assistance, if the service time is more than 6:00 hours but not more than 6:10 hours	679.80
23300	Anaesthesia, perfusion or assistance, if the service time is more than 6:10 hours but not more than 6:20 hours	700.40

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
23310	Anaesthesia, perfusion or assistance, if the service time is more than 6:20 hours but not more than 6:30 hours	721.00
23320	Anaesthesia, perfusion or assistance, if the service time is more than 6:30 hours but not more than 6:40 hours	741.60
23330	Anaesthesia, perfusion or assistance, if the service time is more than 6:40 hours but not more than 6:50 hours	762.20
23340	Anaesthesia, perfusion or assistance, if the service time is more than 6:50 hours but not more than 7:00 hours	782.80
23350	Anaesthesia, perfusion or assistance, if the service time is more than 7:00 hours but not more than 7:10 hours	803.40
23360	Anaesthesia, perfusion or assistance, if the service time is more than 7:10 hours but not more than 7:20 hours	824.00
23370	Anaesthesia, perfusion or assistance, if the service time is more than 7:20 hours but not more than 7:30 hours	844.60
23380	Anaesthesia, perfusion or assistance, if the service time is more than 7:30 hours but not more than 7:40 hours	865.20
23390	Anaesthesia, perfusion or assistance, if the service time is more than 7:40 hours but not more than 7:50 hours	885.80
23400	Anaesthesia, perfusion or assistance, if the service time is more than 7:50 hours but not more than 8:00 hours	906.40
23410	Anaesthesia, perfusion or assistance, if the service time is more than 8:00 hours but not more than 8:10 hours	927.00
23420	Anaesthesia, perfusion or assistance, if the service time is more than 8:10 hours but not more than 8:20 hours	947.60
23430	Anaesthesia, perfusion or assistance, if the service time is more than 8:20 hours but not more than 8:30 hours	968.20
23440	Anaesthesia, perfusion or assistance, if the service time is more than 8:30 hours but not more than 8:40 hours	988.80
23450	Anaesthesia, perfusion or assistance, if the service time is more than 8:40 hours but not more than 8:50 hours	1,009.40
23460	Anaesthesia, perfusion or assistance, if the service time is more than 8:50 hours but not more than 9:00 hours	1,030.00
23470	Anaesthesia, perfusion or assistance, if the service time is more than 9:00 hours but not more than 9:10 hours	1,050.60
23480	Anaesthesia, perfusion or assistance, if the service time is more than 9:10 hours but not more than 9:20 hours	1,071.20
23490	Anaesthesia, perfusion or assistance, if the service time is more than 9:20 hours but not more than 9:30 hours	1,091.80
23500	Anaesthesia, perfusion or assistance, if the service time is more than 9:30 hours but not more than 9:40 hours	1,112.40
23510	Anaesthesia, perfusion or assistance, if the service time is more than 9:40 hours but not more than 9:50 hours	1,133.00
23520	Anaesthesia, perfusion or assistance, if the service time is more than	1,153.60

Clause 5.9.9

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	9:50 hours but not more than 10:00 hours	
23530	Anaesthesia, perfusion or assistance, if the service time is more than 10:00 hours but not more than 10:10 hours	1,174.20
23540	Anaesthesia, perfusion or assistance, if the service time is more than 10:10 hours but not more than 10:20 hours	1,194.80
23550	Anaesthesia, perfusion or assistance, if the service time is more than 10:20 hours but not more than 10:30 hours	1,215.40
23560	Anaesthesia, perfusion or assistance, if the service time is more than 10:30 hours but not more than 10:40 hours	1,236.00
23570	Anaesthesia, perfusion or assistance, if the service time is more than 10:40 hours but not more than 10:50 hours	1,256.60
23580	Anaesthesia, perfusion or assistance, if the service time is more than 10:50 hours but not more than 11:00 hours	1,277.20
23590	Anaesthesia, perfusion or assistance, if the service time is more than 11:00 hours but not more than 11:10 hours	1,297.80
23600	Anaesthesia, perfusion or assistance, if the service time is more than 11:10 hours but not more than 11:20 hours	1,318.40
23610	Anaesthesia, perfusion or assistance, if the service time is more than 11:20 hours but not more than 11:30 hours	1,339.00
23620	Anaesthesia, perfusion or assistance, if the service time is more than 11:30 hours but not more than 11:40 hours	1,359.60
23630	Anaesthesia, perfusion or assistance, if the service time is more than 11:40 hours but not more than 11:50 hours	1,380.20
23640	Anaesthesia, perfusion or assistance, if the service time is more than 11:50 hours but not more than 12:00 hours	1,400.80
23650	Anaesthesia, perfusion or assistance, if the service time is more than 12:00 hours but not more than 12:10 hours	1,421.40
23660	Anaesthesia, perfusion or assistance, if the service time is more than 12:10 hours but not more than 12:20 hours	1,442.00
23670	Anaesthesia, perfusion or assistance, if the service time is more than 12:20 hours but not more than 12:30 hours	1,462.60
23680	Anaesthesia, perfusion or assistance, if the service time is more than 12:30 hours but not more than 12:40 hours	1,483.20
23690	Anaesthesia, perfusion or assistance, if the service time is more than 12:40 hours but not more than 12:50 hours	1,503.80
23700	Anaesthesia, perfusion or assistance, if the service time is more than 12:50 hours but not more than 13:00 hours	1,524.40
23710	Anaesthesia, perfusion or assistance, if the service time is more than 13:00 hours but not more than 13:10 hours	1,545.00
23720	Anaesthesia, perfusion or assistance, if the service time is more than 13:10 hours but not more than 13:20 hours	1,565.60
23730	Anaesthesia, perfusion or assistance, if the service time is more than 13:20 hours but not more than 13:30 hours	1,586.20

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
23740	Anaesthesia, perfusion or assistance, if the service time is more than 13:30 hours but not more than 13:40 hours	1,606.80
23750	Anaesthesia, perfusion or assistance, if the service time is more than 13:40 hours but not more than 13:50 hours	1,627.40
23760	Anaesthesia, perfusion or assistance, if the service time is more than 13:50 hours but not more than 14:00 hours	1,648.00
23770	Anaesthesia, perfusion or assistance, if the service time is more than 14:00 hours but not more than 14:10 hours	1,668.60
23780	Anaesthesia, perfusion or assistance, if the service time is more than 14:10 hours but not more than 14:20 hours	1,689.20
23790	Anaesthesia, perfusion or assistance, if the service time is more than 14:20 hours but not more than 14:30 hours	1,709.80
23800	Anaesthesia, perfusion or assistance, if the service time is more than 14:30 hours but not more than 14:40 hours	1,730.40
23810	Anaesthesia, perfusion or assistance, if the service time is more than 14:40 hours but not more than 14:50 hours	1,751.00
23820	Anaesthesia, perfusion or assistance, if the service time is more than 14:50 hours but not more than 15:00 hours	1,771.60
23830	Anaesthesia, perfusion or assistance, if the service time is more than 15:00 hours but not more than 15:10 hours	1,792.20
23840	Anaesthesia, perfusion or assistance, if the service time is more than 15:10 hours but not more than 15:20 hours	1,812.80
23850	Anaesthesia, perfusion or assistance, if the service time is more than 15:20 hours but not more than 15:30 hours	1,833.40
23860	Anaesthesia, perfusion or assistance, if the service time is more than 15:30 hours but not more than 15:40 hours	1,854.00
23870	Anaesthesia, perfusion or assistance, if the service time is more than15:40 hours but not more than 15:50 hours	1,874.60
23880	Anaesthesia, perfusion or assistance, if the service time is more than 15:50 hours but not more than 16:00 hours	1,895.20
23890	Anaesthesia, perfusion or assistance, if the service time is more than 16:00 hours but not more than 16:10 hours	1,915.80
23900	Anaesthesia, perfusion or assistance, if the service time is more than 16:10 hours but not more than 16:20 hours	1,936.40
23910	Anaesthesia, perfusion or assistance, if the service time is more than 16:20 hours but not more than 16:30 hours	1,957.00
23920	Anaesthesia, perfusion or assistance, if the service time is more than 16:30 hours but not more than 16:40 hours	1,977.60
23930	Anaesthesia, perfusion or assistance, if the service time is more than 16:40 hours but not more than 16:50 hours	1,998.20
23940	Anaesthesia, perfusion or assistance, if the service time is more than 16:50 hours but not more than 17:00 hours	2,018.80
23950	Anaesthesia, perfusion or assistance, if the service time is more than	2,039.40

Clause 5.9.9

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	17:00 hours but not more than 17:10 hours	
23960	Anaesthesia, perfusion or assistance, if the service time is more than 17:10 hours but not more than 17:20 hours	2,060.00
23970	Anaesthesia, perfusion or assistance, if the service time is more than 17:20 hours but not more than 17:30 hours	2,080.60
23980	Anaesthesia, perfusion or assistance, if the service time is more than 17:30 hours but not more than 17:40 hours	2,101.20
23990	Anaesthesia, perfusion or assistance, if the service time is more than 17:40 hours but not more than 17:50 hours	2,121.80
24100	Anaesthesia, perfusion or assistance, if the service time is more than 17:50 hours but not more than 18:00 hours	2,142.40
24101	Anaesthesia, perfusion or assistance, if the service time is more than 18:00 hours but not more than 18:10 hours	2,163.00
24102	Anaesthesia, perfusion or assistance, if the service time is more than 18:10 hours but not more than 18:20 hours	2,183.60
24103	Anaesthesia, perfusion or assistance, if the service time is more than 18:20 hours but not more than 18:30 hours	2,204.20
24104	Anaesthesia, perfusion or assistance, if the service time is more than 18:30 hours but not more than 18:40 hours	2,224.80
24105	Anaesthesia, perfusion or assistance, if the service time is more than 18:40 hours but not more than 18:50 hours	2,245.40
24106	Anaesthesia, perfusion or assistance, if the service time is more than 18:50 hours but not more than 19:00 hours	2,266.00
24107	Anaesthesia, perfusion or assistance, if the service time is more than 19:00 hours but not more than 19:10 hours	2,286.60
24108	Anaesthesia, perfusion or assistance, if the service time is more than 19:10 hours but not more than 19:20 hours	2,307.20
24109	Anaesthesia, perfusion or assistance, if the service time is more than 19:20 hours but not more than 19:30 hours	2,327.80
24110	Anaesthesia, perfusion or assistance, if the service time is more than 19:30 hours but not more than 19:40 hours	2,348.40
24111	Anaesthesia, perfusion or assistance, if the service time is more than 19:40 hours but not more than 19:50 hours	2,369.00
24112	Anaesthesia, perfusion or assistance, if the service time is more than 19:50 hours but not more than 20:00 hours	2,389.60
24113	Anaesthesia, perfusion or assistance, if the service time is more than 20:00 hours but not more than 20:10 hours	2,410.20
24114	Anaesthesia, perfusion or assistance, if the service time is more than 20:10 hours but not more than 20:20 hours	2,430.80
24115	Anaesthesia, perfusion or assistance, if the service time is more than 20:20 hours but not more than 20:30 hours	2,451.40
24116	Anaesthesia, perfusion or assistance, if the service time is more than 20:30 hours but not more than 20:40 hours	2,472.00

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
24117	Anaesthesia, perfusion or assistance, if the service time is more than 20:40 hours but not more than 20:50 hours	2,492.60
24118	Anaesthesia, perfusion or assistance, if the service time is more than 20:50 hours but not more than 21:00 hours	2,513.20
24119	Anaesthesia, perfusion or assistance, if the service time is more than 21:00 hours but not more than 21:10 hours	2,533.80
24120	Anaesthesia, perfusion or assistance, if the service time is more than 21:10 hours but not more than 21:20 hours	2,554.40
24121	Anaesthesia, perfusion or assistance, if the service time is more than 21:20 hours but not more than 21:30 hours	2,575.00
24122	Anaesthesia, perfusion or assistance, if the service time is more than 21:30 hours but not more than 21:40 hours	2,595.60
24123	Anaesthesia, perfusion or assistance, if the service time is more than 21:40 hours but not more than 21:50 hours	2,616.20
24124	Anaesthesia, perfusion or assistance, if the service time is more than 21:50 hours but not more than 22:00 hours	2,636.80
24125	Anaesthesia, perfusion or assistance, if the service time is more than 22:00 hours but not more than 22:10 hours	2,657.40
24126	Anaesthesia, perfusion or assistance, if the service time is more than 22:10 hours but not more than 22:20 hours	2,678.00
24127	Anaesthesia, perfusion or assistance, if the service time is more than 22:20 hours but not more than 22:30 hours	2,698.60
24128	Anaesthesia, perfusion or assistance, if the service time is more than 22:30 hours but not more than 22:40 hours	2,719.20
24129	Anaesthesia, perfusion or assistance, if the service time is more than 22:40 hours but not more than 22:50 hours	2,739.80
24130	Anaesthesia, perfusion or assistance, if the service time is more than 22:50 hours but not more than 23:00 hours	2,760.40
24131	Anaesthesia, perfusion or assistance, if the service time is more than 23:00 hours but not more than 23:10 hours	2,781.00
24132	Anaesthesia, perfusion or assistance, if the service time is more than 23:10 hours but not more than 23:20 hours	2,801.60
24133	Anaesthesia, perfusion or assistance, if the service time is more than 23:20 hours but not more than 23:30 hours	2,822.20
24134	Anaesthesia, perfusion or assistance, if the service time is more than 23:30 hours but not more than 23:40 hours	2,842.80
24135	Anaesthesia, perfusion or assistance, if the service time is more than 23:40 hours but not more than 23:50 hours	2,863.40
24136	Anaesthesia, perfusion or assistance, if the service time is more than 23:50 hours but not more than 24:00 hours	2,884.00
Subgroup 22—Anaesthesia, perfusion and assistance at anaesthesia (modifying components—physical status)		
25000	Anaesthesia, perfusion or assistance in the management of anaesthesia,	20.60

Clause 5.9.9

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	if the patient has severe systemic disease (equivalent to ASA physical status indicator 3)	
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)	41.20
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)	61.80
Subgroup 23—Anaesthesia, perfusion and assistance at anaesthesia (modifying components—other)		
25013	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is aged under 4 years	20.60
25014	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is aged 75 years or more	20.60
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	41.20
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 5.9.1
25030	Assistance in the management of anaesthesia, if the patient requires immediate treatment without which there would be significant threat to life or body part and if more than 50% of the service time occurs between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday	Amount under clause 5.9.1
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 5.9.1
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 5.9.2
25205	Assistance in the management of elective anaesthesia, if: (a) the patient has complex airway problems; or (b) the patient is a neonate; or (c) the patient is a paediatric patient and is receiving one or more of the following services: (i) invasive monitoring, either intravascular or transoesophageal;	Amount under clause 5.9.2

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(ii) organ transplantation; (iii) craniofacial surgery; (iv) major tumour resection; (v) separation of conjoint twins; or (d) there is anticipated to be massive blood loss (greater than 50% of blood volume) during the procedure; or (e) the patient is critically ill, with multiple organ failure; or (f) the service time of the management of anaesthesia exceeds 6 hours and the assistance is provided to the exclusion of attendance on all other patients	

Division 5.10—Group T8: Surgical operations

Subdivision A—Subgroup 1 of Group T8

5.10.1 Meaning of *amount under clause 5.10.1*

In item 30001:

amount under clause 5.10.1 means 50% of the fee that would normally apply for a surgical procedure if the surgical procedure had not been discontinued before completion.

5.10.2 Meaning of *amount under clause 5.10.2*

In item 31340:

amount under clause 5.10.2, 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.

5.10.3 Histopathological proof of malignancy—items 30196 and 30202

For the purposes of items 30196 and 30202, 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.

5.10.4 Restrictions on items 30299 and 30300—patients

A service described in item 30299 or 30300 applies only if pre-operative lymphoscintigraphy is used because the patient is allergic to lymphotrophic dye.

Clause 5.10.5

5.10.5 Items 30440, 30451, 30492 and 30495 do not include imaging

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.

5.10.6 Restrictions on items 30688, 30690, 30692 and 30694—patient notes

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.

5.10.7 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.

5.10.8 Restrictions on items 31569, 31572, 31575, 31578, 31581, 31587 and 31590—services provided on same occasion

(1) A service described in item 31569, 31572, 31575, 31578, 31581, 31587 or 31590 may only be claimed once for a patient for the same occasion.

(2) If 2 or more services described in item 31569, 31572, 31575, 31578, 31581, 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.

5.10.9 Items in Subgroup 1 of Group T8

This clause sets out items in Subgroup 1 of Group T8.

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
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 5.10.1
30003	Localised burns, dressing of, (not involving grafting)—each attendance at which the procedure is performed, including any associated consultation	37.80
30006	Extensive burns, dressing of, without anaesthesia (not involving grafting)—each attendance at which the procedure is performed, including any associated consultation	48.40
30010	Localised burns, dressing of, under general anaesthesia (not involving grafting) (H) (Anaes.)	76.95

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
30014	Extensive burns, dressing of, under general anaesthesia (not involving grafting) (H) (Anaes.)	161.70
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.)	339.25
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.)	660.75
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.)	339.25
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.)	339.25
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.)	54.35
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.)	93.65
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.)	85.80
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.)	122.35
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.)	93.65
30042	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, other than on face or neck, large (more than 7 cm long), involving deeper tissue, other than a service to which another item in Group T4 applies (Anaes.)	193.10
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.)	122.35
30049	Skin and subcutaneous tissue or mucous membrane, repair of wound of, other than wound closure at time of surgery, on face or neck, large (more than 7 cm long), involving deeper tissue (Anaes.)	193.10
30052	Full thickness laceration of ear, eyelid, nose or lip, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.)	264.25

Clause 5.10.9

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
30055	Wounds, dressing of, under general, regional or intravenous sedation, with or without removal of sutures, other than a service associated with a service to which another item in this Group applies (Anaes.)	76.95
30058	Post-operative haemorrhage, control of, under general anaesthesia, as an independent procedure (Anaes.)	150.20
30061	Superficial foreign body, removal of, (including from cornea or sclera) as an independent procedure (Anaes.)	24.45
30062	Etonogestrel subcutaneous implant, removal of, as an independent procedure (Anaes.)	63.20
30064	Subcutaneous foreign body, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes.)	114.30
30068	Foreign body in muscle, tendon or other deep tissue, removal of, as an independent procedure (Anaes.) (Assist.)	288.00
30071	Diagnostic biopsy of skin, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.)	54.35
30072	Diagnostic biopsy of mucous membrane, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.)	54.35
30075	Diagnostic biopsy of lymph node, muscle or other deep tissue or organ, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.)	155.85
30078	Diagnostic drill biopsy of lymph node, deep tissue or organ, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.)	50.45
30081	Diagnostic biopsy of bone marrow by trephine using an open approach, if the biopsy specimen is sent for pathological examination (Anaes.)	114.30
30084	Diagnostic biopsy of bone marrow by trephine using a percutaneous approach, if the biopsy specimen is sent for pathological examination (Anaes.)	61.20
30087	Diagnostic biopsy of bone marrow by aspiration or punch biopsy of synovial membrane, if the biopsy specimen is sent for pathological examination (Anaes.)	30.60
30090	Diagnostic biopsy of pleura, percutaneous, if the biopsy specimen is sent for pathological examination—one or more biopsies on any one occasion (Anaes.)	133.75
30093	Diagnostic needle biopsy of vertebra, if the biopsy specimen is sent for pathological examination (Anaes.)	178.50
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.)	197.10
30097	Personal performance of a Synacthen Stimulation Test, including associated consultation, by a medical practitioner with resuscitation training and access to facilities where life support procedures can be	101.10

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	implemented, if: (a) serum cortisol at 8.30 am to 9.30 am on any day in the preceding month has been measured at greater than 100 nmol/L but less than 400 nmol/L; or (b) the patient is acutely unwell and adrenal insufficiency is suspected	
30099	Sinus, excision of, involving superficial tissue only (Anaes.)	93.65
30103	Sinus, excision of, involving muscle and deep tissue (Anaes.)	191.35
30104	Pre-auricular sinus, excision of, on a patient 10 years of age or over (Anaes.)	132.10
30105	Pre-auricular sinus, excision of, on a patient under 10 years of age (Anaes.)	171.65
30107	Excision of ganglion, other than a service associated with a service to which another item in this Group applies (Anaes.)	228.85
30165	Lipectomy, wedge excision of abdominal apron that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30168, 30171, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non-surgical) treatment; and (b) the abdominal apron interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy (H) (Anaes.) (Assist.)	473.30
30168	Lipectomy, wedge excision of redundant non-abdominal skin and fat that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30165, 30171, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non-surgical) treatment; and (b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy; and (d) the procedure involves one excision only (H) (Anaes.) (Assist.)	473.30
30171	Lipectomy, wedge excision of redundant non-abdominal skin and fat that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30165, 30168, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non-surgical) treatment; and	719.75

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy; and (d) the procedure involves 2 excisions only (H) (Anaes.) (Assist.)	
30172	Lipectomy, wedge excision of redundant non-abdominal skin and fat that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30165, 30168, 30171, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non-surgical) treatment; and (b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy; and (d) the procedure involves 3 or more excisions (H) (Anaes.) (Assist.)	719.75
30176	Lipectomy, radical abdominoplasty (Pitanguy type or similar), with excision of skin and subcutaneous tissue, repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30177, 30179, 45530, 45564 or 45565 applies, if the patient has previously had a massive intra-abdominal or pelvic tumour surgically removed (H) (Anaes.) (Assist.)	1,025.60
30177	Lipectomy, excision of skin and subcutaneous tissue associated with redundant abdominal skin and fat that is a direct consequence of significant weight loss, in conjunction with a radical abdominoplasty (Pitanguy type or similar), with or without repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30179, 45530, 45564 or 45565 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non-surgical) treatment; and (b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy (H) (Anaes.) (Assist.)	1,025.60
30179	Circumferential lipectomy, as an independent procedure, to correct circumferential excess of redundant skin and fat that is a direct consequence of significant weight loss, with or without a radical abdominoplasty (Pitanguy type or similar), not being a service	1,262.30

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 45530, 45564 or 45565 applies, if: (a) the circumferential excess of redundant skin and fat is complicated by intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non-surgical) treatment; and (b) the circumferential excess of redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy (H) (Anaes.) (Assist.)	
30180	Axillary hyperhidrosis, partial excision for (Anaes.)	142.05
30183	Axillary hyperhidrosis, total excision of sweat gland bearing area (Anaes.)	256.50
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 the specialist's specialty (5 or more warts) (Anaes.)	267.35
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.)	153.25
30190	Angiofibromas, trichoepitheliomas or other severely disfiguring tumours of the face or neck (excluding melanocytic naevi, sebaceous hyperplasia, dermatosis papulosa nigra, Campbell De Morgan angiomas and seborrheic or viral warts), suitable for laser ablation as confirmed by the opinion of a specialist in the specialty of dermatology—removal of, by carbon dioxide laser or erbium laser ablation, including associated resurfacing (10 or more tumours) (Anaes.)	413.85
30191	Angiofibromas, trichoepithelioma, epidermal naevi, xanthelasma, pyogenic granuloma, genital angiokeratomas, hereditary haemorrhagic telangiectasia and other severely disfiguring or recurrently bleeding tumours (excluding melanocytic naevi, sebaceous hyperplasia, dermatosis papulosa nigra, Campbell De Morgan angiomas and seborrheic or viral warts), treatment of, with carbon dioxide/erbium or other appropriate laser (or curettage and fine point diathermy for pyogenic granuloma only), if confirmed by the opinion of a specialist in the specialty of dermatology, one or more lesions	66.05
30192	Premalignant skin lesions (including solar keratoses), treatment of, by ablative technique (10 or more lesions) (Anaes.)	41.15
30196	Malignant neoplasm of skin or mucous membrane that has been: (a) proven by histopathology; or (b) confirmed by the opinion of a specialist in the specialty of dermatology or plastic surgery where a specimen has been submitted for histologic confirmation;	131.35

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	removal of, by serial curettage, or carbon dioxide laser or erbium laser excision-ablation, including any associated cryotherapy or diathermy (Anaes.)	
30202	Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by the opinion of a specialist in the specialty of dermatology or plastic surgery—removal of, by liquid nitrogen cryotherapy using repeat freeze-thaw cycles	50.30
30207	Skin lesions, multiple injections with glucocorticoid preparations (Anaes.)	46.40
30210	Keloid and other skin lesions, extensive, multiple injections of glucocorticoid preparations, if undertaken in the operating theatre of a hospital on a patient less than 16 years of age (H) (Anaes.)	169.55
30216	Haematoma, aspiration of (Anaes.)	28.45
30219	Haematoma, furuncle, small abscess or similar lesion not requiring admission to a hospital, incision with drainage of, excluding after-care	28.45
30223	Large haematoma, large abscess, carbuncle, cellulitis or similar lesion, incision with drainage of, excluding after-care (H) (Anaes.)	169.55
30224	Percutaneous drainage of deep abscess using interventional techniques—but not including imaging (Anaes.)	247.20
30225	Abscess drainage tube, exchange of using interventional techniques—but not including imaging (Anaes.)	278.55
30226	Muscle, excision of (limited) or fasciotomy (Anaes.)	155.85
30229	Muscle, excision of (extensive) (Anaes.) (Assist.)	284.00
30232	Muscle, ruptured, repair of (limited), not associated with external wound (Anaes.)	232.70
30235	Muscle, ruptured, repair of (extensive), not associated with external wound (Anaes.) (Assist.)	307.70
30238	Fascia, deep, repair of, for herniated muscle (Anaes.)	155.85
30241	Bone tumour, innocent, excision of, other than a service to which another item in this Group applies (Anaes.) (Assist.)	370.80
30244	Styloid process of temporal bone, removal of (H) (Anaes.) (Assist.)	370.80
30246	Parotid duct, repair of, using micro-surgical techniques (H) (Anaes.) (Assist.)	717.75
30247	Parotid gland, total extirpation of (H) (Anaes.) (Assist.)	769.30
30250	Parotid gland, total extirpation of with preservation of facial nerve (H) (Anaes.) (Assist.)	1,301.75
30251	Recurrent parotid tumour, excision of, with preservation of facial nerve (Anaes.) (Assist.)	1,999.65
30253	Parotid gland, superficial lobectomy of, with exposure of facial nerve (H) (Anaes.) (Assist.)	867.85
30255	Submandibular ducts, relocation of, for surgical control of drooling (H) (Anaes.) (Assist.)	1,155.65

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
30256	Submandibular gland, extirpation of (H) (Anaes.) (Assist.)	463.50
30259	Sublingual gland, extirpation of (Anaes.)	206.60
30262	Salivary gland, dilatation or diathermy of duct (Anaes.)	61.20
30266	Salivary gland, removal of calculus from duct or meatotomy or marsupialisation, one or more such procedures (Anaes.)	155.85
30269	Salivary gland, repair of cutaneous fistula of (Anaes.)	155.85
30272	Tongue, partial excision of (Anaes.) (Assist.)	307.70
30275	Radical excision of intra-oral tumour involving resection of mandible and lymph nodes of neck (commando-type operation) (H) (Anaes.) (Assist.)	1,834.15
30278	Tongue tie, repair of, other than a service to which another item in this Group applies (Anaes.)	48.40
30281	Tongue tie, mandibular frenulum or maxillary frenulum, repair of, in a patient aged 2 years and over, under general anaesthesia (Anaes.)	124.30
30283	Ranula or mucous cyst of mouth, removal of (Anaes.)	213.00
30286	Branchial cyst, removal of, on a patient 10 years of age or over (Anaes.) (Assist.)	413.95
30287	Branchial cyst, removal of, on a patient under 10 years of age (Anaes.) (Assist.)	538.20
30289	Branchial fistula, removal of, on a patient 10 years of age or over (H) (Anaes.) (Assist.)	522.60
30293	Cervical oesophagostomy, or closure of cervical oesophagostomy with or without plastic repair (Anaes.) (Assist.)	463.50
30294	Cervical oesophagectomy with tracheostomy and oesophagostomy, with or without plastic reconstruction, or laryngopharyngectomy with tracheostomy and plastic reconstruction (H) (Anaes.) (Assist.)	1,834.15
30296	Thyroidectomy, total (H) (Anaes.) (Assist.)	1,065.20
30297	Thyroidectomy following previous thyroid surgery (H) (Anaes.) (Assist.)	1,065.20
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.)	663.25
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.)	795.90
30302	Sentinel lymph node biopsy, or biopsies, for breast cancer: (a) involving dissection in a level one axilla; and	530.60

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(b) using lymphotropic dye injection; other than a service to which item 30299, 30300 or 30303 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.)	636.65
30306	Total hemithyroidectomy (H) (Anaes.) (Assist.)	831.00
30310	Partial or subtotal thyroidectomy (H) (Anaes.) (Assist.)	831.00
30314	Thyroglossal cyst or fistula or both, radical removal of, including thyroglossal duct and portion of hyoid bone, on a patient 10 years of age or over (H) (Anaes.) (Assist.)	475.90
30315	Minimally invasive parathyroidectomy. Removal of one or more parathyroid adenomas through a small cervical incision for an image localised adenoma, including thymectomy Applicable only once per occasion on which the service is provided Not applicable to a service performed in association with a service to which item 30317, 30318 or 30320 applies (H) (Anaes.) (Assist.)	1,186.10
30317	Redo parathyroidectomy. Cervical re-exploration for persistent or recurrent hyperparathyroidism, including thymectomy and cervical exploration of the mediastinum Applicable only once per occasion on which the service is provided Not applicable to a service performed in association with a service to which item 30315, 30318 or 30320 applies (H) (Anaes.) (Assist.)	1,420.20
30318	Open parathyroidectomy, exploration and removal of one or more adenomas or hyperplastic glands via a cervical incision including thymectomy and cervical exploration of the mediastinum (when performed) Applicable only once per occasion on which the service is provided Not applicable to a service performed in association with a service to which item 30315, 30317 or 30320 applies (H) (Anaes.) (Assist.)	1,186.10
30320	Removal of a mediastinal parathyroid adenoma via sternotomy or mediastinal thorascopic approach Applicable only once per occasion on which the service is provided Not applicable to a service performed in association with a service to which item 30315, 30317 or 30318 applies (H) (Anaes.) (Assist.)	1,420.20
30323	Excision of phaeochromocytoma or extra-adrenal paraganglioma via endoscopic or open approach (H) (Anaes.) (Assist.)	1,420.20

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
30324	Excision of an adrenocortical tumour or hyperplasia via endoscopic or open approach (H) (Anaes.) (Assist.)	1,420.20
30326	Thyroglossal cyst or fistula or both, radical removal of, including thyroglossal duct and portion of hyoid bone, on a patient under 10 years of age (H) (Anaes.) (Assist.)	618.65
30329	Lymph nodes of groin, limited excision of (Anaes.)	256.95
30330	Lymph nodes of groin, radical excision of (H) (Anaes.) (Assist.)	747.85
30332	Lymph nodes of axilla, limited excision of (sampling) (H) (Anaes.) (Assist.)	360.80
30335	Lymph nodes of axilla, complete excision of, to level I (H) (Anaes.) (Assist.)	901.95
30336	Lymph nodes of axilla, complete excision of, to level II or III (H) (Anaes.) (Assist.)	1,082.40
30382	Enterocutaneous fistula, repair of, if dissection and resection of bowel is performed, with or without anastomosis or formation of a stoma (H) (Anaes.) (Assist.)	1,359.85
30384	Open or minimally invasive excision of a retroperitoneal mass, 4 cm or greater in largest dimension, lasting more than 3 hours, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	1,420.20
30385	Unplanned return to theatre for laparotomy or laparoscopy for control or drainage of intra-abdominal haemorrhage following abdominal surgery (H) (Anaes.) (Assist.)	586.15
30387	Laparoscopy or laparotomy when an operation is performed on abdominal, retroperitoneal or pelvic viscera, excluding lymph node biopsy, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	660.75
30388	Laparotomy for abdominal trauma, including control of haemorrhage (with or without packing) and containment of contamination (H) (Anaes.) (Assist.)	1,108.20
30390	Laparoscopy, diagnostic, with or without aspiration of fluid, on a patient 10 years of age or over, if no other intra-abdominal procedure is performed (H) (Anaes.) (Assist)	228.85
30392	Radical or debulking operation for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure (H) (Anaes.) (Assist.)	701.85
30396	Laparotomy or laparoscopy for generalised intra-peritoneal sepsis (also known as peritonitis), with or without removal of foreign material or enteric contents, with lavage of the entire peritoneal cavity, with or without closure of the abdomen when performed by laparotomy (H) (Anaes.) (Assist.)	1,057.75
30397	Laparostomy, via wound previously made and left open or closed, including change of dressings or packs, with or without drainage of loculated collections (H) (Anaes.)	241.75
30399	Laparostomy, final closure of wound made at previous operation,	332.50

Clause 5.10.9

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	after removal of dressings or packs (H) (Anaes.) (Assist.)	
30400	Laparotomy with insertion of portacath for administration of cytotoxic therapy including placement of reservoir (H) (Anaes.) (Assist.)	658.10
30406	Paracentesis abdominis (Anaes.)	54.35
30408	Peritoneo venous shunt, insertion of (H) (Anaes.) (Assist.)	408.00
30409	Liver biopsy, percutaneous (Anaes.)	181.50
30411	Liver biopsy by wedge excision when performed in association with another intra-abdominal procedure (H) (Anaes.)	92.35
30412	Liver biopsy by core needle, when performed in conjunction with another intra-abdominal procedure (Anaes.)	54.50
30414	Liver, subsegmental resection of, (local excision), other than for trauma (H) (Anaes.) (Assist.)	717.75
30415	Liver, segmental resection of, other than for trauma (H) (Anaes.) (Assist.)	1,435.35
30416	Liver cysts, greater than 5 cm in diameter, marsupialisation of 4 or less (H) (Anaes.) (Assist.)	779.30
30417	Liver cysts, greater than 5 cm in diameter, marsupialisation of 5 or more (H) (Anaes.) (Assist.)	1,168.90
30418	Liver, lobectomy of, other than for trauma (H) (Anaes.) (Assist.)	1,662.30
30419	Liver tumour, other than a hepatocellular carcinoma, destruction of one or more, by local ablation, other than a service associated with a service to which item 50950 or 50952 applies (Anaes.) (Assist.)	850.20
30421	Liver, extended lobectomy of, or central resections of segments 4, 5 and 8, other than for trauma (H) (Anaes.) (Assist.)	2,077.50
30422	Liver, repair of superficial laceration of, for trauma (H) (Anaes.) (Assist.)	702.70
30425	Liver, repair of deep multiple lacerations of, or debridement of, for trauma (H) (Anaes.) (Assist.)	1,359.85
30427	Liver, segmental resection of, for trauma (H) (Anaes.) (Assist.)	1,624.25
30428	Liver, lobectomy of, for trauma (Anaes.) (Assist.)	1,737.65
30430	Liver, extended lobectomy of, or central resections of segments 4, 5 and 8, for trauma (Anaes.) (Assist.)	2,417.40
30431	Liver abscess, single, open or minimally invasive abdominal drainage of, excluding aftercare (Anaes.) (Assist.)	542.40
30433	Liver abscess, multiple, open or minimally invasive abdominal drainage of, excluding aftercare (H) (Anaes.) (Assist.)	755.45
30439	Intraoperative ultrasound of biliary tract, or operative cholangiography, if the service: (a) is performed in association with an intra-abdominal procedure; and (b) is not associated with a service to which item 30443 or 30445 applies	193.10

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(H) (Anaes.) (Assist.)	
30440	Cholangiogram, percutaneous transhepatic, and insertion of biliary drainage tube, using interventional imaging techniques, other than a service associated with a service to which item 30451 applies (Anaes.) (Assist.)	547.70
30441	Intraoperative ultrasound for staging of intra-abdominal tumours (H) (Anaes.)	141.80
30442	Choledochoscopy in conjunction with another procedure (H) (Anaes.)	193.10
30443	Cholecystectomy, by any approach, without cholangiogram (H) (Anaes.) (Assist.)	668.45
30445	Cholecystectomy, by any approach, with attempted or completed cholangiogram or intraoperative ultrasound of the biliary system, when performed via laparoscopic or open approach or when conversion from laparoscopic to open approach is required (H) (Anaes.) (Assist.)	865.85
30448	Cholecystectomy, by any approach, involving removal of common duct calculi via the cystic duct, with or without stent insertion (H) (Anaes.) (Assist.)	1,012.35
30449	Cholecystectomy with removal of common duct calculi via choledochotomy, by any approach, with or without insertion of a stent (H) (Anaes.) (Assist.)	1,125.70
30450	Calculus of biliary tract, extraction of, using interventional imaging techniques (Anaes.) (Assist.)	545.65
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.)	278.55
30452	Choledochoscopy with balloon dilatation of a stricture or passage of stent or extraction of calculi (H) (Anaes.) (Assist.)	392.80
30454	Choledochotomy without cholecystectomy, with or without removal of calculi (H) (Anaes.) (Assist.)	1,371.65
30455	Choledochotomy with cholecystectomy, with removal of calculi, including biliary intestinal anastomosis (H) (Anaes.) (Assist.)	1,371.65
30457	Choledochotomy, intrahepatic, involving removal of intrahepatic bile duct calculi (Anaes.) (Assist.)	1,435.35
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.)	1,055.10
30460	Cholecystoduodenostomy, cholecystoenterostomy, choledochojejunostomy or Roux-en-Y loop as a bypass procedure when no prior biliary surgery performed (H) (Anaes.) (Assist.)	897.45
30461	Radical resection of porta hepatis (including associated neuro-lymphatic tissue), for cancer, suspected cancer or choledochal	1,538.30

Clause 5.10.9

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	cyst, including bile duct excision and biliary-enteric anastomoses, other than a service associated with a service to which item 30440, 30451 or 31454 applies (H) (Anaes.) (Assist.)	
30463	Radical resection of common hepatic duct and right and left hepatic ducts, with 2 duct anastomoses, for cancer, suspected cancer or choledochal cyst (H) (Anaes.) (Assist.)	1,888.75
30464	Radical resection of common hepatic duct and right and left hepatic ducts, for cancer, suspected cancer or choledochal cyst, involving either or both of the following: (a) more than 2 anastomoses; (b) resection of segment (or major portion of segment) of liver (H) (Anaes.) (Assist.)	2,266.50
30469	Biliary stricture, repair of, after one or more operations on the biliary tree (Anaes.) (Assist.)	1,790.65
30472	Repair of bile duct injury, including immediate reconstruction, other than a service associated with a service to which item 30584 applies (H) (Anaes.) (Assist.)	1,386.90
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 30478 or 30479 applies (Anaes.)	184.30
30475	Endoscopic dilatation of stricture of upper gastrointestinal tract (including the use of imaging intensification if clinically indicated) (Anaes.)	363.10
30478	Oesophagoscopy (other than a service to which item 41816, 41822 or 41825 applies), gastroscopy, duodenoscopy, panendoscopy or push enteroscopy, one or more such procedures, if: (a) the procedures are performed using one or more of the following endoscopic procedures: (i) polypectomy; (ii) sclerosing or adrenalin injections; (iii) banding; (iv) endoscopic clips; (v) haemostatic powders; (vi) diathermy; (vii) argon plasma coagulation; and (b) the procedures are for the treatment of one or more of the following: (i) upper gastrointestinal tract bleeding; (ii) polyps; (iii) removal of foreign body; (iv) oesophageal or gastric varices; (v) peptic ulcers; (vi) neoplasia; (vii) benign vascular lesions; (viii) strictures of the gastrointestinal tract;	255.55

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(ix) tumorous overgrowth through or over oesophageal stents; other than a service associated with a service to which item 30473 or 30479 applies (Anaes.)	
30479	Endoscopy with laser therapy, for the treatment of one or more of the following: (a) neoplasia; (b) benign vascular lesions; (c) strictures of the gastrointestinal tract; (d) tumorous overgrowth through or over oesophageal stents; (e) peptic ulcers; (f) angiodysplasia; (g) gastric antral vascular ectasia; (h) post-polypectomy bleeding; other than a service associated with a service to which item 30473 or 30478 applies (Anaes.)	495.35
30481	Percutaneous gastrostomy (initial procedure): (a) including any associated imaging services; and (b) excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.)	371.45
30482	Percutaneous gastrostomy (repeat procedure): (a) including any associated imaging services; and (b) excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.)	264.10
30483	Gastrostomy button, caecostomy antegrade enema device (chait etc.) or stomal indwelling device: (a) non-endoscopic insertion of; or (b) non-endoscopic replacement of; on a patient 10 years of age or over, excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.)	184.25
30484	Endoscopic retrograde cholangio-pancreatography (Anaes.)	379.70
30485	Endoscopic sphincterotomy with or without extraction of stones from common bile duct (Anaes.)	586.15
30488	Small bowel intubation—as an independent procedure (Anaes.)	93.65
30490	Oesophageal prosthesis, insertion of, including endoscopy and dilatation (Anaes.)	547.70
30491	Bile duct, endoscopic stenting of (including endoscopy and dilatation) (Anaes.)	577.85
30492	Bile duct, percutaneous stenting of (including dilatation when performed), using interventional imaging techniques (H) (Anaes.)	819.20
30494	Endoscopic biliary dilatation (H) (Anaes.)	437.55

Clause 5.10.9

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
30495	Percutaneous biliary dilatation for biliary stricture using interventional imaging techniques (H) (Anaes.)	819.20
30515	Gastroenterostomy (including gastroduodenostomy), enterocolostomy or enteroenterostomy, as an independent procedure or in combination with another procedure, only if required for irresectable obstruction, other than a service to which any of items 31569 to 31581 apply (H) (Anaes.) (Assist.)	732.90
30517	Revision of gastroenterostomy, pyloroplasty or gastroduodenostomy (H) (Anaes.) (Assist.)	959.55
30518	Partial gastrectomy, not being a service associated with a service to which any of items 31569 to 31581 apply (H) (Anaes.) (Assist.)	1,027.50
30520	Gastric tumour, 2 cm or greater in diameter, removal of, by local excision, by laparoscopic or open approach, including any associated anastomosis, excluding polypectomy, other than a service to which item 30518 applies (H) (Anaes.) (Assist.)	884.00
30521	Gastrectomy, total, for benign disease (H) (Anaes.) (Assist.)	1,503.40
30526	Gastrectomy, total, and removal of lower oesophagus, performed by open or minimally invasive approach, with anastomosis in the mediastinum, including any of the following (if performed): (a) distal pancreatectomy; (b) nodal dissection; (c) splenectomy (H) (Anaes.) (Assist.)	2,243.70
30529	Antireflux operation by fundoplasty, with oesophagoplasty for stricture or short oesophagus (H) (Anaes.) (Assist.)	1,359.85
30530	Antireflux operation by cardiopexy, with or without fundoplasty (H) (Anaes.) (Assist.)	816.00
30532	Oesophagogastric myotomy (Heller's operation) by endoscopic, abdominal or thoracic approach, whether performed by open or minimally invasive approach, including fundoplication when performed laparoscopically (H) (Anaes.) (Assist.)	936.90
30533	Oesophagogastric myotomy (Heller's operation) via abdominal or thoracic approach, with fundoplasty, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (H) (Anaes.) (Assist.)	1,114.40
30559	Oesophagus, local excision for tumour of (Anaes.) (Assist.)	884.00
30560	Oesophageal perforation, repair of, by abdominal or thoracic approach, including thoracic drainage (H) (Anaes.) (Assist.)	982.05
30562	Enterostomy or colostomy, closure of (not involving resection of bowel), on a patient 10 years of age or over (H) (Anaes.) (Assist.)	619.05
30563	Colostomy or ileostomy, refashioning of, on a patient 10 years of age or over (Anaes.) (Assist.)	619.05
30565	Small intestine, resection of, without anastomosis (including formation of stoma) (H) (Anaes.) (Assist.)	906.65

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
30574	Appendicectomy, when performed in conjunction with another intra-abdominal procedure and during which a specimen is collected and sent for pathological testing (H) (Anaes.)	64.10
30577	Initial pancreatic necrosectomy by open, laparoscopic or endoscopic approach, excluding aftercare (H) (Anaes.) (Assist.)	1,133.30
30583	Distal pancreatectomy with splenic preservation, by open or minimally invasive approach (H) (Anaes.) (Assist.)	1,617.35
30584	Pancreatico-duodenectomy (Whipple's procedure), with or without preservation of pylorus, including any of the following (if performed): (a) cholecystectomy; (b) pancreatico-biliary anastomosis; (c) gastro-jejunal anastomosis (H) (Anaes.) (Assist.)	3,121.55
30589	Pancreatico-jejunostomy for pancreatitis or trauma (H) (Anaes.) (Assist.)	1,301.75
30590	Pancreatico-jejunostomy following previous pancreatic surgery (H) (Anaes.) (Assist.)	1,435.35
30593	Pancreatectomy, near total or total (including duodenum), with or without splenectomy (Anaes.) (Assist.)	1,964.20
30594	Pancreatectomy for pancreatitis following previously attempted drainage procedure or partial resection (H) (Anaes.) (Assist.)	2,266.50
30596	Splenorrhaphy or partial splenectomy (H) (Anaes.) (Assist.)	933.65
30599	Splenectomy, for massive spleen (weighing more than 1,500 g) or involving thoraco-abdominal incision (H) (Anaes.) (Assist.)	1,359.85
30600	Emergency repair of diaphragmatic laceration or hernia, following recent trauma, by any approach, including when performed in conjunction with another procedure indicated as a result of abdominal or chest trauma (H) (Anaes.) (Assist.)	808.60
30601	Diaphragmatic hernia, congenital, or delayed presentation of traumatic rupture, repair of, by thoracic or abdominal approach, on a patient 10 years of age or over, other than a service to which any of items 31569 to 31581 apply (H) (Anaes.) (Assist.)	996.10
30606	Portal hypertension, oesophageal transection via stapler or oversew of gastric varices with or without devascularisation (H) (Anaes.) (Assist.)	1,155.80
30608	Small intestine, resection of, with anastomosis, on a patient under 10 years of age (H) (Anaes.) (Assist.)	1,309.25
30611	Benign tumour of soft tissue (other than tumours of skin, cartilage and bone, simple lipomas covered by item 31345 and lipomata), removal of, by surgical excision, on a patient under 10 years of age, if the specimen excised is sent for histological confirmation of diagnosis, other than a service to which another item in this Group applies (Anaes.) (Assist.)	586.20
30615	Strangulated, incarcerated or obstructed hernia, repair of, without	542.40

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	bowel resection, on a patient 10 years of age or over (H) (Anaes.) (Assist.)	
30618	Lymph nodes of neck, selective dissection of one or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck, on a patient under 10 years of age (Anaes.) (Assist.)	543.40
30619	Laparoscopic splenectomy, on a patient under 10 years of age (H) (Anaes.) (Assist.)	974.20
30621	Repair of symptomatic umbilical, epigastric or linea alba hernia requiring mesh or other repair, by open or minimally invasive approach, in a patient 10 years of age or over, other than a service to which item 30651 or 30655 applies (H) (Anaes.) (Assist.)	424.00
30622	Caecostomy, enterostomy, colostomy, enterotomy, colotomy, cholecystostomy, gastrostomy, gastrotomy, reduction of intussusception, removal of Meckel's diverticulum, suture of perforated peptic ulcer, simple repair of ruptured viscus, reduction of volvulus, pyloroplasty or drainage of pancreas, on a patient under 10 years of age (H) (Anaes.) (Assist.)	705.15
30623	Laparotomy involving division of peritoneal adhesions (if no other intra-abdominal procedure is performed), on a patient under 10 years of age (H) (Anaes.) (Assist.)	705.15
30626	Laparotomy involving division of adhesions in association with another intra-abdominal procedure if the time taken to divide the adhesions is between 45 minutes and 2 hours, on a patient under 10 years of age (H) (Anaes.) (Assist.)	708.40
30627	Laparoscopy, diagnostic, if no other intra-abdominal procedure is performed, on a patient under 10 years of age (H) (Anaes.)	297.55
30628	Hydrocele, tapping of	37.05
30629	Orchidectomy, radical, including spermatic cord, unilateral, for tumour, inguinal approach, without insertion of testicular prosthesis, other than a service associated with a service to which item 30631, 30635, 30641, 30643 or 30644 applies (H) (Anaes.) (Assist.)	542.40
30631	Hydrocele, removal of, other than a service associated with a service to which item 30641, 30642 or 30644 applies (Anaes.)	246.25
30635	Varicocele, surgical correction of, including microsurgical techniques, other than a service associated with a service to which item 30390, 30627, 30641, 30642 or 30644 applies—one procedure (H) (Anaes.) (Assist.)	303.60
30636	Gastrostomy button, caecostomy antegrade enema device (chait etc.) or stomal indwelling device, non-endoscopic insertion of, or non-endoscopic replacement of, on a patient under 10 years of age (Anaes.)	242.60
30637	Enterostomy or colostomy, closure of (not involving resection of bowel), on a patient under 10 years of age (H) (Anaes.) (Assist.)	804.90
30639	Colostomy or ileostomy, refashioning of, on a patient under 10 years of age (Anaes.) (Assist.)	804.90
30640	Repair of large and irreducible scrotal hernia, if surgery exceeds 2	952.05

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	hours, in a patient 10 years of age or over, other than a service to which item 30615, 30621, 30648, 30651 or 30655 applies (H) (Anaes.) (Assist.)	
30641	Orchidectomy, simple or subcapsular, unilateral with or without insertion of testicular prosthesis (H) (Anaes.) (Assist.)	424.00
30642	Orchidectomy, radical, including spermatic cord, unilateral, for tumour, inguinal approach, with insertion of testicular prosthesis, other than a service associated with a service to which item 30631, 30635, 30641, 30643, 30644 or 45051 applies (H) (Anaes.) (Assist.)	788.90
30643	Exploration of spermatic cord, inguinal approach, with or without testicular biopsy, with or without excision of spermatic cord lesion, for a patient under 10 years of age, other than a service associated with a service to which item 30629, 30630 or 30642 applies (H) (Anaes.) (Assist.)	705.15
30644	Exploration of spermatic cord, inguinal approach, with or without testicular biopsy, with or without excision of spermatic cord lesion, for a patient at least 10 years of age, other than a service associated with a service to which item 30629, 30630 or 30642 applies (H) (Anaes.) (Assist.)	542.40
30645	Appendicectomy, on a patient under 10 years of age, other than a service to which item 30574 applies (H) (Anaes.) (Assist.)	602.40
30646	Laparoscopic appendicectomy, on a patient under 10 years of age (H) (Anaes.) (Assist.)	602.40
30648	Femoral or inguinal hernia or infantile hydrocele, repair of, by open or minimally invasive approach, on a patient 10 years of age or over, other than a service to which item 30615 or 30651 applies (H) (Anaes.) (Assist.)	483.35
30649	Haemorrhage, arrest of, following circumcision requiring general anaesthesia, on a patient under 10 years of age (Anaes.)	195.25
30651	Ventral hernia repair involving primary fascial closure by suture, with or without onlay mesh or insertion of intraperitoneal onlay mesh repair, without closure of the defect or advancement of the rectus muscle toward the midline, by open or minimally invasive approach, in a patient 10 years of age or over, other than a service to which item 30621, 30655 or 30657 applies (H) (Anaes.) (Assist.)	542.40
30652	Recurrent groin hernia regardless of size of defect, repair of, with or without mesh, by open or minimally invasive approach, in a patient 10 years of age or over (H) (Anaes.) (Assist.)	542.40
30654	Circumcision of the penis, with topical or local analgesia, other than a service to which item 30658 applies	48.40
30655	Ventral hernia, repair of, with advancement of the rectus muscles to the midline using a retro-rectus, pre-peritoneal or sublay technique, by open or minimally invasive approach, in a patient 10 years of age or over, other than a service to which item 30621 or 30651 applies (H) (Anaes.) (Assist.)	952.05
30657	Unilateral abdominal wall reconstruction with component separation,	1,355.65

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	including transversus abdominus release and external oblique release for abdominal wall closure by mobilising the rectus abdominis muscles to the midline, by open or minimally invasive approach (H) (Anaes.) (Assist.)	
30658	Circumcision of the penis, when performed under general or regional anaesthesia and in conjunction with a service to which an item in Group T7 or Group T10 applies (Anaes.)	147.70
30663	Haemorrhage, arrest of, following circumcision requiring general anaesthesia, on a patient 10 years of age or over (Anaes.)	150.20
30666	Paraphimosis or phimosis, reduction of, under general anaesthesia, with or without dorsal incision, other than a service associated with a service to which another item in this Group applies (Anaes.)	49.35
30672	Coccyx, excision of (H) (Anaes.) (Assist.)	463.50
30676	Pilonidal sinus or cyst, or sacral sinus or cyst, definitive excision of (Anaes.)	394.40
30679	Pilonidal sinus, injection of sclerosant fluid under anaesthesia (Anaes.)	100.20
30680	Balloon enteroscopy, examination of the small bowel (oral approach), with or without biopsy, without intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding if the patient: (a) has recurrent or persistent bleeding; and (b) is anaemic or has active bleeding; and (c) has had an upper gastrointestinal endoscopy and a colonoscopy performed that did not identify the cause of the bleeding; not in association with another item in this Subgroup (other than item 30682 or 30686) (Anaes.)	1,217.40
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.)	1,217.40
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	1,498.20

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(c) has had an upper gastrointestinal endoscopy and a colonoscopy performed that did not identify the cause of the bleeding; not in association with another item in this Subgroup (other than item 30682 or 30686) (Anaes.)	
30686	Balloon enteroscopy, examination of the small bowel (anal approach), with or without biopsy, with one or more of the following procedures—snare polypectomy, removal of foreign body, diathermy, heater probe, laser coagulation or argon plasma coagulation, for diagnosis and management of patients with obscure gastrointestinal bleeding if the patient: (a) has recurrent or persistent bleeding; and (b) is anaemic or has active bleeding; and (c) has had an upper gastrointestinal endoscopy and a colonoscopy performed that did not identify the cause of the bleeding; not in association with another item in this Subgroup (other than item 30680 or 30684) (Anaes.)	1,498.20
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.)	495.35
30688	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the staging of one or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis (Anaes.)	379.70
30690	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, with fine needle aspiration (including aspiration of the locoregional lymph nodes if performed, for the staging of one or more of oesophageal, gastric or pancreatic cancer), not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis (Anaes.)	586.15
30692	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the diagnosis of one or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis (Anaes.)	379.70
30694	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, with fine needle aspiration for the diagnosis of one or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis (Anaes.)	586.15
30720	Appendicectomy, on a patient 10 years of age or over, whether	463.50

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	performed by: (a) laparoscopy or right iliac fossa open incision; or (b) conversion of a laparoscopy to an open right iliac fossa incision; other than a service to which item 30574 applies (H) (Anaes.) (Assist.)	
30721	Laparotomy or laparoscopy, or laparoscopy converted to laparotomy, with or without associated biopsies, including the division of adhesions (if performed, but only if the time taken to divide adhesions is 45 minutes or less), if no other intra-abdominal procedure is performed (H) (Anaes.) (Assist.)	502.85
30722	Laparotomy or laparoscopy, on a patient 10 years of age or over, including any of the following procedures (if performed, and including division of one or more adhesions, but only if the time taken to divide the adhesions is 45 minutes or less): (a) colostomy; (b) colotomy; (c) cholecystostomy; (d) enterostomy; (e) enterotomy; (f) gastrostomy; (g) gastrotomy; (h) caecostomy; (i) gastric fixation by cardiopexy; (j) reduction of intussusception; (k) simple repair of ruptured viscus (including perforated peptic ulcer); (l) reduction of volvulus; (m) drainage of pancreas (H) (Anaes.) (Assist.)	542.40
30723	Laparotomy, laparoscopy or extra-peritoneal approach, for drainage of an intra-abdominal, pancreatic or retroperitoneal collection or abscess (H) (Anaes.) (Assist.)	542.40
30724	Laparotomy or laparoscopy with division of adhesions, lasting more than 45 minutes but less than 2 hours, performed either: (a) as a primary procedure; or (b) when the division of adhesions is performed in conjunction with another primary procedure—to provide access to a surgical field (but excluding mobilisation or normal anatomical dissection of the organ or structure for which the primary procedure is being carried out) (H) (Anaes.) (Assist.)	544.95
30725	Laparotomy or laparoscopy for intestinal obstruction or division of extensive, complex adhesions, lasting 2 hours or more, performed either:	965.75

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) as a primary procedure; or (b) when the division of adhesions is performed in conjunction with another procedure—to provide access to a surgical field, but excluding mobilisation or normal anatomical dissection of the organ or structure for which the other procedure is being carried out (H) (Anaes.) (Assist.)	
30730	Small intestine, resection of, including either of the following: (a) a small bowel diverticulum (such as Meckel's procedure) with anastomosis; (b) stricturoplasty (H) (Anaes.) (Assist.)	1,007.10
30731	Intraoperative enterotomy for visualisation of the small intestine by endoscopy, including endoscopic examination using a flexible endoscope, with or without biopsies (H) (Anaes.) (Assist.)	755.45
30732	Peritonectomy, lasting more than 5 hours, including hyperthermic intra-peritoneal chemotherapy (H) (Anaes.) (Assist.)	4,136.10
30750	Oesophagectomy with colon or jejunal interposition graft, by any approach, including: (a) any gastrointestinal anastomoses (except vascular anastomoses); and (b) anastomoses in the chest or neck (if appropriate) One surgeon (H) (Anaes.) (Assist.)	2,145.80
30751	Oesophagectomy with colon or jejunal interposition graft, by any approach, including: (a) any gastrointestinal anastomoses (except vascular anastomoses); and (b) anastomoses in the chest or neck (if appropriate) Conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	2,145.80
30752	Oesophagectomy with colon or jejunal interposition graft, by any approach, including: (a) any gastrointestinal anastomoses (except vascular anastomoses); and (b) anastomoses in the chest or neck (if appropriate) Conjoint surgery, co-surgeon (H) (Anaes.) (Assist.)	1,609.35
30753	Oesophagectomy, by any approach, including: (a) gastric reconstruction by abdominal mobilisation, thoracotomy or thoracoscopy; and (b) anastomosis in the neck or chest One surgeon (H) (Anaes.) (Assist.)	1,790.65
30754	Oesophagectomy, by any approach, including: (a) gastric reconstruction by abdominal mobilisation, thoracotomy or thoracoscopy; and (b) anastomosis in the neck or chest	1,790.65

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	Conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	
30755	Oesophagectomy by any approach, including: (a) gastric reconstruction by abdominal mobilisation, thoracotomy or thoracoscopy; and (b) anastomosis in the neck or chest Conjoint surgery, co-surgeon (H) (Anaes.) (Assist.)	1,343.00
30756	Antireflux operation by fundoplasty, with or without cardiopexy, by any approach, with or without closure of the diaphragmatic hiatus, other than a service to which item 30601 applies (H) (Anaes.) (Assist.)	906.65
30760	Vagotomy, with or without gastroenterostomy, pyloroplasty or other drainage procedure (H) (Anaes.) (Assist.)	611.95
30761	Bleeding peptic ulcer, control of, by laparoscopy or laparotomy, involving suture of bleeding point or wedge excision (with or without gastric resection), including either of the following (if performed): (a) vagotomy and pyloroplasty; (b) gastroenterostomy (H) (Anaes.) (Assist.)	789.45
30762	Gastrectomy, subtotal or total radical, for carcinoma, by open or minimally invasive approach, including all necessary anastomoses, including either or both of the following (if performed): (a) extended lymph node dissection; (b) splenectomy (H) (Anaes.) (Assist.)	1,730.05
30763	Gastric tumour, 2cm or greater in diameter, removal of, by local excision, by endoscopic approach, including any required anastomosis, excluding polypectomy, other than a service to which item 30518 applies (H) (Anaes.) (Assist.)	702.70
30770	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.)	870.25
30771	Portal hypertension, porto-caval, meso-caval or selective spleno-renal shunt for (H) (Anaes.) (Assist.)	1,755.20
30780	Intrahepatic biliary bypass of left or right hepatic ductal system by Roux-en-Y loop to peripheral ductal system (H) (Anaes.) (Assist.)	1,461.85
30790	Pancreatic cyst anastomosis to stomach, duodenum or small intestine, by endoscopic, open or minimally invasive approach, with or without the use of endoscopic or intraoperative ultrasound (H) (Anaes.) (Assist.)	729.70
30791	Pancreatic necrosectomy, by open, laparoscopic or endoscopic approach, excluding aftercare, subsequent procedure (H) (Anaes.) (Assist.)	453.35
30792	Distal pancreatectomy with splenectomy, by open or minimally invasive approach (H) (Anaes.) (Assist.)	1,242.65

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
30800	Splenectomy, by open or minimally invasive approach, other than a service to which item 30792 applies (H) (Anaes.) (Assist.)	749.40
30810	Exploration of pancreas or duodenum for endocrine tumour, including associated imaging, either: (a) followed by local excision of tumour; or (b) when, after extensive exploration, no tumour is found (H) (Anaes.) (Assist.)	1,193.70
30820	Lymph node of neck, biopsy of, by open procedure, if the specimen excised is sent for pathological examination (Anaes.)	191.35
31000	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (below knee) or foot, utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—6 or fewer sections (Anaes.)	604.45
31001	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (below knee) or foot, utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—7 to 12 sections (inclusive) (Anaes.)	755.45
31002	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (below knee) or foot, utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—13 or more sections (Anaes.)	906.65
31003	Mohs surgery of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—6 or fewer sections Not applicable to a service performed in association with a service to which item 31000 applies (Anaes.)	604.45
31004	Mohs surgery of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—7 to 12 sections (inclusive) Not applicable to a service performed in association with a service to which item 31001 applies (Anaes.)	755.45
31005	Mohs surgery of skin tumour utilising horizontal frozen sections with	906.65

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—13 or more sections Not applicable to a service performed in association with a service to which item 31002 applies (Anaes.)	
31206	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if: (a) the lesion size is not more than 10 mm in diameter; and (b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) the specimen excised is sent for histological examination (Anaes.)	99.35
31211	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if: (a) the lesion size is more than 10 mm, but not more than 20 mm, in diameter; and (b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) the specimen excised is sent for histological examination (Anaes.)	128.10
31216	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if: (a) the lesion size is more than 20 mm in diameter; and (b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) the specimen excised is sent for histological examination (Anaes.)	149.40
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 to 10 lesions and suture, if: (a) the size of each lesion is not more than 10 mm in diameter; and (b) each removal is from cutaneous or subcutaneous tissue by surgical excision (other than by shave excision); and (c) all of the specimens excised are sent for histological examination (Anaes.)	223.25
31221	Tumours, cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of 4 to 10 lesions, if: (a) the size of each lesion is not more than 10 mm in diameter; and (b) each removal is from a mucous membrane by surgical excision (other than by shave excision); and (c) each site of excision is closed by suture; and (d) all of the specimens excised are sent for histological examination (Anaes.)	223.25
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,	396.75

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	if: (a) the size of each lesion is not more than 10 mm in diameter; and (b) each removal is from cutaneous or subcutaneous tissue or mucous membrane by surgical excision (other than by shave excision); and (c) each site of excision is closed by suture; and (d) all of the specimens excised are sent for histological examination (Anaes.)	
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.)	383.90
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.)	383.90
31340	Muscle, bone or cartilage, excision of one or more of, if clinically indicated, and if: (a) the specimen excised is sent for histological confirmation; and (b) a malignant tumour of skin covered by item 31000, 31001, 31002, 31003, 31004, 31005, 31356, 31358, 31359, 31361, 31363, 31365, 31367, 31369, 31371, 31372, 31373, 31374, 31375 or 31376 is excised (Anaes.)	Amount under clause 5.10.2
31345	Lipoma, removal of, by surgical excision or liposuction, if: (a) the lesion is: (i) subcutaneous and 50 mm or more in diameter; or (ii) sub-fascial; and (b) the specimen excised is sent for histological confirmation of diagnosis (Anaes.)	219.50
31346	Liposuction (suction assisted lipolysis) to one regional area for contour problems of abdominal, upper arm or thigh fat because of repeated insulin injections, if: (a) the lesion is subcutaneous; and (b) the lesion is 50 mm or more in diameter; and (c) photographic and/or diagnostic imaging evidence demonstrating the need for this service is documented in the patient notes (Anaes.)	219.50
31350	Benign tumour of soft tissue (other than tumours of skin, cartilage and bone, simple lipomas covered by item 31345 and lipomata), removal of, by surgical excision, on a patient 10 years of age or over, if the specimen excised is sent for histological confirmation of diagnosis, other than a service to which another item in this Group applies (Anaes.) (Assist.)	450.90
31355	Malignant tumour of soft tissue (other than tumours of skin or cartilage and bone), removal of, by surgical excision, if histological	743.45

Clause 5.10.9

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	proof of malignancy is obtained, other than a service to which another item in this Group applies (Anaes.) (Assist.)	
31356	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is less than 6 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.)	230.30
31357	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is less than 6 mm; and (c) the excised specimen is sent for histological examination; not in association with item 45201 (Anaes.)	114.10
31358	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is 6 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	281.85
31359	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision), if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia (the applicable site); and (b) the necessary excision area is at least one third of the surface area of the applicable site; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (H) (Anaes.)	343.55
31360	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical	174.85

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	excision (other than by shave excision) and repair of, if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is 6 mm or more; and (c) the excised specimen is sent for histological examination (Anaes.)	
31361	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is less than 14 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.)	194.30
31362	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is less than 14 mm; and (c) the excised specimen is sent for histological examination; not in association with item 45201 (Anaes.)	139.35
31363	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is 14 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	254.15
31364	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and	174.85

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(b) the necessary excision diameter is 14 mm or more; and (c) the excised specimen is sent for histological examination (Anaes.)	
31365	Malignant skin lesion (other than a malignant skin lesion covered by item 31369, 31370, 31371, 31372 or 31373), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is less than 15 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.)	164.70
31366	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31357, 31360, 31362 or 31364; and (b) the necessary excision diameter is less than 15 mm; and (c) the excised specimen is sent for histological examination; not in association with item 45201 (Anaes.)	99.35
31367	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.)	222.25
31368	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31357, 31360, 31362 or 31364; and (b) the necessary excision diameter is at least 15 mm but not more than 30mm; and (c) the excised specimen is sent for histological examination; not in association with item 45201 (Anaes.)	130.60
31369	Malignant skin lesion (other than a malignant skin lesion covered by	255.90

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is more than 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	
31370	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31357, 31360, 31362 or 31364; and (b) the necessary excision diameter is more than 30 mm; and (c) the excised specimen is sent for histological examination (Anaes.)	149.40
31371	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if: (a) the tumour is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is 6 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	371.45
31372	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if: (a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is less than 14 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.)	321.20
31373	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if: (a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and	371.25

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(b) the necessary excision diameter is 14 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	
31374	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if: (a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and (b) the necessary excision diameter is less than 15 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.)	293.30
31375	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if: (a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and (b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.)	315.65
31376	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if: (a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and (b) the necessary excision diameter is more than 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	365.85
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.)	271.65
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	313.55

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	diameter; and (b) histological confirmation of malignancy is obtained (H) (Anaes.) (Assist.)	
31406	Malignant upper aerodigestive tract tumour more than 40 mm in diameter (excluding tumour of the lip), excision of, if histological confirmation of malignancy has been obtained (Anaes.) (Assist.)	522.50
31409	Parapharyngeal tumour, excision of, by cervical approach (H) (Anaes.) (Assist.)	1,623.40
31412	Recurrent or persistent parapharyngeal tumour, excision of, by cervical approach (H) (Anaes.) (Assist.)	1,999.65
31423	Lymph nodes of neck, selective dissection of one or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck, on a patient 10 years of age or over (Anaes.) (Assist.)	418.05
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.)	836.00
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.)	1,302.85
31432	Lymph nodes of neck, bilateral selective dissection of levels I, II and III (bilateral supraomohyoid dissections) (H) (Anaes.) (Assist.)	1,393.45
31435	Lymph nodes of neck, comprehensive dissection of all 5 lymph node levels on one side of the neck (H) (Anaes.) (Assist.)	1,024.20
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.)	1,623.40
31454	Laparoscopy or laparotomy with drainage of bile, as an independent procedure (H) (Anaes.) (Assist.)	586.15
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.)	255.55
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.)	306.60
31460	Percutaneous gastrostomy tube, jejunal extension to, including any associated imaging services (H) (Anaes.) (Assist.)	371.45
31462	Operative feeding jejunostomy performed in conjunction with major upper gastro-intestinal resection (H) (Anaes.) (Assist.)	542.40
31466	Antireflux operation by fundoplasty, via abdominal or thoracic	1,359.90

Clause 5.10.9

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	approach, with or without closure of the diaphragmatic hiatus, revision procedure, by laparoscopy or open operation (H) (Anaes.) (Assist.)	
31468	Para-oesophageal hiatus hernia, repair of, with complete reduction of hernia, resection of sac and repair of hiatus, with or without fundoplication, other than a service associated with a service to which item 30756 or 31466 applies (H) (Anaes.) (Assist.)	1,494.05
31472	Cholecystoduodenostomy, cholecystoenterostomy, choledochojejunostomy or Roux-en-y loop to provide biliary drainage or bypass, other than a service associated with a service to which item 30584 applies (H) (Anaes.) (Assist.)	1,399.80
31500	Breast, benign lesion up to and including 50 mm in diameter, including simple cyst, fibroadenoma or fibrocystic disease, open surgical biopsy or excision of, with or without frozen section histology (Anaes.)	270.55
31503	Breast, benign lesion more than 50 mm in diameter, excision of (Anaes.) (Assist.)	360.80
31506	Breast, abnormality detected by mammography or ultrasound, if guidewire or other localisation procedure is performed, excision biopsy of (H) (Anaes.) (Assist.)	405.90
31509	Breast, malignant tumour, open surgical biopsy of, with or without frozen section histology (Anaes.)	360.80
31512	Breast, malignant tumour, complete local excision of, with or without frozen section histology (H) (Anaes.) (Assist.)	676.50
31515	Breast, tumour site, re-excision of, following open biopsy or incomplete excision of malignant tumour (H) (Anaes.) (Assist.)	453.85
31516	Breast, malignant tumour, complete local excision of, with or without frozen section histology when targeted intraoperative radiation therapy (using an Intrabeam® or Xoft® Axxent® device) is performed concurrently, if the patient satisfies the requirements mentioned in paragraphs (a) to (g) of item 15900 Applicable only once per breast per lifetime (H) (Anaes.) (Assist.)	902.10
31519	Breast, total mastectomy (H) (Anaes.) (Assist.)	765.90
31524	Breast, subcutaneous mastectomy (H) (Anaes.) (Assist.)	1,082.40
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.)	541.05
31530	Breast, biopsy of solid tumour or tissue of, using a vacuum-assisted breast biopsy device under imaging guidance, for histological examination, if imaging has demonstrated: (a) microcalcification of lesion; or (b) impalpable lesion less than one cm in diameter; including pre-operative localisation of lesion, if performed, other than a service associated with a service to which item 31548 applies	619.85
31533	Fine needle aspiration of an impalpable breast lesion detected by	143.50

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	mammography or ultrasound, imaging guided—but not including imaging (Anaes.)	
31536	Breast, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques, but not including imaging (Anaes.)	197.10
31548	Breast, biopsy of solid tumour or tissue of, using mechanical biopsy device, for histological examination, other than a service associated with a service to which item 31530 applies (Anaes.)	208.10
31551	Breast, haematoma, seroma or inflammatory condition including abscess, granulomatous mastitis or similar, exploration and drainage of, when performed in the operating theatre of a hospital, excluding after-care (H) (Anaes.)	225.50
31554	Breast, microdochotomy of, for benign or malignant condition (H) (Anaes.) (Assist.)	451.05
31557	Breast central ducts, excision of, for benign condition (Anaes.) (Assist.)	360.80
31560	Accessory breast tissue, excision of (Anaes.) (Assist.)	360.80
31563	Inverted nipple, surgical eversion of (Anaes.)	270.25
31566	Accessory nipple, excision of (Anaes.)	135.25
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.)	884.00
31572	Gastric bypass by Roux-en-Y loop 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.)	1,087.80
31575	Sleeve gastrectomy, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (H) (Anaes.) (Assist.)	884.00
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.)	884.00
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.)	1,087.80
31584	Surgical reversal of previous bariatric procedure, including revision or conversion, if: (a) the previous procedure involved any of the following: (i) placement of adjustable gastric banding; (ii) gastric bypass; (iii) sleeve gastrectomy; (iv) gastroplasty (excluding gastric plication); (v) biliopancreatic diversion; and (b) any of items 31569 to 31581 applied to the previous procedure;	1,601.50

Clause 5.10.10

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	other than a service associated with a service to which item 31585 applies (H) (Anaes.) (Assist.)	
31585	Removal of adjustable gastric band (H) (Anaes.) (Assist.)	865.85
31587	Adjustment of gastric band as an independent procedure including any associated consultation	101.90
31590	Adjustment of gastric band reservoir, repair, revision or replacement of (Anaes.) (Assist.)	261.95

Subdivision B—Subgroups 2 and 3 of Group T8

5.10.10 Meaning of foreign body in items 35360 to 35363

In items 35360 to 35363:

foreign body does not include an instrument inserted for the purpose of a service being rendered.

5.10.11 Application of items 32084 and 32087

If a service to which item 32084 or 32087 applies is provided by a practitioner to a patient on more than one occasion on a day, the second service is taken to be a separate service for the purposes of the item if the second service is provided under a second episode of anaesthesia or other sedation.

5.10.12 Restrictions on items 32500 to 32517 and 35321—methods of providing services

Items 32500 to 32517 and 35321 do not apply to the services described in those items if the services are delivered by:

(a) endovenous laser treatment; or
(b) radiofrequency diathermy; or
(c) radiofrequency ablation for varicose veins.

5.10.13 Restrictions on items 35404, 35406 and 35408

Restriction connected with chemotherapy using certain drugs

(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.

Restriction on provider of service in item 35404

(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.

5.10.14 When artificial bowel sphincter is contraindicated for items 32220 and 32221

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.

5.10.15 Meaning of eligible stroke centre

In this Schedule:

eligible stroke centre means a facility that:

(a) has a designated stroke unit; and

(b) is equipped and has staff available or on call so that it is capable of providing all of the following to a patient on a 24-hour basis:

(i) the services of a specialist or consultant physician who has the training required under paragraph (b) of item 35414;

(ii) diagnostic imaging services using advanced imaging techniques, including computed tomography, computed tomography angiography, digital subtraction angiography, magnetic resonance imaging and magnetic resonance angiography;

(iii) care from a team of health practitioners including a stroke physician, a neurologist, a neurosurgeon, a radiologist, an anaesthetist, an intensive care unit specialist, a medical imaging technologist and a nurse; and

(c) has dedicated endovascular angiography facilities; and

(d) has written procedures for assessing and treating patients who have, or may have, experienced a stroke.

Note: A health practitioner may fulfil the role of more than one of the types of health practitioner specified in paragraph (b)(iii). For example, a neurologist may also be a stroke physician.

5.10.16 Items in Subgroups 2 and 3 of Group T8

This clause sets out items in Subgroups 2 and 3 of Group T8.

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 2—Colorectal		
32000	Large intestine, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (H) (Anaes.) (Assist.)	1,073.10
32003	Large intestine, resection of, with anastomosis, including right hemicolectomy (H) (Anaes.) (Assist.)	1,122.50
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	1,197.00

Clause 5.10.16

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	applies (H) (Anaes.) (Assist.)	
32005	Large intestine, sub-total colectomy (resection of right colon, transverse colon and splenic flexure) with anastomosis, other than a service associated with a service to which item 32000, 32003, 32004 or 32006 applies (H) (Anaes.) (Assist.)	1,352.20
32006	Left hemicolectomy, including the descending and sigmoid colon (including formation of stoma) (H) (Anaes.) (Assist.)	1,197.00
32009	Total colectomy and ileostomy (H) (Anaes.) (Assist.)	1,419.90
32012	Total colectomy and ileo-rectal anastomosis (H) (Anaes.) (Assist.)	1,568.45
32015	Total colectomy with excision of rectum and ileostomy—one surgeon (H) (Anaes.) (Assist.)	1,927.60
32018	Total colectomy with excision of rectum and ileostomy, combined synchronous operation—abdominal resection (including after-care) (H) (Anaes.) (Assist.)	1,634.55
32021	Total colectomy with excision of rectum and ileostomy, combined synchronous operation—perineal resection (H) (Assist.)	586.15
32023	Endoscopic insertion of stent or stents for large bowel obstruction, stricture or stenosis, including colonoscopy and any image intensification, if 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.)	577.85
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.)	1,419.90
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.)	1,899.25
32026	Rectum, ultra low restorative resection, with or without covering stoma, if the anastomosis is sited in the anorectal region and is 6 cm or less from the anal verge (H) (Anaes.) (Assist.)	2,045.30
32028	Rectum, low or ultra low restorative resection, with peranal sutured coloanal anastomosis, with or without covering stoma (H) (Anaes.) (Assist.)	2,191.55
32029	Colonic reservoir, construction of, being a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	438.25
32030	Rectosigmoidectomy—(Hartmann's operation) (H) (Anaes.) (Assist.)	1,073.10
32033	Restoration of bowel following Hartmann's or similar operation, including dismantling of the stoma (H) (Anaes.) (Assist.)	1,568.45
32036	Sacrococcygeal and presacral tumour—excision of (H) (Anaes.) (Assist.)	1,989.30
32039	Rectum and anus, abdomino-perineal resection of—one surgeon (H)	1,597.25

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(Anaes.) (Assist.)	
32042	Rectum and anus, abdomino-perineal resection of, combined synchronous operation, abdominal resection (H) (Anaes.) (Assist.)	1,345.55
32045	Rectum and anus, abdomino-perineal resection of, combined synchronous operation—perineal resection (H) (Assist.)	503.60
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.)	778.20
32047	Perineal proctectomy (H) (Anaes.) (Assist.)	906.65
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.)	2,410.45
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.)	2,212.35
32057	Total colectomy with excision of rectum and ileoanal anastomosis with formation of ileal reservoir—conjoint surgery, perineal surgeon (H) (Assist.)	586.15
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.)	2,410.45
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.)	2,212.35
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.)	586.15
32069	Ileostomy reservoir, continent type, creation of, including conversion of existing ileostomy, if appropriate (H) (Anaes.)	1,783.05
32072	Sigmoidoscopic examination (with rigid sigmoidoscope), with or without biopsy	49.80
32075	Sigmoidoscopic examination (with rigid sigmoidoscope), under general anaesthesia, with or without biopsy, other than a service associated with a service to which another item in this Group applies (Anaes.)	78.10
32084	Sigmoidoscopy or colonoscopy up to the hepatic flexure, with or without biopsy, other than a service associated with a service to which any of items 32222 to 32228 applies (Anaes.)	115.90
32087	Endoscopic examination of the colon up to the hepatic flexure by sigmoidoscopy or colonoscopy for the removal of one or more polyps, other than a service associated with a service to which any of items 32222 to 32228 applies (Anaes.)	213.00
32094	Endoscopic dilatation of colorectal strictures including colonoscopy (H) (Anaes.)	574.20

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
32095	Endoscopic examination of small bowel with flexible endoscope passed by stoma, with or without biopsies (Anaes.)	133.00
32096	Rectal biopsy, full thickness, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block (H) (Anaes.) (Assist.)	267.35
32099	Rectal tumour of 5 cm or less in diameter, per anal submucosal excision of (H) (Anaes.) (Assist.)	346.75
32102	Rectal tumour of greater than 5 cm in diameter, indicated by pathological examination, per anal submucosal excision of (H) (Anaes.) (Assist.)	660.40
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.)	803.55
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.)	1,040.20
32105	Anorectal carcinoma—per anal full thickness excision of (Anaes.) (Assist.)	503.60
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.)	1,419.90
32108	Rectal tumour, trans-sphincteric excision of (Kraske or similar operation) (H) (Anaes.) (Assist.)	1,040.20
32111	Rectal prolapse, Delorme procedure for (H) (Anaes.) (Assist.)	660.40
32112	Rectal prolapse, perineal recto-sigmoidectomy for (H) (Anaes.) (Assist.)	803.55
32114	Rectal stricture, per anal release of (Anaes.)	181.50
32115	Rectal stricture, dilatation of (H) (Anaes.)	132.05
32117	Rectal prolapse, abdominal rectopexy of (H) (Anaes.) (Assist.)	1,040.20
32120	Rectal prolapse, perineal repair of (H) (Anaes.) (Assist.)	267.35
32123	Anal stricture, anoplasty for (Anaes.) (Assist.)	346.75
32126	Anal incontinence, Parks' intersphincteric procedure for (H) (Anaes.) (Assist.)	503.60
32129	Anal sphincter, direct repair of (H) (Anaes.) (Assist.)	660.40
32131	Rectocele, transanal repair of rectocele (H) (Anaes.) (Assist.)	555.25
32132	Haemorrhoids or rectal prolapse—sclerotherapy for (Anaes.)	46.90
32135	Haemorrhoids or rectal prolapse—rubber band ligation of, with or without sclerotherapy, cryotherapy or infrared therapy for (Anaes.)	70.30
32138	Haemorrhoidectomy including excision of anal skin tags when performed (Anaes.)	382.65

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
32139	Haemorrhoidectomy involving third or fourth degree haemorrhoids, including excision of anal skin tags when performed (H) (Anaes.) (Assist.)	382.65
32142	Anal skin tags or anal polyps, excision of one or more of (Anaes.)	70.30
32145	Anal skin tags or anal polyps, excision of one or more of, undertaken in the operating theatre of a hospital (H) (Anaes.)	140.50
32147	Perianal thrombosis, incision of (Anaes.)	46.90
32150	Operation for fissure-in-ano, including excision or sphincterotomy but excluding dilatation only (Anaes.) (Assist.)	267.35
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.)	72.90
32156	Fistula-in-ano, subcutaneous, excision of (Anaes.)	137.05
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.)	346.75
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.)	503.60
32165	Anal fistula, repair of by mucosal flap advancement (Anaes.) (Assist.)	660.40
32166	Anal fistula—readjustment of Seton (Anaes.)	214.55
32168	Fistula wound, review of, under general or regional anaesthetic, as an independent procedure (H) (Anaes.)	137.05
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.)	92.35
32174	Intra-anal, perianal or ischio-rectal abscess, drainage of (excluding after-care) (Anaes.)	92.35
32175	Intra-anal, perianal or ischio-rectal abscess, draining of, performed in the operating theatre of a hospital (excluding after-care) (H) (Anaes.)	169.25
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.)	181.30
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.)	267.35
32183	Intestinal sling procedure before radiotherapy (H) (Anaes.) (Assist.)	584.40
32186	Colonic lavage, total, intra-operative (H) (Anaes.) (Assist.)	584.40
32200	Distal muscle, devascularisation of (Anaes.) (Assist.)	307.70
32203	Anal or perineal graciloplasty (H) (Anaes.) (Assist.)	660.75
32206	Stimulator and electrodes, insertion of, following previous graciloplasty (H) (Anaes.) (Assist.)	596.95
32209	Anal or perineal graciloplasty with insertion of stimulator and electrodes	959.30

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(H) (Anaes.) (Assist.)	
32210	Gracilis neosphincter pacemaker, replacement of (Anaes.)	265.80
32212	Ano-rectal application of formalin in the treatment of radiation proctitis, if performed in the operating theatre of a hospital, excluding after-care (H) (Anaes.)	141.80
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; other than a patient who: (c) is medically unfit for surgery; or (d) is pregnant or planning pregnancy; or (e) has irritable bowel syndrome; or (f) has congenital anorectal malformations; or (g) has active anal abscesses or fistulas; or (h) has anorectal organic bowel disease, including cancer; or (i) has functional effects of previous pelvic irradiation; or (j) has congenital or acquired malformations of the sacrum; or (k) has had rectal or anal surgery within the previous 12 months (H) (Anaes.)	687.75
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; other than a patient who: (c) is medically unfit for surgery; or (d) is pregnant or planning pregnancy; or (e) has irritable bowel syndrome; or (f) has congenital anorectal malformations; or (g) has active anal abscesses or fistulas; or (h) has anorectal organic bowel disease, including cancer; or (i) has functional effects of previous pelvic irradiation; or (j) has congenital or acquired malformations of the sacrum; or (k) has had rectal or anal surgery within the previous 12 months (H) (Anaes.) (Assist.)	347.55
32215	Sacral nerve electrode or electrodes, management, adjustment and electronic programming of the neurostimulator by a medical practitioner, to manage faecal incontinence, other than in a patient who:	130.45

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) is medically unfit for surgery; or (b) is pregnant or planning pregnancy; or (c) has irritable bowel syndrome; or (d) has congenital anorectal malformations; or (e) has active anal abscesses or fistulas; or (f) has anorectal organic bowel disease, including cancer; or (g) has functional effects of previous pelvic irradiation; or (h) has congenital or acquired malformations of the sacrum; or (i) has had rectal or anal surgery within the previous 12 months; —each day	
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 patient who: (c) is medically unfit for surgery; or (d) is pregnant or planning pregnancy; or (e) has irritable bowel syndrome; or (f) has congenital anorectal malformations; or (g) has active anal abscesses or fistulas; or (h) has anorectal organic bowel disease, including cancer; or (i) has functional effects of previous pelvic irradiation; or (j) has congenital or acquired malformations of the sacrum; or (k) has had rectal or anal surgery within the previous 12 months; other than a service to which item 32213 applies (H) (Anaes.)	617.60
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; other than a patient who: (c) is medically unfit for surgery; or (d) is pregnant or planning pregnancy; or (e) has irritable bowel syndrome; or (f) has congenital anorectal malformations; or (g) has active anal abscesses or fistulas; or (h) has anorectal organic bowel disease, including cancer; or (i) has functional effects of previous pelvic irradiation; or	162.65

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(j) has congenital or acquired malformations of the sacrum; or (k) has had rectal or anal surgery within the previous 12 months (H) (Anaes.)	
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; other than a patient who: (c) is medically unfit for surgery; or (d) is pregnant or planning pregnancy; or (e) has irritable bowel syndrome; or (f) has congenital anorectal malformations; or (g) has active anal abscesses or fistulas; or (h) has anorectal organic bowel disease, including cancer; or (i) has functional effects of previous pelvic irradiation; or (j) has congenital or acquired malformations of the sacrum; or (k) has had rectal or anal surgery within the previous 12 months (H) (Anaes.)	162.65
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.)	940.55
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.)	940.55
32222	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient: (a) following a positive faecal occult blood test; or (b) who has symptoms consistent with pathology of the colonic mucosa; or (c) who has anaemia or iron deficiency; or (d) for whom diagnostic imaging has shown an abnormality of the colon; or (e) who is undergoing the first examination following surgery for colorectal cancer; or (f) who is undergoing pre-operative evaluation; or (g) for whom a repeat colonoscopy is required due to inadequate bowel preparation for the patient's previous colonoscopy; or (h) for the management of inflammatory bowel disease Applicable only once on a day under a single episode of anaesthesia or other sedation (Anaes.)	347.90
32223	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient:	347.90

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) who has had a colonoscopy that revealed: (i) 1 to 4 adenomas, each of which was less than 10 mm in diameter, had no villous features and had no high grade dysplasia; or (ii) 1 or 2 sessile serrated lesions, each of which was less than 10 mm in diameter, and without dysplasia; or (b) who has a moderate risk of colorectal cancer due to family history; or (c) who has a history of colorectal cancer and has had an initial post-operative colonoscopy that did not reveal any adenomas or colorectal cancer Applicable only once in any 5-year period (Anaes.)	
32224	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient who has a moderate risk of colorectal cancer due to: (a) a history of adenomas, including an adenoma that: (i) was 10 mm or greater in diameter; or (ii) had villous features; or (iii) had high grade dysplasia; or (b) having had a previous colonoscopy that revealed: (i) 5 to 9 adenomas, each of which was less than 10 mm in diameter, had no villous features and had no high grade dysplasia; or (ii) 1 or 2 sessile serrated lesions, each of which was 10 mm or greater in diameter or had dysplasia; or (iii) a hyperplastic polyp that was 10 mm or greater in diameter; or (iv) 3 or more sessile serrated lesions, each of which was less than 10 mm in diameter and had no dysplasia; or (v) 1 or 2 traditional serrated adenomas, of any size Applicable only once in any 3 year period (Anaes.)	347.90
32225	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient who has a high risk of colorectal cancer due to having had a previous colonoscopy that: (a) revealed 10 or more adenomas; or (b) included a piecemeal, or possibly incomplete, excision of a large, sessile polyp Applicable not more than 4 times in any 12-month period (Anaes.)	347.90
32226	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient who has a high risk of colorectal cancer due to: (a) having either: (i) a known or suspected familial condition, such as familial adenomatous polyposis, Lynch syndrome or serrated polyposis syndrome; or (ii) a genetic mutation associated with hereditary colorectal cancer; or (b) having had a previous colonoscopy that revealed: (i) 5 or more sessile serrated lesions, each of which was less than 10 mm in diameter and had no dysplasia; or (ii) 3 or more sessile serrated lesions, 1 or more of which was 10	347.90

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	mm or greater in diameter or had dysplasia; or (iii) 3 or more traditional serrated adenomas, of any size Applicable only once in any 12 month period (Anaes.)	
32227	Endoscopic examination of the colon to the caecum by colonoscopy: (a) for the treatment of bleeding, including one or more of the following: (i) radiation proctitis; (ii) angioectasia; (iii) post-polypectomy bleeding; or (b) for the treatment of colonic strictures with balloon dilatation Applicable only once on a day under a single episode of anaesthesia or other sedation (Anaes.)	488.20
32228	Endoscopic examination of the colon to the caecum by colonoscopy, other than a service to which item 32222, 32223, 32224, 32225 or 32226 applies Applicable only once (Anaes.)	347.90
32229	Removal of one or more polyps during colonoscopy, in association with a service to which item 32222, 32223, 32224, 32225, 32226 or 32228 applies (Anaes.)	280.60
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.)	114.20
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.)	278.55
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.)	555.25
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.)	555.25
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.)	825.45
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.)	964.35

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 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.)	1,241.80
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, if 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: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including radiofrequency diathermy, radiofrequency ablation or cyanoacrylate embolisation; and (c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.)	555.25
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, if it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including radiofrequency diathermy, radiofrequency ablation or cyanoacrylate embolisation; and (c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.)	825.45
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, if 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: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including endovenous laser therapy or cyanoacrylate embolisation; and (c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.)	555.25
32526	Varicose veins, abolition of venous reflux by occlusion of a primary or	825.45

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	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, if it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including endovenous laser therapy or cyanoacrylate embolisation; and (c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.)	
32528	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 cyanoacrylate adhesive, if 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: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including radiofrequency diathermy, radiofrequency ablation or endovenous laser therapy; and (c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.)	555.25
32529	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 cyanoacrylate adhesive, if it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer: (a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and (b) not including radiofrequency diathermy, radiofrequency ablation or endovenous laser therapy; and (c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.)	825.45
32700	Artery of neck, bypass using vein or synthetic material (H) (Anaes.) (Assist.)	1,494.55
32703	Internal carotid artery, transection and reanastomosis of, or resection of small length and reanastomosis of—with or without endarterectomy (H) (Assist.)	1,236.35
32708	Aortic bypass for occlusive disease using a straight non-bifurcated graft (H) (Anaes.) (Assist.)	1,478.95

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
32710	Aortic bypass for occlusive disease using a bifurcated graft with one or both anastomoses to the iliac arteries (H) (Anaes.) (Assist.)	1,643.25
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.)	1,807.65
32712	Ilio-femoral bypass grafting (H) (Anaes.) (Assist.)	1,306.70
32715	Axillary or subclavian to femoral bypass grafting to one or both femoral arteries (H) (Anaes.) (Assist.)	1,306.70
32718	Femoro-femoral or ilio-femoral cross-over bypass grafting (H) (Anaes.) (Assist.)	1,236.35
32721	Renal artery, bypass grafting to (H) (Anaes.) (Assist.)	1,963.80
32724	Renal arteries (both), bypass grafting to (H) (Anaes.) (Assist.)	2,229.95
32730	Mesenteric vessel (single), bypass grafting to (H) (Anaes.) (Assist.)	1,690.15
32733	Mesenteric vessels (multiple), bypass grafting to (H) (Anaes.) (Assist.)	1,963.80
32736	Inferior mesenteric artery, operation on, when performed in conjunction with another intra-abdominal vascular operation (H) (Anaes.) (Assist.)	430.30
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.)	1,345.80
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.)	1,541.55
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.)	1,760.50
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.)	1,909.15
32751	Femoral artery bypass grafting using synthetic graft, with lower anastomosis above or below the knee (H) (Anaes.) (Assist.)	1,236.35
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.)	1,541.55
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.)	430.30
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.)	422.50
32763	Arterial bypass grafting, using vein or synthetic material, other than a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	1,236.35
32766	Arterial or venous anastomosis, other than a service to which another item	821.70

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	in this Subgroup applies, as an independent procedure (H) (Anaes.) (Assist.)	
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.)	284.75
33050	Bypass grafting to replace a popliteal aneurysm using vein, including harvesting vein (when it is the ipsilateral long saphenous vein) (H) (Anaes.) (Assist.)	1,514.30
33055	Bypass grafting to replace a popliteal aneurysm using a synthetic graft (H) (Anaes.) (Assist.)	1,214.35
33070	Aneurysm in the extremities, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)	876.10
33075	Aneurysm in the neck, ligation, suture closure or excision of, without bypass grafting (H) (Anaes.) (Assist.)	1,114.45
33080	Intra-abdominal or pelvic aneurysm, ligation, suture closure or excision of, without bypass grafting (H) (Anaes.) (Assist.)	1,360.45
33100	Aneurysm of common or internal carotid artery, or both, replacement by graft of vein or synthetic material (Anaes.) (Assist.)	1,494.55
33103	Thoracic aneurysm, replacement by graft (H) (Anaes.) (Assist.)	2,096.95
33109	Thoraco-abdominal aneurysm, replacement by graft including re-implantation of arteries (Anaes.) (Assist.)	2,535.25
33112	Suprarenal abdominal aortic aneurysm, replacement by graft including re-implantation of arteries (H) (Anaes.) (Assist.)	2,198.70
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.)	1,478.95
33116	Infrarenal abdominal aortic aneurysm (repair), replacement by tube graft using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.)	1,455.70
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.)	1,643.25
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.)	1,617.55
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.)	1,807.65
33124	Aneurysm of iliac artery (common, external or internal), replacement by graft—unilateral (H) (Anaes.) (Assist.)	1,259.85
33127	Aneurysms of iliac arteries (common, external or internal), replacement by graft—bilateral (Anaes.) (Assist.)	1,651.10
33130	Aneurysm of visceral artery, excision and repair by direct anastomosis or	1,439.75

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	replacement by graft (H) (Anaes.) (Assist.)	
33133	Aneurysm of visceral artery, dissection and ligation of arteries without restoration of continuity (H) (Anaes.) (Assist.)	1,079.70
33136	False aneurysm, repair of, at aortic anastomosis following previous aortic surgery (H) (Anaes.) (Assist.)	2,722.80
33139	False aneurysm, repair of, in iliac artery and restoration of arterial continuity (H) (Anaes.) (Assist.)	1,651.10
33142	False aneurysm, repair of, in femoral artery and restoration of arterial continuity (Anaes.) (Assist.)	1,541.55
33145	Ruptured thoracic aortic aneurysm, replacement by graft (H) (Anaes.) (Assist.)	2,652.50
33148	Ruptured thoraco-abdominal aortic aneurysm, replacement by graft (H) (Anaes.) (Assist.)	3,294.10
33151	Ruptured suprarenal abdominal aortic aneurysm, replacement by graft (H) (Anaes.) (Assist.)	3,129.80
33154	Ruptured infrarenal abdominal aortic aneurysm, replacement by tube graft (H) (Anaes.) (Assist.)	2,316.05
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.)	2,582.05
33160	Ruptured infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to one or both femoral arteries (H) (Anaes.) (Assist.)	2,582.05
33163	Ruptured iliac artery aneurysm, replacement by graft (H) (Anaes.) (Assist.)	2,191.05
33166	Ruptured aneurysm of visceral artery, replacement by anastomosis or graft (Anaes.) (Assist.)	2,191.05
33169	Ruptured aneurysm of visceral artery, simple ligation of (H) (Anaes.) (Assist.)	1,705.80
33172	Aneurysm of major artery, replacement by graft, other than a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	1,330.15
33175	Ruptured aneurysm in the extremities, ligation, suture closure or excision of, without bypass grafting (H) (Anaes.) (Assist.)	1,225.85
33178	Ruptured aneurysm in the neck, ligation, suture closure or excision of, without bypass grafting (H) (Anaes.) (Assist.)	1,558.90
33181	Ruptured intra-abdominal or pelvic aneurysm, ligation, suture closure or excision of, without bypass grafting (H) (Anaes.) (Assist.)	1,905.90
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.)	1,181.40
33506	Innominate or subclavian artery, endarterectomy of, including closure by suture (H) (Anaes.) (Assist.)	1,322.40
33509	Aortic endarterectomy, including closure by suture, other than a service associated with another procedure on the aorta (H) (Anaes.) (Assist.)	1,478.95
33512	Aorto-iliac endarterectomy (one or both iliac arteries), including closure	1,643.25

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	by suture other than a service associated with a service to which item 33515 applies (H) (Anaes.) (Assist.)	
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.)	1,807.65
33518	Iliac endarterectomy, including closure by suture, other than a service associated with another procedure on the iliac artery (Anaes.) (Assist.)	1,322.40
33521	Ilio-femoral endarterectomy (one side), including closure by suture (H) (Anaes.) (Assist.)	1,431.80
33524	Renal artery, endarterectomy of (H) (Anaes.) (Assist.)	1,690.15
33527	Renal arteries (both), endarterectomy of (H) (Anaes.) (Assist.)	1,963.80
33530	Coeliac or superior mesenteric artery, endarterectomy of (H) (Anaes.) (Assist.)	1,690.15
33533	Coeliac and superior mesenteric artery, endarterectomy of (H) (Anaes.) (Assist.)	1,963.80
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.)	1,400.65
33539	Artery of extremities, endarterectomy of, including closure by suture (H) (Anaes.) (Assist.)	1,009.35
33542	Extended deep femoral endarterectomy, if the endarterectomy is at least 7 cm long (H) (Anaes.) (Assist.)	1,439.75
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.)	284.75
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.)	579.15
33551	Vein, harvesting of from leg or arm for patch when not performed through same incision as operation (H) (Anaes.) (Assist.)	284.75
33554	Endarterectomy, in conjunction with an arterial bypass operation to prepare the site for anastomosis—each site (H) (Anaes.) (Assist.)	283.45
33800	Embolus, removal of, from artery of neck (Anaes.) (Assist.)	1,228.45
33803	Embolectomy or thrombectomy, by abdominal approach, of an artery or bypass graft of trunk (H) (Anaes.) (Assist.)	1,173.75
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.)	845.10
33810	Inferior vena cava or iliac vein, closed thrombectomy by catheter via the femoral vein (Anaes.) (Assist.)	616.50
33811	Inferior vena cava or iliac vein, open removal of thrombus or tumour (H) (Anaes.) (Assist.)	1,835.25
33812	Thrombus, removal of, from femoral or other similar large vein (Anaes.) (Assist.)	970.20

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
33815	Major artery or vein of extremity, repair of wound of, with restoration of continuity, by lateral suture (H) (Anaes.) (Assist.)	892.00
33818	Major artery or vein of extremity, repair of wound of, with restoration of continuity, by direct anastomosis (H) (Anaes.) (Assist.)	1,040.70
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.)	1,189.30
33824	Major artery or vein of neck, repair of wound of, with restoration of continuity, by lateral suture (H) (Anaes.) (Assist.)	1,134.50
33827	Major artery or vein of neck, repair of wound of, with restoration of continuity, by direct anastomosis (H) (Anaes.) (Assist.)	1,330.15
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.)	1,525.70
33833	Major artery or vein of abdomen, repair of wound of, with restoration of continuity by lateral suture (H) (Anaes.) (Assist.)	1,385.10
33836	Major artery or vein of abdomen, repair of wound of, with restoration of continuity by direct anastomosis (H) (Anaes.) (Assist.)	1,651.10
33839	Major artery or vein of abdomen, repair of wound of, with restoration of continuity by means of interposition graft (H) (Anaes.) (Assist.)	1,932.65
33842	Artery of neck, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (H) (Anaes.) (Assist.)	954.60
33845	Laparotomy for control of post-operative bleeding or thrombosis after intra-abdominal vascular procedure, if no other procedure is performed (H) (Anaes.) (Assist.)	665.15
33848	Extremity, re-operation on, for control of bleeding or thrombosis after vascular procedure, if no other procedure is performed (H) (Anaes.) (Assist.)	665.15
34100	Major artery of neck, elective ligation or exploration of, other than a service associated with another vascular procedure (H) (Anaes.) (Assist.)	735.60
34103	Great artery (aorta or pulmonary artery) or great vein (superior or inferior vena cava), ligation or exploration of immediate branches or tributaries, or ligation or exploration of the subclavian, axillary, iliac, femoral or popliteal arteries or veins, if the service is not associated with item 32508, 32511, 32520, 32522, 32523, 32526, 32528 or 32529—for a maximum of 2 services provided to the same patient on the same occasion (H) (Anaes.) (Assist.)	430.30
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.)	303.50
34109	Temporal artery, biopsy of (Anaes.) (Assist.)	352.05
34112	Arterio-venous fistula of an extremity, dissection and ligation (H) (Anaes.) (Assist.)	892.00
34115	Arterio-venous fistula of the neck, dissection and ligation (H) (Anaes.)	1,009.35

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(Assist.)	
34118	Arterio-venous fistula of the abdomen, dissection and ligation (Anaes.) (Assist.)	1,439.75
34121	Arterio-venous fistula of an extremity, dissection and repair of, with restoration of continuity (H) (Anaes.) (Assist.)	1,150.15
34124	Arterio-venous fistula of the neck, dissection and repair of, with restoration of continuity (H) (Anaes.) (Assist.)	1,259.85
34127	Arterio-venous fistula of the abdomen, dissection and repair of, with restoration of continuity (H) (Anaes.) (Assist.)	1,651.10
34130	Surgically created arterio-venous fistula of an extremity, closure of (Anaes.) (Assist.)	516.40
34133	Scalenotomy (H) (Anaes.) (Assist.)	579.15
34136	First rib, resection of portion of (H) (Anaes.) (Assist.)	931.00
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.)	931.00
34142	Coeliac artery, decompression of, for coeliac artery compression syndrome, as an independent procedure (H) (Anaes.) (Assist.)	1,150.15
34145	Popliteal artery, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (H) (Anaes.) (Assist.)	837.20
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.)	1,494.55
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.)	2,042.15
34154	Recurrent carotid associated tumour, resection of, with or without repair or replacement of portion of internal or common carotid arteries (Anaes.) (Assist.)	2,433.50
34157	Neck, excision of infected bypass graft, including closure of vessel or vessels (H) (Anaes.) (Assist.)	1,236.35
34160	Aorto-duodenal fistula, repair of, by suture of aorta and repair of duodenum (H) (Anaes.) (Assist.)	2,316.05
34163	Aorto-duodenal fistula, repair of, by insertion of aortic graft and repair of duodenum (H) (Anaes.) (Assist.)	2,973.30
34166	Aorto-duodenal fistula, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo bifemoral grafting (H) (Anaes.) (Assist.)	2,973.30
34169	Infected bypass graft from trunk, excision of, including closure of arteries (H) (Anaes.) (Assist.)	1,651.10
34172	Infected axillo-femoral or femoro-femoral graft, excision of, including closure of arteries (H) (Anaes.) (Assist.)	1,345.80
34175	Infected bypass graft from extremities, excision of including closure of arteries (H) (Anaes.) (Assist.)	1,236.35
34500	Arteriovenous shunt, external, insertion of (Anaes.) (Assist.)	320.90

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
34503	Arteriovenous anastomosis of upper or lower limb, in conjunction with another venous or arterial operation (H) (Anaes.) (Assist.)	430.30
34506	Arteriovenous shunt, external, removal of (H) (Anaes.) (Assist.)	218.95
34509	Arteriovenous anastomosis of upper or lower limb, not in conjunction with another venous or arterial operation (H) (Anaes.) (Assist.)	1,017.15
34512	Arteriovenous access device, insertion of (H) (Anaes.) (Assist.)	1,119.00
34515	Arteriovenous access device, thrombectomy of (H) (Anaes.) (Assist.)	798.05
34518	Stenosis of arteriovenous fistula or prosthetic arteriovenous access device, correction of (H) (Anaes.) (Assist.)	1,337.85
34521	Intra-abdominal artery or vein, cannulation of, for infusion chemotherapy, by open operation (excluding after-care) (H) (Anaes.) (Assist.)	822.00
34524	Arterial cannulation for infusion chemotherapy by open operation, other than a service to which item 34521 applies (excluding after-care) (H) (Anaes.) (Assist.)	430.30
34527	Central vein catheterisation by open technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterisation, on a patient 10 years of age or over (Anaes.)	573.95
34528	Central vein catheterisation by percutaneous technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, on a patient 10 years of age or over (Anaes.)	283.45
34529	Central vein catheterisation by open technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterisation, on a patient under 10 years of age (Anaes.)	746.15
34530	Central venous line, or other chemotherapy device, removal of, by open surgical procedure in the operating theatre of a hospital, on a patient 10 years of age or over (Anaes.)	212.50
34533	Isolated limb perfusion, including cannulation of artery and vein at commencement of procedure, regional perfusion for chemotherapy, or other therapy, repair of arteriotomy and venotomy at conclusion of procedure (excluding after-care) (Anaes.) (Assist.)	1,290.90
34534	Central vein catheterisation by percutaneous technique, using subcutaneous tunnel with pump or access port as with central venous line catheter or other chemotherapy delivery device, on a patient under 10 years of age (Anaes.)	368.45
34538	Central vein catheterisation by percutaneous technique, using subcutaneous tunnelled cuffed catheter or similar device, for the administration of haemodialysis or parenteral nutrition (Anaes.)	283.45
34539	Tunnelled cuffed catheter, or similar device, removal of, by open surgical procedure (Anaes.)	212.50
34540	Central venous line, or other chemotherapy device, removal of, by open surgical procedure in the operating theatre of a hospital, on a patient under 10 years of age (Anaes.)	276.25

Clause 5.10.16

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
34800	Inferior vena cava, plication, ligation, or application of caval clip (Anaes.) (Assist.)	845.10
34803	Inferior vena cava, reconstruction of or bypass by vein or synthetic material (H) (Anaes.) (Assist.)	1,862.40
34806	Cross leg bypass grafting, saphenous to iliac or femoral vein (H) (Anaes.) (Assist.)	1,009.35
34809	Saphenous vein anastomosis to femoral or popliteal vein for femoral vein bypass (H) (Anaes.) (Assist.)	1,009.35
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.)	1,220.60
34815	Vein stenosis, patch angioplasty for, (excluding vein graft stenosis)—using vein or synthetic material (H) (Anaes.) (Assist.)	1,009.35
34818	Venous valve, plication or repair to restore valve competency (H) (Anaes.) (Assist.)	1,111.05
34821	Vein transplant to restore valvular function (Anaes.) (Assist.)	1,510.20
34824	External stent, application of, to restore venous valve competency to superficial vein—one stent (H) (Anaes.) (Assist.)	516.40
34827	External stents, application of, to restore venous valve competency to superficial vein or veins—more than one stent (H) (Anaes.) (Assist.)	626.05
34830	External stent, application of, to restore venous valve competency to deep vein—one stent (Anaes.) (Assist.)	735.60
34833	External stents, application of, to restore venous valve competency to deep vein or veins—more than one stent (H) (Anaes.) (Assist.)	954.60
35000	Lumbar sympathectomy (Anaes.) (Assist.)	735.60
35003	Cervical or upper thoracic sympathectomy by any surgical approach (H) (Anaes.) (Assist.)	954.60
35006	Cervical or upper thoracic sympathectomy, if operation is a re-operation for previous incomplete sympathectomy by any surgical approach (H) (Anaes.) (Assist.)	1,197.20
35009	Lumbar sympathectomy, if operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (H) (Anaes.) (Assist.)	931.00
35012	Sacral or pre-sacral sympathectomy (H) (Anaes.) (Assist.)	735.60
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.)	383.45
35103	Ischaemic limb, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (H) (Anaes.)	244.05
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.)	178.45
35202	Major arteries or veins in the neck, abdomen or extremities, access to, as	850.20

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	part of re-operation after prior surgery on these vessels (H) (Anaes.) (Assist.)	
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.)	536.25
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.)	687.55
35306	Transluminal stent insertion, one or more stents, including associated balloon dilatation for one peripheral artery or vein of one limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding after-care (Anaes.) (Assist.)	634.60
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.)	1,166.60
35309	Transluminal stent insertion, one or more stents, including associated balloon dilatation for visceral arteries or veins, or more than one peripheral artery or vein of one limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding after-care (Anaes.) (Assist.)	793.25
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.)	899.00
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.)	899.00
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.)	370.20
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)	663.60

Clause 5.10.16

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(Anaes.) (Assist.)	
35320	Peripheral arterial or venous catheterisation with administration of thrombolytic or chemotherapeutic agents, by open exposure, excluding associated radiological services or preparation, and excluding after-care (other than a service associated with a service to which an item in Subgroup 11 of Group T1 or item 35317 or 35319 applies, or associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.)	891.40
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.)	846.25
35324	Angioscopy not combined with another procedure, excluding associated radiological services or preparation, and excluding after-care (H) (Anaes.) (Assist.)	317.35
35327	Angioscopy combined with another procedure, excluding associated radiological services or preparation, and excluding after-care (H) (Anaes.) (Assist.)	425.30
35330	Insertion of inferior vena caval filter, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding after-care (Anaes.) (Assist.)	536.25
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.)	616.50
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.)	861.75
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.)	739.05
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.)	616.50
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.)	493.90
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, applicable once (H) (Anaes.) (Assist.)	360.65
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.)	846.25

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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.)	634.80
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.)	846.25
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.)	2,973.30
35414	Mechanical thrombectomy, in a patient with a diagnosis of acute ischaemic stroke caused by occlusion of a large vessel of the anterior cerebral circulation, including intra-operative imaging and aftercare, if: (a) the diagnosis is confirmed by an appropriate imaging modality such as computed tomography, magnetic resonance imaging or angiography; and (b) the service is performed by a specialist or consultant physician with appropriate training that is recognised by the Conjoint Committee for Recognition of Training in Interventional Neuroradiology; and (c) the service is provided in an eligible stroke centre. For any particular patient—applicable once per presentation by the patient at an eligible stroke centre, regardless of the number of times mechanical thrombectomy is attempted during that presentation (H) (Anaes.) (Assist.)	3,641.85

Subdivision C—Subgroups 4, 5 and 6 of Group T8

5.10.17 Restrictions on items in Subgroups 4 and 6 of Group T8—surgical techniques

(1) For items 35581 and 35582, the size of the excised graft material must be histologically tested and confirmed.

(2) Items 38478 to 38766 (other than items 38609, 38615, 38618, 38621, 38624 and 38654) must be performed using open exposure or minimally invasive surgery which excludes percutaneous and transcatheter techniques unless otherwise stated in the item.

Clause 5.10.18

5.10.18 Items in Subgroups 4, 5 and 6 of Group T8

This clause sets out items in Subgroups 4, 5 and 6 of Group T8.

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **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.)	84.60
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.)	83.40
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 described in item 30062) (Anaes.)	55.70
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.)	55.85
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.)	181.50
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.)	267.35
35509	Hymenectomy (Anaes.)	93.10
35513	Bartholin's cyst, excision of (Anaes.)	230.70
35517	Bartholin's cyst or gland, marsupialisation of (Anaes.)	151.95
35518	Ovarian cyst aspiration, for cysts of at least 4 cm in diameter in a premenopausal patient and at least 2 cm in diameter in a postmenopausal patient, by abdominal or vaginal route, using interventional imaging techniques and not associated with services provided for assisted reproductive techniques (Anaes.)	216.30
35520	Bartholin's abscess, incision of (Anaes.)	60.70
35523	Urethra or urethral caruncle, cauterisation of (Anaes.)	60.70
35527	Urethral caruncle, excision of (Anaes.)	151.95
35530	Clitoris, amputation of, if medically indicated (H) (Anaes.) (Assist.)	280.75
35533	Vulvoplasty or labioplasty, for repair of: (a) female genital mutilation; or (b) an anomaly associated with a major congenital anomaly of the uro-gynaecological tract; other than a service associated with a service to which item 35536, 37836, 37050, 37842, 37851 or 43882 applies (H) (Anaes.)	364.05

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
35534	Vulvoplasty or labioplasty, in a patient aged 18 years or more, performed by a specialist in the practice of the specialist's specialty, for a structural abnormality that is causing significant functional impairment, if the patient's labium extends more than 8 cm below the vaginal introitus while the patient is in a standing resting position (H) (Anaes.)	364.05
35536	Vulva, wide local excision of suspected malignancy or hemivulvectomy, one or both procedures (Anaes.) (Assist.)	362.60
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.)	284.00
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.)	332.50
35545	Colposcopically directed CO^2 laser therapy for condylomata, unsuccessfully treated by other methods (Anaes.)	191.05
35548	Vulvectomy, radical, for malignancy (H) (Anaes.) (Assist.)	867.85
35551	Pelvic lymph nodes, radical excision of, unilateral, or sentinel node dissection (including any pre-operative injection) (H) (Anaes.) (Assist.)	962.20
35552	Pelvic lymph nodes, radical excision of, unilateral, following previous similar dissection, radiation or chemotherapy (H) (Anaes.) (Assist.)	1,447.50
35554	Vagina, dilatation of, as an independent procedure including any associated consultation (Anaes.)	45.25
35557	Vagina, removal of simple tumour—(including Gartner duct cyst) (Anaes.)	223.20
35560	Vagina, partial or complete removal of (H) (Anaes.) (Assist.)	711.60
35561	Vaginectomy, radical, for proven invasive malignancy—one surgeon (H) (Anaes.) (Assist.)	1,435.35
35562	Vaginectomy, radical, for proven invasive malignancy, conjoint surgery—abdominal surgeon (including after-care) (H) (Anaes.) (Assist.)	1,178.45
35564	Vaginectomy, radical, for proven invasive malignancy, conjoint surgery—perineal surgeon (H) (Assist.)	544.00
35565	Vaginal reconstruction for congenital absence, gynatresia or urogenital sinus (H) (Anaes.) (Assist.)	711.60
35566	Vaginal septum, excision of, for correction of double vagina (H) (Anaes.) (Assist.)	413.35
35568	Sacrospinous colpopexy for the management of upper vaginal prolapse (H) (Anaes.) (Assist.)	649.90
35569	Plastic repair to enlarge vaginal orifice (H) (Anaes.)	167.35
35570	Anterior vaginal compartment repair by vaginal approach for pelvic organ prolapse:	576.30

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) involving repair of urethrocele and cystocele; and (b) using native tissue without graft; other than a service associated with a service to which item 35573, 35577 or 35578 applies (H) (Anaes.) (Assist.)	
35571	Posterior vaginal compartment repair by vaginal approach for pelvic organ prolapse: (a) involving repair of one or more of the following: (i) perineum; (ii) rectocoele; (iii) enterocoele; and (b) using native tissue without graft; other than a service associated with a service to which item 35573, 35577 or 35578 applies (H) (Anaes.) (Assist.)	576.30
35572	Colpotomy, other than a service to which another item in this Group applies (H) (Anaes.)	128.85
35573	Anterior and posterior vaginal compartment repair by vaginal approach for pelvic organ prolapse: (a) involving anterior and posterior compartment defects; and (b) using native tissue without graft; other than a service associated with a service to which item 35577 or 35578 applies (H) (Anaes.) (Assist.)	864.55
35577	Manchester (Donald Fothergill) operation for pelvic organ prolapse, involving either or both of the following: (a) cervical amputation; (b) anterior and posterior native tissue vaginal wall repairs without graft (H) (Anaes.) (Assist.)	701.85
35578	Le Fort operation for genital prolapse, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	701.85
35581	Vaginal procedure for excision of graft material in symptomatic patients with graft related complications (including graft related pain or discharge and bleeding related to graft exposure), less than $2cm^2$ in its maximum area, either singly or in multiple pieces, other than a service associated with a service to which item 35582 or 35585 applies (H) (Anaes.) (Assist.)	576.30
35582	Vaginal procedure for excision of graft material in symptomatic patients with graft related complications (including graft related pain or discharge and bleeding related to graft exposure), $2cm^2$ or more in its maximum area, either singly or in multiple pieces, other than a service associated with a service to which item 35581 or 35585 applies (H) (Anaes.) (Assist.)	864.55
35585	Abdominal procedure, by open, laparoscopic or robot-assisted approach, if the service: (a) is for the removal of graft material: (i) in symptomatic patients with graft related complications	1,532.85

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(including graft related pain or discharge and bleeding related to graft exposure); or (ii) where the graft has penetrated adjacent organs such as the bladder (including urethra) or bowel; and (b) if required—includes retroperitoneal dissection, and mobilisation, of either or both of the bladder and bowel; other than a service associated with a service to which item 35581 or 35582 applies (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.)	1,201.80
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.)	711.60
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.)	1,532.85
35599	Stress incontinence, procedure using a female synthetic mid-urethral sling, with diagnostic cystoscopy to assess the integrity of the lower urinary tract, other than a service associated with a service to which item 36812 applies (H) (Anaes.) (Assist.)	788.60
35602	Stress incontinence, combined synchronous abdomino-vaginal operation for—abdominal procedure, with or without mesh, (including after-care) (H) (Anaes.) (Assist.)	701.85
35605	Stress incontinence, combined synchronous abdomino-vaginal operation for—vaginal procedure, with or without mesh, (including after-care) (Anaes.) (Assist.)	380.80
35608	Cervix, cauterisation (other than by chemical means), ionisation, diathermy or biopsy of, with or without dilatation of cervix (Anaes.)	66.55
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.)	66.55
35612	Cervix, residual stump, removal of, by abdominal approach (Anaes.) (Assist.)	526.50
35613	Cervix, residual stump, removal of, by vaginal approach (H) (Anaes.) (Assist.)	421.20
35614	Examination of lower genital tract by a Hinselmann-type colposcope in a patient with a previous abnormal cervical smear, an abnormal result from a cervical screening service 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.)	66.45
35615	Vulva, biopsy of, when performed in conjunction with a service to which item 35614 applies	55.85
35616	Endometrium, endoscopic examination of and ablation of, by	467.80

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	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.)	
35618	Cervix, cone biopsy, amputation or repair of, other than a service to which item 35577 or 35578 applies (Anaes.) Note: Item 35577 is specified in a determination made under subsection 3C(1) of the Act.	226.80
35620	Endometrial biopsy if malignancy is suspected in patients with abnormal uterine bleeding or post-menopausal bleeding (Anaes.)	55.50
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.)	626.90
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.)	852.45
35626	Hysteroscopy, including biopsy, performed by a specialist in the practice of the specialist's specialty, if the patient is referred to the specialist 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	86.10
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.)	111.50
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 (H) (Anaes.)	190.45
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.)	226.80
35634	Hysteroscopic resection of uterine septum followed by endometrial ablation by laser or diathermy (Anaes.)	713.45
35635	Hysteroscopy involving resection of the uterine septum (H) (Anaes.)	311.60
35636	Hysteroscopy, involving resection of myoma, or resection of myoma and uterine septum (if both are performed) (H) (Anaes.)	450.55
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.)	423.10
35638	Complicated operative laparoscopy, including use of laser when required, for one or more of the following procedures: (a) oophorectomy; (b) ovarian cystectomy;	740.35

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(c) myomectomy; (d) salpingectomy; (e) salpingostomy; (f) ablation of moderate or severe endometriosis requiring more than 1 hour's operating time; (g) 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.)	
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 35630 applies, if performed (H) (Anaes.)	190.45
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.)	1,293.05
35643	Evacuation of the contents of the gravid uterus by curettage or suction curettage other than a service to which item 35640 applies, including procedures to which item 35626, 35627 or 35630 applies, if performed (Anaes.)	226.80
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 35640 or 35647 applies (Anaes.)	211.90
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.)	331.60
35646	Cervix, colposcopy with radical diathermy of, with or without cervical biopsy, for previously confirmed intraepithelial neoplastic changes of the cervix (Anaes.)	211.90
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.)	211.90
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	331.60

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	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.)	
35649	Hysterotomy or uterine myomectomy, abdominal (H) (Anaes.) (Assist.)	557.70
35653	Hysterectomy, abdominal, sub-total or total, with or without removal of uterine adnexae (H) (Anaes.) (Assist.)	702.05
35657	Hysterectomy, vaginal, with or without uterine curettage, other than a service to which item 35673 applies (H) (Anaes.) (Assist.)	702.05
35658	Uterus (at least equivalent in size to a 10 week gravid uterus), debulking of, before vaginal removal at hysterectomy (H) (Anaes.) (Assist.)	432.90
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.)	906.65
35664	Radical hysterectomy with radical excision of pelvic lymph nodes (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.)	1,511.10
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.)	1,284.25
35670	Hysterectomy, abdominal, with radical excision of pelvic lymph nodes, with or without removal of uterine adnexae (H) (Anaes.) (Assist.)	1,057.50
35673	Hysterectomy, vaginal, (with or without uterine curettage) with salpingectomy, oophorectomy or excision of ovarian cyst, one or more, one or both sides (H) (Anaes.) (Assist.)	788.50
35674	Ultrasound guided needling and injection of ectopic pregnancy	216.30
35677	Ectopic pregnancy, removal of (H) (Anaes.) (Assist.)	557.70
35678	Ectopic pregnancy, laparoscopic removal of (H) (Anaes.) (Assist.)	672.45
35680	Bicornuate uterus, plastic reconstruction for (Anaes.) (Assist.)	605.60
35684	Uterus, suspension or fixation of, as an independent procedure (H) (Anaes.) (Assist.)	490.25
35688	Sterilisation by transection or resection of fallopian tubes, via abdominal or vaginal routes or via laparoscopy using diathermy or another method (H) (Anaes.) (Assist.)	413.35
35691	Sterilisation by interruption of fallopian tubes when performed in conjunction with Caesarean section (H) (Anaes.) (Assist.)	165.10
35694	Tuboplasty (salpingostomy, salpingolysis or tubal implantation into uterus), unilateral or bilateral, one or more procedures (H) (Anaes.) (Assist.)	663.50
35697	Microsurgical tuboplasty (salpingostomy, salpingolysis or tubal	984.55

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	implantation into uterus), unilateral or bilateral, one or more procedures (H) (Anaes.) (Assist.)	
35700	Fallopian tubes, unilateral microsurgical anastomosis of, using operating microscope (H) (Anaes.) (Assist.)	759.70
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.)	70.30
35706	Rubin test for patency of fallopian tubes (Anaes.)	70.30
35709	Fallopian tubes, hydrotubation of, as a repetitive post-operative procedure (Anaes.)	45.25
35710	Falloposcopy, unilateral or bilateral, including hysteroscopy and tubal catheterisation (H) (Anaes.) (Assist.)	482.05
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 (H) (Anaes.) (Assist.)	471.20
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 (H) (Anaes.) (Assist.)	567.35
35720	Radical or debulking operation for advanced gynaecological malignancy, with or without omentectomy (H) (Anaes.) (Assist.)	701.85
35723	Retro-peritoneal lymph node biopsies from above the level of the aortic bifurcation, for staging or restaging of gynaecological malignancy (H) (Anaes.) (Assist.)	502.70
35726	Infra-colic omentectomy with multiple peritoneal biopsies for staging or restaging of gynaecological malignancy (H) (Anaes.) (Assist.)	502.70
35729	Ovarian transposition out of the pelvis, in conjunction with radical hysterectomy for invasive malignancy (H) (Anaes.)	226.60
35730	Ovarian repositioning for one or both ovaries to preserve ovarian function, prior to gonadotoxic radiotherapy when the treatment volume and dose of radiation have a high probability of causing infertility (H) (Anaes.)	226.60
35750	Laparoscopically assisted hysterectomy, including any associated laparoscopy (H) (Anaes.) (Assist.)	816.40
35753	Laparoscopically assisted hysterectomy, with one or more of the following procedures—salpingectomy, oophorectomy, excision of ovarian cyst or treatment of moderate endometriosis, one or both sides, including any associated laparoscopy (H) (Anaes.) (Assist.)	902.75
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.)	1,136.15

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
35756	Laparoscopically assisted hysterectomy, when procedure is completed by open hysterectomy, including any associated laparoscopy (H) (Anaes.) (Assist.)	816.40
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.)	586.15
Subgroup 5—Urological		
36502	Pelvic lymphadenectomy, open or laparoscopic, or both, unilateral or bilateral (H) (Anaes.) (Assist.)	711.60
36503	Renal transplant, other than a service to which item 36506 or 36509 applies (H) (Anaes.) (Assist.)	1,447.50
36504	Rigid cystoscopy using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with biopsy of bladder, not being a service associated with a service to which item 36505, 36507, 36508, 36812, 36830, 36836, 36840, 36845, 36848, 36854, 37203, 37206, 37215, 37230 or 37233 applies (Anaes.)	306.80
36505	Rigid cystoscopy using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with urethroscopy with or without urethral dilatation, not being a service associated with any other urological endoscopic procedure on the lower urinary tract except a service to which item 37327 applies (Anaes.)	241.10
36506	Renal transplant, performed by vascular surgeon and urologist operating together—vascular anastomosis, including after-care (H) (Anaes.) (Assist.)	962.20
36507	Rigid cystoscopy using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with diathermy, resection or visual laser destruction of bladder tumour or other lesion of the bladder, not being a service to which item 36840 or 36845 applies (Anaes.)	403.90
36508	Rigid cystoscopy using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with diathermy, resection or visual laser destruction of multiple tumours in more than 2 quadrants of the bladder or solitary tumour greater than 2 cm in diameter, not being a service to which item 36845 applies (Anaes.)	787.05
36509	Renal transplant, performed by vascular surgeon and urologist operating together—ureterovesical anastomosis, including after-care (H) (Assist.)	814.70
36516	Nephrectomy, complete, by open, laparoscopic or robot-assisted approach, other than a service associated with a service to which item 30390 or 30627 applies (H) (Anaes.) (Assist.)	962.20
36519	Nephrectomy, complete, by open, laparoscopic or robot-assisted approach, complicated by previous surgery on the same kidney, other than a service associated with a service to which item 30390 or 30627 applies (H) (Anaes.) (Assist.)	1,343.45
36522	Nephrectomy, partial, by open, laparoscopic or robot-assisted approach,	1,152.90

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	other than a service associated with a service to which item 30390 or 30627 applies (H) (Anaes.) (Assist.)	
36525	Nephrectomy, partial, by open, laparoscopic or robot-assisted approach: (a) if complicated by previous surgery or ablative procedure on the same kidney; or (b) for a patient with a solitary functioning kidney; or (c) for a patient with an estimated glomerular filtration rate (eGFR) of less than 60ml/min/1.73m^2; other than a service associated with a service to which item 30390 or 30627 applies (H) (Anaes.) (Assist.)	1,638.25
36528	Nephrectomy, radical, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10 cm in diameter, other than a service associated with a service to which item 30390 or 30627 applies (H) (Anaes.) (Assist.)	1,343.45
36529	Nephrectomy, radical, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, with or without adrenalectomy: (a) for a tumour 10 cm or more in diameter; or (b) if complicated by previous open or laparoscopic surgery on the same kidney; other than a service associated with a service to which item 30390 or 30627 applies (H) (Anaes.) (Assist.)	1,658.00
36531	Nephroureterectomy, complete, by open, laparoscopic or robot-assisted approach, including associated bladder repair and any associated endoscopic procedure, other than a service associated with a service to which item 30390 or 30627 applies (H) (Anaes.) (Assist.)	1,204.80
36532	Nephroureterectomy, for tumour, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures, other than a service to which item 36533 applies or a service associated with a service to which item 30390 or 30627 applies (H) (Anaes.) (Assist.)	1,729.20
36533	Nephroureterectomy, for tumour, by open, laparoscopic or robot-assisted approach, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures, if complicated by previous open or laparoscopic surgery on the same kidney or ureter, other than a service associated with a service to which item 30390 or 30627 applies (H) (Anaes.) (Assist.)	2,043.80
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.)	719.40
36543	Nephrolithotomy or pyelolithotomy, or both, extended, for one or more renal stones, including one or more of nephrostomy, pyelostomy, pedicle control with or without freezing, calyorrhaphy or pyeloplasty	1,343.45

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(Anaes.) (Assist.)	
36546	Extracorporeal shock wave lithotripsy (ESWL) to urinary tract and post-treatment care for 3 days, including pre-treatment consultations, unilateral (Anaes.)	719.40
36549	Ureterolithotomy, by open, laparoscopic or robot-assisted approach (H) (Anaes.) (Assist.)	866.90
36552	Nephrostomy or pyelostomy, open, as an independent procedure (H) (Anaes.) (Assist.)	771.55
36558	Renal cyst or cysts, excision or unroofing of (Anaes.) (Assist.)	676.15
36561	Renal biopsy, performed under image guidance (closed) (Anaes.)	179.50
36564	Pyeloplasty (plastic reconstruction of the pelvi-ureteric junction), by open, laparoscopic or robot-assisted approach, with or without the use of a retroperitoneal approach (H) (Anaes.) (Assist.)	962.20
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, laparoscopic or robot-assisted approach, with or without the use of a retroperitoneal approach (H) (Anaes.) (Assist.)	1,057.50
36570	Pyeloplasty, complicated by previous surgery on the same kidney, by open, laparoscopic or robot-assisted approach, with or without the use of a retroperitoneal approach (H) (Anaes.) (Assist.)	1,343.45
36573	Divided ureter, repair of (H) (Anaes.) (Assist.)	962.20
36576	Kidney, exposure and exploration of, including repair or nephrectomy, for trauma, by open, laparoscopic or robot-assisted approach, other than a service associated with: (a) any other procedure performed on the kidney, renal pelvis or renal pedicle; or (b) a service to which item 30390 or 30627 applies (H) (Anaes.) (Assist.)	1,204.80
36579	Ureterectomy, complete or partial: (a) for a tumour within the ureter, proven by histopathology at the time of surgery; or (b) for congenital anomaly; with or without associated bladder repair (H) (Anaes.) (Assist)	771.55
36585	Ureter, transplantation of, into skin (H) (Anaes.) (Assist.)	771.55
36588	Ureter, reimplantation into bladder (H) (Anaes.) (Assist.)	962.20
36591	Ureter, reimplantation into bladder with psoas hitch or Boari flap or both (H) (Anaes.) (Assist.)	1,152.90
36594	Ureter, transplantation of, into intestine (H) (Anaes.) (Assist.)	962.20
36597	Ureter, transplantation of, into another ureter (H) (Anaes.) (Assist.)	962.20
36600	Ureter, transplantation of, into isolated intestinal segment, unilateral (Anaes.) (Assist.)	1,152.90
36603	Ureters, transplantation of, into isolated intestinal segment, bilateral (H) (Anaes.) (Assist.)	1,343.45

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
36604	Ureteric stent, passage of through percutaneous nephrostomy tube, using interventional radiology techniques, but not including imaging (Anaes.)	278.55
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.)	2,409.65
36607	Ureteric stent, insertion of, with balloon dilatation of: (a) the pelvicalyceal system; or (b) ureter; or (c) the pelvicalyceal system and ureter; through a nephrostomy tube using interventional radiology techniques, but not including imaging (H) (Anaes.)	718.70
36608	Ureteric stent, exchange of, percutaneously through the ileal conduit or bladder using interventional radiology techniques, but not including imaging, other than a service associated with a service to which any of items 36811 to 36854 apply (H) (Anaes.)	278.55
36609	Intestinal urinary conduit, reservoir or ureterostomy, revision of (H) (Anaes.) (Assist.)	771.55
36610	Intestinal urinary conduit, incontinent, formation of (including associated small bowel resection and anastomosis), including implantation of one or both ureters into reservoir (H) (Anaes.) (Assist.)	1,846.95
36611	Intestinal urinary reservoir, continent, formation of (including associated small bowel resection and anastomosis), including formation of non-return valves and implantation of one or both ureters into reservoir, performed by open, laparoscopic or robot-assisted approach (H) (Anaes.) (Assist.)	2,913.20
36612	Ureter, exploration of, with or without drainage of, as an independent procedure (H) (Anaes.) (Assist.)	676.15
36615	Ureterolysis, unilateral, with or without repositioning of the ureter, for obstruction of the ureter, if: (a) the obstruction: (i) is evident either radiologically or by proximal ureteric dilatation at operation; and (ii) is secondary to retroperitoneal fibrosis; and (b) there is biopsy proven fibrosis, endometriosis or cancer at the site of the obstruction at time of surgery (H) (Anaes.) (Assist.)	771.55
36618	Reduction ureteroplasty (H) (Anaes.) (Assist.)	676.15
36621	Closure of cutaneous ureterostomy (H) (Anaes.) (Assist.)	483.35
36624	Nephrostomy, percutaneous, using interventional radiology techniques, but not including imaging (Anaes.) (Assist.)	580.75
36627	Nephroscopy, percutaneous, with or without any one or more of stone extraction, biopsy or diathermy, other than a service to which item 36639 or 36645 applies (H) (Anaes.)	719.40
36633	Nephroscopy, percutaneous, with incision of any one or more of renal	771.55

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, other than a service associated with a service to which item 36627, 36639 or 36645 applies (Anaes.) (Assist.)	
36636	Nephroscopy, percutaneous, with incision of any one or more of renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, being a service associated with a service to which item 36627, 36639 or 36645 applies (H) (Anaes.) (Assist.)	416.10
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 applies (H) (Anaes.)	866.90
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.)	1,109.50
36649	Nephrostomy drainage tube, exchange of, using interventional radiology techniques, but not including imaging (Anaes.) (Assist.)	278.55
36650	Nephrostomy tube, removal of, using interventional radiology techniques, but not including imaging, if the ureter has been stented with a double J ureteric stent and that stent is left in place (H) (Anaes.)	155.80
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.)	676.15
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.)	866.90
36656	Pyeloscopy, retrograde, of one collecting system, being a service to which item 36652 applies, plus extraction of 2 or more stones in the renal pelvis or calyces or destruction of stone with ultrasound, electrohydraulic or kinetic lithotripsy or laser in the renal pelvis or calyces, with or without extraction of fragments, other than a service associated with a service performed in the same collecting system to which item 36654 applies (H) (Anaes.) (Assist.)	1,109.50
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 (Anaes.)	687.75
36664	Both:	617.60

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) percutaneous repositioning of sacral nerve lead or leads using fluoroscopic guidance, or open repositioning of sacral nerve lead or leads; and (b) intra-operative test stimulation, to correct displacement or unsatisfactory positioning, if inserted for the management of: (i) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or (ii) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment; other than a service to which item 36663 applies (Anaes.)	
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	130.45
36666	Pulse generator, subcutaneous placement of, and placement and connection of extension wire or wires to sacral nerve electrode or electrodes, for the management of: (a) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or (b) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment (Anaes.)	347.55
36667	Sacral nerve lead or leads, removal of, if the lead was inserted to manage: (a) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or (b) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment (Anaes.)	162.65
36668	Pulse generator, removal of, if the pulse generator was inserted to manage: (a) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or (b) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment (Anaes.)	162.65
36671	Percutaneous tibial nerve stimulation, initial treatment protocol, for the treatment of overactive bladder, by a specialist urologist, gynaecologist or urogynaecologist, if: (a) the patient has been diagnosed with idiopathic overactive bladder; and (b) the patient has been refractory to, is contraindicated or otherwise not suitable for, conservative treatments (including anti-cholinergic agents); and (c) the patient is contraindicated or otherwise not a suitable candidate for botulinum toxin type A therapy; and (d) the patient is contraindicated or otherwise not a suitable candidate	208.10

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	for sacral nerve stimulation; and (e) the patient is willing and able to comply with the treatment protocol; and (f) the initial treatment protocol comprises 12 sessions, delivered over a 3 month period; and (g) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts for 30 minutes Applicable only once, unless the patient achieves at least a 50% reduction in overactive bladder symptoms from baseline at any time during the 3 month treatment period Not applicable to a service associated with a service to which item 36672 or 36673 applies	
36672	Percutaneous tibial nerve stimulation, tapering treatment protocol, for the treatment of overactive bladder, including any associated consultation at the time the percutaneous tibial nerve stimulation treatment is administered, if: (a) the patient responded to the percutaneous tibial nerve stimulation initial treatment protocol and has achieved at least a 50% reduction in overactive bladder symptoms from baseline at any time during the treatment period for the initial treatment protocol; and (b) the tapering treatment protocol comprises no more than 5 sessions, delivered over a 3 month period, and the interval between sessions is adjusted with the aim of sustaining therapeutic benefit of the treatment; and (c) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts for 30 minutes. Not applicable to a service associated with a service to which item 36671 or 36673 applies	208.10
36673	Percutaneous tibial nerve stimulation, maintenance treatment protocol, for the treatment of overactive bladder, including any associated consultation at the time the percutaneous tibial nerve stimulation treatment is administered, if: (a) the patient responded to the percutaneous tibial nerve stimulation initial treatment protocol and to the tapering treatment protocol, and has achieved at least a 50% reduction in overactive bladder symptoms from baseline at any time during the treatment period for the initial treatment protocol; and (b) the maintenance treatment protocol comprises no more than 12 sessions, delivered over a 12 month period, and the interval between sessions is adjusted with the aim of sustaining therapeutic benefit of the treatment; and (c) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts for 30 minutes Not applicable to service associated with a service to which item 36671 or 36672 applies	208.10
36800	Bladder, catheterisation of, if no other procedure is performed (Anaes.)	28.70
36803	Ureteroscopy, of one ureter, with or without any one or more of	485.25

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	cystoscopy, ureteric meatotomy, or ureteric dilatation, other than a service associated with a service to which item 36652, 36654, 36656, 36806, 36809, 36812, 36824 or 36848 applies (Anaes.) (Assist.)	
36806	Ureteroscopy, of one ureter: (a) with or without one or more of the following: (i) cystoscopy; (ii) endoscopic incision of pelviureteric junction or ureteric stricture; (iii) ureteric meatotomy; (iv) ureteric dilatation; and (b) with either or both of the following: (i) extraction of stone from the ureter; (ii) biopsy or diathermy of the ureter; other than: (c) a service associated with a service to which item 36803 or 36812 applies; or (d) a service associated with a service, performed on the same ureter, to which item 36809, 36824 or 36848 applies (H) (Anaes.) (Assist.)	676.15
36809	Ureteroscopy, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, plus destruction of stone in the ureter with ultrasound, electrohydraulic or kinetic lithotripsy or laser, with or without extraction of fragments, other than a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36806, 36824 or 36848 applies to a procedure performed on the same ureter (H) (Anaes.) (Assist.)	866.90
36811	Cystoscopy, with insertion of one or more urethral or prostatic prostheses, other than a service associated with a service to which item 37203, 37207 or 37230 applies (Anaes.)	336.50
36812	Either or both of cystoscopy and urethroscopy, with or without urethral dilatation, other than a service associated with any other urological endoscopic procedure on the lower urinary tract (Anaes.)	173.45
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.)	247.55
36818	Cystoscopy, with ureteric catheterisation, unilateral or bilateral, guided by fluoroscopic imaging of the upper urinary tract, other than a service associated with a service to which item 36824 or 36830 applies (Anaes.)	287.80
36821	Cystoscopy with one or more of ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or of renal pelvis, unilateral (Anaes.) (Assist.)	336.30
36822	Cystoscopy, with ureteric catheterisation, unilateral: (a) guided by fluoroscopic imaging of the upper urinary tract; and	480.25

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(b) including one or more of ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or of renal pelvis; other than a service associated with a service to which item 36818, 36821 or 36830 applies (Anaes.) (Assist.)	
36823	Cystoscopy, with removal of ureteric stent and ureteric catheterisation, unilateral: (a) guided by fluoroscopic imaging of the upper urinary tract; and (b) including either or both of the following: (i) ureteric dilatation; (ii) insertion of ureteric stent of ureter or of renal pelvis; other than a service associated with a service to which item 36818, 36821, 36830 or 36833 applies (Anaes.) (Assist.)	552.20
36824	Cystoscopy with ureteric catheterisation, unilateral or bilateral, other than a service associated with a service to which item 36818 applies (Anaes.)	221.80
36827	Cystoscopy, with controlled hydro-dilatation of the bladder, other than a service associated with a service to which item 37011 or 37245 applies (Anaes.)	239.20
36830	Cystoscopy, with ureteric meatotomy (H) (Anaes.)	211.50
36833	Cystoscopy with removal of ureteric stent or other foreign body in the lower urinary tract, unilateral (Anaes.)	287.80
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.)	239.20
36840	Cystoscopy, with diathermy, resection or visual laser destruction of bladder tumour or other lesion of the bladder, for: (a) a tumour or lesion in only one quadrant of the bladder; or (b) a solitary tumour of not more than 2 cm in diameter; other than a service associated with a service to which item 36845 applies (Anaes.)	336.30
36842	Cystoscopy, with lavage of blood clots from bladder, including any associated cautery of prostate or bladder, other than a service associated with a service to which any of items 36812, 36827 to 36863, 37203, 37206, 37230 and 37233 apply (H) (Anaes.)	338.35
36845	Cystoscopy, with diathermy, resection or visual laser destruction of: (a) multiple tumours in 2 or more quadrants of the bladder; or (b) a solitary bladder tumour of more than 2 cm in diameter (Anaes.)	719.40
36848	Cystoscopy with resection of ureterocele (H) (Anaes.)	239.20
36851	Cystoscopy with injection into bladder wall, other than a service associated with a service to which item 18375 or 18379 applies (H) (Anaes.)	239.20
36854	Cystoscopy with endoscopic incision or resection of external sphincter, bladder neck or both (H) (Anaes.)	485.25

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
36860	Endoscopic examination of intestinal conduit or reservoir (Anaes.)	173.45
36863	Litholapaxy, with or without cystoscopy (H) (Anaes.)	485.25
37000	Bladder, partial excision of (H) (Anaes.) (Assist.)	771.55
37004	Bladder, repair of rupture (H) (Anaes.) (Assist.)	676.15
37008	Open cystostomy or cystotomy, suprapubic, other than: (a) a service to which item 37011 applies; or (b) a service associated with a service to which item 37245 applies; or (c) another open bladder procedure (Anaes.) (Assist.)	433.30
37011	Suprapubic stab cystotomy, other than a service associated with a service to which item 36827 applies (Anaes.)	97.10
37014	Bladder, total excision of (H) (Anaes.) (Assist.)	1,109.50
37015	Bladder, total excision of, following previous open, laparoscopic or robot-assisted surgery, or radiation therapy or chemotherapy, to the pelvis (H) (Anaes.) (Assist.)	1,331.40
37016	Cystectomy, including prostatectomy and pelvic lymph node dissection, other than a service associated with a service to which item 37000, 37014, 37015, 37209, 35551 or 36502 applies (H) (Anaes) (Assist)	2,076.05
37018	Cystectomy, including prostatectomy and pelvic lymph node dissection, following previous open, laparoscopic or robot-assisted surgery, or radiation therapy or chemotherapy, to the pelvis, other than a service associated with a service to which item 37000, 37014, 37015, 37016, 37209, 35551 or 36502 applies (H) (Anaes.) (Assist.)	3,114.15
37019	Cystectomy, including anterior exenteration and pelvic lymph node dissection, other than a service associated with a service to which any of items 37000, 37014, 37015, 35551, 36502 and 35653 to 35756 apply (H) (Anaes.) (Assist.)	2,073.70
37020	Bladder diverticulum, excision or obliteration of (H) (Anaes.) (Assist.)	771.55
37021	Cystectomy, including anterior exenteration and pelvic lymph node dissection, following previous open, laparoscopic or robot-assisted surgery, or radiation therapy or chemotherapy, to the pelvis, other than a service associated with a service to which any of items 37000, 37014, 37015, 35551, 36502 and 35653 to 35756 apply (H) (Anaes.) (Assist.)	3,110.55
37023	Vesical fistula, cutaneous, operation for (H) (Anaes.)	433.30
37026	Cutaneous vesicostomy, establishment of (H) (Anaes.) (Assist.)	433.30
37029	Vesico-vaginal fistula, closure of, by abdominal approach (H) (Anaes.) (Assist.)	962.20
37038	Vesico-intestinal fistula, closure of, excluding bowel resection (H) (Anaes.) (Assist.)	719.75
37039	Bladder stress incontinence, sling procedure for, using a non-autologous biological sling (H) (Anaes.) (Assist.)	701.85
37040	Bladder stress incontinence, sling procedure for, using a non-adjustable synthetic male sling system, other than a service associated with a service to which item 37042 applies (H) (Anaes.) (Assist.)	948.25

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
37041	Bladder aspiration, by needle	48.50
37042	Bladder stress incontinence—sling procedure for, using autologous fascial sling, including harvesting of sling, other than a service associated with a service to which item 35599 applies (H) (Anaes.) (Assist.)	948.25
37043	Bladder stress incontinence, Stamey or similar type needle colposuspension, other than a service associated with a service to which item 35599 applies (H) (Anaes.) (Assist.)	701.85
37044	Bladder stress incontinence, suprapubic procedure for, e.g., Burch colposuspension, other than a service associated with a service to which item 35599 applies (H) (Anaes.) (Assist.)	719.75
37045	Continent catheterisation bladder stomas (for example, Mitrofanoff), formation of (H) (Anaes.) (Assist.)	1,486.60
37046	Suprapubic or perineal procedure for excision of graft material, either singly or in multiple pieces, for a symptomatic patient with graft related complications (including graft related pain or discharge and bleeding related to graft exposure), if not more than one service to which this item applies has been provided to the patient by the same practitioner in the preceding 12 months (H) (Anaes.) (Assist.)	720.50
37047	Bladder enlargement using intestine (H) (Anaes.) (Assist.)	1,733.55
37048	Bladder neck closure for the management of urinary incontinence (H) (Anaes.) (Assist.)	962.20
37050	Bladder exstrophy closure, not involving sphincter reconstruction (H) (Anaes.) (Assist.)	771.55
37053	Bladder transection and re-anastomosis to trigone (H) (Anaes.) (Assist.)	891.40
37200	Prostatectomy, by open, laparoscopic or robot-assisted approach (H) (Anaes.) (Assist.)	1,057.50
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.)	862.45
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.)	432.90
37203	Prostatectomy, transurethral resection using cautery, 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.)	1,084.35

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
37206	Prostatectomy, endoscopic, using diathermy or other ablative techniques: (a) with or without cystoscopy and with or without urethroscopy; and (b) including services to which one or more of items 36854, 37303, 37321 and 37324 apply; continuation, within 10 days, of treatment of benign prostatic hyperplasia that had to be discontinued for medical reasons (H) (Anaes.)	580.75
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.)	1,084.35
37208	Prostate, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy, and with or without urethroscopy, and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203, 37207 or 37245 which had to be discontinued for medical reasons (H) (Anaes.)	580.75
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.)	1,343.45
37210	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated) with or without bladder neck reconstruction, other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (H) (Anaes.) (Assist.)	1,658.00
37211	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated): (a) with or without bladder neck reconstruction; and (b) with pelvic lymphadenectomy; other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (H) (Anaes.) (Assist.)	2,013.60
37213	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated): (a) complicated by: (i) previous radiation therapy (including brachytherapy) on the prostate; or (ii) previous ablative procedures on the prostate; and (b) with bladder neck reconstruction; other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (H) (Anaes.) (Assist.)	2,486.85
37214	Prostatectomy, radical, involving total excision of the prostate, sparing	3,020.65

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	of nerves around the prostate (where clinically indicated): (a) complicated by: (i) previous radiation therapy (including brachytherapy) on the prostate; or (ii) previous ablative procedures on the prostate; and (b) with bladder neck reconstruction and pelvic lymphadenectomy; other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (H) (Anaes.) (Assist.)	
37215	Prostate, biopsy of, endoscopic, with or without cystoscopy (Anaes.)	433.30
37216	Prostate or prostatic bed, needle biopsy of, by the transrectal route, using prostatic ultrasound guidance and obtaining one or more prostatic specimens, being a service associated with a service to which item 55603 applies (Anaes.)	146.15
37217	Prostate, implantation of radio-opaque fiducial markers into the prostate gland or prostate surgical bed, under ultrasound guidance, being an item associated with a service to which item 55603 applies (Anaes.)	143.90
37218	Prostate, injection into, one or more, excluding insertion of fiduciary markers (Anaes.)	143.90
37219	Prostate or prostatic bed, needle biopsy of, by the transperineal route, using prostatic ultrasound guidance and obtaining one or more prostatic specimens, being a service associated with a service to which item 55600 or 55603 applies (Anaes.)	350.75
37220	Prostate, radioactive seed implantation of, urological component, using transrectal ultrasound guidance: (a) for a patient with: (i) localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate); and (ii) a Gleason score of less than or equal to 7 (Grade Group 1 to Grade Group 3); and (iii) a prostate specific antigen (PSA) of not more than 10ng/ml at the time of diagnosis; and (b) performed by a urologist at an approved site in association with a radiation oncologist; and (c) being a service associated with: (i) services to which items 15338 and 55603 apply; and (ii) a service to which item 60506 or 60509 applies (H) (Anaes.)	1,086.50
37221	Prostatic abscess, endoscopic drainage of (H) (Anaes.)	485.25
37223	Prostatic coil, insertion of, under ultrasound control (H) (Anaes.)	214.60
37224	Prostate, diathermy or cauterisation, other than a service associated with a service to which item 37201, 37202, 37203, 37206, 37207, 37208, 37215, 37230 or 37233 applies (Anaes.)	336.30
37226	Prostate or prostatic bed, needle biopsy of, using prostatic magnetic resonance imaging techniques and obtaining one or more prostatic specimens (Anaes.)	292.25

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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	588.75
37230	Prostate, ablation by electrocautery or high-energy transurethral microwave thermotherapy, with or without cystoscopy and with or without urethroscopy (Anaes.)	1,084.35
37233	Prostate, ablation by electrocautery or high-energy transurethral microwave thermotherapy, with or without cystoscopy and with or without urethroscopy, continuation, within 10 days, of a urological procedure of the prostate that had to be discontinued for medical reasons (Anaes.)	580.75
37245	Prostate, endoscopic enucleation of, for the treatment of benign prostatic hyperplasia: (a) with morcellation, including mechanical morcellation or by an endoscopic technique; and (b) with or without cystoscopy; and (c) with or without urethroscopy; other than a service associated with a service to which item 36827, 36854, 37008, 37201, 37202, 37203, 37206, 37207, 37208, 37303, 37321 or 37324 applies (H) (Anaes.)	1,313.30
37300	Urethral sounds, passage of, as an independent procedure (Anaes.)	48.50
37303	Urethral stricture, dilatation of (Anaes.)	77.10
37306	Urethra, repair of rupture of distal section (H) (Anaes.) (Assist.)	676.15
37309	Urethra, repair of rupture of prostatic or membranous segment (H) (Anaes.) (Assist.)	962.20
37318	Urethroscopy, with or without cystoscopy, with one or more of biopsy, diathermy, visual laser destruction of urethral calculi or removal of foreign body or calculi (Anaes.)	287.80
37321	Urethral meatotomy, external (Anaes.)	97.10
37324	Urethrotomy or urethrostomy, internal or external (H) (Anaes.) (Assist.)	239.20
37327	Urethrotomy, optical, for urethral stricture (H) (Anaes.) (Assist.)	336.30
37330	Urethrectomy, partial or complete, for removal of tumour (H) (Anaes.) (Assist.)	676.15
37333	Urethro-vaginal fistula, closure of (H) (Anaes.) (Assist.)	580.75
37336	Urethro-rectal fistula, closure of (H) (Anaes.) (Assist.)	771.55
37338	Urethral synthetic male sling system, division or removal of, for urethral obstruction, sling erosion, pain or infection following previous surgery for urinary incontinence, other than a service associated with a service to which item 37340 or 37341 applies (H) (Anaes.) (Assist.)	948.25
37339	Periurethral or transurethral injection of urethral bulking agents for the treatment of urinary incontinence, including cystoscopy and urethroscopy, other than a service associated with a service to which item 18375 or 18379 applies (Anaes.)	249.60

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
37340	Urethral synthetic sling, division or removal of, for urethral obstruction, sling erosion, pain or infection following previous surgery for urinary incontinence, vaginal approach, other than a service associated with a service to which item 37341 or 37344 applies (H) (Anaes.) (Assist.)	948.25
37341	Urethral sling, division or removal of, for urethral obstruction, sling erosion, pain or infection following previous surgery for urinary incontinence, suprapubic, combined suprapubic and vaginal or combined suprapubic and perineal approach, other than a service associated with a service to which item 37340 or 37344 applies (H) (Anaes.) (Assist.)	948.25
37342	Urethroplasty—single stage operation (H) (Anaes.) (Assist.)	866.90
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.)	1,447.50
37344	Urethral autologous fascial sling (or other biological sling), division or removal of, for urethral obstruction, sling erosion, pain or infection following previous surgery for urinary incontinence, vaginal approach, other than a service to which 37340 or 37341 applies (H) (Anaes.) (Assist.)	948.25
37345	Urethroplasty—2 stage operation—first stage (H) (Anaes.) (Assist.)	719.40
37348	Urethroplasty—2 stage operation—second stage (H) (Anaes.) (Assist.)	719.40
37351	Urethroplasty, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	287.80
37354	Hypospadias, meatotomy and hemi-circumcision (H) (Anaes.) (Assist.)	336.30
37369	Urethra, excision of prolapse of (H) (Anaes.)	194.20
37372	Urethral diverticulum, excision of (H) (Anaes.) (Assist.)	962.20
37375	Urethral sphincter, reconstruction by bladder tubularisation technique or similar procedure (H) (Anaes.) (Assist.)	1,204.80
37381	Artificial urinary sphincter, insertion of cuff, perineal approach (H) (Anaes.) (Assist.)	771.55
37384	Artificial urinary sphincter, insertion of cuff, abdominal approach (H) (Anaes.) (Assist.)	1,204.80
37387	Artificial urinary sphincter, insertion of pressure regulating balloon and pump (H) (Anaes.) (Assist.)	336.30
37388	Artificial urinary sphincter, sterile, percutaneous adjustment of filling volume	101.90
37390	Artificial urinary sphincter, revision or removal of, with or without replacement (H) (Anaes.) (Assist.)	962.20
37393	Priapism, decompression by glanular stab caverno-sospongiosum shunt or penile aspiration with or without lavage (Anaes.)	239.20
37396	Priapism, shunt operation for, other than a service to which item 37393 applies (H) (Anaes.) (Assist.)	771.55
37402	Penis, partial amputation of (H) (Anaes.) (Assist.)	485.25

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
37405	Penis, complete or radical amputation of (H) (Anaes.) (Assist.)	962.20
37408	Penis, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (H) (Anaes.) (Assist.)	485.25
37411	Penis, repair of avulsion (Anaes.) (Assist.)	962.20
37415	Penis, injection of, for the investigation and treatment of erectile dysfunction Applicable not more than twice in a 36-month period	48.50
37417	Penis, correction of chordee by plication techniques including Nesbit's corporoplasty (H) (Anaes.) (Assist.)	580.75
37418	Penis, correction of chordee with incision or excision of fibrous plaque or plaques, with or without mobilisation of one or both of the neuro-vascular bundle and urethra (Anaes.) (Assist.)	771.55
37423	Penis, lengthening by translocation of corpora, in conjunction with partial penectomy or penile epispadias secondary repair, either as primary or secondary procedures (H) (Anaes.) (Assist.)	962.20
37426	Penis, artificial erection device, insertion of, into one or both corpora (H) (Anaes.) (Assist.)	1,014.05
37429	Penis, artificial erection device, insertion of pump and pressure regulating reservoir (H) (Anaes.) (Assist.)	336.30
37432	Penis, artificial erection device, complete or partial revision or removal of components, with or without replacement (H) (Anaes.) (Assist.)	962.20
37435	Penis, frenuloplasty as an independent procedure (Anaes.)	97.10
37438	Scrotum, partial excision of, for histologically proven malignancy or infection (Anaes.) (Assist.)	287.80
37601	Spermatocele or epididymal cyst, excision of, one or more of, on one side (Anaes.)	287.80
37604	Exploration of scrotal contents, with or without fixation and with or without biopsy, unilateral or bilateral, other than a service associated with sperm harvesting for IVF (Anaes.)	287.80
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.)	388.60
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.)	577.00
37607	Bilateral retroperitoneal lymph node dissection, for testicular tumour, other than a service associated with a service to which item 30390 or 30627 applies (H) (Anaes.) (Assist.)	1,443.25
37610	Bilateral retroperitoneal lymph node dissection, for testicular tumour, following previous similar retroperitoneal dissection, retroperitoneal radiation therapy or chemotherapy, other than a service associated with a service to which item 30390 or 30627 applies (H) (Anaes.) (Assist.)	2,171.30

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
37613	Epididymectomy (Anaes.)	287.80
37616	Vasovasostomy or vasoepididymostomy, unilateral, using the operating microscope, other than a service associated with sperm harvesting for IVF (H) (Anaes.) (Assist.)	719.40
37619	Vasovasostomy or vasoepididymostomy, unilateral, other than a service associated with sperm harvesting for IVF (Anaes.) (Assist.)	287.80
37623	Vasotomy or vasectomy, unilateral or bilateral (Anaes.)	239.20
37800	Patent urachus, excision of, on a patient 10 years of age or over (H) (Anaes.) (Assist.)	542.40
37801	Patent urachus, excision of, on a patient under 10 years of age (H) (Anaes.) (Assist.)	705.15
37803	Undescended testis, orchidopexy for, on a patient 10 years of age or over, other than a service to which item 37806 applies (H) (Anaes.) (Assist.)	542.40
37804	Undescended testis, orchidopexy for, on a patient under 10 years of age, other than a service to which item 37807 applies (H) (Anaes.) (Assist.)	705.15
37806	Undescended testis in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for, on a patient 10 years of age or over (Anaes.) (Assist.)	626.70
37807	Undescended testis in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for, on a patient under 10 years of age (Anaes.) (Assist.)	814.70
37809	Undescended testis, revision orchidopexy for, on a patient 10 years of age or over (H) (Anaes.) (Assist.)	626.70
37810	Undescended testis, revision orchidopexy for, on a patient under 10 years of age (H) (Anaes.) (Assist.)	814.70
37812	Impalpable testis, exploration of groin for, on a patient 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.)	578.50
37813	Impalpable testis, exploration of groin for, on a patient 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.)	752.05
37815	Hypospadias, examination under anaesthesia with erection test, on a patient 10 years of age or over (H) (Anaes.)	96.50
37816	Hypospadias, examination under anaesthesia with erection test, on a patient under 10 years of age (H) (Anaes.)	125.50
37818	Hypospadias, glanuloplasty incorporating meatal advancement, on a patient 10 years of age or over (Anaes.) (Assist.)	511.35
37819	Hypospadias, glanuloplasty incorporating meatal advancement, on a patient under 10 years of age (Anaes.) (Assist.)	664.80
37821	Hypospadias, distal, one stage repair, on a patient 10 years of age or over (H) (Anaes.) (Assist.)	866.90
37822	Hypospadias, distal, one stage repair, on a patient under 10 years of age (H) (Anaes.) (Assist.)	1,126.95

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
37824	Hypospadias, proximal, one stage repair, on a patient 10 years of age or over (H) (Anaes.) (Assist.)	1,205.25
37825	Hypospadias, proximal, one stage repair, on a patient under 10 years of age (H) (Anaes.) (Assist.)	1,566.85
37827	Hypospadias, staged repair, first stage, on a patient 10 years of age or over (H) (Anaes.) (Assist.)	555.25
37828	Hypospadias, staged repair, first stage, on a patient under 10 years of age (H) (Anaes.) (Assist.)	721.80
37830	Hypospadias, staged repair, second stage, on a patient 10 years of age or over (Anaes.) (Assist.)	719.40
37831	Hypospadias, staged repair, second stage, on a patient under 10 years of age (Anaes.) (Assist.)	935.35
37833	Hypospadias, repair of urethral fistula, on a patient 10 years of age or over (H) (Anaes.) (Assist.)	343.35
37834	Hypospadias, repair of urethral fistula, on a patient under 10 years of age (H) (Anaes.) (Assist.)	446.35
37836	Epispadias, staged repair, first stage (H) (Anaes.) (Assist.)	723.15
37839	Epispadias, staged repair, second stage (H) (Anaes.) (Assist.)	819.50
37842	Exstrophy of bladder or epispadias, primary or secondary repair with or without bladder neck tightening, with or without ureteric reimplantation (H) (Anaes.) (Assist.)	1,591.05
37845	Congenital disorder of sexual differentiation with urogenital sinus, external genitoplasty, with or without endoscopy (H) (Anaes.) (Assist.)	723.15
37848	Congenital disorder of sexual differentiation with urogenital sinus, external genitoplasty, with endoscopy and vaginoplasty (H) (Anaes.) (Assist.)	1,301.70
37851	Congenital disorder of sexual differentiation, vaginoplasty for, with or without endoscopy (H) (Anaes.) (Assist.)	964.35
37854	Urethral valve, destruction of, including cystoscopy and urethroscopy (H) (Anaes.)	381.30
Subgroup 6—Cardio-thoracic		
38200	Right heart catheterisation with any one or more of the following: (a) fluoroscopy; (b) oximetry; (c) dye dilution curves; (d) cardiac output measurement by any method; (e) shunt detection; (f) exercise stress test (Anaes.)	463.50
38203	Left heart catheterisation by percutaneous arterial puncture, arteriotomy or percutaneous left ventricular puncture with any one or more of the following: (a) fluoroscopy;	553.10

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(b) oximetry; (c) dye dilution curves; (d) cardiac output measurements by any method; (e) shunt detection; (f) exercise stress test (Anaes.)	
38206	Right heart catheterisation with left heart catheterisation via the right heart or by another procedure, with any one or more of the following: (a) fluoroscopy; (b) oximetry; (c) dye dilution curves; (d) cardiac output measurements by any method; (e) shunt detection; (f) exercise stress test (Anaes.)	668.70
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.)	858.60
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.)	1,428.05
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.)	425.30
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.)	369.30
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.)	553.80

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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.)	184.60
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.)	369.30
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.)	553.90
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.)	738.65
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.)	923.20
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.)	738.50
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.)	923.15

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Column 1 Item	Column 2 Description	Column 3 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.)	1,107.75
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.)	448.70
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.)	461.55
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.)	923.15
38256	Temporary transvenous pacemaking electrode, insertion of (Anaes.)	278.10
38270	Balloon valvuloplasty or isolated atrial septostomy, including cardiac catheterisations before and after balloon dilatation (Anaes.) (Assist.)	949.25
38272	Atrial septal defect, closure using a septal occluder or similar device by transcatheter approach (Anaes.) (Assist.)	949.25
38273	Patent ductus arteriosus, transcatheter closure of, including cardiac catheterisation and any imaging associated with the service (H) (Anaes.) (Assist.)	949.25
38274	Ventricular septal defect, transcatheter closure of, with imaging and cardiac catheterisation (H) (Anaes.) (Assist.)	949.25
38275	Myocardial biopsy, by cardiac catheterisation (Anaes.)	310.25
38276	Transcatheter occlusion of left atrial appendage, and cardiac catheterisation performed by the same practitioner, for stroke prevention in a patient who has non-valvular atrial fibrillation and a contraindication to life-long oral anticoagulation therapy, and is at increased risk of thromboembolism demonstrated by: (a) a prior stroke (whether of an ischaemic or unknown type), transient ischaemic attack or non-central nervous system systemic embolism; or (b) at least 2 of the following risk factors: (i) an age of 65 years or more;	949.25

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(ii) hypertension; (iii) diabetes mellitus; (iv) heart failure or left ventricular ejection fraction of 35% or less (or both); (v) vascular disease (prior myocardial infarction, peripheral artery disease or aortic plaque) (H) (Anaes.) (Assist.)	
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.)	200.75
38286	Implantable ECG loop recorder, removal of (H) (Anaes.)	180.80
38287	Ablation of arrhythmia circuit or focus or isolation procedure involving one atrial chamber (Anaes.) (Assist.)	2,183.55
38288	Implantable loop recorder, insertion of, for diagnosis of atrial fibrillation, if: (a) the patient to whom the service is provided has been diagnosed as having had an embolic stroke of undetermined source; and (b) the bases of the diagnosis included the following: (i) the medical history of the patient; (ii) physical examination; (iii) brain and carotid imaging; (iv) cardiac imaging; (v) surface ECG testing including 24-hour Holter monitoring; and (c) atrial fibrillation is suspected; and (d) the patient: (i) does not have a permanent indication for oral anticoagulants; or (ii) does not have a permanent oral anticoagulants contraindication; including initial programming and testing (Anaes.)	200.75
38290	Ablation of arrhythmia circuits or foci, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (H) (Anaes.) (Assist.)	2,780.20
38293	Ventricular arrhythmia with mapping and ablation, including all associated electrophysiological studies performed on the same day (Anaes.) (Assist.)	2,984.25
38300	Transluminal balloon angioplasty of one coronary artery, percutaneous or by open exposure, excluding associated radiological services,	536.25

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	radiological preparation and after-care (Anaes.) (Assist.)	
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.)	687.55
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.)	793.25
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.)	921.30
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.)	1,178.20
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.)	1,265.15
38318	Percutaneous transluminal rotational atherectomy of more than one coronary artery, including balloon angioplasty, with the insertion of one or more stents, if: (a) no lesion of the coronary artery has been stented; and (b) each lesion of the coronary arteries is complex and heavily calcified; and (c) balloon angioplasty with or without stenting is not suitable; excluding associated radiological services, radiological preparation and after-care (H) (Anaes.) (Assist.)	1,650.65
38350	Single chamber permanent transvenous electrode (including cardiac electrophysiological services if used for pacemaker implantation),	664.55

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	insertion, removal or replacement of (Anaes.)	
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.)	265.80
38356	Dual chamber permanent transvenous electrodes (including cardiac electrophysiological services if used for pacemaker implantation), insertion, removal or replacement of (H) (Anaes.)	871.25
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.)	2,984.25
38359	Pericardium, paracentesis of (excluding after-care) (Anaes.)	139.00
38362	Intra-aortic balloon pump, percutaneous insertion of (H) (Anaes.)	400.50
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.)	265.80
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	1,274.20

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Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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.)	
38371	Permanent cardiac synchronisation device capable of defibrillation, insertion, removal or replacement of, for a patient who: (a) has: (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 (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 (H) (Anaes.)	299.50
38384	Automatic defibrillator, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for, primary prevention of sudden cardiac death in: (a) a patient with a left ventricular ejection fraction of less than or equal to 30% at least one month after a myocardial infarct despite optimised medical therapy; or (b) a patient with chronic heart failure associated with mild to moderate symptoms (NYHA II and III) and a left ventricular ejection fraction less than or equal to 35% despite optimised medical therapy; other than a service associated with a service to which item 38213 applies (H) (Anaes.) (Assist.)	1,095.30
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	299.50

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	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.)	
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.)	1,095.30
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.)	299.50
38415	Empyema, radical operation for, involving resection of rib (Anaes.) (Assist.)	415.55
38416	Endoscopic ultrasound guided fine needle aspiration biopsy or biopsies (endoscopy with ultrasound imaging) to obtain one or more specimens from either or both of the following: (a) mediastinal masses; (b) locoregional nodes to stage non-small cell lung carcinoma; other than a service associated with a service to which an item in Subgroup 1 of this Group, or item 38417 or 55054, applies (Anaes.)	586.15
38417	Endobronchial ultrasound guided biopsy or biopsies (bronchoscopy with ultrasound imaging, with or without associated fluoroscopic imaging) to obtain one or more specimens by: (a) transbronchial biopsy or biopsies of peripheral lung lesions; or (b) fine needle aspirations of one or more mediastinal masses; or (c) fine needle aspirations of locoregional nodes to stage non-small cell lung carcinoma; other than a service associated with a service to which an item in Subgroup 1 of this Group, item 38416, 38420 or 38423, or an item in Subgroup I5 of Group I3, applies (Anaes.)	586.15
38418	Thoracotomy, exploratory, with or without biopsy (H) (Anaes.) (Assist.)	997.25
38419	Bronchoscopy, as an independent procedure (Anaes.)	185.25
38420	Bronchoscopy with one or more endobronchial biopsies or other diagnostic or therapeutic procedures (Anaes.)	244.60
38421	Thoracotomy, with pulmonary decortication (H) (Anaes.) (Assist.)	1,594.05
38422	Bronchus, removal of foreign body in (H) (Anaes.) (Assist.)	382.65
38423	Fibreoptic bronchoscopy with one or more transbronchial lung biopsies, with or without bronchial or broncho-alveolar lavage, with or without the use of interventional imaging (Anaes.) (Assist.)	267.35
38424	Thoracotomy, with pleurectomy or pleurodesis, or enucleation of hydatid cysts (H) (Anaes.) (Assist.)	997.25
38425	Endoscopic laser resection of endobronchial tumours for relief of obstruction including any associated endoscopic procedures (H)	628.75

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(Anaes.) (Assist.)	
38426	Trachea or bronchus, dilatation of stricture and endoscopic insertion of stent (H) (Anaes.) (Assist.)	471.70
38427	Thoracoplasty (complete)—3 or more ribs (H) (Anaes.) (Assist.)	1,231.40
38430	Thoracoplasty (in stages)—each stage (H) (Anaes.) (Assist.)	634.60
38436	Thoracoscopy, with or without division of pleural adhesions, including insertion of intercostal catheter, if necessary, with or without biopsy (H) (Anaes.)	259.85
38438	Pneumonectomy or lobectomy or segmentectomy other than a service associated with a service to which item 38418 applies (H) (Anaes.) (Assist.)	1,594.05
38440	Lung, wedge resection of (H) (Anaes.) (Assist.)	1,193.70
38441	Radical lobectomy or pneumonectomy including resection of chest wall, diaphragm, pericardium, or formal mediastinal node dissection (H) (Anaes.) (Assist.)	1,888.75
38446	Thoracotomy or sternotomy, for removal of thymus or mediastinal tumour (H) (Anaes.) (Assist.)	1,231.40
38447	Pericardiectomy via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (H) (Anaes.) (Assist.)	1,594.05
38448	Mediastinum, cervical exploration of, with or without biopsy (H) (Anaes.) (Assist.)	377.75
38449	Pericardiectomy via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass (H) (Anaes.) (Assist.)	2,230.05
38450	Pericardium, transthoracic open surgical drainage of (H) (Anaes.) (Assist.)	891.35
38452	Pericardium, subxiphoid open surgical drainage of (H) (Anaes.) (Assist.)	596.95
38453	Tracheal excision and repair without cardiopulmonary bypass (H) (Anaes.) (Assist.)	1,790.65
38455	Tracheal excision and repair of, with cardiopulmonary bypass (H) (Anaes.) (Assist.)	2,422.00
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.)	1,594.05
38457	Pectus excavatum or pectus carinatum, repair or radical correction of (H) (Anaes.) (Assist.)	1,488.20
38458	Pectus excavatum, repair of, with implantation of subcutaneous prosthesis (H) (Anaes.) (Assist.)	793.25
38460	Sternal wires or wires, removal of (H) (Anaes.)	286.55
38462	Sternotomy wound, debridement of, not involving reopening of the mediastinum (H) (Anaes.)	339.65
38464	Sternotomy wound, debridement of, involving curettage of infected bone with or without removal of wires but not involving reopening of	369.20

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	the mediastinum (H) (Anaes.)	
38466	Sternum, re-operation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring (H) (Anaes.) (Assist.)	996.85
38468	Sternum and mediastinum, re-operation for infection of, involving muscle advancement flaps or greater omentum (H) (Anaes.) (Assist.)	1,535.95
38469	Sternum and mediastinum, re-operation for infection of, involving muscle advancement flaps and greater omentum (H) (Anaes.) (Assist.)	1,790.65
38470	Permanent myocardial electrode, insertion of, by thoracotomy or sternotomy (H) (Anaes.) (Assist.)	997.25
38473	Permanent pacemaker electrode, insertion by open surgical approach (H) (Anaes.) (Assist.)	596.95
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.)	865.45
38477	Valve annuloplasty with insertion of ring other than a service to which item 38478 applies (H) (Anaes.) (Assist.)	2,084.55
38478	Valve annuloplasty with insertion of ring performed in conjunction with item 38480 or 38481 (H) (Anaes.) (Assist.)	1,009.75
38480	Valve repair, one leaflet (H) (Anaes.) (Assist.)	2,084.55
38481	Valve repair, 2 or more leaflets (H) (Anaes.) (Assist.)	2,373.05
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.)	1,790.65
38485	Mitral annulus, reconstruction of, after decalcification, when performed in association with valve surgery (H) (Anaes.) (Assist.)	850.20
38487	Mitral valve, open valvotomy of (H) (Anaes.) (Assist.)	1,790.65
38488	Valve replacement with bioprosthesis or mechanical prosthesis (H) (Anaes.) (Assist.)	1,986.95
38489	Valve replacement with allograft (subcoronary or cylindrical implant), or unstented xenograft (H) (Anaes.) (Assist.)	2,363.10
38490	Sub-valvular structures, reconstruction and re-implantation of, associated with mitral and tricuspid valve replacement (H) (Anaes.) (Assist.)	577.00
38493	Operative management of acute infective endocarditis, in association with heart valve surgery (H) (Anaes.) (Assist.)	2,036.90
38496	Artery harvesting (other than internal mammary), for coronary artery bypass (H) (Anaes.) (Assist.)	649.25
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.)	2,130.55
38498	Coronary artery bypass with the aid of tissue stabilisers, performed	2,130.55

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	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.)	
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.)	2,289.15
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.)	2,289.15
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.)	2,485.45
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.)	2,485.45
38505	Coronary endarterectomy, by open operation, including repair with one or more patch grafts, each vessel (H) (Anaes.) (Assist.)	288.50
38506	Left ventricular aneurysm, plication of (H) (Anaes.) (Assist.)	1,692.15
38507	Left ventricular aneurysm resection with primary repair (H) (Anaes.) (Assist.)	1,986.55
38508	Left ventricular aneurysm resection with patch reconstruction of the left ventricle (H) (Anaes.) (Assist.)	2,485.45
38509	Ischaemic ventricular septal rupture, repair of (H) (Anaes.) (Assist.)	2,485.45
38512	Division of accessory pathway, isolation procedure, procedure on atrioventricular node or perinodal tissues involving one atrial chamber only (H) (Anaes.) (Assist.)	2,183.55
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.)	2,780.20

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
38518	Ventricular arrhythmia with mapping and muscle ablation, with or without aneurysmeotomy (H) (Anaes.) (Assist.)	2,984.25
38550	Ascending thoracic aorta, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (H) (Anaes.) (Assist.)	2,233.10
38553	Ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (H) (Anaes.) (Assist.)	2,829.95
38556	Ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (H) (Anaes.) (Assist.)	3,230.50
38559	Aortic arch and ascending thoracic aorta, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (H) (Anaes.) (Assist.)	2,633.55
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.)	3,230.50
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.)	3,623.30
38568	Descending thoracic aorta, repair or replacement of, without shunt or cardiopulmonary bypass, by open exposure, percutaneous or endovascular means (H) (Anaes.) (Assist.)	1,938.45
38571	Descending thoracic aorta, repair or replacement of, using shunt or cardiopulmonary bypass (H) (Anaes.) (Assist.)	2,134.90
38572	Operative management of acute rupture or dissection, in conjunction with procedures on the thoracic aorta (H) (Anaes.) (Assist.)	2,067.60
38577	Cannulation for, and supervision and monitoring of, the administration of retrograde cerebral perfusion during deep hypothermic arrest (H) (Assist.)	577.00
38588	Cannulation of the coronary sinus for, and supervision of, the retrograde administration of blood or crystalloid for cardioplegia, including pressure monitoring (H) (Assist.)	432.90
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.)	1,594.05
38603	Peripheral cannulation for cardiopulmonary bypass excluding post-operative management (H) (Anaes.) (Assist.)	997.25
38609	Intra-aortic balloon pump, insertion of, by arteriotomy (H) (Anaes.) (Assist.)	498.55
38612	Intra-aortic balloon pump, removal of, with closure of artery by direct suture (Anaes.) (Assist.)	558.90
38613	Intra-aortic balloon pump, removal of, with closure of artery by patch graft (H) (Anaes.) (Assist.)	701.35

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
38615	Insertion of a left or right ventricular assist device, for use as: (a) a bridge to cardiac transplantation in patients with refractory heart failure who are: (i) currently on a heart transplant waiting list; or (ii) expected to be suitable candidates for cardiac transplantation following a period of support on the ventricular assist device; or (b) acute post cardiotomy support for failure to wean from cardiopulmonary transplantation; or (c) cardio-respiratory support for acute cardiac failure which is likely to recover with short term support of less than 6 weeks; not being a service associated with the use of a ventricular assist device as destination therapy in the management of patients with heart failure who are not expected to be suitable candidates for cardiac transplantation (H) (Anaes.) (Assist.)	1,594.05
38618	Insertion of a left and right ventricular assist device, for use as: (a) a bridge to cardiac transplantation in patients with refractory heart failure who are: (i) currently on a heart transplant waiting list; or (ii) expected to be suitable candidates for cardiac transplantation following a period of support on the ventricular assist device; or (b) acute post cardiotomy support for failure to wean from cardiopulmonary transplantation; or (c) cardio-respiratory support for acute cardiac failure which is likely to recover with short term support of less than 6 weeks; not being a service associated with the use of a ventricular assist device as destination therapy in the management of patients with heart failure who are not expected to be suitable candidates for cardiac transplantation (H) (Anaes.) (Assist.)	1,986.95
38621	Left or right ventricular assist device, removal of, as an independent procedure (H) (Anaes.) (Assist.)	793.25
38624	Left and right ventricular assist device, removal of, as an independent procedure (H) (Anaes.) (Assist.)	891.35
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.)	696.70
38637	Patent diseased coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of (H) (Anaes.) (Assist.)	577.00
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.)	997.25
38643	Thoracotomy or sternotomy involving division of adhesions if the time taken to divide the adhesions exceeds 45 minutes (H) (Anaes.) (Assist.)	1,110.65

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
38647	Thoracotomy or sternotomy involving division of extensive adhesions if the time taken to divide the adhesions exceeds 2 hours (H) (Anaes.) (Assist.)	2,221.00
38650	Myomectomy or myotomy for hypertrophic obstructive cardiomyopathy (H) (Anaes.) (Assist.)	1,986.95
38653	Open heart surgery, other than a service to which another item in this Group applies (H) (Anaes.) (Assist.)	1,986.95
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.)	1,274.20
38656	Thoracotomy or median sternotomy for post-operative bleeding (H) (Anaes.) (Assist.)	997.25
38670	Cardiac tumour, excision of, involving the wall of the atrium or inter-atrial septum, without patch or conduit reconstruction (H) (Anaes.) (Assist.)	1,986.55
38673	Cardiac tumour, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit (H) (Anaes.) (Assist.)	2,235.95
38677	Cardiac tumour arising from ventricular myocardium, partial thickness excision of (H) (Anaes.) (Assist.)	2,091.80
38680	Cardiac tumour arising from ventricular myocardium, full thickness excision of including repair or reconstruction (Anaes.) (Assist.)	2,481.20
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.)	1,110.65
38703	Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital	2,002.05

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	heart disease (H) (Anaes.) (Assist.)	
38706	Aorta, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (H) (Anaes.) (Assist.)	1,896.20
38709	Aorta, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (H) (Anaes.) (Assist.)	2,221.00
38712	Aortic interruption, repair of, for congenital heart disease (H) (Anaes.) (Assist.)	2,667.00
38715	Main pulmonary artery, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease (H) (Anaes.) (Assist.)	1,775.45
38718	Main pulmonary artery, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (H) (Anaes.) (Assist.)	2,221.00
38721	Vena cava, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (H) (Anaes.) (Assist.)	1,556.45
38724	Vena cava, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (H) (Anaes.) (Assist.)	2,221.00
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.)	1,556.45
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.)	2,221.00
38733	Systemic pulmonary or cavo-pulmonary shunt, creation of, without cardiopulmonary bypass, for congenital heart disease (H) (Anaes.) (Assist.)	1,556.45
38736	Systemic pulmonary or cavo-pulmonary shunt, creation of, with cardiopulmonary bypass, for congenital heart disease (H) (Anaes.) (Assist.)	2,221.00
38739	Atrial septectomy, with or without cardiopulmonary bypass, for congenital heart disease (H) (Anaes.) (Assist.)	2,002.05
38742	Atrial septal defect, closure by open exposure and direct suture or patch, for congenital heart disease (H) (Anaes.) (Assist.)	2,002.05
38745	Intra-atrial baffle, insertion of, for congenital heart disease (H) (Anaes.) (Assist.)	2,221.00
38748	Ventricular septectomy, for congenital heart disease (H) (Anaes.) (Assist.)	2,221.00
38751	Ventricular septal defect, closure by direct suture or patch (H) (Anaes.) (Assist.)	2,221.00
38754	Intraventricular baffle or conduit, insertion of, for congenital heart disease (H) (Anaes.) (Assist.)	2,780.20
38757	Extracardiac conduit, insertion of, for congenital heart disease (H) (Anaes.) (Assist.)	2,221.00

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
38760	Extracardiac conduit, replacement of, for congenital heart disease (H) (Anaes.) (Assist.)	2,221.00
38763	Ventricular myectomy, for relief of ventricular obstruction, right or left, for congenital heart disease (H) (Anaes.) (Assist.)	2,221.00
38766	Ventricular augmentation, right or left, for congenital heart disease (H) (Anaes.) (Assist.)	2,221.00
38800	Thoracic cavity, aspiration of, for diagnostic purposes, other than a service associated with a service to which item 38803 applies	40.05
38803	Thoracic cavity, aspiration of, with therapeutic drainage (paracentesis), with or without diagnostic sample	80.00
38806	Intercostal drain, insertion of, not involving resection of rib (excluding after-care) (Anaes.)	139.00
38809	Intercostal drain, insertion of, with pleurodesis and not involving resection of rib (excluding after-care) (Anaes.)	171.25
38812	Percutaneous needle biopsy of lung (Anaes.)	217.65

Subdivision D—Subgroups 7 to 11 of Group T8

5.10.19A Restrictions on items 39015, 39503, 39906 and 40104—services provided with intracranial stereotactic procedure

Items 39015, 39503, 39906 and 40104 do not apply to a service if the service is provided in conjunction with the service described in item 40803.

5.10.19 Items in Subgroups 7 to 11 of Group T8

This clause sets out items in Subgroups 7 to 11 of Group T8.

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
Subgroup 7—Neurosurgical		
39000	Lumbar puncture (Anaes.)	78.35
39007	Procedure to obtain access to intracranial space (including subdural space, ventricle or basal cistern), percutaneously or by burr-hole (Anaes.)	165.90
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.)	113.55
39015	Intracranial parenchymal pressure monitoring device, insertion of—including burr-hole (excluding after-care) (H) (Anaes.)	391.25
39018	Cerebrospinal reservoir, ventricular reservoir or external ventricular drain, insertion of, with or without stereotaxy (H) (Anaes.) (Assist.)	860.15
39100	Injection of primary branch of trigeminal nerve with alcohol, cortisone,	247.20

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	phenol, or similar substance (Anaes.)	
39109	Trigeminal gangliotomy by radiofrequency, balloon or glycerol, including stereotaxy (Anaes.) (Assist.)	1,475.05
39113	Cranial nerve, neurectomy or intracranial decompression of, using microsurgical techniques, including stereotaxy and cranioplasty (H) (Anaes.) (Assist.)	2,474.45
39115	Percutaneous neurotomy of posterior divisions (or rami) of spinal nerves by any method, including any associated spinal, epidural or regional nerve block (applicable once in a 30 day period) (Anaes.)	78.35
39118	Percutaneous neurotomy for facet joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.) (Assist.)	309.90
39121	Percutaneous cordotomy (Anaes.) (Assist.)	657.35
39124	Cordotomy or myelotomy, partial or total laminectomy for, or operation for dorsal root entry zone (Drez) lesion (H) (Anaes.) (Assist.)	1,682.30
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.)	310.10
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.)	376.55
39127	Subcutaneous reservoir and spinal catheter, insertion of, for the management of chronic intractable pain (H) (Anaes.)	492.85
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.)	686.65
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.)	701.45
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	133.00
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.)	165.90

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 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.)	354.40
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 (H) (Anaes.)	165.90
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.)	165.90
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.)	629.90
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.)	701.45
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.)	941.80
39140	Epidural catheter, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (Anaes.)	304.70
39300	Nerve, digital or cutaneous, primary repair of, using microsurgical techniques, other than a service associated with a service to which item 39330 applies—applicable once per nerve (H) (Anaes.) (Assist.)	367.70
39303	Nerve, digital or cutaneous, delayed repair of, using microsurgical techniques, including either or both of the following (if performed): (a) neurolysis; (b) transposition of nerve to facilitate repair; other than a service associated with a service to which item 30023 applies—applicable once per nerve (H) (Anaes.) (Assist.)	485.00
39306	Nerve trunk, primary repair of, using microsurgical techniques, other than a service associated with a service to which item 39330 applies (H) (Anaes.) (Assist.)	704.25
39307	Reconstruction of nerve trunk using biological or synthetic nerve conduit, using microsurgical techniques, other than a service associated with a service to which item 39330 applies (Anaes.) (Assist.)	857.55
39309	Nerve trunk, delayed repair of, using microsurgical techniques, including either or both of the following (if performed): (a) neurolysis;	743.35

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(b) transposition of nerve or nerve transfer to facilitate repair; other than a service associated with a service to which item 30023 or 39321 applies (H) (Anaes.) (Assist.)	
39312	Nerve trunk, internal (interfascicular), neurolysis of, using microsurgical techniques, other than a service associated with a service to which item 30023 applies (H) (Anaes.) (Assist.)	414.70
39315	Nerve trunk, nerve graft to, by cable graft, using microsurgical techniques, including any of the following (if performed): (a) harvesting of nerve graft; (b) proximal and distal anastomosis of nerve graft; (c) transposition of nerve to facilitate grafting; (d) neurolysis; other than a service associated with a service to which item 30023 or 39330 applies (H) (Anaes.) (Assist.)	1,071.95
39318	Nerve, digital or cutaneous, nerve graft to, using microsurgical techniques, including either or both of the following (if performed): (a) harvesting of nerve graft from separate donor site; (b) proximal and distal anastomosis of nerve graft; other than a service associated with a service to which item 39330 applies (H) (Anaes.) (Assist.)	665.15
39319	Reconstruction of digital or cutaneous nerve using biological or synthetic nerve conduit, using microsurgical techniques, other than a service associated with a service to which item 39330 applies (Anaes.) (Assist.)	485.00
39321	Transposition of nerve, excluding the ulnar nerve at the elbow, other than a service associated with a service to which item 39330 applies (H) (Anaes.) (Assist.)	492.85
39323	Percutaneous neurotomy by cryotherapy or radiofrequency lesion generator, other than a service to which another item applies (Anaes.) (Assist.)	288.00
39324	Neurectomy or removal of tumour or neuroma from superficial peripheral nerve (Anaes.) (Assist.)	288.00
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.)	492.95
39328	Neurectomy, neurotomy or removal of tumour from deep peripheral nerve, by open operation, for upper limb surgery (H) (Anaes.) (Assist.)	492.95
39329	Extensive neurolysis of radial, median or ulnar nerve trunk nerve in the forearm or arm, other than a service associated with a service to which item 30023, 39303, 39309, 39312, 39315, 39318, 39324, 39327 or 39333 applies (Anaes.)(Assist.)	367.70
39330	Neurolysis by open operation without transposition, other than a service associated with a service to which item 30023, 39321, 39328, 39329, 39332, 39336, 39339, 39342, 39345, 49774 or 49775 applies (H) (Anaes.) (Assist.)	288.00

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
39331	Carpal tunnel release, including division of transverse carpal ligament or release of median nerve, by any method, including either or both of the following (if performed): (a) synovectomy; (b) neurolysis; other than a service associated with a service to which item 30023 or 46339 applies (Anaes.) (Assist.)	288.00
39332	Revision of carpal tunnel release, including division of transverse carpal ligament or release of median nerve, by any method, including either or both of the following (if performed): (a) synovectomy; (b) neurolysis; other than a service associated with a service to which item 30023 or 46339 applies. (Anaes.)(Assist.)	432.05
39333	Brachial plexus, exploration of, other than a service to which another item in this Group applies (Anaes.) (Assist.)	414.70
39336	Ulnar nerve decompression at elbow or wrist (cubital tunnel or Guyon's canal) without transposition, by any method, including neurolysis (if performed), other than a service associated with a service to which item 30023 applies (Anaes.)(Assist.)	288.00
39339	Revision of ulnar nerve decompression at elbow (cubital tunnel) without transposition, by any method, including neurolysis (if performed), other than a service associated with a service to which item 30023 applies (Anaes.)(Assist.)	432.05
39342	Ulnar nerve decompression at elbow (cubital tunnel), including any of the following (if performed): (a) associated transposition; (b) subcutaneous or submuscular transposition of the nerve; (c) medial epicondylectomy; (d) ostetomy and reconstruction of the flexor origin; (e) neurolysis; other than a service associated with a service to which item 30023 applies (Anaes.)(Assist.)	566.75
39345	Localised decompression of radial, median or ulnar nerve, or branches of, in the forearm for compressive neuropathy, including neurolysis (if performed), other than a service associated with a service to which item 30023 applies (Anaes.)(Assist.)	288.00
39503	Facio-hypoglossal nerve or facio-accessory nerve, anastomosis of (H) (Anaes.) (Assist.)	993.70
39604	Any of the following procedures for intracranial haemorrhage or swelling: (a) craniotomy, craniectomy or burr-holes for removal of intracranial haemorrhage, including stereotaxy; (b) craniotomy or craniectomy for brain swelling, stroke or raised intracranial pressure, including for subtemporal decompression, including stereotaxy;	1,866.25

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(c) post-operative re-opening, including for swelling or post-operative cerebrospinal fluid leak (H) (Anaes.) (Assist.)	
39610	Fractured skull, without brain laceration or dural penetration, repair of (H) (Anaes.) (Assist.)	993.70
39612	Fractured skull, with brain laceration or dural penetration but without cerebrospinal fluid, rhinorrhoea or otorrhoea, repair of (H) (Anaes.) (Assist.)	1,165.90
39615	Fractured skull, after trauma, with cerebrospinal fluid, rhinorrhoea or otorrhoea, repair of, including stereotaxy and dermofat graft (H) (Anaes.) (Assist.)	1,989.50
39638	Anterior or middle cranial fossa or cavernous sinus, tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty—conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	4,429.65
39639	Anterior or middle cranial fossa or cavernous sinus, tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty—conjoint surgery, co-surgeon (H) (Assist.)	3,539.75
39641	Anterior or middle cranial fossa or cavernous sinus, tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty—one surgeon (H) (Anaes.) (Assist.)	4,672.15
39651	Petro-clival, clival or foramen magnum tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty—one surgeon (H) (Anaes.) (Assist.)	5,764.25
39654	Petro-clival, clival or foramen magnum tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty—conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	4,429.65
39656	Petro-clival, clival or foramen magnum tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty—conjoint surgery, co-surgeon (H) (Assist.)	3,539.75
39700	Skull tumour, benign or malignant, excision of, including stereotaxy and cranioplasty (H) (Anaes.) (Assist.)	1,885.80
39703	Intracranial tumour, cyst or other brain tissue, either or both of the following: (a) burr-hole and biopsy of; (b) drainage of; including stereotaxy (H) (Anaes.) (Assist.)	1,514.20
39710	Intracranial tumour, one or more, biopsy, drainage, decompression or removal of, through a single craniotomy, including stereotaxy and cranioplasty (H) (Anaes.) (Assist.)	2,521.60
39712	Transcranial tumour, removal or biopsy of one or more of any of the following: (a) meningioma; (b) pinealoma; (c) cranio-pharyngioma;	3,851.65

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(d) pituitary tumour; (e) intraventricular lesion; (f) brain stem lesion; (g) any other intracranial tumour; by any means (with or without endoscopy), through a single craniotomy, including stereotaxy and cranioplasty (H) (Anaes.) (Assist.)	
39715	Pituitary tumour, removal of, by transphenoidal approach, including stereotaxy and dermis, dermofat or fascia grafting, other than a service associated with a service to which item 40600 applies (H) (Anaes.) (Assist.)	2,811.05
39718	Arachnoidal cyst, craniotomy for, including stereotaxy and neuroendoscopy (H) (Anaes.) (Assist.)	1,698.05
39720	Awake craniotomy for functional neurosurgery (H) (Anaes.) (Assist.)	3,603.20
39801	Aneurysm, clipping, proximal ligation, or reinforcement of sac, including stereotaxy and cranioplasty (H) (Anaes.) (Assist.)	5,764.25
39803	Intracranial arteriovenous malformation or fistula, treatment through a craniotomy, including stereotaxy, cranioplasty and all angiography (H) (Anaes.) (Assist.)	5,764.25
39815	Carotid-cavernous fistula, obliteration of—combined cervical and intracranial procedure (Anaes.) (Assist.)	1,901.30
39818	Intracranial vascular bypass using indirect techniques, including stereotaxy (H) (Anaes.) (Assist.)	2,523.45
39821	Intracranial vascular bypass using direct anastomosis techniques, including stereotaxy (H) (Anaes.) (Assist.)	3,595.40
39900	Intracranial infection, treated by burr-hole, including stereotaxy, other than a service associated with a service to which item 40600 applies (H) (Anaes.) (Assist.)	1,514.20
39903	Intracranial infection, treated by craniotomy, including stereotaxy, other than a service associated with a service to which item 40600 applies (H) (Anaes.) (Assist.)	2,273.20
39906	Osteomyelitis of skull or removal of infected bone flap, craniectomy for, other than a service associated with a service to which item 40600 applies (H) (Anaes.) (Assist.)	829.40
40004	Ventricular, lumbar or cisternal shunt diversion, insertion or revision of, including stereotaxy (H) (Anaes.) (Assist.)	1,721.50
40012	Endoscopic ventriculostomy for treatment of cerebrospinal fluid circulation disorders, including stereotaxy (H) (Anaes.) (Assist.)	1,780.20
40018	Lumbar cerebrospinal fluid drain, insertion of (Anaes.)	165.90
40104	Spinal myelomeningocele or spinal meningocele, excision and closure of, other than a service associated with a service to which item 40600 applies (H) (Anaes.) (Assist.)	1,056.35
40106	Chiari malformation, decompression or reconstruction of, including laminectomy, dermofat graft and stereotaxy, other than a service associated with a service to which item 40600 applies (H) (Anaes.)	2,507.80

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(Assist.)	
40109	Encephalocoele or cranial meningocele, excision and closure of, including stereotaxy and dermofat graft (H) (Anaes.) (Assist.)	1,946.40
40112	Tethered cord, release of, including lipomeningocele or diastematomyelia, multiple levels, including laminectomy and rhizolysis, other than a service associated with a service to which item 40600 applies (H) (Anaes.) (Assist.)	2,486.35
40119	Craniostenosis, operation for, other than a service associated with a service to which item 40600 applies (H) (Anaes.) (Assist.)	993.70
40600	Cranioplasty, reconstructive, other than a service associated with a service to which item 39113, 39638, 39639, 39641, 39651, 39654, 39656, 39700, 39710, 39712, 39715, 39801, 39803 or 40703 applies (H) (Anaes.) (Assist.)	993.70
40700	Corpus callosotomy, for epilepsy, including stereotaxy (H) (Anaes.) (Assist.)	2,437.45
40701	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, subcutaneous placement of electrical pulse generator, for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (H) (Anaes.) (Assist.)	354.40
40702	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical repositioning or removal of electrical pulse generator inserted for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (H) (Anaes.) (Assist.)	165.90
40703	Corticectomy, topectomy or partial lobectomy, for epilepsy, including stereotaxy and cranioplasty (H) (Anaes.) (Assist.)	2,521.60
40704	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical placement of lead, including connection of lead to left vagus nerve and intra-operative test stimulation, for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (H) (Anaes.) (Assist.)	701.45
40705	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical repositioning or removal of lead attached to left vagus nerve for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (H) (Anaes.) (Assist.)	629.90

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
40706	Hemispherectomy or functional hemispherectomy, for intractable epilepsy, including stereotaxy (H) (Anaes.) (Assist.)	3,603.25
40707	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, electrical analysis and programming of vagus nerve stimulation therapy device using external wand, for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery	197.40
40708	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical replacement of battery in electrical pulse generator inserted for: (a) management of refractory generalised epilepsy; or (b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (H) (Anaes.) (Assist.)	354.40
40709	Intracranial electrode placement by burr-hole, including stereotaxy (H) (Anaes.) (Assist.)	1,514.20
40712	Intracranial electrode placement by craniotomy, single or multiple, including stereotactic EEG, including stereotaxy (H) (Anaes.) (Assist.)	3,603.25
40801	Functional stereotactic procedure, including computer assisted anatomical localisation, physiological localisation and lesion production, by any method, in the basal ganglia, brain stem or deep white matter tracts, other than a service associated with deep brain stimulation for Parkinson's disease, essential tremor or dystonia (H) (Anaes.) (Assist.)	1,816.55
40803	Intracranial stereotactic procedure by any method, other than: (a) a service to which item 40801 applies; or (b) a service associated with a service to which item 39018, 39109, 39113, 39604, 39615, 39638, 39639, 39641, 39651, 39654, 39656, 39700, 39703, 39710, 39712, 39715, 39718, 39720, 39801, 39803, 39818, 39821, 39900, 39903, 40004, 40012, 40106, 40109, 40700, 40703, 40706, 40709 or 40712 applies (Anaes.) (Assist.)	1,244.15
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, if the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or (b) essential tremor or dystonia, if the patient's symptoms cause severe disability (H) (Anaes.) (Assist.)	2,356.20
40851	Deep brain stimulation (bilateral) functional stereotactic procedure, including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes for the treatment of:	4,123.60

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(a) Parkinson's disease, if the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or (b) essential tremor or dystonia, if the patient's symptoms cause severe disability (H) (Anaes.) (Assist.)	
40852	Deep brain stimulation (unilateral) subcutaneous placement of neuro-stimulator receiver or pulse generator for the treatment of: (a) Parkinson's disease, if the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or (b) essential tremor or dystonia, if the patient's symptoms cause severe disability (H) (Anaes.) (Assist.)	354.40
40854	Deep brain stimulation (unilateral) revision or removal of brain electrode for the treatment of: (a) Parkinson's disease, if the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or (b) essential tremor or dystonia, if the patient's symptoms cause severe disability (H) (Anaes.) (Assist.)	547.70
40856	Deep brain stimulation (unilateral) removal or replacement of neurostimulator receiver or pulse generator for the treatment of: (a) Parkinson's disease, if the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or (b) essential tremor or dystonia, if the patient's symptoms cause severe disability (H) (Anaes.) (Assist.)	265.80
40858	Deep brain stimulation (unilateral) placement, removal or replacement of extension lead for the treatment of: (a) Parkinson's disease, if the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or (b) essential tremor or dystonia, if the patient's symptoms cause severe disability (H) (Anaes.) (Assist.)	547.70
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, if the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or (b) essential tremor or dystonia if the patient's symptoms cause severe disability (H) (Anaes.) (Assist.)	2,104.65
40862	Deep brain stimulation (unilateral) electronic analysis and programming of neurostimulator pulse generator for the treatment of: (a) Parkinson's disease, if the patient's response to medical therapy is not	197.40

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	sustained and is accompanied by unacceptable motor fluctuations; or (b) essential tremor or dystonia, if the patient's symptoms cause severe disability (Anaes.)	
40905	Craniotomy, performed by a neurosurgeon in conjunction with the correction of craniofacial abnormalities (H) (Anaes.) (Assist.)	626.10
Subgroup 8—Ear, nose and throat		
41500	Ear, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.)	85.80
41501	Examination of glottal cycles and vibratory characteristics of the vocal folds, by a specialist in the practice of the specialist's specialty of otolaryngology, using videostroboscopy (capturing audio, video, frequency and intensity), for confirmation of diagnosis, or for confirmation of treatment effectiveness where there is failure to progress or respond as expected, for: (a) dysphonia, if non-stroboscopic techniques of visualising the larynx have failed to identify any frank abnormality of the vocal folds; or (b) benign or malignant vocal fold lesions; or (c) premalignant or malignant laryngeal lesions; or (d) vocal fold motion impairment or glottal insufficiency; or (e) evaluation of vocal fold function after treatment or phonosurgery; other than a service associated with a service to which item 41764 applies, or a service associated with the administration of a general anaesthetic	193.10
41503	Ear, removal of foreign body in, involving incision of external auditory canal (Anaes.)	248.45
41506	Aural polyp, removal of (Anaes.)	149.85
41509	External auditory meatus, surgical removal of keratosis obturans from, other than a service to which another item in this Group applies (Anaes.)	169.55
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.)	609.65
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.)	400.10
41518	External auditory meatus, removal of exostoses in (H) (Anaes.) (Assist.)	966.35
41521	Correction of auditory canal stenosis, including meatoplasty, with or without grafting (H) (Anaes.) (Assist.)	1,028.90
41524	Reconstruction of external auditory canal, being a service associated with a service to which items 41557, 41560 and 41563 apply (H) (Anaes.) (Assist.)	297.25
41527	Myringoplasty, trans-canal approach (Rosen incision) (H) (Anaes.) (Assist.)	611.40
41530	Myringoplasty, post-aural or endaural approach with or without mastoid inspection (H) (Anaes.)	996.10

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
41533	Atticotomy without reconstruction of the bony defect, with or without myringoplasty (H) (Anaes.) (Assist.)	1,190.65
41536	Atticotomy with reconstruction of the bony defect with or without myringoplasty (H) (Anaes.) (Assist.)	1,333.65
41539	Ossicular chain reconstruction (H) (Anaes.) (Assist.)	1,134.05
41542	Ossicular chain reconstruction and myringoplasty (H) (Anaes.) (Assist.)	1,242.65
41545	Mastoidectomy (cortical) (H) (Anaes.) (Assist.)	542.40
41548	Obliteration of the mastoid cavity (H) (Anaes.) (Assist.)	719.75
41551	Mastoidectomy, intact wall technique, with myringoplasty (H) (Anaes.) (Assist.)	1,657.65
41554	Mastoidectomy, intact wall technique, with myringoplasty and ossicular chain reconstruction (H) (Anaes.) (Assist.)	1,953.00
41557	Mastoidectomy (radical or modified radical) (H) (Anaes.) (Assist.)	1,134.05
41560	Mastoidectomy (radical or modified radical) and myringoplasty (H) (Anaes.)	1,242.65
41563	Mastoidectomy (radical or modified radical), myringoplasty and ossicular chain reconstruction (H) (Anaes.) (Assist.)	1,538.30
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.)	1,989.30
41566	Revision of mastoidectomy (radical, modified radical or intact wall), including myringoplasty (H) (Anaes.) (Assist.)	1,134.05
41569	Decompression of facial nerve in its mastoid portion (H) (Anaes.) (Assist.)	1,242.65
41572	Labyrinthotomy or destruction of labyrinth (H) (Anaes.) (Assist.)	1,075.10
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.)	2,534.35
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.)	3,801.65
41578	Cerebello-pontine angle tumour, removal of, by transmastoid, translabyrinthine or retromastoid approach (intracranial procedure)—conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	2,534.35
41579	Cerebello-pontine angle tumour, removal of, by transmastoid, translabyrinthine or retromastoid approach (intracranial procedure)—conjoint surgery, co-surgeon (H) (Assist.)	1,900.80
41581	Tumour involving infra-emporal fossa, removal of, involving craniotomy and radical excision of (H) (Anaes.) (Assist.)	2,915.05
41584	Partial temporal bone resection for removal of tumour involving mastoidectomy with or without decompression of facial nerve (H) (Anaes.) (Assist.)	2,000.55
41587	Total temporal bone resection for removal of tumour (H) (Anaes.)	2,724.70

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(Assist.)	
41590	Endolymphatic sac, transmastoid decompression with or without drainage of (H) (Anaes.) (Assist.)	1,242.65
41593	Translabyrinthine vestibular nerve section (H) (Anaes.) (Assist.)	1,619.55
41596	Retrolabyrinthine vestibular nerve section or cochlear nerve section, or both (H) (Anaes.) (Assist.)	1,810.00
41599	Internal auditory meatus, exploration by middle cranial fossa approach with cranial nerve decompression (H) (Anaes.) (Assist.)	1,810.00
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	524.30
41604	Osseo-integration procedure—fixation of transcutaneous abutment implantation of titanium fixture for use with implantable bone conduction hearing system device, in a patient: (a) with a permanent or long term hearing loss; and (b) unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and (c) with bone conduction thresholds that accord with recognised surgical criteria for the implantable bone conduction hearing system devices; other than a service associated with a service to which item 41554, 45794 or 45797 applies	194.10
41608	Stapedectomy (H) (Anaes.) (Assist.)	1,134.05
41611	Stapes mobilisation (H) (Anaes.) (Assist.)	729.70
41614	Round window surgery including repair of cochleotomy (Anaes.) (Assist.)	1,134.05
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.)	1,134.05
41617	Cochlear implant, insertion of, including mastoidectomy (H) (Anaes.) (Assist.)	1,972.00
41618	Middle ear implant, partially implantable, insertion of, via mastoidectomy, for patients with: (a) stable sensorineural hearing loss; and (b) outer ear pathology that prevents the use of a conventional hearing aid; and (c) a PTA4 of less than 80 dBHL; and (d) bilateral, symmetrical hearing loss with PTA thresholds in both ears within 20 dBHL (0.5-4kHz) of each other; and (e) speech perception discrimination of at least 65% correct for word lists	1,953.00

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	with appropriately amplified sound; and (f) a normal middle ear; and (g) normal tympanometry; and (h) on audiometry, an air-bone gap of less than 10 dBHL (0.5-4kHz) across all frequencies; and (i) no other inner ear disorders (H) (Anaes.) (Assist.)	
41620	Glomus tumour, transtympanic removal of (H) (Anaes.) (Assist.)	857.95
41623	Glomus tumour, transmastoid removal of, including mastoidectomy (H) (Anaes.) (Assist.)	1,242.65
41626	Abscess or inflammation of middle ear, operation for (excluding after-care) (Anaes.)	149.85
41629	Middle ear, exploration of (H) (Anaes.) (Assist.)	542.40
41632	Middle ear, insertion of tube for drainage of (including myringotomy) (Anaes.)	248.45
41635	Clearance of middle ear for granuloma, cholesteatoma and polyp, one or more, with or without myringoplasty (Anaes.) (Assist.)	1,190.65
41638	Clearance of middle ear for granuloma, cholesteatoma and polyp, one or more, with or without myringoplasty with ossicular chain reconstruction (H) (Anaes.) (Assist.)	1,486.20
41641	Perforation of tympanum, cauterisation or diathermy of (Anaes.)	49.35
41644	Excision of rim of eardrum perforation, other than a service associated with myringoplasty (Anaes.)	148.65
41647	Ear toilet requiring use of operating microscope and microinspection of tympanic membrane with or without general anaesthesia (Anaes.)	114.30
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.)	114.30
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.)	74.85
41656	Nasal haemorrhage, posterior, arrest of, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding after-care) (Anaes.)	127.80
41659	Nose, removal of foreign body in, other than by simple probing (Anaes.)	80.70
41662	Nasal polyp or polypi (simple), removal of	85.80
41668	Nasal polyp or polypi, removal of (H) (Anaes.)	228.85
41671	Nasal septum, septoplasty, submucous resection or closure of septal perforation (H) (Anaes.)	502.85
41672	Nasal septum, reconstruction of (H) (Anaes.) (Assist.)	627.30
41674	Cauterisation (other than by chemical means) or cauterisation by chemical means when performed under general anaesthesia or diathermy of septum or turbinates—one or more of these procedures (including any consultation on the same occasion) other than a service associated with	104.60

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	another operation on the nose (Anaes.)	
41677	Nasal haemorrhage, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.)	93.65
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.)	122.00
41686	Dislocation of turbinate or turbinates, one or both sides, other than a service associated with a service to which another item in this Group applies (Anaes.)	74.85
41689	Turbinectomy or turbinectomies, partial or total, unilateral (H) (Anaes.)	142.05
41692	Turbinates, submucous resection of, unilateral (H) (Anaes.)	185.25
41698	Maxillary antrum, proof puncture and lavage of (Anaes.)	33.85
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.)	95.60
41704	Maxillary antrum, lavage of—each attendance at which the procedure is performed, including any associated consultation (Anaes.)	37.80
41707	Maxillary artery, transantral ligation of (H) (Anaes.) (Assist.)	466.75
41710	Antrostomy (radical) (H) (Anaes.) (Assist.)	542.40
41713	Antrostomy (radical) with transantral ethmoidectomy or transantral vidian neurectomy (H) (Anaes.) (Assist.)	631.10
41716	Antrum, intranasal operation on or removal of foreign body from (H) (Anaes.) (Assist.)	307.70
41719	Antrum, drainage of, through tooth socket (Anaes.)	122.35
41722	Oro-antral fistula, plastic closure of (Anaes.) (Assist.)	611.40
41725	Ethmoidal artery or arteries, transorbital ligation of (unilateral) (H) (Anaes.) (Assist.)	466.75
41728	Lateral rhinotomy with removal of tumour (H) (Anaes.) (Assist.)	933.65
41729	Dermoid of nose, excision of, with intranasal extension (H) (Anaes.) (Assist.)	591.70
41731	Fronto-nasal ethmoidectomy by external approach with or without sphenoidectomy (H) (Anaes.) (Assist.)	808.60
41734	Radical fronto-ethmoidectomy with osteoplastic flap (H) (Anaes.) (Assist.)	1,055.10
41737	Frontal sinus, or ethmoidal sinuses on the one side, intranasal operation on (H) (Anaes.) (Assist.)	502.85
41740	Frontal sinus, catheterisation of (H) (Anaes.)	61.20
41743	Frontal sinus, trephine of (H) (Anaes.) (Assist.)	351.15
41746	Frontal sinus, radical obliteration of (Anaes.) (Assist.)	808.60
41749	Ethmoidal sinuses, external operation on (H) (Anaes.) (Assist.)	631.10
41752	Sphenoidal sinus, intranasal operation on (H) (Anaes.) (Assist.)	307.70
41755	Eustachian tube, catheterisation of (Anaes.)	48.40

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
41764	Nasendoscopy or sinoscopy or fibreoptic examination of nasopharynx and larynx, one or more of these procedures, unilateral or bilateral examination of (Anaes.)	127.80
41767	Nasopharyngeal angiofibroma, removal of (Anaes.) (Assist.)	766.90
41770	Pharyngeal pouch, removal of, with or without cricopharyngeal myotomy (H) (Anaes.) (Assist.)	729.70
41773	Pharyngeal pouch, endoscopic resection of (Dohlman's operation) (H) (Anaes.) (Assist.)	611.40
41776	Cricopharyngeal myotomy with or without inversion of pharyngeal pouch (H) (Anaes.) (Assist.)	609.65
41779	Pharyngotomy (lateral), with or without total excision of tongue (H) (Anaes.) (Assist.)	729.70
41782	Partial pharyngectomy via pharyngotomy (Anaes.) (Assist.)	990.70
41785	Partial pharyngectomy via pharyngotomy with partial or total glossectomy (H) (Anaes.) (Assist.)	1,229.00
41786	Uvulopalatopharyngoplasty, with or without tonsillectomy, by any means (H) (Anaes.) (Assist.)	766.90
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.)	591.70
41789	Tonsils or tonsils and adenoids, removal of, in a patient aged less than 12 years (including any examination of the postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a service to which item 41764 applies (H) (Anaes.)	307.70
41793	Tonsils or tonsils and adenoids, removal of, in a patient 12 years of age or over (including any examination of the postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a service to which item 41764 applies (H) (Anaes.)	386.55
41797	Tonsils or tonsils and adenoids, arrest of haemorrhage requiring general anaesthesia, following removal of (H) (Anaes.)	149.85
41801	Adenoids, removal of (including any examination of the postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a service to which item 41764 applies (H) (Anaes.)	169.55
41804	Lingual tonsil or lateral pharyngeal bands, removal of (H) (Anaes.)	93.65
41807	Peritonsillar abscess (quinsy), incision of (Anaes.)	72.90
41810	Uvulotomy or uvulectomy (Anaes.)	37.05
41813	Vallecular or pharyngeal cysts, removal of (H) (Anaes.) (Assist.)	370.80
41816	Oesophagoscopy (with rigid oesophagoscope) (Anaes.)	193.10
41822	Oesophagoscopy (with rigid oesophagoscope) with biopsy (H) (Anaes.)	248.45
41825	Oesophagoscopy (with rigid oesophagoscope) with removal of foreign body (H) (Anaes.) (Assist.)	370.80
41828	Oesophageal stricture, dilatation of, without oesophagoscopy (Anaes.)	54.35
41831	Oesophagus, endoscopic pneumatic dilatation of, for treatment of	371.45

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	achalasia (Anaes.) (Assist.)	
41832	Oesophagus, balloon dilatation of, using interventional imaging techniques (Anaes.)	237.75
41834	Laryngectomy (total) (H) (Anaes.) (Assist.)	1,341.40
41837	Vertical hemi-laryngectomy including tracheostomy (H) (Anaes.) (Assist.)	1,286.15
41840	Supraglottic laryngectomy including tracheostomy (H) (Anaes.) (Assist.)	1,581.35
41843	Laryngopharyngectomy or primary restoration of alimentary continuity after laryngopharyngectomy using stomach or bowel (H) (Anaes.) (Assist.)	1,390.60
41855	Microlaryngoscopy (H) (Anaes.) (Assist.)	299.85
41858	Microlaryngoscopy with removal of juvenile papillomata (H) (Anaes.) (Assist.)	514.20
41861	Microlaryngoscopy with removal of benign lesions of the larynx by laser surgery (H) (Anaes.) (Assist.)	628.75
41864	Microlaryngoscopy with removal of tumour (H) (Anaes.) (Assist.)	424.00
41867	Microlaryngoscopy with arytenoidectomy (H) (Anaes.) (Assist.)	638.25
41868	Laryngeal web, division of, using microlarygoscopic techniques (H) (Anaes.)	404.40
41870	Injection of vocal cord by teflon, fat, collagen or gelfoam (H) (Anaes.) (Assist.)	473.30
41873	Larynx, fractured, operation for (Anaes.) (Assist.)	611.40
41876	Larynx, external operation on, or laryngofissure, with or without cordectomy (Anaes.) (Assist.)	611.40
41879	Laryngoplasty or tracheoplasty, including tracheostomy (H) (Anaes.) (Assist.)	990.70
41880	Tracheostomy by a percutaneous technique using sequential dilatation or partial splitting method to allow insertion of a cuffed tracheostomy tube (H) (Anaes.)	264.40
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.)	418.05
41884	Cricothyrostomy by direct stab or Seldinger technique, using mini tracheostomy device (H) (Anaes.)	94.75
41885	Trache-oesophageal fistula, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (Anaes.) (Assist.)	299.55
41886	Trachea, removal of foreign body in (Anaes.)	185.25
41904	Bronchoscopy with dilatation of tracheal stricture (Anaes.)	256.50
41907	Nasal septum button, insertion of (Anaes.)	127.80
41910	Duct of major salivary gland, transposition of (H) (Anaes.) (Assist.)	406.05
Subgroup 9—Ophthalmology		
42503	Ophthalmological examination under general anaesthesia, other than a service associated with a service to which another item in this Group	106.65

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	applies (H) (Anaes.)	
42504	Glaucoma, implantation of a micro-bypass surgery stent system into the trabecular meshwork, if: (a) conservative therapies have failed, are likely to fail, or are contraindicated; and (b) the service is performed by a specialist with training that is recognised by the Conjoint Committee for the Recognition of Training in Micro-Bypass Glaucoma Surgery (Anaes.)	312.95
42505	Complete removal from the eye of a trans-trabecular drainage device or devices, with or without replacement, following device-related medical complications necessitating complete removal (Anaes.)	312.95
42506	Eye, enucleation of, with or without sphere implant (Anaes.) (Assist.)	500.75
42509	Eye, enucleation of, with insertion of integrated implant (H) (Anaes.) (Assist.)	633.75
42510	Eye, enucleation of, with insertion of hydroxy apatite implant or similar coralline implant (H) (Anaes.) (Assist.)	730.50
42512	Globe, evisceration of (Anaes.) (Assist.)	500.75
42515	Globe, evisceration of, and insertion of intrascleral ball or cartilage (H) (Anaes.) (Assist.)	633.75
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.)	367.70
42521	Anophthalmic socket, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (H) (Anaes.) (Assist.)	1,251.95
42524	Orbit, skin graft to, as a delayed procedure (Anaes.)	212.85
42527	Contracted socket, reconstruction including mucous membrane grafting and stent mould (H) (Anaes.) (Assist.)	422.50
42530	Orbit, exploration with or without biopsy, requiring removal of bone (H) (Anaes.) (Assist.)	657.35
42533	Orbit, exploration of, with drainage or biopsy not requiring removal of bone (H) (Anaes.) (Assist.)	422.50
42536	Orbit, exenteration of, with or without skin graft and with or without temporalis muscle transplant (H) (Anaes.) (Assist.)	868.40
42539	Orbit, exploration of, with removal of tumour or foreign body, requiring removal of bone (H) (Anaes.) (Assist.)	1,236.35
42542	Orbit, exploration of anterior aspect with removal of tumour or foreign body (H) (Anaes.) (Assist.)	524.30
42543	Orbit, exploration of retrobulbar aspect with removal of tumour or foreign body (H) (Anaes.) (Assist.)	919.65
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.)	1,330.15

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
42548	Optic nerve meninges, incision of (H) (Anaes.) (Assist.)	790.15
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.)	657.35
42554	Eye, penetrating wound or rupture of, with incarceration or prolapse of uveal tissue—repair (H) (Anaes.) (Assist.)	766.90
42557	Eye, penetrating wound or rupture of, with incarceration of lens or vitreous—repair (H) (Anaes.) (Assist.)	1,071.95
42563	Intraocular foreign body, removal from anterior segment (Anaes.) (Assist.)	540.00
42569	Intraocular foreign body, removal from posterior segment (H) (Anaes.) (Assist.)	1,071.95
42572	Orbital abscess or cyst, drainage of (Anaes.)	122.15
42573	Dermoid, periorbital, excision of, on a patient 10 years of age or over (Anaes.)	236.65
42574	Dermoid, orbital, excision of (Anaes.) (Assist.)	502.85
42575	Tarsal cyst, extirpation of (Anaes.)	86.05
42576	Dermoid, periorbital, excision of, on a patient under 10 years of age (Anaes.)	307.70
42581	Ectropion or entropion, tarsal cauterisation of (Anaes.)	122.15
42584	Tarsorrhaphy (Anaes.) (Assist.)	288.00
42587	Trichiasis (due to causes other than trachoma), treatment of by cryotherapy, laser or electrolysis—each eyelid (Anaes.)	54.10
42588	Trichiasis (due to trachoma), treatment of by cryotherapy, laser or electrolysis—each eyelid (Anaes.)	54.10
42590	Canthoplasty, medial or lateral (Anaes.) (Assist.)	352.05
42593	Lacrimal gland, excision of palpebral lobe (H) (Anaes.)	212.85
42596	Lacrimal sac, excision of, or operation on (Anaes.) (Assist.)	524.30
42599	Lacrimal canalicular system, establishment of patency by closed operation using silicone tubes or similar, one eye (Anaes.) (Assist.)	657.35
42602	Lacrimal canalicular system, establishment of patency by open operation, one eye (Anaes.) (Assist.)	657.35
42605	Lacrimal canaliculus, immediate repair of (Anaes.) (Assist.)	485.00
42608	Lacrimal drainage by insertion of glass tube, as an independent procedure (Anaes.) (Assist.)	312.95
42610	Nasolacrimal tube (unilateral), removal or replacement of, or lacrimal passages, probing for obstruction, unilateral, with or without lavage—under general anaesthesia (Anaes.)	100.15
42611	Nasolacrimal tube (bilateral), removal or replacement of, or lacrimal passages, probing for obstruction, bilateral, with or without lavage—under general anaesthesia (Anaes.)	150.20
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	50.25

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	service to which item 42610 applies (excluding after-care)	
42615	Nasolacrimal tube (bilateral), removal or replacement of, or lacrimal passages, probing for obstruction, bilateral, including lavage, other than a service associated with a service to which item 42611 applies (excluding after-care)	75.15
42617	Punctum snip operation (Anaes.)	142.50
42620	Punctum, occlusion of, by use of a plug (Anaes.)	54.80
42622	Punctum, permanent occlusion of, by use of electrical cautery (Anaes.)	86.05
42623	Dacryocystorhinostomy (H) (Anaes.) (Assist.)	727.80
42626	Dacryocystorhinostomy if a previous dacryocystorhinostomy has been performed (Anaes.) (Assist.)	1,173.75
42629	Conjunctivorhinostomy including dacryocystorhinostomy and fashioning of conjunctival flaps (H) (Anaes.) (Assist.)	884.15
42632	Conjunctival peritomy or repair of corneal laceration by conjunctival flap (Anaes.)	122.15
42635	Corneal perforations, sealing of, with tissue adhesive (Anaes.) (Assist.)	312.95
42638	Conjunctival graft over cornea (Anaes.) (Assist.)	391.25
42641	Autoconjunctival transplant, or mucous membrane graft (Anaes.) (Assist.)	508.55
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.)	75.05
42647	Corneal scars, removal of, by partial keratectomy, other than a service associated with a service to which item 42686 applies (Anaes.)	212.85
42650	Cornea, epithelial debridement for corneal ulcer or corneal erosion (excluding after-care) (Anaes.)	75.05
42651	Cornea, epithelial debridement for eliminating band keratopathy (Anaes.)	167.30
42652	Corneal collagen cross linking, on a patient with a corneal ectatic disorder, with evidence of progression—per eye (Anaes.)	1,248.65
42653	Cornea, transplantation of (H) (Anaes.) (Assist.)	1,360.75
42656	Cornea, transplantation of, second and subsequent procedures (H) (Anaes.) (Assist.)	1,737.10
42662	Sclera, transplantation of, full thickness, including collection of donor material (H) (Anaes.) (Assist.)	938.85
42665	Sclera, transplantation of, superficial or lamellar, including collection of donor material (Anaes.) (Assist.)	626.05
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	147.65
42668	Corneal sutures, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or operating microscope (Anaes.)	78.35
42672	Corneal incisions, to correct corneal astigmatism of more than $1^1/_2$ dioptres following anterior segment surgery, including appropriate measurements and calculations, performed as an independent procedure	938.85

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(Anaes.) (Assist.)	
42673	Additional corneal incisions, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres, including appropriate measurements and calculations, performed in conjunction with other anterior segment surgery (Anaes.) (Assist.)	469.35
42676	Conjunctiva, biopsy of, as an independent procedure	120.35
42677	Conjunctiva, cautery of, including treatment of pannus—each attendance at which treatment is given including any associated consultation (Anaes.)	63.45
42680	Conjunctiva, cryotherapy to, for melanotic lesions or similar using CO^{2} or N^{20} (Anaes.)	312.95
42683	Conjunctival cysts, removal of (H) (Anaes.)	125.25
42686	Pterygium, removal of (Anaes.)	284.75
42689	Pinguecula, removal of, other than a service associated with the fitting of contact lenses (Anaes.)	122.15
42692	Limbic tumour, removal of, excluding Pterygium (Anaes.) (Assist.)	288.00
42695	Limbic tumour, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Anaes.) (Assist.)	469.35
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.)	618.80
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.)	345.15
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.)	791.45
42703	Intraocular lens or iris prosthesis, insertion of, into the posterior chamber with fixation to the iris or sclera (Anaes.) (Assist.)	595.20
42704	Intraocular lens, removal or repositioning of by open operation—other than a service associated with a service to which item 42701 applies (Anaes.)	485.00
42705	Lens extraction and insertion of intraocular lens, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye, performed in association with a trans-trabecular drainage device or devices, in a patient diagnosed with open angle glaucoma who is not adequately responsive to topical anti-glaucoma medications or who is intolerant of anti-glaucoma medication (Anaes.)	948.05
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.)	829.40
42710	Intraocular lens, removal of, and replacement with a lens inserted into the posterior chamber and fixated to the iris or sclera (Anaes.) (Assist.)	938.85

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
42713	Iris suturing, McCannell technique or similar, for fixation of intraocular lens or repair of iris defect (Anaes.) (Assist.)	391.25
42716	Cataract, juvenile, removal of, including subsequent needlings (Anaes.) (Assist.)	1,244.15
42719	Either or both of the following, via a limbal approach by any method: (a) removal of capsular or lens material; (b) removal of vitreous; other than a service associated with a service to which item 42698, 42702, 42705, 42716, 42725 or 42731 applies (Anaes.) (Assist.)	540.00
42725	Vitrectomy via pars plana sclerotomy, including one or more of the following: (a) removal of vitreous; (b) division of vitreous bands; (c) removal of epiretinal membranes; (d) capsulotomy (H) (Anaes.) (Assist.)	1,392.65
42731	Limbal or pars plana lensectomy combined with vitrectomy, other than a service associated with item 42698, 42702, 42705, 42719 or 42725 (H) (Anaes.) (Assist.)	1,580.55
42734	Capsulotomy, other than by laser, and other than a service associated with a service to which item 42725 or 42731 applies (Anaes.) (Assist.)	312.95
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	312.95
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 the administration of anaesthetic by an anaesthetist (Anaes.)	312.95
42740	Intravitreal injection of therapeutic substances, or the removal of vitreous humour for diagnostic purposes, one or more of, as a procedure associated with other intraocular surgery (Anaes.)	312.95
42741	Posterior juxtascleral depot injection of a therapeutic substance, for the treatment of subfoveal choroidal neovascularisation due to age-related macular degeneration, one or more of (Anaes.)	312.95
42743	Anterior chamber, irrigation of blood from, as an independent procedure (Anaes.) (Assist.)	657.35
42744	Needle revision of glaucoma filtration bleb, following glaucoma filtering procedure (Anaes.)	312.75
42746	Glaucoma, filtering operation for, if conservative therapies have failed, are likely to fail, or are contraindicated (H) (Anaes.) (Assist.)	993.70
42749	Glaucoma, filtering operation for, if previous filtering operation has been performed (H) (Anaes.) (Assist.)	1,244.15

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
42752	Glaucoma, insertion of drainage device incorporating an extraocular reservoir for, such as a Molteno device (H) (Anaes.) (Assist.)	1,392.65
42755	Glaucoma, removal of drainage device incorporating an extraocular reservoir for, such as a Molteno device (H) (Anaes.) (Assist.)	172.15
42758	Goniotomy for the treatment of primary congenital glaucoma, excluding the minimally invasive implantation of glaucoma drainage devices (H) (Anaes.) (Assist.)	727.80
42761	Division of anterior or posterior synechiae, as an independent procedure, other than by laser (Anaes.) (Assist.)	540.00
42764	Iridectomy (including excision of tumour of iris) or iridotomy, as an independent procedure, other than by laser (Anaes.) (Assist.)	540.00
42767	Tumour, involving ciliary body or ciliary body and iris, excision of (H) (Anaes.) (Assist.)	1,134.50
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.)	306.75
42773	Detached retina, pneumatic retinopexy for, other than a service associated with a service to which item 42776 applies (Anaes.) (Assist.)	938.85
42776	Detached retina, buckling or resection operation for (H) (Anaes.) (Assist.)	1,392.65
42779	Detached retina, revision of scleral buckling operation for (H) (Anaes.) (Assist.)	1,737.10
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.)	469.35
42785	Laser iridotomy—each treatment episode to one eye, to a maximum of 3 treatments to that eye in a 2 year period (Anaes.) (Assist.)	367.70
42788	Laser capsulotomy—each treatment episode to one eye, to a maximum of 2 treatments to that eye in a 2 year period—other than a service associated with a service to which item 42702 applies (Anaes.) (Assist.)	367.70
42791	Laser vitreolysis or corticolysis of lens material or fibrinolysis, excluding vitreolysis in the posterior vitreous cavity—each treatment to one eye, to a maximum of 3 treatments to that eye in a 2 year period (Anaes.) (Assist.)	367.70
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.)	70.45
42801	Episcleral radioactive plaque (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, insertion of (H) (Anaes.) (Assist.)	1,092.25
42802	Episcleral radioactive plaque (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, removal of (H) (Anaes.) (Assist.)	545.95
42805	Tantalum markers, surgical insertion to the sclera to localise the tumour base and to assist in planning radiotherapy of choroidal melanomas—one or more of (Anaes.)	610.30
42806	Iris tumour, laser photocoagulation of (Anaes.) (Assist.)	367.70
42807	Photomydriasis, laser	370.20

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
42808	Laser peripheral iridoplasty	370.20
42809	Retina, photocoagulation of, other than a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.)	469.35
42810	Phototherapeutic keratectomy, by laser, for corneal scarring or disease, excluding surgery for refractive error (Anaes.)	590.70
42811	Transpupillary thermotherapy, for choroidal and retinal tumours or vascular malformations (Anaes.)	469.35
42812	Removal of scleral buckling material, from an eye having undergone previous scleral buckling surgery (Anaes.)	172.15
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.)	657.35
42818	Retina, cryotherapy to, as an independent procedure, or when performed in association with item 42770 or 42809 (Anaes.)	610.30
42821	Ocular transillumination, for the diagnosis and measurement of intraocular tumours (Anaes.)	94.05
42824	Retrobulbar injection of alcohol or other drug, as an independent procedure	72.70
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.)	610.30
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 (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.)	758.95
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.)	727.80
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.)	907.65
42845	Readjustment of adjustable sutures, one or both eyes, as an independent procedure following an operation for correction of squint (Anaes.)	197.10
42848	Squint, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 15 years or over (H) (Anaes.) (Assist.)	727.80
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 the	907.65

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	patient's eye or eyes; or (c) has concurrent thyroid eye disease (H) (Anaes.) (Assist.)	
42854	Ruptured medial palpebral ligament or ruptured extra-ocular muscle, repair of (Anaes.) (Assist.)	422.50
42857	Resuturing of wound following intraocular procedures with or without excision of prolapsed iris (Anaes.) (Assist.)	422.50
42860	Eyelid (upper or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid retractors (Anaes.) (Assist.)	938.85
42863	Eyelid, recession of (Anaes.) (Assist.)	805.95
42866	Entropion or tarsal ectropion, repair of, by tightening, shortening or repair of inferior retractors by open operation across the entire width of the eyelid (Anaes.) (Assist.)	782.35
42869	Eyelid closure in facial nerve paralysis, insertion of foreign implant for (Anaes.) (Assist.)	571.25
42872	Eyebrow, elevation of, by skin excision, to correct for a reduced field of vision caused by paretic, involutional, or traumatic eyebrow descent/ptosis to a position below the superior orbital rim (Anaes.)	250.45
43021	Photodynamic therapy, one eye, including the infusion of vertoporfin continuously through a peripheral vein, using a non-thermal laser at a wavelength of 689 nm, for the treatment of choroidal neovascularisation	473.50
43022	Photodynamic therapy, both eyes, including the infusion of vertoporfin continuously through a peripheral vein, using a non-thermal laser at a wavelength of 689 nm, for the treatment of choroidal neovascularisation	568.25
43023	Infusion of vertoporfin for discontinued photodynamic therapy, if a session of therapy that would have been provided under item 43021 or 43022 has been discontinued on medical grounds	92.05
Subgroup 10—Operations for osteomyelitis		
43521	Operation on skull, for chronic osteomyelitis (H) (Anaes.) (Assist.)	483.35
43527	Operation on sternum, clavicle, rib, metacarpus, carpus, phalanx, metatarsus, tarsus, mandible or maxilla (other than alveolar margins), by open or arthroscopic means, for septic arthritis or osteomyelitis—one approach, inclusive of the adjoining joint (H) (Anaes.) (Assist.)	370.80
43530	Operation on scapula, ulna, radius, tibia, fibula, humerus or femur, by open or arthroscopic means, for septic arthritis or osteomyelitis—one approach, inclusive of the adjoining joint (Anaes.) (Assist.)	370.80
43533	Operation on spine or pelvic bones, by open or arthroscopic means, for septic arthritis or osteomyelitis—one approach, inclusive of the adjoining joint (Anaes.) (Assist.)	611.40
Subgroup 11—Paediatric		
43801	Intestinal malrotation with or without volvulus, laparotomy for, not involving bowel resection (H) (Anaes.) (Assist.)	996.10
43804	Intestinal malrotation with or without volvulus, laparotomy for, with bowel resection and anastomosis, with or without formation of stoma (H) (Anaes.) (Assist.)	1,060.55

Clause 5.10.19

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
43805	Umbilical, epigastric or linea alba hernia, repair of, on a patient under 10 years of age (H) (Anaes.)	370.80
43807	Duodenal atresia or stenosis, duodenoduodenostomy or duodenojejunostomy for (H) (Anaes.) (Assist.)	1,157.05
43810	Jejunal atresia, bowel resection and anastomosis for, with or without tapering (H) (Anaes.) (Assist.)	1,349.90
43813	Meconium ileus, laparotomy for, complicated by one or more of associated volvulus, atresia, intestinal perforation with or without meconium peritonitis (H) (Anaes.) (Assist.)	1,349.90
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.)	1,253.40
43819	Aganglionosis Coli, laparotomy for, with or without frozen section biopsies and formation of stoma (H) (Anaes.) (Assist.)	1,012.40
43822	Anorectal malformation, laparotomy and colostomy for (H) (Anaes.) (Assist.)	1,012.40
43825	Neonatal alimentary obstruction, laparotomy for, other than a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	1,157.05
43828	Acute neonatal necrotising enterocolitis, laparotomy for, with resection, including any anastomoses or stoma formation (H) (Anaes.) (Assist.)	1,278.30
43831	Acute neonatal necrotising enterocolitis, if no definitive procedure is possible, laparotomy for (H) (Anaes.) (Assist.)	996.10
43832	Branchial fistula, removal of, on a patient under 10 years of age (H) (Anaes.) (Assist.)	679.40
43834	Bowel resection for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (H) (Anaes.) (Assist.)	1,157.05
43835	Strangulated, incarcerated or obstructed hernia, repair of, without bowel resection, on a patient under 10 years of age (H) (Anaes.) (Assist.)	705.15
43837	Congenital diaphragmatic hernia, repair by thoracic or abdominal approach, with diagnosis confirmed in the first 24 hours of life (H) (Anaes.) (Assist.)	1,446.25
43838	Diaphragmatic hernia, congenital, repair of, by thoracic or abdominal approach, on a patient under 10 years of age, not being a service to which any of items 31569 to 31581 apply (H) (Anaes.) (Assist.)	1,294.90
43840	Congenital diaphragmatic hernia, repair by thoracic or abdominal approach, diagnosed after the first day of life and before 20 days of age (H) (Anaes.) (Assist.)	1,253.40
43841	Femoral or inguinal hernia or infantile hydrocele, repair of, on a patient under 10 years of age, other than a service to which item 30651 or 43835 applies (H) (Anaes.) (Assist.)	628.30
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.)	1,928.45
43846	Oesophageal atresia (with or without repair of tracheo-oesophageal fistula), complete correction of, in infant of birth weight less than 1,500 g	2,073.05

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(H) (Anaes.) (Assist.)	
43849	Oesophageal atresia, gastrostomy for (H) (Anaes.) (Assist.)	530.30
43852	Oesophageal atresia, thoracotomy for, and division of tracheo-oesophageal fistula without anastomosis (H) (Anaes.) (Assist.)	1,687.25
43855	Oesophageal atresia, delayed primary anastomosis for (H) (Anaes.) (Assist.)	1,783.85
43858	Oesophageal atresia, cervical oesophagostomy for (H) (Anaes.) (Assist.)	626.70
43861	Congenital cystadenomatoid malformation or congenital lobar emphysema, thoracotomy and lung resection for (H) (Anaes.) (Assist.)	1,735.65
43864	Gastroschisis, operation for (H) (Anaes.) (Assist.)	1,301.70
43867	Gastroschisis or exomphalos, secondary operation for, with removal of silo (H) (Anaes.) (Assist.)	723.15
43870	Exomphalos containing small bowel only, operation for (H) (Anaes.) (Assist.)	1,012.40
43873	Exomphalos containing small bowel and other viscera, operation for (H) (Anaes.) (Assist.)	1,349.90
43876	Sacrococcygeal teratoma, excision of, by posterior approach (H) (Anaes.) (Assist.)	1,157.05
43879	Sacrococcygeal teratoma, excision of, by combined posterior and abdominal approach (H) (Anaes.) (Assist.)	1,349.90
43882	Cloacal exstrophy, operation for (Anaes.) (Assist.)	1,735.65
43900	Tracheo-oesophageal fistula without atresia, division and repair of (H) (Anaes.) (Assist.)	1,157.05
43903	Oesophageal atresia or corrosive oesophageal stricture, oesophageal replacement for, utilising gastric tube, jejunum or colon (H) (Anaes.) (Assist.)	1,928.45
43906	Oesophagus, resection of congenital, anastomic or corrosive stricture and anastomosis, other than a service to which item 43903 applies (H) (Anaes.) (Assist.)	1,687.25
43909	Tracheomalacia, aortopexy for (H) (Anaes.) (Assist.)	1,687.25
43912	Thoracotomy and excision of one or more of bronchogenic or enterogenous cyst or mediastinal teratoma (H) (Anaes.) (Assist.)	1,594.05
43915	Eventration, plication of diaphragm for (H) (Anaes.) (Assist.)	1,205.25
43930	Hypertrophic pyloric stenosis, pyloromyotomy for (H) (Anaes.) (Assist.)	463.50
43933	Idiopathic intussusception, laparotomy and manipulative reduction of (H) (Anaes.) (Assist.)	542.55
43936	Intussusception, laparotomy and resection with anastomosis (H) (Anaes.) (Assist.)	1,012.40
43939	Ventral hernia following neonatal closure of exomphalos or gastroschisis, repair of (H) (Anaes.) (Assist.)	771.35
43942	Abdominal wall vitello intestinal remnant, excision of (H) (Anaes.)	241.10
43945	Patent vitello intestinal duct, excision of (H) (Anaes.) (Assist.)	1,012.40
43948	Umbilical granuloma, excision of, under general anaesthesia (H) (Anaes.)	144.75

Clause 5.10.19

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
43951	Gastro-oesophageal reflux with or without hiatus hernia, laparotomy and fundoplication for, without gastrostomy (H) (Anaes.) (Assist.)	906.65
43954	Gastro-oesophageal reflux with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (H) (Anaes.) (Assist.)	1,108.95
43957	Gastro-oesophageal reflux, laparotomy and fundoplication for, with or without hiatus hernia, in child with neurological disease, with gastrostomy (H) (Anaes.) (Assist.)	1,205.25
43960	Anorectal malformation, perineal anoplasty of (H) (Anaes.) (Assist.)	424.00
43963	Anorectal malformation, posterior sagittal anorectoplasty of (H) (Anaes.) (Assist.)	1,687.25
43966	Anorectal malformation, posterior sagittal anorectoplasty of, with laparotomy (H) (Anaes.) (Assist.)	1,928.45
43969	Persistent cloaca, total correction of, with genital repair using posterior sagittal approach, with or without laparotomy (H) (Anaes.) (Assist.)	2,651.60
43972	Choledochal cyst, resection of, with one duct anastomosis (H) (Anaes.) (Assist.)	1,928.45
43975	Choledochal cyst, resection of, with 2 duct anastomoses (H) (Anaes.) (Assist.)	2,265.95
43978	Biliary atresia, portoenterostomy for (H) (Anaes.) (Assist.)	1,928.45
43981	Nephroblastoma, neuroblastoma or other malignant tumour, laparotomy (exploratory), including associated biopsies, if no other intra-abdominal procedure is performed (H) (Anaes.) (Assist.)	530.30
43984	Nephroblastoma, radical nephrectomy for (H) (Anaes.) (Assist.)	1,349.90
43987	Neuroblastoma, radical excision of (H) (Anaes.) (Assist.)	1,494.65
43990	Aganglionosis Coli, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends to sigmoid colon (H) (Anaes.) (Assist.)	1,832.10
43993	Aganglionosis Coli, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends into descending or transverse colon with or without resiting of stoma (H) (Anaes.) (Assist.)	1,976.65
43996	Aganglionosis Coli, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or without side to side ileocolonic anastomosis (H) (Anaes.) (Assist.)	2,217.75
43999	Aganglionosis Coli, anal sphincterotomy as an independent procedure for (H) (Anaes.) (Assist.)	277.30
44101	Rectum, examination of, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion, on a patient under 2 years of age (H) (Anaes.) (Assist.)	347.60
44102	Rectum, examination of, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion, on a patient 2 years of age or over (H) (Anaes.) (Assist.)	267.35
44104	Rectal prolapse, submucosal or perirectal injection for, under general anaesthesia, on a patient under 2 years of age (Anaes.)	61.05

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
44105	Rectal prolapse, submucosal or perirectal injection for, under general anaesthesia, on a patient 2 years of age or over (Anaes.)	46.90
44108	Inguinal hernia repair at age less than 12 months (H) (Anaes.) (Assist.)	511.35
44111	Obstructed or strangulated inguinal hernia, repair of, at age less than 12 months, including orchidopexy when performed (Anaes.) (Assist.)	598.95
44114	Inguinal hernia repair at age less than 12 months when orchidopexy also required (H) (Anaes.) (Assist.)	598.95
44130	Lymphadenectomy, for atypical mycobacterial infection or other granulomatous disease (Anaes.) (Assist.)	482.05
44133	Torticollis, open division of sternomastoid muscle for (H) (Anaes.) (Assist.)	382.65
44136	Ingrown toe nail, operation for, under general anaesthesia (Anaes.)	176.35

Subdivision E—Subgroups 12 and 13 of Group T8

5.10.20 Meaning of amount under clause 5.10.20

In item 44376:

amount under clause 5.10.20 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.

5.10.21 Meaning of NOSE Scale

In this Schedule:

NOSE Scale means the *Nasal Obstruction Symptom Evaluation Scale*, developed by Stewart et al, as published in *Otolaryngology-Head and Neck Surgery*, *Volume 130, Issue 2, 2004*, as published on 1 February 2004.

5.10.22 Meaning of maxilla

In items 45720 to 45752:

maxilla includes the zygoma.

5.10.23 Items in Subgroups 12 and 13 of Group T8

This clause sets out items in Subgroups 12 and 13 of Group T8.

Clause 5.10.23

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 12—Amputations		
44325	Amputation of hand, transcarpal (H) (Anaes.) (Assist.)	307.70
44328	Amputation of hand, proximal to wrist radiocarpal joint, through forearm (H) (Anaes.) (Assist.)	370.80
44331	Amputation at shoulder (H) (Anaes.) (Assist.)	611.40
44334	Interscapulothoracic amputation (Anaes.) (Assist.)	1,242.65
44338	Amputation of one digit of one foot, distal to metatarsal head, including any of the following (if performed): (a) resection of bone or joint; (b) excision of neuroma; (c) skin cover with homodigital flaps (H) (Anaes.) (Assist.)	149.85
44342	Amputation of 2 digits of one foot, distal to metatarsal head, including any of the following (if performed): (a) resection of bone or joint; (b) excision of neuroma; (c) skin cover with homodigital flaps (H) (Anaes.) (Assist.)	228.85
44346	Amputation of 3 digits of one foot, distal to metatarsal head, including any of the following (if performed): (a) resection of bone or joint; (b) excision of neuroma; (c) skin cover with homodigital flaps (H) (Anaes.) (Assist.)	264.25
44350	Amputation of 4 digits of one foot, distal to metatarsal head, including any of the following (if performed): (a) resection of bone or joint; (b) excision of neuroma; (c) skin cover with homodigital flaps (H) (Anaes.) (Assist.)	299.85
44354	Amputation of 5 digits of one foot, distal to metatarsal head, including any of the following (if performed): (a) resection of bone or joint; (b) excision of neuroma; (c) skin cover with homodigital flaps (H) (Anaes.) (Assist.)	343.20
44358	Amputation of one ray of one foot, proximal to the metatarsal head, including any of the following (if performed): (a) resection of bone; (b) excision of neuromas; (c) skin cover or recontouring with homodigital flaps (H) (Anaes.) (Assist.)	228.85

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
44359	Amputation of one or more toes of one foot, or amputation at midfoot or hindfoot of one foot, for diabetic or other microvascular disease: (a) including any of the following (if performed): (i) resection of bone; (ii) excision of neuromas; (iii) excision of one or more bones of the foot; (iv) treatment of underlying infection; (v) skin cover or recontouring with homodigital flaps; and (b) excluding aftercare; —applicable only once per foot per occasion on which the service is performed (H) (Anaes.) (Assist.)	274.60
44361	Amputation of foot, at ankle or hindfoot, including any of the following (if performed): (a) resection of bone; (b) excision of neuromas; (c) skin cover (H) (Anaes.) (Assist.)	454.10
44364	Amputation of foot, transtarsal, including any of the following (if performed): (a) resection of bone; (b) excision of neuromas; (c) skin cover (H) (Anaes.) (Assist.)	307.70
44367	Amputation through thigh, at knee or below knee (H) (Anaes.) (Assist.)	543.10
44370	Amputation at hip (H) (Anaes.) (Assist.)	749.40
44373	Hindquarter, amputation of (Anaes.) (Assist.)	1,538.30
44376	Amputation stump, re-amputation of, to provide adequate skin and muscle cover (Anaes.) (Assist.)	Amount under clause 5.10.20
Subgroup 13—Plastic and reconstructive surgery		
45000	Single stage local muscle flap repair, on eyelid, nose, lip, neck, hand, thumb, finger or genitals—not in association with any of items 31356 to 31376 (Anaes.)	563.25
45003	Single stage local myocutaneous flap repair to one defect, simple and small—not in association with any of items 31356 to 31376 (Anaes.)	626.05
45006	Single stage large myocutaneous flap repair to one defect (pectoralis major, latissimus dorsi, or similar large muscle) (H) (Anaes.) (Assist.)	1,079.70
45009	Single stage local muscle flap repair to one defect, simple and small (H) (Anaes.) (Assist.)	394.40
45012	Single stage large muscle flap repair to one defect (pectoralis major, gastrocnemius, gracilis or similar large muscle) (H) (Anaes.) (Assist.)	660.75
45015	Muscle or myocutaneous flap, delay of (H) (Anaes.)	312.95
45018	Dermis, dermofat or fascia graft (other than transfer of fat by	492.85

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	injection): (a) if the service is not associated with neurosurgical services for spinal disorders mentioned in any of items 51011 to 51171; and (b) other than a service associated with a service to which item 39615, 39715, 40106 or 40109 applies (Anaes.) (Assist.)	
45019	Full face chemical peel for severely sun-damaged skin, if: (a) the damage affects at least 75% of the facial skin surface area; and (b) the damage involves photo-damage (dermatoheliosis); and (c) the photo-damage involves: (i) a solar keratosis load exceeding 30 individual lesions; or (ii) solar lentigines; or (iii) freckling, yellowing or leathering of the skin; or (iv) solar kertoses which have proven refractory to, or recurred following, medical therapies; and (d) at least medium depth peeling agents are used; and (e) the chemical peel is performed in the operating theatre of a hospital by a medical practitioner recognised as a specialist in the specialty of dermatology or plastic surgery. Applicable once only in any 12 month period (H) (Anaes.)	412.80
45021	Abrasive therapy for severely disfiguring scarring resulting from trauma, burns or acne—limited to one aesthetic area (Anaes.)	184.55
45024	Abrasive therapy for severely disfiguring scarring resulting from trauma, burns or acne—more than one aesthetic area (Anaes.)	414.70
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.)	184.55
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.)	414.70
45027	Angioma, cauterisation of or injection into, if undertaken in the operating theatre of a hospital (Anaes.)	125.25
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.)	134.45
45033	Angioma (haemangioma or lymphangioma or both), large or involving deeper tissue including facial muscle or breast, excision and suture of (Anaes.)	250.45
45035	Angioma (haemangioma or lymphangioma or both) large and deep, involving muscles or nerves, excision of (H) (Anaes.) (Assist.)	730.50
45036	Angioma (haemangioma or lymphangioma or both) of neck, deep, excision of (H) (Anaes.) (Assist.)	1,173.75
45039	Arteriovenous malformation (3 cm or less) of superficial tissue,	250.45

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	excision of (Anaes.)	
45042	Arteriovenous malformation, (greater than 3 cm), excision of (Anaes.) (Assist.)	320.90
45045	Arteriovenous malformation on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.)	320.90
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.)	805.95
45051	Contour reconstruction by open repair of contour defects, due to deformity, if: (a) contour reconstructive surgery is indicated because the deformity is secondary to congenital absence of tissue or has arisen from trauma (other than trauma from previous cosmetic surgery); and (b) insertion of a non-biological implant is required, other than one or more of the following: (i) insertion of a non-biological implant that is a component of another service specified in Group T8; (ii) injection of liquid or semisolid material; (iii) an oral and maxillofacial implant service to which item 52321 applies; (iv) a service to insert mesh; and (c) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.) (Assist.)	492.95
45054	Limb or chest, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (H) (Anaes.) (Assist.)	256.10
45060	Developmental breast abnormality, single stage correction of, if: (a) the correction involves either: (i) bilateral mastopexy for symmetrical tubular breasts; or (ii) surgery on both breasts with a combination of insertion of one or more implants (which must have at least a 10% volume difference), mastopexy or reduction mammaplasty, if there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least 20% in normally shaped breasts, or 10% in tubular breasts or in breasts with abnormally high inframammary folds; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes Applicable only once per occasion on which the service is provided (H) (Anaes.) (Assist.)	1,322.80
45061	Developmental breast abnormality, 2 stage correction of, first stage, involving surgery on both breasts with a combination of insertion of one or more tissue expanders, mastopexy or reduction mammaplasty, if: (a) there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least:	1,322.80

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(i) 20% in normally shaped breasts; or (ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes. Applicable only once per occasion on which the service is provided (H) (Anaes.) (Assist.)	
45062	Developmental breast abnormality, 2 stage correction of, second stage, involving surgery on both breasts with a combination of exchange of one or more tissue expanders for one or more implants (which must have at least a 10% volume difference), mastopexy or reduction mammaplasty, if: (a) there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least: (i) 20% in normally shaped breasts; or (ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes. Applicable only once per occasion on which the service is provided (H) (Anaes.) (Assist.)	957.25
45200	Single stage local flap, if indicated to repair one defect, simple and small, excluding flap for male pattern baldness and excluding H-flap or double advancement flap—not in association with any of items 31356 to 31376 (Anaes.)	295.90
45201	Muscle, myocutaneous or skin flap, if clinically indicated to repair one surgical excision made in the removal of a malignant or non-malignant skin lesion (only in association with items 31000, 31001, 31002, 31003, 31004, 31005, 31358, 31359, 31360, 31363, 31364, 31369, 31370, 31371, 31373 or 31376)—may be claimed only once per defect (Anaes.)	430.70
45202	Muscle, myocutaneous or skin flap, if clinically indicated to repair one surgical excision made in the removal of a malignant or non-malignant skin lesion in a patient, if the clinical relevance of the procedure is clearly annotated in the patient's record and either: (a) item 45201 applies and additional flap repair is required for the same defect; or (b) item 45201 does not apply and either: (i) the patient has severe pre-existing scarring, severe skin atrophy or sclerodermoid changes; or (ii) the repair is contiguous with a free margin (Anaes.)	430.70
45203	Single stage local flap, if indicated to repair one defect, complicated or large, excluding flap for male pattern baldness and excluding H-flap or double advancement flap—not in association with any of items 31356 to 31376 (Anaes.) (Assist.)	422.50
45206	Single stage local flap if indicated to repair one defect, on eyelid, nose,	399.10

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	lip, ear, neck, hand, thumb, finger or genitals and excluding H-flap or double advancement flap—not in association with any of items 31356 to 31376 (Anaes.)	
45207	H-flap or double advancement flap if indicated to repair one defect, on eyelid, eyebrow or forehead—not in association with any of items 31356 to 31376 (Anaes.)	399.10
45209	Direct flap repair (cross arm, abdominal or similar), first stage (Anaes.) (Assist.)	492.95
45212	Direct flap repair (cross arm, abdominal or similar), second stage (Anaes.)	244.60
45215	Direct flap repair, cross leg, first stage (H) (Anaes.) (Assist.)	1,055.10
45218	Direct flap repair, cross leg, second stage (H) (Anaes.) (Assist.)	473.30
45221	Direct flap repair, small (cross finger or similar), first stage (Anaes.)	272.20
45224	Direct flap repair, small (cross finger or similar), second stage (Anaes.)	122.35
45227	Indirect flap or tubed pedicle, formation of (Anaes.) (Assist.)	463.50
45230	Direct or indirect flap or tubed pedicle, delay of (Anaes.)	231.75
45233	Indirect flap or tubed pedicle, preparation of intermediate or final site and attachment to the site (Anaes.) (Assist.)	492.95
45236	Indirect flap or tubed pedicle, spreading of pedicle, as a separate procedure (H) (Anaes.)	386.55
45239	Direct, indirect or local flap, revision of, by incision and suture, other than a service to which item 45240 applies (Anaes.)	272.20
45240	Direct, indirect or local flap, revision of, by liposuction, other than a service to which item 45239, 45497, 45498 or 45499 applies (Anaes.)	272.20
45400	Free grafting (split skin) of a granulating area, small (Anaes.)	213.00
45403	Free grafting (split skin) of a granulating area, extensive (Anaes.) (Assist.)	424.00
45406	Free grafting (split skin) to burns, including excision of burnt tissue—involving not more than 3% of total body surface (Anaes.) (Assist.)	469.35
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.)	626.05
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.)	860.85
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.)	938.85
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.)	1,017.15
45439	Free grafting (split skin) to one defect, including elective dissection, small (Anaes.)	295.90
45442	Free grafting (split skin) to one defect, including elective dissection,	610.30

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	extensive (Anaes.) (Assist.)	
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.)	579.15
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.)	391.25
45451	Free grafting (full thickness) to one defect, excluding grafts for male pattern baldness (Anaes.) (Assist.)	492.95
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.)	1,304.10
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.)	929.45
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.)	701.35
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.)	1,990.60
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.)	1,418.20
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.)	1,069.60
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.)	1,906.90
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.)	1,438.70
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.)	2,397.00
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.)	1,808.05
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.)	2,885.65
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.)	2,177.25

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
45477	Free grafting (split skin) to burns, including excision of burnt tissue, involving 60% or more but less than 70% of total body surface—conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	3,374.40
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.)	2,545.20
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.)	3,863.05
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.)	2,914.60
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.)	4,401.35
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.)	3,320.80
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.)	549.10
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.)	469.35
45487	Free grafting (split skin) to burns, including excision of burnt tissue—whole of toe (Anaes.) (Assist.)	422.50
45488	Free grafting (split skin) to burns, including excision of burnt tissue—the whole of one digit of the hand (H) (Anaes.) (Assist.)	469.35
45489	Free grafting (split skin) to burns, including excision of burnt tissue—the whole of 2 digits of the hand (H) (Anaes.) (Assist.)	704.25
45490	Free grafting (split skin) to burns, including excision of burnt tissue—the whole of 3 digits of the hand (H) (Anaes.) (Assist.)	939.10
45491	Free grafting (split skin) to burns, including excision of burnt tissue—the whole of 4 digits of the hand (H) (Anaes.) (Assist.)	1,173.75
45492	Free grafting (split skin) to burns, including excision of burnt tissue—the whole of 5 digits of the hand (H) (Anaes.) (Assist.)	1,408.45
45493	Free grafting (split skin) to burns, including excision of burnt tissue—portion of digit of hand (H) (Anaes.) (Assist.)	422.50
45494	Free grafting (split skin) to burns, including excision of burnt tissue—whole of face (excluding ears) (H) (Anaes.) (Assist.)	1,705.05
45496	Flap, free tissue transfer using microvascular techniques—revision of, by open operation (H) (Anaes.)	432.90
45497	Flap, free tissue transfer using microvascular techniques or any breast reconstruction—complete revision of, by liposuction (H) (Anaes.)	338.10
45498	Flap, free tissue transfer using microvascular techniques or any breast reconstruction—staged revision of, by liposuction (first stage) (H)	272.20

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(Anaes.)	
45499	Flap, free tissue transfer using microvascular techniques or any breast reconstruction—staged revision of, by liposuction (second stage) (H) (Anaes.)	202.85
45500	Microvascular repair using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (H) (Anaes.) (Assist.)	1,134.50
45501	Microvascular anastomosis of artery using microsurgical techniques, for re-implantation of limb or digit (H) (Anaes.) (Assist.)	1,846.60
45502	Microvascular anastomosis of vein using microsurgical techniques, for re-implantation of limb or digit (H) (Anaes.) (Assist.)	1,846.60
45503	Micro-arterial or micro-venous graft using microsurgical techniques (H) (Anaes.) (Assist.)	2,112.65
45504	Microvascular anastomosis of artery using microsurgical techniques, for free transfer of tissue including setting in of free flap (H) (Anaes.) (Assist.)	1,846.60
45505	Microvascular anastomosis of vein using microsurgical techniques, for free transfer of tissue including setting in of free flap (H) (Anaes.) (Assist.)	1,846.60
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 the specialist's specialty (Anaes.)	228.85
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 the specialist's specialty (Anaes.)	307.70
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 the specialist's specialty (Anaes.)	194.10
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 the specialist's speciality (Anaes.)	234.85
45519	Extensive burn scars of skin (more than 1% of body surface area), excision of, for correction of scar contracture (H) (Anaes.) (Assist.)	446.45
45520	Reduction mammaplasty (unilateral) with surgical repositioning of nipple, in the context of breast cancer or developmental abnormality of the breast (H) (Anaes.) (Assist.)	936.90
45522	Reduction mammaplasty (unilateral) without surgical repositioning of the nipple:	657.35

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) excluding the treatment of gynaecomastia; and (b) not with insertion of any prosthesis (H) (Anaes.) (Assist.)	
45523	Reduction mammaplasty (bilateral) with surgical repositioning of the nipple: (a) for patients with macromastia and experiencing pain in the neck or shoulder region; and (b) not with insertion of any prosthesis (H) (Anaes.) (Assist.)	1,405.45
45524	Mammaplasty, augmentation (unilateral) in the context of: (a) breast cancer; or (b) developmental abnormality of the breast, if there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least: (i) 20% in normally shaped breasts; or (ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds. Applicable only once per occasion on which the service is provided (H) (Anaes.) (Assist.)	771.70
45527	Breast reconstruction (unilateral), following mastectomy, using a permanent prosthesis (H) (Anaes.) (Assist.)	771.70
45528	Mammaplasty, augmentation, bilateral (other than a service to which item 45527 applies), if: (a) reconstructive surgery is indicated because of: (i) developmental malformation of breast tissue (excluding hypomastia); or (ii) disease of or trauma to the breast (other than trauma resulting from previous elective cosmetic surgery); or (iii) amastia secondary to a congenital endocrine disorder; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.) (Assist.)	1,157.40
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, 30172, 30176, 30177 or 30179 applies (H) (Anaes.) (Assist.)	1,143.95
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.)	1,295.50
45536	Breast reconstruction using breast sharing technique (second stage) including division of pedicle, insetting of breast flap, with closure of donor site or other similar procedure (H) (Anaes.) (Assist.)	476.45

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
45539	Breast reconstruction (unilateral), following mastectomy, using tissue expansion—insertion of tissue expansion unit and all attendances for subsequent expansion injections (H) (Anaes.) (Assist.)	1,114.65
45542	Breast reconstruction (unilateral), following mastectomy, using tissue expansion—removal of tissue expansion unit and insertion of permanent prosthesis (H) (Anaes.) (Assist.)	638.25
45545	Nipple or areola or both, reconstruction of, by any surgical technique (Anaes.) (Assist.)	647.80
45546	Nipple or areola or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple	205.85
45548	Breast prosthesis, removal of, as an independent procedure (Anaes.)	288.00
45551	Breast prosthesis, removal of, with excision of at least half of the fibrous capsule, not with insertion of any prosthesis. The excised specimen must be sent for histopathology and the volume removed must be documented in the histopathology report (H) (Anaes.) (Assist.)	461.65
45553	Breast prosthesis, removal of and replacement with another prosthesis, following medical complications (for rupture, migration of prosthetic material or symptomatic capsular contracture), if: (a) either: (i) it is demonstrated by intra-operative photographs post-removal that removal alone would cause unacceptable deformity; or (ii) the original implant was inserted in the context of breast cancer or developmental abnormality; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.) (Assist.)	594.75
45554	Breast prosthesis, removal and replacement with another prosthesis, following medical complications (for rupture, migration of prosthetic material or symptomatic capsular contracture), including excision of at least half of the fibrous capsule or formation of a new pocket, or both, if: (a) either: (i) it is demonstrated by intra-operative photographs post-removal that removal alone would cause unacceptable deformity; or (ii) the original implant was inserted in the context of breast cancer or developmental abnormality; and (b) the excised specimen is sent for histopathology and the volume removed is documented in the histopathology report; and (c) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.) (Assist.)	727.80
45556	Breast ptosis, correction of (unilateral), in the context of breast cancer or developmental abnormality, if photographic evidence (including anterior, left lateral and right lateral views) and/or diagnostic imaging	797.05

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	evidence demonstrating the clinical need for this service is documented in the patient notes Applicable only once per occasion on which the service is provided (H) (Anaes.) (Assist.)	
45558	Breast ptosis, correction by mastopexy of (bilateral), if: (a) at least two-thirds of the breast tissue, including the nipple, lies inferior to the infra-mammary fold where the nipple is located at the most dependent, inferior part of the breast contour; and (b) if the patient has been pregnant—the correction is performed not less than 1 year, or more than 7 years, after completion of the most recent pregnancy of the patient; and (c) photographic evidence (including anterior, left lateral and right lateral views), with a marker at the level of the inframammary fold, demonstrating the clinical need for this service, is documented in the patient notes Applicable only once per lifetime (H) (Anaes.) (Assist.)	1,195.50
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.)	492.85
45561	Microvascular anastomosis of artery or vein using microsurgical techniques, for supercharging of pedicled flaps (H) (Anaes.) (Assist.)	1,846.60
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.)	1,143.95
45563	Neurovascular island flap, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.)	1,143.95
45564	Free transfer of tissue reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies—conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.)	2,649.50
45565	Free transfer of tissue reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501,	1,987.20

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	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.)	1,114.65
45568	Tissue expander, removal of, with complete excision of fibrous capsule (H) (Anaes.) (Assist.)	461.65
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.)	705.10
45570	Closure of abdomen, repair of musculoaponeurotic layer, being a service associated with item 45569 (Anaes.) (Assist.)	952.05
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.)	303.50
45575	Facial nerve paralysis, free fascia graft for (Anaes.) (Assist.)	749.40
45578	Facial nerve paralysis, muscle transfer for (H) (Anaes.) (Assist.)	867.85
45581	Facial nerve palsy, excision of tissue for (Anaes.)	288.00
45584	Liposuction (suction assisted lipolysis) to one regional area (one limb or trunk), for treatment of post-traumatic pseudolipoma, if photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.)	657.35
45585	Liposuction (suction assisted lipolysis) to one regional area (one limb or trunk), other than a service associated with a service to which item 31525 applies, if: (a) the liposuction is for: (i) the treatment of Barraquer-Simons syndrome, lymphoedema or macrodystrophia lipomatosa; or (ii) the reduction of a buffalo hump that is secondary to an endocrine disorder or pharmacological treatment of a medical condition; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.)	657.35
45587	Meloplasty for correction of facial asymmetry if: (a) the asymmetry is secondary to trauma (including previous surgery), a congenital condition or a medical condition (such as facial nerve palsy); and (b) the meloplasty is limited to one side of the face (H) (Anaes.) (Assist.)	926.95
45588	Meloplasty (excluding browlifts and chinlift platysmaplasties), bilateral, if: (a) surgery is indicated to correct a functional impairment due to a	1,390.55

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	congenital condition, disease (excluding post-acne scarring) or trauma (other than trauma resulting from previous elective cosmetic surgery); and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.) (Assist.)	
45590	Orbital cavity, reconstruction of a wall or floor, with or without foreign implant (H) (Anaes.) (Assist.)	502.85
45593	Orbital cavity, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (H) (Anaes.) (Assist.)	590.65
45596	Maxilla, total resection of (H) (Anaes.) (Assist.)	936.90
45597	Maxilla, total resection of both maxillae (H) (Anaes.) (Assist.)	1,254.25
45599	Mandible, total resection of both sides, including condylectomies, if performed (Anaes.) (Assist.)	974.50
45602	Mandible, including lower border, or maxilla, sub-total resection of (H) (Anaes.) (Assist.)	727.80
45605	Mandible or maxilla, segmental resection of, for tumours or cysts (H) (Anaes.) (Assist.)	611.40
45608	Mandible, hemi-mandibular reconstruction with bone graft, other than a service associated with a service to which item 45599 applies (H) (Anaes.) (Assist.)	860.85
45611	Mandible, condylectomy (H) (Anaes.) (Assist.)	492.95
45614	Eyelid, whole thickness reconstruction of, other than by direct suture only (Anaes.) (Assist.)	611.40
45617	Upper eyelid, reduction of, if: (a) the reduction is for any of the following: (i) skin redundancy that causes a visual field defect (confirmed by an optometrist or ophthalmologist) or intertriginous inflammation of the eyelid; (ii) herniation of orbital fat in exophthalmos; (iii) facial nerve palsy; (iv) post-traumatic scarring; (v) the restoration of symmetry of contralateral upper eyelid in respect of one of the conditions mentioned in subparagraphs (i) to (iv); and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)	244.60
45620	Lower eyelid, reduction of, if: (a) the reduction is for: (i) herniation of orbital fat in exophthalmos, facial nerve palsy or post-traumatic scarring; or (ii) the restoration of symmetry of the contralateral lower eyelid in respect of one of these conditions; and	339.25

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)	
45623	Ptosis of upper eyelid (unilateral), correction of, by: (a) sutured elevation of the tarsal plate on the eyelid retractors (Muller's or levator muscle or levator aponeurosis); or (b) sutured suspension to the brow/frontalis muscle Not applicable to a service for repair of mechanical ptosis to which item 45617 applies (Anaes.) (Assist.)	752.30
45624	Ptosis of upper eyelid, correction of, by: (a) sutured elevation of the tarsal plate on the eyelid retractors (Muller's or levator muscle or levator aponeurosis); or (b) sutured suspension to the brow/frontalis muscle; if a previous ptosis surgery has been performed on that side (Anaes.) (Assist.)	975.40
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.)	195.15
45626	Ectropion or entropion (due to causes other than trachoma), correction of (unilateral) (Anaes.)	339.25
45627	Ectropion or entropion (due to trachoma), correction of (unilateral) (Anaes.)	339.25
45629	Symblepharon, grafting for (Anaes.) (Assist.)	492.95
45632	Rhinoplasty, partial, involving correction of lateral or alar cartilages, if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)	532.70
45635	Rhinoplasty, partial, involving correction of bony vault only, if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)	611.40

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
45641	Rhinoplasty, total, including correction of all bony and cartilaginous elements of the external nose, with or without autogenous cartilage or bone graft from a local site (nasal), if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.)	1,109.20
45644	Rhinoplasty, total, including correction of all bony and cartilaginous elements of the external nose involving autogenous bone or cartilage graft obtained from distant donor site, including obtaining of graft, if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.) (Assist.)	1,331.25
45645	Choanal atresia, repair of by puncture and dilatation (H) (Anaes.)	232.70
45646	Choanal atresia, correction by open operation with bone removal (Anaes.) (Assist.)	936.90
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.)	1,331.25
45650	Rhinoplasty, revision of, if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)	153.75
45652	Rhinophyma of a moderate or severe degree, carbon dioxide laser or erbium laser excision—ablation of (Anaes.)	370.80
45653	Rhinophyma, shaving of (Anaes.)	370.80
45656	Composite graft (chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (Anaes.) (Assist.)	522.60
45658	Correction of a congenital deformity of the ear if: (a) the congenital deformity is not related to a prominent ear; and (b) the deformity has been clinically diagnosed as a constricted ear,	542.40

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	Stahl's ear, or a similar congenital deformity; and (c) photographic evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.) (Assist.)	
45659	Correction of a congenital deformity of the ear if: (a) the patient is less than 18 years of age; and (b) the deformity is characterised by an absence of the antihelical fold and/or large scapha and/or large concha; and (c) photographic evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.) (Assist.)	542.40
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 the specialist's specialty (H) (Anaes.) (Assist.)	2,995.35
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 the specialist's specialty (H) (Anaes.) (Assist.)	1,331.25
45662	Congenital atresia, reconstruction of external auditory canal (H) (Anaes.) (Assist.)	729.70
45665	Lip, eyelid or ear, full thickness wedge excision of, with repair by direct sutures (Anaes.)	339.25
45668	Vermilionectomy, by surgical excision (Anaes.)	339.25
45669	Vermilionectomy for biopsy-confirmed cellular atypia, using carbon dioxide laser or erbium laser excision—ablation (Anaes.)	339.25
45671	Lip or eyelid reconstruction using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.)	867.85
45674	Lip or eyelid reconstruction using full thickness flap (Abbe or similar), second stage (Anaes.)	252.40
45675	Macrocheilia or macroglossia, operation for (H) (Anaes.) (Assist.)	502.85
45676	Macrostomia, operation for (H) (Anaes.) (Assist.)	598.60
45677	Cleft lip, unilateral—primary repair, one stage, without anterior palate repair (H) (Anaes.) (Assist.)	563.25
45680	Cleft lip, unilateral—primary repair, one stage, with anterior palate repair (H) (Anaes.) (Assist.)	704.25
45683	Cleft lip, bilateral—primary repair, one stage, without anterior palate repair (H) (Anaes.) (Assist.)	782.35
45686	Cleft lip, bilateral—primary repair, one stage, with anterior palate repair (H) (Anaes.) (Assist.)	923.50
45689	Cleft lip, lip adhesion procedure, unilateral or bilateral (H) (Anaes.)	272.40

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(Assist.)	
45692	Cleft lip, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.)	312.95
45695	Cleft lip, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (H) (Anaes.) (Assist.)	508.55
45698	Cleft lip, primary columella lengthening procedure, bilateral (H) (Anaes.)	477.35
45701	Cleft lip reconstruction using full thickness flap (Abbe or similar), first stage (H) (Anaes.) (Assist.)	860.85
45704	Cleft lip reconstruction using full thickness flap (Abbe or similar), second stage (Anaes.)	312.95
45707	Cleft palate, primary repair (H) (Anaes.) (Assist.)	813.60
45710	Cleft palate, secondary repair, closure of fistula using local flaps (H) (Anaes.)	508.55
45713	Cleft palate, secondary repair, lengthening procedure (H) (Anaes.) (Assist.)	579.15
45714	Oro-nasal fistula, plastic closure of, including services to which item 45200, 45203 or 45239 applies (H) (Anaes.) (Assist.)	813.60
45716	Velo-pharyngeal incompetence, pharyngeal flap for, or pharyngoplasty for (H) (Anaes.)	813.60
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.)	1,005.95
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.)	1,134.50
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.)	1,282.00
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.)	1,439.75
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.)	1,459.55
45732	Mandible or maxilla, osteotomies or osteectomies of, involving 3 or	1,643.15

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	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.)	
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.)	1,676.35
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.)	1,885.80
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.)	1,844.10
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.)	2,073.45
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.)	2,011.90
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.)	2,253.50
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.)	2,266.85
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.)	2,717.45

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
45755	Temporo-mandibular partial or total meniscectomy (Anaes.) (Assist.)	382.65
45758	Temporo-mandibular joint, arthroplasty (H) (Anaes.) (Assist.)	684.75
45761	Genioplasty, including transposition of nerves and vessels and bone grafts taken from the same site (H) (Anaes.) (Assist.)	779.00
45767	Hypertelorism, correction of, intra-cranial (Anaes.) (Assist.)	2,613.45
45770	Hypertelorism, correction of, sub-cranial (H) (Anaes.) (Assist.)	2,001.85
45773	Treacher Collins Syndrome, periorbital correction of, with rib and iliac bone grafts (Anaes.) (Assist.)	1,824.40
45776	Orbital dystopia (unilateral), correction of, with total repositioning of one orbit, intra-cranial (H) (Anaes.) (Assist.)	1,824.40
45779	Orbital dystopia (unilateral), correction of, with total repositioning of one orbit, extra-cranial (H) (Anaes.) (Assist.)	1,341.40
45782	Fronto-orbital advancement, unilateral (Anaes.) (Assist.)	1,025.60
45785	Cranial vault reconstruction for oxycephaly, brachycephaly, turricephaly or similar condition—(bilateral fronto-orbital advancement) (H) (Anaes.) (Assist.)	1,735.70
45788	Glenoid fossa, zygomatic arch and temporal bone, reconstruction of, (Obwegeser technique) (H) (Anaes.) (Assist.)	1,715.95
45791	Absent condyle and ascending ramus in hemifacial microsomia, construction of, not including harvesting of graft material (H) (Anaes.) (Assist.)	926.95
45794	Osseo-integration procedure—extra-oral, implantation of titanium fixture, not for implantable bone conduction hearing system device (Anaes.)	524.30
45797	Osseo-integration procedure, fixation of transcutaneous abutment, not for implantable bone conduction hearing system device (Anaes.)	194.10
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.)	30.60
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.)	132.10
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.)	339.25
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.)	179.50

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 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.)	256.50
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.)	386.55
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.)	522.60
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.)	611.40
45815	Operation on mandible or maxilla (other than alveolar margins) for chronic osteomyelitis—one bone or in combination with adjoining bones (Anaes.) (Assist.)	370.80
45817	Operation on skull for osteomyelitis (Anaes.) (Assist.)	483.35
45819	Operation on any combination of adjoining bones in the oral and maxillofacial region, being bones referred to in item 45817 (Anaes.) (Assist.)	611.35
45821	Bone growth stimulator in the oral and maxillofacial region, insertion of (Anaes.) (Assist.)	396.25
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 (H) (Anaes.)	113.30
45825	Mandibular or palatal exostosis, excision of (Anaes.) (Assist.)	352.05
45827	Mylohyoid ridge, reduction of (Anaes.) (Assist.)	336.50
45829	Maxillary tuberosity, reduction of (Anaes.)	256.70
45831	Papillary hyperplasia of the palate, removal of—less than 5 lesions (Anaes.) (Assist.)	336.50
45833	Papillary hyperplasia of the palate, removal of—5 to 20 lesions (Anaes.) (Assist.)	422.50
45835	Papillary hyperplasia of the palate, removal of—more than 20 lesions (Anaes.) (Assist.)	524.30
45837	Vestibuloplasty, submucosal or open, including excision of muscle and skin or mucosal graft when performed—unilateral or bilateral (Anaes.) (Assist.)	610.30

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
45839	Floor of mouth lowering (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed—unilateral (Anaes.) (Assist.)	610.30
45841	Alveolar ridge augmentation with bone or alloplast or both—unilateral (Anaes.) (Assist.)	492.85
45843	Alveolar ridge augmentation—unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region (Anaes.) (Assist.)	302.30
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.)	524.30
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.)	194.10
45849	Maxillary sinus, bone graft to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), unilateral (Anaes.) (Assist.)	604.45
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 (H) (Anaes.)	148.80
45853	Absent condyle and ascending ramus in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.)	926.95
45855	Temporomandibular joint, arthroscopy of, with or without biopsy, other than a service associated with another arthroscopic procedure of that joint (Anaes.) (Assist.)	425.30
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.)	680.25
45859	Temporomandibular joint, arthrotomy of, other than a service to which another item in this Subgroup applies (Anaes.) (Assist.)	342.90
45861	Temporomandibular joint, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.)	907.65
45863	Temporomandibular joint, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.)	1,006.15
45865	Arthrocentesis, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.)	302.30
45867	Temporomandibular joint, synovectomy of, other than a service to which another item in this Subgroup applies (Anaes.) (Assist.)	324.95
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	1,236.35

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	techniques (Anaes.) (Assist.)	
45871	Temporomandibular joint, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.)	1,392.65
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.)	1,564.95
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.)	489.75
45877	Temporomandibular joint, arthrodesis of, with synovectomy if performed, other than a service to which another item in this Subgroup applies (Anaes.) (Assist.)	489.75
45879	Temporomandibular joint or joints, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.)	324.95
45882	Treatment of a premalignant lesion of the oral mucosa using cryotherapy, diathermy or carbon dioxide laser	44.75
45885	Ligation of a facial, mandibular or lingual artery or vein, or artery and vein	461.65
45888	Removal of a deep foreign body using interventional imaging techniques	430.30
45891	Repair to one defect using temporalis muscle by a single stage local flap	626.90
45894	Free grafting of a granulating area (mucosa or split skin)	213.00
45897	Grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation, a unilateral alveolar cleft (congenital)	1,112.40
45900	Fixation of the mandible by intermaxillary wiring, excluding wiring for obesity	250.90
45939	Cryosurgery of the peripheral branches of the trigeminal nerve for pain relief	465.20
45945	Treatment of a dislocation of the mandible requiring open reduction	123.50
45975	Treatment of a fracture of the unilateral or bilateral maxilla, not requiring splinting	134.40
45978	Treatment of a fracture of the mandible, not requiring splinting	164.25
45981	Treatment of the zygomatic bone, not requiring surgical reduction	89.10
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	641.60
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	641.60
45990	Treatment of a complicated fracture of the maxilla including viscera,	876.40

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	blood vessels or nerves, requiring open reduction involving the use of a plate	
45993	Treatment of a complicated fracture of the mandible involving viscera, blood vessels or nerves, requiring open reduction involving the use of a plate	876.40
45996	Treatment of a closed fracture of the mandible involving a joint surface	248.45

Subdivision F—Subgroup 14 of Group T8

5.10.24 Items in Subgroup 14 of Group T8

This clause sets out items in Subgroup 14 of Group T8.

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
Subgroup 14—Hand or wrist surgery		
46300	Arthrodesis of interphalangeal or metacarpophalangeal joint of hand, including either or both of the following (if performed): (a) joint debridement; (b) synovectomy; —one joint (H) (Anaes.) (Assist.)	422.55
46303	Arthrodesis of carpometacarpal joint of hand, including either or both of the following (if performed): (a) joint debridement; (b) synovectomy; —one joint (H) (Anaes.) (Assist.)	547.85
46308	Volar plate or soft tissue interposition arthroplasty of interphalangeal or metacarpophalangeal joint of hand, including either or both of the following (if performed): (a) realignment procedures; (b) tendon transfer; —one joint (Anaes.) (Assist.)	547.80
46309	Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) ligament reconstruction; (b) ligament realignment; (c) synovectomy; (d) tendon transfer; —one joint (H) (Anaes.) (Assist.)	547.80
46312	Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal	704.40

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	or metacarpophalangeal joint of hand, including any of the following (if performed): (a) ligament reconstruction; (b) ligament realignment; (c) synovectomy; (d) tendon transfer; —2 joints of one hand (H) (Anaes.) (Assist.)	
46315	Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) ligament reconstruction; (b) ligament realignment; (c) synovectomy; (d) tendon transfer; —3 joints of one hand (H) (Anaes.) (Assist.)	939.15
46318	Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) ligament reconstruction; (b) ligament realignment; (c) synovectomy; (d) tendon transfer; —4 joints of one hand (H) (Anaes.) (Assist.)	1,173.95
46321	Prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) ligament reconstruction; (b) ligament realignment; (c) synovectomy; (d) tendon transfer; —5 joints of one hand (H) (Anaes.) (Assist.)	1,408.75
46322	Revision of prosthetic replacement arthroplasty or hemiarthroplasty of interphalangeal or metacarpal joint of hand, including any of the following (if performed): (a) bone grafting; (b) ligament reconstruction; (c) ligament realignment; (d) synovectomy; (e) tendon or ligament reconstruction; (f) tendon transfer; —one joint (H) (Anaes.)(Assist.)	821.80
46324	Trapezium replacement arthroplasty or prosthetic interpositional replacement of carpometacarpal joint of thumb, including either or both of	958.55

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	the following (if performed): (a) ligament and tendon transfers; (b) rebalancing procedures (H) (Anaes.) (Assist.)	
46325	Excisional arthroplasty of carpometacarpal joint of thumb, with excision of adjacent trapezoid, including either or both of the following (if performed): (a) ligament and tendon transfers; (b) realignment procedures (H) (Anaes.) (Assist.)	958.55
46330	Ligamentous or capsular repair or reconstruction of interphalangeal or metacarpophalangeal joint of hand, including any of the following (if performed): (a) arthrotomy; (b) joint stabilisation; (c) synovectomy; —one joint (H) (Anaes.) (Assist.)	360.10
46333	Ligamentous or capsular repair or reconstruction of interphalangeal or metacarpophalangeal joint of hand with graft, using graft or implant, including any of the following (if performed): (a) arthrotomy; (b) harvest of graft; (c) joint stabilisation; (d) synovectomy; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 apply—one joint (H) (Anaes.) (Assist.)	586.90
46335	Synovectomy of digital extensor tendons of hand, distal to wrist, for diagnosed inflammatory arthritis, including any of the following (if performed): (a) reconstruction of extensor retinaculum; (b) removal of tendon nodules; (c) tenolysis; (d) tenoplasty; other than a service associated with a service to which item 30023, 39331 or 39330 applies—applicable only once per occasion on which the service is performed (Anaes.)(Assist.)	485.10
46336	Synovectomy of interphalangeal, metacarpophalangeal or carpometacarpal joint of hand, including any of the following (if performed): (a) capsulectomy; (b) debridement; (c) ligament or tendon realignment (or both); other than a service combined with a service to which item 46495 applies—one joint (Anaes.) (Assist.)	273.95

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
46339	Synovectomy of digital flexor tendons at wrist level, for diagnosed inflammatory arthritis, including either or both of the following (if performed): (a) tenolysis; (b) release of median nerve and carpal tunnel; other than a service associated with a service to which item 30023, 39331 or 39330 applies—applicable only once per occasion on which the service is performed (H) (Anaes.) (Assist.)	485.10
46340	Synovectomy of wrist flexor or extensor tendons of hand or wrist, for diagnosed inflammatory tenosynovitis, including any of the following (if performed): (a) reconstruction of flexor or extensor retinaculum; (b) removal of tendon nodules; (c) tenolysis; (d) tenoplasty; other than a service associated with a service to which item 30023, 39331 or 39330 applies—one or more compartments (H) (Anaes.) (Assist.)	412.35
46341	Synovectomy of wrist flexor or extensor tendons of hand or wrist, for non-inflammatory tenosynovitis or post traumatic synovitis, including any of the following (if performed): (a) reconstruction of flexor or extensor retinaculum; (b) removal of tendon nodules; (c) tenolysis; (d) tenoplasty; other than a service associated with a service to which item 30023, 39331 or 39330 applies—one or more compartments (H) (Anaes.) (Assist.)	264.45
46342	Synovectomy of distal radioulnar or carpometacarpal joint of hand—one or more joints (H) (Anaes.) (Assist.)	485.10
46345	Resection arthroplasty of distal radioulnar joint of hand, partial or complete, including any of the following (if performed): (a) ligament or tendon reconstruction; (b) joint stabilisation; (c) synovectomy (H) (Anaes.) (Assist.)	586.90
46348	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty; other than a service associated with a service to which item 30023 or 46363 applies—one ray (H) (Anaes.) (Assist.)	254.35
46351	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed):	379.60

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty; other than a service associated with a service to which item 30023 or 46363 applies—2 rays of one hand (H) (Anaes.) (Assist.)	
46354	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty; other than a service associated with a service to which item 30023 or 46363 applies—3 rays of one hand (H) (Anaes.) (Assist.)	508.65
46357	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty; other than a service associated with a service to which item 30023 or 46363 applies—4 rays of one hand (H) (Anaes.) (Assist.)	633.90
46360	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty; other than a service associated with a service to which item 30023 or 46363 applies—5 rays of one hand (H) (Anaes.) (Assist.)	763.10
46363	Trigger finger release, for stenosing tenosynoviti, including either or both of the following (if performed): (a) synovectomy; (b) synovial biopsy; —one ray (Anaes.) (Assist.)	219.10
46364	Digital sympathectomy of hand, using microsurgical techniques, other than a service associated with a service to which item 30023 or 46363 applies—one digit or palmer arch (or both) or radial or ulnar artery (or both) (Anaes.)(Assist.)	485.10
46365	Excision of rheumatoid nodules of hand—one lesion (Anaes.) (Assist.)	273.95
46367	De Quervain's release, including any of the following (if performed): (a) synovectomy of extensor pollicis brevis; (b) synovectomy of abductor pollicis longus tendons; (c) retinaculum reconstruction; other than a service associated with a service to which item 46339 applies (Anaes.) (Assist.)	413.70
46370	Percutaneous fasciotomy for Dupuytren's contracture, by needle or	133.10

Clause 5.10.24

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	chemical method, including either or both of the following (if performed): (a) immediate or delayed manipulation; (b) local or regional nerve block; —one ray (Anaes.)(Assist.)	
46372	Fasciectomy for Dupuytren's contracture, including dissection of nerves (if performed)—one ray (H) (Anaes.) (Assist.)	445.25
46375	Fasciectomy for Dupuytren's contracture, including dissection of nerves (if performed)—2 rays (H) (Anaes.) (Assist.)	528.25
46378	Fasciectomy for Dupuytren's contracture, including dissection of nerves (if performed)—3 rays (H) (Anaes.) (Assist.)	704.40
46379	Fasciectomy for Dupuytren's contracture, including dissection of nerves (if performed)—4 rays (H) (Anaes.) (Assist.)	887.40
46380	Fasciectomy for Dupuytren's contracture, including dissection of nerves (if performed)—5 rays (H) (Anaes.) (Assist.)	1,118.05
46381	Release of interphalangeal joint of hand, by open procedure, when performed in conjunction with an operation for Dupuytren's contracture—one joint (H) (Anaes.) (Assist.)	313.00
46384	Z-plasty or similar local flap procedure, when performed in conjunction with an operation for Dupuytren's contracture, including raising, transfer in-setting and suturing of both components (flaps)—one Z-plasty or local flap procedure (H) (Anaes.) (Assist.)	313.00
46387	Fasciectomy for recurrence of Dupuytren's contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies—one ray (H) (Anaes.) (Assist.)	645.75
46390	Fasciectomy for recurrence of Dupuytren's contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies—2 rays (H) (Anaes.) (Assist.)	861.05
46393	Fasciectomy for recurrence of Dupuytren's contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies—3 rays (H) (Anaes.) (Assist.)	997.85
46394	Fasciectomy for recurrence of Dupuytren's contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis;	1,243.45

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	other than a service associated with a service to which item 30023 applies—4 rays (H) (Anaes.) (Assist.)	
46395	Fasciectomy for recurrence of Dupuytren's contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies—5 rays (H) (Anaes.) (Assist.)	1,549.55
46399	Osteotomy of phalanx or metacarpal of hand, with internal fixation—one bone (H) (Anaes.) (Assist.)	538.80
46401	Operative treatment of non-union of phalanx or metacarpal of hand, including internal fixation (if performed) (Anaes.) (Assist.)	432.45
46408	Reconstruction of tendon of hand or wrist, by tendon graft, including either or both of the following (if performed): (a) harvest of graft; (b) tenolysis; other than a service associated with a service to which item 30023 applies (H) (Anaes.) (Assist.)	720.00
46411	Reconstruction of complete flexor tendon pulley of hand or wrist, with graft, including harvest of graft (if performed)—one pulley (H) (Anaes.) (Assist.)	422.60
46414	Insertion of artificial tendon prosthesis in preparation for grafting of tendon of hand or wrist, including tenolysis (if performed), other than a service associated with a service to which item 30023 applies (Anaes.) (Assist.)	547.70
46417	Transfer of tendon of hand or wrist, for restoration of hand or digit motion, including harvest of donor motor unit (if performed)—one transfer (H) (Anaes.) (Assist.)	508.65
46420	Primary repair of extensor tendon of hand or wrist—one tendon (Anaes.) (Assist.)	212.85
46423	Delayed repair of extensor tendon of hand or wrist, including tenolysis (if performed), other than a service associated with a service to which item 30023 applies (Anaes.) (Assist.)	340.45
46426	Primary repair of flexor tendon of hand or wrist, proximal to A1 pulley, other than a service to repair a tendon of a digit if 2 tendons of the same digit have been repaired during the same procedure—one tendon (H) (Anaes.) (Assist.)	352.10
46432	Primary repair of flexor tendon of hand or wrist, distal to A1 pulley, other than a service to repair a tendon of a digit if 2 tendons of the same digit have been repaired during the same procedure—one tendon (H) (Anaes.) (Assist.)	587.10
46434	Delayed repair of flexor tendon of hand or wrist, including tenolysis (if performed), other than a service associated with a service to which item 30023 applies (Anaes.) (Assist.)	505.80
46438	Closed pin fixation of mallet finger (Anaes.)	140.90

Clause 5.10.24

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
46441	Open reduction of mallet finger, including any of the following (if performed): (a) joint release; (b) pin fixation; (c) tenolysis (Anaes.) (Assist.)	340.45
46442	Open reduction of mallet finger with intra-articular fracture, involving more than one-third of base of terminal phalanx (H) (Anaes.) (Assist.)	292.25
46444	Reconstruction of Boutonniere or swan neck deformity of hand, including either or both of the following (if performed): (a) tendon graft harvest; (b) tendon transfer; —one joint (H) (Anaes.) (Assist.)	508.65
46450	Tenolysis of extensor tendon of hand or wrist, following tendon injury or graft, other than a service: (a) for acute, traumatic injury; or (b) associated with a service to which item 30023 applies; —one ray (H) (Anaes.)	234.85
46453	Tenolysis of flexor tendon of hand or wrist, following tendon injury, repair or graft, other than a service: (a) for acute, traumatic injury; or (b) associated with a service to which item 30023 applies (H) (Anaes.) (Assist.)	391.35
46456	Percutaneous tenotomy of digit of hand (Anaes.)	101.75
46464	Amputation of a supernumerary complete digit of hand (H) (Anaes.) (Assist.)	234.85
46465	Amputation of digit of hand, distal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) resection of bone; (c) skin cover with local flaps; —one ray (H) (Anaes.) (Assist.)	234.85
46468	Amputation of digit of hand, distal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) resection of bone; (c) skin cover with local flaps; —2 rays (H) (Anaes.) (Assist.)	410.85
46471	Amputation of digit of hand, distal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) resection of bone;	586.90

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(c) skin cover with local flaps; —3 rays (H) (Anaes.) (Assist.)	
46474	Amputation of digit of hand, distal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) resection of bone; (c) skin cover with local flaps; —4 rays (H) (Anaes.) (Assist.)	763.10
46477	Amputation of digit of hand, distal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) resection of bone; (c) skin cover with local flaps; —5 rays (H) (Anaes.) (Assist.)	939.15
46480	Amputation of ray of hand, proximal to metacarpal head, including any of the following (if performed): (a) excision of neuroma; (b) recontouring; (c) resection of bone; (d) skin cover with local flaps; —one ray (H) (Anaes.) (Assist.)	391.35
46483	Revision of amputation stump of hand to provide adequate cover, including any of the following (if performed): (a) bone shortening; (b) excision of nail bed remnants; (c) excision of neuroma (H) (Anaes.) (Assist.)	313.00
46486	Accurate reconstruction of nail bed laceration using magnification (H) (Anaes.)	234.85
46489	Secondary reconstruction of nail bed deformity using magnification, including removal of nail (if performed), other than a service associated with a service to which item 46513 or 45451 applies (H) (Anaes.) (Assist.)	273.95
46492	Surgical correction of contracture of joint of hand, flexor or extensor tendon, involving tissues deeper than skin and subcutaneous tissue—one joint (H) (Anaes.) (Assist.)	375.70
46493	Resection of boss of metacarpal base of hand, including either or both of the following (if performed): (a) excision of ganglion; (b) synovectomy (Anaes.) (Assist.)	342.90
46495	Complete excision of one or more ganglia or mucous cysts of interphalangeal, metacarpophalangeal or carpometacarpal joint of hand, including any of the following (if performed):	211.40

Clause 5.10.24

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(a) arthrotomy; (b) osteophyte resections (c) synovectomy; other than a service associated with a service to which item 30107 or 46336 applies—one joint (H) (Anaes.) (Assist.)	
46498	Excision of ganglion of flexor tendon sheath of hand, including any of the following (if performed): (a) flexor tenosynovectomy; (b) sheath excision; (c) skin closure by any method; other than a service associated with a service to which item 30106, 30107 or 46363 applies (Anaes.)	228.85
46500	Excision of ganglion of dorsal wrist joint of hand, including any of the following (if performed): (a) arthrotomy; (b) capsular or ligament repair (or both); (c) synovectomy; other than a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.)	273.95
46501	Excision of ganglion of volar wrist joint of hand, including any of the following (if performed): (a) arthrotomy; (b) capsular or ligament repair (or both); (c) synovectomy; other than a service associated with a service to which item 30106, 30107 or 46325 applies (Anaes.) (Assist.)	342.50
46502	Excision of recurrent ganglion of dorsal wrist joint of hand, including any of the following (if performed): (a) arthrotomy; (b) capsular or ligament repair (or both); (c) synovectomy (Anaes.) (Assist.)	410.90
46503	Excision of recurrent ganglion of volar wrist joint of hand, including any of the following (if performed): (a) arthrotomy; (b) capsular or ligament repair (or both); (c) synovectomy; other than a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.)	393.70
46504	Neurovascular island flap, heterodigital, for pulp re-innervation and soft tissue cover (Anaes.) (Assist.)	1,150.35
46507	Transposition or transfer of digit or ray on vascular pedicle of hand, including any of the following (if performed):	1,560.75

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) nerve transfer; (b) skin closure, by any means; (c) rebalancing procedures (H) (Anaes.) (Assist.)	
46510	Surgical reduction of enlarged elements resulting from macrodactyly, including any of the following (if performed): (a) nerve transfer; (b) skin closure, by any means; (c) rebalancing procedures; —one digit (H) (Anaes.) (Assist.)	365.20
46513	Removal of nail of finger or thumb—one nail (Anaes.)	58.75
46519	Drainage of midpalmar, thenar or hypothenar spaces or dorsum of hand, excluding aftercare (Anaes.) (Assist.)	146.95
46522	Open operation and drainage of infection for flexor tendon sheath of finger or thumb, including either or both of the following (if performed): (a) synovectomy; (b) tenolysis; other than a service associated with a service to which item 30023 applies—one digit (H) (Anaes.) (Assist.)	438.25
46525	Incision for pulp space infection of hand: (a) other than a service: (i) to which another item in this Group applies; or (ii) associated with a service to which item 30023 applies; and (b) excluding aftercare (H) (Anaes.)	58.75
46528	Wedge resection for ingrowing nail of finger or thumb: (a) including each of the following: (i) excision and partial ablation of germinal matrix; (ii) removal of segment of nail; (iii) removal of ungual fold; and (b) including phenolisation (if performed) (Anaes.)	176.35
46531	Partial resection of ingrowing nail of finger or thumb, including phenolisation (Anaes.)	88.60
46534	Complete ablation of nail germinal matrix (H) (Anaes.)	245.05

Subdivision G—Subgroups 15, 16 and 17 of Group T8

5.10.25 Restrictions on items 50303, 50200 and 50201—provider and timing

(1) A service described in item 50303 is applicable once in any 12 month period for each limb.

(2) Items 50200 and 50201 do not apply to a service provided to a patient by a provider if the provider has provided the same service to the patient more than once in the previous 12 months.

5.10.26 Restrictions on items 51011 to 51112 and 51115 to 51171—services provided in conjunction with other services in Group T8

Items 51011 to 51112 and 51115 to 51171 do not apply to a service provided in conjunction with a service to which another item in Group T8 (other than an item in Subgroup 17) applies if the service described in the other item is for the purpose of spinal surgery.

5.10.27 Restrictions on items 51061 to 51066—services provided in conjunction with certain other services

Items 51061 to 51066 do not apply to a service provided in conjunction with a service to which any of items 51020 to 51045 apply.

5.10.28 Meaning of motion segment

In this Schedule:

motion segment includes all anatomical structures (including traversing and exiting nerve roots) between, and including, the top of the pedicle above to the bottom of the pedicle below.

5.10.29 Items in Subgroups 15, 16 and 17 of Group T8

This clause sets out items in Subgroups 15, 16 and 17 of Group T8.

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 15—Orthopaedic		
47000	Treatment of dislocation of mandible, by closed reduction (Anaes.)	73.55
47003	Treatment of dislocation of clavicle, by closed reduction (Anaes.)	88.25
47007	Repair of acromioclavicular or sternoclavicular joint dislocation (acute or chronic), by open, mini-open or arthroscopic technique, including either or both of the following (if performed): (a) ligament augmentation; (b) tendon transfers (Anaes.) (Assist.)	367.35
47009	Treatment of dislocation of shoulder, requiring general anaesthesia, other than a service to which item 47012 applies (Anaes.)	176.35
47012	Treatment of dislocation of shoulder, requiring general anaesthesia, by open reduction (H) (Anaes.) (Assist.)	352.55
47015	Treatment of dislocation of shoulder, not requiring general anaesthesia	88.25
47018	Treatment of dislocation of elbow, by closed reduction (Anaes.)	205.60

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
47021	Treatment of dislocation of elbow, by open reduction (H) (Anaes.) (Assist.)	274.25
47024	Treatment of dislocation of distal or proximal radioulnar joint, by closed reduction, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of treating fracture or dislocation in the same region (Anaes.)	205.60
47027	Treatment of dislocation of distal or proximal radioulnar joint, by open reduction, including either or both of the following (if performed): (a) styloid fracture; (b) triangular fibrocartilage complex repair; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of treating fracture or dislocation in the same region (Anaes.) (Assist.)	274.25
47030	Treatment of dislocation of carpus, carpus on radius and ulna or carpometacarpal joint, by closed reduction (Anaes.)	205.60
47033	Treatment of dislocation of carpus, carpus on radius and ulna or carpometacarpal joint, by open reduction, including ligament repair (if performed) (Anaes.) (Assist.)	274.25
47042	Treatment of dislocation of interphalangeal or metacarpophalangeal joint, by closed reduction (Anaes.)	117.40
47045	Treatment of dislocation of interphalangeal or metacarpophalangeal joint, by open reduction, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) ligament repair; (d) volar plate repair (Anaes.) (Assist.)	156.85
47047	Treatment of dislocation of prosthetic hip, by closed reduction (Anaes.) (Assist.)	337.95
47049	Treatment of dislocation of prosthetic hip, by open reduction (Anaes.) (Assist.)	450.50
47052	Treatment of dislocation of native hip, by closed reduction (Anaes.) (Assist.)	439.35
47053	Treatment of dislocation of native hip, by open reduction, with internal fixation (if performed) (Anaes.) (Assist.)	585.65
47054	Treatment of dislocation of knee, by closed reduction, including application of external fixator (if performed) (Anaes.) (Assist.)	337.95
47057	Treatment of dislocation of patella, by closed reduction (Anaes.)	132.20
47060	Treatment of dislocation of patella, by open reduction (Anaes.) (Assist.)	176.35
47063	Treatment of dislocation of ankle or tarsus, by closed reduction (Anaes.) (Assist.)	264.45
47066	Treatment of dislocation of ankle or tarsus, by open reduction, including	352.55

Clause 5.10.29

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint (H) (Anaes.) (Assist.)	
47069	Treatment of dislocation of toe, by open reduction—one toe (Anaes.)	73.55
47301	Treatment of fracture of middle or proximal phalanx, by closed reduction, requiring anaesthesia—one bone (Anaes.)	90.30
47304	Treatment of fracture of metacarpal, by closed reduction, requiring anaesthesia—one bone (H) (Anaes.)	102.90
47307	Treatment of fracture of phalanx or metacarpal, by closed reduction, including percutaneous K-wire fixation (if performed)—one bone (H) (Anaes.) (Assist.)	208.10
47310	Treatment of fracture of phalanx or metacarpal, by open reduction, with internal fixation (H) (Anaes.) (Assist.)	343.40
47313	Treatment of intra-articular fracture of phalanx or metacarpal, by closed reduction, including: (a) percutaneous K-wire fixation; and (b) external or dynamic fixation (if performed) (H) (Anaes.) (Assist.)	332.95
47316	Treatment of intra-articular fracture of phalanx or metacarpal, by open reduction with fixation, other than a service provided on the same occasion as a service to which item 47319 applies (H) (Anaes.) (Assist.)	660.75
47319	Treatment of intra-articular fracture of proximal end of middle phalanx, by open reduction, with fixation, other than a service provided on the same occasion as a service to which item 47316 applies (H) (Anaes.) (Assist.)	676.35
47348	Treatment of fracture of carpus (excluding scaphoid), by cast immobilisation, other than a service associated with a service to which item 47351 applies (Anaes.)	97.80
47351	Treatment of fracture of carpus (excluding scaphoid), by open reduction, with internal fixation (Anaes.) (Assist.)	245.05
47354	Treatment of fracture of carpal scaphoid, by cast immobilisation, other than a service associated with a service to which item 47357 applies (Anaes.)	176.35
47357	Treatment of fracture of carpal scaphoid, by open reduction, with internal or percutaneous fixation (Anaes.) (Assist.)	391.80
47361	Treatment of fracture of distal end of radius or ulna (or both), by cast immobilisation, other than a service associated with a service to which item 47362, 47364, 47367, 47370 or 47373 applies	137.15
47362	Treatment of fracture of distal end of radius or ulna (or both), by closed reduction, requiring general or major regional anaesthesia, but excluding local infiltration, other than a service associated with a service to which item 47361, 47364, 47367, 47370 or 47373 applies (Anaes.)	205.60

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
47364	Treatment of fracture of distal end of radius or ulna (not involving joint surface), by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (H) (Anaes.) (Assist.)	291.35
47367	Treatment of fracture of distal end of radius, by closed reduction with percutaneous fixation, other than a service associated with a service to which item 47361 or 47362 applies (H) (Anaes.) (Assist.)	232.70
47370	Treatment of intra-articular fracture of distal end of radius, by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (H) (Anaes.) (Assist.)	422.45
47373	Treatment of intra-articular fracture of distal end of ulna, by open reduction with fixation, other than a service associated with a service to which item 47361 or 47362 applies (H) (Anaes.) (Assist.)	301.75
47381	Treatment of fracture of shaft of radius or ulna, by closed reduction (H) (Anaes.)	264.45
47384	Treatment of fracture of shaft of radius or ulna, by open reduction with internal fixation (H) (Anaes.) (Assist.)	352.55
47385	Treatment of: (a) fracture of shaft of radius or ulna; and (b) dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury); by closed reduction (H) (Anaes.) (Assist.)	303.55
47386	Treatment of: (a) fracture of shaft of radius or ulna; and (b) dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury); by open reduction, with internal fixation, including reduction of dislocation (if performed) (H) (Anaes.) (Assist.)	489.75
47387	Treatment of fracture of distal or shaft of radius or ulna (or both), by cast immobilisation, other than a service to which item 47390 or 47393 applies (Anaes.) (Assist.)	284.00
47390	Treatment of fracture of shafts of radius and ulna, by closed reduction (H) (Anaes.)	426.15
47393	Treatment of fracture of shafts of radius and ulna, by open reduction, with internal fixation (H) (Anaes.) (Assist.)	568.10
47396	Treatment of fracture of olecranon, by closed reduction (Anaes.)	195.80
47399	Treatment of fracture of olecranon, by open reduction (H) (Anaes.) (Assist.)	391.80
47402	Treatment of fracture of olecranon, with excision of olecranon fragment and reimplantation of tendon (Anaes.) (Assist.)	293.75
47405	Treatment of fracture of head or neck of radius, by closed reduction (Anaes.)	195.80
47408	Treatment of fracture of head or neck of radius, by open reduction, including internal fixation and excision (if performed) (H) (Anaes.) (Assist.)	391.80

Clause 5.10.29

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
47411	Treatment of fracture of tuberosity of humerus, other than a service to which item 47417 applies (Anaes.)	117.40
47414	Treatment of fracture of tuberosity of humerus, by open reduction (Anaes.)	235.15
47417	Treatment of fracture of tuberosity of humerus and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.)	274.25
47420	Treatment of fracture of tuberosity of humerus and associated dislocation of shoulder, by open reduction (H) (Anaes.) (Assist.)	538.80
47423	Humerus, proximal, treatment of fracture of, other than a service to which item 47426, 47429 or 47432 applies (Anaes.)	225.25
47426	Humerus, proximal, treatment of fracture of, by closed reduction (H) (Anaes.)	337.95
47429	Humerus, proximal, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.)	450.50
47432	Humerus, proximal, treatment of intra-articular fracture of, by open reduction (H) (Anaes.) (Assist.)	563.20
47435	Humerus, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.)	431.05
47438	Humerus, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (H) (Anaes.) (Assist.)	685.85
47441	Humerus, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction (H) (Anaes.) (Assist.)	857.15
47444	Humerus, shaft of, treatment of fracture of, other than a service to which item 47447 or 47450 applies (Anaes.)	235.15
47447	Humerus, shaft of, treatment of fracture of, by closed reduction (H) (Anaes.)	352.55
47450	Humerus, shaft of, treatment of fracture of, by internal or external (H) (Anaes.) (Assist.)	470.30
47451	Humerus, shaft of, treatment of fracture of, by intramedullary fixation (H) (Anaes.) (Assist.)	566.85
47453	Humerus, distal, (supracondylar or condylar), treatment of fracture of, other than a service to which item 47456 or 47459 applies (Anaes.) (Assist.)	274.25
47456	Humerus, distal (supracondylar or condylar), treatment of fracture of, by closed reduction (H) (Anaes.) (Assist.)	411.55
47459	Humerus, distal (supracondylar or condylar), treatment of fracture of, by open reduction (H) (Anaes.) (Assist.)	548.65
47462	Clavicle, treatment of fracture of, other than a service to which item 47465 applies (Anaes.)	117.40
47465	Clavicle, treatment of fracture of, by open reduction (Anaes.) (Assist.)	235.15
47466	Sternum, treatment of fracture of, other than a service to which item 47467 applies (Anaes.)	117.40
47467	Sternum, treatment of fracture of, by open reduction (H) (Anaes.)	235.15

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
47468	Scapula, neck or glenoid region of, treatment of fracture of, by open reduction (Anaes.) (Assist.)	450.50
47471	Ribs (one or more), treatment of fracture of—each attendance	44.75
47474	Pelvic ring, treatment of fracture of, not involving disruption of pelvic ring or acetabulum	195.80
47477	Pelvic ring, treatment of fracture of, with disruption of pelvic ring or acetabulum	245.05
47480	Pelvic ring, treatment of fracture of, requiring traction (H) (Anaes.) (Assist.)	489.75
47483	Pelvic ring, treatment of fracture of, requiring control by external fixation (H) (Anaes.) (Assist.)	587.75
47486	Treatment of fracture of anterior pelvic ring or sacroiliac joint disruption (or both), by open reduction, with internal fixation (H) (Anaes.) (Assist.)	979.60
47489	Treatment of fracture of posterior pelvic ring or sacroiliac joint disruption (or both), by open reduction, with internal fixation (H) (Anaes.) (Assist.)	1,469.40
47495	Treatment of fracture of acetabulum and associated dislocation of hip, including the application and management of traction (if performed), excluding aftercare (Anaes.) (Assist.)	489.75
47498	Treatment of isolated posterior wall fracture of acetabulum and associated dislocation of hip, by open reduction, with internal fixation, including the application and management of traction (if performed) (H) (Anaes.) (Assist.)	734.65
47501	Treatment of anterior or posterior column fracture of acetabulum, by open reduction, with internal fixation, including any of the following (if performed): (a) capsular stabilisation; (b) capsulotomy; (c) osteotomy (H) (Anaes.) (Assist.)	979.60
47511	Treatment of combined column T-Type, transverse, anterior column or posterior hemitransverse fractures of acetabulum, by open reduction, with internal fixation, performed through single or dual approach (including fixation of the posterior wall fracture), including any of the following (if performed): (a) capsular stabilisation; (b) capsulotomy; (c) osteotomy (H) (Anaes.) (Assist.)	1,469.40
47514	Treatment of posterior wall fracture of acetabulum and associated femoral head fracture, by open reduction, with internal fixation (H) (Anaes.) (Assist.)	857.15
47516	Femur, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.)	450.50
47519	Femur, treatment of trochanteric or subcapital fracture of, by internal	901.30

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	fixation (H) (Anaes.) (Assist.)	
47528	Femur, treatment of fracture of, by internal fixation or external fixation (H) (Anaes.) (Assist.)	783.80
47531	Femur, treatment of fracture of shaft, by intramedullary fixation and cross fixation (H) (Anaes.) (Assist.)	999.15
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.)	1,126.55
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.)	450.50
47540	Hip spica or shoulder spica, application of, as an independent procedure (Anaes.)	225.25
47543	Tibia, plateau of, treatment of medial or lateral fracture of, other than a service to which item 47546 or 47549 applies (Anaes.)	235.15
47546	Tibia, plateau of, treatment of medial or lateral fracture of, by closed reduction (Anaes.)	352.55
47549	Treatment of medial or lateral fracture of plateau of tibia, by open reduction, with internal fixation, including any of the following (if performed): (a) arthroscopy; (b) arthrotomy; (c) meniscal repair (H) (Anaes.) (Assist.)	560.05
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.)	391.80
47555	Tibia, plateau of, treatment of both medial and lateral fractures of, by closed reduction (H) (Anaes.)	587.75
47558	Treatment of medial and lateral fractures of tibia, by open reduction, with internal fixation, including any of the following (if performed): (a) arthroscopy; (b) arthrotomy; (c) meniscal repair (H) (Anaes.) (Assist.)	1,038.40
47559	Treatment of medial or lateral (or both) fracture of plateau of tibia, with application of a bridging external fixator to the plateau (Anaes.) (Assist.)	795.25
47561	Treatment of fracture of shaft of tibia, by cast immobilisation, other than a service to which item 47570 or 47573 applies (Anaes.)	284.00
47565	Tibia, shaft of, treatment of fracture of, by internal fixation or external fixation (H) (Anaes.) (Assist.)	741.25
47566	Tibia, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (H) (Anaes.) (Assist.)	944.90
47568	Closed reduction of proximal tibia, distal tibia or shaft of tibia, with or without treatment of fibular fracture (Anaes.) (Assist.)	426.15

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
47570	Tibia, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (Anaes.) (Assist.)	568.10
47573	Treatment of proximal or distal intra-articular fracture of shaft of tibia, by open reduction, with or without treatment of fibular fracture, including any of the following (if performed): (a) arthroscopy; (b) arthrotomy; (c) capsule repair; (d) removal of intervening soft tissue; (e) removal of loose fragments; (f) washout of joint; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of treating a medial malleolus fracture of the distal tibia (H) (Anaes.) (Assist.)	710.20
47579	Treatment of fracture of patella, other than a service to which item 47582 or 47585 applies (Anaes.)	166.55
47582	Treatment of fracture of patella, with internal fixation, including bone grafting (if performed), other than a service associated with a service to which item 47579 or 47585 applies (H) (Anaes.) (Assist.)	440.95
47585	Treatment of proximal or distal fracture of patella, by open reduction, with internal fixation, including any of the following (if performed): (a) arthrotomy; (b) excision of patellar pole, with reattachment of tendon; (c) removal of loose fragments; (d) repair of quadriceps or patellar tendon (or both); (e) stabilisation of patello-femoral joint (H) (Anaes.) (Assist.)	455.85
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.)	1,371.25
47591	Knee joint, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar and tibial articular surfaces and requiring repair or reconstruction of one or more ligaments (H) (Anaes.) (Assist.)	1,665.50
47592	Repair or reconstruction (or both) of acute traumatic chondral injury to the distal femoral or proximal tibial articular surfaces of the knee, using chondral or osteochondral implants or transfers (H) (Anaes.) (Assist.)	339.20
47593	Repair or reconstruction (or both) of acute traumatic chondral injury to the distal femoral and proximal tibial articular surfaces of the knee, using chondral or osteochondral implants or transfers (H) (Anaes.) (Assist.)	830.30
47595	Treatment of fracture of ankle joint, hindfoot, midfoot, metatarsals or toes, by non-surgical management—one leg (Anaes.)	167.60
47597	Treatment of fracture of ankle joint, by closed reduction (Anaes.) (Assist.)	337.95
47600	Treatment of fracture of ankle joint:	587.75

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) by internal fixation of the malleolus, fibula or diastasis; and (b) including any of the following (if performed): (i) arthrotomy; (ii) capsule repair; (iii) removal of loose fragments or intervening soft tissue; (iv) washout of joint (H) (Anaes.) (Assist.)	
47603	Treatment of fracture of ankle joint: (a) by internal fixation of 2 or more of the malleolus, fibula, diastasis and medial tissue interposition; and (b) including any of the following (if performed): (i) arthrotomy; (ii) capsule repair; (iii) removal of loose fragments or intervening soft tissue; (iv) washout of joint (H) (Anaes.) (Assist.)	741.25
47612	Treatment of intra-articular fracture of hindfoot, by closed reduction, with or without dislocation—one foot (Anaes.) (Assist.)	426.15
47615	Treatment of fracture of hindfoot, by open reduction, with or without dislocation, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint; —one foot (Anaes.) (Assist.)	489.75
47618	Treatment of intra-articular fracture of hindfoot, by open reduction, with or without dislocation, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint; —one foot (H) (Anaes.) (Assist.)	612.25
47621	Treatment of intra-articular fracture of midfoot, by closed reduction, with or without dislocation—one foot (Anaes.) (Assist.)	426.15
47624	Treatment of fracture of tarso-metatarsal, by open reduction, with or without dislocation, including any of the following (if performed): (a) arthrotomy; (b) capsule or ligament repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint; —one joint (H) (Anaes.) (Assist.)	587.75
47630	Treatment of fracture of cuneiform, by open reduction, with or without dislocation, including any of the following (if performed):	352.55

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) arthrotomy; (b) capsule or ligament repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint; —one bone (Anaes.) (Assist.)	
47637	Treatment of fractures of metatarsal, by closed reduction—one or more metatarsals of one foot (Anaes.) (Assist.)	199.60
47639	Treatment of fracture of metatarsal, by open reduction, including removal of loose fragments or intervening soft tissue (if performed)—one metatarsal (Anaes.) (Assist.)	235.15
47648	Treatment of fracture of metatarsal, by open reduction, including removal of loose fragments or intervening soft tissue (if performed)—2 metatarsals of one foot (H) (Anaes.) (Assist.)	313.25
47657	Treatment of fracture of metatarsal, by open reduction, including removal of loose fragments or intervening soft tissue (if performed)—3 or more metatarsals of one foot (H) (Anaes.) (Assist.)	489.75
47663	Treatment of fracture of phalanx of toe, by closed reduction—one toe (Anaes.)	146.95
47666	Treatment of fracture or dislocation of phalanx of great toe, by open reduction, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments; (d) removal of intervening soft tissue; (e) washout of joint; —one great toe (Anaes.)	245.05
47672	Treatment of fracture or dislocation of phalanx of toe, by open reduction, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments; (d) removal of intervening soft tissue; (e) washout of joint; —one toe (other than great toe) of one foot (Anaes.)	117.40
47678	Treatment of fracture or dislocation of phalanx of toe, by open reduction, including any of the following (if performed): (a) arthrotomy; (b) capsule repair; (c) removal of loose fragments; (d) removal of intervening soft tissue; (e) washout of joint; —2 or more toes (other than great toe) of one foot (Anaes.)	176.35

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
47735	Nasal bones, treatment of fracture of, other than a service to which item 47738 or 47741 applies—each attendance	44.80
47738	Nasal bones, treatment of fracture of, by reduction (Anaes.)	245.05
47741	Nasal bones, treatment of fracture of, by open reduction involving osteotomies (H) (Anaes.) (Assist.)	499.80
47753	Maxilla, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (H) (Anaes.) (Assist.)	423.10
47756	Mandible, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (H) (Anaes.) (Assist.)	423.10
47762	Zygomatic bone, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.)	248.45
47765	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at one site (H) (Anaes.) (Assist.)	408.00
47768	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (H) (Anaes.) (Assist.)	499.80
47771	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (H) (Anaes.) (Assist.)	574.20
47774	Maxilla, treatment of fracture of, requiring open operation (H) (Anaes.) (Assist.)	453.30
47777	Mandible, treatment of fracture of, requiring open reduction (H) (Anaes.) (Assist.)	453.30
47780	Maxilla, treatment of fracture of, requiring open reduction and internal fixation not involving a plate (H) (Anaes.) (Assist.)	589.30
47783	Mandible, treatment of fracture of, requiring open reduction and internal fixation not involving a plate (Anaes.) (Assist.)	589.30
47786	Maxilla, treatment of fracture of, requiring open reduction and internal fixation involving a plate (H) (Anaes.) (Assist.)	747.85
47789	Mandible, treatment of fracture of, requiring open reduction and internal fixation involving a plate (H) (Anaes.) (Assist.)	747.85
47900	Injection into, or aspiration of, unicameral bone cyst (Anaes.)	176.35
47903	Epicondylitis, open operation for (Anaes.)	245.05
47904	Digital nail of toe, removal of, other than a service to which item 47906 applies (Anaes.)	58.75
47906	Digital nail of toe, removal of (H) (Anaes.)	117.40
47915	Wedge resection for ingrowing nail of toe: (a) including each of the following: (i) removal of segment of nail; (ii) removal of ungual fold; (iii) excision and partial ablation of germinal matrix and portion of nail bed; and (b) including phenolisation (if performed) (Anaes.) (Assist.)	176.35

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
47916	Partial resection for ingrowing nail of toe, including phenolisation (Anaes.)	88.60
47918	Complete ablation of nail germinal matrix: (a) including each of the following: (i) removal of segment of nail; (ii) removal of ungual fold; (iii) excision and ablation of germinal matrix and portion of nail bed; and (b) including phenolisation (if performed) (Anaes.) (Assist.)	245.05
47921	Orthopaedic pin or wire, insertion of, as an independent procedure (Anaes.)	117.40
47924	Removal of one or more buried wires, pins or screws (inserted for internal fixation purposes), with incision, other than a service associated with a service to which item 47927 or 47929 applies—one bone (Anaes.)	39.15
47927	Removal of one or more buried wires, pins or screws (inserted for internal fixation purposes)—one bone (H) (Anaes.)	146.95
47929	Removal of fixation elements (including plate, rod or nail and associated wires, pins, screws or external fixation), other than a service associated with a service to which item 47924 or 47927 applies—one bone (H) (Anaes.) (Assist.)	391.80
47953	Repair of distal biceps brachii tendon, by any method, performed as an independent procedure (Anaes.) (Assist.)	450.50
47954	Repair of traumatic tear or rupture of tendon, other than a service associated with: (a) a service to which item 39330 applies; or (b) a service to which another item in this Schedule applies if the service described in the other item is for the purpose of repairing peripheral nerve items in the same region (Anaes.) (Assist.)	391.80
47955	Repair of gluteal or rectus femoris tendon, by open or arthroscopic means, when performed as an independent procedure, including either or both of the following (if performed): (a) bursectomy; (b) preparation of greater trochanter; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the hip (H) (Anaes.) (Assist.)	678.05
47956	Repair of proximal hamstring tendon, performed as an independent procedure, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the hip (H) (Anaes.) (Assist.)	1,017.05
47964	Iliopsoas tenotomy, by open or arthroscopic means, when performed as an independent procedure, other than a service associated with a service to which another item in this Schedule applies if the service described in the	225.25

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	other item is for the purpose of performing a procedure on the hip (H) (Anaes.) (Assist.)	
47967	Restoration of shoulder function by major muscle tendon transfer, including associated dissection of neurovascular pedicle, excluding micro-anastomosis and biceps tenodesis—one transfer (H) (Anaes.) (Assist.)	450.50
47975	Forearm or calf, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (H) (Anaes.) (Assist.)	384.15
47978	Forearm or calf, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue (H) (Anaes.)	233.30
47981	Forearm, calf or interosseous muscle space of hand, decompression fasciotomy of, other than a service to which another item in this Group applies (Anaes.)	156.65
47982	Forage (Drill decompression), of neck or head of femur, or both (H) (Anaes.) (Assist.)	379.70
47983	Stabilisation of slipped capital femoral epiphysis, by internal fixation (H) (Anaes.) (Assist.)	901.30
47984	Open subcapital realignment of slipped capital femoral epiphysis, other than a service associated with a service to which item 48427 applies (H) (Anaes.) (Assist.)	901.30
48245	Harvesting and insertion of bone graft (autograft) via separate incisions and at separate surgical fields (H) (Anaes.) (Assist.)	325.45
48248	Harvesting and insertion of bone graft (autograft) via separate incisions, including internal fixation of the graft or fusion fixation (or both) (H) (Anaes.) (Assist.)	504.00
48251	Harvesting and insertion of osteochondral graft (autograft) via separate incisions at the same joint or joint complex (H) (Anaes.) (Assist.)	414.75
48254	Harvesting and insertion of pedicled bone flap (autograft), including internal fixation of the bone flap (if performed), other than a service associated with a service to which item 45562, 45504 or 45505 applies (H) (Anaes.) (Assist.)	950.25
48257	Preparation and insertion of metallic, cortical or other graft substitute (allograft), where substitute is structural cortico-cancellous bone or structural bone (or both), including internal fixation (if performed) (H) (Anaes.) (Assist.)	414.75
48400	Osteotomy of phalanx, metatarsal, accessory bone or sesamoid bone, other than a service associated with a service to which item 49851 applies (H) (Anaes.) (Assist.)	342.90
48403	Osteotomy of phalanx or metatarsal, with internal fixation (H) (Anaes.) (Assist.)	538.80
48406	Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, without internal fixation (H) (Anaes.) (Assist.)	342.90
48409	Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, with internal fixation (H) (Anaes.) (Assist.)	538.80

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
48412	Osteotomy of humerus, without internal fixation (H) (Anaes.) (Assist.)	656.20
48415	Osteotomy of humerus, with internal fixation (H) (Anaes.) (Assist.)	832.65
48419	Osteotomy of distal tibia, for correction of deformity, without internal or external fixation, including any of the following (if performed): (a) excision of surrounding osteophytes; (b) release of joint; (c) removal of bone; (d) synovectomy; —one bone (H) (Anaes.) (Assist.)	656.20
48420	Osteotomy of distal tibia, for correction of deformity, with internal or external fixation by any method, including any of the following (if performed): (a) excision of surrounding osteophytes; (b) release of joint; (c) removal of bone; (d) synovectomy; —one bone (H) (Anaes.) (Assist.)	832.65
48421	Osteotomy of proximal tibia, to alter lower limb alignment or rotation (or both), with internal or external fixation (or both) (H) (Anaes.) (Assist.)	956.30
48422	Osteotomy of distal femur, to alter lower limb alignment or rotation (or both), with internal or external fixation (or both) (H) (Anaes.) (Assist.)	950.25
48423	Osteotomy of pelvis, in a patient aged 18 years or over, including any of the following (if performed): (a) associated intra-articular procedures; (b) bone grafting; (c) internal fixation (H) (Anaes.) (Assist.)	783.80
48424	Osteotomy of pelvis, in a patient aged less than 18 years, with application of hip spica, including internal fixation (if performed), other than a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	783.80
48426	Osteotomy of femur, in a patient aged 18 years or over, including either or both of the following (if performed): (a) bone grafting; (b) internal fixation (H) (Anaes.) (Assist.)	950.25
48427	Osteotomy of femur, in a patient aged less than 18 years, including internal fixation (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	950.25
48430	Excision of one or more osteophytes of the foot or ankle, or simple removal of bunion, including any of the following (if performed): (a) capsulotomy;	279.20

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(b) excision of surrounding osteophytes; (c) release of ligaments; (d) removal of one or more associated bursae or ganglia; (e) removal of bone; (f) synovectomy; —each incision (H) (Anaes.)(Assist.)	
48433	Treatment of non-union or malunion, with preservation of the joint, for ankle or hindfoot fracture, with internal or external fixation by any method, including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) excision of surrounding osteophytes; (d) osteotomy; (e) release of joint; (f) removal of bone; (g) removal of hardware; (h) synovectomy; —one bone (H) (Anaes.) (Assist.)	1,111.90
48435	Treatment of non-union or malunion, with preservation of the joint, for midfoot or forefoot fracture, with internal or external fixation by any method, including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) excision of surrounding osteophytes; (d) osteotomy; (e) release of joint; (f) removal of bone; (g) removal of hardware; (h) synovectomy; —one bone (H) (Anaes.) (Assist.)	587.75
48507	Epiphysiodesis of a long bone, in a patient less than 18 years of age (H) (Anaes.) (Assist.)	381.05
48509	Hemiepiphysiodesis, partial growth plate arrest using internal fixation, in a patient less than 18 years of age (H) (Anaes.) (Assist.)	342.90
48512	Epiphysiolysis, release of focal growth plate closure, in a patient less than 18 years of age (H) (Anaes.) (Assist.)	930.65
48900	Shoulder, excision of coraco-acromial ligament or removal of calcium deposit from cuff or both (Anaes.) (Assist.)	293.75
48903	Shoulder, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination (H) (Anaes.) (Assist.)	587.75
48906	Shoulder, repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff, or both—other than a	587.75

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	service associated with a service to which item 48900 applies (H) (Anaes.) (Assist.)	
48909	Shoulder, repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination, other than a service associated with a service to which item 48903 applies (H) (Anaes.) (Assist.)	783.80
48915	Shoulder, hemi-arthroplasty of (H) (Anaes.) (Assist.)	783.80
48918	Anatomic or reverse total shoulder replacement, including any of the following (if performed): (a) associated rotator cuff repair; (b) biceps tenodesis; (c) tuberosity osteotomy; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by open or arthroscopic means (H) (Anaes.) (Assist.)	1,567.50
48921	Shoulder, total replacement arthroplasty, revision of (H) (Anaes.) (Assist.)	1,616.30
48924	Revision of total shoulder replacement, including either or both of the following (if performed): (a) bone graft to humerus; (b) bone graft to scapula (H) (Anaes.) (Assist.)	1,861.30
48927	Shoulder prosthesis, removal of (H) (Anaes.) (Assist.)	381.90
48939	Shoulder, arthrodesis of, with synovectomy if performed (H) (Anaes.) (Assist.)	1,126.55
48942	Arthrodesis of shoulder, with bone grafting or internal fixation, including either or both of the following (if performed): (a) removal of prosthesis; (b) synovectomy; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	1,469.40
48945	Shoulder, diagnostic arthroscopy of (including biopsy)—other than a service associated with another arthroscopic procedure of the shoulder region (H) (Anaes.) (Assist.)	284.00
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.)	636.75
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.)	930.65
48954	Synovectomy of shoulder, performed as an independent procedure, including release of contracture (if performed), other than a service	979.60

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by arthroscopic means (H) (Anaes.) (Assist.)	
48958	Joint stabilisation procedure for multi-directional instability of shoulder, anterior or posterior repair, by open or arthroscopic means, including labral repair or attachment (if performed), excluding bone grafting and removal of hardware, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by arthroscopic means (H) (Anaes.) (Assist.)	1,126.55
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.)	979.60
48972	Tenodesis of biceps, by open or arthroscopic means, performed as an independent procedure (H) (Anaes.) (Assist.)	450.50
48980	Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the shoulder girdle (H) (Anaes.) (Assist.)	832.65
48983	Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the elbow (H) (Anaes.) (Assist.)	610.65
48986	Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the forearm (H) (Anaes.) (Assist.)	832.65
49100	Elbow, arthrotomy of, involving one or more of lavage, removal of loose body or division of contracture (H) (Anaes.) (Assist.)	342.90
49104	Repair of one or more ligaments of the elbow, for acute instability—within 6 weeks after the time of injury (H) (Anaes.) (Assist.)	551.00
49105	Stabilisation of one or more ligaments of the elbow, for chronic instability, including harvesting of tendon graft—6 weeks or more after the time of injury (H) (Anaes.) (Assist.)	808.15
49106	Elbow, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)	979.60
49109	Elbow, total synovectomy of (H) (Anaes.) (Assist.)	734.65
49112	Radial head replacement of elbow, other than a service associated with a service to which item 49115 applies (H) (Anaes.) (Assist.)	734.65
49115	Total or hemi humeral arthroplasty of elbow, excluding isolated radial head replacement and ligament stabilisation procedures, other than a service associated with a service to which item 49112 applies (H) (Anaes.) (Assist.)	1,175.40
49116	Elbow, total replacement arthroplasty of, revision procedure, including removal of prosthesis (H) (Anaes.) (Assist.)	1,551.55
49117	Revision of total replacement arthroplasty of elbow, including bone grafting and removal of prosthesis (H) (Anaes.) (Assist.)	1,861.85
49118	Elbow, diagnostic arthroscopy of, including biopsy and lavage, other than a service associated with another arthroscopic procedure of the elbow (H)	284.00

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(Anaes.) (Assist.)	
49121	Surgery of the elbow, by arthroscopic means, including any of the following (if performed): (a) chondroplasty; (b) drilling of defect; (c) osteoplasty; (d) removal of loose bodies; (e) release of contracture or adhesions; (f) treatment of epicondylitis; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of an arthroscopic procedure of the elbow (H) (Anaes.) (Assist.)	636.75
49124	Excision of olecranon bursa, including bony prominence, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of an arthroscopic procedure of the elbow (Anaes.) (Assist.)	386.55
49200	Wrist, arthrodesis of, with synovectomy if performed, with or without bone graft and internal fixation of the radiocarpal joint (H) (Anaes.) (Assist.)	852.15
49203	Limited fusion of wrist, with or without bone graft, including each of the following: (a) ligament or tendon transfers; (b) partial or total excision of one or more carpal bones; (c) rebalancing procedures; (d) synovectomy (H) (Anaes.) (Assist.)	807.20
49206	Proximal row carpectomy of wrist, including either or both of the following (if performed): (a) styloidectomy; (b) synovectomy (H) (Anaes.) (Assist.)	587.75
49209	Prosthetic replacement of wrist or distal radioulnar joint, including either or both of the following (if performed): (a) ligament realignment; (b) tendon realignment (H) (Anaes.) (Assist.)	783.80
49210	Revision of total replacement arthroplasty of wrist or distal radioulnar joint, including any of the following (if performed): (a) ligament rebalancing; (b) removal of prosthesis; (c) tendon rebalancing (H) (Anaes.) (Assist.)	1,034.60
49212	Arthrotomy of wrist or distal radioulnar joint, for infection, including any	245.05

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	of the following (if performed): (a) joint debridement; (b) removal of loose bodies; (c) synovectomy (H) (Anaes.) (Assist.)	
49213	Sauve-Kapandji procedure of distal radioulnar joint, including any of the following (if performed): (a) radioulnar fusion; (b) osteotomy; (c) soft tissue reconstruction (Anaes.) (Assist.)	876.65
49215	Reconstruction of single or multiple ligaments or capsules of wrist, by open procedure, including any of the following (if performed): (a) arthrotomy; (b) ligament harvesting and grafting; (c) synovectomy; (d) tendon harvesting and grafting; (e) insertion of synthetic ligament substitute (H) (Anaes.) (Assist.)	676.05
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.)	284.00
49219	Diagnosis of carpometacarpal of thumb or joint of digit, by arthroscopic means, including biopsy (if performed) (H) (Anaes.)(Assist.)	284.00
49220	Treatment of carpometacarpal of thumb or joint of digit, by arthroscopic means—one joint (H) (Anaes.) (Assist.)	636.75
49221	Treatment of wrist, by arthroscopic means, including any of the following (if performed): (a) drilling of defect; (b) removal of loose bodies; (c) release of adhesions; (d) synovectomy; (e) debridement; (f) resection of dorsal or volar ganglia; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint (H) (Anaes.) (Assist.)	636.75
49224	Osteoplasty of wrist, by arthroscopic means, including either or both of the following (if performed): (a) excision of the distal ulna; (b) total synovectomy; other than a service associated with a service to which another item in this	734.65

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	Schedule applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint—2 or more distinct areas (H) (Anaes.) (Assist.)	
49227	Treatment of wrist by one of the following: (a) pinning of osteochondral fragment, by arthroscopic means; (b) stabilisation procedure for ligamentous disruption; (c) partial wrist fusion or carpectomy, by arthroscopic means; (d) fracture management; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint (H) (Anaes.) (Assist.)	734.65
49230	Total, hemi or interpositional prosthetic replacement of carpal bone of wrist, for trauma or emergency, including all of the following: (a) ligament and tendon rebalancing procedures; (b) limited wrist fusions; (c) limited bone grafting (H) (Anaes.) (Assist.)	958.55
49233	Excisional arthroplasty of single (or part of) carpal bone of wrist, when transfers of ligaments or tendons, or rebalancing procedures, are not required, including all of the following: (a) radial styloidectomy; (b) ulnar styloidectomy; (c) proximal hamate; (d) partial scaphoid; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a distal radial ulnar joint reconstruction, a proximal row carpectomy or another wrist procedure—applicable once for a single operation (H) (Anaes.) (Assist.)	403.60
49236	Stabilisation of soft tissue of distal radioulnar joint, by open procedure, with or without ligament or tendon grafting, including either or both of the following (if performed): (a) graft harvest; (b) triangular fibrocartilage complex repair or reconstruction (H) (Anaes.)(Assist.)	608.45
49239	Excision of pisiform or hook of hamate, including release of ulnar nerve (if performed) (H) (Anaes.)(Assist.)	302.70
49300	Sacro-iliac joint—arthrodesis of (H) (Anaes.) (Assist.)	542.40
49303	Arthrotomy of hip, by open procedure, including any of the following (if performed): (a) lavage; (b) drainage;	568.10

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(c) biopsy (H) (Anaes.) (Assist.)	
49306	Hip-arthrodesis of, with synovectomy if performed (H) (Anaes.) (Assist.)	1,126.55
49309	Arthrectomy or excision arthroplasty (Girdlestone) of hip, other than a service performed: (a) for the purpose of implant removal; or (b) as stage 1 of a 2-stage procedure (H) (Anaes.) (Assist.)	783.80
49315	Hip, arthroplasty of, unipolar or bipolar (H) (Anaes.) (Assist.)	881.65
49318	Total arthroplasty of hip, including minor bone grafting (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	1,371.25
49319	Bilateral total arthroplasty of hip, including minor bone grafting (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	2,409.15
49321	Total arthroplasty of hip, with internal fixation, including either or both of the following (if performed): (a) structural bone graft; (b) insertion of synthetic substitutes or metal augments; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	1,665.50
49360	Diagnostic arthroscopy of hip, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure of the hip joint by arthroscopic means (H) (Anaes.) (Assist.)	357.90
49363	Treatment of hip, by arthroscopic means, with synovial biopsy, including any procedures to treat bone or soft tissue in the same area (if performed), other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing: (a) a procedure of the hip joint by arthroscopic means; or (b) surgery for femoroacetabular impingement (H) (Anaes.) (Assist.)	431.00
49366	Treatment of hip, by arthroscopic means, including any procedures to treat bone or soft tissue in the same area (if performed), other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing: (a) a procedure of the hip joint by arthroscopic means; or (b) surgery for femoroacetabular impingement (H) (Anaes.) (Assist.)	636.75
49372	Revision arthroplasty of hip, with exchange of head or liner (or both) (H) (Anaes.) (Assist.)	959.80
49374	Revision arthroplasty of hip, with exchange of head and acetabular shell or cup, including minor bone grafting (if performed) (H) (Anaes.) (Assist.)	1,782.55

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
49376	Revision arthroplasty of hip, with exchange of head and acetabular shell or cup, including major bone grafting (if performed) (H) (Anaes.) (Assist.)	2,193.95
49378	Revision arthroplasty of hip, with revision of femoral component (if there is no requirement for femoral osteotomy), including minor bone grafting (if performed) (H) (Anaes.) (Assist.)	1,919.60
49380	Revision arthroplasty of hip, with revision of femoral and acetabular components (if femoral osteotomy is not required), including minor bone grafting (if performed) (H) (Anaes.) (Assist.)	2,331.05
49382	Revision arthroplasty of hip, with revision of femoral and acetabular components (if femoral osteotomy is not required), including major bone grafting (H) (Anaes.) (Assist.)	3,016.65
49384	Revision arthroplasty of hip, for pelvic discontinuity, with revision of acetabular component (H) (Anaes.) (Assist.)	3,565.10
49386	Revision arthroplasty of hip, with revision of femoral component with femoral osteotomy, including minor bone grafting (if performed) (H) (Anaes.) (Assist.)	2,468.15
49388	Revision arthroplasty of hip, including: (a) revision of both of the following: (i) femoral component with femoral osteotomy; (ii) acetabular component; and (b) minor bone grafting (if performed) (H) (Anaes.) (Assist.)	2,879.60
49390	Revision arthroplasty of hip, including: (a) revision of both of the following: (i) femoral component with femoral osteotomy; (ii) acetabular component; and (b) major bone grafting (H) (Anaes.) (Assist.)	3,428.00
49392	Revision arthroplasty of hip, including: (a) either: (i) revision of femoral component with femoral osteotomy; or (ii) proximal femoral replacement; and (b) revision of acetabular component for pelvic discontinuity (H) (Anaes.) (Assist.)	4,799.20
49394	Revision arthroplasty of hip, including: (a) replacement of proximal femur; and (b) revision of the acetabular component; and (c) bone grafting (if performed) (H) (Anaes.) (Assist.)	4,113.60
49396	Revision arthroplasty of hip, including: (a) removal of prosthesis as stage 1 of a 2-stage revision arthroplasty or as a definitive stage procedure; and (b) insertion of temporary prosthesis (if performed)	2,742.35

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(H) (Anaes.) (Assist.)	
49398	Revision arthroplasty of hip, including: (a) revision of femoral component for periprosthetic fracture; and (b) internal fixation; and (c) bone grafting (if performed) (H) (Anaes.) (Assist.)	2,056.85
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.)	391.80
49503	Arthrotomy of knee, including one of the following: (a) meniscal surgery; (b) repair of collateral or cruciate ligament; (c) patellectomy; (d) single transfer of ligament or tendon; (e) repair or replacement of chondral or osteochondral surface (excluding prosthetic replacement); other than a service associated with a service to which another item in this group applies (H) (Anaes.) (Assist.)	509.40
49506	Arthrotomy of knee, including 2 or more of the following: (a) meniscal surgery; (b) repair of collateral or cruciate ligament; (c) patellectomy; (d) single transfer of ligament or tendon; (e) repair or replacement of chondral or osteochondral surface (excluding prosthetic replacement); other than a service associated with a service to which another item in this Group applies (H) (Anaes.) (Assist.)	764.15
49509	Total synovectomy of knee, by open procedure, other than a service performed in association with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing an arthroplasty (H) (Anaes.) (Assist.)	783.80
49512	Primary or revision arthrodesis of knee, including arthrodesis (H) (Anaes.) (Assist.)	1,371.25
49515	Removal of cemented or uncemented knee prosthesis, performed as the first stage of a 2-stage procedure; including: (a) removal of associated cement; and (b) insertion of spacer (if required) (H) (Anaes.) (Assist.)	881.65
49516	Bilateral unicompartmental arthroplasty of femur and proximal tibia of knee (H) (Anaes.) (Assist.)	2,196.65
49517	Unicompartmental arthroplasty of femur and proximal tibia of knee (H) (Anaes.) (Assist.)	1,255.25
49518	Total replacement arthroplasty of knee, including either or both of the following (if performed):	1,371.25

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(a) revision of patello-femoral joint replacement to total knee replacement; (b) patellar resurfacing; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	
49519	Bilateral total replacement arthroplasty of knee, including patellar resurfacing, other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	2,409.15
49521	Complex primary arthroplasty of knee, with revision of components to femur or tibia, including either or both of the following (if performed): (a) ligament reconstruction; (b) patellar resurfacing; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	1,665.50
49524	Complex primary arthroplasty of knee, with revision of components to femur and tibia, including either or both of the following (if performed): (a) ligament reconstruction; (b) patellar resurfacing; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	1,959.30
49525	Revision of uni-compartmental arthroplasty of the knee, with femoral or tibial components (or both) with uni-compartmental implants, other than a service associated with a service to which: (a) item 48245, 48248, 48251, 48254 or 48257 applies; or (b) another item in this Group applies if the service described in the other item is for the purpose of performing surgery on a knee (H) (Anaes.) (Assist.)	1,665.50
49527	Minor revision of total or partial replacement of knee, including either or both of the following: (a) exchange of polyethylene component (including uni); (b) insertion of patellar component; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	1,371.25
49530	Revision of total or partial replacement of knee, with exchange of femoral or tibial component: (a) excluding revision of unicompartmental with unicompartmental implants; and (b) including patellar resurfacing (if performed); other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	2,057.35
49533	Revision of total or partial replacement of knee, with exchange of femoral and tibial components, excluding revision of unicompartmental with unicompartmental implants, including patellar resurfacing (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	2,645.55

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
49534	Replacement of patella and trochlea of patello-femoral joint of knee, performed as a primary procedure (H) (Anaes.) (Assist.)	756.75
49536	Either: (a) repair of cruciate ligaments of knee; or (b) repair or reconstruction of collateral ligaments of knee; by open or arthroscopic means, including either or both of the following (if performed): (c) graft harvest; (d) intraarticular knee surgery; other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.)	979.60
49542	Reconstruction of anterior or posterior cruciate ligament of knee, by open or arthroscopic means, including any of the following (if performed): (a) graft harvest; (b) donor site repair; (c) meniscal repair; (d) collateral ligament repair; (e) extra-articular tenodesis; (f) any other associated intra-articular surgery; other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.)	1,371.25
49544	Reconstruction of 2 or more cruciate or collateral ligaments of knee, by open or arthroscopic means, including any of the following (if performed): (a) ligament repair; (b) graft harvest donor site repair; (c) meniscal repair; (d) any other associated intra-articular surgery; other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.)	1,596.45
49548	Knee, revision of patello-femoral stabilisation (H) (Anaes.) (Assist.)	979.60
49551	Knee, revision of procedures to which item 49536 or 49542 applies (H) (Anaes.) (Assist.)	1,371.25
49554	Revision of total replacement of knee, by anatomic specific allograft of tibia or femur, other than a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	1,959.30
49564	Stabilisation of patellofemoral joint of knee, by combined open and arthroscopic means, including either or both of the following (if performed):	956.30

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) medial soft tissue reconstruction and tendon transfer; (b) tibial tuberosity transfer with bone graft and internal fixation; other than a service associated a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.) (Assist.)	
49565	Reconstruction of patellofemoral joint of knee, by combined open and arthroscopic means, including: (a) both of the following: (i) medial soft tissue reconstruction; (ii) tibial tuberosity transfer; and (b) any of the following (if performed): (i) bone graft; (ii) internal fixation; (iii) trochleoplasty; other than a service associated a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the knee by arthroscopic means (H) (Anaes.)(Assist.)	1,372.60
49569	Knee, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (H) (Anaes.) (Assist.)	783.80
49570	Diagnosis of knee, by arthroscopic means, if the pre-procedure diagnosis is undetermined, including either or both of the following (if performed): (a) biopsy; (b) lavage (H) (Anaes.) (Assist.)	284.00
49572	Partial meniscectomy of knee, by arthroscopic means, for atraumatic meniscus tear, other than a service to which another item of this Schedule applies if the service described in the other item is for the purpose of treating osteoarthritis (H) (Anaes.) (Assist.)	691.15
49574	Removal of loose bodies of knee, by arthroscopic means—one or more bodies (H) (Anaes.) (Assist.)	691.15
49576	Repair of chondral lesion of knee, by arthroscopic means, including either or both of the following (if performed): (a) microfracture; (b) microdrilling; other than a service performed in combination with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing chondral or osteochondral grafts (H) (Anaes.) (Assist.)	691.15
49578	Release of soft tissue, lateral release or osteoplasty of knee, by arthroscopic means, other than a service performed in combination with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of stabilising the patellofemoral joint of the knee (H) (Anaes.) (Assist.)	691.15

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
49580	Partial meniscectomy of knee, by arthroscopic means, for traumatic meniscus tear (H) (Anaes.) (Assist.)	691.15
49582	Meniscal repair of knee, by arthroscopic means (H) (Anaes.) (Assist.)	807.05
49584	Chondral, osteochondral or meniscal graft of knee, by arthroscopic means (H) (Anaes.) (Assist.)	807.05
49586	Synovectomy of knee, by arthroscopic means, for neoplasia or inflammatory arthropathy, other than a service to which another item of this Schedule applies if the service described in the other item is for the purpose of treating uncomplicated osteoarthritis (Anaes.) (Assist.)	807.05
49590	Excision of ganglion, cyst or bursa of knee, by open or arthroscopic means, performed as an independent procedure, other than a service associated with a service to which another item in this Group applies (Anaes.) (Assist.)	386.55
49703	Surgery of ankle joint, by arthroscopic means, including any of the following (if performed): (a) cartilage treatment; (b) removal of loose bodies; (c) synovectomy; (d) excision of joint osteophytes; other than a service associated with a service to which another item in this Group applies if the service described in the other item is for the purpose of performing a procedure on the ankle by arthroscopic means (H) (Anaes.) (Assist.)	636.75
49706	Arthrotomy of joint of ankle, for infection, including removal of loose bodies and joint debridement, including release of joint contracture (if performed) (H) (Anaes.) (Assist.)	342.90
49709	Stabilisation of ligament of ankle or subtalar joint (or both), including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) joint debridement; —one ligament complex, each incision (H) (Anaes.) (Assist.)	734.65
49712	Arthrodesis of ankle, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.)	979.60
49715	Total replacement of ankle, with prosthetic replacement of ankle joint, including any of the following (if performed): (a) capsulotomy;	1,175.40

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.)	
49716	Revision of total ankle replacement: (a) including either: (i) exchange of tibial or talar components (or both) and plastic inserts; or (ii) removal of tibial or talar components (or both) and plastic inserts; and (b) including any of the following (if performed): (i) insertion of cement spacer for infection; (ii) capsulotomy; (iii) joint release; (iv) neurolysis; (v) debridement of cysts; (vi) synovectomy; (vii) joint debridement; other than a service associated with a service to which item 30023 applies (H) (Anaes.) (Assist.)	1,551.55
49717	Revision of total ankle replacement: (a) including either: (i) exchange of tibial and talar components; or (ii) removal of tibial and talar components and conversion to ankle arthrodesis; and (b) including both of the following: (iii) internal or external fixation, by any means; (iv) major bone grafting; and (c) including any of the following (if performed): (i) capsulotomy; (ii) joint release; (iii) neurolysis; (iv) debridement and extensive grafting of cysts; (v) synovectomy; (vi) joint debridement; other than a service associated with a service to which item 30023, 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	1,861.85
49718	Primary repair of major tendon of ankle, by any method, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy; —one tendon (H) (Anaes.) (Assist.)	391.80
49724	Reconstruction of major tendon of ankle, by any method, including any of the following (if performed): (a) synovial biopsy;	685.85

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(b) synovectomy; (c) adjacent tendon transfer; (d) turn down flaps; other than a service associated with a service to which item 49718 applies (H) (Anaes.) (Assist.)	
49727	Lengthening of major tendon of ankle, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy (H) (Anaes.) (Assist.)	293.75
49728	Lengthening of Achilles' tendon, by any method, with gastro-soleus lengthening for the correction of equinous deformity, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy; other than a service associated with a service to which item 49727 applies (H) (Anaes.) (Assist.)	587.60
49730	Surgery of joint of hindfoot (other than ankle or first metatarsophalangeal joint), by arthroscopic means, including any of the following (if performed): (a) cartilage treatment; (b) removal of loose bodies; (c) synovectomy; (d) excision of joint osteophytes; other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the ankle by arthroscopic means— one joint (H) (Anaes.) (Assist.)	636.75
49732	Endoscopy of large tendons of foot, including any of the following (if performed): (a) debridement of tendon and sheath; (b) removal of loose bodies; (c) synovectomy; (d) excision of tendon impingement; other than a service associated with a service to which item 49718 or 49724 applies (H) (Anaes.) (Assist.)	636.75
49734	Arthrotomy of hindfoot, midfoot or metatarsophalangeal joint, for infection, including: (a) removal of loose bodies; and (b) either or both of the following: (i) joint debridement; (ii) release of joint contracture —each incision (H) (Anaes.) (Assist.)	342.90

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
49736	Transfer of major tendon of foot and ankle, including: (a) split or whole transfer to contralateral side of foot; and (b) passage of posterior or anterior tendon to, or through, interosseous membrane; and (c) any of the following (if performed): (i) synovial biopsy; (ii) synovectomy; (iii) tendon lengthening; (iv) insetting of tendon (H) (Anaes.) (Assist.)	685.85
49738	Stabilisation of ligament of talonavicular or metatarsophalangeal joint, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement (H) (Anaes.) (Assist.)	489.75
49740	Revision of arthrodesis of ankle, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint; (e) removal of hardware; (f) neurolysis; (g) osteotomy of non-union or malunion; other than a service associated with a service to which item 30023 applies (H) (Anaes.) (Assist.)	1,469.50
49742	Arthrodesis of extended ankle and hindfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.)	1,387.20
49744	Revision of arthrodesis of extended ankle and hindfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release;	2,080.85

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(c) synovectomy; (d) removal of osteophytes at joint; (e) removal of hardware; (f) neurolysis; (g) osteotomy of non-union or malunion; other than a service associated with a service to which item 30023 applies (H) (Anaes.)(Assist.)	
49760	Arthroereisis of subtalar joint, including any of the following (if performed): (a) capsulotomy; (b) synovectomy; (c) joint debridement (H) (Anaes.) (Assist.)	367.35
49761	Stabilisation of metatarsophalangeal joint at metatarsal, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; —one metatarsal (H) (Anaes.) (Assist.)	538.80
49762	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; —2 metatarsals (H) (Anaes.) (Assist.)	597.90
49763	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer;	657.00

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; —3 metatarsals (H) (Anaes.) (Assist.)	
49764	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; —4 metatarsals (H) (Anaes.) (Assist.)	716.15
49765	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; —5 metatarsals (H) (Anaes.) (Assist.)	775.20
49766	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; —6 metatarsals (H) (Anaes.) (Assist.)	834.40
49767	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy;	893.50

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; —7 metatarsals (H) (Anaes.) (Assist.)	
49768	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; —8 metatarsals (H) (Anaes.) (Assist.)	952.60
49769	Unilateral correction of hallux valgus or varus deformity, by osteotomy of first metatarsal and proximal phalanx of first toe, with internal fixation of both bones, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.)(Assist.)	942.85
49770	Bilateral correction of hallux valgus or varus deformity, by osteotomy of first metatarsal and proximal phalanx of first toe, with internal fixation of both bones, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.)(Assist.)	1,567.20
49771	Synovectomy of major tendon of ankle, for extensive synovitis by any method, including any of the following (if performed): (a) tenolysis; (b) debridement of ligament or tendon (or both); (c) release of ligament or tendon (or both); (d) excision of tubercule or osteophyte; (e) reconstruction of tendon retinaculum;	386.55

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(f) neurolysis; other than a service associated with a service to which item 30023 applies—each incision (H) (Anaes.) (Assist.)	
49772	Excision of rheumatoid nodules or gouty tophi, excluding aftercare, including any of the following (if performed): (a) capsulotomy; (b) debridement of ligament or tendon (or both); (c) release of ligament or tendon (or both); (d) excision of tubercle or osteophyte; —each incision (H) (Anaes.) (Assist.)	341.15
49773	Revision of excision of intermetatarsal or digital neuroma, including any of the following (if performed): (a) release of tissues; (b) excision of bursae; (c) neurolysis; other than a service associated with a service to which item 30023 applies—one web space (H) (Anaes.) (Assist.)	422.85
49774	Release of tarsal tunnel, including any of the following (if performed): (a) release of ligaments; (b) synovectomy; (c) neurolysis; other than a service associated with a service to which item 30023 applies—one foot (H) (Anaes.) (Assist.)	288.00
49775	Revision of release of tarsal tunnel, including any of the following (if performed): (a) release of ligaments; (b) synovectomy; (c) neurolysis; other than a service associated with a service to which item 30023 applies—one foot (H) (Anaes.) (Assist.)	388.85
49776	Revision of arthrodesis of joint of hindfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint; (e) removal of hardware; (f) neurolysis; (g) osteotomy of non-union or malunion; other than a service associated with a service to which item 30023 applies (H) (Anaes.) (Assist.)	1,223.00

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
49777	Arthrodesis of joint of midfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint; —one joint (H) (Anaes.) (Assist.)	724.15
49778	Arthrodesis of joints of midfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints; —2 joints (H) (Anaes.) (Assist.)	1,086.25
49779	Arthrodesis of joints of midfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints; —3 joints (H) (Anaes.) (Assist.)	1,267.25
49780	Arthrodesis of joints of midfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints; —4 joints (H) (Anaes.) (Assist.)	1,448.30
49781	Revision of arthrodesis of joint of midfoot, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of ostephytes at joint; (e) removal of hardware; (f) osteotomy of non-union or malunion; —one joint (H) (Anaes.) (Assist.)	1,086.25
49782	Revision of total ankle replacement, including:	588.35

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) bone grafting of perioperative cysts to the tibia or talus (or both); and (b) retention of implants; and (c) any of the following (if performed): (i) capsulotomy; (ii) joint release; (iii) neurolysis; (iv) debridement and grafting of cysts; (v) synovectomy; (vi) joint debridement; other than a service associated with a service to which item 30023 applies (H) (Anaes.) (Assist.)	
49783	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; —3 joints (H) (Anaes) (Assist.)	789.00
49784	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; —4 joints (H) (Anaes) (Assist.)	901.60
49785	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; —5 joints (H) (Anaes) (Assist.)	1,014.25
49786	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; —6 joints (H) (Anaes) (Assist.)	1,126.90

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
49787	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; —7 joints (H) (Anaes) (Assist.)	1,239.50
49788	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joints, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; —8 joints (H) (Anaes) (Assist.)	1,352.15
49789	Bilateral arthrodesis of first metatarsophalangeal joint, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.)	1,163.05
49790	Revision of arthrodesis of first metatarsophalangeal joint, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of exostosis at joint; (e) removal of hardware; (f) osteotomy of non-union or malunion (H) (Anaes.) (Assist.)	1,010.20
49791	Arthrodesis of hallux interphalangeal or lesser metatarsophalangeal joint, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.)	458.00
49792	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal	514.45

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; —one or 2 toes (H) (Anaes.) (Assist.)	
49793	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; —3 toes (H) (Anaes.) (Assist.)	600.20
49794	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; —4 toes (H) (Anaes.) (Assist.)	685.90
49795	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; —5 toes (H) (Anaes.) (Assist.)	771.65
49796	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; —6 toes (H) (Anaes.) (Assist.)	857.40
49797	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method;	943.10

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; —7 toes (H) (Anaes.) (Assist.)	
49798	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; —8 toes (H) (Anaes.) (Assist.)	1,028.85
49800	Primary repair of flexor or extensor tendon of foot, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy; —one toe (Anaes.) (Assist)	137.15
49803	Secondary repair of flexor or extensor tendon of foot, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy; —one toe (Anaes.) (Assist)	176.35
49806	Subcutaneous tenotomy of foot, by small percutaneous incisions—one or more tendons (Anaes.)	137.15
49809	Open tenotomy or lengthening of foot, by open incision, with or without tenoplasty, including either or both of the following (if performed): (a) synovial biopsy; (b) synovectomy; —one toe (Anaes.) (Assist)	225.25
49812	Advancement of tendon or ligament transfer of foot, including: (a) side to side transfer, harvesting and transfer for ligament or minor foot tendon reconstruction; and (b) either or both of the following (if performed): (i) synovial biopsy; (ii) synovectomy; —one major tendon or toe (H) (Anaes.) (Assist.)	450.50
49814	Reconstruction of major tendon of ankle, by any method, including: (a) osteotomy of hindfoot, with internal fixation; and (b) lengthening of major tendon of ankle; and (c) any of the following (if performed): (i) synovial biopsy;	1,028.70

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(ii) synovectomy; (iii) adjacent tendon transfer; (iv) turn down flaps; other than a service associated with a service to which item 49718 applies (H) (Anaes.) (Assist.)	
49815	Triple arthrodesis of hindfoot joints, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints (H) (Anaes.) (Assist.)	1,426.85
49818	Release of plantar fascia, including excision of calcaneal spur (if performed) (H) (Anaes.) (Assist.)	284.00
49821	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joint, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; —one joint (Anaes.) (Assist.) (H)	450.50
49824	Excisional or interpositional arthroplasty of metatarsophalangeal or tarsometatarsal joint, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; —2 joints (Anaes.) (Assist.) (H)	788.70
49827	Unilateral correction of hallux valgus or varus deformity of the foot, by local tendon transfer, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)	489.75
49830	Bilateral correction of hallux valgus or varus deformity of the foot, by local tendon transfer, including any of the following (if performed): (a) exostectomy; (b) removal of bursae;	857.15

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)	
49833	Unilateral correction of hallus valgus or varus deformity of the foot, by osteotomy of first metatarsal, without internal fixation, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)	538.80
49836	Bilateral correction of hallus valgus or varus deformity of the foot by osteotomy of first metatarsal, without internal fixation, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)	930.65
49837	Unilateral correction of hallus valgus or varus deformity of the foot, by osteotomy of first metatarsal, with internal fixation, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)	673.45
49838	Bilateral correction of hallus valgus or varus deformity of the foot by osteotomy of first metatarsal, with internal fixation or arthrodesis of first metatarsophalangeal joint, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)	1,163.05
49839	Total replacement of first metatarsophalangeal joint, with replacement of both joint surfaces, including any of the following (if performed):	538.80

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(a) capsulotomy; (b) synovectomy; (c) joint debridement (H) (Anaes.) (Assist.)	
49845	Unilateral arthrodesis of first metatarsophalangeal joint, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints (H) (Anaes.) (Assist.)	673.45
49851	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal (or both) joints of lesser toe, including any of the following (if performed): (a) internal fixation, by any method; (b) capsulotomy; (c) tendon lengthening; (d) joint release; (e) synovectomy; (f) removal of osteophytes at joints; —one toe (H) (Anaes.)	450.50
49854	Radical plantar fasciotomy or fasciectomy, with extensive incision into foot and excision of fascia, including excision of calcaneal spur (if performed), other than a service associated with a service to which 49818 applies (H) (Anaes.) (Assist.)	391.80
49857	Hemi joint replacement of first or lesser metatarsophalangeal joint, including any of the following (if performed): (a) capsulotomy; (b) synovectomy; (c) joint debridement (H) (Anaes.) (Assist.)	362.45
49860	Synovectomy of metatarsophalangeal joints, including any of the following (if performed): (a) capsulotomy; (b) debridement; (c) release of ligament or tendon (or both); —one or more joints on one foot (H) (Anaes.) (Assist.)	338.45
49866	Excision of intermetatarsal or digital neuroma, including any of the following (if performed): (a) release of metatarsal or digital ligament; (b) excision of bursae; (c) neurolysis;	313.25

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	other than a service associated with a service to which item 30023 applies—one web space (H) (Anaes.) (Assist.)	
49878	Talipes equinovarus, calcaneo valgus or metatarsus varus, treatment by cast, splint or manipulation—each attendance (Anaes.)	58.75
49881	Complete excision of one or more ganglia or bursae: (a) including excision of bony prominence or mucinous cyst of interphalangeal or metatarsophalangeal joint and surrounding tissues; and (b) including any of the following (if performed): (i) arthrotomy; (ii) synovectomy; (iii) osteophyte resections; (iv) neurolysis; (v) skin closure, by any local method; other than a service associated with a service to which item 30023 applies—each incision (H) (Anaes.) (Assist.)	228.85
49884	Complete excision of one or more ganglia or bursae: (a) including excision of bony prominence or mucinous cyst of ankle, hindoot or midfoot joint and surrounding tissues; and (b) including any of the following (if performed): (i) arthrotomy; (ii) synovectomy; (iii) osteophyte resections; (iv) neurolysis; (v) capsular or ligament repair; (vi) skin closure, by any method; other than a service associated with a service to which item 30023 applies—each incision. (H) (Anaes.) (Assist.)	386.55
49887	Revision of complete excision of one or more ganglia or bursae: (a) including excision of bony prominence or mucinous cyst of interphalangeal or metatarsophalangeal joint and surrounding tissues; and (b) including any of the following (if performed): (i) arthrotomy; (ii) synovectomy; (iii) osteophyte resections; (iv) neurolysis; (v) skin closure, by any method; other than a service associated with a service to which item 30023 or 49881 applies—each incision (H) (Anaes.) (Assist.)	309.00
49890	Revision of complete excision of one or more ganglia or bursae: (a) including excision of bony prominence or mucinous cyst of ankle, hindoot or midfoot joint and surrounding tissues; and (b) including any of the following (if performed): (i) arthrotomy; (ii) synovectomy;	521.80

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(iii) osteophyte resections; (iv) neurolysis; (v) capsular or ligament repair; (vi) skin closure, by any method; other than a service associated with a service to which item 30023 or 49884 applies—each incision (H) (Anaes.) (Assist.)	
50107	Stabilisation of joint of hip, by open means, including any of the following (if performed): (a) repair of capsule; (b) labrum; (c) capsulorraphy; (d) repair of ligament; (e) internal fixation; other than a service associated with a service to which another item in this Group applies (H) (Anaes.) (Assist.)	489.75
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.)	375.70
50115	Manipulation of one or more joints, excluding spine, other than a service associated with a service to which another item in this Group applies (H) (Anaes.)	148.80
50118	Arthrodesis of joint of hindfoot, by any method, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joints; —one joint (H) (Anaes.) (Assist.)	815.30
50130	Joint or joints, application of external fixator to, other than for treatment of fractures (H) (Anaes.) (Assist.)	324.95
50200	Core needle biopsy of aggressive or potentially malignant bone or soft tissue tumour, excluding aftercare (Anaes.)	195.80
50201	Incisional biopsy of aggressive or potentially malignant bone or soft tissue tumour, excluding aftercare (Anaes.) (Assist.)	342.80
50203	Intralesional or marginal excision of bone or soft tissue tumour (Anaes.) (Assist.)	431.05
50206	Intralesional or marginal excision of bone tumour, with at least one of the following: (a) autograft; (b) allograft; (c) cementation (H) (Anaes.) (Assist.)	636.75
50209	Intralesional or marginal excision of bone tumour, with at least 2 of the following:	783.80

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) autograft; (b) allograft; (c) cementation (H) (Anaes.) (Assist.)	
50212	Wide excision of malignant or aggressive bone or soft tissue tumour (or both), affecting a limb, trunk or scapula (H) (Anaes.) (Assist.)	1,714.30
50215	Wide excision of malignant or aggressive bone or soft tissue tumour (or both), with intercalary reconstruction of bone by prosthesis, allograft or autograft (H) (Anaes.) (Assist.)	2,155.10
50218	Wide excision of malignant or aggressive bone or soft tissue tumour (or both), with reconstruction, replacement or arthrodesis of adjacent joint, by prosthesis, allograft or autograft (H) (Anaes.) (Assist.)	2,840.95
50221	Wide excision of malignant or aggressive bone or soft tissue tumour (or both) of pelvis, sacrum or spine, without reconstruction (H) (Anaes.) (Assist.)	2,644.85
50224	Wide excision of malignant or bone or soft tissue tumour (or both) of pelvis, sacrum or spine, with reconstruction of bone defect, or one or more joints, by any technique (Anaes.) (Assist.)	2,938.80
50233	Treatment of malignant aggressive bone or soft tissue tumour (or both) by hindquarter or forequarter amputation (H) (Anaes.) (Assist.)	2,253.10
50236	Treatment of malignant or aggressive bone or soft tissue tumour (or both), by hip disarticulation, shoulder disarticulation or amputation through the proximal one third of the femur (H) (Anaes.) (Assist.)	1,763.30
50239	Treatment of malignant or aggressive bone or soft tissue tumour (or both), by amputation, other than a service associated with a service to which item 50233 or 50236 applies (H) (Anaes.) (Assist.)	1,175.40
50242	Revision of endoprosthetic replacement, if item 50218 or 50224, or an item that describes a service substantially similar to either of those items, applied to the initial procedure: (a) including any of the following: (i) rebushing; (ii) patella resurfacing; (iii) polyethylene exchange or similar; and (b) excluding removal of prosthetic from bone (H) (Anaes.) (Assist.)	881.65
50245	Revision of reconstructive procedure, if item 50215, 50218 or 50224, or an item that describes a service substantially similar to any of those items, applied to the initial procedure, by any technique or combination of techniques (H) (Anaes.) (Assist.)	2,645.05
50300	Gradual correction of joint deformity, with application of external fixator (H) (Anaes.) (Assist.)	1,204.60
50303	Limb lengthening, by gradual distraction, with application of external fixator or intra-medullary device (H) (Anaes.) (Assist.)	1,644.65
50306	Bipolar limb lengthening: (a) with application of external fixator or intra-medullary device; and	2,567.90

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(b) by any of the following: (i) gradual distraction; (ii) bone transport; (iii) fixator extension, to correct for an adjacent joint deformity (H) (Anaes.) (Assist.)	
50309	Ring fixator or similar device, adjustment of, with or without insertion or removal of fixation pins, performed under general anaesthesia, other than a service to which item 50303 or 50306 applies (H) (Anaes.) (Assist.)	317.45
50310	Major adjustment of ring fixator or similar device, other than a service associated with a service to which item 50303, 50306, or 50309 applies	45.40
50312	Ankle, synovectomy of, by arthroscopic or other means—not associated with another arthroscopic procedure of the ankle (H) (Anaes.) (Assist.)	782.70
50321	Release of soft tissue of talipes equinovarus, by open means (H) (Anaes.) (Assist.)	966.45
50324	Revision of release of soft tissue of talipes equinovarus, by open means (H) (Anaes.) (Assist.)	1,377.85
50330	Post-operative manipulation, and change of plaster, of vertical, congenital talipes equinovarus or talus, other than a service to which item 50321 or 50324 applies (H) (Anaes.)	237.95
50333	Excision of tarsal coalition, with interposition of muscle, fat graft or similar graft, including any of the following (if performed): (a) capsulotomy; (b) synovectomy; (c) excision of osteophytes; —one coalition (H) (Anaes.) (Assist.)	641.80
50335	Treatment of vertical, congenital talus, by percutaneous or open stabilisation of talonavicular joint and Achilles' tenotomy (H) (Anaes.) (Assist.)	641.80
50336	Talus, vertical, congenital, combined anterior and posterior reconstruction (H) (Anaes.) (Assist.)	959.40
50339	Tibialis anterior or tibialis posterior tendon transfer (split or whole) (H) (Anaes.) (Assist.)	614.40
50345	Hyperextension deformity of toe, release incorporating V-Y plasty of skin, lengthening of extensor tendons and release of capsule contracture (H) (Anaes.) (Assist.)	360.70
50348	Knee, deformity of, post-operative manipulation and change of plaster, performed under general anaesthesia (H) (Anaes.)	237.95
50351	Treatment of developmental dislocation of hip, by open reduction, including application of hip spica (H) (Anaes.) (Assist.)	1,661.95
50352	Treatment of developmental dysplasia of hip, including supervision of initial application of splint, harness or cast, other than a service to which another item in this Group applies (Anaes.)	58.75
50354	Resection and fixation of congenital pseudarthrosis of tibia (Anaes.) (Assist.)	1,363.20

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
50357	Transfer of tendon of rectus femoris or medial or lateral hamstring (H) (Anaes.) (Assist.)	584.30
50360	Combined medial and lateral hamstring tendon transfer (H) (Anaes.) (Assist.)	678.05
50369	Unilateral posterior release of knee contracture, with multiple tendon lengthening or tenotomies, including release of joint capsule (if performed), other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of knee replacement (H) (Anaes.) (Assist.)	678.05
50372	Bilateral posterior release of knee contracture, with multiple tendon lengthening or tenotomies, including release of joint capsule (if performed), other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of knee replacement (H) (Anaes.) (Assist.)	1,190.15
50375	Unilateral medial release of hip contracture, with lengthening or division of the adductors and psoas, including division of obturator nerve (if performed) (H) (Anaes.) (Assist.)	519.30
50378	Bilateral medial release of hip contracture, with lengthening or division of adductors and psoas, including division of obturator nerve (if performed) (H) (Anaes.) (Assist.)	908.85
50381	Unilateral anterior release of hip contracture, with lengthening or division of hip flexors and psoas, including division of joint capsule (if performed) (H) (Anaes.) (Assist.)	678.05
50384	Bilateral anterior release of hip contracture, with lengthening or division of hip flexors and psoas, including division of joint capsule (if performed) (H) (Anaes.) (Assist.)	1,190.15
50390	Application of cast under general anaesthesia, for patient with perthes, cerebral palsy, or other neuromuscular conditions, affecting hips or knees (H) (Anaes.)	237.95
50393	Acetabular shelf procedure, other than a service associated with a service to which another item of this Schedule applies if the service described in the other item is for the purpose of performing arthroplasty on the hip (H) (Anaes.) (Assist.)	879.90
50394	Multiple peri-acetabular osteotomy, including internal fixation (if performed) (H) (Anaes.) (Assist.)	2,889.90
50395	Osteotomy and distillation of greater trochanter, with internal fixation (H) (Anaes.) (Assist.)	950.25
50396	Amputation of congenital abnormalities or duplication of digits of the hand or foot, including any of the following (if performed): (a) splitting of phalanx or phalanges; (b) ligament reconstruction; (c) joint reconstruction (H) (Anaes.) (Assist.)	483.40
50399	Forearm, radial aplasia or dysplasia (radial club hand), centralisation or radialisation of (H) (Anaes.) (Assist.)	959.40

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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.)	1,363.20
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.)	1,839.25
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.)	1,363.20
50420	Patella, congenital dislocation of, reconstruction of the quadriceps (H) (Anaes.) (Assist.)	1,125.20
50423	Tibia, fibula or both, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (Anaes.) (Assist.)	1,038.65
50426	Removal of one or more lesions from bone, for osteochondroma occurring solitary or in association with hereditary multiple exotoses, with histological examination—one approach (H) (Anaes.) (Assist.)	483.40
50428	Percutaneous drilling of osteochondritis dessicans or other osteochondral lesion, for a patient: (a) with open growth plates; or (b) less than 18 years of age (H) (Anaes.) (Assist.)	807.05
50450	Unilateral single event multilevel surgery, for a patient less than 18 years of age with hemiplegic cerebral palsy, comprising 3 or more of the following: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; (b) correction of muscle imbalance by transfer of a tendon or tendons; (c) correction of femoral torsion by rotational osteotomy of the femur; (d) correction of tibial torsion by rotational osteotomy of the tibia; (e) correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis with synovectomy if performed, or os calcis lengthening; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)	1,276.65
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	1,276.65

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	femur, subtalar arthrodesis with synovectomy if performed, or os calcis lengthening; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)	
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.)	1,445.70
50456	Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)	1,445.70
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.)	2,158.50
50461	Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises bilateral soft tissue surgery and bilateral femoral osteotomies, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of torsional abnormality of the femur by rotational osteotomy and internal fixation; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)	2,158.50
50465	Bilateral single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies, with:	3,040.20

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)	
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.)	3,040.20
50470	Bilateral single event multilevel surgery, for a patient less than 18 years of age with cerebral palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; and (e) correction of bilateral pes valgus by os calcis lengthening or subtalar fusion; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)	3,855.70
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	3,855.70

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	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.)	
50475	Single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, for the correction of crouch gait, including: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation; and (d) correction of patella alta and quadriceps insufficiency by patella tendon shortening or reconstruction; and (e) correction of tibial torsion by rotational osteotomy of the tibia with internal fixation; and (f) correction of foot instability by os calcis lengthening or subtalar fusion; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)	4,449.10
50476	Single event multilevel surgery, for a patient less than 18 years of age with diplegic cerebral palsy, for the correction of crouch gait including: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation; and (d) correction of patella alta and quadriceps insufficiency by patella tendon shortening or reconstruction; and (e) correction of tibial torsion by rotational osteotomy of the tibia with internal fixation; and (f) correction of foot instability by os calcis lengthening or subtalar fusion; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)	4,449.10
50508	Treatment of fracture of distal end of radius or ulna (or both), by closed reduction, for a patient with open growth plates (Anaes.)	411.20
50512	Treatment of fracture of distal end of radius or ulna (or both), by open or closed reduction, with internal fixation, for a patient with open growth plates (H) (Anaes.) (Assist.)	548.70

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
50524	Radius or ulna, shaft of, with open growth plate, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction (H) (Anaes.) (Assist.)	425.10
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.)	685.70
50532	Treatment of fracture of shafts of radius or ulna (or both), by closed reduction, for a patient with open growth plate (H) (Anaes.)	596.60
50536	Treatment of fracture of shafts of radius or ulna (or both), by open or closed reduction, with internal fixation, for a patient with open growth plate (H) (Anaes.) (Assist.)	795.40
50540	Olecranon, with open growth plate, treatment of fracture of, by open reduction (H) (Anaes.) (Assist.)	548.70
50544	Radius, with open growth plate, treatment of fracture of head or neck of, by closed reduction of (Anaes.)	274.25
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.)	548.70
50552	Humerus, proximal, with open growth plate, treatment of fracture of, by closed reduction (H) (Anaes.)	473.20
50556	Treatment of fracture of proximal humerus, by open or closed reduction, with internal fixation, for a patient with open growth plate (H) (Anaes.) (Assist.)	630.80
50560	Humerus, shaft of, with open growth plate, treatment of fracture of, by closed reduction (H) (Anaes.)	493.65
50564	Treatment of fracture of shaft of humerus, by open or closed reduction, with internal or external fixation, for a patient with open growth plate (H) (Anaes.) (Assist.)	658.25
50568	Humerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by closed reduction (H) (Anaes.)	576.05
50572	Humerus, with open growth plate, supracondylar or condylar, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (H) (Anaes.) (Assist.)	768.00
50576	Treatment of fracture of femur, by closed reduction or traction, including application of hip spica (if performed), for a patient with open growth plate (Anaes.) (Assist.)	630.80
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.)	658.25
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.)	630.80

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
50588	Tibia and fibula, with open growth plates, treatment of fracture of, by internal fixation (H) (Anaes.) (Assist.)	822.75
50592	Treatment of fracture of shaft of femur, by open or closed reduction, with internal or external fixation, for a patient with open growth plate (H) (Anaes.) (Assist.)	999.15
50596	Treatment of fracture of shaft of tibia, by open or closed reduction, including casting, for a patient with open growth plate (H) (Anaes.) (Assist.)	312.35
50600	Scoliosis or kyphosis, in a child, manipulation of deformity and application of a localiser cast, under general anaesthesia (H) (Anaes.) (Assist.)	452.30
50604	Scoliosis or kyphosis, in a child or adolescent, spinal fusion for (without instrumentation) (H) (Anaes.) (Assist.)	1,919.75
50608	Scoliosis or kyphosis, in a child or adolescent, treatment by segmental instrumentation and fusion of the spine, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.)	3,565.85
50612	Scoliosis or kyphosis, in a child or adolescent, with spinal deformity, treatment by segmental instrumentation, utilising separate anterior and posterior approaches, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.)	5,072.05
50616	Scoliosis, in a child or adolescent, re-exploration for adjustment or removal of segmental instrumentation used for correction of spine deformity (H) (Anaes.) (Assist.)	644.45
50620	Scoliosis, in a child or adolescent, revision of failed scoliosis surgery, involving more than one of osteotomy, fusion, removal of instrumentation or instrumentation, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.)	3,565.85
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.)	3,565.85
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.)	4,404.75
50632	Scoliosis or kyphosis, in a child or adolescent, requiring segmental instrumentation and fusion of the spine down to and including the pelvis or sacrum, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.)	3,702.90
50636	Scoliosis, in a child or adolescent, requiring anterior decompression of the spinal cord with vertebral resection and instrumentation in the presence of spinal cord involvement, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.)	4,114.30
50640	Scoliosis, in a child or adolescent, congenital, resection and fusion of abnormal vertebra via an anterior or posterior approach, other than a service to which any of items 51011 to 51171 apply (H) (Anaes.) (Assist.)	2,274.35
50644	Spine, bone graft to, for a child or adolescent, associated with surgery for correction of scoliosis or kyphosis or both (H) (Anaes.) (Assist.)	2,194.40

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
50654	Treatment of hip dysplasia or dislocation, for a patient under the age of 18 years, by examination or closed reduction (or both), with or without arthrography of the hip under anaesthesia, and with application or reapplication of a hip spica (H) (Assist.) (Anaes.)	516.75
Subgroup 16—Radiofrequency and microwave tissue ablation		
50950	Unresectable primary malignant tumour of the liver, destruction of, by percutaneous ablation (including any associated imaging services), other than a service associated with a service to which item 30419 or 50952 applies (Anaes.)	850.20
50952	Unresectable primary malignant tumour of the liver, destruction of, by open or laparoscopic ablation (including any associated imaging services), if a multi-disciplinary team has assessed that percutaneous ablation cannot be performed or is not practical because of one or more of the following clinical circumstances: (a) percutaneous access cannot be achieved; (b) vital organs or tissues are at risk of damage from the percutaneous ablation procedure; (c) resection of one part of the liver is possible, however there is at least one primary liver tumour in an unresectable portion of the liver that is suitable for ablation; other than a service associated with a service to which item 30419 or 50950 applies (Anaes.)	850.20
Subgroup 17—Spinal surgery		
51011	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, one motion segment, not being a service associated with a service to which item 51012, 51013, 51014 or 51015 applies (H) (Anaes.) (Assist.)	1,493.65
51012	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, 2 motion segments, not being a service associated with a service to which item 51011, 51013, 51014 or 51015 applies (H) (Anaes.) (Assist.)	1,991.30
51013	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, 3 motion segments, not being a service associated with a service to which item 51011, 51012, 51014 or 51015 applies (H) (Anaes.) (Assist.)	2,489.20
51014	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, 4 motion segments, not being a service associated with a service to which item 51011, 51012, 51013 or 51015 applies (H) (Anaes.) (Assist.)	2,987.05
51015	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, more than 4 motion segments, not being a service associated with a service to which item 51011, 51012, 51013 or 51014 applies (H) (Anaes.) (Assist.)	3,484.90
51020	Simple fixation of part of one vertebra (not motion segment) including pars interarticularis, spinous process or pedicle, or simple interspinous wiring between 2 adjacent vertebral levels, not being a service associated	796.45

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	with: (a) interspinous dynamic stabilisation devices; or (b) a service to which item 51021, 51022, 51023, 51024, 51025 or 51026 applies (H) (Anaes.) (Assist.)	
51021	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, one motion segment, not being a service associated with a service to which item 51020, 51022, 51023, 51024, 51025 or 51026 applies (H) (Anaes.) (Assist.)	1,333.15
51022	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 2 motion segments, not being a service associated with a service to which item 51020, 51021, 51023, 51024, 51025 or 51026 applies (H) (Anaes.) (Assist.)	1,658.30
51023	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 3 or 4 motion segments, not being a service associated with a service to which item 51020, 51021, 51022, 51024, 51025 or 51026 applies (H) (Anaes.) (Assist.)	1,973.45
51024	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 5 or 6 motion segments, not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51025 or 51026 applies (H) (Anaes.) (Assist.)	2,278.30
51025	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 7 to 12 motion segments, not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51024 or 51026 applies (H) (Anaes.) (Assist.)	2,662.90
51026	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, more than 12 motion segments, not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51024 or 51025 applies (H) (Anaes.) (Assist.)	2,915.45
51031	Spine, posterior and/or posterolateral bone graft to, one motion segment, not being a service associated with a service to which item 51032, 51033, 51034, 51035 or 51036 applies (H) (Anaes.) (Assist.)	979.60
51032	Spine, posterior and/or posterolateral bone graft to, 2 motion segments, not being a service associated with a service to which item 51031, 51033, 51034, 51035 or 51036 applies (H) (Anaes.) (Assist.)	1,175.55
51033	Spine, posterior and/or posterolateral bone graft to, 3 motion segments, not being a service associated with a service to which item 51031, 51032, 51034, 51035 or 51036 applies (H) (Anaes.) (Assist.)	1,371.50
51034	Spine, posterior and/or posterolateral bone graft to, 4 to 7 motion segments, not being a service associated with a service to which item 51031, 51032, 51033, 51035 or 51036 applies (H) (Anaes.) (Assist.)	1,469.40

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
51035	Spine, posterior and/or posterolateral bone graft to, 8 to 11 motion segments, not being a service associated with a service to which item 51031, 51032, 51033, 51034 or 51036 applies (H) (Anaes.) (Assist.)	1,567.35
51036	Spine, posterior and/or posterolateral bone graft to, 12 or more motion segments, not being a service associated with a service to which item 51031, 51032, 51033, 51034 or 51035 applies (H) (Anaes.) (Assist.)	1,665.35
51041	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), one motion segment, not being a service associated with a service to which item 51042, 51043, 51044 or 51045 applies (H) (Anaes.) (Assist.)	1,126.55
51042	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 2 motion segments, not being a service associated with a service to which item 51041, 51043, 51044 or 51045 applies (H) (Anaes.) (Assist.)	1,577.20
51043	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 3 motion segments, not being a service associated with a service to which item 51041, 51042, 51044 or 51045 applies (H) (Anaes.) (Assist.)	1,971.55
51044	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 4 motion segments, not being a service associated with a service to which item 51041, 51042, 51043 or 51045 applies (H) (Anaes.) (Assist.)	2,140.50
51045	Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 5 or more motion segments, not being a service associated with a service to which item 51041, 51042, 51043 or 51044 applies (H) (Anaes.) (Assist.)	2,253.15
51051	Pedicle subtraction osteotomy, one vertebra, not being a service associated with a service to which item 51052, 51053, 51054, 51055, 51056, 51057, 51058 or 51059 applies (H) (Anaes.) (Assist.)	1,924.95
51052	Pedicle subtraction osteotomy, 2 vertebrae, not being a service associated with a service to which item 51051, 51053, 51054, 51055, 51056, 51057, 51058 or 51059 applies (H) (Anaes.) (Assist.)	2,341.20
51053	Vertebral column resection osteotomy performed through single posterior approach, one vertebra, not being a service associated with a service to which item 51051, 51052, 51054, 51055, 51056, 51057, 51058 or 51059 applies (H) (Anaes.) (Assist.)	2,663.70
51054	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtotal excision is defined as removal of more than 50% of the vertebral body), one vertebra, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51055, 51056, 51057, 51058 or 51059 applies (H) (Anaes.) (Assist.)	1,420.30
51055	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtotal excision is defined as removal of more than 50% of the vertebral body), 2 vertebrae, not being a service associated with:	2,130.45

Clause 5.10.29

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51056, 51057, 51058 or 51059 applies (H) (Anaes.) (Assist.)	
51056	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtotal excision is defined as removal of more than 50% of the vertebral body), 3 or more vertebrae, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51055, 51057, 51058 or 51059 applies (H) (Anaes.) (Assist.)	2,485.50
51057	Vertebral body, en bloc excision of (complete spondylectomy), one vertebra, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51058 or 51059 applies (H) (Anaes.) (Assist.)	2,497.25
51058	Vertebral body, en bloc excision of (complete spondylectomy), 2 vertebrae, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51057 or 51059 applies (H) (Anaes.) (Assist.)	2,809.90
51059	Vertebral body, en bloc excision of (complete spondylectomy), 3 or more vertebrae, not being a service associated with: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51057 or 51058 applies (H) (Anaes.) (Assist.)	3,433.75
51061	Spinal fusion, anterior and posterior, including spinal instrumentation at one motion segment, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51062, 51063, 51064, 51065 or 51066 applies (H) (Anaes.) (Assist.)	2,949.50
51062	Spinal fusion, anterior and posterior, including spinal instrumentation at 2 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51063, 51064, 51065 or 51066 applies (H) (Anaes.) (Assist.)	3,823.25
51063	Spinal fusion, anterior and posterior, including spinal instrumentation at 3 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51062, 51064, 51065 or 51066 applies (H) (Anaes.) (Assist.)	4,630.65
51064	Spinal fusion, anterior and posterior, including spinal instrumentation at 4 to 7 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to	5,153.55

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	which item 51061, 51062, 51063, 51065 or 51066 applies (H) (Anaes.) (Assist.)	
51065	Spinal fusion, anterior and posterior, including spinal instrumentation at 8 to 11 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51062, 51063, 51064 or 51066 applies (H) (Anaes.) (Assist.)	5,699.80
51066	Spinal fusion, anterior and posterior, including spinal instrumentation at 12 or more motion segments, posterior and/or posterolateral bone graft, and anterior column fusion not being a service associated with a service to which item 51061, 51062, 51063, 51064 or 51065 applies (H) (Anaes.) (Assist.)	6,001.25
51071	Removal of intradural lesion, not being a service associated with a service to which item 51072 or 51073 applies (H) (Anaes.) (Assist.)	2,601.30
51072	Craniocervical junction lesion, transoral approach for, not being a service associated with a service to which item 51071 or 51073 applies (H) (Anaes.) (Assist.)	2,705.35
51073	Removal of intramedullary tumour or arteriovenous malformation, not being a service associated with a service to which item 51071 or 51072 applies (H) (Anaes.) (Assist.)	3,433.75
51102	Thoracoplasty in combination with thoracic scoliosis correction—3 or more ribs (H) (Anaes.) (Assist.)	1,231.40
51103	Odontoid screw fixation (H) (Anaes.) (Assist.)	2,164.05
51110	Spine, treatment of fracture, dislocation or fracture-dislocation, with immobilisation by calipers or halo, not including application of skull tongs or calipers as part of operative positioning (Anaes.)	783.80
51111	Skull calipers or halo, insertion of, as an independent procedure (H) (Anaes.)	333.10
51112	Plaster jacket, application of, as an independent procedure (Anaes.)	225.25
51113	Halo, application of, in addition to spinal fusion for scoliosis, or other conditions (H) (Anaes.)	249.80
51114	Halo-thoracic orthosis—application of both halo and thoracic jacket (H) (Anaes.)	440.95
51115	Halo-femoral traction, as an independent procedure (Anaes.)	440.95
51120	Bone graft, harvesting of autogenous graft, via separate incision or via subcutaneous approach, in conjunction with spinal fusion, other than for the purposes of bone graft obtained from the cervical, thoracic, lumbar or sacral spine (H) (Anaes.)	245.05
51130	Lumbar artificial intervertebral total disc replacement, at one motion segment only, including removal of disc and marginal osteophytes: (a) for a patient who: (i) has not had prior spinal fusion surgery at the same lumbar level; and (ii) does not have vertebral osteoporosis; and (iii) has failed conservative therapy; and	1,866.35

Clause 5.11.1

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(b) not being a service associated with a service to which item 51011, 51012, 51013, 51014 or 51015 applies (H) (Anaes.) (Assist.)	
51131	Cervical artificial intervertebral total disc replacement, at one motion segment only, including removal of disc and marginal osteophytes, for a patient who: (a) has not had prior spinal surgery at the same cervical level; and (b) is skeletally mature; and (c) has symptomatic degenerative disc disease with radiculopathy; and (d) does not have vertebral osteoporosis; and (e) has failed conservative therapy (H) (Anaes.) (Assist.)	1,126.55
51140	Previous spinal fusion, re-exploration for, involving adjustment or removal of instrumentation up to 3 motion segments, not being a service associated with a service to which item 51141 applies (H) (Anaes.) (Assist.)	460.40
51141	Previous spinal fusion, re-exploration for, involving adjustment or removal of instrumentation more than 3 motion segments, not being a service associated with a service to which item 51140 applies (H) (Anaes.) (Assist.)	851.70
51145	Wound debridement or excision for post-operative infection or haematoma following spinal surgery (H) (Anaes.) (Assist.)	460.40
51150	Coccyx, excision of (H) (Anaes.) (Assist.)	463.50
51160	Anterior exposure of thoracic or lumbar spine, one motion segment, not being a service to which item 51165 applies (H) (Anaes.) (Assist.)	1,196.60
51165	Anterior exposure of thoracic or lumbar spine, more than one motion segment, not being a service to which item 51160 applies (H) (Anaes.) (Assist.)	1,508.75
51170	Syringomyelia or hydromyelia, craniotomy for, with or without duraplasty, intradural dissection, plugging of obex or local cerebrospinal fluid shunt (H) (Anaes.) (Assist.)	2,273.15
51171	Syringomyelia or hydromyelia, treatment by direct cerebrospinal fluid shunt (for example, syringosubarachnoid shunt, syringopleural shunt or syringoperitoneal shunt) (H) (Anaes.) (Assist.)	954.60

Division 5.11—Group T9: Assistance at operations

5.11.1 Meaning of amount under clause 5.11.1

In item 51303:

amount under clause 5.11.1, 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.

5.11.2 Meaning of amount under clause 5.11.2

In item 51309:

amount under clause 5.11.2, 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.

5.11.3 Meaning of amount under clause 5.11.3

In item 51312:

amount under clause 5.11.3, 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.

5.11.4 Restrictions on items in Group T9—medical practitioner providing 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.

5.11.5 Items in Group T9

This clause sets out items in Group T9.

Group T9—Assistance at operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
51300	Assistance at any operation mentioned in an item in Group T8 that includes "(Assist.)" for which the fee does not exceed $580.95 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 $580.95	89.80
51303	Assistance at any operation mentioned in an item in Group T8 that includes "(Assist.)" for which the fee exceeds $580.95 or at a series or combination of operations mentioned in an item in Group T8 that include "(Assist.)" for which the aggregate fee exceeds $580.95	Amount under clause 5.11.1
51306	Assistance at a birth involving Caesarean section	129.70
51309	Assistance at a series or combination of operations that include	Amount under

Clause 5.11.5

Group T9—Assistance at operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	"(Assist.)" and assistance at a birth involving Caesarean section	clause 5.11.2
51312	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615 and 16627	Amount under clause 5.11.3
51315	Assistance at cataract and intraocular lens surgery covered by item 42698, 42701, 42702, 42704, 42705 or 42707, when performed in association with services covered by item 42551 to 42569, 42653, 42656, 42725, 42746, 42749, 42752, 42776 or 42779	283.45
51318	Assistance at cataract and intraocular lens surgery, if patient has: (a) total loss of vision, including no potential for central vision, in the fellow eye; or (b) one of the following in the fellow eye: (i) vitreous loss; (ii) rupture of posterior capsule; (iii) loss of nuclear material into the vitreous; (iv) intraocular haemorrhage; (v) intraocular infection (endophthalmitis); (vi) cystoid macular oedema; (vii) corneal decompensation; (viii) retinal detachment; or (c) pseudo exfoliation, subluxed lens, iridodonesis, phacodonesis, retinal detachment, corneal scarring, pre-existing uveitis, bound down miosed pupil, nanophthalmos, spherophakia, Marfan's syndrome, homocysteinuria or previous blunt trauma causing intraocular damage	187.05

Part 6—Oral and maxillofacial services

Division 6.1—Preliminary

6.1.1 Restriction on items Groups O1 to O11—providers of services

Items 51700 to 53706 apply only to a service provided in the course of dental practice by a dental practitioner approved by the Minister before 1 November 2004 for the definition of ***professional service*** in subsection 3(1) of the Act.

Division 6.2—Group O1: Consultations

6.2.1 Items in Group O1

This clause sets out items in Group O1.

Group O1—Consultations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
51700	Professional attendance by an approved dental practitioner in the practice of oral and maxillofacial surgery—initial attendance at consulting rooms, hospital or residential aged care facility if the patient is referred to the approved dental practitioner	89.00
51703	Professional attendance by an approved dental practitioner in the practice of oral and maxillofacial surgery—an attendance after the initial attendance in a single course of treatment, at consulting rooms, hospital or residential aged care facility if the patient is referred to the approved dental practitioner	44.75

Division 6.3—Group O2: Assistance at operation

6.3.1 Meaning of amount under clause 6.3.1

In item 51803:

amount under clause 6.3.1, 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.

6.3.2 Restrictions on items in Group O2—approved dental practitioner providing 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.

6.3.3 Items in Group O2

This clause sets out items in Group O2.

Group O2—Assistance at operation

Column 1 Item	Column 2 Description	Column 3 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 $580.95 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 $580.95	89.80
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 $580.95 or at a series or combination of operations mentioned in an item that include "(Assist.)" if the aggregate fee exceeds $580.95	Amount under clause 6.3.1

Division 6.4—Group O3: General surgery

6.4.1 Items in Group O3

This clause sets out items in Group O3.

Group O3—General surgery

Column 1 Item	Column 2 Description	Column 3 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.)	339.25
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.)	76.95
51904	Lipectomy—wedge excision of skin or fat—one excision (Anaes.) (Assist.)	473.30
51906	Lipectomy—wedge excision of skin or fat—2 or more excisions (Anaes.) (Assist.)	719.75
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.)	85.80

Group O3—General surgery

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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.)	122.35
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.)	122.35
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.)	193.10
52010	Full thickness laceration of ear, eyelid, nose or lip, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.)	264.25
52012	Superficial foreign body, removal of, as an independent procedure (Anaes.)	24.45
52015	Subcutaneous foreign body, removal of, requiring incision and suture, as an independent procedure (Anaes.)	114.30
52018	Foreign body in muscle, tendon or other deep tissue, removal of, as an independent procedure (Anaes.) (Assist.)	288.00
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.)	30.60
52024	Biopsy of skin or mucous membrane, as an independent procedure (Anaes.)	54.35
52025	Lymph node of neck, biopsy of (Anaes.)	191.35
52027	Biopsy of lymph node, muscle or other deep tissue or organ, as an independent procedure and other than a service to which item 52025 applies (Anaes.)	155.85
52030	Sinus, excision of, involving superficial tissue only (Anaes.)	93.65
52033	Sinus, excision of, involving muscle and deep tissue (Anaes.)	191.35
52034	Premalignant lesions of the oral mucous, treatment by cryotherapy, diathermy or carbon dioxide laser	44.75
52035	Endoscopic laser therapy for neoplasia and benign vascular lesions of the oral cavity (Anaes.)	495.35
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.)	132.10
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.)	339.25
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	179.50

Clause 6.4.1

Group O3—General surgery

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.)	
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.)	256.50
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.)	386.55
52051	Tumour, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.)	522.60
52054	Tumour, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.)	611.40
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)	28.45
52056	Haematoma in the oral and maxillofacial region, aspiration of (Anaes.)	28.45
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.)	169.55
52058	Percutaneous drainage of deep abscess in the oral and maxillofacial region, using interventional imaging techniques—but not including imaging (Anaes.)	247.20
52059	Abscess in the oral and maxillofacial region drainage tube, exchange of using interventional imaging techniques—but not including imaging (Anaes.)	278.55
52060	Muscle in the oral and maxillofacial region, excision of (Anaes.)	197.10
52061	Muscle, in the oral and maxillofacial region, ruptured, repair of (limited), not associated with external wound (Anaes.)	232.70
52062	Muscle, in the oral and maxillofacial region, ruptured, repair of (extensive), not associated with external wound (Anaes.) (Assist.)	307.70
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.)	370.80
52064	Bone cyst in the oral and maxillofacial region, injection into or aspiration of (Anaes.)	176.35

Group O3—General surgery

Column 1 Item	Column 2 Description	Column 3 Fee ($)
52066	Submandibular gland, extirpation of (Anaes.) (Assist.)	463.50
52069	Sublingual gland, extirpation of (Anaes.)	206.60
52072	Salivary gland, dilatation or diathermy of duct (Anaes.)	61.20
52073	Salivary gland, repair of cutaneous fistula of (Anaes.)	155.85
52075	Salivary gland, removal of calculus from duct or meatotomy or marsupialisation, one or more such procedures (Anaes.)	155.85
52078	Tongue, partial excision of (Anaes.) (Assist.)	307.70
52081	Tongue tie, division or excision of frenulum (Anaes.)	48.40
52084	Tongue tie, mandibular frenulum or maxillary frenulum, division or excision of frenulum, in a patient aged not less than 2 years (Anaes.)	124.30
52087	Ranula or mucous cyst of mouth, removal of (Anaes.)	213.00
52090	Operation on mandible or maxilla (other than alveolar margins) for chronic osteomyelitis—one bone or in combination with adjoining bones (Anaes.) (Assist.)	370.80
52092	Operation on skull for osteomyelitis (Anaes.) (Assist.)	483.35
52094	Operation on any combination of adjoining bones in the oral and maxillofacial region, being bones referred to in item 52092 (Anaes.) (Assist.)	611.35
52095	Bone growth stimulator in the oral and maxillofacial region, insertion of (Anaes.) (Assist.)	396.25
52096	Orthopaedic pin or wire, insertion of, into maxilla or mandible or zygoma, as an independent procedure (Anaes.)	117.40
52097	External fixation in the oral and maxillofacial region, removal of, in the operating theatre of a hospital (H) (Anaes.)	166.55
52098	External fixation in the oral and maxillofacial region, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.)	195.80
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.)	146.95
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.)	146.95
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.)	274.25
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 (H) (Anaes.)	113.30

Clause 6.4.1

Group O3—General surgery

Column 1 Item	Column 2 Description	Column 3 Fee ($)
52108	Lip, full thickness wedge excision of, with repair by direct sutures (Anaes.) (Assist.)	339.25
52111	Vermilionectomy (Anaes.) (Assist.)	339.25
52114	Mandible or maxilla, segmental resection of, for tumours or cysts (Anaes.) (Assist.)	611.40
52117	Mandible, including lower border, or maxilla, sub-total resection of (Anaes.) (Assist.)	727.80
52120	Mandible, hemimandiblectomy of, including condylectomy, if performed (Anaes.) (Assist.)	860.85
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.)	860.85
52123	Mandible, total resection of both sides, including condylectomies if performed (Anaes.) (Assist.)	974.50
52126	Maxilla, total resection of (Anaes.) (Assist.)	936.90
52129	Maxilla, total resection of both maxillae (Anaes.) (Assist.)	1,254.25
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.)	460.40
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.)	636.75
52132	Tracheostomy (Anaes.)	259.05
52133	Cricothyrostomy by direct stab or Seldinger technique, using mini tracheostomy device (Anaes.)	94.75
52135	Post-operative or post-nasal haemorrhage, or both, control of, if undertaken in the operating theatre of a hospital (H) (Anaes.)	150.20
52138	Maxillary artery, ligation of (Anaes.) (Assist.)	466.75
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.)	461.65
52144	Foreign body, deep, removal of using interventional imaging techniques (Anaes.) (Assist.)	430.30
52147	Duct of major salivary gland, transposition of (Anaes.) (Assist.)	406.05
52148	Parotid duct, repair of, using micro-surgical techniques (Anaes.) (Assist.)	717.75
52158	Submandibular ducts, relocation of, for surgical control of drooling (Anaes.) (Assist.)	1,155.65
52180	Aggressive or potentially malignant bone or deep soft tissue tumour in the oral and maxillofacial region, biopsy of (not including after-care) (Anaes.)	195.80
52182	Bone or malignant deep soft tissue tumour in the oral and maxillofacial region, lesional or marginal excision of (Anaes.) (Assist.)	431.05
52184	Bone tumour in the oral and maxillofacial region, lesional or marginal excision of, combined with any one of liquid nitrogen freezing,	636.75

Group O3—General surgery		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	autograft, allograft or cementation (Anaes.) (Assist.)	
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.)	783.80

Division 6.5—Group O4: Plastic and reconstructive

6.5.1 Meaning of maxilla

In items 52342 to 52375:

maxilla includes the zygoma.

6.5.2 Items in Group O4

This clause sets out items in Group O4.

Group O4—Plastic and reconstructive		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
52300	Single-stage local flap, if indicated, repair to one defect, with skin or mucosa (Anaes.) (Assist.)	295.90
52303	Single-stage local flap, if indicated, repair to one defect, with buccal pad of fat (Anaes.) (Assist.)	422.50
52306	Single-stage local flap, if indicated, repair to one defect, using temporalis muscle (Anaes.) (Assist.)	626.90
52309	Free grafting (mucosa or split skin) of a granulating area (Anaes.)	213.00
52312	Free grafting (mucosa, split skin or connective tissue) to one defect, including elective dissection (Anaes.) (Assist.)	295.90
52315	Free grafting, full thickness, to one defect (mucosa or skin) (Anaes.) (Assist.)	492.95
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.)	146.95
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.)	245.05
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.)	492.95
52324	Direct flap repair, using tongue, first stage (Anaes.) (Assist.)	492.95
52327	Direct flap repair, using tongue, second stage (Anaes.)	244.60
52330	Palatal defect (oro-nasal fistula), plastic closure of, including services to	813.60

Clause 6.5.2

Group O4—Plastic and reconstructive

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	which item 52300, 52303, 52306 or 52324 applies (Anaes.) (Assist.)	
52333	Cleft palate, primary repair (Anaes.) (Assist.)	813.60
52336	Cleft palate, secondary repair, closure of fistula using local flaps (Anaes.) (Assist.)	508.55
52337	Alveolar cleft (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes.) (Assist.)	1,112.40
52339	Cleft palate, secondary repair, lengthening procedure (Anaes.) (Assist.)	579.15
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.)	1,005.95
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.)	1,134.50
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.)	1,282.00
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.)	1,439.75
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.)	1,459.55
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.)	1,643.15
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.)	1,676.35
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.)	1,885.80
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.)	1,844.10
52369	Mandible and maxilla, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of one jaw and 2 such procedures	2,073.45

Group O4—Plastic and reconstructive

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	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.)	
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.)	2,011.90
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.)	2,253.50
52378	Genioplasty including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	779.00
52379	Face, contour reconstruction of one region, using autogenous bone or cartilage graft (Anaes.) (Assist.)	1,331.25
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.)	2,266.85
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.)	2,717.45
52420	Mandible, fixation by intermaxillary wiring, excluding wiring for obesity	250.90
52424	Dermis, dermofat or fascia graft (excluding transfer of fat by injection) in the oral and maxillofacial region (Anaes.) (Assist.)	492.85
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.)	1,134.50
52440	Cleft lip, unilateral—primary repair, one stage, without anterior palate repair (Anaes.) (Assist.)	563.25
52442	Cleft lip, unilateral—primary repair, one stage, with anterior palate repair (Anaes.) (Assist.)	704.25
52444	Cleft lip, bilateral—primary repair, one stage, without anterior palate repair (Anaes.) (Assist.)	782.35
52446	Cleft lip, bilateral—primary repair, one stage, with anterior palate repair (Anaes.) (Assist.)	923.50
52450	Cleft lip, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.)	312.95
52452	Cleft lip, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.)	508.55

Clause 6.6.1

Group O4—Plastic and reconstructive		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
52456	Cleft lip reconstruction using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.)	860.85
52458	Cleft lip reconstruction using full thickness flap (Abbe or similar), second stage (Anaes.)	312.95
52460	Velo-pharyngeal incompetence, pharyngeal flap for, or pharyngoplasty for (Anaes.)	813.60
52480	Composite graft (chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (Anaes.) (Assist.)	522.60
52482	Macrocheilia or macroglossia, operation for (Anaes.) (Assist.)	502.85
52484	Macrostomia, operation for (Anaes.) (Assist.)	598.60

Division 6.6—Group O5: Preprosthetic

6.6.1 Items in Group O5

This clause sets out items in Group O5.

Group O5—Preprosthetic		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
52600	Mandibular or palatal exostosis, excision of (Anaes.) (Assist.)	352.05
52603	Mylohyoid ridge, reduction of (Anaes.) (Assist.)	336.50
52606	Maxillary tuberosity, reduction of (Anaes.)	256.70
52609	Papillary hyperplasia of the palate, removal of—less than 5 lesions (Anaes.) (Assist.)	336.50
52612	Papillary hyperplasia of the palate, removal of—5 to 20 lesions (Anaes.) (Assist.)	422.50
52615	Papillary hyperplasia of the palate, removal of—more than 20 lesions (Anaes.) (Assist.)	524.30
52618	Vestibuloplasty, submucosal or open, including excision of muscle and skin or mucosal graft when performed—unilateral or bilateral (Anaes.) (Assist.)	610.30
52621	Floor of mouth lowering (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed—unilateral (Anaes.) (Assist.)	610.30
52624	Alveolar ridge augmentation with bone or alloplast or both—unilateral (Anaes.) (Assist.)	492.85
52626	Alveolar ridge augmentation—unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.)	302.30
52627	Osseo-integration procedure—extra oral implantation of titanium fixture (Anaes.) (Assist.)	524.30

Group O5—Preprosthetic		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
52630	Osseo-integration procedure—fixation of transcutaneous abutment (Anaes.)	194.10
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.)	524.30
52636	Osseo-integration procedure—fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.)	194.10

Division 6.7—Group O6: Neurosurgical

6.7.1 Items in Group O6

This clause sets out items in Group O6.

Group O6—Neurosurgical		
Column 1	**Column 2**	**Column 3**
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.)	288.00
52803	Nerve trunk, internal (interfascicular), neurolysis of, using microsurgical techniques (Anaes.) (Assist.)	414.70
52806	Neurectomy, neurotomy or removal of tumour from superficial peripheral nerve (Anaes.) (Assist.)	288.00
52809	Neurectomy, neurotomy or removal of tumour from deep peripheral nerve (Anaes.) (Assist.)	492.95
52812	Nerve trunk, primary repair of, using microsurgical techniques (Anaes.) (Assist.)	704.25
52815	Nerve trunk, secondary repair of, using microsurgical techniques (Anaes.) (Assist.)	743.35
52818	Nerve, transposition of (Anaes.) (Assist.)	492.95
52821	Nerve graft to nerve trunk (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.) (Assist.)	1,071.95
52824	Peripheral branches of the trigeminal nerve, cryosurgery of, for pain relief (Anaes.) (Assist.)	461.65
52826	Injection of primary branch of trigeminal nerve with alcohol, cortisone, phenol, or similar substance (Anaes.)	247.20
52828	Cutaneous nerve, primary repair of, using microsurgical techniques (Anaes.) (Assist.)	367.70
52830	Cutaneous nerve, secondary repair of, using microsurgical techniques (Anaes.) (Assist.)	485.00
52832	Cutaneous nerve, nerve graft to, using microsurgical techniques (Anaes.)	665.15

Clause 6.8.1

Group O6—Neurosurgical		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(Assist.)	

Division 6.8—Group O7: Ear, nose and throat

6.8.1 Items in Group O7

This clause sets out items in Group O7.

Group O7—Ear, nose and throat		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
53000	Maxillary antrum, proof puncture and lavage of (Anaes.)	33.85
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.)	95.60
53004	Maxillary antrum, lavage of—each attendance at which the procedure is performed, including any associated consultation (Anaes.)	37.05
53006	Antrostomy (radical) (Anaes.) (Assist.)	542.40
53009	Antrum, intranasal operation on or removal of foreign body from (Anaes.) (Assist.)	307.70
53012	Antrum, drainage of, through tooth socket (Anaes.)	122.35
53015	Oro-antral fistula, plastic closure of (Anaes.) (Assist.)	611.40
53016	Nasal septum, septoplasty, submucous resection or closure of septal perforation (Anaes.) (Assist.)	502.85
53017	Nasal septum, reconstruction of (Anaes.) (Assist.)	627.30
53019	Maxillary sinus, bone graft to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), unilateral (Anaes.) (Assist.)	604.45
53052	Post-nasal space, direct examination of, with or without biopsy (Anaes.)	127.80
53054	Nasendoscopy or sinoscopy or fibreoptic examination of nasopharynx—one or more of these procedures (Anaes.)	127.80
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.)	74.85
53058	Nasal haemorrhage, posterior, arrest of, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding after-care) (Anaes.)	127.80
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.)	104.60

Group O7—Ear, nose and throat		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
53062	Post-surgical nasal haemorrhage, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.)	93.65
53064	Cryotherapy to nose in the treatment of nasal haemorrhage (Anaes.)	169.55
53068	Turbinectomy or turbinectomies, partial or total, unilateral (Anaes.)	142.05
53070	Turbinates, submucous resection of, unilateral (Anaes.)	185.25

Division 6.9—Group O8: Temporomandibular joint

6.9.1 Items in Group O8

This clause sets out items in Group O8.

Group O8—Temporomandibular joint		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
53200	Mandible, treatment of a dislocation of, not requiring open reduction (Anaes.)	73.55
53203	Mandible, treatment of a dislocation of, requiring open reduction (Anaes.)	123.50
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 (H) (Anaes.)	148.80
53209	Glenoid fossa, zygomatic arch and temporal bone, reconstruction of (Obwegeser technique) (Anaes.) (Assist.)	1,715.95
53212	Absent condyle and ascending ramus in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.)	926.95
53215	Temporomandibular joint, arthroscopy of, with or without biopsy, other than a service associated with another arthroscopic procedure of that joint (Anaes.) (Assist.)	425.30
53218	Temporomandibular joint, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions—one or more of such procedures (Anaes.) (Assist.)	680.25
53220	Temporomandibular joint, arthrotomy of, other than a service to which another item in this Group applies (Anaes.) (Assist.)	342.90
53221	Temporomandibular joint, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.)	907.65
53224	Temporomandibular joint, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.)	1,006.15
53225	Arthrocentesis, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space (Anaes.) (Assist.)	302.30

Clause 6.10.1

Group O8—Temporomandibular joint		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
53226	Temporomandibular joint, synovectomy of, other than a service to which another item in this Group applies (Anaes.) (Assist.)	324.95
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.)	1,236.35
53230	Temporomandibular joint, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.)	1,392.65
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.)	1,564.95
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.)	489.75
53239	Temporomandibular joint, arthrodesis of, other than a service to which another item in this Group applies (Anaes.) (Assist.)	489.75
53242	Temporomandibular joint or joints, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.)	324.95

Division 6.10—Group O9: Treatment of fractures

6.10.1 Items in Group O9

This clause sets out items in Group O9.

Group O9—Treatment of fractures		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
53400	Maxilla, unilateral or bilateral, treatment of fracture of, not requiring splinting	134.40
53403	Mandible, treatment of fracture of, not requiring splinting	164.25
53406	Maxilla, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.)	423.10
53409	Mandible, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.)	423.10
53410	Zygomatic bone, treatment of fracture of, not requiring surgical reduction	89.10
53411	Zygomatic bone, treatment of fracture of, requiring surgical reduction, by temporal, intra-oral or other approach (Anaes.)	248.45
53412	Zygomatic bone, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at one site (Anaes.) (Assist.)	408.00
53413	Zygomatic bone, treatment of fracture of, requiring surgical reduction	499.80

Group O9—Treatment of fractures

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.)	
53414	Zygomatic bone, treatment of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.)	574.20
53415	Maxilla, treatment of fracture of, requiring open reduction (Anaes.) (Assist.)	453.30
53416	Mandible, treatment of fracture of, requiring open reduction (Anaes.) (Assist.)	453.30
53418	Maxilla, treatment of fracture of, requiring open reduction and internal fixation not involving a plate (Anaes.) (Assist.)	589.30
53419	Mandible, treatment of fracture of, requiring open reduction and internal fixation not involving a plate (Anaes.) (Assist.)	589.30
53422	Maxilla, treatment of fracture of, requiring open reduction and internal fixation involving a plate (Anaes.) (Assist.)	747.85
53423	Mandible, treatment of fracture of, requiring open reduction and internal fixation involving a plate (Anaes.) (Assist.)	747.85
53424	Maxilla, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving a plate (Anaes.) (Assist.)	641.60
53425	Mandible, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving a plate (Anaes.) (Assist.)	641.60
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.)	876.40
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.)	876.40
53439	Mandible, treatment of a closed fracture of, involving a joint surface (Anaes.)	248.45
53453	Orbital cavity, reconstruction of a wall or floor with or without foreign implant (Anaes.) (Assist.)	502.85
53455	Orbital cavity, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.)	590.65
53458	Nasal bones, treatment of fracture of, other than a service to which item 53459 or 53460 applies	44.80
53459	Nasal bones, treatment of fracture of, by reduction (Anaes.)	245.05
53460	Nasal bones, treatment of fractures of, by open reduction involving osteotomies (Anaes.) (Assist.)	499.80

Clause 6.11.1

Division 6.11—Group O11: Regional or field nerve blocks

6.11.1 Items in Group O11

This clause sets out items in Group O11.

Group O11—Regional or field nerve blocks

Column 1 Item	Column 2 Description	Column 3 Fee ($)
53700	Trigeminal nerve, primary division of, injection of an anaesthetic agent	129.90
53702	Trigeminal nerve, peripheral branch of, injection of an anaesthetic agent	65.05
53704	Facial nerve, injection of an anaesthetic agent	39.15
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	129.90

Part 7—Dictionary

Note: All references in this Part to a provision are references to a provision in this Schedule, unless otherwise indicated.

7.1.1 Dictionary

In this Schedule:

2013 estimated resident population means the preliminary estimated resident population as at 30 June 2013, as published by the Australian Bureau of Statistics.

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.

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.

after-hours rural area means an area that is:

(a) a Modified Monash 2 area; or

(b) a Modified Monash 3 area; or

(c) a Modified Monash 4 area; or

(d) a Modified Monash 5 area; or

(e) a Modified Monash 6 area; or

(f) a Modified Monash 7 area.

amount under clause 2.1.1 has the meaning given by clause 2.1.1.

amount under clause 2.18.3 has the meaning given by clause 2.18.3.

amount under clause 2.20.2 has the meaning given by clause 2.20.2.

Clause 7.1.1

amount under clause 5.3.1 has the meaning given by clause 5.3.1.

amount under clause 5.7.1 has the meaning given by clause 5.7.1.

amount under clause 5.9.1 has the meaning given by clause 5.9.1.

amount under clause 5.9.2 has the meaning given by clause 5.9.2.

amount under clause 5.10.1 has the meaning given by clause 5.10.1.

amount under clause 5.10.2 has the meaning given by clause 5.10.2.

amount under clause 5.10.20 has the meaning given by clause 5.10.20.

amount under clause 5.11.1 has the meaning given by clause 5.11.1.

amount under clause 5.11.2 has the meaning given by clause 5.11.2.

amount under clause 5.11.3 has the meaning given by clause 5.11.3.

amount under clause 6.3.1 has the meaning given by clause 6.3.1.

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.

ASGC has the meaning given by clause 3.2.1.

ASGS means the July 2016 edition of the Australian Statistical Geography Standard, published by the Australian Bureau of Statistics, as existing on 1 July 2020.

Note: The ASGS could in 2021 be viewed on the Australian Bureau of Statistics' website (https://www.abs.gov.au).

associated general practitioner:

(a) for item 732—has the meaning given by clause 2.16.2; and
(b) for item 2712—has the meaning given by clause 2.20.5.

Australian Type 2 Diabetes Risk Assessment Tool means the *Australian Type 2 Diabetes Risk Assessment Tool*, developed by the Baker Heart and Diabetes Institute, as existing on 1 July 2020.

Note: The *Australian Type 2 Diabetes Risk Assessment Tool* could in 2021 be viewed on the Department's website (http://www.health.gov.au).

birth, in items 16515, 16519, 16522, 16527, 16528, 16590, 20855, 20946, 20958, 51306 and 51309, includes the following:

(a) induction of labour by surgical or intravenous infusion methods;
(b) forceps or vacuum extraction;
(c) caesarean section;
(d) breech birth;
(e) management of multiple births;
(f) episiotomy;
(g) repair of tears;
(h) evacuation of the products of conception by manual removal.

brachytherapy treatment verification means a quality assurance procedure:

(a) that is designed to facilitate accurate and reproducible delivery of brachytherapy to a site or region of the body as specified in a treatment prescription or in a dose plan generated from a treatment prescription; and

(b) that utilises the capture and assessment of appropriate images using any of the following:

(i) x-rays;

(ii) computed tomography;

(iii) ultrasound, if the ultrasound equipment is capable of producing images in 3 dimensions; and

(c) that includes making a record of the assessment and correcting any significant treatment delivery inaccuracies detected.

bulk-billed, for Division 3.2, has the meaning given by clause 3.2.1.

care recipient means a person to whom residential care (as defined in section 41-3 of the *Aged Care Act 1997*) is provided.

case conference team, for item 880, has the meaning given by clause 2.16.18.

cervical screening service means a service to which item 73070, 73071, 73072, 73073, 73074, 73075 or 73076 of the pathology services table applies.

cervical smear service means a service to which former item 73053, 73055, 73057 or 73069 of the pathology services table applied.

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.

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.

comprehensive hyperbaric medicine facility has the meaning given by clause 5.2.1.

concessional beneficiary has the meaning given by clause 3.2.1.

contribute to a multidisciplinary care plan, for items 729 and 731, has the meaning given by clause 2.16.3.

coordinating, for item 880, has the meaning given by clause 2.16.17.

coordinating a review of team care arrangements, for item 732, has the meaning given by clause 2.16.5.

coordinating the development of team care arrangements, for item 723, has the meaning given by clause 2.16.4.

Clause 7.1.1

designated area has the meaning given by clause 3.2.1.

eating disorder treatment and management plan means a plan prepared in accordance with clause 2.31.3, including any modifications to the plan made in accordance with clause 2.31.4.

ECG means electrocardiogram.

EEG means electroencephalogram.

eligible allied health provider means any of the following:

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

eligible disability has the meaning given by clause 2.6.1.

eligible non-vocationally recognised medical practitioner has the meaning given by clause 1.1.2.

eligible stroke centre has the meaning given by clause 5.10.15.

embryology laboratory services has the meaning given by clause 5.2.2.

EMG means electromyogram.

EOG means electrooculogram.

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 5.10.10.

general intensive care unit means an area within a hospital 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 a meaning affected by clause 1.1.3.

GP management plan, for item 10997, has the meaning given by clause 3.1.1.

gravely ill patient lacking current goals of care means a patient to whom all of the following apply:

(a) the patient either:
  (i) is suffering a life-threatening acute illness or injury; or
  (ii) is suffering acute illness or injury and, apart from the illness or injury, has a high risk of dying within 12 months;
(b) one or more alternatives to management of the illness or injury are clinically appropriate for the patient;
(c) either:
  (i) there is not a record of goals of care for the patient that can readily be retrieved by providers of health care for the patient and that identifies interventions that should, or should not, be made in care of the patient; or
  (ii) there is such a record but it is reasonable to expect that, due to changes in the patient's condition, the goals recorded will change substantially.

Group A1 disqualified general practitioner means a general practitioner:

(a) who is partly disqualified under an agreement that is in effect under section 92 of the Act in respect of a service to which an item in Group A1 applies; or
(b) in relation to whom a final determination under section 106TA of the Act containing a direction under paragraph 106U(1)(g) that the practitioner be partly disqualified is in effect in respect of a service to which an item in Group A1 applies.

(H) has the meaning given by clause 1.1.7.

immunisation means the administration of a registered vaccine to a person for any purpose other than as part of a mass immunisation of persons.

intensive care unit means a general intensive care unit or a neo-natal intensive care unit.

living in a community setting, for item 900, has the meaning given by clause 2.17.1.

maxilla:

(a) for items 45720 to 45752—has the meaning given by clause 5.10.22; and
(b) for items 52342 to 52375—has the meaning given by clause 6.5.1.

mental disorder has the meaning given by clause 2.20.1.

mental health skills training means training of that name 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.

Clause 7.1.1

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.

Modified Monash 2 area means a Statistical Area Level 1 under the ASGS that:

(a) is categorised under the ASGS as RA 1 (Inner Regional Australia) or RA 2 (Outer Regional Australia); and

(b) satisfies any of the following criteria:

(i) the area is in an Urban Centre and Locality with a 2013 estimated resident population of more than 50,000;

(ii) the area is in an Urban Centre and Locality, the geographic centre of which is no more than 20 km road distance from the boundary of another Urban Centre and Locality with a 2013 estimated resident population of more than 50,000;

(iii) the area is not in an Urban Centre and Locality, but the geographic centre of the area is no more than 20 km road distance from the boundary of an Urban Centre and Locality with a 2013 estimated resident population of more than 50,000; and

(c) is not a Modified Monash 7 area.

Modified Monash 3 area means a Statistical Area Level 1 under the ASGS that:

(a) is categorised under the ASGS as RA 1 (Inner Regional Australia) or RA 2 (Outer Regional Australia); and

(b) satisfies any of the following criteria:

(i) the area is in an Urban Centre and Locality with a 2013 estimated resident population of more than 15,000 but no more than 50,000;

(ii) the area is in an Urban Centre and Locality, the geographic centre of which is no more than 15 km road distance from the boundary of another Urban Centre and Locality with a 2013 estimated resident population of more than 15,000 but no more than 50,000;

(iii) the area is not in an Urban Centre and Locality, but the geographic centre of the area is no more than 15 km road distance from the boundary of an Urban Centre and Locality with a 2013 estimated resident population of more than 15,000 but no more than 50,000; and

(c) is not a Modified Monash 2 area or Modified Monash 7 area.

Modified Monash 4 area means a Statistical Area Level 1 under the ASGS that:

(a) is categorised under the ASGS as RA 1 (Inner Regional Australia) or RA 2 (Outer Regional Australia); and

(b) satisfies any of the following criteria:

(i) the area is in an Urban Centre and Locality with a 2013 estimated resident population of at least 5,000 but no more than 15,000;

(ii) the area is in an Urban Centre and Locality, the geographic centre of which is no more than 10 km road distance from the boundary of

another Urban Centre and Locality with a 2013 estimated resident population of at least 5,000 but no more than 15,000;

(iii) the area is not in an Urban Centre and Locality, but the geographic centre of the area is no more than 10 km road distance from the boundary of an Urban Centre and Locality with a 2013 estimated resident population of at least 5,000 but no more than 15,000; and

(c) is not a Modified Monash 2 area, Modified Monash 3 area or Modified Monash 7 area.

Modified Monash 5 area means a Statistical Area Level 1 under the ASGS that:

(a) is categorised under the ASGS as RA 1 (Inner Regional Australia) or RA 2 (Outer Regional Australia); and

(b) is not a Modified Monash 2 area, Modified Monash 3 area, Modified Monash 4 area or Modified Monash 7 area.

Modified Monash 6 area means a Statistical Area Level 1 under the ASGS that:

(a) is categorised under the ASGS as RA 3 (Remote Australia); and

(b) is not a Modified Monash 7 area.

Modified Monash 7 area means a Statistical Area Level 1 under the ASGS that:

(a) is entirely located on an island or islands more than 5 km from the Australian mainland or Tasmania, as measured between coastlines at the low water mark; or

(b) is located on Magnetic Island; or

(c) is categorised under the ASGS as RA 4 (Very Remote Australia).

motion segment has the meaning given by clause 5.10.29.

multidisciplinary care plan:

(a) for items 729 and 731—has the meaning given by clause 2.16.6; and

(b) for item 10997—has the meaning given by clause 3.1.1.

multidisciplinary case conference has the meaning given by clause 1.1.4.

multidisciplinary case conference team has the meaning given by clause 1.1.5.

multidisciplinary discharge case conference, for items 735, 739, 743, 747, 750 and 758, has the meaning given by clause 2.16.14.

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 phosphatise;
(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;
(p) extracorporeal magnetic innervation.

NOSE Scale has the meaning given by clause 5.10.21.

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 2.16.15; and
(b) for items mentioned in Subgroups 2 and 4 of Group A24—has the meaning given by clause 2.21.1; and
(c) for items 6029 to 6042—has the meaning given by clause 2.27.1; and
(d) for items 6064 to 6075—has the meaning given by clause 2.28.1.

outcome measurement tool 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 2.16.16; 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; and

(c) for items 6035 to 6042—has the meaning given by clause 2.27.2; and

(d) for items 6071 to 6075—has the meaning given by clause 2.28.2.

participating in a video conferencing consultation: a medical practitioner is ***participating in a video conferencing consultation*** if:

(a) the medical practitioner attends a patient who is receiving a service under an item in this Schedule from a specialist or consultant physician; and

(b) the specialist or consultant physician is providing the service:

(i) in relation to the specialist's or consultant physician's speciality to the patient; and

(ii) by way of a video conferencing consultation.

patient's medical condition requires urgent assessment has the meaning given by clause 2.14.1.

patient's usual general practitioner means a general 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 3.1.1.

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

practice location, 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.

practice midwife has the meaning given by clause 5.5.2.

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.

Clause 7.1.1

preparation of goals of care for a patient, by a medical practitioner, means the carrying out of all of the following activities by the practitioner:

(a) comprehensively evaluating the patient's medical, physical, psychological and social issues;

(b) identifying major issues that require goals of care for the patient to be set;

(c) assessing the patient's capacity to make decisions about goals of care for the patient;

(d) discussing care of the patient with the patient, or a person (the ***surrogate***) who can make decisions on the patient's behalf about care for the patient, and as appropriate with any of the following:

(i) members of the patient's family;

(ii) other persons who provide care for the patient;

(iii) other health practitioners;

(e) offering in that discussion reasonable options for care of the patient, including alternatives to intensive or escalated care;

(f) agreeing with the patient or the surrogate on goals of care for the patient that address all major issues identified;

(g) recording the agreed goals so that:

(i) the record can be readily retrieved by other providers of health care for the patient; and

(ii) interventions that should, or should not, be made in care of the patient are identified.

preparing a GP management plan, for item 721, has the meaning given by clause 2.16.7.

qualified adult sleep medicine practitioner has the meaning given by clause 4.1.2.

qualified medical acupuncturist has the meaning given by clause 2.10.1.

qualified paediatric sleep medicine practitioner has the meaning given by clause 4.1.2.

qualified sleep medicine practitioner has the meaning given by clause 4.1.2.

RACP Advisory Committee has the meaning given by clause 4.1.2.

RACP Appeal Committee has the meaning given by clause 4.1.2.

RACP Credentialling Subcommittee has the meaning given by clause 4.1.2.

radiation oncology treatment verification means a quality assurance procedure:

(a) that is designed to facilitate accurate and reproducible delivery of radiation therapy to a site or region of the body as specified in a treatment prescription or a dose plan generated from a treatment prescription; and

(b) that utilises the capture and assessment of appropriate images using any of the following:

(i) x-rays;

(ii) computed tomography;

(iii) ultrasound, if the ultrasound equipment is capable of producing images in 3 dimensions; and

(c) that includes making a record of the assessment and correcting any significant treatment delivery inaccuracies detected.

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.

referring practitioner, in relation to a referral, means the person making the referral.

Note: Division 4 of Part 11 of the *Health Insurance Regulations 2018* prescribes the manner in which patients are to be referred when an item in this Schedule specifies a service that is to be rendered by a specialist or consultant physician to a patient who has been referred.

regional, rural or remote area means either of the following:

(a) an area classified as RRMAs 3-7 under the Rural, Remote and Metropolitan Areas Classification;

(b) Norfolk Island.

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*, as existing on 1 July 2020.

report, for Division 4.1, has the meaning given by clause 4.1.1.

residential aged care facility means a facility where residential care (as defined in section 41-3 of the *Aged Care Act 1997*) is provided.

residential medication management review, for item 903, has the meaning given by clause 2.17.2.

reviewing a GP management plan, for item 732, has the meaning given by clause 2.16.8.

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 2.6.2; and

(b) for item 289—has the meaning given by clause 2.11.4.

Rural, Remote and Metropolitan Areas Classification means the document so titled, as existing on 1 July 2020, setting out certain categories of areas in Australia that have been determined by the Department by reference to population size and remoteness of locality on the basis of 1991 census data published by the Australian Bureau of Statistics in 1994.

service time has the meaning given by clause 5.9.3.

single course of treatment has the meaning given by clause 1.1.6.

SLA has the meaning given by clause 3.2.1**.**

Clause 7.1.1

SSD has the meaning given by clause 3.2.1.

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, identified as such on the Department's website on 1 July 2020.

Note: Maps showing telehealth eligible areas could in 2021 be viewed on the Department's website (http://www.health.gov.au).

treatment cycle, in relation to assisted reproductive services, has the meaning given by clause 5.2.3.

unreferred service has the meaning given by clause 3.2.1.

unsociable hours means the period starting at 11 pm on a day and ending at 7 am on the next day.

Urban Centre and Locality means an area defined as an Urban Centre and Locality under the ASGS.

Schedule 2—Repeals

Health Insurance (General Medical Services Table) Regulations (No. 2) 2020

1 The whole of this instrument

Repeal the instrument.