Health Insurance (General Medical Services Table) Regulations 2021

made under the

Health Insurance Act 1973

Compilation No. 15

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About this compilation

This compilation

This is a compilation of the *Health Insurance (General Medical Services Table) Regulations 2021* that shows the text of the law as amended and in force on 1 March 2024 (the ***compilation date***).

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

Uncommenced amendments

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

Application, saving and transitional provisions for provisions and amendments

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

Editorial changes

For more information about any editorial changes made in this compilation, see the endnotes.

Modifications

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

Self-repealing provisions

If a provision of the compiled law has been repealed in accordance with a provision of the law, details are included in the endnotes.

Contents

1 Name

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

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.

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:

(i) who is registered under the MedicarePlus for Other Medical Practitioners Program; and

(ii) who successfully completed the requirements of that Program, as evidenced by written advice from the Chief Executive Medicare; or

Note: The MedicarePlus for Other Medical Practitioners Program will cease on 31 December 2023.

(b) a medical practitioner who:

(i) as at 30 June 2023, was registered under:

(A) the After Hours Other Medical Practitioners Program; or

(B) the Outer Metropolitan (Other Medical Practitioners) Relocation Incentive Program; or

(C) the Rural Other Medical Practitioners' Program; and

(ii) is registered under, and providing general medical services in accordance with, the Other Medical Practitioners Extension Program; or

(c) a medical practitioner:

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

(ii) providing general medical services in accordance with that Program.

Note: The MedicarePlus for Other Medical Practitioners Program will cease on 31 December 2023.

(2) In subclause (1):

After Hours Other Medical Practitioners Program means the program by that name that, before 1 July 2023, was administered by the Chief Executive Medicare.

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

Other Medical Practitioners Extension Program means the program by that name 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 the program by that name that, before 1 July 2023, was administered by the Chief Executive Medicare.

Rural Other Medical Practitioners' Program means the program by that name that, before 1 July 2023, was administered by the Chief Executive Medicare.

Note 1: The After Hours Other Medical Practitioners Program, the Outer Metropolitan (Other Medical Practitioners) Relocation Incentive Program and the Rural Other Medical Practitioners' Program ceased on 30 June 2023.

Note 2: The MedicarePlus for Other Medical Practitioners Program will cease on 31 December 2023.

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*.

Clause 1.1.4

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 235, 236, 237, 238, 239, 240, 735 to 758, 825 to 828, 930, 933, 935, 937, 943, 945, 946, 948, 959, 961, 962, 964, 969, 971, 972, 973, 975, 986, 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 133, 385 to 388, 2801 to 2840, 3005 to 3028, 6007 to 6015, 6018, 6019, 6024, 6051, 6052, 6058, 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.

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

(1) Use this clause for items 104 to 111, 115 to 137, 141 to 147, 289 to 388, 2801 to 2840, 3005 to 3028, 6007 to 6015, 6018 to 6028, 6051 to 6063, 16401, 16404, 16407, 16408, 16508, 16509, 16533, 16534, 17640 to 17655, 90260, 90261, 90266 and 90267.

(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, 105 and 151.

(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.

(3) The item also does not apply to an attendance on a patient if the attendance is in association with a service to which an item in Group I5 of the diagnostic imaging services table applies, unless the practitioner providing the service considers the attendance is necessary for the management or treatment of the patient.

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, 16404, 91823, 91825, 91826, 91833, 91836, 92611, 92612, 92613 and 92618.

Note: Some of these items are specified in determinations made under subsection 3C(1) of the Act.

(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 $330.20 or more.

1.2.5 Professional attendance services—matters included

(1) Use this clause for items 3 to 338, 348 to 388, 410 to 417, 585 to 600, 733, 737, 741, 745, 761, 763, 766, 769, 772, 776, 788, 789, 792, 900, 903, 969, 971, 972, 973, 975, 986, 2497 to 2840, 3005 to 3028, 5000 to 5267, 6007 to 6015, 6018 to 6024, 6051 to 6063, 13899, 16401, 16404, 16406, 16407, 16508, 16509, 16533, 16534, 17610 to 17690, 90020 to 90096, 90098, 90183, 90188, 90202, 90212, 90215 and 90250 to 90278.

(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, 123, 124, 151, 165, 179, 181, 185, 187, 189, 191, 203, 206, 301, 303, 5000 to 5267 and 90020 to 90098; 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 147, 151, 165, 177, 179, 181, 185, 187, 189, 191, 193 to 338, 348 to 417, 585 to 600, 733, 737, 741, 745, 761, 763, 766, 769, 772, 776, 788, 789, 792, 2497 to 2840, 3005 to 3028, 35570, 35571, 35573, 35577, 35581, 35582, 35585, 4001 to 6015, 6018 to 6024, 6051 to 6058, 6062, 6063, 10801 to 10816, 11012 to 11021, 11304, 11600, 11627, 11705, 11724, 11731, 12000 to 12004, 12201, 13030 to 13104, 13106 to 13110, 13209, 13290 to 13700, 13815 to 13899, 14100 to 14124, 14203 to 14212, 14216, 14219, 14224, 14255 to 14288, 15600, 16003 to 16512, 16515 to 51318, 90020 to 90096, 90098, 90183, 90188, 90202, 90212, 90215 and 90250 to 90278.

(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) the planning, management and supervision of the patient on home dialysis to which item 13104 applies;
(b) participating in a video conferencing consultation referred to in item 294.

1.2.7 Personal attendance by medical practitioners—application and matters included

(1) Use this clause for items 3 to 230, 233, 245 to 723, 732, 733, 737, 741, 745, 761, 763, 766, 769, 772, 776, 788, 789, 792, 900, 903, 2700 to 6015, 6018 to 6024, 6028, 6051 to 6058, 6062, 6063, 10801 to 10816, 11012 to 11021, 11304, 11600, 11627, 11705, 11724, 11728, 11731, 11820, 11823, 12000, 12003, 12004, 12201, 13030 to 13104, 13106 to 13110, 13209, 13290 to 13700, 13815 to 13899, 14100 to 14124, 14203 to 14212, 14216, 14219, 14224, 14255 to 14288, 15600, 16003 to 16512, 16515 to 51318, 90020 to 90096, 90098, 90183, 90188, 90202, 90212, 90215 and 90250 to 90278.

(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) the planning, management and supervision of the patient on home dialysis to which item 13104 applies;
  (b) participating in a video conferencing consultation referred to in item 294.

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

Items 3 to 10816, 90020 to 90096, 90098, 90183, 90188, 90202, 90212, 90215 and 90250 to 90278 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, 11302, 11303, 11306, 11309, 11312, 11315, 11318, 11324, 11332, 11340, 11341, 11342, 11343, 11345, 11503, 11505, 11506, 11507, 11508, 11512, 11602, 11604, 11605, 11607, 11610, 11611, 11612, 11614, 11615, 11704, 11707, 11713, 11714, 11716, 11717, 11721, 11723, 11725, 11726, 11727, 11729, 11730, 11732, 11735, 11800, 11810, 11830, 11833, 11900, 11912, 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, 13212, 13215, 13218, 13221, 13703, 13706, 13750, 13755, 13757, 13760, 14050, 14217, 14218, 14220, 14221, 15000 to 15336, 15339 to 15357, 15500 to 15539, 16514 and 41764.

(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, consultant physician or medical practitioner to a patient on a day if an electrocardiogram service to which item 11716, 11717, 11723, 11729, 11732 or 11735 applies is provided by the specialist, consultant physician or medical practitioner to the patient on the same day.

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

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.

Division 1.3—Indexation of fees

1.3.1 Indexation—1 November 2023

(1) At the start of 1 November 2023 (the ***indexation time***), each amount covered by subclause (2) is replaced by the amount worked out using the following formula:

1.005 × the amount of the fee immediately before the indexation time

Note: The indexed fees could in 2023 be viewed on the Department's MBS Online website (http://www.health.gov.au).

(2) The amounts covered by this subclause are the fee for each item in a Group in this Schedule, other than the fee for the following:
- (a) an item in Group A2;
- (b) an item in Group A7 (other than items 193, 197 and 199);
- (c) an item in Group A23;
- (d) items 90092, 90093, 90095, 90096, 90098, 90183, 90188, 90202, 90212 and 90215 in Group A35;
- (e) items 90254, 90255, 90256, 90257, 90265, 90275 and 90277 in Group A36;
- (f) an item in Group T10.

(3) To avoid doubt, a fee listed in any of the following items is not indexed under subclause (1):
- (a) items in a Group that list the fee as a percentage of a fee listed in another item in the Group;
- (b) items in a Group that list the fee as an amount under a specified clause in this Schedule;
- (c) a table item of the following tables:
  - (i) table 2.1.1;
  - (ii) table 2.1.2;
  - (iii) table 2.20.2;
  - (iv) table 2.20.2A;
  - (v) table 5.3.1.

(4) An amount worked out under subclause (1) is to be rounded up or down to the nearest 5 cents (rounding down if the amount is an exact multiple of 2.5 cents).

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	29.00	2.30
2	24	The fee for item 23	29.00	2.30
3	37	The fee for item 36	29.00	2.30
4	47	The fee for item 44	29.00	2.30
5	58	$8.50	15.50	0.70
6	59	$16.00	17.50	0.70
7	60	$35.50	15.50	0.70
8	65	$57.50	15.50	0.70
9	124	The fee for item 123	29.00	2.30
10	165	$88.20	15.50	0.70
11	195	The fee for item 193	28.60	2.25
12	414	The fee for item 410	28.50	2.25
13	415	The fee for item 411	28.50	2.25
14	416	The fee for item 412	28.50	2.25
15	417	The fee for item 413	28.50	2.25
16	5003	The fee for item 5000	28.60	2.25
17	5010	The fee for item 5000	51.45	3.65

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) ($)	Column 4 Amount if more than 6 patients ($)
18	5023	The fee for item 5020	28.60	2.25
19	5028	The fee for item 5020	51.45	3.65
20	5043	The fee for item 5040	28.60	2.25
21	5049	The fee for item 5040	51.45	3.65
22	5063	The fee for item 5060	28.60	2.25
23	5067	The fee for item 5060	51.45	3.65
24	5076	The fee for item 5071	28.60	2.25
25	5077	The fee for item 5071	51.45	3.65
26	5220	$18.50	15.50	0.70
27	5223	$26.00	17.50	0.70
28	5227	$45.50	15.50	0.70
29	5228	$67.50	15.50	0.70
30	5260	$18.50	27.95	1.25
31	5261	$112.20	15.50	0.70
32	5262	$112.20	27.95	1.25
33	5263	$26.00	31.55	1.25
34	5265	$45.50	27.95	1.25
35	5267	$67.50	27.95	1.25
36	90272	The fee for item 90271	28.60	2.25
37	90274	The fee for item 90273	28.60	2.25
38	90276	The fee for item 90275	22.85	1.80
39	90278	The fee for item 90277	22.85	1.80

2.1.2 Meaning of amount under clause 2.1.2

In an item of this Schedule mentioned in column 1 of table 2.1.2:

amount under clause 2.1.2 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 2.1.2—Amount under clause 2.1.2

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	181	The fee for item 179	23.20	1.85
2	187	The fee for item 185	23.20	1.85
3	191	The fee for item 189	23.20	1.85
4	206	The fee for item 203	23.20	1.85
5	303	The fee for item 301	23.20	1.85

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.

Note: The fees in Group A1 are indexed in accordance with clause 1.3.1.

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 at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan;	39.10

Clause 2.2.1

Group A1—General practitioner attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	
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 at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one place on one occasion—each patient	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 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	Amount under 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;	111.50

Group A1—General practitioner 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	
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
123	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 60 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation	191.20
124	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 60 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation— an attendance on one or more patients at one place on one occasion—each patient	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.

Group A2—Other non-referred attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 1—Other medical practitioner attendances		
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, but not more than 60 minutes (other than a service to which any other item applies) by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	61.00
151	Professional attendance at consulting rooms lasting more than 60 minutes (other than a service to which any other item applies) by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	98.40
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:	Amount under clause 2.1.1

Group A2—Other non-referred attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	
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, but not more than 60 minutes—an attendance on one or more patients at one place on one occasion—each patient, by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	Amount under clause 2.1.1
165	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 60 minutes—an attendance on one or more patients at one place on one occasion—each patient, by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	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.

Note: The fees in Group A3 are indexed in accordance with clause 1.3.1.

Group A3—Specialist attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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	45.40

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 consulting rooms or hospital, other than a service to which item 16404 applies	
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 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	83.95
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 $330.20 or more For any particular patient, once only on the same day	45.40
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	45.40

Group A3—Specialist attendances to which no other item applies		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	single course of treatment, if: (a) the attending practitioner performs a scheduled operation on the patient on the same day; and (b) the operation is a service to which an item in Group T8 applies; and (c) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $330.20 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.

Note: The fees in Group A4 are indexed in accordance with clause 1.3.1.

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
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	79.75

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 ($)**
	(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 $330.20 or more For any particular patient, once only on the same day	
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 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 $330.20 or more For any particular patient, once only on the same day	45.40
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	278.75

Group A4—Consultant physician (other than psychiatry) attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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 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	139.55

Clause 2.6.1

Group A4—Consultant physician (other than psychiatry) attendances to which no other item applies		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(f) this item has not applied more than twice in any 12 month period	

Division 2.6—Group A29: Attendance services for complex neurodevelopmental 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;

(q) fetal alcohol spectrum disorder;

(r) Lesch-Nyhan syndrome;

(s) 22q deletion syndrome.

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.

Note: The fees in Group A29 are indexed in accordance with clause 1.3.1.

Group A29—Attendance services for complex neurodevelopmental disorder or disability

Column 1 Item	Column 2 Description	Column 3 Fee ($)
135	Professional attendance lasting at least 45 minutes by a consultant physician in the practice of the consultant physician's specialty of paediatrics, following referral of the patient to the consultant paediatrician by a referring practitioner, for a patient aged under 25, if the consultant paediatrician: (a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of a complex neurodevelopmental disorder (such as autism spectrum disorder) is made (if appropriate, using information provided by an eligible allied health provider); and (b) develops a treatment and management plan, which must include: (i) documentation of the confirmed diagnosis; and (ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and (iii) a risk assessment; and (iv) treatment options (which may include biopsychosocial recommendations); and (c) provides a copy of the treatment and management plan to: (i) the referring practitioner; and (ii) one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 137, 139, 289, 92140, 92141, 92142 or 92434) Applicable only once per lifetime	278.75
137	Professional attendance lasting at least 45 minutes by a specialist or consultant physician (not including a general practitioner), following referral of the patient to the specialist or consultant physician by a referring practitioner, for a patient aged under 25, if the specialist or consultant physician:	278.75

Clause 2.6.3

Group A29—Attendance services for complex neurodevelopmental disorder or disability		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of an eligible disability is made (if appropriate, using information provided by an eligible allied health provider); and (b) develops a treatment and management plan, which must include: (i) documentation of the confirmed diagnosis; and (ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and (iii) a risk assessment; and (iv) treatment options (which may include biopsychosocial recommendations); and (c) provides a copy of the treatment and management plan to: (i) the referring practitioner; and (ii) one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 139, 289, 92140, 92141, 92142 or 92434) Applicable only once per lifetime	
139	Professional attendance lasting at least 45 minutes, at a place other than a hospital, by a general practitioner (not including a specialist or consultant physician), for a patient aged under 25, if the general practitioner: (a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of an eligible disability is made (if appropriate, using information provided by an eligible allied health provider); and (b) develops a treatment and management plan, which must include: (i) documentation of the confirmed diagnosis; and (ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and (iii) a risk assessment; and (iv) treatment options (which may include biopsychosocial recommendations); and (c) provides a copy of the treatment and management plan to one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 137, 289, 92140, 92141, 92142 or 92434) Applicable only once per lifetime	139.95

Division 2.7—Group A28: Geriatric medicine

2.7.1 Items in Group A28

This clause sets out items in Group A28.

Note: The fees in Group A28 are indexed in accordance with clause 1.3.1.

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; 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	478.05
143	Professional attendance lasting more than 30 minutes at consulting	298.85

Clause 2.7.1

Group A28—Geriatric medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
145	Professional attendance lasting more than 60 minutes at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine, if: (a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and (c) during the attendance: (i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail utilising appropriately validated assessment tools if indicated (the ***assessment***); and (ii) the patient's various health problems and care needs are identified and prioritised (the ***formulation***); and (iii) a detailed management plan is prepared (the ***management plan***) setting out: (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	579.65

Group A28—Geriatric medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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

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.

Note: The fees in Group A5 are indexed in accordance with clause 1.3.1.

Group A5—Prolonged attendances to which no other item applies

Column 1 Item	Column 2 Description	Column 3 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 patient in imminent danger of death	537.55
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.

Note: The fees in Group A6 are indexed in accordance with clause 1.3.1.

Group A6—Group therapy

Column 1 Item	Column 2 Description	Column 3 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

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

Note 1: Various restrictions, limitations and other requirements apply to items in Subgroups 5, 6, 7, 9 and 11 of Group A7. The restrictions, limitations and other requirements are set out in the following Divisions:

(a) for items in Subgroup 5—Division 2.15;
(b) for items in Subgroup 6—Division 2.16;
(c) for items in Subgroup 7—Division 2.17;
(d) for items in Subgroup 9—Division 2.20;
(e) for items in Subgroup 11—Division 2.22.

Note 2: A number of expressions used in Subgroups 6, 7 and 9 of Group A7 are defined in Divisions 2.16, 2.17 and 2.20, including the following:

(a) contribute to a multidisciplinary care plan (see clause 2.16.3);
(b) coordinating a review of team care arrangements (see clause 2.16.5);
(c) multidisciplinary care plan (see clause 2.16.6);
(d) organise and coordinate (see clause 2.16.15);
(e) participate (see clause 2.16.16);
(f) preparing a GP management plan (see clause 2.16.7);
(g) residential medication management review (see clause 2.17.2);
(h) review of a GP mental health treatment plan (see clause 2.20.4).

Clause 2.10.1

2.10.1 Restriction on treatment time

For the purposes of items 193 to 199, treatment time for a medical practitioner does not include the period:

(a) commencing immediately after the practitioner has completed applying all acupuncture stimuli on or through a patient's skin; and

(b) ending immediately before the practitioner begins to remove the acupuncture stimuli from the patient;

unless the practitioner personally attends the patient during that period for a consultation related to the condition for which the acupuncture was performed or another consultation.

2.10.1A Application of items 214 to 220

(1) Items 214 to 220 apply only to a service provided in the course of a personal attendance by one or more prescribed medical practitioners on a single patient on a single occasion.

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

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

2.10.2 Items in Group A7

This clause sets out items in Group A7.

Note: The fees in items 193, 197 and 199 of Group A7 are indexed in accordance with clause 1.3.1.

Group A7—Acupuncture and non-specialist practitioner items		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 1—Acupuncture		
193	Professional attendance by a medical practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia as an acupuncturist, at a place other than a hospital, for treatment lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation,	38.55

Group A7—Acupuncture and non-specialist practitioner items		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	at which acupuncture is performed by the medical practitioner by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	
195	Professional attendance by a medical practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia as an acupuncturist, on one or more patients at a hospital, for treatment lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the medical practitioner by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	Amount under clause 2.1.1
197	Professional attendance by a medical practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia as an acupuncturist, at a place other than a hospital, for treatment lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the medical practitioner by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	74.60
199	Professional attendance by a medical practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia as an acupuncturist, at a place other than a hospital, for treatment lasting at least 40 minutes and including any of the	109.85

Group A7—Acupuncture and non-specialist practitioner items		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the medical practitioner by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	
Subgroup 2—Prescribed medical practitioner attendance to which no other item applies		
179	Professional attendance at consulting rooms lasting not more than 5 minutes (other than a service to which any other item applies) by a prescribed medical practitioner in an eligible area—each attendance	15.15
181	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item applies) lasting not more than 5 minutes—an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area—each patient	Amount under clause 2.1.2
185	Professional attendance at consulting rooms lasting more than 5 minutes but not more than 25 minutes (other than a service to which any other item applies) by a prescribed medical practitioner in an eligible area—each attendance	33.10
187	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item applies) lasting more than 5 minutes but not more than 25 minutes—an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area—each patient	Amount under clause 2.1.2
189	Professional attendance at consulting rooms lasting more than 25 minutes but not more than 45 minutes (other than a service to which any other applies) by a prescribed medical practitioner in an eligible area—each attendance	64.10
191	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item applies) lasting more than 25 minutes but not more than 45 minutes—an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area—each patient	Amount under clause 2.1.2
203	Professional attendance at consulting rooms lasting more than 45 minutes but not more than 60 minutes (other than a service to which any other item applies) by a prescribed medical practitioner in an eligible area—each attendance	94.40
206	Professional attendance (other than an attendance at consulting rooms	Amount under

Group A7—Acupuncture and non-specialist practitioner items		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	or a residential aged care facility or a service to which any other item applies) lasting more than 45 minutes but not more than 60 minutes—an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area—each patient	clause 2.1.2
301	Professional attendance at consulting rooms lasting more than 60 minutes (other than a service to which any other item in this Schedule applies) by a prescribed medical practitioner in an eligible area—each attendance	152.95
303	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item applies) lasting more than 60 minutes—an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area—each patient	Amount under clause 2.1.2
Subgroup 3—Prescribed medical practitioner prolonged attendances to which no other item applies		
214	Professional attendance by a prescribed medical practitioner for a period of not less than one hour but less than 2 hours (other than a service to which another item applies) on a patient in imminent danger of death	195.10
215	Professional attendance by a prescribed medical practitioner for a period of not less than 2 hours but less than 3 hours (other than a service to which another item applies) on a patient in imminent danger of death	325.10
218	Professional attendance by a prescribed medical practitioner for a period of not less than 3 hours but less than 4 hours (other than a service to which another item applies) on a patient in imminent danger of death	454.90
219	Professional attendance by a prescribed medical practitioner for a period of not less than 4 hours but less than 5 hours (other than a service to which another item applies) on a patient in imminent danger of death	585.20
220	Professional attendance by a prescribed medical practitioner for a period of 5 hours or more (other than a service to which another item applies) on a patient in imminent danger of death	650.20
Subgroup 4—Prescribed medical practitioner group therapy		
221	Professional attendance for the purpose of Group therapy lasting at least one hour given under the direct continuous supervision of a prescribed medical practitioner, involving members of a family and persons with close personal relationships with that family—each Group of 2 patients	103.50
222	Professional attendance for the purpose of Group therapy lasting at least one hour given under the direct continuous supervision of a prescribed medical practitioner, involving members of a family and persons with close personal relationships with that family—each	109.10

Clause 2.10.2

Group A7—Acupuncture and non-specialist practitioner items		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	Group of 3 patients	
223	Professional attendance for the purpose of Group therapy lasting at least one hour given under the direct continuous supervision of a prescribed medical practitioner, involving members of a family and persons with close personal relationships with that family—each Group of 4 or more patients	132.70
Subgroup 5—Prescribed medical practitioner health assessments		
224	Professional attendance by a prescribed medical practitioner to perform a brief health assessment, lasting not more than 30 minutes and including: (a) collection of relevant information, including taking a patient history; and (b) a basic physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing the patient with preventive health care advice and information	52.25
225	Professional attendance by a prescribed medical practitioner to perform a standard health assessment, lasting more than 30 minutes but less than 45 minutes, including: (a) detailed information collection, including taking a patient history; and (b) an extensive physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing a preventive health care strategy for the patient	121.45
226	Professional attendance by a prescribed medical practitioner to perform a long health assessment, lasting at least 45 minutes but less than 60 minutes, including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition and physical function; and (c) initiating interventions and referrals as indicated; and (d) providing a basic preventive health care management plan for the patient	167.55
227	Professional attendance by a prescribed medical practitioner to perform a prolonged health assessment, lasting at least 60 minutes, including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition, and physical, psychological and social function; and (c) initiating interventions and referrals as indicated; and (d) providing a comprehensive preventive health care management	236.70

Group A7—Acupuncture and non-specialist practitioner items		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	plan for the patient	
228	Professional attendance by a prescribed medical practitioner at consulting rooms or in a place other than a hospital or a residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent—applicable not more than once in a 9 month period and only if the following items are not applicable within the same 9 month period: (a) item 715; (b) item 92004 or 92011 of the Telehealth and Telephone Determination	186.90
Subgroup 6—Prescribed medical practitioner management plans, team care arrangements and multidisciplinary care plans and case conferences		
229	Attendance by a prescribed medical practitioner, for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 235 to 240 and 735 to 758 apply)	127.05
230	Attendance by a prescribed medical practitioner, to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 235 to 240 and 735 to 758 apply)	100.70
231	Either: (a) contribution to a multidisciplinary care plan, for a patient, prepared by another provider; or (b) contribution to a review of a multidisciplinary care plan, for a patient, prepared by another provider; by a prescribed medical practitioner, other than a service associated with a service to which any of items 235 to 240 and 735 to 758 apply	62.00
232	Either: (a) contribution to a multidisciplinary care plan, for a patient in a residential aged care facility, prepared by that facility, or contribution to a review of a multidisciplinary care plan, for a patient, prepared by such a facility; or (b) contribution to a multidisciplinary care plan, for a patient, prepared by another provider before the patient is discharged from a hospital or contribution to a review of a multidisciplinary care plan, for a patient, prepared by another provider; by a prescribed medical practitioner, other than a service associated with a service to which any of items 235 to 240 and 735 to 758 apply	62.00
233	Attendance by a prescribed medical practitioner: (a) to review a GP management plan prepared by a medical practitioner (or an associated medical practitioner); or (b) to coordinate a review of team care arrangements which have been coordinated by the medical practitioner (or the associated medical practitioner)	63.45

Clause 2.10.2

Group A7—Acupuncture and non-specialist practitioner items		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
235	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes but less than 20 minutes, other than a service associated with a service to which any of items 229 to 233 and 721 to 732 apply	62.30
236	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes but less than 40 minutes, other than a service associated with a service to which any of items 229 to 233 and 721 to 732 apply	106.50
237	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts at least 40 minutes, other than a service associated with a service to which any of items 229 to 233 and 721 to 732 apply	177.50
238	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes but less than 20 minutes, other than a service associated with a service to which any of items 229 to 233 and 721 to 732 apply	45.75
239	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or	78.40

Group A7—Acupuncture and non-specialist practitioner items		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes but less than 40 minutes, other than a service associated with a service to any of items 229 to 233 and 721 to 732 apply	
240	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential 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 any of items 229 to 233 and 721 to 732 apply	130.50
243	Attendance by a prescribed medical practitioner, as a member of a case conference team, to lead and coordinate a multidisciplinary case conference on a patient with cancer, to develop a multidisciplinary treatment plan, if the case conference lasts at least 10 minutes, with a multidisciplinary team of at least 3 other medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers	61.00
244	Attendance by a prescribed medical practitioner, as a member of a case conference team, to participate in a multidisciplinary case conference on a patient with cancer, to develop a multidisciplinary treatment plan, if the case conference lasts 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	28.45
969	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference if the conference lasts for at least 15 minutes, but for less than 20 minutes	62.30
971	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference if the conference lasts for at least 20 minutes, but for less than 40 minutes	106.50
972	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference if the conference lasts for at least 40 minutes	177.55
973	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference if the conference lasts for at least 15 minutes, but for less than 20 minutes	45.75
975	Attendance by a prescribed medical practitioner, as a member of a	78.40

Group A7—Acupuncture and non-specialist practitioner items		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	multidisciplinary case conference team, to participate in a mental health case conference if the conference lasts for at least 20 minutes, but for less than 40 minutes	
986	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference if the conference lasts for at least 40 minutes	130.50
Subgroup 7—Prescribed medical practitioner domiciliary and residential medication management review		
245	Participation by a prescribed medical practitioner in a Domiciliary Medication Management Review (***DMMR***) for a patient living in a community setting, in which the prescribed medical practitioner, with the patient's consent: (a) assesses the patient as: (i) having a chronic medical condition or a complex medication regimen; and (ii) not having the patient's therapeutic goals met; and (b) following that assessment: (i) refers the patient to a community pharmacy or an accredited pharmacist for the DMMR; and (ii) provides relevant clinical information required for the DMMR; and (c) discusses with the reviewing pharmacist the results of the DMMR including suggested medication management strategies; and (d) develops a written medication management plan following discussion with the patient; and (e) provides the written medication management plan to a community pharmacy chosen by the patient For any particular patient—applicable not more than once in each 12 month period, and only if item 900 does not apply in the same 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR	136.35
249	Participation by a prescribed medical practitioner in a residential medication management review ***(RMMR***) for a patient who is a permanent resident of a residential aged care facility—other than an RMMR for a resident in relation to whom, in the preceding 12 months, this item or item 903 has applied, unless there has been a significant change in the resident's medical condition or medication management plan requiring a new RMMR	93.35
Subgroup 9—Prescribed medical practitioner mental health care		
272	Professional attendance by a prescribed medical practitioner (who has not undertaken mental health skills training), lasting at least 20 minutes but less than 40 minutes, for the preparation of a GP mental health treatment plan for a patient	63.15
276	Professional attendance by a prescribed medical practitioner (who has	92.95

Group A7—Acupuncture and non-specialist practitioner items		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	not undertaken mental health skills training), lasting at least 40 minutes, for the preparation of a GP mental health treatment plan for a patient	
277	Professional attendance by a prescribed medical practitioner to: (a) review a GP mental health treatment plan which a medical practitioner, or an associated medical practitioner, has prepared; or (b) to review a Psychiatrist Assessment and Management Plan	63.15
279	Professional attendance by a prescribed medical practitioner, in relation to a mental disorder, lasting at least 20 minutes and involving: (a) taking relevant history and identifying the presenting problem (to the extent not previously recorded); and (b) providing treatment and advice; and (c) if appropriate, referral for other services or treatments; and (d) documenting the outcomes of the consultation	63.15
281	Professional attendance by a prescribed medical practitioner (who has undertaken mental health skills training), lasting at least 20 minutes but less than 40 minutes, for the preparation of a GP mental health treatment plan for a patient	80.15
282	Professional attendance by a prescribed medical practitioner (who has undertaken mental health skills training), lasting at least 40 minutes, for the preparation of a GP mental health treatment plan for a patient	118.10
283	Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for mental disorders that have been assessed by a medical practitioner; and (b) lasting at least 30 minutes but less than 40 minutes	81.70
285	Professional attendance at a place other than consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for mental disorders that have been assessed by a medical practitioner; and (b) lasting at least 30 minutes but less than 40 minutes	Amount under clause 2.20.2A
286	Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for mental disorders that have been assessed by a medical practitioner; and (b) lasting at least 40 minutes	116.90
287	Professional attendance at a place other than consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of	Amount under clause 2.20.2A

Clause 2.10.2

Group A7—Acupuncture and non-specialist practitioner items		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	this service: (a) for providing focussed psychological strategies for mental disorders that have been assessed by a medical practitioner; and (b) lasting at least 40 minutes	
309	Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 30 minutes but less than 40 minutes	81.70
311	Professional attendance at a place other than consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 30 minutes but less than 40 minutes	Amount under clause 2.20.2A
313	Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 40 minutes	116.90
315	Professional attendance at a place other than consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 40 minutes	Amount under clause 2.20.2A
Subgroup 11—Prescribed medical practitioner pregnancy support counselling		
792	Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, lasting at least 20 minutes, for the purpose of providing non-directive pregnancy support counselling to a person who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item, or item 4001, 81000, 81005, 81010, 92136, 92137, 92138, 92139, 93026 or 93029, applies in	67.45

Group A7—Acupuncture and non-specialist practitioner items		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	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. For items 92136, 92137, 92138, 92139, 93026 and 93029, see the Telehealth and Telephone Determination.	

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

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 Certain services may be provided by video conference rather than at consulting rooms

A service provided to a patient under item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318 or 319 may be provided by video conference rather than at consulting rooms if the service is associated with a service to which item 294 applies.

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.

Note: The fees in Group A8 are indexed in accordance with clause 1.3.1.

Group A8—Consultant psychiatrist attendances to which no other item applies		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
289	Professional attendance lasting at least 45 minutes, by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant psychiatrist by a referring practitioner, for a patient aged under 25, if	278.75

Clause 2.11.5

Group A8—Consultant psychiatrist attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	the consultant psychiatrist: (a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of a complex neurodevelopmental disorder (such as autism spectrum disorder) is made (if appropriate, using information provided by an eligible allied health provider); and (b) develops a treatment and management plan, which must include: (i) documentation of the confirmed diagnosis; and (ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and (iii) a risk assessment; and (iv) treatment options (which may include biopsychosocial recommendations); and (c) provides a copy of the treatment and management plan to: (i) the referring practitioner; and (ii) one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 137, 139, 92140, 92141, 92142 or 92434) Applicable only once per lifetime	
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, by a medical practitioner in general practice (including a general practitioner, but not a specialist or consultant physician) or a participating nurse practitioner, for an assessment or management; and (b) during the attendance, the consultant: (i) if it is clinically appropriate to do so—uses an appropriate outcome tool; and (ii) carries out a mental state examination; and (iii) undertakes a comprehensive diagnostic assessment; and (c) the consultant decides that it is clinically appropriate for the patient to be managed by the referring practitioner without ongoing management by the consultant; and (d) within 2 weeks after the attendance, the consultant prepares and gives to the referring practitioner a written report, which includes: (i) the comprehensive diagnostic assessment of the patient; and (ii) a management plan for the patient for the next 12 months that comprehensively evaluates the patient's biopsychosocial factors and makes recommendations to the referring practitioner to manage the patient's ongoing	505.70

Group A8—Consultant psychiatrist attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	care in a biopsychosocial model; and (e) if clinically appropriate, the consultant explains the diagnostic assessment and management plan, and gives a copy, to: (i) the patient; and (ii) the patient's carer (if any), if the patient agrees; and (f) in the preceding 12 months, a service to which this item or item 92435 applies has not been provided to the patient	
293	Professional attendance lasting more than 30 minutes, but not more than 45 minutes, at consulting rooms by a consultant physician in the practice of the consultant physician's specialty of psychiatry, if: (a) the patient is being managed by a medical practitioner or a participating nurse practitioner in accordance with a management plan prepared by the consultant in accordance with item 291 or item 92435; and (b) the attendance follows referral of the patient to the consultant, by the medical practitioner or participating nurse practitioner managing the patient, for review of the management plan and the associated comprehensive diagnostic assessment; and (c) during the attendance, the consultant: (i) if it is clinically appropriate to do so—uses an appropriate outcome tool; and (ii) carries out a mental state examination; and (iii) reviews the comprehensive diagnostic assessment and undertakes additional assessment as required; and (iv) reviews the management plan; and (d) within 2 weeks after the attendance, the consultant prepares and gives to the referring practitioner a written report, which includes: (i) the revised comprehensive diagnostic assessment of the patient; and (ii) a revised management plan including updated recommendations to the referring practitioner to manage the patient's ongoing care in a biopsychosocial model; and (e) if clinically appropriate, the consultant explains the diagnostic assessment and management plan, and gives a copy, to: (i) the patient; and (ii) the patient's carer (if any), if the patient agrees; and (f) in the preceding 12 months, a service to which item 291 or item 92435 applies has been provided to the patient; and (g) in the preceding 12 months, a service to which this item or item 92436 applies has not been provided to the patient	316.15
294	Professional attendance on a patient by a consultant physician practising in the consultant physician's specialty of psychiatry if: (a) the attendance is by video conference; and (b) except for the requirement for the attendance to be at consulting rooms—item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312,	50% of the fee for the relevant item referred to in paragraph (b) of column 2

Clause 2.11.5

Group A8—Consultant psychiatrist attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	314, 316, 318 or 319 would otherwise apply to the attendance; and (c) the patient is not an admitted patient; and (d) the patient is bulk-billed; and (e) the patient: (i) is located: (A) within a Modified Monash 2, 3, 4, 5, 6 or 7 area; and (B) at the time of the attendance—at least 15 km by road from the physician; or (ii) is a care recipient in a residential 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	
296	Professional attendance lasting more than 45 minutes by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance at consulting rooms if the patient: (a) is a new patient for this consultant physician; or (b) has not received a professional attendance from this consultant physician in the preceding 24 months; other than attendance on a patient in relation to whom this item or any of items 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 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; other than attendance on a patient in relation to whom this item or any of items 296, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 has applied in the preceding 24 months (H)	274.95
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	328.75

Group A8—Consultant psychiatrist attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(b) has not received a professional attendance from this consultant physician in the preceding 24 months; other than attendance on a patient in relation to whom this item or any of items 296, 297, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 has applied in the preceding 24 months	
300	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting not more than 15 minutes at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient	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, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient	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, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient	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, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient	194.00
308	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 75 minutes at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient	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 ($)**
310	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting not more than 15 minutes at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient	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, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient	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, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient	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, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient	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, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient	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: (a) the formulation of the patient's clinical presentation indicates intensive psychotherapy is a clinically appropriate and indicated	205.20

Group A8—Consultant psychiatrist attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	treatment; and (b) that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 91873 and 92437 applies have not exceeded 160 attendances in a calendar year for the patient	
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—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	191.80

Clause 2.11.5

Group A8—Consultant psychiatrist attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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
341	An interview, lasting not more than 15 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 343, 345, 347, 349, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient	48.40
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
343	An interview, lasting more than 15 minutes but not more than 30 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 341, 345, 347, 349, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient	96.60
344	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the	69.10

Group A8—Consultant psychiatrist attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
345	An interview, lasting more than 30 minutes but not more than 45 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 341, 343, 347, 349, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient	148.70
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
347	An interview, lasting more than 45 minutes but not more than 75 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 341, 343, 345, 349, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient	205.20
349	An interview, lasting more than 75 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient;	238.15

Clause 2.12.1

Group A8—Consultant psychiatrist attendances to which no other item applies		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	if that service and another service to which this item or any of items 341, 343, 345, 347, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient	

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 385 to 388 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.

Note: The fees in Group A12 are indexed in accordance with clause 1.3.1.

Group A12—Consultant occupational physician attendances to which no other item applies		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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	45.40

Group A12—Consultant occupational physician attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	practitioner—an attendance after the initial attendance in a single course of treatment	
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

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.

Note: The fees in Group A13 are indexed in accordance with clause 1.3.1.

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	20.65

Clause 2.13.2

Group A13—Public health physician attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
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; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	45.15
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	Amount under clause 2.1.1

Group A13—Public health physician attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	
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; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	Amount under clause 2.1.1
417	Professional attendance by a public health physician in the practice of 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 Other Medical Practitioners Extension Program (within the meaning of subclause 1.1.2(2)) who:
  (a) was registered under the After Hours Other Medical Practitioners Program on or before 30 June 2023; and
  (b) 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 provided by:
  (a) a medical practitioner other than a general practitioner; or
  (b) an eligible non-vocationally recognised medical practitioner registered under the Other Medical Practitioners Extension Program (within the meaning of subclause 1.1.2(2)) who:
    (i) was registered under the After Hours Other Medical Practitioners Program on or before 30 June 2023; and
    (ii) provides the service through a medical deputising service.

2.14.5 Items in Group A11

This clause sets out items in Group A11.

Note: The fees in Group A11 are indexed in accordance with clause 1.3.1.

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 practitioner to return to, and specially open, the consulting rooms for the attendance	135.10
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	127.25

Clause 2.15.1

Group A11—Urgent attendances after hours		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	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	

Division 2.15—Group A14 and Subgroup 5 of Group A7: Health assessments

Note: Items in Subgroup 5 of Group A7 are set out in Division 2.10.

2.15.1 Restrictions on items in Group A14 and Subgroup 5 of Group A7

(1) 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) Items 224 to 228 apply only to a service provided in the course of a personal attendance by a single prescribed medical 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, 707, 224, 225, 226 or 227:

(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) a health assessment, in accordance with clause 2.15.10, for a patient who:

(i) is a veteran, being 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;

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

(ha) Subclass 790 (Safe Haven Enterprise) visa;

(i) Subclass 866 (Protection) visa.

2.15.3 Application of items 715 and 228

(1) Items 715 and 228 apply 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 items 715 and 228, 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, or attending

prescribed medical practitioner, as the case may be, based on the identification of a specific risk factor, is at risk of developing a chronic disease.

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

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

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

(5) In this clause:

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

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

2.15.6 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 or a prescribed medical practitioner; and
  (b) measurement of the patient's blood pressure, pulse rate and rhythm; and
  (c) assessment of the patient's medication; and
  (d) assessment of the patient's continence; and
  (e) assessment of the patient's immunisation status for influenza, tetanus and pneumococcus; and
  (f) assessment of the patient's physical functions, including the patient's activities of daily living and whether or not the patient has had a fall in the last 3 months; and

(g) assessment of the patient's psychological function, including the patient's cognition and mood; and
(h) assessment of the patient's social function, including:
(i) the availability and adequacy of paid, and unpaid, help; and
(ii) whether the patient is responsible for caring for another person.

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

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

2.15.7 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 or a prescribed medical practitioner; and
(b) taking a detailed patient history of the resident; and
(c) conducting a comprehensive medical examination of the resident; and
(d) developing a list of diagnoses and medical problems based on the medical history and examination; and
(e) giving a written copy of a summary of the outcomes of the assessment to the residential aged care facility for the resident's medical records.

(3) A Comprehensive Medical Assessment must also include:
(a) making a written summary of the Comprehensive Medical Assessment; and
(b) giving a copy of the summary to the residential aged care facility; and
(c) offering the resident a copy of the summary.

(4) A Comprehensive Medical Assessment may be provided:
(a) on admission to a residential aged care facility, if a Comprehensive Medical Assessment has not already been provided in another residential aged care facility in the last 12 months; and
(b) at 12 month intervals after that assessment.

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

2.15.8 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 or the prescribed medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report; and
(d) offering relevant disability professionals (if the general practitioner or the prescribed medical practitioner considers it appropriate and the patient or, if appropriate, the patient's carer, agrees) a copy of the report or extracts of the report.

(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 or a prescribed medical practitioner; and
(b) taking the patient's history; and
(c) examining the patient; and
(d) performing or arranging any required investigations; and
(e) assessing the patient, using the information gained in paragraphs (b), (c) and (d); and
(f) developing a management plan addressing the patient's health care needs, health problems and relevant conditions; and
(g) making or arranging any necessary interventions and referrals.

(3) A health assessment for a refugee or other humanitarian entrant must also include:
(a) keeping a record of the health assessment; and

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

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

2.15.10 Health assessment for a veteran

(1) A health assessment for a veteran is an assessment of:
(a) the 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 *Veteran Health Check* tool, as existing on 2 September 2021.

Note 1: The *Veteran Health Check* tool could in 2021 be viewed on the Department of Veterans' Affairs' website (http://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' website (http://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, or a prescribed medical 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 or a prescribed medical practitioner; and
(b) taking the patient's history, including the following:
(i) mother's pregnancy history;
(ii) birth and neo-natal history;

(iii) breastfeeding history;
(iv) weaning, food access and dietary history;
(v) physical activity engaged in;
(vi) previous presentations, hospital admissions and medication use;
(vii) relevant family medical history;
(viii) immunisation status;
(ix) vision and hearing (including neo-natal hearing screening);
(x) development (including achievement of age-appropriate milestones);
(xi) family relationships, social circumstances and whether the 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 or a prescribed medical practitioner; and

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

(i) current health problems and risk factors;

(ii) relevant family medical history;

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

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

(v) sexual and reproductive health;

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

(vii) hearing loss;

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

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

(x) vision; and

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

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

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

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

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

(v) urinalysis (by dipstick) for proteinuria;

(vi) eye examination; and

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

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

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

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

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

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

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

2.15.14 Restrictions on health assessments for Group A14 and Subgroup 5 of Group A7

(1) A health assessment mentioned in an item in Group A14 or Subgroup 5 of Group A7 must not include a health screening service.

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

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

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

(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 or prescribed medical practitioner—provision to patients of information on recommended interventions.

(6) In this clause:

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

2.15.15 Items in Group A14

This clause sets out items in Group A14.

Note: The fees in Group A14 are indexed in accordance with clause 1.3.1.

Group A14—Health assessments		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
701	Professional attendance by a general practitioner (other than a specialist	61.75

Group A14—Health assessments		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
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 (d) providing a basic preventive health care management plan for the patient	198.00
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 and Subgroup 6 of Group A7: GP management plans, team care arrangements and multidisciplinary care plans and case conferences

Note: Items in Subgroup 6 of Group A7 are set out in Division 2.10.

Subdivision A—General

2.16.1 Restrictions on items 729 to 866 and items 229 to 240—services by certain medical practitioners

(1) Items 729 to 866 and items 229 to 240 apply only to a service provided by:
  (a) a medical practitioner (other than a medical practitioner employed by the proprietor of a hospital that is not a private hospital); or
  (b) a medical practitioner who:
    (i) is employed by the proprietor of a hospital that is not a private hospital; and
    (ii) provides the service otherwise than in the course of employment by that proprietor.

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

Subdivision B—Subgroup 1 of Group A15 and Subgroup 6 of Group A7

2.16.2 Meaning of associated general practitioner

(1) 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) In item 233:

associated medical practitioner means a medical practitioner who, if not engaged in the same general practice as the prescribed medical 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, 731, 231 and 232:

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 items 723 and 230:

coordinating the development of team care arrangements means a process by which a general practitioner (for item 723) or a prescribed medical practitioner (for item 230):

(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 items 732 and 233:

coordinating a review of team care arrangements means a process by which a general practitioner (for item 732) or a prescribed medical practitioner (for item 233):

(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, 731, 231 and 232:

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

(a) is prepared for the patient by:
  (i) a general practitioner (for items 729 and 731) or a prescribed medical practitioner (for items 231 and 232), in consultation with 2 other collaborating providers, each of whom provides a different kind of treatment or service to the patient, and one of whom may be another medical practitioner; or
  (ii) a collaborating provider (other than a general practitioner or a prescribed medical practitioner, as the case may be), in consultation with at least 2 other collaborating providers, each of whom provides a different kind of treatment or service to the patient; and
(b) describes, at least, treatment and services to be provided to the patient by the collaborating providers.

(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 items 721 and 229:

preparing a GP management plan, for a patient, means a process by which a general practitioner (for item 721) or a prescribed medical practitioner (for item 229):
(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 items 732 and 233:

reviewing a GP management plan means a process by which a general practitioner (for item 732) or a prescribed medical practitioner (for item 233):

(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, 732, 229, 230, 231, 232 and 233—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, 732, 229, 230, 231, 232 and 233

Item	Column 1 Items of this Schedule	Column 2 Description of patient
1	721, 732, 229 and 233 (if the service is for preparing a GP management plan or reviewing a GP management plan)	The patient: (a) is a private in-patient of a hospital; or (b) is not a public in-patient of a hospital or a care recipient in a residential aged care facility
2	723, 732, 230 and 233 (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

Table 2.16.9—Application of items 721, 723, 729, 731, 732, 229, 230, 231, 232 and 233

Item	Column 1 Items of this Schedule	Column 2 Description of patient
		(ii) is not a public in-patient of a hospital or a care recipient in a residential aged care facility
3	729 and 231	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 and 232	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

(1A) Despite subclause (1), items 723, 732, 230 and 233 also apply to a service for a patient if:

(a) the service is provided for the purpose of coordinating the development of team care arrangements, or coordinating a review of team care arrangements, for the patient; and

(b) the patient:

(i) is referred for a service to which any of the following items apply:

(A) an item in Subgroup 2 of Group A20;

(B) an item in Subgroup 9 of Group A7;

(C) an item in Subgroup 3 or 10 of Group A40;

(D) an item in Group M6 or M7;

(E) an item in Subgroup 1, 2, 3, 4, 6, 7, 8 or 9 of Group M18; or

(ii) has an eating disorder treatment and management plan; and

(c) the patient is described in column 2 of an item in table 2.16.9.

(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, 732, 229, 230 and 233

Items 721, 723 and 732

(1) 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.

Items 229, 230 and 233

(2) Items 229, 230 and 233 apply only to a service provided in the course of personal attendance by a single prescribed medical practitioner on a single patient.

2.16.11 Restrictions on other items—services provided on same day as services in items 721, 723, 732, 229, 230 and 233

The following items do not apply to a service described in the item that is provided by a medical practitioner or a prescribed medical 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, 732, 229, 230 or 233:

(a) items 3, 4, 23, 24, 36, 37, 44, 47, 52, 53, 54, 57, 58, 59, 60, 65, 123, 124, 151 and 165;

(b) items 179, 181, 185, 187, 189, 191, 203, 206, 301, 303, 733, 737, 741, 745, 761, 763, 766, 769, 2197 and 2198;

(c) items 585, 588, 591, 594, 599 and 600;

(d) items 5000, 5003, 5020, 5023, 5040, 5043, 5060, 5063, 5071 and 5076;

(e) items 5200, 5203, 5207, 5208, 5209, 5220, 5223, 5227, 5228 and 5261;

(f) items 91790, 91792, 91794, 91800, 91801, 91802, 91803, 91804, 91805, 91806, 91807, 91808, 91890, 91891, 91892, 91893, 91900, 91903, 91906, 91910, 91913, 91916, 91920, 91923, 91926, 92210 and 92211.

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

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
		general practitioner
2	723 (if subclause 2.16.9(1) applies to the item)	(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 in accordance with subclause 2.16.9(1)) 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
2A	723 (if subclause 2.16.9(1A) applies to the item)	(a) In the 3 months before performance of the service, being a service to which item 732 (for coordinating the review of team care arrangements in accordance with subclause 2.16.9(1A)) 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 2.16.12A

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 (if subclause 2.16.9(1) applies to the item)	Each service: (a) may be performed: (i) once in a 3 month period; and (ii) on the same day; but (b) 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
5A	732 (if subclause 2.16.9(1A) applies to the item	The service, being a service to which item 732 (for coordinating the review of team care arrangements) applies: (a) may be performed once in a 3 month period; but (b) 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.

2.16.12A Conditions relating to timing of services in items 229, 230, 231, 232 and 233 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 229, 230, 231, 232 and 233 apply in the circumstances mentioned in table 2.16.12A.

Table 2.16.12A—Conditions relating to timing of services in items 229, 230, 231, 232 and 233

Item	Column 1 Item of this Schedule	Column 2 Circumstances
1	229	The circumstances are that: (a) in the 3 months before performance of the service by a prescribed medical practitioner for a patient, being a service to which any of the following items (for reviewing a GP management plan) apply but had not been performed for the patient: (i) item 231, 232, 233, 729, 731 or 732; (ii) item 92026, 92027, 92028, 92057, 92058, 92059 or 92103 of the Telehealth and Telephone Determination; and (b) a service to which item 721, or item 92024, 92026 or 92055 of the Telehealth and Telephone Determination, applies has not been performed in the past 12 months; and (c) the service to which item 229 applies is not performed more than once in a 12 month period; and (d) the service to which item 229 applies: (i) is not performed by a person who is a recognised specialist in palliative medicine who is treating a palliative patient who has been referred to the prescribed medical practitioner; and (ii) is not a service to which an item in Subgroup 3 or 4 of Group A24 applies because of the treatment of the palliative patient by the medical practitioner
2	230 (if subclause 2.16.9(1) applies to the item)	The circumstances are that: (a) in the 3 months before performance of the service by a prescribed medical practitioner for a patient, being a service to which any of the following items (for coordinating a review of team care arrangements) apply but had not been performed for the patient: (i) item 233 or 723 (performed in accordance with subclause 2.16.9(1)); (ii) item 92028 or 92059 of the Telehealth and Telephone Determination; and (b) a service to which item 723 (performed in accordance with subclause 2.16.9(1)), or item 92025 or 92056 of the Telehealth and Telephone Determination, applies has not been performed in the past 12 months; and (c) the service to which item 230 (performed in accordance with subclause 2.16.9(1)) applies is not performed more than once in a 12 month period; and (d) the service to which item 230 applies: (i) is not performed by a person who is a recognised specialist in palliative medicine who is treating a palliative patient who has been referred to the prescribed medical practitioner; and (ii) is not a service to which an item in Subgroup 3 or 4 of Group A24 applies because of the treatment of the palliative patient by a medical practitioner
3	230 (if	The circumstances are that:

Clause 2.16.12A

Table 2.16.12A—Conditions relating to timing of services in items 229, 230, 231, 232 and 233

Item	Column 1 Item of this Schedule	Column 2 Circumstances
	subclause 2.16.9(1A) applies to the item)	(a) in the 3 months before performance of the service by a prescribed medical practitioner for a patient, being a service to which any of the following items (for coordinating a review of team care arrangements) apply but had not been performed for the patient: (i) item 233 or 723 (performed in accordance with subclause 2.16.9(1A)); (ii) item 92028 or 92059 of the Telehealth and Telephone Determination; and (b) a service to which item 723 (performed in accordance with subclause 2.16.9(1A)), or item 92025 or 92056 of the Telehealth and Telephone Determination, applies has not been performed in the past 12 months; and (c) the service to which item 230 (performed in accordance with subclause 2.16.9(1A)) applies is not performed more than once in a 12 month period; and (d) the service to which item 230 applies: (i) is not performed by a person who is a recognised specialist in palliative medicine who is treating a palliative patient who has been referred to the prescribed medical practitioner; and (ii) is not a service to which an item in Subgroup 3 or 4 of Group A24 applies because of the treatment of the palliative patient by a medical practitioner
4	231	The circumstances are that: (a) either: (i) in the 3 months before performance of the service by a prescribed medical practitioner for a patient, being a service to which any of the following items apply but had not been performed for the patient: (A) item 232, 233, 731 or 732; (B) item 92027, 92028, 92058 or 92059 of the Telehealth and Telephone Determination; or (ii) in the 12 months before performance of the service, being a service that has not been performed for the patient: (A) by a medical practitioner who performs the service to which item 231 or 729, or item 92026 or 92057 of the Telehealth and Telephone Determination, would, but for this item, apply; and (B) for which a payment has been made under item 229, 230, 721 or 723, or item 92024, 92025, 92055 or 92056 of the Telehealth and Telephone Determination; and (b) a service to which item 729, or item 92026 or 92057 of the Telehealth and Telephone Determination, applies is performed not more than once in a 3 month period; and (c) the service to which item 231 applies is performed not more than

Table 2.16.12A—Conditions relating to timing of services in items 229, 230, 231, 232 and 233

Item	Column 1 Item of this Schedule	Column 2 Circumstances
		once in a 3 month period
5	232	The circumstances are that: (a) in the 3 months before performance of the service by a prescribed medical practitioner for a patient, being a service to which any of the following items apply but had not been performed for the patient: (i) item 229, 230, 231, 233, 721, 723, 729 or 732; (ii) item 92024, 92025, 92026, 92028, 92055, 92056, 92057 or 92059 of the Telehealth and Telephone Determination; and (b) a service to which item 731, or item 92027 or 92058 of the Telehealth and Telephone Determination, applies is performed not more than once in a 3 month period; and (c) the service to which item 232 applies is performed not more than once in a 3 month period
6	233 (if subclause 2.16.9(1) applies to the item)	The circumstances are that each service may be performed by a prescribed medical practitioner for a patient, if: (a) a service to which any of the following items apply but has not been claimed in the past 3 months: (i) item 732 (performed in accordance with subclause 2.16.9(1); (ii) item 92028 or 92059 of the Telehealth and Telephone Determination; and (b) the service is performed once in a 3 month period; and (c) the service is performed on the same day; and (d) the service: (i) is not performed by a person who is a recognised specialist in palliative medicine who is treating a palliative patient who has been referred to the prescribed medical practitioner; and (ii) is not a service to which an item in Subgroup 3 or 4 of Group A24 applies because of the treatment of the palliative patient by a medical practitioner
7	233 (if subclause 2.16.9(1A) applies to the item)	The circumstances are that each service may be performed by a prescribed medical practitioner for a patient, if: (a) a service to which any of the following items apply but has not been claimed in the past 3 months: (i) item 732 (performed in accordance with subclause 2.16.9(1A); (ii) item 92028 or 92059 of the Telehealth and Telephone Determination; and (b) the service is performed once in a 3 month period; and (c) the service is performed on the same day; and (d) the service: (i) is not performed by a person who is a recognised specialist in palliative medicine who is treating a palliative patient who

Table 2.16.12A—Conditions relating to timing of services in items 229, 230, 231, 232 and 233		
Item	**Column 1 Item of this Schedule**	**Column 2 Circumstances**
		has been referred to the prescribed medical practitioner; and (ii) is not a service to which an item in Subgroup 3 or 4 of Group A24 applies because of the treatment of the palliative patient by the medical 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.

Note: The fees in Group A15 are indexed in accordance with clause 1.3.1.

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 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	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 ($)**
	(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 235, 236, 237, 238, 239, 240, 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 235, 236, 237, 735, 739, 743, 820, 822, 823, 825, 826, 828, 830, 832, 834, 835, 837, 838, 855, 857, 858, 861, 864, 866, 930, 933, 935, 946, 948, 959, 969, 971 and 972:

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 238, 239, 240, 747, 750, 758, 825, 826, 828, 835, 837, 838, 937, 943, 945, 961, 962, 964, 973, 975 and 986:

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.

2.16.19A Restrictions on items 930 to 964, 969, 971, 972, 973, 975 and 986

Items 930 to 964, 969, 971, 972, 973, 975 and 986 apply to a patient only if the patient:

(a) is referred for a service to which any of the following items apply:

(i) an item in Subgroup 2 of Group A20;

(ii) an item in Subgroup 9 of Group A7;

(iii) an item in Subgroup 3 or 10 of Group A40;

(iv) an item in Group M6 or M7;

(v) an item in Subgroup 1, 2, 3, 4, 6, 7, 8 or 9 of Group M18; or

(b) has an eating disorder treatment and management plan.

2.16.20 Items in Subgroup 2 of Group A15

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

Note: The fees in Group A15 are indexed in accordance with clause 1.3.1.

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 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)	73.55
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	54.05

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	(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)	
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 apply)	92.60
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	105.50

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 ($)
	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	
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 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	146.90
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	231.05

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	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	
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 least 45 minutes, with the multidisciplinary case conference team	293.70
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	39.50

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 ($)
	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	
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
930	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference, if the conference lasts for at least 15 minutes, but for less than 20 minutes	77.45
933	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference, if the conference lasts for at least 20 minutes, but for less than 40 minutes	132.45
935	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference, if the conference lasts for at least 40 minutes	220.80
937	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference, if the conference lasts for at least 15 minutes, but for less than 20 minutes	56.90
943	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference, if the conference lasts for at least 20 minutes, but for less than 40 minutes	97.50
945	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference, if the conference lasts for at least 40 minutes	162.30
946	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	154.60
948	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	232.05

Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
959	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference of at least 45 minutes, with the multidisciplinary case conference team	309.15
961	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to participate in a mental health case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	111.05
962	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to participate in a mental health case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	177.10
964	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to participate in a mental health case conference of at least 45 minutes, with the multidisciplinary case conference team	243.20

Division 2.17—Group A17 and Subgroup 7 of Group A7: Domiciliary and residential medication management reviews

Note: Items in Subgroup 7 of Group A7 are set out in Division 2.10.

2.17.1 Meaning of living in a community setting

In items 900 and 245:

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 items 903 and 249:

residential medication management review means a collaborative service provided by a general practitioner (for item 903), or a prescribed medical practitioner (for item 249), and a pharmacist to review the medication management needs of a care recipient in a residential aged care facility.

(2) A medical practitioner's involvement in a residential medication management review includes all of the following:
   (a) discussing the proposed review with the resident and seeking the resident's consent to the review;
   (b) collaborating with the reviewing pharmacist about the pharmacist's involvement in the review;
   (c) providing input from the resident's most recent comprehensive medical assessment or, if such an assessment has not been undertaken, providing relevant clinical information for the review and for the resident's records;
   (d) subject to subclause (4), participating in a post-review discussion (either face-to-face or by telephone) with the pharmacist to discuss the outcomes of the review including:
      (i) the findings of the review; and
      (ii) medication management strategies; and
      (iii) means to ensure that the strategies are implemented and reviewed, including any issues for implementation and follow-up;
   (e) developing or revising the resident's medication management plan after discussion with the reviewing pharmacist, and finalising the plan after discussion with the resident.

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

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

2.17.3 Restrictions on items 900, 903, 245 and 249

Items 900 and 903

(1) 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.

Items 245 and 249

(2) Items 245 and 249 apply only to a service provided in the course of personal attendance by a single prescribed medical practitioner on a single patient.

2.17.4 Items in Group A17

This clause sets out items in Group A17.

Note: The fees in Group A17 are indexed in accordance with clause 1.3.1.

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, and only if item 245 does not apply in the same 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR	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 or item 249 has applied, unless there has been a significant change in the resident's medical condition or medication management plan requiring a new RMMR	110.30

Division 2.20—Group A20 and Subgroup 9 of Group A7: Mental health care

Note: Items in Subgroup 9 of Group A7 are set out in Division 2.10.

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

(1) In items 2723, 2727, 2741 and 2745:

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	28.60	2.25
2	2727	The fee for item 2725	28.60	2.25
3	2741	The fee for item 2739	28.60	2.25
4	2745	The fee for item 2743	28.60	2.25

(2) A reference in subclause (1) to an attendance on a patient includes, in relation to an attendance to which item 2741 or 2745 applies, an attendance on a person other than a patient as part of a patient's treatment.

2.20.2A Meaning of amount under clause 2.20.2A

(1) In an item of this Schedule mentioned in column 1 of table 2.20.2A:

amount under clause 2.20.2A 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 2.20.2A—Amount under clause 2.20.2A

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	285	The fee for item 283	22.90	1.80
2	287	The fee for item 286	22.90	1.80
3	311	The fee for item 309	22.90	1.80
4	315	The fee for item 313	22.90	1.80

(2) A reference in subclause (1) to an attendance on a patient includes, in relation to an attendance to which item 311 or 315 applies, an attendance on a person other than a patient as part of a patient's treatment.

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 or a prescribed medical practitioner for the patient that includes:

(i) an assessment of the patient's mental disorder, including administration of an outcome measurement tool (except if considered clinically inappropriate); and

(ii) formulation of the mental disorder, including provisional diagnosis or diagnosis; and
(iii) treatment goals with which the patient agrees; and
(iv) any actions to be taken by the patient; and
(v) a plan for either or both of the following:
(A) crisis intervention;
(B) relapse prevention; and
(vi) referral and treatment options for the patient; and
(vii) arrangements for providing the referral and treatment options mentioned in subparagraph (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, or to a person other than the patient as part of the patient's treatment, by a clinical psychologist (items 80000 to 80025, 91166, 91167, 91168, 91171, 91181, 91182, 91198 and 91199); and
(ii) focussed psychological strategies services provided to the patient, or to a person other than the patient as part of the patient's treatment, by a general practitioner or prescribed medical practitioner mentioned in paragraph 2.20.7(1)(b) to provide those services (items 2721 to 2745, 91818, 91819, 91842, 91843, 91859, 91861, 91864 and 91865); and
(iii) focussed psychological strategies services provided to the patient, or to a person other than the patient as part of the patient's treatment, by an allied mental health professional (items 80100 to 80175, 91169, 91170, 91172, 91173, 91174, 91175, 91176, 91177, 91183, 91184, 91185, 91186, 91187, 91188, 91194, 91195, 91196, 91197, 91200, 91201, 91202, 91203, 91204 and 91205); and
(iv) focussed psychological strategies services provided to the patient, or to a person other than the patient as part of the patient's treatment, by a prescribed medical practitioner mentioned in

paragraph 2.20.7A(1)(b) to provide those services (items 283, 285, 286, 287, 309, 311, 313, 315, 91820, 91821, 91844, 91845, 91862, 91863, 91866, 91867).

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 or a prescribed medical 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 and associated medical practitioner

(1) 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) In item 277:

associated medical practitioner means a medical practitioner who, if not engaged in the same general practice as the prescribed medical practitioner

mentioned in the 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 and Subgroup 9 of Group A7 (GP mental health treatment plans)

Patients provided with certain services

(1) Items 2700, 2701, 2712, 2713, 2715, 2717, 272, 276, 277, 279, 281 and 282 apply only to a patient with a mental disorder.

(2) Items 2700, 2701, 2712, 2715, 2717, 272, 276, 277, 281 and 282 apply only to:
  (a) a patient in the community; and
  (b) a private in-patient (including a private in-patient who is a resident of an aged care facility) being discharged from hospital; and
  (c) a service provided in the course of personal attendance by a single medical practitioner on a single patient.

Timing of certain services—items 2700, 2701, 2715 and 2717

(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 item 2700, 2701, 2715, 2717, 92112, 92113, 92116 or 92117;
  (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.

Timing of certain services—items 272, 276, 281 and 282

(8A) Unless exceptional circumstances exist, items 272, 276, 281 and 282 cannot be claimed:

(a) with a service to which any of the following apply:

(i) items 235 to 240, 279, 735 to 758 and 2713;

(ii) items 92115, 92121 and 92133 of the Telehealth and Telephone Determination; or

(b) more than once in a 12 month period from the provision of any of the items for a particular patient; or

(c) within 3 months following the provision of a service to which item 277 or 2712, or item 92114, 92120, 92126 or 92132 of the Telehealth and Telephone Determination, applies; or

(d) more than once in a 12 month period from the provision of any of items 92118, 92119, 92122 or 92123 of the Telehealth and Telephone Determination.

Item 277

(8B) Item 277 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 any of the following:

(i) item 272, 276, 281, 282, 2700, 2701, 2715 or 2717;

(ii) item 92112, 92113, 92116, 92117, 92118, 92119, 92122 or 92123 of the Telehealth and Telephone Determination;

(b) a psychiatrist assessment and management plan under item 291, or item 92435 or 92475 of the Telehealth and Telephone Determination.

(8C) Item 277 does not apply:

(a) to a service to which any of the following apply:

(i) item 235, 236, 237, 238, 239 240 or 279;

(ii) item 735, 739, 743, 747, 750 or 758;

(iii) item 2713;

(iv) item 92121, 92133, 92115 or 92127 of the Telehealth and Telephone Determination; 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 under any of the following:

(A) item 272, 276, 281, 282, 2700, 2701, 2715 or 2717;

(B) item 92112, 92113, 92116, 92117, 92118, 92119, 92122 or 92123 of the Telehealth and Telephone Determination.

Item 279

(8D) Item 279 does not apply in association with a service to which any of the following apply:

(a) item 272, 276, 277, 281, 282, 2700, 2701, 2715, 2717 or 2712;

(b) item 92112, 92113, 92114, 92116, 92117, 92118, 92119, 92120, 92122, 92123 or 92132 of the Telehealth and Telephone Determination.

Items 281 and 282—practitioner training

(8E) Items 281 and 282 apply only if the prescribed medical 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, or to a person other than the patient as part of the patient's treatment, if, in the calendar year, 6 other services to which any of the items in Subgroup 2 of Group A20 apply have already been provided to or in relation to the patient; 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, or to a person other than the patient as part of the patient's treatment, if, in the calendar year, 10 other services to which an item in Subgroup 2 of Group A20, or item 283, 285, 286, 287, 309, 311, 313, 315, 80000 to 80016, 80100 to 80116, 80125 to 80141, 80150 to 80166, 91166, 91167, 91168, 91169, 91170, 91171, 91172, 91173, 91174, 91175, 91176, 91177, 91181, 91182, 91183, 91184, 91185, 91186, 91187, 91188, 91194, 91195, 91196, 91197, 91198, 91199, 91200, 91201, 91202, 91203, 91204, 91205, 91818, 91819, 91820, 91821, 91842, 91843, 91844, 91845, 91859, 91861, 91862, 91863, 91864, 91865, 91866 or 91867, apply, have already been provided to or in relation to the patient.

(3) In addition to the restrictions in subclauses (1) and (2) of this clause, item 2739, 2741, 2743 or 2745 applies to a service provided by a general practitioner to a person other than the patient only if:

(a) the general practitioner determines it is clinically appropriate to provide focussed psychological strategies services to a person other than the patient, and makes a written record of this determination in the patient's records; and

(b) the general practitioner:

(i) explains the service to the patient; and

(ii) obtains the patient's consent for the service to be provided to the other person as part of the patient's treatment; and

(iii) makes a written record of the consent; and

(c) the service is provided as part of the patient's treatment; and

(d) the patient is not in attendance during the provision of the service; and

(e) in the calendar year, no more than one other service to which any of items 309, 311, 313, 315, 2739, 2741, 2743, 2745, 80002, 80006, 80012, 80016, 80102, 80106, 80112, 80116, 80129, 80131, 80137, 80141, 80154, 80156, 80162, 80166, 91168, 91171, 91174, 91177, 91194, 91195, 91196, 91197, 91198, 91199, 91200, 91201, 91202, 91203, 91204, 91205, 91859, 91861, 91862, 91863, 91864, 91865, 91866 or 91867 apply has already been provided to or in relation to the patient.

Note: The patient's consent may be withdrawn at any time.

2.20.7A Restrictions on items in Subgroup 9 of Group A7 (focussed psychological strategies)

(1) Items 283, 285, 286, 287, 309, 311, 313 and 315 apply 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 prescribed medical 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 item 283, 285, 286, 287, 309, 311, 313 or 315, or an item in 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 item 283, 285, 286, 287, 309, 311, 313 or 315, or an item in Subgroup 2 of Group A20, applies.

(2) Items 283, 285, 286, 287, 309, 311, 313 and 315 do not apply to:

(a) a service which:

(i) is provided by a prescribed medical practitioner to a patient, or to a person other than the patient as part of the patient's treatment, if, in the calendar year, 6 other services to which any of the following items apply have already been provided to the patient or to the person:

(A) item 283, 285, 286, 287 309, 311, 313 or 315;

(B) an item in Subgroup 2 of Group A20;

(C) item 91818, 91819, 91820, 91821, 91842, 91843, 91844, 91845, 91859, 91861, 91862, 91863, 91864, 91865, 91866 or 91867 of the Telehealth and Telephone Determination applies; or

(ii) is provided before the prescribed 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, or to a person other than the patient as part of the patient's treatment, if, in the calendar year, 10 other services to which any of the following items apply have already been provided to the patient or to the person:

(i) item 283, 285, 286, 287, 309, 311, 313, 315, 80000 to 80016, 80100 to 80116, 80125 to 80141, 80150 to 80166, 91166, 91167, 91168, 91169, 91170, 91171, 91172, 91173, 91174, 91175, 91176, 91177, 91181, 91182, 91183, 91184, 91185, 91186, 91187, 91188, 91194, 91195, 91196, 91197, 91198, 91199, 91200, 91201, 91202, 91203, 91204, 91205, 91818, 91819, 91820, 91821, 91842, 91843, 91844, 91845, 91859, 91861, 91862, 91863, 91864, 91865, 91866 or 91867;

(ii) an item in Subgroup 2 of Group A20.

(3) In addition to the restrictions in subclauses (1) and (2) of this clause, item 309, 311, 313 or 315 applies to a service provided by a prescribed medical practitioner to a person other than the patient only if:

(a) the prescribed medical practitioner determines it is clinically appropriate to provide focussed psychological strategies services to a person other than the patient, and makes a written record of this determination in the patient's records; and

(b) the prescribed medical practitioner:

(i) explains the service to the patient; and
(ii) obtains the patient's consent for the service to be provided to the other person as part of the patient's treatment; and
(iii) makes a written record of the consent; and

(c) the service is provided as part of the patient's treatment; and

(d) the patient is not in attendance during the provision of the service; and

(e) in the calendar year, no more than one other service to which item 309, 311, 313, 315, 2739, 2741, 2743, 2745, 80002, 80006, 80012, 80016, 80102, 80106, 80112, 80116, 80129, 80131, 80137, 80141, 80154, 80156, 80162, 80166, 91168, 91171, 91174, 91177, 91194, 91195, 91196, 91197, 91198, 91199, 91200, 91201, 91202, 91203, 91204, 91205, 91859, 91861, 91862, 91863, 91864, 91865, 91866 or 91867 applies has already been provided to or in relation to the patient.

Note: The patient's consent may be withdrawn at any time.

2.20.8 Items in Group A20

This clause sets out items in Group A20.

Note: The fees in Group A20 are indexed in accordance with clause 1.3.1.

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	94.75

Group A20—Mental health care		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
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 for provision of this service, and lasting at least 30 minutes, but less than 40 minutes	Amount under clause 2.20.2
2725	Professional attendance at consulting rooms by a 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
2739	Professional attendance at consulting rooms by a general practitioner (not including a specialist or a consultant physician) registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 30 minutes, but less than 40 minutes	98.05
2741	Professional attendance at a place other than consulting rooms by a general practitioner (not including a specialist or a consultant physician) registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service:	Amount under clause 2.20.2

Group A20—Mental health care		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) for providing focussed psychological strategies to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 30 minutes, but less than 40 minutes	
2743	Professional attendance at consulting rooms by a general practitioner (not including a specialist or a consultant physician) registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 40 minutes	140.30
2745	Professional attendance at a place other than consulting rooms by a general practitioner (not including a specialist or a consultant physician) registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 40 minutes	Amount under clause 2.20.2

Division 2.21—Group A24: Palliative and pain medicine

2.21.1 Meaning of organise and coordinate

In the items 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).

Clause 2.21.2

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.

Note: The fees in Group A24 are indexed in accordance with clause 1.3.1.

Group A24—Palliative and pain medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 1—Pain medicine attendances		
2801	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—initial attendance in a single course of treatment	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	79.75

Group A24—Palliative and pain medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
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
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	105.50

Group A24—Palliative and pain medicine		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	the conference) of at least 15 minutes but less than 30 minutes	
2972	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes	168.25
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

Group A24—Palliative and pain medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 3—Palliative medicine attendances		
3005	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—initial attendance in a single course of treatment	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
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	220.45

Clause 2.21.4

Group A24—Palliative and pain medicine		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	minutes but less than 45 minutes	
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
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	105.50

Group A24—Palliative and pain medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	patient is discharged from a hospital (H)	
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

Division 2.22—Group A27 and Subgroup 11 of Group A7: Pregnancy support counselling

Note: Items in Subgroup 11 of Group A7 are set out in Division 2.10.

2.22.1 Restrictions on items 4001 and 792

(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.

(1A) A service to which item 792 applies must not be provided by a prescribed medical practitioner who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination.

(2) Items 4001 and 792 do 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 items 4001 and 729:

non-directive pregnancy support counselling means counselling provided by a general practitioner (for item 4001) or a prescribed medical practitioner (for item 729) to a patient in which:

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

(b) the medical practitioner does not impose the medical practitioner's views or values about what the patient should or should not do in relation to the pregnancy.

(4) A service to which item 4001 or 729 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.

Note: The fees in Group A27 are indexed in accordance with clause 1.3.1.

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.

Note: The fees in Group A21 are indexed in accordance with clause 1.3.1.

Group A21—Professional attendances at recognised emergency departments of private hospitals		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 1—Consultations		
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

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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
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	76.90

Clause 2.23.1

Group A21—Professional attendances at recognised emergency departments of private hospitals		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	specialty of emergency medicine) involving medical decision-making of ordinary complexity	
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
Subgroup 2—Prolonged professional attendances to which no other Group applies		
5039	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine for preparation of goals of care by the specialist for a gravely ill patient lacking current goals of care if: (a) the specialist takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the 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	148.25

Group A21—Professional attendances at recognised emergency departments of private hospitals		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	patient by the specialist that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019	
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 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	209.00

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, 5060 and 5071 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, 5067, 5076 and 5077 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.

Note: The fees in Group A22 are indexed in accordance with clause 1.3.1.

Group A22—General practitioner after-hours attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **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 unit, by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1
5020	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies),	51.00

Group A22—General practitioner after-hours attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	lasting at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	
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 at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients on one occasion—each patient	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 at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential 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; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care;	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 ($)**
	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 clinically relevant: (a) taking an extensive patient history;	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 ($)**
	(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
5071	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 60 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	220.25
5076	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 60 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1

Clause 2.25.1

Group A22—General practitioner after-hours attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
5077	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 60 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential 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, 5208 and 5209 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.

Group A23—Other non-referred after-hours attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **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	31.00

Group A23—Other non-referred after-hours attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	item applies) by a medical practitioner (other than a general practitioner)	
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, but not more than 60 minutes, (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)	71.00
5209	Professional attendance at consulting rooms lasting more than 60 minutes (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)	122.40
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, but not more than 60 minutes—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1
5261	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 60 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,	Amount under clause 2.1.1

Clause 2.26.1

Group A23—Other non-referred after-hours attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
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 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	Amount under clause 2.1.1
5265	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is 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, but not more than 60 minutes, by a medical practitioner (other than a general practitioner)—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1
5262	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 at the facility and is not a resident of a self-contained unit, lasting more than 60 minutes by a medical practitioner (other than a general practitioner)—an attendance on one or more patients at one residential 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.

Note: The fees in Group A26 are indexed in accordance with clause 1.3.1.

Group A26—Neurosurgery attendances to which no other item applies		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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

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.

Note: The fees in Group A31 are indexed in accordance with clause 1.3.1.

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; (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	278.75
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:	139.55

Clause 2.27.4

Group A31—Addiction medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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	
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

Group A31—Addiction medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
6032	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	119.65
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.

Note: The fees in Group A32 are indexed in accordance with clause 1.3.1.

Group A32—Sexual health medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **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 (b) is the first or only time in a single course of treatment that a comprehensive assessment is provided	159.35
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:	139.55

Clause 2.28.3

Group A32—Sexual health medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified sexual health medicine specialist treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient, being an attendance to which item 104, 105, 110, 116, 119, 132, 133, 6051 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	
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	79.75

Group A32—Sexual health medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
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 less than 15 minutes, with the multidisciplinary case conference team	36.05
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.

Note: The fees in Group A9 are indexed in accordance with clause 1.3.1.

Group A9—Contact lenses

Column 1 Item	Column 2 Description	Column 3 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
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	128.50

Group A9—Contact lenses		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(difference between spherical equivalents)	
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 contact lens for correction, if the condition is specified on the patient's account	128.50
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, 90051 or 90054 applies is the amount listed in the item plus $60.55.

(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, 90096, 90098, 90183, 90188, 90202, 90212 or 90215 applies is the amount listed in the item plus $43.95.

2.30.2 Items in Group A35

This clause sets out items in Group A35.

Note: The fees in Group A35 are indexed in accordance with clause 1.3.1.

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

Column 1 Item	Column 2 Description	Column 3 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 at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (subject to clause 2.30.1)	39.10
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;	75.75

	(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)	
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
90054	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 60 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (subject to clause 2.30.1)	191.20
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 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	16.00

	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, but less than 60 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
90098	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 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 60 minutes—an attendance on one or more patients at one residential aged care facility on one occasion by a medical practitioner who is not a general practitioner—each patient (subject to subclause 2.30.1(2))	88.20
90183	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 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 by a prescribed medical practitioner in an eligible area—each patient (subject to subclause 2.30.1(2))	15.15
90188	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 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 5 minutes but not more than 25 minutes—an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area—each patient (subject to subclause 2.30.1(2))	33.10
90202	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional	64.10

	attendance at a self-contained unit) or professional attendance at consulting rooms within such a complex, if the patient is a care recipient in the 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 by a prescribed medical practitioner in an eligible area—each patient (subject to subclause 2.30.1(2))	
90212	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 but not more than 60 minutes—an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area—each patient (subject to subclause 2.30.1(2))	94.40
90215	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 60 minutes—an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area—each patient (subject to subclause 2.30.1(2))	152.95

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.

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 and 287, 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: 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.

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) Item 90261 does 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.

2.31.9 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.

(1A) A reference in subclause (1) to a service providing a treatment to a patient includes any service to which item 309, 311, 313, 315, 2739, 2741, 2743, 2745, 80002, 80006, 80012, 80016, 80102, 80106, 80112, 80116, 80129, 80131, 80137, 80141, 80154, 80156, 80162, 80166, 91168, 91171, 91174, 91177, 91194, 91195, 91196, 91197, 91198, 91199, 91200, 91201, 91202, 91203, 91204, 91205, 91859, 91861, 91862, 91863, 91864, 91865, 91866, or 91867 applies that is provided to another person as part of the patient's treatment.

(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.

(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, 309, 311, 313 and 315;
(b) items 2721, 2723, 2725, 2727, 2739, 2741, 2743 and 2745;
(c) items in Groups M6, M7 and M16 other than item 82350;
(d) items 90271, 90272, 90273, 90274, 90275, 90276, 90277 and 90278;
(e) items 91166, 91167, 91168, 91169, 91170, 91171, 91172, 91173, 91174, 91175, 91176, 91177, 91181 to 91188, 91194, 91195, 91196, 91197, 91198, 91199, 91200, 91201, 91202, 91203, 91204, 91205, 91818, 91819, 91820, 91821, 91842, 91843, 91844, 91845, 91859, 91861, 91862, 91863, 91864, 91865, 91866, 91867, 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.

Note: The fees in Group A36 are indexed in accordance with clause 1.3.1.

Group A36—Eating disorders

Column 1 Item	Column 2 Description	Column 3 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	63.15
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	92.95
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	80.15

Clause 2.31.10

Group A36—Eating disorders		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
90257	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to prepare an eating disorder treatment and management plan, lasting at least 40 minutes, if the practitioner has successfully completed mental health skills training	118.10
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
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	63.15
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
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

Group A36—Eating disorders		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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	81.70
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	116.90
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

Division 2.32—Group A37: Cardiothoracic surgeon attendance for lead extraction

2.32.1 Items in Group A37

This clause sets out items in Group A37.

Note: The fees in Group A37 are indexed in accordance with clause 1.3.1.

Group A37—Cardiothoracic surgeon attendance for lead extraction		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
90300	Professional attendance by a cardiothoracic surgeon in the practice of the surgeon's speciality, if: (a) the service is: (i) performed in conjunction with a service (the ***lead extraction service***) to which item 38358 applies; or (ii) performed in conjunction with a service (the ***leadless pacemaker extraction service***) to which item 38373 or 38374 applies; and (b) the surgeon: (i) is providing surgical backup for the provider (who is not a cardiothoracic surgeon) who is performing the lead	895.25

		extraction service or the leadless pacemaker extraction service; and (ii) is present for the duration of the lead extraction service or the leadless pacemaker extraction service, other than during the low risk pre and post extraction phases; and (iii) is able to immediately scrub in and perform a thoracotomy if major complications occur
	(H)	

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.

Clause 3.1.4

3.1.4 Items in Group M12

This clause sets out items in Group M12.

Note: The fees in Group M12 are indexed in accordance with clause 1.3.1.

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		
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	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 (c) the service is consistent with the needs identified through the health assessment	24.95
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	12.50

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	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	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	

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

3.2.1 Definitions

In this Division:

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

general practice support service means a service to which an item specified in subclause 3.2.2A(2) applies.

MyMedicare means the registration program by that name administered by the Department.

MyMedicare service means a service to which an item specified in subclause 3.2.2B(2) applies that is provided:

(a) to a person enrolled in MyMedicare; and

(b) at the general practice at which the person is so enrolled.

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 Application of items 10990, 10991, 10992, 75855, 75856, 75857 and 75858

If item 10990, 10991, 10992, 75855, 75856, 75857 or 75858 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.

3.2.2A Application of items 75870, 75871, 75872, 75873, 74874, 75875 and 75876

(1) If item 75870, 75871, 75872, 75873, 75874, 75875 or 75876 applies to a medical service, the fee mentioned in that item applies in addition to the fee mentioned in an item specified in subclause (2) that applies to the service.

(2) For the purposes of subclause (1), items 23, 24, 36, 37, 44, 47, 53, 54, 57, 59, 60, 65, 123, 124, 151, 165, 185, 187, 189, 191, 203, 206, 301, 303, 737, 741, 745,

763, 766, 769, 776, 788, 789, 2197, 2198, 2200, 5020, 5023, 5028, 5040, 5043, 5049, 5060, 5063, 5067, 5071, 5076, 5077, 5203, 5207, 5208, 5209, 5223, 5227, 5228, 5261, 5262, 5263, 5265, 5267, 90035, 90043, 90051, 90054, 90093, 90095, 90096, 90098, 90188, 90202, 90212, 90215, 91800, 91803, 91806, 91891 and 91893 are specified.

3.2.2B Application of items 75880, 75881, 75882, 75883, 75884 and 75885

(1) If item 75880, 75881, 75882, 75883, 75884 or 75885 applies to a medical service, the fee mentioned in that item applies in addition to the fee mentioned in an item specified in subclause (2) that applies to the service.

(2) For the purposes of subclause (1), items 91801, 91802, 91804, 91805, 91807, 91808, 91900, 91903, 91906, 91910, 91913, 91916, 91920, 91923 and 91926 are specified.

3.2.3 Items in Group M1

This clause sets out items in Group M1.

Note: The fees in Group M1 are indexed in accordance with clause 1.3.1.

Group M1—Management of bulk-billed services		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 1—Management of general bulk-billed services		
10990	A medical service to which an item in this Schedule (other than this item) applies, if: (a) the service is an unreferred service; and (b) the service is provided to a person who is: (i) under the age of 16; or (ii) a concessional beneficiary; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) any other item in this Schedule applying to the service; other than a service associated with a service: (e) to which another item in this Group applies; or (f) that is a general practice support service; or (g) that is a MyMedicare service	7.65
10991	A medical service to which an item in this Schedule (other than this item) applies, if: (a) the service is an unreferred service; and (b) the service is provided to a person who is: (i) under the age of 16; or (ii) a concessional beneficiary; and (c) the person 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 ($)**
	(d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) any other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in a Modified Monash 2 area; other than a service associated with a service: (f) to which another item in this Group applies; or (g) that is a general practice support service; or (h) that is a MyMedicare service	
10992	A medical service to which: (a) item 585, 588, 591, 594, 599, 600, 5003, 5010, 5220 or 5260 applies; or (b) item 761 or 772 applies (see the *Health Insurance (Section 3C General Medical Services – Other Medical Practitioner) Determination 2018*); if: (c) the service is an unreferred service; and (d) the service is provided to a person who is under the age of 16 or is a concessional beneficiary; and (e) the person is not an admitted patient of a hospital; and (f) the service is not provided in consulting rooms; and (g) the service is provided in any of the following areas: (i) a Modified Monash 2 area; (ii) a Modified Monash 3 area; (iii) a Modified Monash 4 area; (iv) a Modified Monash 5 area; (v) a Modified Monash 6 area; (vi) a Modified Monash 7 area; and (h) the service is provided by, or on behalf of, a medical practitioner whose practice location is not in an area mentioned in paragraph (g); and (i) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) the other item mentioned in paragraph (a) or (b) applying to the service	11.60
75855	A medical service to which an item in this Schedule (other than this item) applies, if: (a) the service is an unreferred service; and (b) the service is provided to a person who is: (i) under the age of 16; or (ii) a concessional beneficiary; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for:	12.30

Clause 3.2.3

Group M1—Management of bulk-billed services		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(i) this item; and (ii) any other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in: (i) a Modified Monash 3 area; or (ii) a Modified Monash 4 area; other than a service associated with a service: (f) to which another item in this Group applies; or (g) that is a general practice support service; or (h) that is a MyMedicare service	
75856	A medical service to which an item in this Schedule (other than this item) applies, if: (a) the service is an unreferred service; and (b) the service is provided to a person who is: (i) under the age of 16; or (ii) a concessional beneficiary; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) any other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in a Modified Monash 5 area; other than a service associated with a service: (f) to which another item in this Group applies; or (g) that is a general practice support service; or (h) that is a MyMedicare service	13.10
75857	A medical service to which an item in this Schedule (other than this item) applies, if: (a) the service is an unreferred service; and (b) the service is provided to a person who is: (i) under the age of 16; or (ii) a concessional beneficiary; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) any other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in a Modified Monash 6 area; other than a service associated with a service: (f) to which another item in this Group applies; or (g) that is a general practice support service; or (h) that is a MyMedicare service	13.85
75858	A medical service to which an item in this Schedule (other than this	14.65

Group M1—Management of bulk-billed services		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	item) applies, if: (a) the service is an unreferred service; and (b) the service is provided to a person who is: (i) under the age of 16; or (ii) a concessional beneficiary; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) any other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in a Modified Monash 7 area; other than a service associated with a service: (f) to which another item in this Group applies; or (g) that is a general practice support service; or (h) that is a MyMedicare service	
Subgroup 2—General support service		
75870	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if: (a) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the general practice support service item applying to the attendance service; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75883, 75884 or 75885 applies	24.25
75871	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if: (a) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the general practice support service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 2 area; other than an attendance service associated with a service to which	36.90

Group M1—Management of bulk-billed services		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75883, 75884 or 75885 applies	
75872	Professional attendance (the ***attendance service***) if: (a) item 763, 766, 769, 776, 788, 789, 2198, 2200, 5023, 5028, 5043, 5049, 5063, 5067, 5076, 5077, 5223, 5227, 5228, 5261, 5263, 5265, 5267 or 5262 applies; and (b) the attendance service is an unreferred service; and (c) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and (d) the patient is not an admitted patient of a hospital; and (e) the attendance service is not provided in consulting rooms; and (f) the attendance service is provided in any of the following areas: (i) a Modified Monash 2 area; (ii) a Modified Monash 3 area; (iii) a Modified Monash 4 area; (iv) a Modified Monash 5 area; (v) a Modified Monash 6 area; (vi) a Modified Monash 7 area; and (g) the attendance service is provided by, or on behalf of, a general practitioner, a medical practitioner or a prescribed medical practitioner whose practice location is not in an area mentioned in paragraph (f); and (h) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) an item mentioned in paragraph (a) that applies to the service	36.90
75873	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if: (a) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the general practice support service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in: (i) a Modified Monash 3 area; or (ii) a Modified Monash 4 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75874, 75875, 75876, 75880, 75881, 75882, 75883,	39.20

Group M1—Management of bulk-billed services		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	75884 or 75885 applies	
75874	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if: (a) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the general practice support service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 5 area; other than an attendance service associated with a service which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75875, 75876, 75880, 75881, 75882, 75883, 75884 or 75885 applies	41.65
75875	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if: (a) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the general practice support service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 6 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75876, 75880, 75881, 75882, 75883, 75884 or 75885 applies	43.95
75876	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if: (a) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the general practice support service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location	46.65

Clause 3.2.3

Group M1—Management of bulk-billed services		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	in a Modified Monash 7 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75880, 75881, 75882, 75883, 75884 or 75885 applies	
Subgroup 3—Patients enrolled in MyMedicare		
75880	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if: (a) the attendance service is provided to a patient: (i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (ii) who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the MyMedicare service item applying to the attendance service; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75881, 75882, 75883, 75884 or 75885 applies	24.25
75881	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if: (a) the attendance service is provided to a patient: (i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (ii) who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the MyMedicare service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 2 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75882, 75883, 75884 or 75885 applies	36.90
75882	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical	39.20

Group M1—Management of bulk-billed services

Column 1 Item	Column 2 Description	Column 3 Fee ($)
	practitioner, at which a MyMedicare service is provided, if: (a) the attendance service is provided to a patient: (i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (ii) who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the MyMedicare service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in: (i) a Modified Monash 3 area; or (ii) a Modified Monash 4 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75883, 75884 or 75885 applies	
75883	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if: (a) the attendance service is provided to a patient: (i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (ii) who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the MyMedicare service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 5 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75884 or 75885 applies	41.65
75884	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if: (a) the attendance service is provided to a patient: (i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (ii) who is under the age of 16 or who is a concessional	43.95

Clause 3.2.3

Group M1—Management of bulk-billed services		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the MyMedicare service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 6 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75883 or 75885 applies	
75885	Professional attendance (the ***attendance service***) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if: (a) the attendance service is provided to a patient: (i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (ii) who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the MyMedicare service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 7 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75883 or 75884 applies	46.65

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, 11716, 11717, 11723 and 11735—reports

(1) Items 11704, 11705, 11716, 11717, 11723 and 11735 apply to a service only if:

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

(b) if the service was requested—a copy of the report is provided to the requesting practitioner.

(2) The report must:

(a) be in writing; and

(b) be prepared by a specialist or consultant physician; and

(c) include an interpretation of the trace, including the indicators for the investigation; and
(d) 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
(e) if appropriate—include a copy of the trace and any measurements taken or automatically generated; and
(f) 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—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, 11730 and 11732—patient limitations

(1) Items 11729, 11730 and 11732 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, 11730 and 11732—safety requirements

(1) Items 11729, 11730 and 11732 apply to a service provided to a patient only if:

(a) the service is performed on premises equipped with resuscitation equipment, including a defibrillator; and

(b) a person trained in the matters mentioned in subclause (2) and cardiopulmonary resuscitation is in continuous personal attendance during the monitoring and recording; and

(c) at the time the service is performed, a second person trained in cardiopulmonary resuscitation is located at the premises and is immediately available to respond if required; and

(d) at least one of the persons mentioned in paragraphs (b) and (c) is a medical practitioner.

(2) For the purposes of paragraph (1)(b), the matters are:

(a) how to safely perform exercise or pharmacological stress monitoring and recording; and

(b) how to recognise the symptoms and signs of cardiac disease.

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.

Note: The fees in Group D1 are indexed in accordance with clause 1.3.1.

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	338.85

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
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 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	338.85
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	175.70

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	involving multifocal multichannel objective perimetry—3 or more studies	
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
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	42.50

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
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 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	107.85
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, if: (a) the service is not for the purposes of programming either an auditory	200.30

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	implant or the sound processor of an auditory implant; and (b) a service to which item 82300 applies has not been performed on the patient on the same day; other than a service associated with a service to which item 11340, 11341 or 11343 applies (Anaes.)	
11302	Programming an auditory implant or the sound processor of an auditory implant, unilateral, performed by or on behalf of a medical practitioner, if a service to which item 82301, 82302 or 82304 applies has not been performed on the patient on the same day Applicable up to a total of 4 services to which this item, item 11342 or item 11345 applies on the same day	203.50
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, if a service to which item 82306 applies has not been performed on the patient on the same day	22.80
11309	Audiogram, air conduction, if a service to which item 82309 applies has not been performed on the patient on the same day	27.35
11312	Audiogram, air and bone conduction or air conduction and speech discrimination, if a service to which item 82312 applies has not been performed on the patient on the same day	38.65
11315	Audiogram, air and bone conduction and speech, if a service to which item 82315 applies has not been performed on the patient on the same day	51.20
11318	Audiogram, air and bone conduction and speech, with other cochlear tests, if a service to which item 82318 applies has not been performed on the patient on the same day	63.20
11324	Impedance audiogram involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a medical practitioner, if a service to which item 82324 applies has not been performed on the patient on the same day	21.00
11332	Oto-acoustic emission audiometry for the detection of outer hair cell functioning in the cochlea, performed by or on behalf of a specialist or consultant physician, when middle ear pathology has been excluded, if: (a) the service is performed: (i) on an infant or child who is at risk of permanent hearing impairment; or (ii) on an individual who is at risk of oto-toxicity due to medications or medical intervention; or (iii) on an individual at risk of noise induced hearing loss; or (iv) to assist in the diagnosis of auditory neuropathy; and (b) a service to which item 82332 applies has not been performed on the patient on the same day	60.95

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
11340	Investigation of the vestibular function to assist in the diagnosis, treatment or management of a vestibular or related disorder, performed by or on behalf of a medical practitioner: (a) to assess one or more of the following: (i) the organs of the peripheral vestibular system (utricle, saccule, lateral, superior and posterior semicircular canals, and vestibular nerve); (ii) muscular or eye movement responses elicited by vestibular stimulation; (iii) static signs of vestibular dysfunction; (iv) the central ocular-motor function; and (b) using up to 2 clinically recognised tests; other than a service associated with a service to which item 11015, 11021, 11024, 11027, 11205 or 11300 applies	196.80
11341	Investigation of the vestibular function to assist in the diagnosis, treatment or management of a vestibular or related disorder, performed by or on behalf of a medical practitioner: (a) to assess one or more of the following: (i) the organs of the peripheral vestibular system (utricle, saccule, lateral, superior and posterior semicircular canals, and vestibular nerve); (ii) muscular or eye movement responses elicited by vestibular stimulation; (iii) static signs of vestibular dysfunction; (iv) the central ocular-motor function; and (b) using 3 or 4 clinically recognised tests; other than a service associated with a service to which item 11015, 11021, 11024, 11027, 11205 or 11300 applies	394.50
11343	Investigation of the vestibular function to assist in the diagnosis, treatment or management of a vestibular or related disorder, performed by or on behalf of a medical practitioner: (a) to assess one or more of the following: (i) the organs of the peripheral vestibular system (utricle, saccule, lateral, superior and posterior semicircular canals, and vestibular nerve); (ii) muscular or eye movement responses elicited by vestibular stimulation; (iii) static signs of vestibular dysfunction; (iv) the central ocular-motor function; and (b) using 5 or more clinically recognised tests; other than a service associated with a service to which item 11015, 11021, 11024, 11027, 11205 or 11300 applies	590.25
Subgroup 4—Respiratory		
11503	Complex measurement of properties of the respiratory system, including	144.25

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	the lungs and respiratory muscles, that is performed: (a) in a respiratory laboratory; and (b) under the supervision of a specialist or consultant physician who is responsible for staff training, supervision, quality assurance and the issuing of written reports on tests performed; and (c) using any of the following tests: (i) measurement of absolute lung volumes by any method; (ii) measurement of carbon monoxide diffusing capacity by any method; (iii) measurement of airway or pulmonary resistance by any method; (iv) inhalation provocation testing, including pre-provocation spirometry and the construction of a dose response curve, using a recognised direct or indirect bronchoprovocation agent and post-bronchodilator spirometry; (v) provocation testing involving sequential measurement of lung function at baseline and after exposure to specific sensitising agents, including drugs, or occupational asthma triggers; (vi) spirometry performed before and after simple exercise testing undertaken as a provocation test for the investigation of asthma, in premises equipped with resuscitation equipment and personnel trained in Advanced Life Support; (vii) measurement of the strength of inspiratory and expiratory muscles at multiple lung volumes; (viii) simulated altitude test involving exposure to hypoxic gas mixtures and oxygen saturation at rest and/or during exercise with or without an observation of the effect of supplemental oxygen; (ix) calculation of pulmonary or cardiac shunt by measurement of arterial oxygen partial pressure and haemoglobin concentration following the breathing of an inspired oxygen concentration of 100% for 15 minutes or greater; (x) if the measurement is for the purpose of determining eligibility for pulmonary arterial hypertension medications subsidised under the Pharmaceutical Benefits Scheme or eligibility for the provision of portable oxygen—functional exercise test by any method (including 6 minute walk test and shuttle walk test); each occasion at which one or more tests are performed Not applicable to a service performed in association with a spirometry or sleep study service to which item 11505, 11506, 11507, 11508, 11512, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Not applicable to a service to which item 11507 applies	
11505	Measurement of spirometry, that: (a) involves a permanently recorded tracing, performed before and after	42.80

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
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; 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	104.30
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	302.60

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(ii) breathlessness out of proportion with impairment due to known conditions; or (iii) functional status and prognosis in a patient with significant cardiac or pulmonary disease for whom complex procedures such as organ transplantation are considered; or (iv) anaesthetic and perioperative risks in a patient undergoing major surgery who is assessed as substantially above average risk after standard evaluation; and (b) the test has been requested by a specialist or consultant physician following professional attendance on the patient by the specialist or consultant physician; and (c) a respiratory scientist and a medical practitioner are in constant attendance during the test; and (d) the test is performed in a respiratory laboratory equipped with airway management and defibrillator equipment; and (e) there is continuous measurement of at least the following: (i) work rate; (ii) pulse oximetry; (iii) respired oxygen and carbon dioxide partial pressures and respired volumes; (iv) ECG; (v) heart rate and blood pressure; and (f) interpretation and preparation of a permanent report is provided by a specialist or consultant physician who is also responsible for the supervision of technical staff and quality assurance	
11512	Measurement of spirometry: (a) that includes continuous measurement of the relationship between flow and volume during expiration or during expiration and inspiration, performed before and after inhalation of a bronchodilator; and (b) that is performed with a respiratory scientist in continuous attendance; and (c) that is performed in a respiratory laboratory equipped to perform complex lung function tests; and (d) that is performed under the supervision of a specialist or consultant physician who is responsible for staff training, supervision, quality assurance and the issuing of written reports; and (e) for which a permanently recorded tracing and written report is provided; and (f) for which 3 or more spirometry recordings are performed; each occasion at which one or more such tests are performed Not applicable for a service associated with a service to which item 11503 or 11507 applies	64.25

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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
11607	Continuous ambulatory blood pressure recording for 24 hours or more for a patient if: (a) the patient has a clinic blood pressure measurement (using a sphygmomanometer or a validated oscillometric blood pressure monitoring device) of either or both of the following measurements: (i) systolic blood pressure greater than or equal to 140 mmHg and less than or equal to 180 mmHg; (ii) diastolic blood pressure greater than or equal to 90 mmHg and less than or equal to 110 mmHg; and (b) the patient has not commenced anti-hypertensive therapy; and (c) the recording includes the patient's resting blood pressure; and (d) the recording is conducted using microprocessor-based analysis equipment; and (e) the recording is interpreted by a medical practitioner and a report is prepared by the same medical practitioner; and (f) a treatment plan is provided for the patient; and (g) the service: (i) is not provided in association with ambulatory electrocardiogram recording; and	107.20

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(ii) is not associated with a service to which any of the following items apply: (A) 177; (B) 224 to 228; (C) 229 to 244; (D) 699; (E) 701 to 707; (F) 715; (G) 721 to 732; (H) 735 to 758. Applicable only once in any 12 month period Note: Items 177 and 699 are specified in determinations made under subsection 3C(1) of the Act.	
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, 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	66.30
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 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	32.55

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
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
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
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	174.30

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
11717	Ambulatory electrocardiogram monitoring, by a specialist or consultant physician, if the service: (a) utilises a patient activated, single or multiple event memory recording device that: (i) is connected continuously to the patient for between 7 and 30 days; and (ii) is capable of recording for at least 20 seconds prior to each activation and for 15 seconds after each activation; and (b) includes transmission, analysis, interpretation and reporting (including the indication for the investigation); and (c) is for the investigation of recurrent episodes of: (i) unexplained syncope; or (ii) palpitation; or (iii) other symptoms where a cardiac rhythm disturbance is suspected and where infrequent episodes have occurred; and (d) is not associated with a service to which item 11716, 11723, 11735, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable only once in any 3 month period	102.40
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 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 11704, 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	54.05

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
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
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 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	158.35

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
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	158.35

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	Applicable only once in any 24 month period	
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
11732	Multi-channel electrocardiogram monitoring and recording during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts), performed by a cardiologist with relevant expertise in genetic heart disease, if: (a) the patient is: (i) under investigation or treatment for long QT syndrome, catecholaminergic polymorphic ventricular tachycardia or arrhythmogenic cardiomyopathy; or (ii) a first degree relative of a person with confirmed long QT syndrome, catecholaminergic polymorphic ventricular tachycardia, arrhythmogenic cardiomyopathy or unexplained sudden cardiac death at 40 years of age or younger; and (b) the monitoring and recording: (i) is for at least 20 minutes; and (ii) includes resting electrocardiogram; and (c) the cardiologist produces a report that includes interpretation of the monitoring and recording data (commenting on the significance of the data) and discussion of the relationship of the data to clinical decision making for the patient in the clinical context; and (d) the service is not provided on the same occasion as a service to which item 11704, 11705, 11707, 11714, 11729 or 11730 applies Applicable once per day	167.55
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	133.10

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(c) includes interpretation and report; and (d) is not a service: (i) provided in association with ambulatory blood pressure monitoring; or (ii) associated with a service to which item 11716, 11717, 11723, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable not more than 4 times in any 12 month period	
11736	Implanted loop recording via remote monitoring (including reprogramming (if required), retrieval of stored data, analysis, interpretation and report), for the investigation of atrial fibrillation, if the service: (a) is provided to a patient who has been diagnosed as having had an embolic stroke of undetermined source; and (b) is not a service to which item 38288 applies Applicable not more than 4 times in any 12 month period	36.75
11737	Implanted electrocardiogram loop recording via remote monitoring (including reprogramming (if required), retrieval of stored data, analysis, interpretation and report), by a medical practitioner, if the service is: (a) an investigation for a patient with: (i) cryptogenic stroke; or (ii) recurrent unexplained syncope; and (b) not a service to which item 38285 applies Applicable only once in any 4 week period	36.75
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

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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 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	1,279.15
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, not being a service associated with a service to which item 11912, 11917 or 11919 applies	28.65
11912	Cystometrography: (a) with measurement of any one or more of the following:	205.50

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(i) urine flow rate; (ii) urethral pressure profile; (iii) urethral sphincter electromyography; and (b) with simultaneous measurement of: (i) rectal pressure; or (ii) stomal or vaginal pressure if rectal pressure is not possible; not being a service associated with a service to which any of items 11012 to 11027, 11900, 11917, 11919 and 36800 or an item in Group I3 of the diagnostic imaging services table applies (Anaes.)	
11917	Cystometrography, in conjunction with real time ultrasound of one or more components of the urinary tract: (a) with measurement of any one or more of the following: (i) urine flow rate; (ii) urethral pressure profile; (iii) urethral sphincter electromyography; and (b) with simultaneous measurement of: (i) rectal pressure; or (ii) stomal or vaginal pressure if rectal pressure is not possible; including all imaging associated with cystometrography, not being a service associated with a service to which any of items 11012 to 11027, 11900, 11912, 11919 and 36800 or an item in Group I3 of the diagnostic imaging services table applies (Anaes.)	445.75
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 and 36800 applies (Anaes.)	445.75
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	40.50

Clause 4.1.5

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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	
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 (d) not being a service associated with a service to which item 12000, 12001, 12002, 12003, 12012, 12017, 12021, 12022 or 12024 applies	82.40
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	2,489.85

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
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: (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	611.80

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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 (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	611.80

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	sleep medicine practitioner or a consultant respiratory physician (either face-to-face or by video conference), the qualified adult sleep medicine practitioner or consultant respiratory physician establishes that the sleep-related breathing disorder is responsible for the patient's symptoms; and (d) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (e) there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement; (ix) position; and (f) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (g) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (h) the overnight assessment is not provided to the patient on the same occasion that a service 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	611.80

Clause 4.1.5

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Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	the patient) are unavailable or have been equivocal; (iii) the patient has undergone a therapeutic intervention (including, but not limited to, positive airway pressure, upper airway surgery, positional therapy, appropriate oral appliance, weight loss of more than 10% in the previous 6 months or oxygen therapy), and there is either clinical evidence of sub-optimal response or uncertainty about control of sleep-disordered breathing; and (b) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and (c) there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures: (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (d) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (e) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (f) the follow-up study is not provided to the patient on the same occasion that a service 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:	611.80

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Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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	
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;	611.80

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Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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	
12210	Overnight paediatric investigation, for at least 8 hours, for a patient less than 12 years of age, if: (a) the patient is referred by a medical practitioner; and (b) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner before the investigation; and (c) there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and	730.30

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Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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 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	657.90

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Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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 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	730.30

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	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 (e) polygraphic records are: (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of	657.90

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Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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

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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;	950.70

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	(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 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	950.70

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Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	of a qualified adult sleep medicine practitioner; and (e) polygraphic records are: (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12203, 12204, 12205, 12208, 12250 or 12254 is provided to the patient Applicable only once in a 12 month period	
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:	996.85

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Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12213, 12217 or 12265 is provided to the patient Applicable only once in a 12 month period	
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	996.85

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Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and (f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12213, 12217 or 12261 is provided to the patient Applicable only once in a 12 month period	
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	1,069.20

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	(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	
12272	Maintenance of wakefulness test for the assessment of the ability to maintain wakefulness for a patient less than 12 years of age, if: (a) a qualified paediatric sleep medicine practitioner determines that testing to objectively confirm the ability to maintain wakefulness is necessary; and (b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following, in accordance with current professional guidelines: (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and (c) immediately following the overnight 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	1,069.20

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	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 For any particular patient, once only in a 24 month period	106.55
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	106.55

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Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
12321	Bone densitometry, using dual energy X-ray absorptiometry, involving the measurement of 2 or more sites at least 12 months after a significant change in therapy (including interpretation and reporting), for: (a) established low bone mineral density; or (b) confirming a presumptive diagnosis of low bone mineral density made on the basis of one or more fractures occurring after minimal trauma; other than a service associated with a service to which item 12306, 12312 or 12315 applies For any particular patient, once only in a 12 month period	106.55
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	52.00

Group D1—Miscellaneous diagnostic procedures and investigations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	at the time of presentation	
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

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.

Note: The fees in Group D2 are indexed in accordance with clause 1.3.1.

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*	88.10

Clause 4.2.2

Group D2—Nuclear medicine (non-imaging)		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	in patients with peptic ulcer disease; (other than a service associated with a service to which item 66900 applies)	

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 and 13201:

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 or item 73384, 73385, 73386 or 73387 of the pathology services table) 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.

5.2.6A Restriction on items 14217 and 14220—maintenance therapy

A service under item 14217 or 14220 cannot be provided to a patient as maintenance therapy for the prevention of further relapse of the patient's depression.

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.

Note: The fees in Group T1 are indexed in accordance with clause 1.3.1.

Clause 5.2.10

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 the hyperbaric chamber of at least 1 hour 30 minutes and not more than 3 hours, including any associated attendance	269.35
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:	615.95

Group T1—Miscellaneous therapeutic procedures		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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	
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 proceeding to oocyte retrieval, involving the use of drugs to induce superovulation and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, transfer of frozen embryos or donated embryos or ova or a service to which item 13201, 13202, 13203 or 13218 applies, being services rendered during one treatment cycle—initial cycle in a single calendar year	3,236.75
13201	Assisted reproductive technologies superovulated treatment cycle proceeding to oocyte retrieval, involving the use of drugs to induce superovulation and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, transfer of frozen embryos or donated embryos or ova or a service to which item 13200, 13202, 13203 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 or 13218 applies, being services rendered during one treatment cycle	484.40
13203	Ovulation monitoring services for artificial insemination or gonadotrophin, stimulated ovulation induction, including quantitative estimation of hormones and ultrasound examinations, being services rendered during one treatment cycle but excluding a service to which	506.45

Clause 5.2.10

Group T1—Miscellaneous therapeutic procedures		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	item 13200, 13201, 13202, 13212, 13215 or 13218 applies	
13207	Biopsy of an embryo, from a patient who is eligible for a service described in item 73384 under clause 2.7.3A of the pathology services table, for the purpose of providing a sample for pre-implantation genetic testing—applicable to one or more tests performed in one assisted reproductive treatment cycle	115.00
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
13212	Oocyte retrieval for the purpose of assisted reproductive technologies—only if rendered in connection with a service to which item 13200 or 13201 applies (Anaes.)	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 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 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
13241	Open surgical testicular sperm retrieval, unilateral, using operating microscope, including the exploration of scrotal contents, with biopsy, for the purposes of intracytoplasmic sperm injection, for male factor infertility, not being a service associated with a service to which item 13218 or 37604 applies (H) (Anaes.)	884.45
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

Group T1—Miscellaneous therapeutic procedures		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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
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 (H) (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, other than a service associated with a service to which item 22052 applies	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,	75.90

Clause 5.2.10

Group T1—Miscellaneous therapeutic procedures		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	polycythemia vera or porphyria cutanea tarda	
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
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	119.50

Group T1—Miscellaneous therapeutic procedures		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	from implantation or management of the device—each day after the first day	
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 rostered to intensive care, including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling, bladder catheterisation and blood sampling—management on the first day (H)	376.75
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,	80.00

Clause 5.2.10

Group T1—Miscellaneous therapeutic procedures		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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)	
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
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	266.90

Group T1—Miscellaneous therapeutic procedures		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	300 cm^2 (Anaes.)	
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 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.)	158.65
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
14212	Intussusception, management of fluid or gas reduction for (Anaes.)	192.75
14216	Professional attendance on a patient by a psychiatrist, who has undertaken training in Repetitive Transcranial Magnetic Stimulation (rTMS), for treatment mapping for rTMS, if the patient: (a) has not previously received any prior transcranial magnetic stimulation therapy in a public or private setting; and (b) is at least 18 years old; and (c) is diagnosed with a major depressive episode; and (d) has failed to receive satisfactory improvement for the major depressive episode despite the adequate trialling of at least 2 different classes of antidepressant medications, unless contraindicated, and all of the following apply: (i) the patient's adherence to antidepressant treatment has been formally assessed;	186.40

Clause 5.2.10

Group T1—Miscellaneous therapeutic procedures		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(ii) the trialling of each antidepressant medication has been at the recommended therapeutic dose for a minimum of 3 weeks; (iii) where clinically appropriate, the treatment has been titrated to the maximum tolerated therapeutic dose; and (e) has undertaken psychological therapy, if clinically appropriate	
14217	Repetitive Transcranial Magnetic Stimulation (rTMS) treatment of up to 35 services provided by, or on behalf of, a psychiatrist who has undertaken training in rTMS, if the patient has previously received a service under item 14216—each service up to 35 services	160.00
14218	Implanted infusion pump, refilling of reservoir with a therapeutic agent or agents for infusion to the subarachnoid space or accessing the side port to assess catheter patency, with or without pump reprogramming, for the management of chronic pain, including cancer pain	101.90
14219	Professional attendance on a patient by a psychiatrist, who has undertaken training in Repetitive Transcranial Magnetic Stimulation (rTMS), for treatment mapping for rTMS, if the patient: (a) is at least 18 years old; and (b) is diagnosed with a major depressive episode; and (c) has failed to receive satisfactory improvement for the major depressive episode despite the adequate trialling of at least 2 different classes of antidepressant medications, unless contraindicated, and all of the following apply: (i) the patient's adherence to antidepressant treatment has been formally assessed; (ii) the trialling of each antidepressant medication has been at the recommended therapeutic dose for a minimum of 3 weeks; (iii) where clinically appropriate, the treatment has been titrated to the maximum tolerated therapeutic dose; and (d) has undertaken psychological therapy, if clinically appropriate; and (e) has previously received an initial service under item 14217 and the patient: (i) has relapsed after a remission following the initial service; and (ii) has had a satisfactory clinical response to the service under item 14217 (which has been assessed by a validated major depressive disorder tool at least 4 months after receiving that service)	186.40
14220	Repetitive Transcranial Magnetic Stimulation (rTMS) treatment of up to 15 services provided by, or on behalf of, a psychiatrist who has undertaken training in rTMS, if the patient has previously received: (a) a service under item 14217 (which was not provided in the previous 4 months); and	160.00

Group T1—Miscellaneous therapeutic procedures		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(b) a service under item 14219 Each service up to 15 services	
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 (H) (Anaes.)	169.25
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
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	115.85

Clause 5.2.10

Group T1—Miscellaneous therapeutic procedures		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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.)	
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 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.)	40.75
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

Group T1—Miscellaneous therapeutic procedures

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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 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
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	154.40

Clause 5.3.1

Group T1—Miscellaneous therapeutic procedures		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies	
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	18.80
2	15009	The fee for item 15006	20.40
3	15103	The fee for item 15100	20.65
4	15109	The fee for item 15106	24.95
5	15115	The fee for item 15112	52.05
6	15214	The fee for item 15211	35.10
7	15230	The fee for item 15215	41.80
8	15233	The fee for item 15218	41.80
9	15236	The fee for item 15221	41.80
10	15239	The fee for item 15224	41.80
11	15242	The fee for item 15227	41.80
12	15260	The fee for item 15245	41.80

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 ($)
13	15263	The fee for item 15248	41.80
14	15266	The fee for item 15251	41.80
15	15269	The fee for item 15254	41.80
16	15272	The fee for item 15257	41.80

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.

Note: The fees in Group T2 are indexed in accordance with clause 1.3.1.

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	62.05

Group T2—Radiation oncology		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	treatment is given—one field—treatment delivered to primary site (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,	62.05

Clause 5.3.4

Group T2—Radiation oncology		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	with electron facilities—attendance at which treatment is given—one field—treatment delivered to primary site (lung)	
15248	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 (prostate)	62.05
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

Group T2—Radiation oncology		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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 by a fixed or dynamic gantry linear accelerator or by a helical non C-arm based linear accelerator) Applicable once for each treatment	190.35
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

Clause 5.3.4

Group T2—Radiation oncology		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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 techniques (Anaes.)	817.25
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	973.50

Group T2—Radiation oncology		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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	
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
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	282.10

Clause 5.3.4

Group T2—Radiation oncology		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	which item 15503 applies)	
15513	Radiation source localisation using a simulator or x-ray machine or CT of a single area, if views in more than one plane are required, for brachytherapy treatment planning for Iodine 125 seed implantation of localised prostate cancer, being a service associated with a service to which item 15338 applies	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 opposed fields to one area with up to 2 shielding blocks	80.10
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	685.30

Group T2—Radiation oncology		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
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 (d) the image set up is required to be suitable for the generation of quality digitally reconstructed radiographic images	739.35
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	901.65

Clause 5.3.4

Group T2—Radiation oncology		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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	
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 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	1,166.20
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	3,448.10

Group T2—Radiation oncology		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
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; —each attendance at which treatment is verified	47.85
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	79.70

Clause 5.3.4

Group T2—Radiation oncology		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	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	
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.

Note: The fees in Group T3 are indexed in accordance with clause 1.3.1.

Group T3—Therapeutic nuclear medicine		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **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.)	1,554.25
16006	Administration of a therapeutic dose of Iodine 131 for thyroid cancer by single dose technique	1,047.70
16009	Administration of a therapeutic dose of Iodine 131 for thyrotoxicosis by single dose technique	507.55
16012	Intravenous administration of a therapeutic dose of Phosphorous 32	2,915.10
16015	Administration of Strontium 89 for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan), if systemic antineoplastic therapy is unavailable or has failed to control the patient's disease and either: (a) the disease is poorly controlled by conventional radiotherapy; or (b) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain	4,251.20
16018	Administration of 153 Sm-lexidronam for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan), if systemic antineoplastic therapy is unavailable or has failed to control the patient's disease, and: (a) the disease is poorly controlled by conventional radiotherapy; or (b) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain	4,814.70

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.

(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 item 10990, 10991, 10992, 75855, 75856, 75857 or 75858.

(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.

Note: The fees in Group T4 are indexed in accordance with clause 1.3.1.

Group T4—Obstetrics

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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,	28.35

Group T4—Obstetrics		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
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 after referral of the patient to the specialist—an attendance after the initial attendance in a single course of treatment	44.75
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	55.55

Clause 5.5.4

Group T4—Obstetrics		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	item 82130, 82135 or 82140 applies is not provided Applicable once for a pregnancy	
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 attendance that is not a routine antenatal attendance	49.05
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	656.40

Group T4—Obstetrics		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	practitioner has not provided any of the antenatal care (Anaes.)	
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 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	1,695.35

Clause 5.5.4

Group T4—Obstetrics		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(ii) the patient receiving ongoing care by a psychologist or psychiatrist to treat the symptoms of a mental health disorder; or (iii) the patient having a GP mental health treatment plan; or (iv) the patient having a management plan prepared in accordance with item 291; (n) disclosure or evidence of domestic violence; (o) any of the following conditions either diagnosed pre-pregnancy or evident at the first antenatal visit before 20 weeks gestation: (i) pre-existing hypertension requiring antihypertensive medication prior to pregnancy; (ii) cardiac disease (co-managed with a specialist physician and with echocardiographic evidence of myocardial dysfunction); (iii) previous renal or liver transplant; (iv) renal dialysis; (v) chronic liver disease with documented oesophageal varices; (vi) renal insufficiency in early pregnancy (serum creatinine greater than 110 mmol/L); (vii) neurological disorder that confines the patient to a wheelchair throughout pregnancy; (viii) maternal height of less than 148 cm; (ix) a body mass index greater than or equal to 40; (x) pre-existing diabetes mellitus on medication prior to pregnancy; (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

Group T4—Obstetrics

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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 mucosa, repair of, as an independent procedure (Anaes.)	270.30
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	148.40

Clause 5.6.1

Group T4—Obstetrics		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	patient; and (c) a service to which item 16590 applies is not provided in relation to the same pregnancy Applicable once for a pregnancy	
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
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.

Note: The fees in Group T6 are indexed in accordance with clause 1.3.1.

Group T6—Examination by anaesthetist		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
17610	Professional attendance by a medical practitioner in the practice of anaesthesia for a brief consultation involving a targeted history and	45.40

Group T6—Examination by anaesthetist		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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)	
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 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)	125.15
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	125.15

Clause 5.7.1

Group T6—Examination by anaesthetist		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	more than 45 minutes, (other than a service associated with a service to which any of items 2801 to 3000 apply)	
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 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)	41.75

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) $20.90 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) $31.50 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.

Note: The fees in Group T7 are indexed in accordance with clause 1.3.1.

Group T7—Regional or field nerve blocks

Column 1 Item	Column 2 Description	Column 3 Fee ($)
18213	Intravenous regional anaesthesia of limb by retrograde perfusion of local anaesthetic agent	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 first hour (Anaes.)	Amount under clause 5.7.1
18222	Continuous infusion, or injection by catheter, of a therapeutic substance (not contrast agent) to maintain regional anaesthesia or analgesia, subsequent injection or revision of, if the period of continuous medical practitioner attendance is 15 minutes or less	39.15
18225	Continuous infusion, or injection by catheter, of a therapeutic substance (not contrast agent) to maintain regional anaesthesia or analgesia, subsequent injection or revision of, if the period of continuous medical practitioner attendance is more than 15 minutes	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, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach	65.05
18230	Intrathecal or epidural injection of neurolytic substance (not contrast agent) by any route, including transforaminal route (Anaes.)	248.10
18232	Intrathecal or epidural injection (including translaminar and	197.60

Clause 5.7.2

Group T7—Regional or field nerve blocks		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	transforaminal approaches) of therapeutic substance or substances (anaesthetic, steroid or chemotherapeutic agents): (a) other than a service to which another item in this Group applies; and (b) not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (Anaes.)	
18233	Epidural injection of blood for blood patch (Anaes.)	197.60
18234	Trigeminal nerve, primary branch (ophthalmic, maxillary or mandibular branches, excluding infraorbital nerve), injection of an anaesthetic agent or steroid, but not in association with a service to which an item in Group T8 applies, unless a targeted percutaneous technique is used (Anaes.)	129.90
18236	Trigeminal nerve, peripheral branch (including infraorbital nerve), injection of an anaesthetic agent, but not in association with a service to which an item in Group T8 applies, unless a targeted percutaneous technique is used (Anaes.)	65.05
18238	Facial nerve, injection of an anaesthetic agent, other than a service associated with a service to which item 18240 applies, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach	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, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach	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, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach	104.90
18254	Brachial plexus, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach	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, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (Anaes.)	65.05
18264	Pudendal nerve or dorsal nerve (or both), injection of an anaesthetic	104.90

Group T7—Regional or field nerve blocks		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach	
18266	Ulnar, radial or median nerve, main trunk of, one or more of, injections of an anaesthetic agent, not being associated with a brachial plexus block, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach	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
18276	Paravertebral nerves, injection of an anaesthetic agent, (multiple levels)	129.90
18278	Sciatic nerve, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach	92.20
18280	Sphenopalatine ganglion, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (Anaes.)	129.90
18282	Carotid sinus, injection of an anaesthetic agent, as an independent percutaneous procedure	104.90
18284	Cervical or thoracic sympathetic chain, injection of an anaesthetic agent (Anaes.)	153.60
18286	Lumbar or pelvic sympathetic chain, injection of an anaesthetic agent (Anaes.)	153.60
18288	Coeliac plexus or splanchnic nerves, injection of an anaesthetic agent, not in association with a service to which an item in Group T8 applies, unless the nerve block is performed using a targeted percutaneous approach (Anaes.)	153.60
18290	Cranial nerve other than trigeminal, destruction by a neurolytic agent under image guidance, other than a service associated with the injection of botulinum toxin (Anaes.)	259.85
18292	Nerve branch, destruction by a neurolytic agent under image guidance, other than a service to which another item in this Group applies or a service associated with the injection of botulinum toxin except a service to which item 18354 applies (Anaes.)	129.90
18294	Coeliac plexus or splanchnic nerves, destruction by a neurolytic agent under image guidance (Anaes.)	183.15
18296	Lumbar or pelvic sympathetic chain, destruction by a neurolytic agent under image guidance (Anaes.)	156.65
18297	Assistance at the administration of an epidural blood patch (a service	61.75

Group T7—Regional or field nerve blocks		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	to which item 18233 applies) by another medical practitioner	
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.

Note: The fees in Group T11 are indexed in accordance with clause 1.3.1.

Group T11—Botulinum toxin		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
18350	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of hemifacial spasm in a patient who is at least 12 years of age, including all such injections on any one day	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	259.85

Group T11—Botulinum toxin		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	such injections on any one day	
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
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	277.85

Clause 5.8.3

Group T11—Botulinum toxin		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	such injections on any one day	
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 treatment of bilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.)	129.90
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,	129.90

Group T11—Botulinum toxin		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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)	
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 (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.)	239.20

Division 5.9—Group T10: Anaesthesia performed in connection with certain services (Relative Value Guide)

5.9.1A Meaning of *base unit*

In an item in Group T10:

base unit means an amount of $21.80.

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) $109.05; 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.

Restriction on item 22054

(4) Item 22054 does not apply to a service if the service is performed on diagnostic imaging equipment that exceeds the applicable life age of the equipment within the meaning of the diagnostic imaging services table.

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.

(3) Items 23010 to 24136 apply to a service provided to a patient under anaesthesia, but only if the anaesthesia start and end times are recorded in writing.

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	5 base units

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	in this Subgroup applies	
20102	Initiation of the management of anaesthesia for plastic repair of cleft lip	6 base units
20104	Initiation of the management of anaesthesia for electroconvulsive therapy	4 base units
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	5 base units
20124	Initiation of the management of anaesthesia for otoscopy	4 base units
20140	Initiation of the management of anaesthesia for procedures on eye, other than a service to which another item in this Subgroup applies	5 base units
20142	Initiation of the management of anaesthesia for lens surgery	5 base units
20143	Initiation of the management of anaesthesia for retinal surgery	6 base units
20144	Initiation of the management of anaesthesia for corneal transplant	7 base units
20145	Initiation of the management of anaesthesia for vitrectomy	7 base units
20146	Initiation of the management of anaesthesia for biopsy of conjunctiva	5 base units
20147	Initiation of the management of anaesthesia for squint repair	6 base units
20148	Initiation of the management of anaesthesia for ophthalmoscopy	4 base units
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	6 base units
20162	Initiation of the management of anaesthesia for intranasal surgery for malignancy or for intranasal ablation	7 base units
20164	Initiation of the management of anaesthesia for biopsy of soft tissue of the nose and accessory sinuses	4 base units
20170	Initiation of the management of anaesthesia for intraoral procedures, including biopsy, other than a service to which another item in this Subgroup applies	6 base units
20172	Initiation of the management of anaesthesia for repair of cleft palate	7 base units
20174	Initiation of the management of anaesthesia for excision of retropharyngeal tumour	9 base units
20176	Initiation of the management of anaesthesia for radical intraoral surgery	10 base units
20190	Initiation of the management of anaesthesia for procedures on facial bones, other than a service to which another item in this Subgroup applies	5 base units
20192	Initiation of the management of anaesthesia for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction)	10 base units
20210	Initiation of the management of anaesthesia for intracranial procedures,	15 base units

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 ($)**
	other than a service to which another item in this Subgroup applies	
20212	Initiation of the management of anaesthesia for subdural taps	5 base units
20214	Initiation of the management of anaesthesia for burr holes of the cranium	9 base units
20216	Initiation of the management of anaesthesia for intracranial vascular procedures, including those for aneurysms or arterio-venous abnormalities	20 base units
20220	Initiation of the management of anaesthesia for spinal fluid shunt procedures	10 base units
20222	Initiation of the management of anaesthesia for ablation of an intracranial nerve	6 base units
20225	Initiation of the management of anaesthesia for all cranial bone procedures	12 base units
20230	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the head or face	12 base units
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	5 base units
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	15 base units
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	6 base units
20321	Initiation of the management of anaesthesia for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy	10 base units
20330	Initiation of the management of anaesthesia for laser surgery to the airway (excluding nose and mouth)	8 base units
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	10 base units
20352	Initiation of the management of anaesthesia for simple ligation of major vessels of neck	5 base units
20355	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the neck	12 base units
Subgroup 3—Thorax		
20400	Initiation of the management of anaesthesia for procedures on the skin or subcutaneous tissue of the anterior part of the chest, other than a service to which another item in this Subgroup applies	3 base units

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
20401	Initiation of the management of anaesthesia for procedures on the breast, other than a service to which another item in this Subgroup applies	4 base units
20402	Initiation of the management of anaesthesia for reconstructive procedures on breast, including implant reconstruction and exchange	5 base units
20403	Initiation of the management of anaesthesia for axillary dissection or sentinel node biopsy	5 base units
20404	Initiation of the management of anaesthesia for mastectomy	6 base units
20405	Initiation of the management of anaesthesia for reconstructive procedures on the breast using myocutaneous flaps	8 base units
20406	Initiation of the management of anaesthesia for radical or modified radical procedures on breast with internal mammary node dissection	13 base units
20410	Initiation of the management of anaesthesia for electrical conversion of arrhythmias	4 base units
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	5 base units
20440	Initiation of the management of anaesthesia for percutaneous bone marrow biopsy of the sternum	4 base units
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	5 base units
20452	Initiation of the management of anaesthesia for radical surgery on clavicle, scapula or sternum	6 base units
20470	Initiation of the management of anaesthesia for partial rib resection, other than a service to which another item in this Subgroup applies	6 base units
20472	Initiation of the management of anaesthesia for thoracoplasty	10 base units
20474	Initiation of the management of anaesthesia for radical procedures on chest wall	13 base units
20475	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior thorax	10 base units
Subgroup 4—Intrathoracic		
20500	Initiation of the management of anaesthesia for open procedures on the oesophagus	15 base units
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	6 base units
20522	Initiation of the management of anaesthesia for needle biopsy of pleura	4 base units
20524	Initiation of the management of anaesthesia for pneumocentesis	4 base units
20526	Initiation of the management of anaesthesia for thoracoscopy	10 base units

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 ($)**
20528	Initiation of the management of anaesthesia for mediastinoscopy	8 base units
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	13 base units
20542	Initiation of the management of anaesthesia for pulmonary decortication	15 base units
20546	Initiation of the management of anaesthesia for pulmonary resection with thoracoplasty	15 base units
20548	Initiation of the management of anaesthesia for intrathoracic repair of trauma to trachea and bronchi	15 base units
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	20 base units
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	10 base units
20604	Initiation of the management of anaesthesia for posterior cervical laminectomy with the patient in the sitting position	13 base units
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	10 base units
20622	Initiation of the management of anaesthesia for thoracolumbar sympathectomy	13 base units
20630	Initiation of the management of anaesthesia for procedures in lumbar region, other than a service to which another item in this Subgroup applies	8 base units
20632	Initiation of the management of anaesthesia for lumbar sympathectomy	7 base units
20634	Initiation of the management of anaesthesia for chemonucleolysis	10 base units
20670	Initiation of the management of anaesthesia for extensive spine or spinal cord procedures, or both	13 base units
20680	Initiation of the management of anaesthesia for manipulation of spine when performed in the operating theatre of a hospital	3 base units
20690	Initiation of the management of anaesthesia for percutaneous spinal procedures, other than a service to which another item in this Subgroup applies	5 base units
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	3 base units

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
20702	Initiation of the management of anaesthesia for percutaneous liver biopsy	4 base units
20703	Initiation of the management of anaesthesia for procedures on the nerves, muscles, tendons and fascia of the upper abdominal wall, other than a service to which another item in this Subgroup applies	4 base units
20704	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior upper abdomen	10 base units
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	7 base units
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	5 base units
20740	Initiation of the management of anaesthesia for upper gastrointestinal endoscopic procedures	5 base units
20745	Initiation of the management of anaesthesia for any of the following: (a) upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage; (b) endoscopic retrograde cholangiopancreatography; (c) upper gastrointestinal endoscopic ultrasound; (d) percutaneous endoscopic gastrostomy; (e) upper gastrointestinal endoscopic mucosal resection of tumour	7 base units
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	5 base units
20752	Initiation of the management of anaesthesia for repair of incisional hernia or wound dehiscence, or both	6 base units
20754	Initiation of the management of anaesthesia for procedures on an omphalocele	7 base units
20756	Initiation of the management of anaesthesia for transabdominal repair of diaphragmatic hernia	9 base units
20770	Initiation of the management of anaesthesia for procedures on major upper abdominal blood vessels	15 base units
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	8 base units
20791	Initiation of the management of anaesthesia for bariatric surgery in a	10 base units

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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 ($)**
	patient with clinically severe obesity	
20792	Initiation of the management of anaesthesia for partial hepatectomy (excluding liver biopsy)	13 base units
20793	Initiation of the management of anaesthesia for extended or trisegmental hepatectomy	15 base units
20794	Initiation of the management of anaesthesia for pancreatectomy, partial or total	12 base units
20798	Initiation of the management of anaesthesia for neuro endocrine tumour removal in the upper abdomen	10 base units
20799	Initiation of the management of anaesthesia for percutaneous procedures on an intra-abdominal organ in the upper abdomen	6 base units
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	3 base units
20802	Initiation of the management of anaesthesia for lipectomy of the lower abdomen	5 base units
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	4 base units
20804	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the anterior or posterior lower abdomen	10 base units
20806	Initiation of the management of anaesthesia for laparoscopic procedures in the lower abdomen	7 base units
20810	Initiation of the management of anaesthesia for lower intestinal endoscopic procedures	4 base units
20815	Initiation of the management of anaesthesia for extracorporeal shock wave lithotripsy to urinary tract	6 base units
20820	Initiation of the management of anaesthesia for procedures on the skin, its derivatives or subcutaneous tissue of the lower posterior abdominal wall	5 base units
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	4 base units
20832	Initiation of the management of anaesthesia for repair of incisional herniae or wound dehiscence, or both, of the lower abdomen	6 base units
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	6 base units
20841	Initiation of the management of anaesthesia for bowel resection, including laparoscopic bowel resection, other than a service to which	8 base units

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	another item in this Subgroup applies	
20842	Initiation of the management of anaesthesia for amniocentesis	4 base units
20844	Initiation of the management of anaesthesia for abdominoperineal resection, including pull through procedures, ultra low anterior resection and formation of bowel reservoir	10 base units
20845	Initiation of the management of anaesthesia for radical prostatectomy	10 base units
20846	Initiation of the management of anaesthesia for radical hysterectomy	10 base units
20847	Initiation of the management of anaesthesia for ovarian malignancy	10 base units
20848	Initiation of the management of anaesthesia for pelvic exenteration	10 base units
20850	Initiation of the management of anaesthesia for caesarean section	12 base units
20855	Initiation of the management of anaesthesia for caesarean hysterectomy or hysterectomy within 24 hours of birth	15 base units
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	6 base units
20862	Initiation of the management of anaesthesia for renal procedures, including upper one-third of ureter	7 base units
20863	Initiation of the management of anaesthesia for nephrectomy	10 base units
20864	Initiation of the management of anaesthesia for total cystectomy	10 base units
20866	Initiation of the management of anaesthesia for adrenalectomy	10 base units
20867	Initiation of the management of anaesthesia for neuro endocrine tumour removal in the lower abdomen	10 base units
20868	Initiation of the management of anaesthesia for renal transplantation (donor or recipient)	10 base units
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	15 base units
20882	Initiation of the management of anaesthesia for inferior vena cava ligation	10 base units
20884	Initiation of the management of anaesthesia for percutaneous umbrella insertion	5 base units
20886	Initiation of the management of anaesthesia for percutaneous procedures on an intra-abdominal organ in the lower abdomen	6 base units
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	3 base units
20902	Initiation of the management of anaesthesia for anorectal procedures (including surgical haemorrhoidectomy, but not banding of haemorrhoids)	4 base units

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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 ($)**
20904	Initiation of the management of anaesthesia for radical perineal procedures, including radical perineal prostatectomy or radical vulvectomy	7 base units
20905	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the perineum	10 base units
20906	Initiation of the management of anaesthesia for vulvectomy	4 base units
20910	Initiation of the management of anaesthesia for transurethral procedures (including urethrocyctoscopy), other than a service to which another item in this Subgroup applies	4 base units
20911	Initiation of the management of anaesthesia for endoscopic ureteroscopic surgery including laser procedures	5 base units
20912	Initiation of the management of anaesthesia for transurethral resection of bladder tumour or tumours	5 base units
20914	Initiation of the management of anaesthesia for transurethral resection of prostate	7 base units
20916	Initiation of the management of anaesthesia for bleeding post-transurethral resection	7 base units
20920	Initiation of the management of anaesthesia for procedures on external genitalia, other than a service to which another item in this Subgroup applies	4 base units
20924	Initiation of the management of anaesthesia for procedures on undescended testis, unilateral or bilateral	4 base units
20926	Initiation of the management of anaesthesia for radical orchidectomy, inguinal approach	4 base units
20928	Initiation of the management of anaesthesia for radical orchidectomy, abdominal approach	6 base units
20930	Initiation of the management of anaesthesia for orchiopexy, unilateral or bilateral	4 base units
20932	Initiation of the management of anaesthesia for complete amputation of penis	4 base units
20934	Initiation of the management of anaesthesia for complete amputation of penis with bilateral inguinal lymphadenectomy	6 base units
20936	Initiation of the management of anaesthesia for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy	8 base units
20938	Initiation of the management of anaesthesia for insertion of penile prosthesis	4 base units
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	4 base units
20942	Initiation of the management of anaesthesia for vaginal procedures (including repair operations and urinary incontinence procedures)	5 base units

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
20943	Initiation of the management of anaesthesia for transvaginal assisted reproductive services	4 base units
20944	Initiation of the management of anaesthesia for vaginal hysterectomy	6 base units
20946	Initiation of the management of anaesthesia for vaginal birth	8 base units
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	4 base units
20950	Initiation of the management of anaesthesia for culdoscopy	5 base units
20952	Initiation of the management of anaesthesia for hysteroscopy	4 base units
20954	Initiation of the management of anaesthesia for correction of inverted uterus	10 base units
20956	Initiation of the management of anaesthesia for evacuation of retained products of conception, as a complication of confinement	4 base units
20958	Initiation of the management of anaesthesia for manual removal of retained placenta or for repair of vaginal or perineal tear following birth	5 base units
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	7 base units
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	3 base units
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	5 base units
21112	Initiation of the management of anaesthesia for percutaneous bone marrow biopsy of the anterior iliac crest	4 base units
21114	Initiation of the management of anaesthesia for percutaneous bone marrow biopsy of the posterior iliac crest	5 base units
21116	Initiation of the management of anaesthesia for percutaneous bone marrow harvesting from the pelvis	6 base units
21120	Initiation of the management of anaesthesia for procedures on the bony pelvis	6 base units
21130	Initiation of the management of anaesthesia for body cast application or revision, when performed in the operating theatre of a hospital	3 base units
21140	Initiation of the management of anaesthesia for interpelviabdominal (hindquarter) amputation	15 base units
21150	Initiation of the management of anaesthesia for radical procedures for tumour of the pelvis, except hindquarter amputation	10 base units
21155	Initiation of the management of anaesthesia for microvascular free	10 base units

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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 ($)**
	tissue flap surgery involving the anterior or posterior pelvis	
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	4 base units
21170	Initiation of the management of anaesthesia for open procedures involving symphysis pubis or sacroiliac joint	8 base units
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	3 base units
21199	Initiation of the management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg	4 base units
21200	Initiation of the management of anaesthesia for closed procedures involving hip joint, when performed in the operating theatre of a hospital	4 base units
21202	Initiation of the management of anaesthesia for arthroscopic procedures of the hip joint	4 base units
21210	Initiation of the management of anaesthesia for open procedures involving hip joint, other than a service to which another item in this Subgroup applies	6 base units
21212	Initiation of the management of anaesthesia for hip disarticulation	10 base units
21214	Initiation of the management of anaesthesia for primary total hip replacement	10 base units
21215	Initiation of management of anaesthesia for revision total hip replacement	15 base units
21216	Initiation of the management of anaesthesia for bilateral total hip replacement	14 base units
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	4 base units
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	6 base units
21232	Initiation of the management of anaesthesia for above knee amputation	5 base units
21234	Initiation of the management of anaesthesia for radical resection of the upper two-thirds of femur	8 base units
21260	Initiation of the management of anaesthesia for procedures involving veins of upper leg, including exploration	4 base units
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	8 base units
21272	Initiation of the management of anaesthesia for femoral artery ligation	4 base units

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
21274	Initiation of the management of anaesthesia for femoral artery embolectomy	6 base units
21275	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the upper leg	10 base units
21280	Initiation of the management of anaesthesia for microsurgical reimplantation of upper leg	15 base units
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	3 base units
21321	Initiation of the management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of knee or popliteal area, or both	4 base units
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	4 base units
21360	Initiation of the management of anaesthesia for open procedures on lower one-third of femur	5 base units
21380	Initiation of the management of anaesthesia for closed procedures on knee joint when performed in the operating theatre of a hospital	3 base units
21382	Initiation of the management of anaesthesia for arthroscopic procedures of knee joint	4 base units
21390	Initiation of the management of anaesthesia for closed procedures on upper ends of tibia, fibula or patella, or any of them, when performed in the operating theatre of a hospital	3 base units
21392	Initiation of the management of anaesthesia for open procedures on upper ends of tibia, fibula or patella, or any of them	4 base units
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	4 base units
21402	Initiation of the management of anaesthesia for knee replacement	7 base units
21403	Initiation of the management of anaesthesia for bilateral knee replacement	10 base units
21404	Initiation of the management of anaesthesia for disarticulation of knee	5 base units
21420	Initiation of the management of anaesthesia for cast application, removal or repair, involving knee joint, undertaken in a hospital	3 base units
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	4 base units
21432	Initiation of the management of anaesthesia for repair of arteriovenous fistula of knee or popliteal area	5 base units
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	8 base units

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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 ($)**
	this Subgroup applies	
21445	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the knee or popliteal area	10 base units
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	3 base units
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	4 base units
21462	Initiation of the management of anaesthesia for all closed procedures on lower leg, ankle or foot	3 base units
21464	Initiation of the management of anaesthesia for arthroscopic procedure of ankle joint	4 base units
21472	Initiation of the management of anaesthesia for repair of Achilles tendon	5 base units
21474	Initiation of the management of anaesthesia for gastrocnemius recession	5 base units
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	4 base units
21482	Initiation of the management of anaesthesia for radical resection of bone involving lower leg, ankle or foot	5 base units
21484	Initiation of the management of anaesthesia for osteotomy or osteoplasty of tibia or fibula	5 base units
21486	Initiation of the management of anaesthesia for total ankle replacement	7 base units
21490	Initiation of the management of anaesthesia for lower leg cast application, removal or repair, undertaken in a hospital	3 base units
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	8 base units
21502	Initiation of the management of anaesthesia for embolectomy of the lower leg	6 base units
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	4 base units
21522	Initiation of the management of anaesthesia for venous thrombectomy of the lower leg	5 base units
21530	Initiation of the management of anaesthesia for microsurgical reimplantation of lower leg, ankle or foot	15 base units
21532	Initiation of the management of anaesthesia for microsurgical reimplantation of toe	8 base units

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
21535	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the lower leg	10 base units
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	3 base units
21610	Initiation of the management of anaesthesia for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla, including axillary dissection	5 base units
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	4 base units
21622	Initiation of the management of anaesthesia for arthroscopic procedures of shoulder joint	5 base units
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	5 base units
21632	Initiation of the management of anaesthesia for radical resection involving humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint	6 base units
21634	Initiation of the management of anaesthesia for shoulder disarticulation	9 base units
21636	Initiation of the management of anaesthesia for interthoracoscapular (forequarter) amputation	15 base units
21638	Initiation of the management of anaesthesia for total shoulder replacement	10 base units
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	8 base units
21652	Initiation of the management of anaesthesia for procedures for axillary-brachial aneurysm	10 base units
21654	Initiation of the management of anaesthesia for bypass graft of arteries of shoulder or axilla	8 base units
21656	Initiation of the management of anaesthesia for axillary-femoral bypass graft	10 base units
21670	Initiation of the management of anaesthesia for procedures on veins of shoulder or axilla	4 base units
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	3 base units
21682	Initiation of the management of anaesthesia for shoulder spica application, when undertaken in a hospital	4 base units

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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 ($)**
21685	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the shoulder or axilla	10 base units
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	3 base units
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	4 base units
21712	Initiation of the management of anaesthesia for open tenotomy of the upper arm or elbow	5 base units
21714	Initiation of the management of anaesthesia for tenoplasty of the upper arm or elbow	5 base units
21716	Initiation of the management of anaesthesia for tenodesis for rupture of long tendon of biceps	5 base units
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	3 base units
21732	Initiation of the management of anaesthesia for arthroscopic procedures of elbow joint	4 base units
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	5 base units
21756	Initiation of the management of anaesthesia for radical procedures on the upper arm or elbow	6 base units
21760	Initiation of the management of anaesthesia for total elbow replacement	7 base units
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	8 base units
21772	Initiation of the management of anaesthesia for embolectomy of arteries of the upper arm	6 base units
21780	Initiation of the management of anaesthesia for procedures on veins of upper arm, other than a service to which another item in this Subgroup applies	4 base units
21785	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the upper arm or elbow	10 base units
21790	Initiation of the management of anaesthesia for microsurgical reimplantation of upper arm	15 base units
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	3 base units

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
21810	Initiation of the management of anaesthesia for procedures on the nerves, muscles, tendons, fascia, or bursae of the forearm, wrist or hand	4 base units
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	3 base units
21830	Initiation of the management of anaesthesia for open procedures on the radius, ulna, wrist, or hand bones, other than a service to which another item in this Subgroup applies	4 base units
21832	Initiation of the management of anaesthesia for total wrist replacement	7 base units
21834	Initiation of the management of anaesthesia for arthroscopic procedures of the wrist joint	4 base units
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	8 base units
21842	Initiation of the management of anaesthesia for embolectomy of artery of forearm, wrist or hand	6 base units
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	4 base units
21860	Initiation of the management of anaesthesia for forearm, wrist, or hand cast application, removal or repair, when undertaken in a hospital	3 base units
21865	Initiation of the management of anaesthesia for microvascular free tissue flap surgery involving the forearm, wrist or hand	10 base units
21870	Initiation of the management of anaesthesia for microsurgical reimplantation of forearm, wrist or hand	15 base units
21872	Initiation of the management of anaesthesia for microsurgical reimplantation of a finger	8 base units
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	3 base units
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	5 base units
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	7 base units
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	9 base units
21882	Initiation of the management of anaesthesia for excision or	11 base units

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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 ($)**
	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	
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	13 base units
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	15 base units
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	17 base units
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	19 base units
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	21 base units
Subgroup 17—Anaesthesia for radiological or other diagnostic or therapeutic procedures		
21900	Initiation of the management of anaesthesia for injection procedure for hysterosalpingography	3 base units
21906	Initiation of the management of anaesthesia for injection procedure for myelography—lumbar or thoracic	5 base units
21908	Initiation of the management of anaesthesia for injection procedure for myelography—cervical	6 base units
21910	Initiation of the management of anaesthesia for injection procedure for myelography—posterior fossa	9 base units
21912	Initiation of the management of anaesthesia for injection procedure for discography—lumbar or thoracic	5 base units
21914	Initiation of the management of anaesthesia for injection procedure for discography—cervical	6 base units
21915	Initiation of the management of anaesthesia for peripheral arteriogram	5 base units
21916	Initiation of the management of anaesthesia for arteriograms—cerebral, carotid or vertebral	5 base units
21918	Initiation of the management of anaesthesia for retrograde arteriogram—brachial or femoral	5 base units
21922	Initiation of the management of anaesthesia for computerised axial tomography scanning, magnetic resonance scanning or digital subtraction angiography scanning	6 base units
21925	Initiation of the management of anaesthesia for retrograde cystography, retrograde urethrography or retrograde cystourethrography	4 base units
21926	Initiation of the management of anaesthesia for fluoroscopy	4 base units

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
21930	Initiation of the management of anaesthesia for bronchography	6 base units
21935	Initiation of the management of anaesthesia for phlebography	5 base units
21936	Initiation of the management of anaesthesia for heart—2 dimensional real time transoesophageal examination	5 base units
21939	Initiation of the management of anaesthesia for peripheral venous cannulation	3 base units
21941	Initiation of the management of anaesthesia for cardiac catheterisation (including coronary arteriography, ventriculography, cardiac mapping or insertion of automatic defibrillator or transvenous pacemaker)	7 base units
21942	Initiation of the management of anaesthesia for cardiac electrophysiological procedures including radio frequency ablation	10 base units
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	5 base units
21945	Initiation of the management of anaesthesia for lumbar puncture, cisternal puncture or epidural injection	5 base units
21949	Initiation of the management of anaesthesia for harvesting of bone marrow for the purpose of transplantation	5 base units
21952	Initiation of the management of anaesthesia for diagnostic muscle biopsy to assess for malignant hyperpyrexia	4 base units
21955	Initiation of the management of anaesthesia for electroencephalography	5 base units
21959	Initiation of the management of anaesthesia for brain stem evoked response audiometry	5 base units
21962	Initiation of the management of anaesthesia for electrocochleography by extratympanic method or transtympanic membrane insertion method	5 base units
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	5 base units
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)	8 base units
21970	Initiation of the management of anaesthesia during hyperbaric therapy, if the medical practitioner is confined in the chamber (including the administration of oxygen)	15 base units
21973	Initiation of the management of anaesthesia for brachytherapy using radioactive sealed sources	5 base units
21976	Initiation of the management of anaesthesia for therapeutic nuclear medicine	5 base units
21980	Initiation of the management of anaesthesia for radiotherapy	5 base units

Clause 5.9.9

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **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	3 base units
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.)"	4 base units
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	4 base units
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	4 base units
22007	Endotracheal intubation with flexible fibreoptic scope associated with difficult airway, when performed in association with the management of anaesthesia	4 base units
22008	Double lumen endobronchial tube or bronchial blocker, insertion of, when performed in association with the management of anaesthesia	4 base units
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	3 base units
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;	3 base units

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(iv) cardiac intracavity blood pressure; and (b) is conducted by indwelling catheter; and (c) is performed in association with the administration of anaesthesia for a procedure (the ***current procedure***) and not as a service to which item 13876 applies; and (d) is performed, on a day, on a patient: (i) who is categorised as having a high risk of complications or develops during the current procedure either complications or a high risk of complications; and (ii) for whom monitoring of that type of blood pressure to which item 22012 applies has already been performed on the day in association with the administration of anaesthesia for another discrete procedure; and (e) has not previously been performed in association with the current procedure for that type of blood pressure	
22015	Right heart balloon catheter, insertion of, including pulmonary wedge pressure and cardiac output measurement, when performed in association with the management of anaesthesia	6 base units
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	4 base units
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	4 base units
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	5 base units
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	3 base units
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	2 base units
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	1 base unit
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	9 base units

Clause 5.9.9

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	
22052	Transfusion of blood by an anaesthetist, including collection from donor, when used for intra-operative normovolaemic haemodilution, where the service is provided on the same occasion as the administration of anaesthesia by the same anaesthetist, other than a service associated with a service to which item 13703 applies	6 base units
22053	Insertion of lumbar cerebrospinal fluid drain, by an anaesthetist at the request of the treating specialist, where the service is provided on the same occasion as the administration of anaesthesia by the same anaesthetist, other than a service associated with a service to which item 40018 applies	6 base units
22054	Intraoperative two-dimensional or three-dimensional real time transoesophageal echocardiography by an anaesthetist, where the service: (a) is provided on the same day as a service to which item 38477, 38484, 38499, 38516 or 38517 applies; and (b) includes Doppler techniques with colour flow mapping and recordings on digital media; and (c) is performed during cardiac valve surgery (replacement or repair); and (d) incorporates sequential assessment of cardiac function and valve competence before and after the surgical procedure; and (e) is not associated with a service to which item 21936, 22051, 55118, 55130 or 55135 applies; and (f) is provided on the same occasion as the administration of anaesthesia by the same anaesthetist	18 base units
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	12 base units
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	30 base units
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	5 base units
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	15 base units

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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	6 base units
22905	Initiation of the management of anaesthesia for restorative dental work	6 base units
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	1 base unit
23025	Anaesthesia, perfusion or assistance, if the service time is more than 15 minutes but not more than 30 minutes	2 base units
23035	Anaesthesia, perfusion or assistance, if the service time is more than 30 minutes but not more than 45 minutes	3 base units
23045	Anaesthesia, perfusion or assistance, if the service time is more than 45 minutes but not more than 1 hour	4 base units
23055	Anaesthesia, perfusion or assistance, if the service time is more than 1 hour but not more than 1:15 hours	5 base units
23065	Anaesthesia, perfusion or assistance, if the service time is more than 1:15 hours but not more than 1:30 hours	6 base units
23075	Anaesthesia, perfusion or assistance, if the service time is more than 1:30 hours but not more than 1:45 hours	7 base units
23085	Anaesthesia, perfusion or assistance, if the service time is more than 1:45 hours but not more than 2:00 hours	8 base units
23091	Anaesthesia, perfusion or assistance, if the service time is more than 2:00 hours but not more than 2:10 hours	9 base units
23101	Anaesthesia, perfusion or assistance, if the service time is more than 2:10 hours but not more than 2:20 hours	10 base units
23111	Anaesthesia, perfusion or assistance, if the service time is more than 2:20 hours but not more than 2:30 hours	11 base units
23112	Anaesthesia, perfusion or assistance, if the service time is more than 2:30 hours but not more than 2:40 hours	12 base units
23113	Anaesthesia, perfusion or assistance, if the service time is more than 2:40 hours but not more than 2:50 hours	13 base units
23114	Anaesthesia, perfusion or assistance, if the service time is more than 2:50 hours but not more than 3:00 hours	14 base units
23115	Anaesthesia, perfusion or assistance, if the service time is more than 3:00 hours but not more than 3:10 hours	15 base units
23116	Anaesthesia, perfusion or assistance, if the service time is more than 3:10 hours but not more than 3:20 hours	16 base units
23117	Anaesthesia, perfusion or assistance, if the service time is more than 3:20 hours but not more than 3:30 hours	17 base units

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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 ($)**
23118	Anaesthesia, perfusion or assistance, if the service time is more than 3:30 hours but not more than 3:40 hours	18 base units
23119	Anaesthesia, perfusion or assistance, if the service time is more than 3:40 hours but not more than 3:50 hours	19 base units
23121	Anaesthesia, perfusion or assistance, if the service time is more than 3:50 hours but not more than 4:00 hours	20 base units
23170	Anaesthesia, perfusion or assistance, if the service time is more than 4:00 hours but not more than 4:10 hours	21 base units
23180	Anaesthesia, perfusion or assistance, if the service time is more than 4:10 hours but not more than 4:20 hours	22 base units
23190	Anaesthesia, perfusion or assistance, if the service time is more than 4:20 hours but not more than 4:30 hours	23 base units
23200	Anaesthesia, perfusion or assistance, if the service time is more than 4:30 hours but not more than 4:40 hours	24 base units
23210	Anaesthesia, perfusion or assistance, if the service time is more than 4:40 hours but not more than 4:50 hours	25 base units
23220	Anaesthesia, perfusion or assistance, if the service time is more than 4:50 hours but not more than 5:00 hours	26 base units
23230	Anaesthesia, perfusion or assistance, if the service time is more than 5:00 hours but not more than 5:10 hours	27 base units
23240	Anaesthesia, perfusion or assistance, if the service time is more than 5:10 hours but not more than 5:20 hours	28 base units
23250	Anaesthesia, perfusion or assistance, if the service time is more than 5:20 hours but not more than 5:30 hours	29 base units
23260	Anaesthesia, perfusion or assistance, if the service time is more than 5:30 hours but not more than 5:40 hours	30 base units
23270	Anaesthesia, perfusion or assistance, if the service time is more than 5:40 hours but not more than 5:50 hours	31 base units
23280	Anaesthesia, perfusion or assistance, if the service time is more than 5:50 hours but not more than 6:00 hours	32 base units
23290	Anaesthesia, perfusion or assistance, if the service time is more than 6:00 hours but not more than 6:10 hours	33 base units
23300	Anaesthesia, perfusion or assistance, if the service time is more than 6:10 hours but not more than 6:20 hours	34 base units
23310	Anaesthesia, perfusion or assistance, if the service time is more than 6:20 hours but not more than 6:30 hours	35 base units
23320	Anaesthesia, perfusion or assistance, if the service time is more than 6:30 hours but not more than 6:40 hours	36 base units
23330	Anaesthesia, perfusion or assistance, if the service time is more than 6:40 hours but not more than 6:50 hours	37 base units
23340	Anaesthesia, perfusion or assistance, if the service time is more than	38 base units

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	6:50 hours but not more than 7:00 hours	
23350	Anaesthesia, perfusion or assistance, if the service time is more than 7:00 hours but not more than 7:10 hours	39 base units
23360	Anaesthesia, perfusion or assistance, if the service time is more than 7:10 hours but not more than 7:20 hours	40 base units
23370	Anaesthesia, perfusion or assistance, if the service time is more than 7:20 hours but not more than 7:30 hours	41 base units
23380	Anaesthesia, perfusion or assistance, if the service time is more than 7:30 hours but not more than 7:40 hours	42 base units
23390	Anaesthesia, perfusion or assistance, if the service time is more than 7:40 hours but not more than 7:50 hours	43 base units
23400	Anaesthesia, perfusion or assistance, if the service time is more than 7:50 hours but not more than 8:00 hours	44 base units
23410	Anaesthesia, perfusion or assistance, if the service time is more than 8:00 hours but not more than 8:10 hours	45 base units
23420	Anaesthesia, perfusion or assistance, if the service time is more than 8:10 hours but not more than 8:20 hours	46 base units
23430	Anaesthesia, perfusion or assistance, if the service time is more than 8:20 hours but not more than 8:30 hours	47 base units
23440	Anaesthesia, perfusion or assistance, if the service time is more than 8:30 hours but not more than 8:40 hours	48 base units
23450	Anaesthesia, perfusion or assistance, if the service time is more than 8:40 hours but not more than 8:50 hours	49 base units
23460	Anaesthesia, perfusion or assistance, if the service time is more than 8:50 hours but not more than 9:00 hours	50 base units
23470	Anaesthesia, perfusion or assistance, if the service time is more than 9:00 hours but not more than 9:10 hours	51 base units
23480	Anaesthesia, perfusion or assistance, if the service time is more than 9:10 hours but not more than 9:20 hours	52 base units
23490	Anaesthesia, perfusion or assistance, if the service time is more than 9:20 hours but not more than 9:30 hours	53 base units
23500	Anaesthesia, perfusion or assistance, if the service time is more than 9:30 hours but not more than 9:40 hours	54 base units
23510	Anaesthesia, perfusion or assistance, if the service time is more than 9:40 hours but not more than 9:50 hours	55 base units
23520	Anaesthesia, perfusion or assistance, if the service time is more than 9:50 hours but not more than 10:00 hours	56 base units
23530	Anaesthesia, perfusion or assistance, if the service time is more than 10:00 hours but not more than 10:10 hours	57 base units
23540	Anaesthesia, perfusion or assistance, if the service time is more than 10:10 hours but not more than 10:20 hours	58 base units

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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 ($)**
23550	Anaesthesia, perfusion or assistance, if the service time is more than 10:20 hours but not more than 10:30 hours	59 base units
23560	Anaesthesia, perfusion or assistance, if the service time is more than 10:30 hours but not more than 10:40 hours	60 base units
23570	Anaesthesia, perfusion or assistance, if the service time is more than 10:40 hours but not more than 10:50 hours	61 base units
23580	Anaesthesia, perfusion or assistance, if the service time is more than 10:50 hours but not more than 11:00 hours	62 base units
23590	Anaesthesia, perfusion or assistance, if the service time is more than 11:00 hours but not more than 11:10 hours	63 base units
23600	Anaesthesia, perfusion or assistance, if the service time is more than 11:10 hours but not more than 11:20 hours	64 base units
23610	Anaesthesia, perfusion or assistance, if the service time is more than 11:20 hours but not more than 11:30 hours	65 base units
23620	Anaesthesia, perfusion or assistance, if the service time is more than 11:30 hours but not more than 11:40 hours	66 base units
23630	Anaesthesia, perfusion or assistance, if the service time is more than 11:40 hours but not more than 11:50 hours	67 base units
23640	Anaesthesia, perfusion or assistance, if the service time is more than 11:50 hours but not more than 12:00 hours	68 base units
23650	Anaesthesia, perfusion or assistance, if the service time is more than 12:00 hours but not more than 12:10 hours	69 base units
23660	Anaesthesia, perfusion or assistance, if the service time is more than 12:10 hours but not more than 12:20 hours	70 base units
23670	Anaesthesia, perfusion or assistance, if the service time is more than 12:20 hours but not more than 12:30 hours	71 base units
23680	Anaesthesia, perfusion or assistance, if the service time is more than 12:30 hours but not more than 12:40 hours	72 base units
23690	Anaesthesia, perfusion or assistance, if the service time is more than 12:40 hours but not more than 12:50 hours	73 base units
23700	Anaesthesia, perfusion or assistance, if the service time is more than 12:50 hours but not more than 13:00 hours	74 base units
23710	Anaesthesia, perfusion or assistance, if the service time is more than 13:00 hours but not more than 13:10 hours	75 base units
23720	Anaesthesia, perfusion or assistance, if the service time is more than 13:10 hours but not more than 13:20 hours	76 base units
23730	Anaesthesia, perfusion or assistance, if the service time is more than 13:20 hours but not more than 13:30 hours	77 base units
23740	Anaesthesia, perfusion or assistance, if the service time is more than 13:30 hours but not more than 13:40 hours	78 base units
23750	Anaesthesia, perfusion or assistance, if the service time is more than	79 base units

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	13:40 hours but not more than 13:50 hours	
23760	Anaesthesia, perfusion or assistance, if the service time is more than 13:50 hours but not more than 14:00 hours	80 base units
23770	Anaesthesia, perfusion or assistance, if the service time is more than 14:00 hours but not more than 14:10 hours	81 base units
23780	Anaesthesia, perfusion or assistance, if the service time is more than 14:10 hours but not more than 14:20 hours	82 base units
23790	Anaesthesia, perfusion or assistance, if the service time is more than 14:20 hours but not more than 14:30 hours	83 base units
23800	Anaesthesia, perfusion or assistance, if the service time is more than 14:30 hours but not more than 14:40 hours	84 base units
23810	Anaesthesia, perfusion or assistance, if the service time is more than 14:40 hours but not more than 14:50 hours	85 base units
23820	Anaesthesia, perfusion or assistance, if the service time is more than 14:50 hours but not more than 15:00 hours	86 base units
23830	Anaesthesia, perfusion or assistance, if the service time is more than 15:00 hours but not more than 15:10 hours	87 base units
23840	Anaesthesia, perfusion or assistance, if the service time is more than 15:10 hours but not more than 15:20 hours	88 base units
23850	Anaesthesia, perfusion or assistance, if the service time is more than 15:20 hours but not more than 15:30 hours	89 base units
23860	Anaesthesia, perfusion or assistance, if the service time is more than 15:30 hours but not more than 15:40 hours	90 base units
23870	Anaesthesia, perfusion or assistance, if the service time is more than15:40 hours but not more than 15:50 hours	91 base units
23880	Anaesthesia, perfusion or assistance, if the service time is more than 15:50 hours but not more than 16:00 hours	92 base units
23890	Anaesthesia, perfusion or assistance, if the service time is more than 16:00 hours but not more than 16:10 hours	93 base units
23900	Anaesthesia, perfusion or assistance, if the service time is more than 16:10 hours but not more than 16:20 hours	94 base units
23910	Anaesthesia, perfusion or assistance, if the service time is more than 16:20 hours but not more than 16:30 hours	95 base units
23920	Anaesthesia, perfusion or assistance, if the service time is more than 16:30 hours but not more than 16:40 hours	96 base units
23930	Anaesthesia, perfusion or assistance, if the service time is more than 16:40 hours but not more than 16:50 hours	97 base units
23940	Anaesthesia, perfusion or assistance, if the service time is more than 16:50 hours but not more than 17:00 hours	98 base units
23950	Anaesthesia, perfusion or assistance, if the service time is more than 17:00 hours but not more than 17:10 hours	99 base units

Clause 5.9.9

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

Column 1 Item	Column 2 Description	Column 3 Fee ($)
23960	Anaesthesia, perfusion or assistance, if the service time is more than 17:10 hours but not more than 17:20 hours	100 base units
23970	Anaesthesia, perfusion or assistance, if the service time is more than 17:20 hours but not more than 17:30 hours	101 base units
23980	Anaesthesia, perfusion or assistance, if the service time is more than 17:30 hours but not more than 17:40 hours	102 base units
23990	Anaesthesia, perfusion or assistance, if the service time is more than 17:40 hours but not more than 17:50 hours	103 base units
24100	Anaesthesia, perfusion or assistance, if the service time is more than 17:50 hours but not more than 18:00 hours	104 base units
24101	Anaesthesia, perfusion or assistance, if the service time is more than 18:00 hours but not more than 18:10 hours	105 base units
24102	Anaesthesia, perfusion or assistance, if the service time is more than 18:10 hours but not more than 18:20 hours	106 base units
24103	Anaesthesia, perfusion or assistance, if the service time is more than 18:20 hours but not more than 18:30 hours	107 base units
24104	Anaesthesia, perfusion or assistance, if the service time is more than 18:30 hours but not more than 18:40 hours	108 base units
24105	Anaesthesia, perfusion or assistance, if the service time is more than 18:40 hours but not more than 18:50 hours	109 base units
24106	Anaesthesia, perfusion or assistance, if the service time is more than 18:50 hours but not more than 19:00 hours	110 base units
24107	Anaesthesia, perfusion or assistance, if the service time is more than 19:00 hours but not more than 19:10 hours	111 base units
24108	Anaesthesia, perfusion or assistance, if the service time is more than 19:10 hours but not more than 19:20 hours	112 base units
24109	Anaesthesia, perfusion or assistance, if the service time is more than 19:20 hours but not more than 19:30 hours	113 base units
24110	Anaesthesia, perfusion or assistance, if the service time is more than 19:30 hours but not more than 19:40 hours	114 base units
24111	Anaesthesia, perfusion or assistance, if the service time is more than 19:40 hours but not more than 19:50 hours	115 base units
24112	Anaesthesia, perfusion or assistance, if the service time is more than 19:50 hours but not more than 20:00 hours	116 base units
24113	Anaesthesia, perfusion or assistance, if the service time is more than 20:00 hours but not more than 20:10 hours	117 base units
24114	Anaesthesia, perfusion or assistance, if the service time is more than 20:10 hours but not more than 20:20 hours	118 base units
24115	Anaesthesia, perfusion or assistance, if the service time is more than 20:20 hours but not more than 20:30 hours	119 base units
24116	Anaesthesia, perfusion or assistance, if the service time is more than	120 base units

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	20:30 hours but not more than 20:40 hours	
24117	Anaesthesia, perfusion or assistance, if the service time is more than 20:40 hours but not more than 20:50 hours	121 base units
24118	Anaesthesia, perfusion or assistance, if the service time is more than 20:50 hours but not more than 21:00 hours	122 base units
24119	Anaesthesia, perfusion or assistance, if the service time is more than 21:00 hours but not more than 21:10 hours	123 base units
24120	Anaesthesia, perfusion or assistance, if the service time is more than 21:10 hours but not more than 21:20 hours	124 base units
24121	Anaesthesia, perfusion or assistance, if the service time is more than 21:20 hours but not more than 21:30 hours	125 base units
24122	Anaesthesia, perfusion or assistance, if the service time is more than 21:30 hours but not more than 21:40 hours	126 base units
24123	Anaesthesia, perfusion or assistance, if the service time is more than 21:40 hours but not more than 21:50 hours	127 base units
24124	Anaesthesia, perfusion or assistance, if the service time is more than 21:50 hours but not more than 22:00 hours	128 base units
24125	Anaesthesia, perfusion or assistance, if the service time is more than 22:00 hours but not more than 22:10 hours	129 base units
24126	Anaesthesia, perfusion or assistance, if the service time is more than 22:10 hours but not more than 22:20 hours	130 base units
24127	Anaesthesia, perfusion or assistance, if the service time is more than 22:20 hours but not more than 22:30 hours	131 base units
24128	Anaesthesia, perfusion or assistance, if the service time is more than 22:30 hours but not more than 22:40 hours	132 base units
24129	Anaesthesia, perfusion or assistance, if the service time is more than 22:40 hours but not more than 22:50 hours	133 base units
24130	Anaesthesia, perfusion or assistance, if the service time is more than 22:50 hours but not more than 23:00 hours	134 base units
24131	Anaesthesia, perfusion or assistance, if the service time is more than 23:00 hours but not more than 23:10 hours	135 base units
24132	Anaesthesia, perfusion or assistance, if the service time is more than 23:10 hours but not more than 23:20 hours	136 base units
24133	Anaesthesia, perfusion or assistance, if the service time is more than 23:20 hours but not more than 23:30 hours	137 base units
24134	Anaesthesia, perfusion or assistance, if the service time is more than 23:30 hours but not more than 23:40 hours	138 base units
24135	Anaesthesia, perfusion or assistance, if the service time is more than 23:40 hours but not more than 23:50 hours	139 base units
24136	Anaesthesia, perfusion or assistance, if the service time is more than 23:50 hours but not more than 24:00 hours	140 base units

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Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 22—Anaesthesia, perfusion and assistance at anaesthesia (modifying components—physical status)		
25000	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient has severe systemic disease (equivalent to ASA physical status indicator 3)	1 base unit
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)	2 base units
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)	3 base units
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	1 base unit
25014	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is aged 75 years or more	1 base unit
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	2 base units
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:	Amount under

Group T10—Anaesthesia performed in connection with certain services (Relative Value Guide)		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) the patient has complex airway problems; or (b) the patient is a neonate; or (c) the patient is a paediatric patient and is receiving one or more of the following services: (i) invasive monitoring, either intravascular or transoesophageal; (ii) organ transplantation; (iii) craniofacial surgery; (iv) major tumour resection; (v) separation of conjoint twins; or (d) there is anticipated to be massive blood loss (greater than 50% of blood volume) during the procedure; or (e) the patient is critically ill, with multiple organ failure; or (f) the service time of the management of anaesthesia exceeds 6 hours and the assistance is provided to the exclusion of attendance on all other patients	clause 5.9.2

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.

5.10.5 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.

5.10.5A Meaning of *treatment cycle*

In item 30665:

treatment cycle, for a patient, means a series of treatments for the patient that:

(a) begins on the day of the initial failed attempt at biliary stone removal via ERCP extraction techniques; and

(b) ends at the conclusion of the aftercare period for the procedure (being either the lithotripsy procedure or a definitive surgical management procedure) that has resulted in removal of the biliary stones.

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, 60072, 60075 or 60078 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.

Note: The fees in Group T8 are indexed in accordance with clause 1.3.1.

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	Burns, involving 1% or more but less than 3% of total body surface, dressing of (including redressing of any related donor site, if required), without anaesthesia, if medical practitioner is present—each attendance at which the procedure is performed Not applicable for skin reactions secondary to radiotherapy	37.80
30006	Burns, involving 3% or more but less than 10% of total body surface, dressing of (including redressing of any related donor site, if required), without anaesthesia, if medical practitioner is present—each attendance at which the procedure is performed Not applicable for skin reactions secondary to radiotherapy	48.40
30007	Burns, involving 10% or more of total body surface, dressing of (including redressing of any related donor site, if required), without anaesthesia, if medical practitioner is present—each attendance at which the procedure is performed Not applicable for skin reactions secondary to radiotherapy	170.20
30010	Burns, involving not more than 3% of total body surface, dressing of (including redressing of any related donor site, if required), in an operating theatre under general anaesthesia or intravenous sedation, if medical practitioner is present (H) (Anaes.)	76.95
30014	Burns, involving 3% or more but less than 20% of total body surface, dressing of (including redressing of any related donor site, if required), in an operating theatre under general anaesthesia or intravenous sedation, if medical practitioner is present (H) (Anaes.)	161.70
30015	Burns, involving 20% or more but less than 50% of total body surface, or burns of less than 20% of total body surface involving 1% or more of total body surface within the hands or face, dressing of (including redressing of any related donor site, if required), in an operating theatre under general anaesthesia or intravenous sedation, if medical practitioner is present (H) (Anaes.) (Assist.)	255.30
30016	Burns, involving 50% or more of total body surface, dressing of (including redressing of any related donor site, if required), in an operating theatre under general anaesthesia or intravenous sedation, if medical practitioner is present (H) (Anaes.) (Assist.)	382.95
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	339.25

Clause 5.10.9

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	wound if carried out (Anaes.) (Assist.)	
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
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

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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 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	101.10
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

Clause 5.10.9

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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
30166	Removal of redundant abdominal skin and lipectomy, as a wedge excision, for functional problems following significant weight loss equivalent to at least 5 body mass index points and if there has been a stable weight for a period of at least 6 months prior to surgery, other than a service associated with a service to which item 30175, 30176, 30177, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070, 46072, 46080, 46082, 46084, 46086, 46088 or 46090 applies (H) (Anaes.) (Assist.)	821.45
30169	Removal of redundant non-abdominal skin and lipectomy for functional problems following significant weight loss equivalent to at least 5 body mass index points and if there has been a stable weight for a period of at least 6 months prior to surgery, one or 2 non-abdominal areas, other than a service associated with a service to which item 30175, 30176, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070, 46072, 46080, 46082, 46084, 46086, 46088 or 46090 applies (H) (Anaes.) (Assist.)	657.15
30175	Radical abdominoplasty, with repair of rectus diastasis, excision of skin and subcutaneous tissue, and transposition of umbilicus, not being a laparoscopic procedure, if: (a) the patient has an abdominal wall defect as a consequence of pregnancy; and (b) the patient: (i) has a diastasis of at least 3cm measured by diagnostic imaging prior to this service; and (ii) has either or both of the following: (A) at least moderately severe pain or discomfort at the site of the diastasis in the abdominal wall during functional use and the pain or discomfort has been documented in the patient's records by the practitioner providing the service; (B) low back pain or urinary symptoms likely due to rectus diastasis and the pain or symptoms have been documented in the patient's records by the practitioner providing the service; and (iii) has failed to respond to non-surgical conservative treatment, that must have included physiotherapy; and (iv) has not been pregnant in the last 12 months; and (c) the service is not a service associated with a service to which item 30166, 30169, 30176, 30177, 30179, 30651, 30655, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070, 46072, 46080, 46082, 46084, 46086, 46088 or 46090 applies	1,062.50

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	Applicable once per lifetime (H) (Anaes.) (Assist.)	
30176	Radical abdominoplasty, with excision of skin and subcutaneous tissue, repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30166, 30169, 30175, 30177, 30179, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies, if the patient has previously had a massive intra-abdominal or pelvic tumour surgically removed (H) (Anaes.) (Assist.)	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, with or without repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30166, 30175, 30176, 30179, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070, 46072, 46080, 46082, 46084, 46086, 46088 or 46090 applies, if: (a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non-surgical) treatment; and (b) the redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy (H) (Anaes.) (Assist.)	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, not being a service associated with a service to which item 30175, 30176, 30177, 45530, 45531, 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070, 46072, 46080, 46082, 46084, 46086, 46088 or 46090 applies, if: (a) the circumferential excess of redundant skin and fat is complicated by intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non-surgical) treatment; and (b) the circumferential excess of redundant skin and fat interferes with the activities of daily living; and (c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy (H) (Anaes.) (Assist.)	1,262.30
30180	Axillary hyperhidrosis, partial excision for (Anaes.)	142.05
30183	Axillary hyperhidrosis, total excision of sweat gland bearing area (Anaes.)	256.50

Clause 5.10.9

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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; removal of, by serial curettage, or carbon dioxide laser or erbium laser excision-ablation, including any associated cryotherapy or diathermy (Anaes.)	131.35
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	169.55

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	a hospital (H) (Anaes.)	
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, including removal of tumour, other than a service associated with a service to which item 39321, 39324, 39327 or 39330 applies (H) (Anaes.) (Assist.)	769.30
30250	Parotid gland, total extirpation of, with preservation of facial nerve, including: (a) removal of tumour; and (b) exposure or mobilisation of facial nerve; other than a service associated with a service to which item 39321, 39324, 39327 or 39330 applies (H) (Anaes.) (Assist.)	1,301.75
30251	Recurrent parotid tumour, excision of, with preservation of facial nerve, including: (a) removal of tumour; and (b) exposure or mobilisation of facial nerve; other than a service associated with a service to which item 39321, 39324, 39327 or 39330 applies (H) (Anaes.) (Assist.)	1,999.65
30253	Parotid gland, superficial lobectomy of, with exposure of facial nerve, including: (a) removal of tumour; and	867.85

Clause 5.10.9

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(b) exposure or mobilisation of facial nerve; other than a service associated with a service to which item 39321, 39324, 39327 or 39330 applies (H) (Anaes.) (Assist.)	
30255	Submandibular ducts, relocation of, for surgical control of drooling (H) (Anaes.) (Assist.)	1,155.65
30256	Submandibular gland, extirpation of, other than a service associated with a service to which item 31423, 31426, 31429, 31432, 31435 or 31438 applies on the same side (H) (Anaes.) (Assist.)	463.50
30257	Sialendoscopy, of submandibular or parotid duct, with or without removal of calculus or treatment of stricture (Anaes.)	528.55
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, with or without resection of mandible, including dissection of lymph glands of neck, unilateral, other than a service associated with a service to which item 31423, 31426, 31429, 31432, 31435 or 31438 applies on the same side (H) (Anaes.) (Assist.)	1,834.15
30278	Tongue tie, repair of, other than: (a) a service to which another item in this Subgroup applies; or (b) a service associated with a service to which item 45009 applies (Anaes.)	48.40
30281	Tongue tie, mandibular frenulum or maxillary frenulum, repair of, in a person aged 2 years and over, under general anaesthesia, other than a service associated with a service to which item 45009 applies (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

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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, involving dissection in an axilla, using preoperative lymphoscintigraphy and/or lymphotropic dye injection (H) (Anaes.) (Assist.)	777.85
30305	Sentinel lymph node biopsy or biopsies for breast cancer, involving dissection along internal mammary chain (H) (Anaes.) (Assist.)	777.90
30306	Total hemithyroidectomy (H) (Anaes.) (Assist.)	831.00
30310	Partial or subtotal thyroidectomy (H) (Anaes.) (Assist.)	831.00
30311	Sentinel lymph node biopsy or biopsies for cutaneous melanoma, using preoperative lymphoscintigraphy and/or lymphotropic dye injection, if: (a) the primary lesion is greater than 1.0 mm in depth (or at least 0.8 mm in depth in the presence of ulceration); and (b) appropriate excision of the primary melanoma has occurred; and (c) the service is not associated with a service to which item 30075, 30078, 30299, 30305, 30329, 30332, 30618, 30820, 31423, 52025 or 52027 applies Applicable to only one lesion per occasion on which the service is provided (H) (Anaes.) (Assist.)	647.65
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)	1,186.10

Clause 5.10.9

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	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.)	
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
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 (H) (Anaes.) (Assist.)	360.80
30336	Lymph nodes of axilla, complete excision of (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	701.85

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	malignancy, with or without omentectomy, as an independent procedure (H) (Anaes.) (Assist.)	
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, after removal of dressings or packs (H) (Anaes.) (Assist.)	332.50
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

Clause 5.10.9

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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 (H) (Anaes.) (Assist.)	193.10
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

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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 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.)	1,538.30
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 associated with a service to which item 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 associated with a service to which item 41822 or 41825 applies), gastroscopy, duodenoscopy, panendoscopy or push enteroscopy, one or more such procedures, if: (a) the procedures are performed using one or more of the following	255.55

Clause 5.10.9

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	endoscopic procedures: (i) polypectomy; (ii) sclerosing or adrenalin injections; (iii) banding; (iv) endoscopic clips; (v) haemostatic powders; (vi) diathermy; (vii) argon plasma coagulation; and (b) the procedures are for the treatment of one or more of the following: (i) upper gastrointestinal tract bleeding; (ii) polyps; (iii) removal of foreign body; (iv) oesophageal or gastric varices; (v) peptic ulcers; (vi) neoplasia; (vii) benign vascular lesions; (viii) strictures of the gastrointestinal tract; (ix) tumorous overgrowth through or over oesophageal stents; other than a service associated with a service to which item 30473 or 30479 applies (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

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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 cholangiopancreatography, other than a service to which item 30664 or 30665 applies (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
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

Clause 5.10.9

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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
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	2,266.50

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	drainage procedure or partial resection (H) (Anaes.) (Assist.)	
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 bowel resection, on a patient 10 years of age or over (H) (Anaes.) (Assist.)	542.40
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

Clause 5.10.9

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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
30630	Insertion of testicular prosthesis, at least 6 months after orchidectomy (H) (Anaes.) (Assist.)	518.90
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 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.)	952.05
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	542.40

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	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.)	
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 associated with a service to which item 30175, 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 associated with a service to which item 30175, 30621 or 30651 applies (H) (Anaes.) (Assist.)	952.05
30657	Unilateral abdominal wall reconstruction with component separation, including transversus abdominus release and external oblique release for abdominal wall closure by mobilising the rectus abdominis muscles to the midline, by open or minimally invasive approach (H) (Anaes.) (Assist.)	1,355.65
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
30661	Minor surgical repair following a complication from the circumcision of a penis, when performed in conjunction with a service to which an item in Group T7 or Group T10 applies, other than a service associated with a service to which item 45206 applies (H) (Anaes.)	405.50
30662	Complex surgical repair following a complication from the	810.90

Clause 5.10.9

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	circumcision of a penis, including single stage local flap, if indicated, to repair one defect, on genitals (other than a service associated with a service to which item 37819, 37822, 45200, 45201, 45202, 45203 or 45206 applies) (H) (Anaes.) (Assist.)	
30663	Haemorrhage, arrest of, following circumcision requiring general anaesthesia, on a patient 10 years of age or over (Anaes.)	150.20
30664	Endoscopic retrograde cholangiopancreatography (ERCP), with single operator, single use peroral cholangiopancreatoscopy (POCPS) and biopsy, for the diagnosis of biliary strictures for a patient for whom: (a) a previous ERCP service has been provided; and (b) results from guided brush cytology or intraductal biopsy (or both) are indeterminate Applicable not more than 2 times in a 12 month period, or not more than 3 times in a 12 month period if the patient has been diagnosed with primary sclerosing cholangitis (PSC) (H) (Anaes.) (Assist.)	644.40
30665	Endoscopic retrograde cholangiopancreatography (ERCP), with single operator, single use peroral cholangiopancreatoscopy (POCPS) and electrohydraulic or laser lithotripsy for the removal of biliary stones that are: (a) greater than 10mm in diameter; or (b) proximal to a stricture; for a patient for whom there has been at least one failed attempt at removal via ERCP extraction techniques Applicable not more than 2 times per treatment cycle (H) (Anaes.) (Assist.)	901.35
30666	Paraphimosis or phimosis, reduction of, under general anaesthesia, with or without dorsal incision, other than a service associated with a service to which another item in this Group applies (Anaes.)	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	1,217.40

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	performed that did not identify the cause of the bleeding; not in association with another item in this Subgroup (other than item 30682 or 30686) (Anaes.)	
30682	Balloon enteroscopy, examination of the small bowel (anal approach), with or without biopsy, without intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding if the patient: (a) has recurrent or persistent bleeding; and (b) is anaemic or has active bleeding; and (c) has had an upper gastrointestinal endoscopy and a colonoscopy performed that did not identify the cause of the bleeding; not in association with another item in this Subgroup (other than item 30680 or 30684) (Anaes.)	1,217.40
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 (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.)	1,498.20
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	379.70

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	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.)	
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 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.)	463.50
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;	542.40

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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.)	
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: (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.)	965.75
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

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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 Conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	1,790.65
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	789.45

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	gastric resection), including either of the following (if performed): (a) vagotomy and pyloroplasty; (b) gastroenterostomy (H) (Anaes.) (Assist.)	
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
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	604.45

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	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.)	
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 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.)	906.65
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	99.35

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(c) the specimen excised is sent for histological examination (Anaes.)	
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), lipomas, cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of 4 to 10 lesions and suture, if: (a) the size of each lesion is not more than 10 mm in diameter; and (b) each removal is from cutaneous or subcutaneous tissue by surgical excision (other than by shave excision); and (c) all of the specimens excised are sent for histological examination (Anaes.)	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), lipomas, cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of more than 10 lesions, if: (a) the size of each lesion is not more than 10 mm in diameter; and (b) each removal is from cutaneous or subcutaneous tissue or mucous membrane by surgical excision (other than by shave excision); and (c) each site of excision is closed by suture; and (d) all of the specimens excised are sent for histological examination (Anaes.)	396.75

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383 is excised (Anaes.)	Amount under clause 5.10.2
31344	Lipoma, removal of, by surgical excision or liposuction, if: (a) the lesion: (i) is subcutaneous and 150mm or more in diameter; or (ii) is submuscular, intramuscular or involves dissection of a named nerve or vessel and is 50 mm or more in diameter; and (b) a specimen of the excised lipoma is sent for histological confirmation of diagnosis (H) (Anaes.) (Assist.)	691.90
31345	Lipoma, removal of, by surgical excision or liposuction, if: (a) the lesion is: (i) subcutaneous and 50 mm or more in diameter but less than 150 mm in diameter; or (ii) sub-fascial; and (b) the specimen excised is sent for histological confirmation of diagnosis (Anaes.)	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,	450.90

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	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.)	
31355	Malignant tumour of soft tissue (other than tumours of skin or cartilage and bone), removal of, by surgical excision, if histological proof of malignancy is obtained, other than a service to which another item in this Group applies (Anaes.) (Assist.)	743.45
31356	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), 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, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from 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, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision), if: (a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or	343.55

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Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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.)	
31360	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (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.)	174.85
31361	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is less than 14 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.)	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, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from face, neck, scalp, nipple-areola	254.15

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	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.)	
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 (b) the necessary excision diameter is 14 mm or more; and (c) the excised specimen is sent for histological examination (Anaes.)	174.85
31365	Malignant skin lesion (other than a malignant skin lesion covered by item 31369, 31370, 31371, 31372, 31373, 31377, 31378 or 31379), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is less than 15 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with item 45201 (Anaes.)	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, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is at least 15 mm but not more	222.25

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	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.)	
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 item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and (b) the necessary excision diameter is 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.)	255.90
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, including excision of the primary tumour bed, if: (a) the tumour is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and (b) the necessary excision diameter is 6 mm or more; and	371.45

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	
31372	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, including excision of the primary tumour bed, if: (a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is less than 14 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with a service to which item 45201 applies (Anaes.)	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, including excision of the primary tumour bed, if: (a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is 14 mm or more; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	371.25
31374	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, including excision of the primary tumour bed, if: (a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and (b) the necessary excision diameter is less than 15 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with a service to which item 45201 applies (Anaes.)	293.30
31375	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cell carcinoma of skin, definitive	315.65

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	surgical excision (other than by shave excision) and repair of, including excision of the primary tumour bed, if: (a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and (b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; not in association with a service to which item 45201 applies (Anaes.)	
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, including excision of the primary tumour bed, if: (a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and (b) the necessary excision diameter is more than 30 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	365.85
31377	Clinically suspected melanoma, 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 a service to which item 45201 applies (Anaes.)	115.95
31378	Clinically suspected melanoma, 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 (Anaes.)	177.65
31379	Clinically suspected melanoma, 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	141.60

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(b) the necessary excision diameter is less than 14 mm; and (c) the excised specimen is sent for histological examination; not in association with a service to which item 45201 applies (Anaes.)	
31380	Clinically suspected melanoma, 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 (Anaes.)	177.65
31381	Clinically suspected melanoma, 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 31377, 31378, 31379 or 31380; and (b) the necessary excision diameter is less than 15 mm; and (c) the excised specimen is sent for histological examination; not in association with a service to which item 45201 applies (Anaes.)	100.95
31382	Clinically suspected melanoma, 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 31377, 31378, 31379 or 31380; and (b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and (c) the excised specimen is sent for histological examination; not in association with a service to which item 45201 applies (Anaes.)	132.70
31383	Clinically suspected melanoma, 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 31377, 31378, 31379 or 31380; and (b) the necessary excision diameter is more than 30 mm; and (c) the excised specimen is sent for histological examination (Anaes.)	151.80
31386	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from the head or neck; and	782.55

Clause 5.10.9

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(b) the necessary excision diameter is more than 50 mm; and (c) the excision involves at least 2 critical areas (eyelid, nose, ear, mouth); and (d) the excised specimen is sent for histological examination; and (e) malignancy is confirmed from the excised specimen or previous biopsy; and (f) the service is not covered by item 31387 (H) (Anaes.) (Assist.)	
31387	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from the head or neck; and (b) the necessary excision diameter is more than 70 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy; and (e) the service is not covered by item 31386 (H) (Anaes.) (Assist.)	704.20
31388	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375, 31376, 31377, 31378, 31379, 31380, 31381, 31382 or 31383), surgical excision (other than by shave excision) and repair of, if: (a) the lesion is excised from the trunk or limbs; and (b) the necessary excision diameter is more than 120 mm; and (c) the excised specimen is sent for histological examination; and (d) malignancy is confirmed from the excised specimen or previous biopsy (H) (Anaes.) (Assist.)	633.75
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 diameter; and (b) histological confirmation of malignancy is obtained (H) (Anaes.) (Assist.)	313.55
31406	Malignant upper aerodigestive tract tumour more than 40 mm in	522.50

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	diameter (excluding tumour of the lip), excision of, if histological confirmation of malignancy has been obtained (Anaes.) (Assist.)	
31409	Parapharyngeal tumour, excision of, by cervical approach (H) (Anaes.) (Assist.)	1,623.40
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, other than a service associated with a service to which item 30256 or 30275 applies on the same side (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, other than a service associated with a service to which item 30256 or 30275 applies on the same side (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, other than a service associated with a service to which item 30256 or 30275 applies on the same side (H) (Anaes.) (Assist.)	1,302.85
31432	Lymph nodes of neck, bilateral selective dissection of levels I, II and III (bilateral supraomohyoid dissections), other than a service associated with a service to which item 30256 or 30275 applies on the same side (H) (Anaes.) (Assist.)	1,393.45
31435	Lymph nodes of neck, comprehensive dissection of all 5 lymph node levels on one side of the neck, other than a service associated with a service to which item 30256 or 30275 applies on the same side (H) (Anaes.) (Assist.)	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, other than a service associated with a service to which item 30256 or 30275 applies on the same side (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	306.60

Clause 5.10.9

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(H) (Anaes.)	
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 approach, with or without closure of the diaphragmatic hiatus, revision procedure, by laparoscopy or open operation (H) (Anaes.) (Assist.)	1,359.90
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, other than a service associated with a service to which: (a) item 45523 or 45558 applies; and (b) item 31513, 31514, 45520, 45522 or 45556 applies on the same side (if performed by the same medical practitioner) (H) (Anaes.) (Assist.)	676.50
31513	Breast, malignant tumour, complete local excision of, with simultaneous reshaping of the breast parenchyma using techniques such as round block or rotation flaps, other than a service associated with a service to which: (a) item 45523 or 45558 applies; and (b) item 31512, 31514, 45520, 45522 or 45556 applies on the same side (H) (Anaes.) (Assist.)	930.95

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
31514	Breast, malignant tumour, complete local excision of, with simultaneous ipsilateral pedicled breast reduction, including repositioning of the nipple, other than a service associated with a service to which: (a) item 45523 or 45558 applies; and (b) item 31512, 31513, 45520, 45522 or 45556 applies on the same side (H) (Anaes.) (Assist.)	1,342.20
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	Total mastectomy (unilateral) (H) (Anaes.) (Assist.)	765.90
31520	Total mastectomy (bilateral) (H) (Anaes.) (Assist.)	1,410.75
31522	Skin sparing mastectomy (unilateral) (H) (Anaes.) (Assist.)	1,139.30
31523	Skin sparing mastectomy (bilateral) (H) (Anaes.) (Assist.)	1,993.85
31525	Mastectomy for gynaecomastia (unilateral), with or without liposuction (suction assisted lipolysis), if: (a) breast enlargement is not due to obesity and is not proportionate to body habitus; and (b) sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes; not being a service associated with a service to which item 45585 applies (H) (Anaes.) (Assist.)	541.05
31526	Mastectomy for gynaecomastia (bilateral), with or without liposuction (suction assisted lipolysis), if: (a) breast enlargement is not due to obesity and is not proportionate to body habitus; and (b) sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes; not being a service associated with a service to which item 45585 applies (H) (Anaes.) (Assist.)	996.65
31528	Nipple sparing mastectomy (unilateral) (H) (Anaes.) (Assist.)	1,139.30
31529	Nipple sparing mastectomy (bilateral) (H) (Anaes.) (Assist.)	1,993.85
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	619.85

Clause 5.10.9

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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	
31533	Fine needle aspiration of an impalpable breast lesion detected by mammography or ultrasound, imaging guided—but not including imaging (Anaes.)	143.50
31536	Breast, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques, but not including imaging (Anaes.)	197.10
31537	Insertion of a marker clip into a breast, including axilla, following a breast biopsy and using imaging (but not including the associated imaging), if additional surgery, neoadjuvant systemic therapy, follow up imaging or radiation may be required and the insertion is for any of the following reasons: (a) to mark the site of a lesion that has been totally or almost completely removed; (b) to confirm biopsy site if multiple lesions are present; (c) to confirm biopsy site of an ill-defined lesion; (d) future surgery or preoperative localisation is considered to be potentially difficult due to lesion conspicuity; (e) preoperative localisation is likely to be carried out using a modality different from the biopsy modality; (f) for correlation across modalities for diagnostic reasons (Anaes.)	208.50
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, with or without flap repair, if the nipple cannot readily be everted manually (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

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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; other than a service associated with a service to which item 31585 applies (H) (Anaes.) (Assist.)	1,601.50
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.

5.10.15 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.

Note: The fees in Group T8 are indexed in accordance with clause 1.3.1.

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, 32006 or 32030 applies (H) (Anaes.) (Assist.)	1,197.00
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, 32006 or 32030 applies (H) (Anaes.) (Assist.)	1,352.20
32006	Left hemicolectomy, including the descending and sigmoid colon (including formation of stoma), other than a service associated with a service to which item 32024, 32025, 32026 or 32028 applies (H) (Anaes.) (Assist.)	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

Clause 5.10.16

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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 32000, 32030, 32106 or 32232 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 32000, 32030, 32106 or 32232 applies (H) (Anaes.) (Assist.)	1,899.25
32026	Rectum, ultra-low restorative resection, with or without covering stoma and with or without colonic reservoir, if the anastomosis is sited in the anorectal region and is 6 cm or less from the anal verge, not being a service associated with a service to which item 32000, 32030, 32106, 32117 or 32232 applies (H) (Anaes.) (Assist.)	2,238.45
32028	Rectum, low or ultra-low restorative resection, with per anal sutured coloanal anastomosis, with or without covering stoma and with or without colonic reservoir, not being a service associated with a service to which item 32000, 32030, 32106, 32117 or 32232 applies (H) (Anaes.) (Assist.)	2,377.80
32030	Rectosigmoidectomy, including formation of stoma (H) (Anaes.) (Assist.)	1,073.10
32033	Restoration of bowel continuity following rectosigmoidectomy 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) (Anaes.) (Assist.)	1,597.25
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	Restorative proctectomy, involving rectal resection with formation of ileal	2,410.45

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	reservoir and ileoanal anastomosis, including ileostomy mobilisation, with or without mucosectomy or temporary loop ileostomy, 1 surgeon (H) (Anaes.) (Assist.)	
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
32095	Endoscopic examination of small bowel with flexible endoscope passed by stoma, with or without biopsies (Anaes.)	133.00
32096	Rectal biopsy, full thickness, to diagnose or exclude Hirschsprung's Disease, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block (H) (Anaes.) (Assist.)	267.35
32105	Anorectal carcinoma—per anal full thickness excision of (Anaes.) (Assist.)	503.60
32106	Anterolateral intraperitoneal rectal tumour, per anal excision of, using rectoscopy digital viewing system and pneumorectum, if: (a) clinically appropriate; and (b) removal requires dissection within the peritoneal cavity; excluding use of a colonoscope as the operating platform and not being a service associated with a service to which item 32024, 32025 or 32232 applies (Anaes.) (Assist.)	1,419.90
32108	Rectal tumour, trans-sphincteric excision of (Kraske or similar operation) (H) (Anaes.) (Assist.)	1,040.20
32117	Rectal prolapse, abdominal rectopexy of, excluding ventral mesh rectopexy, not being a service associated with a service to which	1,375.80

Clause 5.10.16

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	item 32025 or 32026 applies (H) (Anaes.) (Assist.)	
32118	Treatment of external rectal prolapse, or of symptomatic high grade rectal intussusception (the rectum descends to the level of or into the anal canal, confirmed by diagnostic imaging): (a) by minimally invasive surgery involving: (i) ventral dissection of the extra-peritoneal rectum; and (ii) suspension of the rectum from the sacral promontory by means of a prosthesis; and (b) including suspension of the vagina if performed, and any associated repair; other than a service associated with a service to which item 30390, 35595 or 35597 applies (H) (Anaes.) (Assist.)	1,621.50
32123	Anal stricture, anoplasty for (Anaes.) (Assist.)	346.75
32129	Anal sphincter repair (H) (Anaes.) (Assist.)	660.40
32131	Rectocele, transanal repair of rectocele (H) (Anaes.) (Assist.)	555.25
32135	Treatment of haemorrhoids or rectal prolapse, including rubber band ligation or sclerotherapy for, not being a service to which item 32139 applies (Anaes.)	70.30
32139	Operative treatment of haemorrhoids involving third-degree or fourth-degree haemorrhoids, including excision of anal skin tags when performed, not being a service associated with a service to which item 32135 or 32233 applies (H) (Anaes.) (Assist.)	382.65
32147	Perianal thrombosis, incision of (Anaes.)	46.90
32150	Operation for anal fissure, including excision, injection of Botulinum toxin or sphincterotomy, excluding dilatation (Anaes.) (Assist.)	267.35
32156	Anal fistula, 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	Operative treatment of anal fistula, repair by mucosal advancement flap, including ligation of inter-sphincteric fistula tract (LIFT) or other complex sphincter sparing surgery (Anaes.) (Assist.)	660.40
32166	Anal fistula—readjustment of Seton (Anaes.)	214.55
32171	Anorectal examination, with or without biopsy, under general anaesthetic, with or without faecal disimpaction, other than a service associated with a service to which another item in this Group applies (H) (Anaes.)	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

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
32183	Intestinal sling procedure before radiotherapy (H) (Anaes.) (Assist.)	584.40
32186	Colonic lavage, total, intra-operative (H) (Anaes.) (Assist.)	584.40
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, placement of, percutaneous or open, including intraoperative test stimulation and programming, for the management of faecal incontinence (H) (Anaes.)	687.75
32215	Sacral nerve electrode or electrodes, management, adjustment and electronic programming of the neurostimulator by a medical practitioner, to manage faecal incontinence, not being a service associated with a service to which item 32213, 32216, 32218 or 32237 applies Applicable once per day for the same patient by the same practitioner	130.45
32216	Sacral nerve lead or leads, inserted for the management of faecal incontinence in a patient with faecal incontinence refractory to conservative non-surgical treatment, either: (a) percutaneous surgical repositioning of the lead or leads, using fluoroscopic guidance; or (b) open surgical repositioning of the lead or leads; to correct displacement or unsatisfactory positioning (including intraoperative test stimulation), not being a service associated with a service to which item 32213 applies (H) (Anaes.)	617.60
32218	Sacral nerve lead or leads, removal (H) (Anaes.)	162.65
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: (a) who has had a colonoscopy that revealed: (i) 1 to 4 adenomas, each of which was less than 10 mm in	347.90

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	347.90

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(ii) 3 or more sessile serrated lesions, 1 or more of which was 10 mm or greater in diameter or had dysplasia; or (iii) 3 or more traditional serrated adenomas, of any size 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
32230	Endoscopic mucosal resection using electrocautery of a non-invasive sessile or flat superficial colorectal neoplasm which is at least 25mm in diameter, if the service is: (a) provided by a specialist gastroenterologist or surgical endoscopist; and (b) supported by photographic evidence to confirm the size of the polyp in situ, and (c) performed within 6 months after a service to which item 32222, 32223, 32224, 32225, 32226 or 32228 applies has been performed Applicable only once per polyp (H) (Anaes.)	695.25
32231	Rectal tumour, per anal excision of (H) (Anaes.) (Assist.)	365.00
32232	Rectal tumour, per anal excision of, using a rectoscopy digital viewing system and pneumorectum if clinically appropriate and excluding use of a colonoscope as the operating platform, not being a service associated with a service to which item 32024, 32025 or 32106 applies (H) (Anaes.) (Assist.)	989.55
32233	Perineal repair of rectal prolapse, not being a service associated with a service to which item 32139 applies (H) (Anaes.) (Assist.)	702.80
32234	Rectal stricture, treatment of (H) (Anaes.)	139.00
32235	Anal skin tags or anal polyps, excision of one or more of (Anaes.)	134.15
32236	Anal warts, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block), not being a service associated with a service to which item 35507 or 35508 applies (H) (Anaes.)	190.85
32237	Neurostimulator or receiver, subcutaneous placement of, replacement of, or removal of, including programming and placement and connection of an	309.50

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	extension wire or wires to sacral nerve electrode(s), for the management of faecal incontinence (H) (Anaes.) (Assist.)	
Subgroup 3—Vascular		
32500	Varicose veins, multiple injections of sclerosant using continuous compression techniques, including associated consultation, one or both legs, if: (a) proximal reflux of 0.5 seconds or longer has been demonstrated; and (b) the service is not for cosmetic purposes; and (c) the service is not associated with: (i) any other varicose vein operation on the same leg (excluding aftercare); or (ii) a service on the same leg (excluding aftercare) to which any of the following items apply: (A) 35200; (B) 59970 to 60078; (C) 60500 to 60509; (D) 61109 Applicable to a maximum of 6 treatments in a 12 month period (Anaes.)	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 ligation of one or more incompetent perforating veins in one leg of a patient, if the service: (a) is performed by open surgical technique (not including endoscopic ligation) and the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; and (b) is not associated with: (i) any other varicose vein operation on the same leg; or (ii) a service (on the same leg) to which item 35200, 60072, 60075 or 60078 applies (H) (Anaes.) (Assist.)	555.25
32508	Varicose veins, complete dissection at the sapheno-femoral or	555.25

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	sapheno-popliteal junction, with or without either ligation or stripping, or both, of the great or small saphenous veins in one leg of a patient, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both, if the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (a) ache; (b) pain; (c) tightness; (d) skin irritation; (e) heaviness; (f) muscle cramps; (g) limb swelling; (h) discolouration; (i) discomfort; (j) any other signs or symptoms attributable to venous dysfunction (H) (Anaes.) (Assist.)	
32511	Varicose veins, complete dissection at the sapheno-femoral and sapheno-popliteal junction, with or without either ligation or stripping, or both, of the great or small saphenous veins in one leg of a patient, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both, if the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (a) ache; (b) pain; (c) tightness; (d) skin irritation; (e) heaviness; (f) muscle cramps; (g) limb swelling; (h) discolouration; (i) discomfort; (j) any other signs or symptoms attributable to venous dysfunction (H) (Anaes.) (Assist.)	825.45
32514	Varicose veins, ligation of the great or small saphenous vein in the same leg of a patient, with or without stripping, by re-operation for recurrent veins in the same territory—one leg—including excision or injection of either tributaries or incompetent perforating veins, or both, if the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (a) ache;	964.35

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(b) pain; (c) tightness; (d) skin irritation; (e) heaviness; (f) muscle cramps; (g) limb swelling; (h) discolouration; (i) discomfort; (j) any other signs or symptoms attributable to venous dysfunction (H) (Anaes.) (Assist.)	
32517	Varicose veins, ligation of the great and small saphenous vein in the same leg of a patient, with or without stripping, by re-operation for recurrent veins in either territory—one leg—including excision or injection of either tributaries or incompetent perforating veins, or both, if the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (a) ache; (b) pain; (c) tightness; (d) skin irritation; (e) heaviness; (f) muscle cramps; (g) limb swelling; (h) discolouration; (i) discomfort; (j) any other signs or symptoms attributable to venous dysfunction (H) (Anaes.) (Assist.)	1,241.80
32520	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great or small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using a laser probe introduced by an endovenous catheter, if all of the following apply: (a) it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) of the patient demonstrates reflux of 0.5 seconds or longer; (b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps;	555.25

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include radiofrequency diathermy, radiofrequency ablation or cyanoacrylate adhesive; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.)	
32522	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great and small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using a laser probe introduced by an endovenous catheter, if all of the following apply: (a) it is documented by duplex ultrasound that the great and small saphenous veins of the patient demonstrate reflux of 0.5 seconds or longer; (b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include radiofrequency diathermy, radiofrequency ablation or cyanoacrylate adhesive; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045;	825.45

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.)	
32523	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great or small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using a radiofrequency catheter introduced by an endovenous catheter, if all of the following apply: (a) it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer; (b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include endovenous laser therapy or cyanoacrylate adhesive; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.)	555.25
32526	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great and small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using a	825.45

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	radiofrequency catheter introduced by an endovenous catheter, if all of the following apply: (a) it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer; (b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include endovenous laser therapy or cyanoacrylate adhesive; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.)	
32528	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great or small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using cyanoacrylate adhesive, if all of the following apply: (a) it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer; (b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps;	555.25

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include radiofrequency diathermy, radiofrequency ablation or endovenous laser therapy; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078; (vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.)	
32529	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great and small saphenous vein (and major tributaries of saphenous veins as necessary) in one leg of a patient, using cyanoacrylate adhesive, if all of the following apply: (a) it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer; (b) the patient has significant signs or symptoms (including one or more of the following signs or symptoms) attributable to venous reflux: (i) ache; (ii) pain; (iii) tightness; (iv) skin irritation; (v) heaviness; (vi) muscle cramps; (vii) limb swelling; (viii) discolouration; (ix) discomfort; (x) any other signs or symptoms attributable to venous dysfunction; (c) the service does not include radiofrequency diathermy, radiofrequency ablation or endovenous laser therapy; (d) the service is not associated with a service (on the same leg) to which any of the following items apply: (i) 32500 to 32507; (ii) 35200; (iii) 59970 to 60021; (iv) 60036 to 60045; (v) 60060 to 60078;	825.45

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(vi) 60500 to 60509; (vii) 61109 The service includes all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) (Anaes.)	
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
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	1,236.35

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	anastomosis above or below the knee (H) (Anaes.) (Assist.)	
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 in this Subgroup applies, as an independent procedure (H) (Anaes.) (Assist.)	821.70
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

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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 replacement by graft (H) (Anaes.) (Assist.)	1,439.75
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	2,191.05

Clause 5.10.16

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(Anaes.) (Assist.)	
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 by suture other than a service associated with a service to which item 33515 applies (H) (Anaes.) (Assist.)	1,643.25
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

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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
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

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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.) (Assist.)	1,009.35
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

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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
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	573.95

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	chemotherapy delivery device, including any associated percutaneous central vein catheterisation, on a patient 10 years of age or over (Anaes.)	
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
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.)	1,111.05

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(Assist.)	
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 part of re-operation after prior surgery on these vessels (H) (Anaes.) (Assist.)	850.20
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

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
35307	Transluminal stent insertion, one or more stents (not drug-eluting), with or without associated balloon dilatation, for one carotid artery, percutaneous (not direct), with or without an embolic protection device, for a patient who: (a) meets the requirements for carotid endarterectomy; and (b) has medical or surgical comorbidities that cause the patient to be at high risk of perioperative complications from carotid endarterectomy; excluding associated radiological services, radiological preparation and after-care (H) (Anaes.) (Assist.)	1,166.60
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) (Anaes.) (Assist.)	663.60
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	846.25

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	services or preparation, and excluding after-care (other than a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.)	
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
35401	Vertebroplasty, for one or more fractures in one or more vertebrae, performed by an interventional radiologist, for the treatment of a painful osteoporotic thoracolumbar vertebral compression fracture of the thoracolumbar spinal segment (T11, T12, L1 or L2), if: (a) pain is severe (numeric rated pain score greater than or equal to 7 out of 10); and (b) symptoms are poorly controlled by opiate therapy; and (c) severe pain duration is 3 weeks or less; and (d) there is MRI (or SPECT-CT if MRI unavailable) evidence of acute vertebral fracture Applicable only once for the same fracture, but is applicable for a new fracture of the same vertebra or vertebrae (H) (Anaes.)	710.50
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

Clause 5.10.17

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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
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 and one of items 60072, 60075 and 60078, 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 38485 to 38766 (other than items 38609, 38615, 38618, 38621 and 38624) and items 38817 and 38818 must be performed using open exposure or minimally invasive surgery which excludes percutaneous and transcatheter techniques unless otherwise stated in the item.

5.10.17A Items 38244, 38247, 38307, 38308, 38310, 38316, 38317 and 38319—patient eligibility and timing

(1) A patient is eligible for a service to which item 38244, 38247, 38307, 38308, 38310, 38316, 38317 or 38319 applies if:
  (a) subclause (2) applies to the patient; and
  (b) a service to which the item applies has not been provided to the patient in the previous 3 months, unless:
    (i) the patient experiences a new acute coronary syndrome or angina, as described in paragraph (2)(a), (b) or (c), in that period; or
    (ii) for a service to which item 38316, 38317 or 38319 applies—the service was provided to the patient in that period as a subsequent stage following an initial primary percutaneous coronary intervention procedure.

(2) This subclause applies to a patient who has:
  (a) an acute coronary syndrome evidenced by any of the following:
    (i) ST segment elevation;
    (ii) new left bundle branch block;
    (iii) troponin elevation above the local upper reference limit;
    (iv) new resting wall motion abnormality or perfusion defect;
    (v) cardiogenic shock;
    (vi) resuscitated cardiac arrest;
    (vii) ventricular fibrillation;
    (viii) sustained ventricular tachycardia; or
  (b) unstable angina or angina equivalent with a crescendo pattern, rest pain or other high-risk clinical features, such as hypotension, dizziness, pallor, diaphoresis or syncope occurring at a low threshold; or
  (c) either of the following, detected on computed tomography coronary angiography:
    (i) significant left main coronary artery disease with greater than 50% stenosis or a cross-sectional area of less than 6 mm^2;
    (ii) severe proximal left anterior descending coronary artery disease (with stenosis of more than 70% or a cross-sectional area of less than 4 mm^2 before the first major diagonal branch).

5.10.17B Items 38248 and 38249—patient eligibility

(1) A patient is eligible for a service to which item 38248 or 38249 applies if:
  (a) subclause (2) applies to the patient; or

(b) the patient is recommended for coronary angiography as a result of a heart team conference that meets the requirements of subclause (3).

(2) This subclause applies to a patient who has:

(a) limiting angina or angina equivalent, despite an adequate trial of optimal medical therapy; or

(b) high risk features, including at least one of the following:

(i) myocardial ischaemia demonstrated on functional imaging;

(ii) ST segment elevation, sustained ST depression, hypotension or a Duke treadmill score of minus 11 or less, demonstrated by stress electrocardiogram testing;

(iii) computed tomography coronary angiography evidence of one or more coronary arteries with stenosis of 70% or more; or

(iv) left ventricular dysfunction with an ejection fraction of less than 40% or segmental wall motion abnormality at rest.

(3) For the purposes of paragraph (1)(b), the requirements for a heart team conference are as follows:

(a) the conference must be conducted by a team of specialists or consultant physicians practising in the speciality of cardiology or cardiothoracic surgery, including each of the following:

(i) an interventional cardiologist;

(ii) a non-interventional cardiologist;

(iii) a specialist or consultant physician; and

(b) the team must:

(i) assess the patient's risk and technical suitability to receive the service; and

(ii) make a recommendation about whether or not the patient is suitable for invasive coronary angiography; and

(c) a record of the conference must be created, and must include the following:

(i) the particulars of the assessment of the patient during the conference;

(ii) the recommendations made as a result of the conference;

(iii) the names of the members of the team making the recommendations.

5.10.17C Items 38311, 38313, 38314, 38320, 38322 and 38323—patient eligibility

(1) A patient is eligible for a service to which item 38311, 38313, 38314, 38320, 38322 or 38323 applies if:

(a) subclause (2) applies to the patient; or

(b) the patient is recommended for the service as a result of a heart team conference that meets the requirements of subclause (4).

(2) This subclause applies to a patient if:

(a) the patient has any of the following:

(i) limiting angina or angina equivalent despite an adequate trial of optimal medical therapy;

(ii) myocardial ischaemia demonstrated on functional imaging;
(iii) high risk features such as ST segment elevation, sustained ST depression, hypotension or a Duke treadmill score of minus 11 or less, demonstrated by stress electrocardiogram testing; and

(b) the patient has either of the following in a vascular territory treated:
(i) a stenosis of 70% or more;
(ii) a fractional flow reserve of 0.80 or less, or non-hyperaemic pressure ratios distal to the lesions of 0.89 or less; and

(c) for items 38314 and 38323—either:
(i) the patient does not have diabetes mellitus and the multi-vessel coronary artery disease of the patient meets the criterion in subclause (3); or
(ii) despite a recommendation that surgery is preferable, the patient has expressed a preference for catheter-based intervention.

(3) For the purposes of subparagraph (2)(c)(i), the criterion for the multi-vessel coronary artery disease is that the disease does not involve any of the following:
(a) stenosis of more than 50% in the left main coronary artery;
(b) bifurcation lesions involving side branches with a diameter of more than 2.75 mm;
(c) chronic vessel occlusions for more than 3 months;
(d) severely angulated or calcified lesions;
(e) a SYNTAX score of more than 23.

(4) For the purposes of paragraph (1)(b), the requirements for a heart team conference are as follows:
(a) the conference must be conducted by a team of specialists or consultant physicians practising in the speciality of cardiology or cardiothoracic surgery, including each of the following:
(i) an interventional cardiologist;
(ii) a specialist or consultant physician;
(iii) for items 38314 and 38323—a cardiothoracic surgeon;
(iv) for items 38311, 38313, 38320 and 38322—a cardiothoracic surgeon or a non-interventional cardiologist; and

(b) the team must:
(i) assess the patient's risk and technical suitability to receive the service; and
(ii) make a recommendation about whether or not the patient is suitable for percutaneous coronary intervention; and

(c) a record of the conference must be created, and must include the following:
(i) the particulars of the assessment of the patient during the conference;
(ii) the recommendations made as a result of the conference;
(iii) the names of the members of the team making the recommendations.

5.10.17D Restriction on items 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38320, 38322, 38323, 38316, 38317 and 38319—reports and clinical notes

Items 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38320, 38322, 38323, 38316, 38317 and 38319 apply to a service provided to a patient only if a report or clinical note:

(a) is prepared for the service; and

(b) includes documentation that demonstrates how the item applies to the service, including how the patient is eligible for the service.

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.

Note: The fees in Group T8 are indexed in accordance with clause 1.3.1.

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
35503	Introduction of an intra-uterine device for abnormal uterine bleeding or contraception or for endometrial protection during oestrogen replacement therapy, if the service is not associated with a service to which another item in this Group applies (other than a service described in item 30062, 35506 or 35620) (Anaes.)	83.40
35506	Intra-uterine device, removal of under general anaesthesia, for a retained or embedded device, not being a service associated with a service to which another item in this Group applies (other than a service described in item 35503) (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 32236 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 32236 applies (H) (Anaes.) (Assist.)	267.35
35509	Hymenectomy (Anaes.)	93.10
35513	Bartholin's abscess, cyst or gland, excision of (Anaes.)	230.70
35517	Bartholin's abscess, cyst or gland, marsupialisation of (Anaes.)	151.95
35518	Ovarian cyst aspiration, for cysts of at least 4 cm in diameter in a	216.30

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	premenopausal patient and at least 2 cm in diameter in a postmenopausal patient, by abdominal or vaginal route, using interventional imaging techniques and not associated with services provided for assisted reproductive techniques, and not in cases of suspected or possible malignancy (Anaes.)	
35527	Urethral caruncle, symptomatic excision of, if: (a) conservative management has failed; or (b) there is a suspicion of malignancy (Anaes.)	151.95
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
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 or hemivulvectomy, one or both procedures, for suspected malignancy or vulval lesions with a high risk of malignancy (Anaes.) (Assist.)	362.60
35539	Colposcopically directed laser therapy for histologically confirmed high grade intraepithelial neoplastic changes of the vagina, vulva, urethra or anal canal, including any associated biopsies—one anatomical site (Anaes.)	284.00
35545	Colposcopically directed laser therapy for condylomata, unsuccessfully treated by other methods (Anaes.)	191.05
35548	Vulvectomy, radical, for malignancy (H) (Anaes.) (Assist.)	1,301.75
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, or sentinel node dissection 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, complete excision of benign tumour (including Gartner duct cyst), with histological documentation (Anaes.)	223.20
35560	Partial or complete vaginectomy, for either or both of the following:	711.60

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) deeply infiltrating vaginal endometriosis, if accompanied by histological confirmation from excised tissue; (b) pre-invasive or invasive lesions Not being a service associated with hysterectomy for non-invasive indications (H) (Anaes.) (Assist.)	
35561	Vaginectomy, radical, for proven invasive malignancy—one surgeon (H) (Anaes.) (Assist.)	1,597.25
35562	Vaginectomy, radical, for proven invasive malignancy, conjoint surgery—abdominal surgeon (including after-care) (H) (Anaes.) (Assist.)	1,345.55
35564	Vaginectomy, radical, for proven invasive malignancy, conjoint surgery—perineal surgeon (H) (Assist.)	672.80
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	Procedures for the management of symptomatic upper vaginal (vault or cervical) prolapse by sacrospinous or ilococcygeus fixation (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: (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.)	576.30
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
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,	701.85

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	involving either or both of the following: (a) cervical amputation; (b) anterior and posterior native tissue vaginal wall repairs without graft (H) (Anaes.) (Assist.)	
35578	Colpocleisis for pelvic organ prolapse, not being a service associated with a service to which another item (other than item 35599) in this Subgroup applies (H) (Anaes.) (Assist.)	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 (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.)	1,532.85
35591	Rectovaginal fistula repair of, by vaginal route approach, not being a service associated with a service to which item 35592, 35596, 37029, 37333 or 37336 applies (H) (Anaes.) (Assist.)	962.20
35592	Vesicovaginal fistula closure of, by vaginal approach, not being a service associated with a service to which item 35591, 35596, 37029, 37333 or 37336 applies (H) (Anaes.) (Assist.)	962.20
35595	Procedure for the management of symptomatic vaginal vault or cervical prolapse, by uterosacral ligament suspension, by any approach, without graft, if the uterosacral ligaments are separately identified, transfixed and then incorporated into rectovaginal and pubocervical fascia of the vaginal vault, including cystoscopy to check ureteric integrity (H) (Anaes.) (Assist.)	649.90

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
35596	Fistula between genital and urinary or alimentary tracts, repair of, other than a service to which item 35591, 35592, 37029, 37333 or 37336 applies (H) (Anaes.) (Assist.)	962.20
35597	Sacral colpopexy, by any approach where graft or mesh is secured to vault, anterior and posterior compartments and to sacrum for correction of symptomatic upper vaginal vault prolapse (H) (Anaes.) (Assist.)	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
35608	Cervix, one or more biopsies, cauterisation (other than by chemical means), ionisation, diathermy or endocervical curettage of, with or without dilatation of cervix (Anaes.)	66.55
35609	Cervix, cone biopsy or amputation (Anaes.)	226.80
35610	Cervix, cone biopsy for histologically proven malignancy (Anaes.)	396.95
35611	Removal of cervical or vaginal polyp or polypi, with or without dilatation of cervix, not being a service associated with a service to which item 35608 applies (Anaes.)	66.55
35612	Cervix, residual stump, removal of, by abdominal approach for non-malignant lesions (Anaes.) (Assist.)	526.50
35614	Examination of the lower genital tract using a colposcope in a patient who: (a) has a human papilloma virus related gynaecology indication; or (b) has symptoms or signs suspicious of lower genital tract malignancy; or (c) is undergoing follow-up treatment of lower genital tract malignancy; or (d) is undergoing assessment or surveillance of a vulvovaginal pre-malignant or malignant disease; or (e) is undergoing assessment or surveillance as part of an identified at risk population	66.45
35615	Vulva or vagina, biopsy of, when performed in conjunction with a service to which item 35614 applies	73.25
35616	Endometrial ablation by thermal balloon or radiofrequency electrosurgery, for abnormal uterine bleeding, with or without endometrial sampling, including any hysteroscopy performed on the same day (H) (Anaes.)	467.80
35620	Endometrial biopsy for pathological assessment in women with abnormal uterine bleeding or post-menopausal bleeding (Anaes.)	55.50
35622	Endometrial ablation, using hysteroscopically guided electrosurgery or laser energy for abnormal uterine bleeding, with or without endometrial sampling, not being a service associated with a service	626.90

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	to which item 30390 applies (H) (Anaes.)	
35623	Endometrial ablation and resection of myoma or uterine septum (or both), using hysteroscopic guided electrosurgery or laser energy, for abnormal uterine bleeding, with or without endometrial sampling (H) (Anaes.)	852.45
35626	Hysteroscopy for investigation of suspected intrauterine pathology, with or without local anaesthesia, including any associated endometrial biopsy, not being a service associated with a service to which item 35630 applies	233.10
35630	Hysteroscopy for investigation of suspected intrauterine pathology if performed under general anaesthesia, including any associated endometrial biopsy, not being a service associated with a service to which item 35626 applies (H) (Anaes.)	190.45
35631	Operative laparoscopy, including any of the following: (a) unilateral or bilateral ovarian cystectomy; (b) salpingo-oophorectomy; (c) salpingectomy for tubal pathology (including ectopic pregnancy by tubal removal or salpingostomy, but excluding sterilisation); (d) excision of mild endometriosis; not being a service associated with a service to which any other intraperitoneal or retroperitoneal procedure item (other than item 30724 or 30725) applies (H) (Anaes.) (Assist.)	740.35
35632	Complicated operative laparoscopy, including either or both of the following: (a) excision of moderate endometriosis; (b) laparoscopic myomectomy for a myoma of at least 4cm, including incision and repair of the uterus; not being a service associated with a service to which any other intraperitoneal or retroperitoneal procedure item (other than item 30724 or 30725 or 35658) applies (H) (Anaes.) (Assist.)	925.40
35633	Hysteroscopy, under visual guidance, including any of the following: (a) removal of an intra-uterine device; (b) removal of polyps by any method; (c) division of minor intrauterine adhesions (Anaes.)	226.80
35635	Hysteroscopy involving division of: (a) a uterine septum; or (b) moderate to severe intrauterine adhesions (H) (Anaes.)	311.60
35636	Hysteroscopy, resection of myoma or myoma and uterine septum (if both are performed) (H) (Anaes.)	450.55
35637	Operative laparoscopy, including any of the following:	423.10

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) excision or ablation of minimal endometriosis; (b) division of pathological adhesions; (c) sterilisation by application of clips, division, destruction or removal of tubes; not being a service associated with another laparoscopic procedure (H) (Anaes.) (Assist.)	
35640	Uterus, curettage of, with or without dilation (including curettage for incomplete miscarriage), if performed under: (a) general anaesthesia; or (b) epidural or spinal (intrathecal) nerve block; or (c) sedation; including procedures (if performed) to which item 35626 or 35630 applies (Anaes.)	190.45
35641	Severe endometriosis, laparoscopic resection of, involving 2 of the following procedures: (a) resection of the pelvic side wall including dissection of endometriosis or scar tissue from the ureter; (b) resection of the Pouch of Douglas; (c) resection of an ovarian endometrioma greater than 2 cm in diameter; (d) dissection of bowel from uterus from the level of the endocervical junction or above; (H) (Anaes.) (Assist.)	1,293.05
35643	Evacuation of the contents of the gravid uterus by curettage or suction curettage, if performed under: (a) local anaesthesia; or (b) general anaesthesia; or (c) epidural or spinal (intrathecal) nerve block; or (d) sedation; including procedures (if performed) to which item 35626 or 35630 applies (Anaes.)	226.80
35644	Cervix, ablation by electrocoagulation diathermy, laser or cryotherapy, with colposcopy, including any local anaesthesia and biopsies, for previously biopsy confirmed HSIL (CIN 2/3) in a patient with a Type 1 or 2 (completely visible) transformation zone, if there is: (a) no evidence of invasive or glandular disease; and (b) no discordance between cytology and previous histology; not being a service associated with a service to which item 35647 or 35648 applies (Anaes.)	211.90
35645	Cervix, ablation by electrocoagulation diathermy, laser or cryotherapy, with colposcopy, including any local anaesthesia or	331.60

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	biopsies, in conjunction with ablative therapy of additional areas of biopsy proven high grade intraepithelial lesions of one or more sites of the vagina, vulva, urethra or anus, for previously biopsy confirmed HSIL (CIN2/3) in a patient with a Type 1 of 2 (completely visible) transformation zone, if there is: (a) no evidence of invasive or glandular disease; and (b) no discordance between cytology and previous histology; not being a service associated with a service to which item 35647 or 35648 applies (Anaes.)	
35647	Cervix, complete excision of the endocervical transformation zone, using large loop or laser therapy, including any local anaesthesia and biopsies (Anaes.)	211.90
35648	Cervix, complete excision of the endocervical transformation zone, using large loop or laser therapy, including any local anaesthesia and biopsies, in conjunction with ablative treatment of additional areas of biopsy-proven high grade intraepithelial lesions of one or more sites of the vagina, vulva, urethra or anus (Anaes.)	331.60
35649	Myomectomy, one or more myomas, when undertaken by an open abdominal approach (H) (Anaes.) (Assist.)	557.70
35653	Hysterectomy, abdominal, with or without removal of fallopian tubes and ovaries (H) (Anaes.) (Assist.)	702.05
35657	Hysterectomy, vaginal, with or without uterine curettage, inclusive of posterior culdoplasty, not being a service associated with a service to which item 35673 applies (H) (Anaes.) (Assist.)	702.05
35658	Uterus (at least equivalent in size to a 10 week gravid uterus), debulking of, prior to vaginal or laparoscopic removal at hysterectomy or myoma of at least 4 cm removed by laparoscopy when retrieved from the abdomen (H) (Anaes.) (Assist.)	432.90
35661	Hysterectomy, abdominal, that concurrently requires extensive retroperitoneal dissection with exposure of one or both ureters and complex side wall dissection, including when performed with one or more of the following procedures: (a) salpingectomy; (b) oophorectomy; (c) excision of ovarian cyst (H) (Anaes.) (Assist.)	1,755.35
35667	Radical hysterectomy or radical trachelectomy (with or without excision of uterine adnexae) for proven malignancy, including excision of any one or more of the following: (a) parametrium; (b) paracolpos; (c) upper vagina; (d) contiguous pelvic peritoneum;	1,658

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	utilising nerve sparing techniques and involving ureterolysis, if performed (H) (Anaes.) (Assist.)	
35668	Hysterectomy, radical (with or without excision of uterine adnexae) including excision of any one or more of the following: (a) parametrium; (b) paracolpos; (c) upper vagina; (d) contiguous pelvic peritoneum; utilising nerve sparing techniques and involving ureterolysis, if performed in a patient with malignancy and previous pelvic radiation or chemotherapy treatment (H) (Anaes.) (Assist.)	1,926.35
35669	Hysterectomy, peripartum, performed for histologically proven placenta increta or percreta, or placenta accreta, if the patient has been referred to another practitioner for the management of severe intractable peripartum haemorrhage (H) (Anaes.)(Assist.)	1,926.35
35671	Hysterectomy, peripartum, for ongoing intractable haemorrhage where other haemorrhage control techniques have failed, for the purpose of providing lifesaving emergency treatment, not being a service associated with a service to which item 35667, 35668 or 35669 applies (H) (Anaes.) (Assist.)	1,511.10
35673	Hysterectomy, vaginal, with or without uterine curettage, with salpingectomy, oophorectomy or excision of ovarian cyst, one or more, one or both sides, inclusive of a posterior culdoplasty, not being a service associated with a service to which item 35657 applies (H) (Anaes.) (Assist.)	788.50
35674	Ultrasound guided needling and injection of ectopic pregnancy	216.30
35680	Bicornuate uterus, plastic reconstruction for (Anaes.) (Assist.)	605.60
35691	Sterilisation by interruption of fallopian tubes when performed in conjunction with Caesarean section (H) (Anaes.) (Assist.)	165.10
35694	Tuboplasty (salpingostomy or salpingolysis), unilateral or bilateral, one or more procedures (H) (Anaes.) (Assist.)	663.50
35697	Microsurgical or laparoscopic tuboplasty (salpingostomy, salpingolysis or tubal implantation into uterus), unilateral or bilateral, one or more procedures (H) (Anaes.) (Assist.)	984.55
35700	Fallopian tubes, unilateral microsurgical or laparoscopic anastomosis of (H) (Anaes.) (Assist.)	759.70
35703	Hydrotubation of fallopian tubes as a non-repetitive procedure (Anaes.)	70.30
35717	Laparotomy, involving oophorectomy, salpingectomy, salpingo-oophorectomy, removal of ovarian, parovarian, fimbrial or broad ligament cyst—one or more such procedures, unilateral or bilateral, including adhesiolysis, for benign disease (including ectopic pregnancy by tubal removal or salpingostomy), not being a	887.75

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	service associated with hysterectomy (H) (Anaes.) (Assist.)	
35720	Radical debulking, involving the radical excision of a macroscopically disseminated gynaecological malignancy from the pelvic cavity, including resection of peritoneum from the following: (a) the pelvic side wall; (b) the pouch of Douglas; (c) the bladder; for macroscopic disease confined to the pelvis, not being a service associated with a service to which item 35721 applies (H) (Anaes.) (Assist.)	1659.55
35721	Radical debulking, involving the radical excision of a macroscopically disseminated gynaecological malignancy from the abdominal and pelvic cavity, where cancer has extended beyond the pelvis, including any of the following: (a) resection of peritoneum over any of the following: (i) the diaphragm; (ii) the paracolic gutters; (iii) the greater or lesser omentum; (iv) the porta hepatis; (b) cytoreduction of recurrent gynaecological malignancy from the abdominal cavity following previous abdominal surgery, radiation or chemotherapy; (c) cytoreduction of recurrent gynaecological malignancy from the pelvic cavity following previous pelvic surgery, radiation or chemotherapy; not being a service to which a service associated with a service to which item 35720 or 35726 applies (H) (Anaes.) (Assist.)	3,319.15
35723	Para-aortic lymph node dissection from above the level of the aortic bifurcation (unilateral), for staging or restaging of gynaecological malignancy (H) (Anaes.) (Assist.)	1,466.35
35724	Para-aortic lymph node dissection (pelvic or above the aortic bifurcation) after prior similar dissection, radiotherapy or chemotherapy for malignancy (H) (Anaes.) (Assist.)	2,171.30
35726	Infra-colic omentectomy, with or without multiple peritoneal biopsies, for staging or restaging of gynaecological malignancy, not being a service associated with a service to which item 35721 applies (H) (Anaes.) (Assist.)	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	Hysterectomy, laparoscopic assisted vaginal, by any approach,	816.40

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	including any endometrial sampling, with or without removal of the tubes or ovarian cystectomy or removal of the ovaries and tubes due to other pathology, not being a service associated with a service to which item 35595 or 35673 applies (H) (Anaes.) (Assist.)	
35751	Hysterectomy, laparoscopic, by any approach, including any endometrial sampling, with or without removal of the tubes, not being a service associated with a service to which item 35595 applies (H) (Anaes.) (Assist.)	816.40
35753	Hysterectomy, complex laparoscopic, by any approach, including endometrial sampling, with either or both of the following procedures: (a) unilateral or bilateral salpingo-oophorectomy (excluding salpingectomy); (b) excision of moderate endometriosis or ovarian cyst; including any associated laparoscopy, not being a service associated with a service to which item 35595 applies (H) (Anaes.) (Assist.)	902.75
35754	Hysterectomy, complex laparoscopic, by any approach, that concurrently requires either extensive retroperitoneal dissection or complex side wall dissection, or both, with any of the following procedures (if performed): (a) endometrial sampling; (b) unilateral or bilateral salpingectomy, oophorectomy or salpingo-oophorectomy; (c) excision of ovarian cyst; (d) any other associated laparoscopy; not being a service associated with a service to which item 35595 or 35641 applies (H) (Anaes.) (Assist.)	1,744.35
35756	Hysterectomy, laparoscopic, by any approach, if the procedure is completed by open hysterectomy for control of bleeding or extensive pathology, including any associated laparoscopy, not being a service associated with a service to which item 35595 or 35641 applies (H) (Anaes.) (Assist.)	1,488.90
35759	Procedure for the control of post-operative haemorrhage following gynaecological surgery, under general anaesthesia, utilising a vaginal, abdominal or laparoscopic approach if no other procedure is performed (H) (Anaes.) (Assist.)	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	306.80

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	bladder, not being a service associated with a service to which item 36505, 36507, 36508, 36812, 36830, 36836, 36840, 36845, 36848, 36854, 37203 or 37215 applies (Anaes.)	
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, other than a service associated with a service to which item 30390 or 30627 applies (H) (Anaes.) (Assist.)	1,152.90
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

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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
36530	Renal cell carcinoma, not more than 4 cm in diameter, destruction of, by percutaneous, laparoscopic or open cryoablation (including any associated imaging services), if: (a) malignancy has previously been confirmed by histopathological examination; and (b) a multi-disciplinary team has reviewed treatment options for the patient and assessed that partial nephrectomy is not suitable; and (c) the service is not a service associated with a service to which item 36522 or 36525 applies (H) (Anaes.)	856.10
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	1,343.45

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	more renal stones, including one or more of nephrostomy, pyelostomy, pedicle control with or without freezing, calyorrhaphy or pyeloplasty (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

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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
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

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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 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.)	771.55
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	1,109.50

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	service associated with a service performed in the same collecting system to which item 36654 applies (H) (Anaes.) (Assist.)	
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: (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.)	617.60
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:	162.65

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or (b) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment (Anaes.)	
36671	Percutaneous tibial nerve stimulation, initial treatment protocol, for the treatment of overactive bladder, by a specialist urologist, gynaecologist or urogynaecologist, if: (a) the patient has been diagnosed with idiopathic overactive bladder; and (b) the patient has been refractory to, is contraindicated or otherwise not suitable for, conservative treatments (including anti-cholinergic agents); and (c) the patient is contraindicated or otherwise not a suitable candidate for botulinum toxin type A therapy; and (d) the patient is contraindicated or otherwise not a suitable candidate for sacral nerve stimulation; and (e) the patient is willing and able to comply with the treatment protocol; and (f) the initial treatment protocol comprises 12 sessions, delivered over a 3 month period; and (g) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts for 30 minutes 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	208.10
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	208.10

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	item 36671 or 36673 applies	
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 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.)	485.25
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	866.90

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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.)	
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 (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.)	480.25
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

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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 or 37215 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 and 37203 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
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

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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
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
37044	Bladder stress incontinence, suprapubic operation for (such as Burch colposuspension), open or laparoscopic route, using native tissue without graft, with diagnostic cystoscopy to assess the integrity of the lower urinary tract, not being a service associated with a service to which item 35599 or 36812 applies (H) (Anaes.)	806.50

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(Assist.)	
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, 37207, 37208, 37245, 37303, 37321 or 37324 applies (H) (Anaes.)	862.45
37203	Prostatectomy, transurethral resection using cautery, with or without cystoscopy, and with or without urethroscopy, and including services to which item 36854, 37201, 37207, 37208, 37245, 37303, 37321 or 37324 applies (H) (Anaes.)	1,084.35
37204	Cytoscopy with insertion of prostatic implants for the treatment of benign prostatic hyperplasia (Anaes.)	876.75
37205	Prostate, ablation by water vapour with or without cytoscopy and with or without urethrosocopy (Anaes.)	355.95
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, 37203, 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

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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 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.)	3,020.65
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	143.90

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	prostate gland or prostate surgical bed, under ultrasound guidance, being an item associated with a service to which item 55603 applies (Anaes.)	
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, 37203, 37207, 37208 or 37215 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
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
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;	1,313.30

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	other than a service associated with a service to which item 36827, 36854, 37008, 37201, 37203, 37207, 37208, 37303, 37321 or 37324 applies (H) (Anaes.)	
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
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	1,447.50

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	laparotomy, symphysectomy and suprapubic cystotomy, with or without re-routing of the urethra around the crura (H) (Anaes.) (Assist.)	
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
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

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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
37613	Epididymectomy (Anaes.)	287.80
37616	Vasovasostomy or vasoepididymostomy, unilateral, using the operating microscope, other than a service associated with sperm	719.40

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	harvesting for IVF (H) (Anaes.) (Assist.)	
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

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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; other than a service associated with a service to which item 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38254 or 38368 applies (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; (b) oximetry; (c) dye dilution curves; (d) cardiac output measurements by any method; (e) shunt detection; (f) exercise stress test; other than a service associated with a service to which item 38200, 38206, 38244, 38247, 38248, 38249, 38251, 38252 or 38254 applies (Anaes.)	553.10
38206	Right heart catheterisation with left heart catheterisation via the right heart or by another procedure, with any one or more of the following: (a) fluoroscopy; (b) oximetry; (c) dye dilution curves; (d) cardiac output measurements by any method; (e) shunt detection; (f) exercise stress test; other than a service associated with a service to which item 38200, 38203, 38244, 38247, 38248, 38249, 38251, 38252 or 38254 applies (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 for:	1,428.05

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) the investigation of supraventricular tachycardia involving 4 or more catheters; or (b) complex tachycardia inductions; or (c) multiple catheter mapping; or (d) acute intravenous anti-arrhythmic drug testing with pre and post drug inductions; or (e) catheter ablation to intentionally induce complete atrioventricular block; or (f) intraoperative mapping; other than a service associated with a service to which item 38209 or 38213 applies (Anaes.)	
38213	Cardiac electrophysiological study, performed either: (a) during insertion of implantable defibrillator; or (b) for defibrillation threshold testing at a different time to implantation; other than a service associated with a service to which item 38209 or 38212 applies (Anaes.)	425.30
38241	Use of a coronary pressure wire, if the service is: (a) performed during selective coronary angiography, percutaneous angioplasty or transluminal insertion of one or more stents; and (b) to measure fractional flow reserve, non-hyperaemic pressure ratios or coronary flow reserve in intermediate coronary artery or graft lesions (stenosis of 50 to 70%); and (c) to determine whether revascularisation is appropriate, if previous functional imaging: (i) has not been performed; or (ii) has been performed but the results are inconclusive or do not apply to the vessel being interrogated; and (d) performed on one or more coronary vascular territories (Anaes.)	488.70
38244	Selective coronary angiography: (a) for a patient who is eligible for the service under clause 5.10.17A; and (b) with placement of one or more catheters and injection of opaque material into native coronary arteries; and (c) with or without left heart catheterisation, left ventriculography or aortography; and (d) including all associated imaging; other than a service associated with a service to which 38200, 38203, 38206, 38247, 38248, 38249, 38251 or 38252 applies (Anaes)	920.00
38247	Selective coronary and graft angiography:	1,473.95

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) for a patient who is eligible for the service under clause 5.10.17A; and (b) with placement of one or more catheters and injection of opaque material into the native coronary arteries; and (c) if free coronary grafts attached to the aorta or direct internal mammary artery grafts are present—with placement of one or more catheters and injection of opaque material into those grafts (irrespective of the number of grafts); and (d) with or without left heart catheterisation, left ventriculography or aortography; and (e) including all associated imaging; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38248, 38249, 38251 or 38252 applies (Anaes)	
38248	Selective coronary angiography: (a) for a patient who is eligible for the service under clause 5.10.17B; and (b) as part of the management of the patient; and (c) with placement of catheters and injection of opaque material into native coronary arteries; and (d) with or without left heart catheterisation, left ventriculography or aortography; and (e) including all associated imaging; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38249, 38251 or 38252 applies—applicable each 3 months (Anaes.)	920.00
38249	Selective coronary and graft angiography: (a) for a patient who is eligible for the service under clause 5.10.17B; and (b) as part of the management of the patient; and (c) with placement of one or more catheters and injection of opaque material into the native coronary arteries; and (d) if free coronary grafts attached to the aorta or direct internal mammary artery grafts are present—with placement of one or more catheters and injection of opaque material into those grafts (irrespective of the number of grafts); and (e) with or without left heart catheterisation, left ventriculography or aortography; and (f) including all associated imaging; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38251 or 38252 applies—applicable once each 3 months (Anaes.)	1,473.95
38251	Selective coronary angiography:	920.00

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) for a symptomatic patient with valvular or other non-coronary structural heart disease; and (b) as part of the management of the patient for: (i) pre-operative assessment for planning non-coronary cardiac surgery, including by transcatheter approaches; or (ii) evaluation of valvular heart disease or other non-coronary structural heart disease where clinical impression is discordant with non-invasive assessment; and (c) with placement of catheters and injection of opaque material into native coronary arteries; and (d) with or without left heart catheterisation, left ventriculography or aortography; and (e) including all associated imaging; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249 or 38252 applies—applicable once each 12 months (Anaes.)	
38252	Selective coronary and graft angiography: (a) for a symptomatic patient with valvular or other non-coronary structural heart disease; and (b) as part of the management of the patient for: (i) pre-operative assessment for planning non-coronary cardiac surgery, including by transcatheter approaches; or (ii) evaluation of valvular heart disease or other non-coronary structural heart disease where clinical impression is discordant with non-invasive assessment; and (c) with placement of one or more catheters and injection of opaque material into the native coronary arteries; and (d) if free coronary grafts attached to the aorta or direct internal mammary artery grafts are present—with placement of one or more catheters and injection of opaque material into those grafts (irrespective of the number of grafts); and (e) with or without left heart catheterisation, left ventriculography or aortography; and (f) including all associated imaging; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249 or 38251 applies—applicable once each 12 months (Anaes.)	1,473.95
38254	Right heart catheterisation: (a) performed at the same time as a service to which item 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313 or 38314 applies; and (b) including any of the following (if performed): (i) fluoroscopy; (ii) oximetry;	463.50

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(iii) dye dilution curves; (iv) cardiac output measurement; (v) shunt detection; (vi) exercise stress test (Anaes.)	
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 or patent foramen closure: (a) for congenital heart disease in a patient with documented evidence of right heart overload or paradoxical embolism; and (b) using a septal occluder or similar device, by transcatheter approach; and (c) including right or left heart catheterisation (or both); other than a service associated with a service to which item 38200, 38203, 38206 or 38254 applies (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 cardiac catheterisation, excluding imaging (H) (Anaes.) (Assist.)	777.60
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, if: (a) the patient is at increased risk of thromboembolism demonstrated by: (i) a prior stroke (whether of an ischaemic or unknown type), transient ischaemic attack or non-central nervous system systemic embolism; or (ii) at least 2 of the following risk factors: (A) an age of 65 years or more; (B) hypertension; (C) diabetes mellitus; (D) heart failure or left ventricular ejection fraction of 35% or less (or both); (E) vascular disease (prior myocardial infarction, peripheral artery disease or aortic plaque); and (b) the patient has an absolute and permanent contraindication to oral anticoagulation (confirmed by written documentation that is provided by a medical practitioner, independent of the practitioner rendering the service); and (c) the service is not associated with a service to which item 38200,	949.25

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	38203, 38206 or 38254 applies (H) (Anaes.) (Assist.)	
38285	Insertion of implantable ECG loop recorder, by a specialist or consultant physician, for the diagnosis of a primary disorder, including initial programming and testing, if: (a) the patient has recurrent unexplained syncope and does not have a structural heart defect associated with a high risk of sudden cardiac death; and (b) a diagnosis has not been achieved through all other available cardiac investigations; and (c) a neurogenic cause is not suspected (Anaes.)	160.55
38286	Removal of implantable ECG loop recorder (Anaes.)	144.60
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
38307	Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17A; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and	1,844.60

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; (ii) transluminal insertion of one or more stents; and (d) performed on one coronary vascular territory; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.)	
38308	Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17A; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 2 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.)	2,122.25
38309	Percutaneous transluminal rotational atherectomy of one or more coronary arteries, including all associated imaging, if: (a) the target stenosis within at least one coronary artery is heavily calcified and balloon angioplasty with or without stenting is not feasible without rotational artherectomy; and (b) the service is performed in conjunction with a service to which item 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies Applicable only once on each occasion the service is performed (Anaes.) (Assist.)	1,250.70
38310	Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17A; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated	2,399.90

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 3 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.)	
38311	Percutaneous coronary intervention: (a) for a patient: (i) eligible under clause 5.10.17C for the service and a service to which item 38314 applies; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on one coronary vascular territory; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.)	1,844.60
38313	Percutaneous coronary intervention: (a) for a patient: (i) eligible under clause 5.10.17C for the service and a service to which item 38314 applies; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 2 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.)	2,122.25

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
38314	Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17C; and (ii) for whom selective coronary angiography has not been completed in the previous 3 months; and (b) including selective coronary angiography and all associated imaging, catheter and contrast; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (c) performed on 3 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38316, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.)	2,399.90
38316	Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17A; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on one coronary vascular territory; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38317, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.)	1,648.95
38317	Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17A; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 2 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200,	2,088.80

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38319, 38320, 38322 or 38323 applies (Anaes.) (Assist.)	
38319	Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17A; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 3 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38320, 38322 or 38323 applies (Anaes.) (Assist.)	2,366.45
38320	Percutaneous coronary intervention: (a) for a patient: (i) eligible under clause 5.10.17C for the service and a service to which item 38323 applies; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on one coronary vascular territory; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38322 or 38323 applies (Anaes.) (Assist.)	1,648.95
38322	Percutaneous coronary intervention: (a) for a patient: (i) eligible under clause 5.10.17C for the service and a service to which item 38323 applies; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and	2,088.80

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(ii) transluminal insertion of one or more stents; and (d) performed on 2 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320 or 38323 applies (Anaes.) (Assist.)	
38323	Percutaneous coronary intervention: (a) for a patient: (i) eligible for the service under clause 5.10.17C; and (ii) for whom selective coronary angiography has been completed in the previous 3 months; and (b) including any associated coronary angiography; and (c) including either or both: (i) percutaneous angioplasty; and (ii) transluminal insertion of one or more stents; and (d) performed on 3 coronary vascular territories; and (e) excluding aftercare; other than a service associated with a service to which item 38200, 38203, 38206, 38244, 38247, 38248, 38249, 38251, 38252, 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320 or 38322 applies (Anaes.) (Assist.)	2,366.45
38325	Use of intravascular ultrasound (IVUS) during transluminal insertion of stents, to optimise procedural strategy, appropriate stent size and assessment of stent apposition, for a patient documented with: (a) one or more left main coronary artery lesions; or (b) one or more lesions at least 28mm in length in other locations; if performed in association with a service to which item 38307, 38308, 38310, 38311, 38313, 38314, 38316, 38317, 38319, 38320, 38322 or 38323 applies Applicable once per episode of care (for one or more lesions) (H) (Anaes.)	508.70
38350	Single chamber permanent transvenous electrode (including cardiac electrophysiological services if used for pacemaker implantation), insertion, removal or replacement of (Anaes.)	664.55
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

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
38358	Extraction of one or more chronically implanted transvenous pacing or defibrillator leads, by percutaneous method, with locking stylets and snares, with extraction sheaths (if any), if: (a) the leads have been in place for more than 6 months and require removal; and (b) the service is performed: (i) in association with a service to which item 61109 or 60509 applies; and (ii) by a specialist or consultant physician who has undertaken the training to perform the service; and (iii) in a facility where cardiothoracic surgery is available and a thoracotomy can be performed immediately and without transfer; and (c) if the service is performed by an interventional cardiologist—a cardiothoracic surgeon is in attendance during the service (H) (Anaes.) (Assist.)	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	Insertion, removal or replacement of permanent cardiac synchronisation device, if the patient: (a) has all of the following: (i) chronic heart failure, classified as New York Heart Association class III or IV (despite optimised medical therapy); (ii) left ventricular ejection fraction of less than 35%; (iii) QRS duration of greater than or equal to 130 ms; or (b) has all of the following: (i) chronic heart failure, classified as New York Heart Association class II (despite optimised medical therapy); (ii) left ventricular ejection fraction of less than 35%; (iii) QRS duration of greater than or equal to 150 ms; other than a service associated with a service to which item 38212 applies (H) (Anaes.) (Assist.)	265.80
38368	Insertion, removal or replacement of permanent transvenous left ventricular electrode, through the coronary sinus, for the purpose of cardiac resynchronisation therapy, including right heart catheterisation and any associated venograms, if the patient: (a) has all of the following: (i) chronic heart failure, classified as New York Heart Association class III or IV (despite optimised medical therapy); (ii) left ventricular ejection fraction of less than 35%; (iii) QRS duration of greater than or equal to 130 ms; or (b) has all of the following:	1,274.20

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(i) chronic heart failure, classified as New York Heart Association class II (despite optimised medical therapy); (ii) left ventricular ejection fraction of less than 35%; (iii) QRS duration of greater than or equal to 150 ms; other than a service associated with a service to which item 35200, 38200 or 38212 applies (H) (Anaes.) (Assist.)	
38372	Leadless permanent cardiac pacemaker, single-chamber ventricular, percutaneous insertion of, for the treatment of bradycardia, including cardiac electrophysiological services (other than a service associated with a service to which item 38350 applies) (H) (Anaes.)	830.30
38373	Leadless permanent cardiac pacemaker, single-chamber ventricular, percutaneous retrieval and replacement of, including cardiac electrophysiological services, during the same percutaneous procedure, if: (a) the service is performed by a specialist or consultant physician who has undertaken training to perform the service; and (b) if the service is performed at least 4 weeks after the pacemaker was inserted—the service is performed in a facility where cardiothoracic surgery is available and a thoracotomy can be performed immediately and without transfer; and (c) if the service is performed by an interventional cardiologist at least 4 weeks after the pacemaker was inserted—a cardiothoracic surgeon is in attendance during the service; other than a service associated with a service to which item 38350 applies (H) (Anaes.)	830.30
38374	Leadless permanent cardiac pacemaker, single-chamber ventricular, percutaneous retrieval of, if: (a) the service is performed by a specialist or consultant physician who has undertaken training to perform the service; and (b) if the service is performed at least 4 weeks after the pacemaker was inserted—the service is performed in a facility where cardiothoracic surgery is available and a thoracotomy can be performed immediately and without transfer; and (c) if the service is performed by an interventional cardiologist at least 4 weeks after the pacemaker was inserted—a cardiothoracic surgeon is in attendance during the service (H) (Anaes.)	830.30
38375	Leadless permanent cardiac pacemaker, single-chamber ventricular, explantation of, by open surgical approach (H) (Anaes.) (Assist.)	3,107.15
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;	586.15

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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.)	
38417	Endobronchial ultrasound guided biopsy or biopsies (bronchoscopy with ultrasound imaging, with or without associated fluoroscopic imaging) to obtain one or more specimens by: (a) transbronchial biopsy or biopsies of peripheral lung lesions; or (b) fine needle aspirations of one or more mediastinal masses; or (c) fine needle aspirations of locoregional nodes to stage non-small cell lung carcinoma; other than a service associated with a service to which an item in Subgroup 1 of this Group, item 38416, 38420 or 38423, or an item in Subgroup 15 of Group I3, applies (Anaes.)	586.15
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
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
38425	Endoscopic resection of endobronchial tumours for relief of obstruction including any associated endoscopic procedures, other than a service associated with a service to which another item in Group T8 applies (H) (Anaes.) (Assist.)	628.75
38426	Trachea or bronchus, dilatation of stricture and endoscopic insertion of stent (H) (Anaes.) (Assist.)	471.70
38428	Bronchoscopy with treatment of tracheal stricture (Anaes.)	256.50
38429	Tracheal excision and repair of, without cardiopulmonary bypass (H) (Anaes.) (Assist.)	1,819.30
38431	Tracheal excision and repair of, with cardiopulmonary bypass (H) (Anaes.) (Assist.)	2,460.75
38467	Insertion, removal or replacement of permanent myocardial electrode, by open surgical approach, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	997.25
38471	Insertion of implantable defibrillator, including insertion of patches for the insertion of one or more transvenous endocardial leads, if the patient has one of the following: (a) a history of haemodynamically significant ventricular arrhythmias in the presence of structural heart disease; (b) documented high-risk genetic cardiac disease; (c) ischaemic heart disease, with a left ventricular ejection fraction of less than 30% at least one month after experiencing a	1,095.30

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	myocardial infarction and while on optimised medical therapy; (d) chronic heart failure, classified as New York Heart Association class II or III, with a left ventricular ejection fraction of less than 35% (despite optimised medical therapy); other than a service to which item 38212 applies (H) (Anaes.) (Assist)	
38472	Insertion, replacement or removal of implantable defibrillator generator, if the patient has one of the following: (a) a history of haemodynamically significant ventricular arrhythmias in the presence of structural heart disease; (b) documented high-risk genetic cardiac disease; (c) ischaemic heart disease, with a left ventricular ejection fraction of less than 30% at least one month after experiencing a myocardial infarction and while on optimised medical therapy; (d) chronic heart failure, classified as New York Heart Association class II or III, with a left ventricular ejection fraction of less than 35% (despite optimised medical therapy); other than a service to which item 38212 applies (H) (Anaes.) (Assist)	299.50
38474	Repair, augmentation or replacement of branch pulmonary arteries—left or right (or both), with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,257.10
38477	Valve annuloplasty with insertion of ring, other than: (a) a service to which item 38516 or 38517 applies; or (b) a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,084.55
38484	Aortic or pulmonary valve replacement with bioprosthesis or mechanical prosthesis, including retrograde cardioplegia (if performed), other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,112.20
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
38490	Reconstruction and re-implantation of sub-valvular structures, if performed in conjunction with a service to which item 38499 applies (H) (Anaes.) (Assist.)	577.00
38493	Operative management of acute infective endocarditis, in association with heart valve surgery (H) (Anaes.) (Assist.)	2,036.90
38499	Mitral or tricuspid valve replacement with bioprosthesis or	2,112.20

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	mechanical prosthesis, including retrograde cardioplegia (if performed), other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	
38502	Coronary artery bypass, including cardiopulmonary bypass, with or without retrograde cardioplegia, with or without vein grafts, and including at least one of the following: (a) harvesting of left internal mammary artery and vein graft material; (b) harvesting of left internal mammary artery; (c) harvesting of vein graft material; other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist)	2,451.55
38508	Repair or reconstruction of left ventricular aneurysm, including plication, resection and primary and patch repairs, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	1,996.20
38509	Repair of ischaemic ventricular septal rupture, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,485.45
38510	Artery harvesting (other than of the left internal mammary), for coronary artery bypass, if: (a) more than one arterial graft is required; and (b) the service is performed in conjunction with coronary artery bypass surgery performed by any medical practitioner (H) (Anaes.) (Assist.)	649.25
38511	Coronary artery bypass, with the aid of tissue stabilisers, if the service is performed: (a) without cardiopulmonary bypass; and (b) in conjunction with a service to which item 38502 applies (H) (Anaes.) (Assist.)	624.30
38512	Division of accessory pathway, isolation procedure, procedure on atrioventricular node or perinodal tissues involving one atrial chamber only, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,183.55
38513	Creation of Y-graft, T-graft and graft-to-graft extensions, with micro-arterial or micro-venous anastomosis using microsurgical techniques, if: (a) the service is for one or more anastomoses; and	1,040.55

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(b) the service is performed in conjunction with a service to which item 38502 applies (H) (Anaes.) (Assist.)	
38515	Division of accessory pathway, isolation procedure, procedure on atrioventricular node or perinodal tissues involving both atrial chambers and including curative surgery for atrial fibrillation, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,780.20
38516	Simple valve repair: (a) with or without annuloplasty; and (b) including quadrangular resection, cleft closure or alfieri; and (c) including retrograde cardioplegia (if performed); other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist)	2,641.60
38517	Complex valve repair: (a) with or without annuloplasty; and (b) including retrograde cardioplegia (if performed); and (c) including one of the following: (i) neochords; (ii) chordal transfer; (iii) patch augmentation; (iv) multiple leaflets; other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist)	3,251.20
38518	Ventricular arrhythmia with mapping and muscle ablation, with or without aneurysmeotomy, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,984.25
38519	Valve explant of a previous prosthesis, if performed during open cardiac surgery, not being a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	1,100.00
38550	Repair or replacement of ascending thoracic aorta: (a) including: (i) cardiopulmonary bypass; and (ii) retrograde cardioplegia (if performed); and (b) not including valve replacement or repair or implantation of coronary arteries; other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,337.50

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
38553	Repair or replacement of ascending thoracic aorta: (a) including: (i) aortic valve replacement or repair; and (i) cardiopulmonary bypass; and (ii) retrograde cardioplegia (if performed); and (b) not including implantation of coronary arteries; other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,942.90
38554	Valve sparing aortic root surgery, with reimplantation of aortic valve and coronary arteries and replacement of the ascending aorta, including cardiopulmonary bypass, and including retrograde cardioplegia (if performed), other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist)	4,236.45
38555	Simple replacement or repair of aortic arch, performed in conjunction with a service to which item 38550, 38553, 38554, 38556, 38568 or 38571 applies, including: (a) deep hypothermic circulatory arrest; and (b) peripheral cannulation for cardiopulmonary bypass; and (c) antegrade or retrograde cerebral perfusion (if performed); other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38603, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,641.60
38556	Repair or replacement of ascending thoracic aorta, including: (a) aortic valve replacement or repair; and (b) implantation of coronary arteries; and (c) cardiopulmonary bypass; and (d) retrograde cardioplegia (if performed); other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	3,282.20
38557	Complex replacement or repair of aortic arch, performed in conjunction with a service, performed by any medical practitioner, to which item 38550, 38553, 38554, 38556, 38568 or 38571 applies, including: (a) debranching and reimplantation of head and neck vessels; and (b) deep hypothermic circulatory arrest; and (c) peripheral cannulation for cardiopulmonary bypass; and (d) antegrade or retrograde cerebral perfusion (if performed); other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies	4,572.00

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(H) (Anaes.) (Assist.)	
38558	Aortic repair involving augmentation of hypoplastic or interrupted aortic arch, if: (a) the patient is a neonate; and (b) the service includes: (i) the use of antegrade cerebral perfusion or deep hypothermic circulatory arrest and associated myocardial preservation; and (ii) retrograde cardioplegia; other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	5,083.70
38568	Repair or replacement of descending thoracic aorta, without shunt or cardiopulmonary bypass, by open exposure, percutaneous or endovascular means, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	1,938.45
38571	Repair or replacement of descending thoracic aorta, with shunt or cardiopulmonary bypass, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,209.65
38572	Operative management of acute rupture or dissection, if the service: (a) is performed in conjunction with a service to which item 38550, 38553, 38554, 38555, 38556, 38557, 38558, 38568, 38571, 38706 or 38709 applies; and (b) is not associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38603, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,067.60
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, other than a service: (a) in which peripheral cannulation is used in preference to central cannulation for valve or coronary bypass procedures; or (b) associated with a service to which item 38555 or 38572 applies (H) (Anaes.) (Assist.)	997.25
38609	Insertion of intra-aortic balloon pump, by arteriotomy, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	498.55

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
38612	Removal of intra-aortic balloon pump, with closure of artery by direct suture, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	558.90
38615	Insertion of a left or right ventricular assist device, for use as: (a) a bridge to cardiac transplantation in patients with refractory heart failure who are: (i) currently on a heart transplant waiting list; or (ii) expected to be suitable candidates for cardiac transplantation following a period of support on the ventricular assist device; or (b) acute post cardiotomy support for failure to wean from cardiopulmonary transplantation; or (c) cardio-respiratory support for acute cardiac failure which is likely to recover with short term support of less than 6 weeks; other than a service associated with a service to which: (d) item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies; or (e) another item in this Schedule applies if the service described in the item is for the use of a ventricular assist device as destination therapy in the management of a patient with heart failure who is not expected to be a suitable candidate for cardiac transplantation (H) (Anaes.) (Assist.)	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; other than a service associated with a service to which: (d) item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies; or (e) another item in this Schedule applies if the service described in the item is for the use of a ventricular assist device as destination therapy in the management of a patient with heart failure who is not expected to be a suitable candidate for cardiac transplantation (H) (Anaes.) (Assist.)	1,986.95

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
38621	Left or right ventricular assist device, removal of, as an independent procedure, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38627, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	793.25
38624	Left and right ventricular assist device, removal of, as an independent procedure, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38627, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	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, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	696.70
38637	Patent diseased coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	577.00
38653	Open heart surgery, other than a service: (a) to which another item in this Group applies; or (b) associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,090.50
38670	Cardiac tumour, excision of, involving the wall of the atrium or inter-atrial septum, without patch or conduit reconstruction, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	1,986.55
38673	Cardiac tumour, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,235.95
38677	Cardiac tumour arising from ventricular myocardium, partial thickness excision of, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,091.80
38680	Cardiac tumour arising from ventricular myocardium, full thickness excision of including repair or reconstruction, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,481.20
38700	Patent ductus arteriosus, shunt, collateral or other single large	1,110.65

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	
38703	Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,008.85
38706	Aorta, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	1,896.20
38709	Anastomosis or repair of aorta, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,235.45
38715	Main pulmonary artery, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	1,775.45
38718	Banding, debanding or repair of main pulmonary artery, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,245.70
38721	Vena cava, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	1,556.45
38724	Vena cava, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,264.55
38727	Anastomosis or repair of intrathoracic vessels, without cardiopulmonary bypass, performed as a primary procedure, other than a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38700, 38703, 38706, 38709, 38715, 38718, 38721, 38724, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	1,556.45
38730	Anastomosis or repair of intrathoracic vessels, with cardiopulmonary bypass, performed as a primary procedure, other than a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38700, 38703, 38706, 38709, 38715, 38718, 38721, 38724, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,221.00

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
38733	Systemic pulmonary or cavo-pulmonary shunt, creation of, without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	1,556.45
38736	Systemic pulmonary or cavo-pulmonary shunt, creation of, with cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,221.00
38739	Atrial septectomy, with or without cardiopulmonary bypass, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,036.55
38742	Atrial septal defect, closure by open exposure and direct suture or patch, for congenital heart disease in a patient with documented evidence of right heart overload or paradoxical embolism, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,002.05
38745	Intra-atrial baffle, insertion of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,221.00
38748	Ventricular septectomy, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,221.00
38751	Ventricular septal defect, closure by direct suture or patch, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,221.00
38754	Intraventricular baffle or conduit, insertion of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,780.20
38757	Extracardiac conduit, insertion of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,221.00
38760	Extracardiac conduit, replacement of, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,221.00

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
38764	Ventricular myectomy, for relief of right or left ventricular obstruction, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	2,221.00
38766	Ventricular augmentation, right or left, for congenital heart disease, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18260, 33824, 38816, 38828 or 45503 applies (H) (Anaes.) (Assist.)	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
38812	Percutaneous needle biopsy of lung (Anaes.)	217.65
38815	Thoracoscopy, with or without division of pleural adhesions, with or without biopsy, including insertion of intercostal catheter where necessary, other than a service associated with: (a) a service to which item 18258, 18260 or 38828 applies; or (b) a service to which item 38816 applies that is performed on the same lung (H) (Anaes.) (Assist.)	264.00
38816	Thoracotomy, exploratory, with or without biopsy, including insertion of an intercostal catheter where necessary, other than a service associated with: (a) a service to which item 18258, 18260 or 38828 applies; or (b) a service to which item 38815 applies that is performed on the same lung (H) (Anaes.) (Assist.)	1,013.20
38817	Thoracotomy, thoracoscopy or sternotomy, by any procedure: (a) including any division of adhesions if the time taken to divide the adhesions exceeds 30 minutes; and (b) other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18258, 18260, 33824, 38815, 38816, 38818, 38828 or 45503 applies (H) (Anaes.) (Assist.)	1,592.75
38818	Thoracotomy, thoracoscopy or median sternotomy for post-operative bleeding, other than a service associated with a service to which item 11704, 11705, 11707, 11714, 18258, 18260, 33824, 38815, 38816, 38817, 38828 or 45503 applies (H) (Anaes.) (Assist.)	1,013.20
38820	Lung, wedge resection of, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38820, 38821 or 38828 applies (H) (Anaes.) (Assist.)	1,212.80

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
38821	Lung, wedge resection of, 2 or more wedges, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38820 or 38828 applies (H) (Anaes.) (Assist.)	1,819.20
38822	Pneumonectomy, lobectomy, bilobectomy or segmentectomy, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38823, 38824 or 38828 applies (H) (Anaes.) (Assist.)	1,619.55
38823	Radical lobectomy, pneumonectomy, bilobectomy, segmentectomy or formal mediastinal node dissection (greater than 4 nodes), other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38822, 38824 or 38828 applies (H) (Anaes.) (Assist.)	2,001.10
38824	Segmentectomy, lobectomy, bilobectomy or pneumonectomy, including resection of chest wall, diaphragm, pericardium, and formal mediastinal node dissection (greater than 4 nodes), other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38822, 38823 or 38828 applies (H) (Anaes.) (Assist.)	2,501.35
38828	Intercostal drain, insertion of: (a) not involving resection of rib; and (b) excluding aftercare; and (c) other than a service associated with a service to which item 38815, 38816, 38829, 38830, 38831, 38832, 38833 or 38834 applies (Anaes.)	141.20
38829	Intercostal drain, insertion of, with pleurodesis: (a) not involving resection of rib; and (b) excluding aftercare; and (c) other than a service associated with a service to which item 38815, 38816, 38828, 38830, 38831, 38832, 38833 or 38834 applies (Anaes.)	174.00
38830	Empyema, radical operation for, involving resection of rib, other than a service associated with a service to which item 38828, 38829, 38831, 38832, 38833 or 38834 applies (H) (Anaes.) (Assist.)	422.20
38831	Thoracoscopy or thoracotomy and drainage of paraneumonic effusion and empyema, exploratory, with or without biopsy, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38829, 38830, 38832, 38833 or 38834 applies (H) (Anaes.) (Assist.)	1,519.80
38832	Thoracotomy or thoracoscopy, with pulmonary decortication, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38829, 38830, 38831, 38833 or 38834 applies (H) (Anaes.) (Assist.)	1,619.55
38833	Thoracotomy or thoracoscopy, with pleurectomy or pleurodesis, other than a service associated with a service to which item 18258,	1,013.20

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	18260, 38815, 38816, 38828, 38829, 38830, 38831, 38832 or 38834 applies (H) (Anaes.) (Assist.)	
38834	Thoracotomy and radical extra pleural pneumonectomy or radical lung preserving decortication and pleurectomy for malignancy, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38829, 38830, 38831, 38832 or 38833 applies (H) (Anaes.) (Assist.)	3,752.10
38837	Mediastinum, cervical exploration of, with or without biopsy, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) (Assist.)	383.80
38838	Thoracotomy or thoracoscopy or sternotomy, for removal of thymus or mediastinal tumour, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) (Assist.)	1,251.10
38839	Pericardium, subxiphoid open surgical drainage of, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38840 applies (H) (Anaes.) (Assist.)	606.50
38840	Pericardium, transthoracic (thoracotomy or thoracoscopy) open surgical drainage of, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38839 applies (H) (Anaes.) (Assist.)	905.60
38841	Pericardiectomy via sternotomy or thoracoscopy or anterolateral thoracotomy without cardiopulmonary bypass, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) (Assist.)	1,619.55
38842	Pericardiectomy via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) (Assist.)	2,265.75
38845	Sternal wire or wires, removal of, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.)	291.15
38846	Pectus excavatum or pectus carinatum, repair or radical correction of, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38847, 38848 or 38849 applies (H) (Anaes.) (Assist.)	1,512.00
38847	Pectus excavatum, repair of, with implantation of subcutaneous prosthesis, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38846, 38848 or 38849 applies (H) (Anaes.) (Assist.)	805.95
38848	Pectus excavatum, repair of, with insertion of a concave bar, by any method, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38846 or 38847 applies (H) (Anaes.) (Assist.)	1,209.60

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
38849	Pectus excavatum, removal of a concave bar, by any method, not being a service associated with a service to which item 18258, 18260, 38815, 38816, 38828, 38846 or 38847 applies (H) (Anaes.) (Assist.)	604.75
38850	Sternotomy wound, debridement of, not involving reopening of the mediastinum, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38851 applies (H) (Anaes.)	345.10
38851	Sternotomy wound, debridement of, involving curettage of infected bone, with or without removal of wires, but not involving reopening of the mediastinum, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38850 applies (H) (Anaes.)	375.10
38852	Sternum, reoperation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38853 applies (H) (Anaes.) (Assist.)	1,012.80
38853	Sternum and mediastinum, reoperation for infection of, involving muscle advancement flaps and/or greater omentum, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38828 or 38852 applies (H) (Anaes.) (Assist.)	1,587.80
38857	Chest wall resection, sternum and/or ribs without reconstruction, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38824, 38828 or 38858 applies (H) (Anaes.) (Assist.)	1,918.95
38858	Chest wall resection, sternum and / or ribs with reconstruction, other than a service associated with a service to which item 18258, 18260, 38815, 38816, 38824, 38828 or 38857 applies (H) (Anaes.) (Assist.)	2,501.35
38859	Plating of multiple ribs for flail segment, other than a service associated with a service to which item 18258, 18260, 38815, 38816 or 38828 applies (H) (Anaes.) (Assist.)	1,013.20
38864	Intrathoracic operations on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than one of those organs, not being a service to which another item in this Group applies, other than a service associated with a service to which item 18258, 18260 or 38828 applies (H) (Anaes.) (Assist.)	1,619.55

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.

5.10.19AB Item 41764—additional application

In addition to the application of item 41764 as provided by clauses 1.2.6 and 1.2.7, item 41764 also applies to a service provided by an eligible speech pathologist on behalf of a specialist in the practice of the specialist's speciality of otolaryngology head and neck surgery, if:

(a) the service is performed following a written request made by the specialist to assist the specialist in the diagnosis, treatment or management of a laryngeal condition or related disorder in the patient; and

(b) the service is performed in a medical facility; and

(c) the service is performed on the patient individually and in person; and

(d) after the service is performed, the eligible speech pathologist gives the specialist:

(i) recorded dynamic images of, and a copy of the results of, the service; and

(ii) relevant written comments, prepared by the eligible speech pathologist, about those results; and

(e) a service to which item 41764 applies has not been performed on the same patient on the same day.

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.

Note: The fees in Group T8 are indexed in accordance with clause 1.3.1.

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 of one or more zygo-apophyseal or costo-transverse joints with one or more of contrast media, local anaesthetic or corticosteroid under image guidance (Anaes.)	113.55
39014	Medial branch block of one or more primary posterior rami, injection of an anaesthetic agent under image guidance (Anaes.)	129.90

Clause 5.10.19

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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 (ophthalmic, maxillary or mandibular branches) with alcohol, cortisone, phenol, or similar neurolytic substance, under image guidance (Anaes.)	247.20
39109	Trigeminal gangliotomy by radiofrequency, balloon or glycerol, including stereotaxy (Anaes.) (Assist.)	1,475.05
39110	Left lumbar percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.)	278.90
39111	Right lumbar percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.)	278.90
39113	Cranial nerve, neurectomy or intracranial decompression of, using microsurgical techniques, including stereotaxy and cranioplasty (H) (Anaes.) (Assist.)	2,474.45
39116	Left thoracic percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.)	309.90
39117	Right thoracic percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.)	309.90
39118	Left cervical percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.)	340.90
39119	Right cervical percutaneous zygapophyseal joint denervation by radio-frequency probe, or cryoprobe, using radiological imaging control Applicable to one or more services provided in a single attendance, for not more than 3 attendances in a 12 month period (Anaes.)	340.90
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	Spinal catheter, insertion or replacement of, and connection to a subcutaneous implanted infusion pump, for the management of chronic pain, including cancer pain (H) (Anaes.) (Assist.)	310.10

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
39126	All of the following: (a) infusion pump, subcutaneous implantation or replacement of; (b) connection of the pump to a spinal catheter; (c) filling of reservoir with a therapeutic agent or agents; with or without programming the pump, for the management of chronic pain, including cancer pain (H) (Anaes.) (Assist.)	376.55
39127	Subcutaneous reservoir and spinal catheter, insertion of, for the management of chronic pain, including cancer pain (H) (Anaes.)	492.85
39128	All of the following: (a) infusion pump, subcutaneous implantation of; (b) spinal catheter, insertion of; (c) connection of pump to catheter; (d) filling of reservoir with a therapeutic agent or agents; with or without programming the pump, for the management of chronic pain, including cancer pain (H) (Anaes.) (Assist.)	686.65
39129	Peripheral lead or leads, percutaneous placement of, including intraoperative test stimulation, for the management of chronic neuropathic pain (H) (Anaes.) (Assist.)	631.30
39130	Epidural lead or leads, percutaneous placement of, including intraoperative test stimulation, for the management of chronic neuropathic pain or pain from refractory angina pectoris (H) (Anaes.) (Assist.)	701.45
39131	Epidural or peripheral nerve electrodes (management, adjustment or reprogramming, of neurostimulator), with a medical practitioner attending, for the management of chronic neuropathic pain or pain from refractory angina pectoris—each day	133.00
39133	Either: (a) subcutaneously implanted infusion pump, removal of; or (b) spinal catheter, removal or repositioning of; for the management of chronic pain, including cancer pain (H) (Anaes.)	165.90
39134	Neurostimulator or receiver, subcutaneous placement of, including placement and connection of extension wires to epidural or peripheral nerve electrodes, for the management of chronic neuropathic pain or pain from refractory angina pectoris (H) (Anaes.) (Assist.)	354.40
39135	Neurostimulator or receiver that was inserted for the management of chronic neuropathic pain or pain from refractory angina pectoris, open surgical removal of, performed in the operating theatre of a hospital (H) (Anaes.) (Assist.)	165.90
39136	Epidural or peripheral nerve lead that was implanted for the management of chronic neuropathic pain or pain from refractory angina pectoris, open surgical removal of, performed in the operating theatre of a hospital (H) (Anaes.) (Assist.)	165.90

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
39137	Epidural or peripheral nerve lead that was implanted for the management of chronic neuropathic pain or pain from refractory angina pectoris, open surgical repositioning of, to correct displacement or unsatisfactory positioning, including intraoperative test stimulation, other than a service to which item 39130, 39138 or 39139 applies (H) (Anaes.) (Assist.)	629.90
39138	Peripheral nerve lead or leads, surgical placement of, including intraoperative test stimulation, for the management of chronic neuropathic pain where the leads are intended to remain in situ long term (H) (Anaes.) (Assist.)	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 neuropathic pain or pain from refractory angina pectoris (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
39141	Epidural or peripheral nerve electrodes (management, adjustment, or reprogramming of neurostimulator), with a medical practitioner attending remotely by video conference, for the management of chronic neuropathic pain or pain from refractory angina pectoris—each day	135.15
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 that is performed at the same site—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; (b) transposition of nerve or nerve transfer to facilitate repair; other than a service associated with: (c) a service to which item 39321 applies; or (d) a service to which item 30023 applies that is performed at the same	743.35

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	site (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 that is performed at the same site (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: (e) a service to which item 39330 applies; or (f) a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	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 denervation (excluding medial branch nerve) by cryotherapy or radiofrequency probe, other than a service to which another item applies, applicable not more than 6 times for a given nerve in a 12 month period (Anaes.)	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:	367.70

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) a service to which item 39303, 39309, 39312, 39315, 39318, 39324 or 39327 applies; or (b) a service to which item 30023 applies that is performed at the same site (Anaes.) (Assist.)	
39330	Neurolysis by open operation without transposition, other than a service associated with: (a) a service to which item 39321, 39328, 39329, 39332, 39336, 39339, 39342, 39345, 49774 or 49775 applies; or (b) a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	288.00
39331	Carpal tunnel release, including division of transverse carpal ligament or release of median nerve, by any method, including either or both of the following (if performed): (a) synovectomy; (b) neurolysis; other than a service associated with: (c) a service to which item 46339 applies; or (d) a service to which item 30023 applies that is performed at the same site (Anaes.) (Assist.)	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: (c) a service to which item 46339 applies; or (d) a service to which item 30023 applies that is performed at the same site (Anaes.) (Assist.)	432.05
39336	Ulnar nerve decompression at elbow or wrist (cubital tunnel or Guyon's canal) without transposition, by any method, including neurolysis (if performed), other than a service associated with a service to which item 30023 applies that is performed at the same site (Anaes.)(Assist.)	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 that is performed at the same site (Anaes.)(Assist.)	432.05
39342	Ulnar nerve decompression at elbow (cubital tunnel), including any of the following (if performed):	566.75

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) associated transposition; (b) subcutaneous or submuscular transposition of the nerve; (c) medial epicondylectomy; (d) ostetomy and reconstruction of the flexor origin; (e) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site (Anaes.)(Assist.)	
39345	Localised decompression of radial, median or ulnar nerve, or branches of, in the forearm for compressive neuropathy, including neurolysis (if performed), other than a service associated with a service to which item 30023 applies that is performed at the same site (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; (c) post-operative re-opening, including for swelling or post-operative cerebrospinal fluid leak (H) (Anaes.) (Assist.)	1,866.25
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

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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; (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.)	3,851.65
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

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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, other than a service associated with a service to which item 22053 applies (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.) (Assist.)	2,507.80
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, 40703 or 41887 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	354.40

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (H) (Anaes.) (Assist.)	
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
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)	1,514.20

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(Anaes.) (Assist.)	
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
40804	Magnetic resonance imaging—scan of head (including magnetic resonance angiography if performed) by a radiologist on request by a specialist or consultant physician, for the sole purpose of guiding focused ultrasound for the treatment of medically refractory essential tremor in association with the services described in items 40805 and 40806, including: (a) stereotactic scan of brain, with frame in place; and (b) assistance with computerised planning; and (c) interpretation of intraprocedural imaging Applicable once per patient per lifetime (H) (Anaes.)	1,035.55
40805	Neurological assessment and evaluation during the treatment of medically refractory essential tremor with magnetic resonance imaging-guided focused ultrasound, performed by a neurologist in association with the services described in items 40804 and 40806, including: (a) assistance with target localisation incorporating anatomical and physiological techniques; and (b) continuous intraprocedural neurological assessment and evaluation Applicable once per patient per lifetime (H) (Anaes.)	2,139.70
40806	Treatment of medically refractory essential tremor with magnetic resonance imaging-guided focused ultrasound, performed by a neurosurgeon in association with the services described in items 40804 and 40805, including: (a) computer assisted anatomical localisation; and (b) frame placement; and (c) target verification using anatomical and physiological techniques; and (d) delivery of treatment with lesion production in the basal ganglia, brain	3,295.85

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	stem, thalamus or deep white matter tracts Applicable once per patient per lifetime (H) (Anaes.)	
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: (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.)	4,123.60
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:	547.70

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **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.)	
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 sustained and is accompanied by unacceptable motor fluctuations; or (b) essential tremor or dystonia, if the patient's symptoms cause severe disability (Anaes.)	197.40
40863	Deep brain stimulation (unilateral), remote electronic analysis and programming of neurostimulator pulse generator for the treatment of: (a) Parkinson's disease, if the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or (b) essential tremor or dystonia, if the patient's symptoms cause severe disability Applicable not more than 8 times in any 12 month period	200.55
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	193.10

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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	
41503	Ear, foreign body in (other than ventilating tube), removal of, involving incision of external auditory canal, other than a service associated with a service to which another item in this Subgroup applies (Anaes.)	248.45
41506	Aural polyp, removal of (Anaes.)	149.85
41509	External auditory meatus, surgical removal of keratosis obturans from, performed under general anaesthesia, other than: (a) a service to which another item in this Subgroup applies; or (b) a service associated with a service to which item 41647 applies (H) (Anaes.)	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, other than a service associated with a service to which an item in Subgroup 18 applies (H) (Anaes.) (Assist.)	1,028.90
41524	Reconstruction of external auditory canal (H) (Anaes.) (Assist.)	297.25
41539	Ossicular chain reconstruction, other than a service associated with a service to which item 41611 applies (H) (Anaes.) (Assist.)	1,134.05
41542	Ossicular chain reconstruction and myringoplasty, other than a service associated with a service to which item 41611 applies (H) (Anaes.) (Assist.)	1,242.65
41548	Obliteration of the mastoid cavity (H) (Anaes.) (Assist.)	719.75
41569	Decompression of facial nerve in its mastoid portion, other than a service associated with a service to which item 41617 applies (H) (Anaes.) (Assist.)	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	3,801.65

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	applies (H) (Anaes.) (Assist.)	
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.) (Assist.)	2,724.70
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 bone conduction hearing system device, in a patient: (a) with a permanent or long term hearing loss; and (b) unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and (c) with bone conduction thresholds that accord with recognised criteria for the implantable bone conduction hearing device being inserted; other than a service associated with a service to which item 41554, 45794 or 45797 applies (Anaes.)	631.30
41608	Stapedectomy (H) (Anaes.) (Assist.)	1,134.05
41611	Stapes mobilisation, other than a service associated with a service to which item 41539 or 41542, or an item in Subgroup 18, applies (H) (Anaes.) (Assist.)	729.70
41614	Round window surgery including repair of cochleotomy, other than a service associated with a service to which item 41617 applies (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, cochleotomy and exposure of facial nerve where required, other than a service	1,972.00

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	associated with a service to which item 41569 or 41614 applies (H) (Anaes.) (Assist.)	
41618	Middle ear implant, partially implantable, insertion of, via mastoidectomy, for patients with: (a) stable sensorineural hearing loss; and (b) outer ear pathology that prevents the use of a conventional hearing aid; and (c) a PTA4 of less than 80 dBHL; and (d) bilateral, symmetrical hearing loss with PTA thresholds in both ears within 20 dBHL (0.5-4kHz) of each other; and (e) speech perception discrimination of at least 65% correct for word lists with appropriately amplified sound; and (f) a normal middle ear; and (g) normal tympanometry; and (h) on audiometry, an air-bone gap of less than 10 dBHL (0.5-4kHz) across all frequencies; and (i) no other inner ear disorders (H) (Anaes.) (Assist.)	1,953.00
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	Incision of tympanic membrane, or installation of therapeutic agent, to the middle ear through an intact drum: (a) not including local anaesthetic; and (b) excluding aftercare; and (c) other than a service associated with a service to which item 41632 applies (Anaes.)	149.85
41632	Middle ear, insertion of tube for drainage of (including myringotomy), other than a service associated with a service to which item 41626 applies (Anaes.)	248.45
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	Micro-inspection of tympanic membrane and auditory canal, requiring use of operating microscope or endoscope, including any removal of wax, with or without general anaesthesia, other than a service associated with a service to which item 41509 applies. Not applicable for the removal of uncomplicated wax in the absence of other disorders of the ear (Anaes.)	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

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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, other than a service associated with a service to which item 41702, 41703 or 41705 applies on the same side	85.80
41668	Nasal polyp or polypi, removal of (Anaes.)	228.85
41674	Cauterisation (other than by chemical means) or cauterisation by chemical means when performed under general anaesthesia or diathermy of septum or turbinates—one or more of these procedures (including any consultation on the same occasion) other than a service associated with another operation on the nose (Anaes.)	104.60
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
41698	Maxillary antrum, proof puncture and lavage of, other than a service associated with a service to which item 41702, 41703, 41705, 41710, 41734 or 41737 applies on the same side (Anaes.)	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 or sphenopalatine artery, ligation of (H) (Anaes.) (Assist.)	466.75
41713	Vidian neurectomy or exposure of vidian canal (H) (Anaes.) (Assist.)	631.10
41719	Antrum, drainage of, through tooth socket, other than a service associated with a service to which item 41722 applies (Anaes.)	122.35
41722	Oro-antral fistula, plastic closure of, other than a service associated with a service to which item 41719 or 45009 applies (Anaes.) (Assist.)	611.40
41725	Ligation of ethmoidal artery or arteries, anterior, posterior or both, by any approach (unilateral) (H) (Anaes.) (Assist.)	466.75
41728	Removal of sinonasal or nasopharyngeal tumour, excluding inflammatory nasal polyps, by any approach (H) (Anaes.) (Assist.)	933.65
41740	Frontal sinus, catheterisation of, other than a service associated with a service to which item 41749 applies on the same side (H) (Anaes.)	61.20
41743	Frontal sinus, trephine of, other than a service associated with a service to	351.15

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	which item 41749 applies on the same side (H) (Anaes.) (Assist.)	
41746	Paranasal sinus, radical obliteration of, including any graft harvest (Anaes.) (Assist.)	808.60
41749	Paranasal sinus, external operation on, unilateral, other than a service associated with a service to which item 41740 or 41743 applies on the same side (H) (Anaes.) (Assist.)	631.10
41755	Eustachian tube, catheterisation of (Anaes.)	48.40
41764	Nasendoscopy or sinoscopy or fibreoptic examination of nasopharynx and larynx, one or more of these procedures, unilateral or bilateral examination, other than a service associated with a service to which item 41693, 41702, 41703, 41705, 41734 or 41737 applies (Anaes.)	127.80
41770	Pharyngeal pouch, removal of, with or without cricopharyngeal myotomy (H) (Anaes.) (Assist.)	729.70
41776	Cricopharyngeal myotomy, by any approach, including open inversion of pharyngeal pouch or endoscopic repair of pharyngeal pouch (H) (Anaes.) (Assist.)	620.25
41779	Pharyngotomy (lateral), with or without total excision of tongue (H) (Anaes.) (Assist.)	729.70
41785	Partial pharyngectomy, by any approach, with or without partial glossectomy (H) (Anaes.) (Assist.)	1,205.60
41786	Uvulopalatopharyngoplasty, with or without tonsillectomy, by any means (H) (Anaes.) (Assist.)	766.90
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	Removal of lingual tonsil (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
41822	Oesophagoscopy, with rigid oesophagoscope, with or without biopsy, other than a service associated with a service to which item 30473 or	203.20

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	30478 applies (H) (Anaes.)	
41825	Removal of a foreign body from the pharynx, larynx or oesophagus, by any means, other than a service associated with a service to which item 30478 applies (H) (Anaes.) (Assist.)	370.80
41828	Oesophageal stricture, dilatation of, without oesophagoscopy (Anaes.)	54.35
41831	Oesophagus, endoscopic pneumatic dilatation of, for treatment of achalasia (Anaes.) (Assist.)	371.45
41832	Oesophagus, balloon dilatation of, using interventional imaging techniques (Anaes.)	237.75
41834	Total laryngectomy, including cricopharyngeal myotomy and tracheo-oesophageal puncture (H) (Anaes.) (Assist.)	1,672.60
41837	Complete vertical hemi-laryngectomy, involving removal of true and false vocal cords, including tracheostomy. Applicable only once per provider per patient per lifetime (H) (Anaes.) (Assist.)	1,286.15
41840	Total supraglottic laryngectomy, involving removal of ventricular folds, epiglottis and aryepiglottic folds including tracheostomy. Applicable only once per provider per patient per lifetime (H) (Anaes.) (Assist.)	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, by any approach, with or without biopsy (H) (Anaes.) (Assist.)	299.85
41861	Microlaryngoscopy with complete removal of benign or malignant lesions of the larynx, including papillomata, by any approach or technique, unilateral, other than a service associated with a service to which item 41870 applies on the same side (H) (Anaes.) (Assist.)	628.75
41867	Microlaryngoscopy, with partial or complete arytenoidectomy or arytenoid repositioning (H) (Anaes.) (Assist.)	638.25
41870	Laryngeal augmentation or modification by injection techniques, other than a service associated with a service to which item 41879 applies or item 41861 applies on the same side (Anaes.) (Assist.)	473.30
41873	Larynx, fractured, operation for (H) (Anaes.) (Assist.)	611.40
41876	Larynx, external operation on, or laryngofissure, with or without cordectomy (Anaes.) (Assist.)	611.40
41879	Tracheoplasty, laryngoplasty or thyroplasty, not by injection techniques, including tracheostomy, other than a service associated with a service to which item 41870 applies (H) (Anaes.) (Assist.)	990.70
41880	Tracheostomy by a percutaneous technique (H) (Anaes.)	264.40
41881	Tracheostomy by open exposure of the trachea (H) (Anaes.) (Assist.)	418.05
41884	Cricothyrostomy (H) (Anaes.)	94.75
41885	Trache-oesophageal fistula, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures	299.55

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(Anaes.) (Assist.)	
41886	Trachea, removal of foreign body in (Anaes.)	185.25
41887	Pituitary tumour, removal of, by trans-sphenoidal approach, including stereotaxy and dermis, dermofat or fascia grafting, as part of conjoint surgery, other than a service associated with a service to which item 40600 applies (H) (Anaes.) (Assist.)	2,856.05
41888	Fractured skull, after trauma only, or spontaneous defects with cerebrospinal fluid rhinorrhoea or otorrhoea, repair of, including stereotaxy and dermofat graft (H) (Anaes.) (Assist.)	2,021.35
41890	Orbit, decompression of, by fenestration of 2 or more walls, or by the removal of intraorbital peribulbar and retrobulbar fat from each quadrant of the orbit, one eye by endonasal approach (H) (Anaes.) (Assist.)	1,351.45
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 applies (H) (Anaes.)	106.65
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)	1,251.95

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(Anaes.) (Assist.)	
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
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	54.10

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	cryotherapy, laser or electrolysis—each eyelid (Anaes.)	
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 service to which item 42610 applies (excluding after-care)	50.25
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

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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 (Anaes.) (Assist.)	938.85
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

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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
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;	1,392.65

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(c) removal of epiretinal membranes; (d) capsulotomy (H) (Anaes.) (Assist.)	
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
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

Clause 5.10.19

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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
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	172.15

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	previous scleral buckling surgery (Anaes.)	
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 patient's eye or eyes; or (c) has concurrent thyroid eye disease (H) (Anaes.) (Assist.)	907.65
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

Clause 5.10.19

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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
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

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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 (H) (Anaes.) (Assist.)	2,073.05

Clause 5.10.19

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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 (H) (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

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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
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

Clause 5.10.20

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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
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, laparoscopic or open repair of, at age less than 12 months (H) (Anaes.) (Assist.)	638.35
44111	Obstructed or strangulated inguinal hernia, laparoscopic or open repair of, at age less than 12 months, including orchidopexy when performed (H) (Anaes.) (Assist.)	716.45
44114	Inguinal hernia, laparoscopic or open repair of, at age less than 12 months when orchidopexy also required (H) (Anaes.) (Assist.)	716.45
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.

5.10.21A Restrictions on items 46101 to 46111—services provided on the same occasion

Only one of items 46101, 46102, 46103, 46104, 46105, 46106, 46107, 46108, 46109, 46110 and 46111 may be claimed per provider per operation.

5.10.22 Midface procedures

In items 46150 to 46158:

maxilla includes any procedure that involves the adjacent 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.

Note: The fees in Group T8 are indexed in accordance with clause 1.3.1.

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**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

Clause 5.10.23

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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
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

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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 31383 (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 31383 (Anaes.)	626.05
45006	Single stage large myocutaneous flap repair to one defect (pectoralis major, latissimus dorsi, or similar large muscle), other than a service associated with a service to which any of items 45524 to 45542 apply (H) (Anaes.) (Assist.)	1,079.70
45009	Single stage local muscle flap repair to one defect, simple and small, other than a service associated with a service to which item 30278, 30281 or 41722 applies (H) (Anaes.) (Assist.)	394.40
45012	Single stage large muscle flap repair to one defect (pectoralis major, gastrocnemius, gracilis or similar large muscle), other than a service associated with a service to which any of items 45524 to 45542 apply (H) (Anaes.) (Assist.)	852.30
45015	Muscle or myocutaneous flap, delay of (H) (Anaes.)	312.95
45018	Dermis, dermofat or fascia graft (other than transfer of fat by injection): (a) if the service is not associated with neurosurgical services for spinal disorders mentioned in any of items 51011 to 51171; and (b) other than a service associated with a service to which item 39615, 39715, 40106 or 40109 applies (Anaes.) (Assist.)	492.85
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 of face resulting from trauma, burns or acne, if sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes—limited to one claim per patient per episode (Anaes.)	184.55

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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	Vascular anomaly, cauterisation of or injection into, if undertaken in the operating theatre of a hospital (H) (Anaes.)	125.25
45030	Vascular anomaly, of skin, mucous membrane and/or subcutaneous tissue, small, excision and suture of (Anaes.)	148.65
45033	Vascular anomaly, large or involving deeper tissue including facial muscle, excision and suture of (Anaes.) (Assist.)	269.35
45035	Vascular anomaly, large, deep, and involving major neurovascular structures, excision of, including dissection of muscles, nerves or major vessels (H) (Anaes.) (Assist.)	730.50
45036	Vascular anomaly, of neck, deep and involving major neurovascular structures, excision of, including dissection of cranial nerves and major vessels, (H) (Anaes.) (Assist.)	1,173.75
45045	Vascular anomaly 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.)	357.10

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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: (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.)	1,322.80
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 31383 (Anaes.)	295.90

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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, 31376, 31378, 31380 or 31383)—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 31383 (Anaes.) (Assist.)	422.50
45206	Single stage local flap if indicated to repair one defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals and excluding H-flap or double advancement flap—not in association with any of items 31356 to 31383 (Anaes.)	399.10
45207	H-flap or double advancement flap if indicated to repair one defect, on eyelid, eyebrow or forehead—not in association with any of items 31356 to 31383 (Anaes.)	399.10
45209	Pedicled flap repair (forehead, cross arm, cross leg, abdominal or similar), first stage of a multistage procedure (H) (Anaes.) (Assist.)	492.95
45212	Pedicled flap repair (forehead, cross arm, cross leg, abdominal or similar), subsequent stage of a multistage procedure (Anaes.) (Assist.)	244.60
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
45239	Direct, indirect, free or local flap, revision of, by incision and suture and/or liposuction, applicable once per flap, not being a service associated with a service to which item 45497 applies (Anaes.)	272.20
45440	Split thickness skin graft to a small defect that is: (a) less than 40 mm in diameter:	311.45

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(i) on areas below the knee; or (ii) distal to the ulnar styloid; or (iii) on the genital area; or (iv) on areas above the clavicle; or (b) less than 80 mm in diameter on any other part of the body (Anaes.) (Assist.)	
45443	Split thickness skin graft to a large defect that is: (a) 40 mm or more in diameter: (i) on areas below the knee; or (ii) distal to the ulnar styloid; or (iii) on the genital area; or (iv) on areas above the clavicle; or (b) 80 mm or more in diameter on any other part of the body (Anaes.) (Assist.)	642.35
45451	Full thickness skin graft to one defect, with an average diameter of 5 mm or more (Anaes.) (Assist.)	492.95
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 autologous breast reconstruction, revision of, by liposuction, other than a service associated with a service to which item 45239 applies (H) (Anaes.)	347.20
45500	Microvascular repair using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit; cannot be claimed by the same provider for both artery and vein (H) (Anaes.) (Assist.)	1,134.50
45501	Microvascular anastomosis of artery or vein using microsurgical techniques, for replantation or revascularisation of limb or digit, if the limb or digit is devitalised and the repair is critical for restoration of blood supply, other than a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies (H) (Anaes.) (Assist.)	1,846.60
45502	Microvascular anastomoses of artery and vein using microsurgical techniques, for replantation or revascularisation of limb or digit, if the limb or digit is devitalised and the repair is critical for restoration of blood supply, including anastomoses of all required vessels for that extremity or digit, unless a micro-arterial or micro-venous graft is being used, other than a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies (H) (Anaes.) (Assist.)	2,915.50
45503	Micro-arterial or micro-venous graft using microsurgical techniques, if the graft is critical for restoration of blood supply, including harvest of graft and suturing of all related anastomoses (not to be claimed in the context of cardiac surgery) (H) (Anaes.) (Assist.)	2,112.65

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Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
45504	Microvascular anastomosis of artery, vein or veins, using microsurgical techniques, for free transfer of tissue, including setting in of free flap, other than: (a) a service for the purpose of breast reconstruction; or (b) a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies (H) (Anaes.) (Assist.)	1,846.60
45505	Microvascular anastomoses of artery and vein or veins, using microsurgical techniques, for free transfer of tissue, including setting in of free flap, other than: (a) a service for the purpose of breast reconstruction; or (b) a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies (H) (Anaes.) (Assist.)	2,943.50
45507	Microvascular repair using microsurgical techniques, with restoration of continuity of artery and vein of distal extremity or digit, including anastomoses of all required vessels for that extremity or digit, other than a service associated with a service to which item 45564, 45565 or 45567 applies (H) (Anaes.) (Assist.)	1,791.25
45510	Scar, of face or neck, not more than 3 cm in length, revision of, if: (a) undertaken in the operating theatre of a hospital; or (b) performed by a specialist in the practice of the specialist's specialty (Anaes.)	240.85
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, if: (a) the service is: (i) undertaken in the operating theatre of a hospital; or (ii) performed by a specialist in the practice of the specialist's specialty; and (b) the service is not performed in conjunction with the insertion of breast implants for cosmetic purposes; and (c) the incision made for revision of the scar is not used as an approach for another procedure (including a non-rebatable procedure); and (d) sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes (Anaes.)	194.10

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
45518	Scar, other than on face or neck, more than 7 cm in length, revision of, if: (a) the service is: (i) undertaken in the operating theatre of a hospital; or (ii) performed by a specialist in the practice of the specialist's specialty; and (b) the service is not performed in conjunction with the insertion of breast implants for cosmetic purposes; and (c) the incision made for revision of the scar is not used as an approach for another procedure (including a non-rebatable procedure); and (d) sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes (Anaes.)	234.85
45520	Reduction mammaplasty (unilateral) with surgical repositioning of nipple, in the context of breast cancer or developmental abnormality of the breast, other than a service associated with a service to which item 31512, 31513 or 31514 applies on the same side (H) (Anaes.) (Assist.)	936.90
45522	Reduction mammaplasty (unilateral) without surgical repositioning of the nipple: (a) excluding the treatment of gynaecomastia; and (b) not with insertion of any prosthesis; other than a service associated with a service to which item 31512, 31513 or 31514 applies on the same side (H) (Anaes.) (Assist.)	657.35
45523	Reduction mammaplasty (bilateral) with surgical repositioning of the nipple: (a) for patients with macromastia who are experiencing pain in the neck or shoulder region; and (b) not with insertion of any prosthesis; other than a service associated with a service to which item 31512, 31513 or 31514 applies (H) (Anaes.) (Assist.)	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, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.)	771.70

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
45527	Breast reconstruction (unilateral), following mastectomy, using a permanent prosthesis, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.)	1,173.25
45528	Mammaplasty, augmentation, bilateral (other than a service to which item 45527 applies), if: (a) reconstructive surgery is indicated because of: (i) developmental malformation of breast tissue (excluding hypomastia); or (ii) disease of or trauma to the breast (other than trauma resulting from previous elective cosmetic surgery); or (iii) amastia secondary to a congenital endocrine disorder; and (b) photographic or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.)	1,157.40
45529	Breast reconstruction (bilateral), following mastectomy, using permanent prostheses, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.)	2,053.10
45530	Post-mastectomy breast reconstruction, autologous (unilateral), using a large muscle or myocutaneous flap, isolated on its vascular pedicle, excluding repair of muscular aponeurotic layer, other than a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45006 or 45012 applies (H) (Anaes.) (Assist.)	1,143.95
45531	Post-mastectomy breast reconstruction, autologous (bilateral), using a large muscle or myocutaneous flap, isolated on its vascular pedicle, excluding repair of muscular aponeurotic layer, other than a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45006 or 45012 applies (H) (Anaes.) (Assist.)	2,107.15
45532	Revision of post-mastectomy breast reconstruction, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.)	296.65
45534	Autologous fat grafting, unilateral service (harvesting, preparation and injection of adipocytes) if: (a) the autologous fat grafting is for one or more of the following purposes: (i) the correction of defects arising from treatment and prevention of breast cancer in patients with contour defects, greater than or equal to 20% volume asymmetry, post-treatment pain or poor prosthetic coverage; (ii) the preparation of post mastectomy thin or irradiated skin flaps in patients intending to have breast reconstruction; (iii) breast reconstruction in breast cancer patients; (iv) the correction of developmental disorders of the breast; and (b) photographic and/or diagnostic imaging evidence demonstrating	657.35

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	the clinical need for this service is documented in the patient notes Up to a total of 4 services per side (for total treatment of a single breast), other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.)	
45535	Autologous fat grafting, bilateral service (harvesting, preparation and injection of adipocytes) if: (a) the autologous fat grafting is for one or more of the following purposes: (i) the correction of defects arising from treatment and prevention of breast cancer in patients with contour defects, greater than or equal to 20% volume asymmetry, post-treatment pain or poor prosthetic coverage; (ii) the preparation of post mastectomy thin or irradiated skin flaps in patients intending to have breast reconstruction; (iii) breast reconstruction in breast cancer patients; (iv) the correction of developmental disorders of the breast; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes Up to a total of 4 services, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.)	1,150.40
45537	Perforator flap, such as a thoracodorsal artery perforator (TDAP) flap or a lateral intercostal artery perforator (LICAP) flap, or similar, raising on a named source vessel, for reconstruction of a partial mastectomy defect, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.)	861.50
45538	Perforator flap, such as a deep inferior epigastric perforator (DIEP) flap or similar, raising in preparation for microsurgical transfer of a free flap for post-mastectomy breast reconstruction, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.)	985.70
45539	Breast reconstruction (unilateral), following mastectomy, using tissue expansion—insertion of tissue expansion unit and all attendances for subsequent expansion injections, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.)	1,579.35
45540	Breast reconstruction (bilateral), following mastectomy, using tissue expansion—insertion of tissue expansion unit and all attendances for subsequent expansion injections, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.)	2,763.80
45541	Breast reconstruction (bilateral), following mastectomy, using tissue expansion—removal of tissue expansion unit and insertion of permanent prosthesis, other than a service associated with a service to which item 45006 or 45012 applies (H) (Anaes.) (Assist.)	1,175.65
45542	Breast reconstruction (unilateral), following mastectomy, using tissue expansion—removal of tissue expansion unit and insertion of permanent prosthesis, other than a service associated with a service to	638.25

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	which item 45006 or 45012 applies (H) (Anaes.) (Assist.)	
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
45547	Revision of breast prosthesis pocket, if: (a) breast prosthesis or tissue expander has been placed for the purpose of breast reconstruction in the context of breast cancer or for developmental breast abnormality; and (b) the prosthesis or tissue expander has migrated or rotated from its intended position or orientation; and (c) the existing prosthesis is used (H) (Anaes.) (Assist.)	766.05
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	727.80

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(c) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.) (Assist.)	
45556	Breast ptosis, correction of (unilateral), in the context of breast cancer or developmental abnormality, if photographic evidence (including anterior, left lateral and right lateral views) and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes Applicable only once per occasion on which the service is provided, other than a service associated with a service to which item 31512, 31513 or 31514 applies on the same side (H) (Anaes.) (Assist.)	797.05
45558	Correction of bilateral breast ptosis by mastopexy, if: (a) at least two-thirds of the breast tissue, including the nipple, lies inferior to the inframammary fold where the nipple is located at the most dependent, inferior part of the breast contour; and (b) photographic evidence (including anterior, left lateral and right lateral views), with a marker at the level of the inframammary fold, demonstrating the clinical need for this service, is documented in the patient notes Applicable only once per lifetime, other than a service associated with a service to which item 31512, 31513 or 31514 applies (H) (Anaes.) (Assist.)	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 and/or vein, if considered necessary to salvage a vascularly compromised pedicled or free flap, either during the primary procedure or at a subsequent return to theatre (H) (Anaes.) (Assist.)	1,846.60
45562	Free transfer of tissue (microvascular free flap) for non-breast defect involving raising of tissue on vascular pedicle, including direct repair of secondary cutaneous defect (if performed), other than a service associated with a service to which item 45564, 45565, 45567, 46060, 46062, 46064, 46066, 46068, 46070 or 46072 applies (H) (Anaes.) (Assist.)	1,143.95
45563	Neurovascular island flap for restoration of essential sensation in the digits or sole of the foot, or for genital reconstruction, including: (a) direct repair of secondary cutaneous defect (if performed); and (b) formal dissection of the neurovascular pedicle; other than a service performed on simple V-Y flaps or other standard flaps, such as rotation or keystone (H) (Anaes.) (Assist.)	1,143.95
45564	Free transfer of tissue (reconstructive surgery) for the repair of major tissue defect of the head and neck or other non-breast defect, using	2,649.50

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	microvascular techniques, all necessary elements of the operation including (but not limited to): (a) anastomoses of all required vessels; and (b) raising of tissue on a vascular pedicle; and (c) preparation of recipient vessels; and (d) transfer of tissue; and (e) insetting of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed; other than a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505, 45507, 45562 or 45567 applies—conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.)	
45565	Free transfer of tissue (reconstructive surgery) for the repair of major tissue defect of the head and neck or other non-breast defect, using microvascular techniques, all necessary elements of the operation including (but not limited to): (a) anastomoses of all required vessels; and (b) raising of tissue on a vascular pedicle; and (c) preparation of recipient vessels; and (d) transfer of tissue; and (e) insetting of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed; other than a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505, 45507, 45562 or 45567 applies—conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.)	1,987.20
45566	Insertion of a temporary prosthetic tissue expander which requires subsequent removal, including all attendances for subsequent expansion injections, other than a service for breast or post-mastectomy tissue expansion (H) (Anaes.) (Assist.)	1,114.65
45567	Free transfer of tissue (reconstructive surgery) for the repair of major tissue defect of the head and neck or other non-breast defect, using microvascular techniques, all necessary elements of the operation including (but not limited to): (a) anastomoses of all required vessels; and (b) raising of tissue on a vascular pedicle; and (c) preparation of recipient vessels; and (d) transfer of tissue; and (e) insetting of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed; other than a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505,	3,216.55

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	45507, 45562, 45564 or 45565 applies—single surgeon (H) (Anaes.) (Assist.)	
45568	Tissue expander, removal of, including complete excision of fibrous capsule if performed (H) (Anaes.) (Assist.)	461.65
45571	Closure of abdomen with reconstruction of umbilicus, with or without lipectomy, to be used following the harvest of an autologous flap, being a service associated with a service to which item 45530, 45531, 45562, 45564, 45565, 45567, 46080, 46082, 46084, 46086, 46088 or 46090 applies, including repair of the musculoaponeurotic layer of the abdomen (including insertion of prosthetic mesh if used) (H) (Anaes.) (Assist.)	1,133.55
45572	Intra-operative tissue expansion using a prosthetic tissue expander, performed under general anaesthetic or intravenous sedation during an operation, if combined with a service to which another item in Group T8 applies (including expansion injections), not to be used for breast tissue expansion (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 paralysis, 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 or 31526 applies, if: (a) the liposuction is for: (i) the treatment of Barraquer-Simons syndrome, lymphoedema or macrodystrophia lipomatosa; or (ii) the reduction of a buffalo hump that is secondary to an endocrine disorder or pharmacological treatment of a medical condition; and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.)	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),	1,390.55

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	bilateral, if: (a) surgery is indicated to correct a functional impairment due to a congenital condition, disease (excluding post-acne scarring) or trauma (other than trauma resulting from previous elective cosmetic surgery); and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (H) (Anaes.) (Assist.)	
45589	Autologous fat grafting (harvesting, preparation and injection of adipocytes) if: (a) the autologous fat grafting is for either or both of the following purposes: (i) the correction of asymmetry arising from volume and contour defects in craniofacial disorders—up to a total of 4 services if each service is provided at least 3 months after the previous service; (ii) the treatment of burn scar or associated skin graft in the context of scar contracture, contour deformity or neuropathic pain, for patients who have undergone a minimum of 3 months of topical therapies, including silicone and pressure therapy, with an unsatisfactory or minimal level of improvement—up to a total of 4 services per region of the body (upper or lower limbs, trunk, neck or face) if each service provided per region of the body is provided at least 3 months after the previous such service; and (b) both: (i) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes; and (ii) for craniofacial disorders, evidence of diagnosis of the qualifying craniofacial disorder is documented in the patient notes (H) (Anaes.)	657.35
45590	Orbital cavity, reconstruction of wall or floor, with or without bone graft, cartilage graft or foreign implant, other than a service associated with a service to which item 45594 applies on the same side (H) (Anaes.) (Assist.)	502.85
45592	Orbital cavity, reconstruction of wall and floor with bone graft, cartilage graft or foreign implant, other than a service associated with a service to which item 45594 applies on the same side (H) (Anaes.) (Assist.)	932.25
45594	Orbital cavity, exploration of wall or floor without bone graft, cartilage graft or foreign implant, other than a service associated with a service to which item 45590 or 45592 applies on the same side (H) (Anaes.) (Assist.)	436.90

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
45596	Hemimaxillectomy (H) (Anaes.) (Assist.)	936.90
45597	Total maxillectomy (bilateral) (H) (Anaes.) (Assist.)	1,254.25
45599	Mandible, total resection of, other than a service associated with a service to which item 45608 applies (H) (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, segmental mandibular or maxilla reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (H) (Anaes.) (Assist.)	860.85
45609	Mandible, maxilla or skull base, reconstruction of, using bony free flap, all osteotomies, shaping, inset and fixation by any means, including all necessary 3 dimensional planning, if performed in conjunction with one or more services covered by items 46060 to 46068 (H) (Anaes.) (Assist.)	906.10
45611	Mandible, condylectomy of (H) (Anaes.) (Assist.)	492.95
45614	Eyelid, reconstruction of a defect (greater than one quarter of the length of the lid) involving all 3 layers of the eyelid, if unable to be closed by direct suture or wedge excision, including all flaps and grafts that may be required (H) (Anaes.) (Assist.)	913.50
45617	Upper eyelid, reduction of, if: (a) the reduction is for any of the following: (i) history of a demonstrated visual impairment; (ii) intertriginous inflammation of the eyelid; (iii) herniation of orbital fat in exophthalmos; (iv) facial nerve palsy; (v) post-traumatic scarring; (vi) the restoration of symmetry of contralateral upper eyelid in respect of one of the conditions mentioned in subparagraphs (i) to (v); and (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)	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 (b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)	339.25

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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 one or both lateral cartilages, one or both alar cartilages or one or both lateral cartilages and alar cartilages, if: (a) the indication for surgery is: (i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or (ii) significant acquired, congenital or developmental deformity; and (b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (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; other than a service associated with a service to which item 45718 applies (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
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 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 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
45665	Lip, eyelid or ear, full thickness wedge excision of, with repair by direct sutures, excluding eyelid wedge when performed in conjunction with a cosmetic eyelid procedure (Anaes.)	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, single stage or first stage of a two-stage flap reconstruction of a defect involving all 3 layers of tissue, if the flap is switched from the opposing lip or eyelid respectively (H) (Anaes.) (Assist.)	867.85
45674	Lip or eyelid reconstruction, second stage of a two-stage flap reconstruction, division of the pedicle and inset of flap and closure of the donor (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 of nasolabial complex, one stage, without anterior palate repair (H) (Anaes.) (Assist.)	625.25
45680	Cleft lip, unilateral—primary repair of nasolabial complex, one stage, with anterior palate repair (H) (Anaes.) (Assist.)	815.40
45683	Cleft lip, bilateral—primary repair of nasolabial complex, one stage,	905.85

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	without anterior palate repair (H) (Anaes.) (Assist.)	
45686	Cleft lip, bilateral—primary repair of nasolabial complex, one stage, with anterior palate repair (H) (Anaes.) (Assist.)	1,069.20
45689	Cleft lip, lip adhesion procedure, unilateral or bilateral (H) (Anaes.) (Assist.)	272.40
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, repair of, including a local flap for closure (H) (Anaes.) (Assist.)	813.60
45716	Velo-pharyngeal incompetence, pharyngeal flap for, or pharyngoplasty for (H) (Anaes.)	813.60
45717	Alveolar cleft (congenital), unilateral, bone grafting of, including local flap closure of associated oro-nasal fistulae and ridge augmentation, other than a service associated with a service to which item 45718 applies (H) (Anaes.) (Assist.)	1,287.95
45718	Face, contour restoration of one region, for the correction of deformity using autogenous bone or cartilage, if the deformity: (a) is secondary to congenital absence of tissue; or (b) has arisen from: (i) trauma (other than from previous cosmetic surgery); or (ii) a diagnosed pathological process; other than a service associated with a service to which item 45644 or 45717 (alveolar bone grafting) applies (H) (Anaes.) (Assist.)	1,401.25
45761	Genioplasty, including transposition of nerves and vessels and bone grafts taken from the same site, if: (a) the deformity: (i) is secondary to congenital absence of tissue; or	779.00

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(ii) has arisen from trauma (other than from previous cosmetic surgery) or a diagnosed pathological process; and (b) the service is required for maintaining lip competency; and (c) sufficient photographic evidence demonstrating the clinical need for the service is included in patient notes (H) (Anaes.) (Assist.)	
45767	Hypertelorism, correction of, using intracranial approach (H) (Anaes.) (Assist.)	2,613.45
45773	Syndromic orbital dystopia, such as Treacher Collins Syndrome, bilateral facial or periorbital reconstruction, with bone grafts from a distant site (H) (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 (H) (Anaes.) (Assist.)	1,025.60
45785	Cranial vault reconstruction for single suture synostosis (H) (Anaes.) (Assist.)	1,735.70
45788	Glenoid fossa, construction of, from bone and cartilage graft, and creation of condyle and ascending ramus of mandible, in hemifacial microsomia, not including harvesting of graft material (H) (Anaes.) (Assist.)	1,715.95
45791	Absent condyle and ascending ramus in craniofacial microsomia, construction of, not including harvesting of graft material (H) (Anaes.) (Assist.)	926.95
45794	Osseo-integration procedure, first stage, implantation of fixture, following congenital absence, tumour or trauma, other than a service associated with a service to which item 41603 applies (Anaes.)	524.30
45797	Osseo-integration procedure, second stage, fixation of transcutaneous abutment, following congenital absence, tumour or trauma, other than a service associated with a service to which item 41603 applies (Anaes.)	194.10
45801	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), in the oral cavity, removal from mucosa or submucosal tissues, if the removal is by surgical excision and suture (Anaes.)	147.80
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	256.50

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	applies, involving muscle, bone, or other deep tissue (Anaes.)	
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: (a) mandible or maxilla (other than alveolar margins) for chronic osteomyelitis with radiological and laboratory evidence of osteomyelitis; or (b) mandible or maxilla for necrosis of the jaw from any cause including medication or radiation that requires debridement of the alveolar bone or beyond (Anaes.) (Assist.)	370.80
45823	Arch bars or similar, one or more, that were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia, if the service is undertaken in the operating theatre of a hospital (H) (Anaes.)	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, surgical reduction of—cannot be claimed more than once per occasion of service (Anaes.) (Assist.)	336.50
45837	Vestibuloplasty, submucosal or open, including excision of muscle and skin or mucosal graft when performed—unilateral or bilateral (Anaes.) (Assist.)	610.30
45841	Alveolar ridge augmentation with bone or alloplast or both—unilateral (Anaes.) (Assist.)	492.85
45845	Osseo-integration procedure, intra-oral implantation of titanium or similar fixture to facilitate restoration of the dentition following: (a) resection of part of the maxilla or mandible for a benign or a malignant tumour; or (b) segmental loss from trauma or congenital absence of a segment of the maxilla or mandible (multiple adjacent teeth) Fixture must be placed at site of the missing segment following	524.30

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	appropriate reconstructive procedures (Anaes.)	
45847	Osseo-integration procedure, fixation of transmucosal abutment to fixtures that are placed following: (a) resection of part of the maxilla or mandible for a benign or a malignant tumour; or (b) segmental loss from trauma or congenital absence of a segment of the maxilla or mandible (multiple adjacent teeth) Fixture must be placed at site of the missing segment following appropriate reconstructive procedures (Anaes.)	194.10
45849	Maxillary sinus, allograft, bone graft or both, to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), unilateral (Anaes.) (Assist.)	604.45
45851	Temporomandibular joint, manipulation of, as an independent procedure performed in the operating theatre of a hospital, other than a service associated with a service to which any other item in this Group applies (H) (Anaes.)	148.80
45855	Temporomandibular joint, arthroscopy of, with or without biopsy, other than a service associated with another arthroscopic procedure of that joint (H) (Anaes.) (Assist.)	318.20
45857	Temporomandibular joint, arthroscopy of, removal of loose bodies, debridement, or lysis and lavage or biopsy (including repositioning of meniscus where indicated)—one or more such procedures of that joint, other than a service associated with any other arthroscopic or open procedure of the temporomandibular joint (H) (Anaes.) (Assist.)	680.25
45865	Arthrocentesis, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.)	302.30
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 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
45874	Temporomandibular joint, including condylar head and glenoid fossa, total alloplastic replacement (H) (Anaes.) (Assist.)	1,443.35
45882	Treatment of a premalignant lesion of the oral mucosa using cryotherapy, diathermy or carbon dioxide laser	44.75
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	Grafting (mucosa or split skin), in the oral cavity of a mucosal defect (Anaes.)	213.00

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
45939	Cryosurgery of the peripheral branches of the trigeminal nerve for pain relief	465.20
46050	Perforator flap, raising on a named source vessel, for pedicled transfer for head or neck or other non-breast reconstruction (H) (Anaes.) (Assist.)	861.50
46052	Perforator Flap, such as anterolateral thigh flap or similar, raising in preparation for microsurgical transfer of a free flap for head or neck or other non-breast reconstruction (H) (Anaes.) (Assist.)	271.90
46060	Free transfer of tissue with a vascularised bone component (including chimeric/composite flap), for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to): (a) anastomoses of all required vessels using microvascular techniques; and (b) harvesting of flap (including osteotomies); and (c) raising of tissue on a vascular pedicle; and (d) preparation of recipient vessels; and (e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed; other than the following: (g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base; (h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Single surgeon (H) (Anaes.) (Assist.)	2,915.50
46062	Free transfer of tissue with a vascularised bone component (including chimeric/composite flap), for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to): (a) anastomoses of all required vessels using microvascular techniques; and (b) harvesting of flap (including osteotomies); and (c) raising of tissue on a vascular pedicle; and (d) preparation of recipient vessels; and (e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed; other than the following: (g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base;	2,788.80

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.)	
46064	Free transfer of tissue with a vascularised bone component (including chimeric/composite flap), for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to): (a) anastomoses of all required vessels using microvascular techniques; and (b) harvesting of flap (including osteotomies); and (c) raising of tissue on a vascular pedicle; and (d) preparation of recipient vessels; and (e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed; other than the following: (g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base; (h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.)	2,091.70
46066	Double free flap, including one free transfer of tissue with a vascularized bone component, for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to): (a) anastomoses of all required vessels using microvascular techniques; and (b) harvesting of flap (including osteotomies); and (c) raising of tissue on a vascular pedicle; and (d) preparation of recipient vessels; and (e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed; other than the following: (g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base; (h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.)	4,183.15

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
46068	Double free flap, including one free transfer of tissue with a vascularized bone component, for the repair of major defect of the head or neck or other non-breast defect, all necessary elements of the operation, including (but not limited to): (a) anastomoses of all required vessels using microvascular techniques; and (b) harvesting of flap (including osteotomies); and (c) raising of tissue on a vascular pedicle; and (d) preparation of recipient vessels; and (e) transfer of tissue, including fixation of bony element and inset of tissue at recipient site; and (f) direct repair of secondary cutaneous defect, if performed; other than the following: (g) bony reshaping for purposes of reconstruction of maxilla, mandible or skull base; (h) a service associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.)	3,137.55
46070	Double free flap, including 2 free transfers of tissue (reconstructive surgery) for the repair of major tissue defect, involving anastomoses of all required vessels using microvascular techniques, all necessary elements of the operation, including (but not limited to): (a) raising each flap of tissue on a separate vascular pedicle; and (b) preparation of recipient vessels; and (c) transfer of tissue; and (d) inset of tissue at recipient site; and (e) direct repair of secondary cutaneous defect, if performed; other than a service: (f) performed in the context of breast reconstruction; or (g) associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.)	4,183.15
46072	Double free flap, including 2 free transfers of tissue (reconstructive surgery) for the repair of major tissue defect, involving anastomoses of all required vessels using microvascular techniques, all necessary elements of the operation including (but not limited to): (a) raising each flap of tissue on a separate vascular pedicle; and (b) preparation of recipient vessels; and (c) transfer of tissue; and (d) inset of tissue at recipient site; and	3,137.55

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(e) direct repair of secondary cutaneous defect, if performed; other than a service: (f) performed in the context of breast reconstruction; or (g) associated with a service to which item 30166, 30169, 30175, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies Conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.)	
46080	Post-mastectomy breast reconstruction, autologous, single surgeon (unilateral) using a myocutaneous or perforator flap, by microsurgical transfer: (a) including anastomosis of artery and one or more veins (including repair of secondary skin defect); but (b) excluding repair of muscular aponeurotic layer; other than a service associated with a service to which item 30166, 30169, 30175, 30177 or 30179 applies (H) (Anaes.) (Assist.)	3,216.55
46082	Post-mastectomy breast reconstruction, autologous, single surgeon (bilateral) using a myocutaneous or perforator flap, by microsurgical transfer: (a) including anastomoses of arteries and veins (including repair of secondary skin defect); but (b) excluding repair of muscular aponeurotic layer; other than a service associated with a service to which item 30166, 30169, 30175, 30177 or 30179 applies (H) (Anaes.) (Assist.)	5,629.00
46084	Post-mastectomy breast reconstruction, autologous, conjoint surgery (unilateral) using a myocutaneous or perforator flap, by microsurgical transfer: (a) including anastomosis of artery and one or more veins (including repair of secondary skin defect); but (b) excluding repair of muscular aponeurotic layer; other than a service associated with a service to which item 30166, 30169, 30175, 30177 or 30179 applies—conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.)	2,788.80
46086	Post-mastectomy breast reconstruction, autologous, conjoint surgery (unilateral) using a myocutaneous or perforator flap, by microsurgical transfer: (a) including anastomosis of artery and one or more veins (including repair of secondary skin defect); but (b) excluding repair of muscular aponeurotic layer; other than a service associated with a service to which item 30166, 30169, 30175, 30177 or 30179 applies—conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.)	2,091.70
46088	Post-mastectomy breast reconstruction, autologous, conjoint surgery	4,880.35

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(bilateral) using a myocutaneous or perforator flap, by microsurgical transfer: (a) including anastomosis of artery and one or more veins (including repair of secondary skin defect); but (b) excluding repair of muscular aponeurotic layer; other than a service associated with a service to which item 30166, 30169, 30175, 30177 or 30179 applies—conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.)	
46090	Post-mastectomy breast reconstruction, autologous, conjoint surgery (bilateral) using a myocutaneous or perforator flap, by microsurgical transfer: (a) including anastomoses of arteries and veins (including repair of secondary skin defect); but (b) excluding repair of muscular aponeurotic layer; other than a service associated with a service to which item 30166, 30169, 30175, 30177 or 30179 applies—conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.)	3,660.40
46092	Lower pole coverage of reconstructive breast prosthesis, following mastectomy, using muscle or fascia turnover flap or autologous dermal flaps, if the service is performed in combination with a service to which item 31522, 31523, 31528, 31529, 45527, 45539 or 45542 applies (H) (Anaes.) (Assist.)	444.70
46094	Lower pole coverage or complete implant coverage of reconstructive breast prosthesis, following mastectomy, using allograft or synthetic products (H) (Anaes.) (Assist.)	328.55
46100	Excision of burnt tissue, or definitive burn wound closure, if: (a) the area of burn excised involves more than 1% of hands, face or anterior neck; and (b) the service is performed in conjunction with a service (the ***co-claimed service***) to which any of items 46101 to 46135 (other than item 46112 or 46124) apply; other than a service to which item 46136 applies	40% of the fee for the co-claimed service
46101	Excision of burnt tissue, if the area of burn excised involves not more than 1% of the total body surface (Anaes.) (Assist.)	369.65
46102	Excision of burnt tissue, if the area of burn excised involves more than 1% but less than 3% of the total body surface (H) (Anaes.) (Assist.)	586.80
46103	Excision of burnt tissue, if the area of burn excised involves 3% or more but less than 10% of the total body surface (H) (Anaes.) (Assist.)	643.65
46104	Excision of burnt tissue, if the area of burn excised involves 10% or more but less than 20% of the total body surface, excluding aftercare (H) (Anaes.) (Assist.)	981.95
46105	Excision of burnt tissue, if the area of burn excised involves 20% or more but less than 30% of total body surface, excluding aftercare (H)	1,320.60

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(Anaes.) (Assist.)	
46106	Excision of burnt tissue, if the area of burn excised involves 30% or more but less than 40% of total body surface, excluding aftercare (H) (Anaes.) (Assist.)	1,659.80
46107	Excision of burnt tissue, if the area of burn excised involves 40% or more but less than 50% of total body surface, excluding aftercare (H) (Anaes.) (Assist.)	1,998.45
46108	Excision of burnt tissue, if the area of burn excised involves 50% or more but less than 60% of total body surface, excluding aftercare (H) (Anaes.) (Assist.)	2,336.50
46109	Excision of burnt tissue, if the area of burn excised involves 60% or more but less than 70% of total body surface, excluding aftercare (H) (Anaes.) (Assist.)	2,675.20
46110	Excision of burnt tissue, if the area of burn excised involves 70% or more but less than 80% of total body surface, excluding aftercare (H) (Anaes.) (Assist.)	3,048.05
46111	Excision of burnt tissue, if the area of burn excised involves 80% or more of total body surface, excluding aftercare (H) (Anaes.) (Assist.)	3,413.65
46112	Excision of burnt tissue, if the area of burn excised involves whole of face (excluding ears)—may be claimed with any one of items 46101 to 46111, based on the percentage total body surface (excluding the face), other than a service associated with a service to which item 46100 applies and excluding aftercare (H) (Anaes.) (Assist.)	1,884.50
46113	Excised burn wound closure, or closure of skin defect secondary to burns contracture release, if the defect area is not more than 1% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision or contracture release; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound (Anaes.) (Assist.)	369.65
46114	Excised burn wound closure, or closure of skin defect secondary to burns contracture release, if the defect area is more than 1% but not more than 3% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision or contracture release; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound (H) (Anaes.) (Assist.)	586.80

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
46115	Excised burn wound closure or closure of skin defect secondary to burns contracture release, if the defect area is more than 3% but not more than 10% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision or contracture release; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound (H) (Anaes.) (Assist.)	643.65
46116	Excised burn wound closure or closure of skin defect secondary to burns contracture release, if the defect area is more than 10% but less than 20% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision or contracture release; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.)	981.95
46117	Excised burn wound closure, if the defect area is 20% or more but less than 30% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.)	1,320.60
46118	Excised burn wound closure, if the defect area is 30% or more but less than 40% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.)	1,659.80
46119	Excised burn wound closure, if the defect area is 40% or more but less than 50% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves:	1,998.45

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.)	
46120	Excised burn wound closure, if the defect area is 50% or more but less than 60% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.)	2,336.50
46121	Excised burn wound closure, if the defect area is 60% or more but less than 70% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.)	2,675.20
46122	Excised burn wound closure, if the defect area is 70% or more but less than 80% of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.)	3,048.05
46123	Excised burn wound closure, if the defect area is 80% or more of total body surface and if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and (b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare (H) (Anaes.) (Assist.)	3,413.65
46124	Excised burn wound closure of whole of face, if the service: (a) is performed at the same time as the procedure for the primary burn wound excision; and	1,884.50

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(b) involves: (i) autologous skin grafting for definitive closure; or (ii) allogenic skin grafting, or biosynthetic skin substitutes, to temporize the excised wound; excluding aftercare, other than a service associated with a service to which item 46100 applies (H) (Anaes.) (Assist.)	
46125	Non-excisional debridement of superficial or mid-dermal partial thickness burns, if the area of burn involves less than 1% of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements) (Anaes.) (Assist.)	369.65
46126	Non-excisional debridement of superficial or mid-dermal partial thickness burns, if the area of burn involves 1% or more but less than 3% of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements) (Anaes.) (Assist.)	586.80
46127	Non-excisional debridement of superficial or mid-dermal partial thickness burns, if the area of burn involves 3% or more but less than 10% of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements) (H) (Anaes.) (Assist.)	812.90
46128	Non-excisional debridement of superficial or mid-dermal partial thickness burns, if the area of burn involves 10% or more but less than 30% of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements), excluding aftercare (H) (Anaes.) (Assist.)	1,490.25
46129	Non-excisional debridement of superficial or mid-dermal partial thickness burns, if the area of burn involves 30% or more of total body surface, and application of skin substitute (skin allograft or biosynthetic epidermal replacements), excluding aftercare (H) (Anaes.) (Assist.)	2,727.10
46130	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, if the defect area involves less than 1% of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure or simple dressings (Anaes.) (Assist.)	369.65
46131	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, if the defect area involves 1% or more but less than 3% of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure or simple dressings (H) (Anaes.) (Assist.)	586.80
46132	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, if the defect area involves 3% or more but less than 10% of total body surface, using autologous tissue (split skin graft or other) following	643.65

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	previous procedure using non-autologous temporary wound closure or simple dressings (H) (Anaes.) (Assist.)	
46133	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis or secondary to release of burns scar contracture, if the defect area involves 10% or more but less than 20% of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure or simple dressings, excluding aftercare (H) (Anaes.) (Assist.)	981.95
46134	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis, if the defect area involves 20% or more but less than 30% of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure, excluding aftercare (H) (Anaes.) (Assist.)	2,173.15
46135	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis, if the defect area involves 30% or more of total body surface, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure, excluding aftercare (H) (Anaes.) (Assist.)	3,413.65
46136	Definitive burn wound closure, or closure of skin defect secondary to necrotising fasciitis, of whole of face, using autologous tissue (split skin graft or other) following previous procedure using non-autologous temporary wound closure, excluding aftercare, other than a service associated with a service to which item 46100 applies (H) (Anaes.) (Assist.)	1,884.50
46140	Burns contracture, release of, by excision or incision of scar, if the defect resulting from surgery is less than 1% of total body surface, including direct repair if performed (Anaes.) (Assist.)	281.95
46141	Burns contracture, release of, by excision or incision of scar, if the defect resulting from surgery is 1% or more but less than 3% of total body surface (H) (Anaes.) (Assist.)	423.00
46142	Burns contracture, release of, by excision or incision of scar, if the defect resulting from surgery is 3% or more but less than 10% of total body surface (H) (Anaes.) (Assist.)	507.45
46143	Burns contracture, release of, by excision or incision of scar, if the defect resulting from surgery is 10% or more but less than 20% of total body surface (H) (Anaes.) (Assist.)	657.80
46150	Mandible or maxilla, procedure for advancement, retrusion or alteration of tilt, by osteotomy in standard planes, including fixation by any means (including application of distractors if used)—one service per patient on the same occasion (H) (Anaes.) (Assist.)	1,456.40
46151	Mandible and maxilla (bimaxillary), procedure for advancement, retrusion or alteration of tilt, or combination of these, by osteotomies in standard planes, including fixation by any means (including application of distractors if used)—conjoint surgery, principal specialist surgeon, one service per patient on the same occasion (H)	1,588.00

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(Anaes.) (Assist.)	
46152	Mandible and maxilla (bimaxillary), procedure for advancement, retrusion or alteration of tilt, or combination of these, by osteotomies in standard planes, including fixation by any means (including application of distractors if used)—conjoint surgery, conjoint specialist surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.)	1,191.00
46153	Mandible and maxilla (bimaxillary), procedure for advancement, retrusion or alteration of tilt, or combination of these, by osteotomies in standard planes, including fixation by any means (including application of distractors if used)—single surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.)	1,984.90
46154	Maxilla, procedure for reshaping arch of, by complex segmental osteotomies, including fixation by any means (including application of distractors if used), one service per patient on the same occasion (H) (Anaes.) (Assist.)	1,662.20
46155	Mandible, procedure for reshaping arch of, by complex segmental osteotomies, including genioplasty (if performed) and fixation by any means (including application of distractors if used), one service per patient on the same occasion (H) (Anaes.) (Assist.)	1,662.20
46156	Mandible and maxilla (bimaxillary), procedure for any combination of arch reshaping, advancement, retrusion or tilting of, involving complex segmental osteotomies, with or without standard osteotomies, including genioplasty (if performed) and fixation by any means (including application of distractors if used)—conjoint surgery, principal specialist surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.)	1,897.60
46157	Mandible and maxilla (bimaxillary), procedure for any combination of arch reshaping, advancement, retrusion or tilting of, involving complex segmental osteotomies, with or without standard osteotomies, including genioplasty (if performed) and fixation by any means (including application of distractors if used)—conjoint surgery, conjoint specialist surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.)	1,423.20
46158	Mandible and maxilla (bimaxillary), procedure for any combination of arch reshaping, advancement, retrusion or tilting of, involving complex segmental osteotomies, with or without standard osteotomies, including genioplasty (if performed) and fixation by any means (including application of distractors if used)—single surgeon, one service per patient on the same occasion (H) (Anaes.) (Assist.)	2,371.95
46159	Midfacial osteotomies, Le Fort II or Le Fort III—conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.)	2,098.55
46160	Midfacial osteotomies, Le Fort II or Le Fort III—conjoint surgery, conjoint specialist surgeon (H) (Anaes.) (Assist.)	1,573.90
46161	Midfacial osteotomies, Le Fort II or Le Fort III—single surgeon (H)	2,623.15

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(Anaes.) (Assist.)	
46170	Decompression of thoracic outlet, primary, for thoracic outlet syndrome, using any approach, including (if performed) division of scalene muscles, cervical rib and/or first rib resection (H) (Anaes.) (Assist.)	1,095.25
46171	Decompression of thoracic outlet, repeat (revision) procedure, for thoracic outlet syndrome, using any approach, including (if performed) division of scalene muscles, cervical rib and/or first rib resection (H) (Anaes.) (Assist.)	1,861.90
46172	Removal or debulking of brachial plexus tumour, involving intraneural dissection, either supraclavicular or infraclavicular dissection (H) (Anaes.) (Assist.)	2,738.05
46173	Removal or debulking of brachial plexus tumour, involving intraneural dissection, both supraclavicular and infraclavicular dissection (H) (Anaes.) (Assist.)	3,833.30
46174	Exploration of the brachial plexus, either supraclavicular or infraclavicular, including any neurolyses performed and intraoperative neurophysiological recordings, but excluding reconstruction of elements (H) (Anaes.) (Assist.)	2,738.05
46175	Exploration of the brachial plexus, both supraclavicular and infraclavicular, including any neurolyses performed and intraoperative neurophysiological recordings, but excluding reconstruction of elements (H) (Anaes.) (Assist.)	4,380.90
46176	Exploration of the brachial plexus, posterior subscapular approach, all necessary elements of the operation including (but not limited to): (a) resection of the first rib and/or second rib; and (b) vertebral laminectomies or facetectomies, if performed; and (c) any neurolyses performed; and (d) intraoperative neurophysiological recordings; excluding the following: (e) reconstruction of elements of the plexus; (f) spinal instrumentation (H) (Anaes.) (Assist.)	1,095.25
46177	Reconstruction of deficit of the brachial plexus, single cord or trunk, by any appropriate method, single surgeon (H) (Anaes.) (Assist.)	1,861.90
46178	Reconstruction of deficit of the brachial plexus, single cord or trunk, by any appropriate method, conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	1,861.90
46179	Reconstruction of deficit of the brachial plexus, single cord or trunk, by any appropriate method, conjoint surgery, conjoint surgeon (H) (Anaes.) (Assist.)	1,549.75
46180	Reconstruction of deficit of the brachial plexus, more than a single cord or trunk, but less than the whole plexus, by any appropriate	2,738.05

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	method, single surgeon (H) (Anaes.) (Assist.)	
46181	Reconstruction of deficit of the brachial plexus, more than a single cord or trunk, but less than the whole plexus, by any appropriate method, conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	2,738.05
46182	Reconstruction of deficit of the brachial plexus, more than a single cord or trunk, but less than the whole plexus, by any appropriate method, conjoint surgery, conjoint surgeon (H) (Anaes.) (Assist.)	2,283.55
46183	Reconstruction of deficit of the brachial plexus, whole plexus, by any appropriate method, single surgeon (H) (Anaes.) (Assist.)	3,285.65
46184	Reconstruction of deficit of the brachial plexus, whole plexus, by any appropriate method, conjoint surgery, principal surgeon (H) (Anaes.) (Assist.)	3,285.65
46185	Reconstruction of deficit of the brachial plexus, whole plexus, by any appropriate method, conjoint surgery, conjoint surgeon (H) (Anaes.) (Assist.)	2,738.05

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.

Note: The fees in Group T8 are indexed in accordance with clause 1.3.1.

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):	547.80

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) realignment procedures; (b) tendon transfer; —one joint (Anaes.) (Assist.)	
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 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.)	704.40
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;	1,408.75

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(c) synovectomy; (d) tendon transfer; —5 joints of one hand (H) (Anaes.) (Assist.)	
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	Prosthetic interpositional replacement of carpometacarpal joint, including either or both of the following (if performed): (a) ligament and tendon transfers; (b) rebalancing procedures (H) (Anaes.) (Assist.)	958.55
46325	Excisional arthroplasty of carpometacarpal joint, including any of the following (if performed): (a) ligament and tendon transfers; (b) realignment procedures; (c) excision of adjacent trapezoid (H) (Anaes.) (Assist.)	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

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
46335	Synovectomy of digital extensor tendons of hand, distal to wrist, for diagnosed inflammatory arthritis, including any of the following (if performed): (a) reconstruction of extensor retinaculum; (b) removal of tendon nodules; (c) tenolysis; (d) tenoplasty; other than a service associated with: (e) a service to which item 39330 applies; or (f) a service to which item 30023 applies that is performed at the same site Applicable once per hand per occasion on which the service is performed (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
46339	Synovectomy of digital flexor tendons at wrist level, for diagnosed inflammatory arthritis, including either or both of the following (if performed): (a) tenolysis; (b) release of median nerve and carpal tunnel; other than a service associated with: (c) a service to which item 39330 or 39331 applies; or (d) a service to which item 30023 applies that is performed at the same site Applicable once per wrist per occasion on which the service is performed (H) (Anaes.) (Assist.)	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: (e) a service to which item 39330 applies; or (f) if this service is performed on the wrist flexor tendons—a service to which item 39331 applies; or	412.35

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(g) a service to which item 30023 applies that is performed at the same site —one or more compartments per limb (H) (Anaes.) (Assist.)	
46341	Synovectomy of wrist flexor or extensor tendons of hand or wrist, for non-inflammatory tenosynovitis or post traumatic synovitis, including any of the following (if performed): (a) reconstruction of flexor or extensor retinaculum; (b) removal of tendon nodules; (c) tenolysis; (d) tenoplasty; other than a service associated with: (e) a service to which item 39330 applies; or (f) if this service is performed on the wrist flexor tendons—a service to which item 39331 applies; or (g) a service to which item 30023 applies that is performed at the same site —one or more compartments per limb (H) (Anaes.) (Assist.)	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: (d) a service to which item 30023 applies that is performed at the same site; or (e) a service to which item 46363 applies that is performed on the same ray —one ray (H) (Anaes.) (Assist.)	254.35
46351	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty;	379.60

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	other than a service associated with: (d) a service to which item 30023 applies that is performed at the same site; or (e) a service to which item 46363 applies that is performed on one of the same rays —2 rays of one hand (H) (Anaes.) (Assist.)	
46354	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules; (b) tenolysis; (c) tenoplasty; other than a service associated with: (d) a service to which item 30023 applies that is performed at the same site; or (e) a service to which item 46363 applies that is performed on one of the same rays —3 rays of one hand (H) (Anaes.) (Assist.)	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: (d) a service to which item 30023 applies that is performed at the same site; or (e) a service to which item 46363 applies that is performed on one of the same rays —4 rays of one hand (H) (Anaes.) (Assist.)	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: (d) a service to which item 30023 applies that is performed at the same site; or (e) a service to which item 46363 applies that is performed on one of the same rays —5 rays of one hand (H) (Anaes.) (Assist.)	763.10
46363	Trigger finger release, for stenosing tenosynovitis, including either or both of the following (if performed):	219.10

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) synovectomy; (b) synovial biopsy; —one ray (Anaes.) (Assist.)	
46364	Digital sympathectomy of hand, using microsurgical techniques, other than a service associated with: (a) a service to which item 46363 applies; or (b) a service to which item 30023 applies that is performed at the same site —one digit or palmer arch (or both) or radial or ulnar artery (or both) (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 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.)	133.10
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):	645.75

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site—one ray (H) (Anaes.) (Assist.)	
46390	Fasciectomy for recurrence of Dupuytren's contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site—2 rays (H) (Anaes.) (Assist.)	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 that is performed at the same site—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; other than a service associated with a service to which item 30023 applies that is performed at the same site—4 rays (H) (Anaes.) (Assist.)	1,243.45
46395	Fasciectomy for recurrence of Dupuytren's contracture, including either or both of the following (if performed): (a) dissection of nerves; (b) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site—5 rays (H) (Anaes.) (Assist.)	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 that is performed at the same site (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

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
46414	Insertion of artificial tendon prosthesis in preparation for grafting of tendon of hand or wrist, including tenolysis (if performed), other than a service associated with a service to which item 30023 applies that is performed at the same site (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 that is performed at the same site (Anaes.) (Assist.)	340.45
46426	Primary repair of flexor tendon of hand or wrist, proximal to A1 pulley—one tendon (H) (Anaes.) (Assist.)	352.10
46432	Primary repair of flexor tendon of hand, distal to A1 pulley, other than a service to repair a tendon of a digit if 2 tendons of the same digit have been repaired during the same procedure—one tendon (H) (Anaes.) (Assist.)	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 that is performed at the same site (Anaes.) (Assist.)	505.80
46438	Closed pin fixation of mallet finger (Anaes.)	140.90
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 that is performed at the same site; —one ray (H) (Anaes.)	234.85
46453	Tenolysis of flexor tendon of hand or wrist, following tendon injury,	391.35

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	repair or graft, other than a service: (a) for acute, traumatic injury; or (b) associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	
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; (c) skin cover with local flaps; —3 rays (H) (Anaes.) (Assist.)	586.90
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):	391.35

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) excision of neuroma; (b) recontouring; (c) resection of bone; (d) skin cover with local flaps; —one ray (H) (Anaes.) (Assist.)	
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 acute 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): (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.)	211.40
46498	Excision of ganglion of flexor tendon sheath of hand, including any of the following (if performed): (a) flexor tenosynovectomy; (b) sheath excision; (c) skin closure by any method; other than a service associated with: (d) a service to which item 30107 applies; or (e) a service to which item 46363 applies that is performed on the same ray	228.85

Clause 5.10.24

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(Anaes.) (Assist.)	
46500	Excision of ganglion of dorsal wrist joint of hand, including any of the following (if performed): (a) arthrotomy; (b) capsular or ligament repair (or both); (c) synovectomy; other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.)	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 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 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): (a) nerve transfer; (b) skin closure, by any means; (c) rebalancing procedures (H) (Anaes.) (Assist.)	1,560.75
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;	365.20

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(c) rebalancing procedures; —one digit (H) (Anaes.) (Assist.)	
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 that is performed at the same site—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 that is performed at the same site; 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.) (Assist.)	245.05

Subdivision G—Subgroups 15, 16 and 17 of Group T8

5.10.25 Restrictions on items 50200 and 50201—provider and timing

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.

Note: The fees in Group T8 are indexed in accordance with clause 1.3.1.

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 15—Orthopaedic		
47000	Mandible, treatment of dislocation of, by closed reduction, requiring general anaesthesia or intravenous sedation, if performed in the operating theatre of a hospital (H) (Anaes.)	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

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
47018	Treatment of dislocation of elbow, by closed reduction (Anaes.)	205.60
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.)	676.05
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.)	676.05
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.)	438.55
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

Clause 5.10.29

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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 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.)	352.55
47069	Treatment of dislocation of toe, by closed 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 reduction, with fixation by	391.80

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	any means (Anaes.) (Assist.)	
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
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

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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
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 fixation (H) (Anaes.) (Assist.)	470.30

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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.)	538.80
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
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
47491	Combined anterior and posterior pelvic ring disruption, including sacroiliac joint disruption, treatment of fracture by open reduction and internal fixation of both anterior and posterior ring segments (H) (Anaes.) (Assist.)	1,616.30
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,	734.65

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	including the application and management of traction (if performed) (H) (Anaes.) (Assist.)	
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 fixation (H) (Anaes.) (Assist.)	901.30
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

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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
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	710.20

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	purpose of treating a medial malleolus fracture of the distal tibia (H) (Anaes.) (Assist.)	
47577	Treatment of fracture of fibula proximal to ankle, by open reduction, with internal fixation, including any of the following (if performed): (a) internal fixation; (b) arthrotomy; (c) capsule repair; (d) removal of loose fragments or intervening soft tissue; (e) washout of joint (H) (Anaes.)(Assist.)	621.75
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

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
47600	Treatment of fracture of ankle joint: (a) by internal fixation of the malleolus, fibula or diastasis; and (b) including any of the following (if performed): (i) arthrotomy; (ii) capsule repair; (iii) removal of loose fragments or intervening soft tissue; (iv) washout of joint (H) (Anaes.) (Assist.)	587.75
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 hindfoot bone (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 hindfoot bone (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;	587.75

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(d) washout of joint; —one joint (H) (Anaes.) (Assist.)	
47630	Treatment of fracture of cuneiform, by open reduction, with or without dislocation, including any of the following (if performed): (a) arthrotomy; (b) capsule or ligament repair; (c) removal of loose fragments or intervening soft tissue; (d) washout of joint; —one bone (Anaes.) (Assist.)	352.55
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 of one foot (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):	176.35

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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.)	
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 or mandible, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (H) (Anaes.) (Assist.)	423.10
47762	Zygomatic arch, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach, other than a service associated with a service to which another item in this Group applies (Anaes.)	248.45
47765	Zygomaticomaxillary complex/malar, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at one or more sites (H) (Anaes.) (Assist.)	492.10
47766	Naso-orbital-ethmoidal complex, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at one or more sites (H) (Anaes.) (Assist.)	658.20
47786	Maxilla, treatment of fracture of, requiring open reduction and internal fixation involving a one or more plates (H) (Anaes.) (Assist.)	747.85
47789	Mandible, treatment of fracture of, requiring open reduction and internal fixation involving a one or more plates (H) (Anaes.) (Assist.)	747.85
47790	Tendon, large, lengthening of, as an independent procedure (Anaes.) (Assist.)	298.45
47791	Tenosynovectomy, not being a service associated with a service to which another item in this Group applies (Anaes.) (Assist.)	278.65
47792	Joint stabilisation procedure of acromioclavicular joint or sternoclavicular joint, including any of the following (if performed): (a) arthrotomy; (b) osteotomy, with or without fixation; (c) local tendon transfer; (d) local tendon lengthening or release; (e) ligament repair; (f) joint debridement; not being a service associated with a service to which another item in	497.60

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	this Group applies (H) (Anaes.) (Assist.)	
47795	Joint stabilisation procedure of scapulothoracic joint, other than a service associated with a service to which another item in this Group (other than item 38828 or 48406) applies (H) (Anaes.) (Assist.)	518.10
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
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	391.80

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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.)	
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
47960	Tenotomy, subcutaneous, other than a service to which another item in this Group applies (Anaes.)	137.15
47964	Iliopsoas tenotomy, by open or arthroscopic means, when performed as an independent procedure, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the hip (H) (Anaes.) (Assist.)	225.25
47967	Restoration of shoulder or elbow function by major muscle tendon transfer, including associated dissection of neurovascular pedicle, excluding micro-anastomosis and biceps tenodesis—one transfer (H) (Anaes.) (Assist.)	450.50
47968	Open tenotomy of one or more tendons of shoulder, with or without tenoplasty, to restore shoulder function, other than a service to which another item in this Group applies—applicable once per joint per occasion on which this service is performed (Anaes.)	238.30
47970	Open tenotomy of one or more tendons of scapula, with or without tenoplasty, to restore scapula function, other than a service to which another item in this Group applies—applicable once per joint per occasion on which this service is performed (Anaes.)	238.30
47973	Open tenotomy of one or more tendons of elbow, with or without tenoplasty, to restore elbow function, other than a service to which another item in this Group applies—applicable once per joint per occasion on which this service is performed (Anaes.)	238.30
47975	Forearm or calf, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (H) (Anaes.)	384.15

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(Assist.)	
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	Operation on foot: (a) with either or both of the following: (i) osteotomy of phalanx or metatarsal for correction of deformity; (ii) excision of accessory bone or sesamoid bone; and (b) including any of the following (if performed): (i) removal of bone; (ii) excision of surrounding osteophytes; (iii) synovectomy; (iv) joint release; —one bone (H) (Anaes.) (Assist.)	342.90
48403	Osteotomy of phalanx of first toe or metatarsal, for correction of deformity, with internal fixation, including any of the following (if performed):	538.80

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) removal of bone; (b) excision of surrounding osteophytes; (c) synovectomy; (d) joint release; —one bone (H) (Anaes.) (Assist.)	
48406	Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, for correction of deformity, including any of the following (if performed): (a) removal of bone; (b) excision of surrounding osteophytes; (c) synovectomy; (d) joint release; —one bone (H) (Anaes.) (Assist.)	342.90
48409	Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, for correction of deformity, with internal fixation, including any of the following (if performed): (a) removal of bone; (b) excision of surrounding osteophytes; (c) synovectomy; (d) joint release; —one bone (H) (Anaes.) (Assist.)	538.80
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.)	956.30

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(Assist.)	
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; (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.)	279.20
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;	1,111.90

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(h) synovectomy; —one bone (H) (Anaes.) (Assist.)	
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
48436	Excision of one or more exostoses of the hand, distal to the wrist, including any of the following (if performed): (a) excision of surrounding osteophytes; (b) release of ligaments; (c) removal of one or more associated bursae or ganglia; (d) removal of bone; (e) synovectomy; other than a service associated with a service to which another item in this Schedule applies that: (f) is an arthroscopic procedure, arthrodesis, arthroplasty or osteotomy, or involves the removal of hardware; and (g) is performed on the same joint or bone; —each incision (H) (Anaes.) (Assist.)	295.30
48438	Excision of one or more exostoses in the wrist including any of the following (if performed): (a) capsulotomy; (b) excision of surrounding osteophytes; (c) release of ligaments; (d) removal of one or more associated bursae or ganglia; (e) removal of bone; (f) synovectomy; other than: (g) a service to which 48436 applies; or (h) a service associated with a service to which another item in this Schedule applies that: (i) is an arthroscopic procedure, arthrodesis, arthroplasty or	295.30

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	osteotomy, or involves the removal of hardware; and (ii) is performed on the same joint or bone; —each incision (H) (Anaes.) (Assist.)	
48440	Excision of one or more exostoses in the arm or shoulder, including the radius, ulna, humerus, acromion, clavicle, or scapula, including any of the following (if performed): (a) capsulotomy; (b) excision of surrounding osteophytes; (c) release of ligaments; (d) removal of one or more associated bursae or ganglia; (e) removal of bone; (f) synovectomy; other than: (g) a service to which 48438 applies; or (h) a service associated with a service to which another item in this Schedule applies that: (i) is an arthroscopic procedure, arthrodesis, arthroplasty or osteotomy, or involves the removal of hardware; and (ii) is performed on the same joint or bone; —each incision (H) (Anaes.) (Assist.)	295.30
48442	Excision of one or more exostoses in the hip, including pelvis and femur, including any of following (if performed): (a) capsulotomy; (b) excision of surrounding osteophytes; (c) release of ligaments; (d) removal of one or more associated bursae or ganglia; (e) removal of bone; (f) synovectomy; other than: (g) a service to which 48444 applies; or (h) a service associated with a service to which another item in this Schedule applies that: (i) is an arthroscopic procedure, arthrodesis, arthroplasty or osteotomy, or involves the removal of hardware; and (ii) is performed on the same joint or bone; —each incision (H) (Anaes.) (Assist.)	295.30
48444	Excision of one or more exostoses in the knee, tibia or fibula, including any of following (if performed): (a) capsulotomy; (b) excision of surrounding osteophytes; (c) release of ligaments;	295.30

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(d) removal of one or more associated bursae or ganglia; (e) removal of bone; (f) synovectomy; other than: (g) a service to which item 48430 applies; or (h) a service associated with a service to which another item in this Schedule applies that: (i) is an arthroscopic procedure, arthrodesis, arthroplasty or osteotomy, or involves the removal of hardware; and (ii) is performed on the same joint or bone; —each incision (H) (Anaes.) (Assist.)	
48446	Treatment of non-union or malunion of fracture of pelvis, including bone graft, and including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) osteotomy; (d) removal of hardware; (e) internal fixation; other than a service associated with a service to which item 48245, 48248, 48251, 48254, 48257 or 47929 applies that is performed on the same bone —one bone (H) (Anaes.) (Assist.)	1,328.20
48448	Treatment of non-union or malunion of fracture of femur, including bone graft, and including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) osteotomy; (d) removal of hardware; (e) internal fixation; other than a service associated with a service to which item 48245, 48248, 48251, 48254, 48257 or 47929 applies that is performed on the same bone —one bone (H) (Anaes.) (Assist.)	1,328.20
48450	Treatment of non-union or malunion of fracture of tibia or fibula, proximal to ankle, including bone graft, and including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) osteotomy; (d) removal of hardware; (e) internal fixation;	1,203.80

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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 48245, 48248, 48251, 48254, 48257 or 47929 applies that is performed on the same bone —one bone (H) (Anaes.) (Assist.)	
48452	Treatment of non-union or malunion of fracture of humerus, including bone graft, and including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) osteotomy; (d) removal of hardware; (e) internal fixation; other than a service associated with a service to which item 48245, 48248, 48251, 48254, 48257 or 47929 applies that is performed on the same bone —one bone (H) (Anaes.) (Assist.)	1,203.80
48454	Treatment of non-union or malunion of fracture of radius, ulna, or carpus including bone graft, and including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) osteotomy; (d) removal of hardware; (e) internal fixation; other than a service associated with a service to which item 48245, 48248, 48251, 48254, 48257 or 47929 applies that is performed on the same bone —one bone (H) (Anaes.) (Assist.)	892.90
48456	Treatment of non-union or malunion of fracture of hand, distal to wrist, including bone graft, and including any of the following (if performed): (a) arthrotomy; (b) debridement; (c) osteotomy; (d) removal of hardware; (e) internal fixation; other than a service associated with a service to which item 48245, 48248, 48251, 48254, 48257 or 47929 applies that is performed on the same bone —one bone (H) (Anaes.) (Assist.)	892.90
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,	342.90

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	in a patient less than 18 years of age (H) (Anaes.) (Assist.)	
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 service associated with a service to which item 48900 applies (H) (Anaes.) (Assist.)	587.75
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
48919	Anatomic or reverse total shoulder replacement with bone graft, including any of the following (if performed): (a) associated rotator cuff repair; (b) biceps tenodesis; (c) tuberosity osteotomy; other than a service associated with: (d) a service to which another item in this Schedule applies that is performed on the shoulder region by open or arthroscopic means; or (e) a service to which item 48245, 48248, 48251, 48254 or 48257 applies that is performed on the same joint (H) (Anaes.) (Assist.)	1,877.60
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):	1,861.30

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) bone graft to humerus; (b) bone graft to scapula (H) (Anaes.) (Assist.)	
48925	Arthroplasty of shoulder, other than: (a) a service to which another item applies; or (b) a service associated with a service to which any of items 48900 to 48909, 48948, 48951, or 48960 applies that is performed on the same joint (H) (Anaes.) (Assist.)	773.25
48927	Shoulder prosthesis, removal of (H) (Anaes.) (Assist.)	381.90
48932	Arthroplasty of acromioclavicular joint or sternoclavicular joint, other than: (a) a service to which another item applies; or (b) a service associated with a service to which another item in this Schedule applies that is performed on the same joint by arthroscopic means —one joint (H) (Anaes.) (Assist.)	773.25
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
48943	Arthrodesis of acromioclavicular or sternoclavicular joint, including either or both of the following (if performed): (a) joint debridement; (b) synovectomy —one joint (H) (Anaes.) (Assist.)	518.10
48944	Arthrodesis of scapulothoracic joint, including either or both of the following (if performed): (a) joint debridement; (b) synovectomy —one joint (H) (Anaes.) (Assist.)	518.10
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—	636.75

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	other than a service associated with another arthroscopic procedure of the shoulder region (H) (Anaes.) (Assist.)	
48951	Shoulder, arthroscopic division of coraco-acromial ligament including acromioplasty—other than a service associated with another arthroscopic procedure of the shoulder region (H) (Anaes.) (Assist.)	930.65
48952	Surgery of acromioclavicular joint or sternoclavicular joint, by arthroscopic means, including any of the following (if performed): (a) cartilage treatment; (b) removal of loose bodies; (c) synovectomy; (d) excision of joint osteophytes; other than a service associated with a service to which another item in this Group applies that is performed on the same joint by arthroscopic means (H) (Anaes.) (Assist.)	673.60
48953	Surgery of scapulothoracic joint, by arthroscopic means, including any of the following (if performed): (a) cartilage treatment; (b) removal of loose bodies; (c) synovectomy; (d) excision of joint osteophytes; other than a service associated with a service to which another item in this Group applies that is performed on the same joint by arthroscopic means (H) (Anaes.) (Assist.)	673.60
48954	Synovectomy of shoulder, performed as an independent procedure, including release of contracture (if performed), other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by arthroscopic means (H) (Anaes.) (Assist.)	979.60
48958	Joint stabilisation procedure for multi-directional instability of shoulder, anterior or posterior repair, by open or arthroscopic means, including labral repair or reattachment (if performed), excluding bone grafting and removal of hardware, other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by arthroscopic means (H) (Anaes.) (Assist.)	1,126.55
48959	Latarjet procedure by open or arthroscopic means, including any of the following (if performed) but excluding removal of hardware: (a) labral repair or reattachment; (b) bone grafting; (c) tendon transfer; other than a service associated with a service to which another item in this Schedule applies that is performed on the shoulder region by	1,664.15

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	arthroscopic means (H) (Anaes.) (Assist.)	
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
49113	Removal of radial head prosthesis (H) (Anaes.) (Assist.)	773.25
49114	Revision of radial head replacement (H) (Anaes.) (Assist.)	773.25
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) (Anaes.) (Assist.)	284.00
49121	Surgery of the elbow, by arthroscopic means, including any of the following (if performed): (a) chondroplasty;	636.75

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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.)	
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
49127	Elbow joint, arthroplasty of, other than a service to which another item applies (H) (Anaes.) (Assist.)	773.25
49200	Wrist, arthrodesis of, with synovectomy if performed, with or without 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

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
49212	Arthrotomy of wrist or distal radioulnar joint, including any of the following (if performed): (a) joint debridement; (b) removal of loose bodies; (c) synovectomy (H) (Anaes.) (Assist.)	245.05
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, 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 joint of thumb or joint of digit, by arthroscopic means, including biopsy (if performed) (H) (Anaes.)(Assist.)	284.00
49220	Treatment of carpometacarpal joint 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	734.65

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	the following (if performed): (a) excision of the distal ulna; (b) total synovectomy; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint—2 or more distinct areas (H) (Anaes.) (Assist.)	
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, including any of the following (if performed): (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 any of the following (if performed): (a) radial styloidectomy; (b) ulnar styloidectomy; (c) proximal hamate; (d) partial scaphoid; other than a service associated with a service to which another item in this Schedule applies if the service described in the other item is for the purpose of performing a distal radioulnar joint reconstruction, a proximal row carpectomy or a limited wrist fusion—applicable once for a single operation (H) (Anaes.) (Assist.)	403.60
49236	Stabilisation of soft tissue of distal radioulnar joint, with or without ligament or tendon grafting, including either or both of the following (if performed): (a) graft harvest; (b) triangular fibrocartilage complex repair or reconstruction (H) (Anaes.)(Assist.)	608.45
49239	Excision of pisiform or hook of hamate or sesamoid bone of hand, including release of ulnar nerve (if performed) (H) (Anaes.)(Assist.)	302.70

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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; (c) biopsy (H) (Anaes.) (Assist.)	568.10
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	Complex primary arthroplasty of hip, with internal fixation, including either or both of the following (if performed): (a) structural bone graft; (b) insertion of synthetic substitutes or metal augments; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	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	Diagnostic arthroscopy of hip, with synovial biopsy, other than a service associated with a service to which another item in this Schedule applies that is performed on the hip joint by arthroscopic means (H) (Anaes.) (Assist.)	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	636.75

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(b) surgery for femoroacetabular impingement (H) (Anaes.) (Assist.)	
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
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

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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) (H) (Anaes.) (Assist.)	2,742.35
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

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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 arthroplasty of knee, including either or both of the following (if performed): (a) revision of patello-femoral joint replacement to total knee replacement; (b) patellar resurfacing; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	1,371.25
49519	Bilateral total arthroplasty of knee, including patellar resurfacing, other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	2,409.15
49521	Complex primary arthroplasty of knee, using revision femoral or tibial components, including either or both of the following (if performed): (a) ligament reconstruction; (b) patellar resurfacing; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	1,665.50
49524	Complex primary arthroplasty of knee: (a) using revision femoral and tibial components; or (b) using revision femoral or tibial components including anatomic specific allograft of femur or tibia; including either or both of the following (if performed): (c) ligament reconstruction; (d) patellar resurfacing; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	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	1,665.50

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	other item is for the purpose of performing surgery on a knee (H) (Anaes.) (Assist.)	
49527	Minor revision of total or partial arthroplasty of knee, including either or both of the following: (a) exchange of polyethylene component (including uni); (b) insertion of patellar component; other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	1,371.25
49530	Revision of total or partial arthroplasty of knee, with exchange of femoral or tibial component: (a) excluding revision of unicompartmental with unicompartmental implants; and (b) including patellar resurfacing (if performed); other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	2,057.35
49533	Revision of total or partial arthroplasty of knee, with exchange of femoral and tibial components, excluding revision of unicompartmental with unicompartmental implants, including patellar resurfacing (if performed), other than a service associated with a service to which item 48245, 48248, 48251, 48254 or 48257 applies (H) (Anaes.) (Assist.)	2,645.55
49534	Arthroplasty 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;	1,371.25

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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.)	
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): (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.)	956.30
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	1,372.60

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	(H) (Anaes.)(Assist.)	
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
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
49592	Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the hip, including pelvis and proximal	1,256.50

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	femur (H) (Anaes.) (Assist.)	
49594	Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the knee, including distal femur, proximal fibula and proximal tibia (H) (Anaes.) (Assist.)	1,005.20
49596	Excision of heterotopic ossification, myositis ossificans or post-traumatic ossification in the lower leg, other than a service to which item 49594 applies (H) (Anaes.) (Assist.)	753.90
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, 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; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint	1,175.40

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(H) (Anaes.) (Assist.)	
49716	Revision of total ankle replacement: (a) including either: (i) exchange of tibial or talar components (or both) or plastic inserts; or (ii) removal of tibial or talar components (or both) and plastic inserts; and (b) including any of the following (if performed): (i) insertion of cement spacer for infection; (ii) capsulotomy; (iii) joint release; (iv) neurolysis; (v) debridement of cysts; (vi) synovectomy; (vii) joint debridement; other than a service associated with a service to which item 30023 applies (H) (Anaes.) (Assist.)	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 that is performed at the same site (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, including: (a) removal of loose bodies; and (b) either or both of the following: (i) joint debridement;	342.90

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(ii) release of joint contracture —each incision (H) (Anaes.) (Assist.)	
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 that is performed at the same site (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	2,080.85

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint; (e) removal of hardware; (f) neurolysis; (g) osteotomy of non-union or malunion; other than a service associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.)(Assist.)	
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.)	854.90
49763	Stabilisation of metatarsophalangeal joint at metatarsals, including any	997.40

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; —3 metatarsals (H) (Anaes.) (Assist.)	
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.)	1,139.85
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.)	1,282.40
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;	1,424.85

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(g) ligament repair; (h) joint debridement; —6 metatarsals (H) (Anaes.) (Assist.)	
49767	Stabilisation of metatarsophalangeal joint at metatarsals, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) osteotomy, with or without fixation; (e) local tendon transfer; (f) local tendon lengthening or release; (g) ligament repair; (h) joint debridement; —7 metatarsals (H) (Anaes.) (Assist.)	1,567.35
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.)	1,709.80
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;	1,567.20

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.)(Assist.)	
49771	Synovectomy of major tendon of ankle, for extensive synovitis by any method, including any of the following (if performed): (a) tenolysis; (b) debridement of ligament or tendon (or both); (c) release of ligament or tendon (or both); (d) excision of tubercule or osteophyte; (e) reconstruction of tendon retinaculum; (f) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site—each incision (H) (Anaes.) (Assist.)	386.55
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 that is performed at the same site—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 that is performed at the same site—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;	388.85

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(c) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site—one foot (H) (Anaes.) (Assist.)	
49776	Revision of arthrodesis of joint of hindfoot, by open or arthroscopic means, with internal or external fixation by any method, including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint; (e) removal of hardware; (f) neurolysis; (g) osteotomy of non-union or malunion; other than a service associated with a service to which item 30023 applies that is performed at the same site—may only be claimed once per joint (H) (Anaes.) (Assist.)	1,223.00
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;	1,267.25

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	—3 joints (H) (Anaes.) (Assist.)	
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: (a) bone grafting of perioperative cysts to the tibia or talus (or both); and (b) retention of implants; and (c) any of the following (if performed): (i) capsulotomy; (ii) joint release; (iii) neurolysis; (iv) debridement and grafting of cysts; (v) synovectomy; (vi) joint debridement; other than a service associated with a service to which item 30023 applies that is performed at the same site (H) (Anaes.) (Assist.)	588.35
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):	901.60

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) capsulotomy; (b) joint release; (c) synovectomy; (d) local tendon transfer; (e) joint debridement; —4 joints (H) (Anaes) (Assist.)	
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
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,	1,163.05

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	including any of the following (if performed): (a) capsulotomy; (b) joint release; (c) synovectomy; (d) removal of osteophytes at joint (H) (Anaes.) (Assist.)	
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 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.)	514.45
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;	600.20

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	—3 toes (H) (Anaes.) (Assist.)	
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; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; —7 toes (H) (Anaes.) (Assist.)	943.10
49798	Arthrodesis, osteotomy or interpositional arthroplasty of proximal or distal joint (or both) of lesser toe, including any of the following (if performed):	1,028.85

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) internal fixation, by any method; (b) capsulotomy; (c) joint release; (d) synovectomy; (e) removal of osteophytes at joints; —8 toes (H) (Anaes.) (Assist.)	
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; (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.)	1,028.70

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer	857.15

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(H) (Anaes.) (Assist.)	
49833	Unilateral correction of hallux valgus or varus deformity of the foot, by osteotomy of first metatarsal, without internal fixation, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)	538.80
49836	Bilateral correction of hallux valgus or varus deformity of the foot by osteotomy of first metatarsal, without internal fixation, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)	930.65
49837	Unilateral correction of hallux valgus or varus deformity of the foot, by osteotomy of first metatarsal, with internal fixation, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)	673.45
49838	Bilateral correction of hallux valgus or varus deformity of the foot by osteotomy of first metatarsal, with internal fixation or arthrodesis of first metatarsophalangeal joint, including any of the following (if performed): (a) exostectomy; (b) removal of bursae; (c) synovectomy; (d) capsule repair; (e) capsule or tendon release or transfer (H) (Anaes.) (Assist.)	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.) (Assist.)	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):	313.25

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(a) release of metatarsal or digital ligament; (b) excision of bursae; (c) neurolysis; other than a service associated with a service to which item 30023 applies that is performed at the same site—one web space (H) (Anaes.) (Assist.)	
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 that is performed at the same site—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, hindfoot or midfoot joint and surrounding tissues; and (b) including any of the following (if performed): (i) arthrotomy; (ii) synovectomy; (iii) osteophyte resections; (iv) neurolysis; (v) capsular or ligament repair; (vi) skin closure, by any method; other than a service associated with a service to which item 30023 applies that is performed at the same site—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;	309.00

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	other than a service associated with: (c) a service to which item 49881 applies; or (d) a service to which item 30023 applies that is performed at the same site —each incision (H) (Anaes.) Assist.)	
49890	Revision of complete excision of one or more ganglia or bursae: (a) including excision of bony prominence or mucinous cyst of ankle, hindfoot or midfoot joint and surrounding tissues; and (b) including any of the following (if performed): (i) arthrotomy; (ii) synovectomy; (iii) osteophyte resections; (iv) neurolysis; (v) capsular or ligament repair; (vi) skin closure, by any method; other than a service associated with: (c) a service to which item 49884 applies; or (d) a service to which item 30023 applies that is performed at the same site —each incision (H) (Anaes.) (Assist.)	521.80
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;	815.30

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(d) removal of osteophytes at joints; —one joint (H) (Anaes.) (Assist.)	
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: (a) autograft; (b) allograft; (c) cementation (H) (Anaes.) (Assist.)	783.80
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 aggressive bone or soft tissue tumour (or both) of pelvis, sacrum or spine, with reconstruction of bone defect, or one or more joints, by any technique (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

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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 (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.)	2,567.90
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	Synovectomy or debridement, and microfracture, of ankle joint for osteochondral large defect greater than 1.5cm^2, by arthroscopic or open means, including any of the following (if performed): (a) capsulotomy; (b) debridement or release of ligament; (c) debridement or release of tendon; other than a service associated with a service to which any of the following apply: (d) item 49703;	782.70

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(e) another item in this Schedule if the service described in the other item is for the purpose of performing an arthroscopic procedure of the ankle (H) (Anaes.) (Assist.)	
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
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	678.05

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	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.)	
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
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	1,839.25

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	by resection of the distal femur and proximal tibia followed by knee fusion and rotationplasty (Anaes.) (Assist.)	
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 femur, subtalar arthrodesis with synovectomy if performed, or os calcis lengthening;	1,276.65

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	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	3,040.20

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	of age with diplegic cerebral palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)	
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;	3,855.70

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (H) (Anaes.) (Assist.)	
50471	Bilateral single event multilevel surgery, for a patient less than 18 years of age with cerebral palsy, that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation, with: (a) lengthening of a contracted muscle tendon unit or units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening; and (b) correction of muscle imbalance by transfer of a tendon or tendons; and (c) correction of abnormal torsion of the femur by rotational osteotomy with internal fixation; and (d) correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation; and (e) correction of bilateral pes valgus by os calcis lengthening or subtalar fusion; conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (H) (Anaes.) (Assist.)	3,855.70
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	4,449.10

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	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.)	
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
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,	658.25

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	with internal or external fixation, for a patient with open growth plate (H) (Anaes.) (Assist.)	
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
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

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
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
50654	Examination or closed reduction (or both) of hip for a patient under the age of 18 years, including any of the following (if performed): (a) diagnostic injection; (b) arthrography; (c) application or reapplication of a hip spica (H) (Anaes.) (Assist.)	516.75
Subgroup 16—Tissue ablation		
50950	Unresectable primary malignant tumour of the liver, destruction of, by percutaneous ablation (including any associated imaging services), other than a service associated with a service to which item 30419 or 50952 applies (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	850.20

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	50950 applies (Anaes.)	
Subgroup 17—Spinal surgery		
51011	Direct spinal decompression or exposure (via a partial or a total laminectomy or a partial vertebrectomy), or a posterior spinal release, one motion segment, not being a service associated with a service to which item 51012, 51013, 51014 or 51015 applies (H) (Anaes.) (Assist.)	1,493.65
51012	Direct spinal decompression or exposure (via a partial or a total laminectomy or a partial vertebrectomy), or a posterior spinal release, 2 motion segments, not being a service associated with a service to which item 51011, 51013, 51014 or 51015 applies (H) (Anaes.) (Assist.)	1,991.30
51013	Direct spinal decompression or exposure (via a partial or a total laminectomy or a partial vertebrectomy), or a posterior spinal release, 3 motion segments, not being a service associated with a service to which item 51011, 51012, 51014 or 51015 applies (H) (Anaes.) (Assist.)	2,489.20
51014	Direct spinal decompression or exposure (via a partial or a total laminectomy or a partial vertebrectomy), or a posterior spinal release, 4 motion segments, not being a service associated with a service to which item 51011, 51012, 51013 or 51015 applies (H) (Anaes.) (Assist.)	2,987.05
51015	Direct spinal decompression or exposure (via a partial or a total laminectomy or a partial vertebrectomy), or a posterior spinal release, more than 4 motion segments, not being a service associated with a service to which item 51011, 51012, 51013 or 51014 applies (H) (Anaes.) (Assist.)	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 with: (a) interspinous dynamic stabilisation devices; or (b) a service to which item 51021, 51022, 51023, 51024, 51025 or 51026 applies (H) (Anaes.) (Assist.)	796.45
51021	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, one motion segment, excluding vertebral body tethering for the treatment of scoliosis and not being a service associated with a service to which item 51020, 51022, 51023, 51024, 51025 or 51026 applies (H) (Anaes.) (Assist.)	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, excluding vertebral body tethering for the treatment of scoliosis and not being a service associated with a service to which item 51020, 51021, 51023, 51024, 51025 or 51026 applies (H) (Anaes.) (Assist.)	1,658.30

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Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
51023	Fixation of motion segment with vertebral body screw, pedicle screw or hook instrumentation including sublaminar tapes or wires, 3 or 4 motion segments, excluding vertebral body tethering for the treatment of scoliosis and not being a service associated with a service to which item 51020, 51021, 51022, 51024, 51025 or 51026 applies (H) (Anaes.) (Assist.)	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, excluding vertebral body tethering for the treatment of scoliosis and not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51025 or 51026 applies (H) (Anaes.) (Assist.)	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, excluding vertebral body tethering for the treatment of scoliosis and not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51024 or 51026 applies (H) (Anaes.) (Assist.)	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, excluding vertebral body tethering for the treatment of scoliosis and not being a service associated with a service to which item 51020, 51021, 51022, 51023, 51024 or 51025 applies (H) (Anaes.) (Assist.)	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
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.)	1,665.35

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(Assist.)	
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: (a) anterior column fusion when at the same motion segment; or (b) a service to which item 51051, 51052, 53, 51054, 51056, 51057, 51058 or 51059 applies	2,130.45

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Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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

Group T8—Surgical operations

Column 1 Item	Column 2 Description	Column 3 Fee ($)
51064	Spinal fusion, anterior and posterior, including spinal instrumentation at 4 to 7 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51062, 51063, 51065 or 51066 applies (H) (Anaes.) (Assist.)	5,153.55
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 or primary extradural tumour or lesion, where the pathology is confirmed by histology—not including removal of synovial or juxtafacet cyst and, not being a service associated with a service to which item 51072 or 51073 applies (H) (Anaes.) (Assist.)	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

Clause 5.10.29

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
51130	Lumbar artificial intervertebral total disc replacement, at one motion segment only, including removal of disc and marginal osteophytes: (a) for a patient who: (i) has not had prior spinal fusion surgery at the same lumbar level; and (ii) does not have vertebral osteoporosis; and (iii) has failed conservative therapy; and (b) not being a service associated with a service to which item 51011, 51012, 51013, 51014 or 51015 applies (H) (Anaes.) (Assist.)	1,866.35
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, excluding vertebral body tethering for the treatment of scoliosis and 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

Subdivision H—Subgroups 18 to 21 of Group T8

5.10.30 Items in Subgroups 18 to 21 of Group T8

This clause sets out items in Subgroups 18 to 21 of Group T8.

Note: The fees in Group T8 are indexed in accordance with clause 1.3.1.

Group T8—Surgical operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
Subgroup 18—Myringoplasty and Tympanomastoid Procedures		
41527	Myringoplasty, by trans-canal approach, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	621.20
41530	Myringoplasty, post-aural or endaural approach, with or without mastoid inspection, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.)	1,012.05
41533	Atticotomy without reconstruction of the bony defect, with or without myringoplasty, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	1,209.70
41536	Atticotomy with reconstruction of the bony defect, with or without myringoplasty, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	1,355.00
41545	Mastoidectomy (cortical), other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	551.10
41551	Mastoidectomy, intact wall technique, with myringoplasty, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	1,684.15
41554	Mastoidectomy, intact wall technique, with myringoplasty and ossicular chain reconstruction, other than a service associated with a service to which item 41603 or another item in this Subgroup applies (H) (Anaes.) (Assist.)	1,984.25
41557	Mastoidectomy (radical or modified radical), other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	1,152.20
41560	Mastoidectomy (radical or modified radical) and myringoplasty, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.)	1,262.55
41563	Mastoidectomy (radical or modified radical), myringoplasty and ossicular chain reconstruction, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	1,562.90
41564	Mastoidectomy (radical or modified radical), obliteration of the mastoid cavity, blind sac closure of external auditory canal and obliteration of	2,021.15

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	eustachian tube, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	
41566	Revision of mastoidectomy (radical, modified radical or intact wall), including myringoplasty, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	1,152.20
41629	Middle ear, exploration of, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	551.10
41635	Clearance of middle ear for granuloma, cholesteatoma and polyp, one or more, with or without myringoplasty, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	1,209.70
41638	Clearance of middle ear for granuloma, cholesteatoma and polyp, one or more, with or without myringoplasty with ossicular chain reconstruction, other than a service associated with a service to which another item in this Subgroup applies (H) (Anaes.) (Assist.)	1,510.00
Subgroup 19—Functional Sinus Surgery		
41702	Functional sinus surgery of the ostiomeatal unit, including ethmoid, unilateral, other than a service associated with a service to which item 41662, 41698, 41703, 41705, 41710 or 41764 applies on the same side (H) (Anaes.) (Assist.)	721.40
41703	Functional sinus surgery, complete dissection of all 5 sinuses and creation of single sinus cavity, unilateral, other than a service associated with a service to which item 41662, 41698, 41702, 41705, 41710, 41734, 41737, 41752 or 41764 applies on the same side (H) (Anaes.) (Assist.)	1,066.50
41705	Functional sinus surgery, complete dissection of all 5 sinuses to create a single sinus cavity, with extended drilling of frontal sinuses, unilateral, other than a service associated with a service to which item 41662, 41698, 41702, 41703, 41710, 41734, 41737, 41752 or 41764 applies on the same side (H) (Anaes.) (Assist.)	1,735.30
Subgroup 20—Sinus Procedures		
41710	Antrostomy, by any approach, other than a service associated with a service to which item 41698, 41702, 41703 or 41705 applies on the same side (H) (Anaes.) (Assist.)	374.05
41734	Endoscopic Lothrop procedure or radical external frontal sinusotomy with osteoplastic flap, unilateral, other than a service associated with a service to which item 41698, 41703, 41705 or 41764 applies on the same side (H) (Anaes.) (Assist.)	1,072.00
41737	Frontal sinus, unilateral, intranasal operation on, including complete dissection of frontal recess and exposure of frontal sinus ostium (excludes simple probing, dilatation or irrigation of frontal sinus), other than a service associated with a service to which item 41698, 41703, 41705 or 41764 applies on the same side (H) (Anaes.) (Assist.)	510.90

Group T8—Surgical operations		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
41752	Sphenoidal sinus, unilateral, intranasal operation on, other than a service associated with a service to which item 41703 or 41705 applies on the same side (H) (Anaes.) (Assist.)	312.60
Subgroup 21—Airway Procedures		
41671	Septal surgery, including septoplasty, septal reconstruction, septectomy, closure of septal perforation or other modifications of the septum, not including cauterisation, by any approach, other than a service associated with a service to which item 41689, 41692 or 41693 applies (H) (Anaes.) (Assist.)	554.50
41689	Turbinate reduction, partial or total, unilateral or bilateral, other than a service associated with a service to which item 41671, 41692 or 41693 applies (Anaes.)	216.50
41692	Turbinate, submucous resection with removal of bone, unilateral or bilateral, other than a service associated with a service to which item 41671, 41689 or 41693 applies (H) (Anaes.)	282.35
41693	Septal surgery with submucous resection of turbinates, unilateral or bilateral, other than a service associated with a service to which item 41671, 41689, 41692 or 41764 applies (H) (Anaes.) (Assist.)	810.90

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.

Note: The fees in Group T9 are indexed in accordance with clause 1.3.1.

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 $614.55 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 $614.55	89.80
51303	Assistance at any operation mentioned in an item in Group T8 that includes "(Assist.)" for which the fee exceeds $614.55 or at a series or combination of operations mentioned in an item in Group T8 that include "(Assist.)" for which the aggregate fee exceeds $614.55	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 "(Assist.)" and assistance at a birth involving Caesarean section	Amount under 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	187.05

Group T9—Assistance at operations		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	(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	

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.

Note: The fees in Group O1 are indexed in accordance with clause 1.3.1.

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.

Note: The fees in Group O2 are indexed in accordance with clause 1.3.1.

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 $614.55 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 $614.55	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 $614.55 or at a series or combination of operations mentioned in an item that include "(Assist.)" if the aggregate fee exceeds $614.55	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.

Note: The fees in Group O3 are indexed in accordance with clause 1.3.1.

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

Clause 6.4.1

Group O3—General surgery		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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
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	495.35

Group O3—General surgery		
Column 1 **Item**	**Column 2** **Description**	**Column 3** **Fee ($)**
	the oral cavity (Anaes.)	
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 from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.)	179.50
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

Clause 6.4.1

Group O3—General surgery		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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
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	195.80

Group O3—General surgery		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	conjunction with operations involving internal fixation or bone grafting or both (Anaes.)	
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
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	94.75

Clause 6.5.1

Group O3—General surgery		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	tracheostomy device (Anaes.)	
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, autograft, allograft or cementation (Anaes.) (Assist.)	636.75
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.

Note: The fees in Group O4 are indexed in accordance with clause 1.3.1.

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 which item 52300, 52303, 52306 or 52324 applies (Anaes.) (Assist.)	813.60
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	1,439.75

Clause 6.5.2

Group O4—Plastic and reconstructive		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
	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.)	
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 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.)	2,073.45
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

Group O4—Plastic and reconstructive

Column 1 Item	Column 2 Description	Column 3 Fee ($)
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
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

Clause 6.6.1

Division 6.6—Group O5: Preprosthetic

6.6.1 Items in Group O5

This clause sets out items in Group O5.

Note: The fees in Group O5 are indexed in accordance with clause 1.3.1.

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
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.

Note: The fees in Group O6 are indexed in accordance with clause 1.3.1.

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.) (Assist.)	665.15

Division 6.8—Group O7: Ear, nose and throat

6.8.1 Items in Group O7

This clause sets out items in Group O7.

Note: The fees in Group O7 are indexed in accordance with clause 1.3.1.

Clause 6.9.1

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
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.

Note: The fees in Group O8 are indexed in accordance with clause 1.3.1.

Group O8—Temporomandibular joint

Column 1 Item	Column 2 Description	Column 3 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
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

Clause 6.10.1

Group O8—Temporomandibular joint		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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.

Note: The fees in Group O9 are indexed in accordance with clause 1.3.1.

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 and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.)	499.80
53414	Zygomatic bone, treatment of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.)	574.20

Group O9—Treatment of fractures		
Column 1	**Column 2**	**Column 3**
Item	**Description**	**Fee ($)**
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

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.

Clause 7.1.1

Note: The fees in Group O11 are indexed in accordance with clause 1.3.1.

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:

2016 estimated resident population means the preliminary estimated resident population as at 30 June 2016, 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 2.1.2 has the meaning given by clause 2.1.2.

amount under clause 2.20.2 has the meaning given by clause 2.20.2.

amount under clause 2.20.2A has the meaning given by clause 2.20.2A.

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.

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.

associated medical practitioner:

(a) for item 233—has the meaning given by subclause 2.16.2(2); and
(b) for item 277—has the meaning given by subclause 2.20.5(2).

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: 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.

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, 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.

Clause 7.1.1

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, 731, 231 and 232, 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 items 732 and 233, has the meaning given by clause 2.16.5.

coordinating the development of team care arrangements, for items 723 and 230, has the meaning given by clause 2.16.4.

coronary vascular territory, for an item in Subgroup 6 of Group T8 (cardio-thoracic surgical operations), means a vascular territory that is supplied by:

(a) the left anterior descending artery; or
(b) the circumflex artery; or
(c) the right coronary artery; or
(d) one or more branches of an artery mentioned in paragraph (a), (b) or (c); or
(e) one or more coronary bypass grafts.

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 area means a Modified Monash 2 area, a Modified Monash 3 area, a Modified Monash 4 area, a Modified Monash 5 area, a Modified Monash 6 area or a Modified Monash 7 area.

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 items 245 and 900, has the meaning given by clause 2.17.1.

maxilla:

(a) for items 46150 to 46158—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 case conference means a process by which a multidisciplinary case conference team carries out all of the following activities relevant to a patient's mental health:

(a) discussing the 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 mental health 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.

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.

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 2016 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 2016 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 2016 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 2016 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 2016 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 2016 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 2016 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 2016 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 2016 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 231, 233, 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 235, 236, 237, 238, 239, 240, 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;
(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 235, 236, 237, 735, 739, 743, 820, 822, 823, 825, 826, 828, 830, 832, 834, 835, 837, 838, 855, 857, 858, 861, 864, 866, 969, 971 and 972—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 238, 239, 240, 747, 750, 758, 825, 826, 828, 835, 837, 838, 973, 975 and 986—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.

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 items 229 and 721, has the meaning given by clause 2.16.7.

prescribed medical practitioner means a medical practitioner:

(a) who is not a general practitioner, specialist or consultant physician; and
(b) who:
    (i) is registered under section 3GA of the Act and is practising during the period, and in the location, in respect of which the medical practitioner is registered, and insofar as the circumstances specified for the purposes of paragraph 19AA(3)(b) of the Act apply; or
    (ii) is covered by an exemption under subsection 19AB(3) of the Act; or
    (iii) first became a medical practitioner before 1 November 1996.

qualified adult sleep medicine practitioner has the meaning given by clause 4.1.2.

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 items 249 and 903, has the meaning given by clause 2.17.2.

reviewing a GP management plan, for items 233 and 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.

team care arrangements means a plan under item 723 or 732 (for a review of team care arrangements under item 723).

Telehealth and Telephone Determination means the *Health Insurance (Section 3C General Medical Services – Telehealth and Telephone Attendances) Determination 2021*.

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:

(a) in relation to assisted reproductive services—has the meaning given by clause 5.2.3; and

(b) for item 30665—has the meaning given by clause 5.10.5A.

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.

Endnotes

Endnote 1—About the endnotes

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

The following endnotes are included in every compilation:

Endnote 1—About the endnotes
Endnote 2—Abbreviation key
Endnote 3—Legislation history
Endnote 4—Amendment history

Abbreviation key—Endnote 2
The abbreviation key sets out abbreviations that may be used in the endnotes.

Legislation history and amendment history—Endnotes 3 and 4
Amending laws are annotated in the legislation history and amendment history.

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

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

Editorial changes
The *Legislation Act 2003* authorises First Parliamentary Counsel to make editorial and presentational changes to a compiled law in preparing a compilation of the law for registration. The changes must not change the effect of the law. Editorial changes take effect from the compilation registration date.

If the compilation includes editorial changes, the endnotes include a brief outline of the changes in general terms. Full details of any changes can be obtained from the Office of Parliamentary Counsel.

Misdescribed amendments
A misdescribed amendment is an amendment that does not accurately describe how an amendment is to be made. If, despite the misdescription, the amendment can be given effect as intended, then the misdescribed amendment can be incorporated through an editorial change made under section 15V of the *Legislation Act 2003*.

If a misdescribed amendment cannot be given effect as intended, the amendment is not incorporated and "(md not incorp)" is added to the amendment history.

Endnote 2—Abbreviation key

ad = added or inserted

am = amended

amdt = amendment

c = clause(s)

C[x] = Compilation No. x

Ch = Chapter(s)

def = definition(s)

Dict = Dictionary

disallowed = disallowed by Parliament

Div = Division(s)

ed = editorial change

exp = expires/expired or ceases/ceased to have effect

F = Federal Register of Legislation

gaz = gazette

LA = *Legislation Act 2003*

LIA = *Legislative Instruments Act 2003*

(md) = misdescribed amendment can be given effect

(md not incorp) = misdescribed amendment cannot be given effect

mod = modified/modification

No. = Number(s)

o = order(s)

Ord = Ordinance

orig = original

par = paragraph(s)/subparagraph(s) /sub-subparagraph(s)

pres = present

prev = previous

(prev…) = previously

Pt = Part(s)

r = regulation(s)/rule(s)

reloc = relocated

renum = renumbered

rep = repealed

rs = repealed and substituted

s = section(s)/subsection(s)

Sch = Schedule(s)

Sdiv = Subdivision(s)

SLI = Select Legislative Instrument

SR = Statutory Rules

Sub-Ch = Sub-Chapter(s)

SubPt = Subpart(s)

underlining = whole or part not commenced or to be commenced

Endnote 3—Legislation history

Name	Registration	Commencement	Application, saving and transitional provisions
Health Insurance (General Medical Services Table) Regulations 2021	2 June 2021 (F2021L00678)	1 July 2021 (s 2(1) item 1)	
Health Insurance Legislation Amendment (2021 Measures No. 1) Regulations 2021	2 June 2021 (F2021L00681)	Sch 1 (items 34–39, 43–95B): 1 July 2021 (s 2(1) item 3)	—
Health Insurance (General Medical Services Table) Amendment (2021 Measures No. 1) Regulations 2021	25 June 2021 (F2021L00854)	1 July 2021 (s 2(1) item 1)	—
Health Insurance (General Medical Services Table) Amendment (2021 Measures No. 2) Regulations 2021	6 Aug 2021 (F2021L01081)	7 Aug 2021 (s 2(1) item 1)	—
Health Insurance Legislation Amendment (2021 Measures No. 2) Regulations 2021	17 Sept 2021 (F2021L01281)	Sch 1: 1 Nov 2021 (s 2(1) item 1)	—
Health Insurance Legislation Amendment (Rural Bulk-billing Incentive) Regulations 2021	9 Dec 2021 (F2021L01748)	Sch 1 (items 9–23): 1 Jan 2022 (s 2(1) item 1)	—
Health Insurance Legislation Amendment (2021 Measures No. 4) Regulations 2021	17 Dec 2021 (F2021L01812)	Sch 1 (items 1–127): 1 Mar 2022 (s 2(1) item 1)	—
Health Insurance Legislation Amendment (2021 Measures No. 3) Regulations 2021	17 Dec 2021 (F2021L01814)	Sch 1 (items 6–24) and Sch 2 (items 1–28): 1 Jan 2022 (s 2(1) item 1)	—
Health Insurance Legislation Amendment (2022 Measures No. 1) Regulations 2022	22 Mar 2022 (F2022L00367)	Sch 1 (items 11–37, 40–43, 49–121): 1 July 2022 (s 2(1) items 2, 3)	—
Health Insurance (General Medical Services Table) Amendment (Pain Management Services) Regulations 2022	5 Apr 2022 (F2022L00527)	11 Apr 2022 (s 2(1) item 1)	—
Health Insurance Legislation Amendment (2022 Measures No. 2) Regulations 2022	21 July 2022 (F2022L01000)	Sch 1 (items 1–11): 1 Aug 2022 (s 2(1) item 1)	—

Endnote 3—Legislation history

Name	Registration	Commencement	Application, saving and transitional provisions
Health Insurance Legislation Amendment (2022 Measures No. 3) Regulations 2022	22 Aug 2022 (F2022L01099)	Sch 1: 1 Nov 2022 (s 2(1) item 2) Sch 5: 1 July 2022 (s 2(1) item 3)	—
Health Insurance Legislation Amendment (2022 Measures No. 4) Regulations 2022	25 Nov 2022 (F2022L01518)	Sch 1 (items 1–147, 151–160): 1 Mar 2023 (s 2(1) item 1)	—
Health Insurance (General Medical Services Table) Amendment (2023 Measures No. 1) Regulations 2023	6 Feb 2023 (F2023L00089)	Sch 1: 1 Mar 2023 (s 2(1) items 2, 3)	—
Health Insurance Legislation Amendment (2023 Measures No. 1) Regulations 2023	4 Apr 2023 (F2023L00416)	Sch 1: 5 Apr 2023 (s 2(1) item 2) Sch 2 (items 3–23), Sch 3 (items 8-30), Sch 4 and Sch 5 (items 1–10): 1 July 2023 (s 2(1) items 3–6)	—
Health Insurance Legislation Amendment (2023 Measures No. 2) Regulations 2023	8 June 2023 (F2023L00744)	Sch 1 (items 5–7): 1 July 2023 (s 2(1) item 1)	—
Health Insurance Legislation Amendment (2023 Measures No. 3) Regulations 2023	16 Oct 2023 (F2023L01386)	Sch 1: 17 Oct 2023 (s 2(1) item 2) Sch 2 (items 3–24), Sch 4 and Sch 5: 1 Nov 2023 (s 2(1) items 3, 4)	—
Health Insurance Legislation Amendment (2024 Measures No. 1) Regulations 2024	2 Feb 2024 (F2024L00134)	Sch 1 (items 1–49, 52–156): 1 Mar 2024 (s 2(1) item 1)	—

Endnote 4—Amendment history

Provision affected	How affected
s 2	rep LA s 48D
s 5	rep LA s 48C
Schedule 1	
Part 1	
Division 1.1	
c 1.1.2	rs F2023L00416; F2023L00744
c 1.1.5	am F2023L00416; F2023L01386
c 1.1.6	am F2021L01814; F2022L00367
Division 1.2	
c 1.2.2	am F2021L01814
c 1.2.3	am F2021L01281; F2023L01386
c 1.2.4	am F2021L00854; F2022L00367; F2023L00416; F2023L01386; F2024L00134
	ed C15
c 1.2.5	am F2021L01814; F2022L01518; F2023L01386
	ed C14
c 1.2.6	am F2021L01812; F2021L01814; F2022L01099; F2022L01518; F2023L01386
c 1.2.7	am F2021L01812; F2021L01814
	ed C5
	am F2022L01099; F2022L01518; F2023L00416; F2023L01386
c 1.2.8	am F2022L01518; F2023L01386
c 1.2.11	am F2021L00681
	ed C1
	am F2021L01281; F2021L01812; F2022L01518
	ed C10
	am F2023L01386; F2024L00134
c 1.2.13	am F2021L00681; F2024L00134
Division 1.3	
Division 1.3	ad F2022L00367
c 1.3.1	ad F2022L00367
	am F2022L01518; F2023L00416 (Sch 2 item 6 md not incorp); F2023L01386
Part 2	
Division 2.1	
c 2.1.1	am F2022L00367; F2022L01099; F2023L00416; F2023L01386
c 2.1.2	ad F2023L01386
Division 2.2	
c 2.2.1	am F2022L00367
Group A1 Table	am F2023L01386

Endnote 4—Amendment history

Provision affected	How affected
Division 2.3	
Group A2 Table	am F2023L01386
Division 2.4	
c 2.4.1	am F2022L00367
Group A3 Table	am F2021L01814; F2022L00367; F2023L00416; F2023L01386
Division 2.5	
c 2.5.1	am F2022L00367
Group A4 Table	am F2021L01814; F2022L00367; F2023L00416; F2023L01386
Division 2.6	
Division 2.6 heading	rs F2022L01518
c 2.6.1	am F2022L01518
c 2.6.3	am F2022L00367
Group A29 Table	am F2022L01518
Division 2.7	
c 2.7.1	am F2022L00367
Group A28 Table	am F2021L01814
Division 2.8	
c 2.8.2	am F2022L00367
Division 2.9	
c 2.9.1	am F2022L00367
Division 2.10	
Division 2.10	am F2023L01386
c 2.10.1	rs F2022L01099
c 2.10.1A	ad F2023L01386
c 2.10.2	am F2022L00367; F2023L01386
Group A7 Table	am F2022L01099; F2023L01386
Division 2.11	
c 2.11.1	rs F2021L01814
	rep F2024L00134
c 2.11.3	rep F2021L01814
	ad F2023L00416
c 2.11.5	am F2022L00367
Group A8 Table	am F2021L01814; F2022L01518; F2023L00416; F2024L00134
	ed C15
Division 2.12	
c 2.12.1	am F2021L01814
c 2.12.2	am F2022L00367
Division 2.13	
c 2.13.2	am F2022L00367
Group A12 Table	am F2021L01814

Endnote 4—Amendment history

Provision affected	How affected
Division 2.14	
c 2.14.4	rs F2023L00416; F2023L00744
c 2.14.5	am F2022L00367
Division 2.15	
Division 2.15 heading	rs F2023L01386
c 2.15.1	rs F2023L01386
c 2.15.2	am F2021L01814; F2022L01518; F2023L01386
c 2.15.3	am F2023L01386
c 2.15.5	am F2023L01386
c 2.15.6	am F2023L01386
c 2.15.7	am F2023L01386
c 2.15.8	am F2023L01386
c 2.15.9	am F2023L01386
c 2.15.10	am F2021L01814; F2023L01386
c 2.15.11	am F2023L01386
c 2.15.12	am F2023L01386
c 2.15.13	am F2023L01386
c 2.15.14	am F2023L01386
c 2.15.15	am F2022L00367
Division 2.16	
Division 2.16 heading	rs F2023L01386
Subdivision A	
c 2.16.1	am F2023L01386
Subdivision B	
Subdivision B heading	rs F2023L01386
c 2.16.2	am F2023L01386
c 2.16.3	am F2023L01386
c 2.16.4	am F2023L01386
c 2.16.5	am F2023L01386
c 2.16.6	am F2023L01386
c 2.16.7	am F2023L01386
c 2.16.8	am F2023L01386
c 2.16.9	am F2023L00416; F2023L01386
c 2.16.10	rs F2023L01386
c 2.16.11	am F2022L01518
	rs F2023L01386
c 2.16.12	am F2023L00416
c 2.16.12A	ad F2023L01386
c 2.16.13	am F2022L00367

Provision affected	How affected
Subdivision C	
c 2.16.14	am F2023L01386
c 2.16.15	am F2023L00416; F2023L01386
c 2.16.16	am F2023L00416; F2023L01386
c 2.16.19A	ad F2023L00416
	am F2023L01386
c 2.16.20	am F2022L00367
Group A15 Table	am F2023L00416; F2023L01386
Division 2.17	
Division 2.17 heading	rs F2023L01386
c 2.17.1	am F2023L01386
c 2.17.2	am F2023L01386
c 2.17.3	rs F2023L01386
c 2.17.4	am F2022L00367
Group A17 Table	am F2023L01386
Division 2.18	rep F2024L00134
c 2.18.1	rep F2021L01814
c 2.18.2	rep F2021L01814
c 2.18.3	rep F2021L01814
c 2.18.4	rep F2024L00134
c 2.18.5	rep F2024L00134
Group A30 Table	am F2021L01814
	rep F2024L00134
Division 2.19	rep F2022L01099
c 2.19.1	rep F2022L01099
c 2.19.2	rep F2022L01099
c 2.19.3	am F2022L00367
	rep F2022L01099
Group A18 Table	rep F2022L01099
c 2.19.4	rep F2022L01099
Group A19 Table	rep F2022L01099
Division 2.20	
Division 2.20 heading	rs F2023L01386
c 2.20.2	am F2022L00367
	rs F2022L01518
	am F2023L00416; F2023L01386
c 2.20.2A	ad F2023L01386
c 2.20.3	am F2022L01518; F2023L01386
c 2.20.4	am F2023L01386
c 2.20.5	rs F2023L01386

Endnote 4—Amendment history

Provision affected	How affected
c 2.20.6	am F2022L01000; F2023L01386
c 2.20.7	am F2022L01518
c 2.20.7A	ad F2023L01386
c 2.20.8	am F2022L00367
Group A20 Table	am F2021L01814; F2022L01518
Division 2.21	
c 2.21.4	am F2022L00367
Group A24 Table	am F2021L01814
Division 2.22	
Division 2.22 heading	rs F2023L01386
c 2.22.1	am F2023L01386
c 2.22.2	am F2022L00367
Division 2.23	
c 2.23.1	am F2022L00367
Group A21 Table	am F2023L01386
Division 2.24	
c 2.24.1	am F2023L01386
c 2.24.2	am F2022L00367
Group A22 Table	am F2023L01386
Division 2.25	
c 2.25.1	am F2023L01386
Group A23 Table	am F2023L01386
Division 2.26	
c 2.26.1	am F2022L00367
Group A26 Table	am F2021L01814
Division 2.27	
c 2.27.4	am F2022L00367
Group A31 Table	am F2021L01814
Division 2.28	
c 2.28.3	am F2022L00367
Group A32 Table	am F2021L01814
Division 2.29	
c 2.29.2	am F2022L00367
Division 2.30	
c 2.30.1	am F2022L01099; F2023L00416; F2023L01386
c 2.30.2	am F2022L00367
	ed C14
Group A35 Table	am F2023L01386
Division 2.31	
c 2.31.5	am F2021L01814; F2023L01386

Endnote 4—Amendment history

Provision affected	How affected
c 2.31.7	am F2021L01814
c 2.31.8	am F2021L01814
	rep F2022L01518
c 2.31.9	am F2021L01814; F2022L01518
c 2.31.10	am F2022L00367
Group A36 Table	am F2021L01814; F2022L00367; F2022L01518; F2023L00416; F2023L01386
Division 2.32	
Division 2.32	ad F2021L00681
c 2.32.1	ad F2021L00681
	am F2022L00367
Group A37 Table	ad F2021L00681
	am F2021L01814; F2023L01386
Part 3	
Division 3.1	
c 3.1.4	am F2022L00367
Group M12 Table	am F2021L01814
Division 3.2	
c 3.2.1	am F2021L01748; F2023L00416; F2023L01386
c 3.2.2	rs F2021L01748
c 3.2.2A	ad F2023L01386
c 3.2.2B	ad F2023L01386
c 3.2.3	am F2022L00367
Group M1 Table	am F2021L01748; F2023L01386
Part 4	
Division 4.1	
c 4.1.3A	rs F2021L00681
c 4.1.3B	am F2021L00681
c 4.1.3D	am F2024L00134
c 4.1.3E	am F2024L00134
c 4.1.5	am F2022L00367
Group D1 Table	am F2021L00681; F2021L01281; F2021L01812; F2022L00367
	ed C7
	am F2022L01099; F2022L01518; F2023L01386; F2024L00134
Division 4.2	
c 4.2.2	am F2022L00367
Part 5	
Division 5.2	
c 5.2.2	am F2021L01812
c 5.2.4	am F2022L00367
c 5.2.6A	ad F2021L01281

Endnote 4—Amendment history

Provision affected	How affected
c 5.2.10	am F2022L00367
Group T1 Table	am F2021L00681; F2021L01281; F2021L01812; F2021L01814; F2024L00134
Division 5.3	
c 5.3.1	am F2022L00367; F2023L00416; F2023L01386
c 5.3.4	am F2022L00367
Division 5.4	
c 5.4.1	am F2022L00367
Group T3 Table	am F2023L00416
Division 5.5	
c 5.5.3	am F2021L01748
c 5.5.4	am F2022L00367
Group T4 Table	am F2021L01814
Division 5.6	
c 5.6.1	am F2022L00367
Group T6 Table	am F2021L01814
Division 5.7	
c 5.7.1	am F2022L00367; F2023L00416; F2023L01386
c 5.7.2	am F2022L00367
Group T7 Table	am F2021L01812
Division 5.8	
c 5.8.3	am F2022L00367
Division 5.9	
c 5.9.1A	ad F2024L00134
c 5.9.2	am F2023L00416; F2023L01386
c 5.9.4	am F2024L00134
c 5.9.5	am F2021L01812
Group T10 Table	am F2021L01812; F2022L00367; F2023L00416 (Sch 2 item 23 table item 177 md not incorp); F2023L01386; F2024L00134
Division 5.10	
Subdivision A	
c 5.10.4	am F2021L01281
	rep F2023L00416
c 5.10.5A	ad F2024L00134
c 5.10.7	am F2022L01099
c 5.10.9	am F2022L00367
Group T8 Table	am F2021L01281; F2022L01099; F2022L01518; F2023L00089; F2023L00416; F2023L00744; F2024L00134
Subdivision B	
c 5.10.14	am F2022L00367
	rep F2023L00416

Provision affected	How affected
c 5.10.16	am F2022L00367
Group T8 Table	am F2021L01281
	ed C3
	am F2021L01814; F2022L00367; F2022L01000; F2022L01099; F2023L00416; F2023L01386; F2024L00134
Subdivision C	
c 5.10.17	am F2021L00681; F2022L01518
c 5.10.17A	ad F2021L00681
c 5.10.17B	ad F2021L00681
c 5.10.17C	ad F2021L00681
c 5.10.17D	ad F2021L00681
c 5.10.18	am F2022L00367
Group T8 Table	am F2021L00681; F2021L01281; F2021L01812; F2021L01814; F2022L00367; F2022L01000; F2022L01099; F2022L01518; F2023L00416; F2023L01386; F2024L00134
	ed C15
Subdivision D	
c 5.10.19AB	ad F2022L01518
c 5.10.19	am F2022L00367
Group T8 Table	am F2021L01281; F2021L01812; F2022L00527; F2022L01099; F2022L01518; F2023L00089; F2023L00416; F2023L01386; F2024L00134
Subdivision E	
c 5.10.21A	ad F2023L00416
c 5.10.22	rs F2023L00416
c 5.10.23	am F2022L00367
Group T8 Table	am F2021L01281; F2021L01814; F2022L01099; F2022L01518; F2023L00416; F2023L01386; F2024L00134
Subdivision F	
c 5.10.24	am F2022L00367
Group T8 Table	am F2021L01281; F2024L00134
Subdivision G	
c 5.10.25	rs F2021L01081
c 5.10.29	am F2022L00367
Group T8 Table	am F2021L00681; F2021L00854; F2021L01081; F2021L01281; F2021L01814
	ed C5
	am F2022L01099; F2023L00416; F2023L01386; F2024L00134
	ed C15
Subdivision H	
Subdivision H	ad F2022L01518
c 5.10.30	ad F2022L01518
Group T8 Table	ad F2022L01518

Endnote 4—Amendment history

Provision affected	How affected
	am F2023L00089; F2023L01386
Division 5.11	
c 5.11.5	am F2022L00367
Group T9 Table	am F2022L00367
	ed C7
	am F2023L00416; F2023L01386
Part 6	
Division 6.2	
c 6.2.1	am F2022L00367
Division 6.3	
c 6.3.3	am F2022L00367
Group O2 Table	am F2022L00367
	ed C7
	am F2023L00416
	ed C12
	am F2023L01386
Division 6.4	
c 6.4.1	am F2022L00367
Division 6.5	
c 6.5.2	am F2022L00367
Division 6.6	
c 6.6.1	am F2022L00367
Division 6.7	
c 6.7.1	am F2022L00367
Division 6.8	
c 6.8.1	am F2022L00367
Division 6.9	
c 6.9.1	am F2022L00367
Division 6.10	
c 6.10.1	am F2022L00367
Division 6.11	
c 6.11.1	am F2022L00367
Part 7	
c 7.1.1	am F2021L00681; F2021L01281; F2021L01748; F2021L01814; F2022L01099; F2023L00416; F2023L01386; F2024L00134
Schedule 2	rep LA s 48C

Endnote 5—Editorial changes

In preparing this compilation for registration, the following kinds of editorial change(s) were made under the *Legislation Act 2003*.

Subclause 1.2.4(1) of Schedule 1

Kind of editorial change

Change to punctuation

Details of editorial change

Schedule 1 item 15 of the *Health Insurance Legislation Amendment (2024 Measures No. 1) Regulations 2024* instructs to omit "and 16404" and substitute "16404, 91823, 91825, 91826, 91833, 91836, 92611, 92612, 92613 and 92618" in subclause 1.2.4(1) of Schedule 1.

Subclause 1.2.4(1) of Schedule 1 reads as follows:

> (1) Use this clause for items 105, 116, 119, 386, 2806, 2814, 3010, 3014, 6009 to 6015, 6019, 6052 16404, 91823, 91825, 91826, 91833, 91836, 92611, 92612, 92613 and 92618.

There is no comma after "6052".

This compilation was editorially changed to insert a comma after "6052" in subclause 1.2.4(1) of Schedule 1 to correct the punctuation.

Schedule 1 (item 294, column 2, paragraph (b))

Kind of editorial change

Changes to punctuation and change to grammar, syntax or the use of conjunctives or disjunctives

Details of editorial change

Schedule 1 item 37 of the *Health Insurance Legislation Amendment (2024 Measures No. 1) Regulations 2024* instructs to omit "348, 350 or 352" from paragraph (b) in column 2 of item 294 of Schedule 1.

Paragraph (b) of item 294 of Schedule 1 reads as follows:

(b) except for the requirement for the attendance to be at consulting rooms—item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, would otherwise apply to the attendance; and

A comma appears between "318" and "319" and a comma appears after "319".

This compilation was editorially changed to omit the comma after "318" and substitute "or" and to omit the comma after "319" in paragraph (b) of column 2 of item 294 of Schedule 1 to correct the punctuation and grammatical error.

Schedule 1 (item 296, column 2)

Kind of editorial change

Give effect to the misdescribed amendment as intended

Details of editorial change

Schedule 1 item 38 of the *Health Insurance Legislation Amendment (2024 Measures No. 1) Regulations 2024* instructs to omit ", or item 297 or 299 or any of items of 300 to 308" and substitute "or any of items 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437" from column 2 of item 296 of Schedule 1.

The text ", or item 297 or 299 or any of items of 300 to 308" does not appear in column 2 of item 296 of Schedule 1. However, the text ", or item 297 or 299 or any of items 300 to 308" does appear.

This compilation was editorially changed to omit ", or item 297 or 299 or any of items 300 to 308" and substitute "or any of items 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437" from column 2 of item 296 of Schedule 1 to give effect to the misdescribed amendment as intended.

Schedule 1 (item 38557, column 2)

Kind of editorial change

Give effect to the misdescribed amendment as intended

Details of editorial change

Schedule 1 item 68 of the *Health Insurance Legislation Amendment (2024 Measures No. 1) Regulations 2024* instructs to insert ", performed by any medical practitioner," after "with a service" from column 2 of item 38557 of Schedule 1.

The words "with a service" appear twice in column 2 of item 38557 of Schedule 1.

This compilation was editorially changed to insert ", performed by any medical practitioner," after "with a service" (first occurring) from column 2 of item 38557 of Schedule 1 to give effect to the misdescribed amendment as intended.

Schedule 1 (item 49518, column 2)

Kind of editorial change

Give effect to the misdescribed amendment as intended

Details of editorial change

Schedule 1 item 132 of the *Health Insurance Legislation Amendment (2024 Measures No. 1) Regulations 2024* instructs to omit "replacement" from column 2 of items 49518 and 49519 of Schedule 1.

The word "replacement" appears three times in column 2 of item 49518 of Schedule 1.

This compilation was editorially changed to omit "replacement" (first occurring) from column 2 of item 49518 of Schedule 1 to give effect to the misdescribed amendment as intended.