Australian Government
Department of Health and Ageing

Medicare Benefits Schedule Book

Diagnostic Imaging Services

Category 5

Operating from 01 January 2010

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At the time of printing, the relevant legislation giving authority for the changes included in this edition of the book may still be subject to the approval of Executive Council and the usual Parliamentary scrutiny. This book is not a legal document, and, in cases of discrepancy, the legislation will be the source document for payment of Medicare benefits.

The latest Medicare Benefits Schedule information is available from *MBS Online* at http://www.health.gov.au/mbsonline

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G.1.1. THE MEDICARE BENEFITS SCHEDULE - INTRODUCTION

Schedules of Services

Each professional service contained in the book has been allocated a unique item number. Located with the item number and description for each service is the Schedule fee and Medicare benefit, together with a reference to an explanatory note relating to the item (if applicable).

If the service attracts an anaesthetic, the word (Anaes.) appears following the description. Where an operation qualifies for the payment of benefits for an assistant, the relevant items are identified by the inclusion of the word (Assist.) in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

In some cases two levels of fees are applied to the same service in General Medical Services, with each level of fee being allocated a separate item number. The item identified by the letter "S" applies in the case where the procedure has been rendered by a recognised specialist in the practice of his or her specialty and the patient has been referred. The item identified by the letter "G" applies in any other circumstance.

Higher rates of benefits are also provided for consultations by a recognised consultant physician where the patient has been referred by another medical practitioner or an approved dental practitioner (oral surgeons).

Differential fees and benefits also apply to services listed in Category 5 (Diagnostic Imaging Services). The conditions relating to these services are set out in Category 5.

Explanatory Notes

Explanatory notes relating to the Medicare benefit arrangements and notes that have general application to services are located at the beginning of the schedule, while notes relating to specific items are located at the beginning of each Category. While there may be a reference following the description of an item to specific notes relating to that item, there may also be general notes relating to each Group of items.

G.1.2. MEDICARE - AN OUTLINE

The Medicare Program ('Medicare') provides access to medical and hospital services for all Australian residents and certain categories of visitors to Australia. **Medicare Australia** administers Medicare and the payment of Medicare benefits. The major elements of Medicare are contained in the *Health Insurance Act 1973*, as amended, and include the following:

(a). Free treatment for public patients in public hospitals.

(b). The payment of 'benefits', or rebates, for professional services listed in the Medicare Benefits Schedule (MBS). In general, the Medicare benefit is 85% of the Schedule fee, otherwise the benefits are

- i. 100% of the Schedule fee for services provided by a general practitioner to non-referred, non-admitted patients;
- ii. 100% of the Schedule fee for services provided on behalf of a general practitioner by a practice nurse or registered Aboriginal Health Worker;
- iii. 75% of the Schedule fee for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients);
- iv. 75% of the Schedule fee for professional services rendered as part of a privately insured episode of hospital-substitute treatment.

Medicare benefits are claimable only for 'clinically relevant' services rendered by an appropriate health practitioner. A 'clinically relevant' service is one which is generally accepted by the relevant profession as necessary for the appropriate treatment of the patient.

When a service is not clinically relevant, the fee and payment arrangements are a private matter between the practitioner and the patient.

Services listed in the MBS must be rendered according to the provisions of the relevant Commonwealth, State and Territory laws. For example, medical practitioners must ensure that the medicines and medical devices they use have been supplied to them in strict accordance with the provisions of the *Therapeutic Goods Act 1989.*

Where a Medicare benefit has been inappropriately paid, Medicare Australia may request its return from the practitioner concerned.

G.1.3. MEDICARE BENEFITS AND BILLING PRACTICES

Key information on Medicare benefits and billing practices

The *Health Insurance Act 1973* stipulates that Medicare benefits are payable for professional services. A professional service is a clinically relevant service which is listed in the MBS. A medical service is clinically relevant if it is generally accepted in the medical profession as necessary for the appropriate treatment of the patient.

Medical practitioners are free to set their fees for their professional service. However, the amount specified in the patient's account must be the amount charged for the service specified. The fee may not include a cost of goods or services which are not part of the MBS service specified on the account.

Billing practices contrary to the Act
A *non-clinically relevant service* must not be included in the charge for a Medicare item. The non-clinically relevant service must be separately listed on the account and not billed to Medicare.

Goods supplied for the patient's home use (such as wheelchairs, oxygen tanks, continence pads) must not be included in the consultation charge. Medicare benefits are limited to services which the medical practitioner provides at the time of the consultation – any other services must be separately listed on the account and must not be billed to Medicare.

Charging part of all of an episode of hospital treatment or a hospital substitute treatment to a non-admitted consultation is prohibited. This would constitute a false or misleading statement on behalf of the medical practitioner and no Medicare benefits would be payable.

An account may not be re-issued to include charges and out-of-pocket expenses excluded in the original account. The account can only be reissued to correct a genuine error.

Potential consequence of improperly issuing an account
The potential consequences for improperly issuing an account are
(a). No Medicare benefits will be paid for the service;
(b). The medical practitioner who issued the account, or authorised its issue, may face charges under sections 128A or 128B of the *Health Insurance Act 1973*.
(c). Medicare benefits paid as a result of a false or misleading statement will be recoverable from the doctor under section 129AC of the *Health Insurance Act 1973*.

Providers should be aware that Medicare Australia is legally obliged to investigate doctors suspected of making false or misleading statements, and may refer them for prosecution if the evidence indicates fraudulent charging to Medicare. If Medicare benefits have been paid inappropriately or incorrectly, Medicare Australia will take recovery action.

G.2.1. PROVIDER ELIGIBILITY FOR MEDICARE

To be eligible to provide medical service which will attract Medicare benefits, or to provide services for or on behalf of another practitioner, practitioners must meet one of the following criteria:
(a) be a recognised specialist, consultant physician or general practitioner; or
(b) be in an approved placement under section 3GA of the *Health Insurance Act 1973*; or
(c) be a temporary resident doctor with an exemption under section 19AB of the *Health Insurance Act 1973*, and working in accord with that exemption .

Any practitioner who does not satisfy the requirements outlined above may still practice medicine but their services will not be eligible for Medicare benefits.

NOTE: New Zealand citizens entering Australia do so under a special temporary entry visa and are regarded as temporary resident doctors.

NOTE: It is an offence under Section 19CC of the *Health Insurance Act 1973* to provide a service without first informing a patient where a Medicare benefit is not payable for that service (i.e. the service is not listed in the MBS).

Non-medical practitioners
To be eligible to provide services which will attract Medicare benefits under MBS items 10950-10977 and MBS items 80000-89000, allied health professionals, dentists, and dental specialists must be
(a) registered according to State or Territory law or, absent such law, be members of a professional association with uniform national registration requirements; and
(b) registered with Medicare Australia to provide these services.

G.2.2. PROVIDER NUMBERS

Practitioners eligible to have Medicare benefits payable for their services and/or who for Medicare purposes wish to raise referrals for specialist services and requests for pathology or diagnostic imaging services, may apply ***in writing*** to Medicare

Australia for a Medicare provider number for the locations where these services/referrals/requests will be provided. The form may be downloaded from www.medicareaustralia.gov.au

For Medicare purposes, an account/receipt issued by a practitioner must include the practitioner's name and ***either*** the provider number for the location where the service was provided ***or*** the address where the services were provided.

Medicare provider number information is released in accord with the secrecy provisions of the *Health Insurance Act 1973* (section 130) to authorized external organizations including private health insurers, the Department of Veterans' Affairs and the Department of Health and Ageing.

When a practitioner ceases to practice at a given location they must inform Medicare promptly. Failure to do so can lead to the misdirection of Medicare cheques and Medicare information.

Practitioners at practices participating in the Practice Incentives Program (PIP) should use a provider number linked to that practice. Under PIP, only services rendered by a practitioner whose provider number is linked to the PIP will be considered for PIP payments.

G.2.3. LOCUM TENENS

Where a locum tenens will be in a practice for more than two weeks ***or*** in a practice for less than two weeks but on a regular basis, the locum should apply for a provider number for the relevant location. If the locum will be in a practice for less than two weeks and will not be returning there, they should contact Medicare Australia (provider liaison – 132 150) to discuss their options (for example, use one of the locum's other provider numbers).

A locum must use the provider number allocated to the location if

(a) they are an approved general practice or specialist trainee with a provider number issued for an approved training placement; or
(b) they are associated with an approved rural placement under Section 3GA of the *Health Insurance Act 1973*; or
(c) they have access to Medicare benefits as a result of the issue of an exemption under section 19AB of the *Health Insurance Act 1973* (i.e. they have access to Medicare benefits at specific practice locations); or
(d) they will be at a practice which is participating in the Practice Incentives Program; or
(e) they are associated with a placement on the MedicarePlus for Other Medical Practitioners (OMPs) program, the After Hours OMPs program, the Rural OMPs program or Outer Metropolitan OMPs program.

G.2.4. OVERSEAS TRAINED DOCTOR

Ten year moratorium

Section 19AB of the *Health Insurance Act 1973* states that services provided by overseas trained doctors (including New Zealand trained doctors) and former overseas medical students trained in Australia, will not attract Medicare benefits for 10 years from ***either***

(a) their date of registration as a medical practitioner for the purposes of the *Health Insurance Act 1973;* ***or***
(b) their date of permanent residency (the reference date from will vary from care to case).

Exclusions - Practitioners who **before 1 January 1997** had

(a) registered with a State or Territory medical board ***and*** retained a continuing right to remain in Australia; ***or***
(b) lodged a valid application with the Australian Medical Council (AMC) to undertake examinations whose successful completion would normally entitle the candidate to become a medical practitioner.

The Minister of Health and Ageing may grant an overseas trained doctor (OTD) or occupational trainee (OT) an exemption to the requirements of the ten year moratorium, with or without conditions. When applying for a Medicare provider number, the OTD or OT must

(a) demonstrate that they need a provider number and that their employer supports their request; and
(b) provide the following documentation:
    i. Australian medical registration papers; and
    ii. a copy of their personal details in their passport and all Australian visas and entry stamps; and
    iii. a letter from the employer stating why the person requires a Medicare provider number and/or prescriber number is required; and
    iv. a copy of the employment contract.

G.2.5. ADDRESSES OF MEDICARE AUSTRALIA, SCHEDULE INTERPRETATION AND CHANGES TO PROVIDER DETAILS

Medicare Australia,
GPO Box 9822,
in the Capital City in each State

Phone: 132-150 for all States and Territories (local call cost)

NEW SOUTH WALES **Medicare Australia Paramatta Office** 130 George Street PARRAMATTA NSW 2165	**VICTORIA** **Medicare Australia Melbourne Office** 595 Collins Street MELBOURNE VIC 3000	**QUEENSLAND** **Medicare Australia Brisbane Office** 143 Turbot Street BRISBANE QLD 4000
SOUTH AUSTRALIA **Medicare Australia Adelaide Office** 209 Greenhill Road EASTWOOD SA 5063	**WESTERN AUSTRALIA** **Medicare Australia Perth Office** Bank West Tower 108 St. George's Terrace PERTH WA 6000	**TASMANIA** **Medicare Australia Hobart Office** 242 Liverpool Street HOBART TAS 7000
NORTHERN TERRITORY As per South Australia	**AUSTRALIAN CAPITAL TERRITORY** **Medicare Australia National Office** 134 Reed Street TUGGERANONG ACT 2901	

Schedule Interpretations
The day-to-day administration and payment of benefits under the Medicare arrangements is the responsibility of Medicare Australia. Inquiries concerning matters of interpretation of Schedule items should be directed to Medicare Australia and not to the Department of Health and Ageing. The following telephone number 132 150 has been reserved by Medicare Australia exclusively for inquiries relating to the Schedule:

Changes to Provider Details
It is important that Medicare Australia be notified promptly of changes to practice addresses to ensure correct provider details for each practice location. Changes to practice address details can be made in writing to the Medicare Australia office, listed above, in the State of the practice location.

G.3.1. PATIENT ELIGIBILITY FOR MEDICARE

An "eligible person" is a person who resides permanently in Australia. This includes New Zealand citizens and holders of permanent residence visas. Applicants for permanent residence may also be eligible persons, depending on circumstances. Eligible persons must enrol with Medicare before they can receive Medicare benefits.

Medicare covers services provided only in Australia. It does not refund treatment or evacuation expenses overseas.

G.3.2. MEDICARE CARDS

The **green** Medicare card is for people permanently in Australia. Cards may be issued for individuals or families.

The **blue** Medicare card bearing the words “INTERIM CARD” is for people who have applied for permanent residence.

Visitors from countries with which Australia has a Reciprocal Health Care Agreement receive a card bearing the words "RECIPROCAL HEALTH CARE"

G.3.3. VISITORS TO AUSTRALIA AND TEMPORARY RESIDENTS

Visitors and temporary residents in Australia are not eligible for Medicare and should therefore have adequate private health insurance.

G.3.4. RECIPROCAL HEALTH CARE AGREEMENTS

Australia has Reciprocal Health Care Agreements with New Zealand, Ireland, the United Kingdom, the Netherlands, Sweden, Finland, Norway, Italy and Malta.

Visitors from these countries are entitled to medically necessary treatment while they are in Australia, comprising public hospital care (as public patients), Medicare benefits and drugs under the Pharmaceutical Benefits Scheme (PBS). Visitors must enrol with Medicare Australia to receive benefits. A passport is sufficient for public hospital care and PBS drugs.

Exceptions:

- Visitors from Ireland and New Zealand are entitle to public hospital care and PBS drugs, and should present their passports before treatment as they are not issued with Medicare careds.

- Visitors from Italy and Malta are covered for a period of six months only.

The Agreements do not cover treatment as a private patient in a public or private hospital. People visiting Australia for the purpose of receiving treatment are not covered.

G.4.1. GENERAL PRACTICE

Some MBS items may only be used by general practitioners. For MBS purposes a general practitioner is a medical practitioner who is

(a) vocationally registered under section 3F of the *Health Insurance Act 1973* (see General Explanatory Note below); or

(b) a Fellow of the Royal Australian College of General Practitioners (FRACGP), who participates in, and meets the requirements for the RACGP Quality Assurance and Continuing Medical Education Program; or

(c) a Fellow of the Australian College of Rural and Remote Medicine (FACRRM) who participates in, and meets the requirements for the ACRRM Quality Assurance and Continuing Medical Education Program; or

(d) is undertaking an approved general practice placement in a training program for ***either*** the award of FRACGP ***or*** a training program recognised by the RACGP being of an equivalent standard; or

(e) is undertaking an approved general practice placement in a training program for ***either*** the award of FACRRM ***or*** a training program recognised by ACRRM as being of an equivalent standard.

A medical practitioner seeking recognition as an FRACGP should apply to Medicare Australia, having completed an application form available from Medicare Australia's website. A general practice trainee should apply to General Practice Education and Training Limited (GPET) for a general practitioner trainee placement. GPET will advise Medicare Australia when a placement is approved. General practitioner trainees need to apply for a provider number using the appropriate provider number application form available on Medicare Australia's website.

Vocational recognition of general practitioners
The only qualifications leading to vocational recognition are FRACGP and FACRRM. The criteria for recognition as a GP are:

(a) certification by the RACGP that the practitioner
- is a Fellow of the RACGP; and
- practice is, or will be within 28 days, predominantly in general practice; and
- has met the minimum requirements of the RACGP for taking part in continuing medical education and quality assurance programs.

(b) certification by the General Practice Recognition Eligibility Committee (GPREC) that the practitioner
- is a Fellow of the RACGP; and
- practice is, or will be within 28, predominantly in general practice; and
- has met minimum requirements of the RACGP for taking part in continuing medical education and quality assurance programs.

(c) certification by ACRRM that the practitioner
- is a Fellow of ACRRM; and
- has met the minimum requirements of the ACRRM for taking part in continuing medical education and quality assurance programs.

In assessing whether a practitioner's medical practice is predominantly in general practice, the practitioner must have at least 50% of clinical time and services claimed against Medicare. Regard will also be given as to whether the practitioner provides a comprehensive primary medical service, including treating a wide range of patients and conditions using a variety of accepted medical skills and techniques, providing services away from the practitioner's surgery on request, for example, home visits and making appropriate provision for the practitioner's patients to have access to after hours medical care.

Further information on eligibility for recognition should be directed to:

Program Relations Officer, RACGP
Tel: (03) 8699 0494 Email at: qacpd@racgp.org.au

Secretary, General Practice Recognition Eligibility Committee:
Tel: (02) 6124 6753 Email at co.medicare.eligibility@medicareaustralia.gov.au

Executive Assistant, ACRRM:
Tel: (07) 3105 8200 Email at acrrm@acrrm.org.au

How to apply for vocational recognition

Medical practitioners seeking vocational recognition should apply to Medicare Australia using the approved Application Form available on the Medicare Australia website: www.medicareaustralia.gov.au. Applicants should forward their applications, as appropriate, to

Chief Executive Officer
The Royal Australian College of General Practitioners
College House
1 Palmerston Crescent
SOUTH MELBOURNE VIC 3205

Chief Executive Officer
Australian College of Rural and Remote Medicine
GPO Box 2507
BRISBANE QLD 4001

Secretary
The General Practice Recognition Eligibility Committee
Medicare Australia
PO Box 1001
TUGGERANONG ACT 2901

The relevant body will forward the application together with its certification of eligibility to the Medicare Australia CEO for processing.

Continued vocational recognition is dependent upon:

(a) the practitioner's practice continuing to be predominantly in general practice (for medical practitioners in the Register only); and

(b) the practitioner continuing to meet minimum requirements for participation in continuing professional development programs approved by the RACGP or the ACRRM.

Further information on continuing medical education and quality assurance requirements should be directed to the RACGP or the ACRRM depending on the college through which the practitioner is pursuing, or is intending to pursue, continuing medical education.

Medical practitioners refused certification by the RACGP, the ACRRM or GPREC may appeal in writing to the General Practice Recognition Appeal Committee (GPRAC), Medicare Australia, PO Box 1001, Tuggeranong, ACT, 2901.

Removal of vocational recognition status

A medical practitioner may at any time request Medicare Australia to remove their name from the Vocational Register of General Practitioners.

Vocational recognition status can also be revoked if the RACGP, the ACRRM or GPREC certifies to Medicare Australia that it is no longer satisfied that the practitioner should remain vocationally recognised. Appeals of the decision to revoke vocational recognition may be made in writing to GPRAC, at the above address.

A practitioner whose name has been removed from the register, or whose determination has been revoked for any reason must make a formal application to re-register, or for a new determination.

G.5.1. RECOGNITION AS A SPECIALIST OR CONSULTANT PHYSICIAN

A medical practitioner who:

- is registered as a specialist under State or Territory law; or
- holds a fellowship of a specified specialist College and has obtained, after successfully completing an appropriate course of study, a relevant qualification from a relevant College

and has formally applied and paid the prescribed fee, may be recognised by the Minister as a specialist or consultant physician for the purposes of the *Health Insurance Act 1973*.

A relevant specialist College may also give Medicare Australia's Chief Executive Officer a written notice stating that a medical practitioner meets the criteria for recognition.

A medical practitioner who is training for a fellowship of a specified specialist College and is undertaking training placements in a private hospital or in general practice, may provide services which attract Medicare rebates. Specialist trainees should consult the information available at www.medicareaustralia.gov.au.

Once the practitioner is recognised as a specialist or consultant physician for the purposes of the *Health Insurance Act 1973*, Medicare benefits will be payable at the appropriate higher rate for services rendered in the relevant speciality, provided the patient has been appropriately referred to them.

Further information about applying for recognition is available at www.medicareaustralia.gov.au.

G.5.2. EMERGENCY MEDICINE

A practitioner will be acting as an emergency medicine specialist when treating a patient within 30 minutes of the patient's presentation, and that patient is

(a) at risk of serious morbidity or mortality requiring urgent assessment and resuscitation; or
(b) suffering from suspected acute organ or system failure; or
(c) suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or
(d) suffering from a drug overdose, toxic substance or toxin effect; or
(e) experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or
(f) suffering acute severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or
(g) suffering acute significant haemorrhage requiring urgent assessment and treatment; and
(h) treated in, or via, a bona fide emergency department in a hospital.

Benefits are not payable where such services are rendered in the accident and emergency departments or outpatient departments of public hospitals.

G.6.1. REFERRAL OF PATIENTS TO SPECIALISTS OR CONSULTANT PHYSICIANS

For certain services provided by specialists and consultant physicians, the Medicare benefit payable is dependent on acceptable evidence that the service has been provided following referral from another practitioner.

A reference to a referral in this Section does not refer to written requests made for pathology services or diagnostic imaging services.

What is a Referral?

A "referral" is a request to a specialist or a consultant physician for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s).

Subject to the exceptions in the paragraph below, for a valid "referral" to take place

(i) the referring practitioner must have undertaken a professional attendance with the patient and turned his or her mind to the patient's need for referral and have communicated relevant information about the patient to the specialist or consultant physician (this need not mean an attendance on the occasion of the referral);
(ii) the instrument of referral must be in writing as a letter or note to a specialist or to a consultant physician and must be signed and dated by the referring practitioner; and
(iii) the specialist or consultant physician to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

The exceptions to the requirements in paragraph above are that

(a) sub-paragraphs (i),(ii) and (iii) do not apply to
- a pre-anaesthesia consultation by a specialist anaesthetist (items 16710-17625);

(b) sub-paragraphs (ii) and (iii) do not apply to
- a referral generated during an episode of hospital treatment, for a privately insured service provided or arranged by that hospital, where the hospital records provide evidence of a referral (including the referring practitioner's signature); or
- an emergency where the referring practitioner or the specialist or the consultant physician was of the opinion that the service be rendered as quickly as possible; and

(c) sub-paragraph (iii) does not apply to instances where a written referral was completed by a referring practitioner but was lost, stolen or destroyed.

Examination by Specialist Anaesthetists

A referral is not required in the case of pre-anaesthesia consultation items 17610-17625. However, for benefits to be payable at the specialist rate for consultations, other than pre-anaesthesia consultations by specialist anaesthetists (items 17640 - 17655) a referral is required.

Who can Refer?
The general practitioner is regarded as the primary source of referrals. Cross-referrals between specialists and/or consultant physicians should usually occur in consultation with the patient's general practitioner.

Referrals are to be made as follows:-
(a) to a recognised consultant physician -
(i) by another medical practitioner; or
(ii) by an approved dental practitioner [1] (oral surgeon), where the referral arises out of a dental service;
(b) to a recognised specialist -
(i) by another medical practitioner; or
(ii) by a registered dental practitioner [2], where the referral arises out of a dental service; or
(iii) by a registered optometrist where the specialist is an ophthalmologist.

[1] See paragraph OB.1 for the definition of an approved dental practitioner.

[2] A registered dental practitioner is a dentist registered with the Dental Board of the State or Territory where s/he practices. A registered dental practitioner may or may not be an approved dental practitioner.

Billing
Routine Referrals
In addition to providing the usual information required to be shown on accounts, receipts or assignment forms, specialists and consultant physicians must provide the following details (unless there are special circumstances as indicated in paragraph below):-

- - name and either practice address or provider number of the referring practitioner;
- - date of referral; and
- - period of referral (when other than for 12 months) expressed in months, eg "3", "6" or "18" months, or "indefinitely" should be shown.

Special Circumstances
(i) Lost, stolen or destroyed referrals.
If a referral has been made but the letter or note of referral has been lost, stolen or destroyed, benefits will be payable at the referred rate if the account, receipt or the assignment form shows the name of the referring medical practitioner, the practice address or provider number of the referring practitioner (if either of these are known to the consultant physician or specialist) and the words 'Lost referral'. This provision only applies to the initial attendance. For subsequent attendances to attract Medicare benefits at the referred rate a duplicate or replacement letter of referral must be obtained by the specialist or the consultant physician.

(ii) Emergencies
If the referral occurred in an emergency, benefit will be payable at the referred rate if the account, receipt or assignment form is endorsed 'Emergency referral'. This provision only applies to the initial attendance. For subsequent attendances to attract Medicare benefits at the referred rate the specialist/consultant physician must obtain a letter of referral.

(iii) Hospital referrals.
Private Patients - Where a referral is generated during an episode of hospital treatment for a privately insured service provided or arranged by that hospital, benefits will be payable at the referred rate if the account, receipt or assignment form is endorsed 'Referral within (name of hospital)' and the patient's hospital records show evidence of the referral (including the referring practitioner's signature). However, in other instances where a medical practitioner within a hospital is involved in referring a patient (e.g. to a specialist or a consultant physician in private rooms) the normal referral arrangements apply, including the requirement for a referral letter or note and its retention by the specialist or the consultant physician billing for the service.

Public Hospital Patients
Under the 2003-2008 Australian Health Care Agreements, State and Territory Governments were responsible for the provision of public hospital services to eligible persons in accordance with the terms and conditions of the Agreements. On expiry of the Agreements on 30 June 2008, the Minister for Health and Ageing made a series of determinations after an amendment to the Health Care (Appropriation) Act 1998. These determinations, known as 2008-09 Health Care Determinations, effectively rolled over the terms and conditions of the 2003-08 Agreements to 30 June 2009.

Bulk Billing
Bulk billing assignment forms should show the same information as detailed above. However, faster processing of the claim will be facilitated where the provider number (rather than the practice address) of the referring practitioner is shown.

Period for which Referral is Valid
The referral is valid for the period specified in the referral which is taken to commence on the date of the specialist's or consultant physician's first service covered by that referral.

Specialist Referrals
Where a referral originates from a specialist or a consultant physician, the referral is valid for 3 months, except where the referred patient is an admitted patient. For admitted patients, the referral is valid for 3 months or the duration of the admission whichever is the longer.

As it is expected that the patient's general practitioner will be kept informed of the patient's progress, a referral from a specialist or a consultant physician must include the name of the patient's general practitioners and/or practice. Where a patient is unable or unwilling to nominate a general practitioner or practice this must be stated in the referral.

Referrals by other Practitioners
Where the referral originates from a practitioner other than those listed in *Specialist Referrals*, the referral is valid for a period of 12 months, unless the referring practitioner indicates that the referral is for a period more or less than 12 months (eg. 3, 6 or 18 months or valid indefinitely). Referrals for longer than 12 months should only be used where the patient's clinical condition requires continuing care and management of a specialist or a consultant physician for a specific condition or specific conditions.

Definition of a Single Course of Treatment
A single course of treatment involves an initial attendance by a specialist or consultant physician and the continuing management/treatment up to the stage where the patient is referred back to the care of the referring practitioner. It also includes any subsequent review of the patient's condition by the specialist or the consultant physician that may be necessary. Such a review may be initiated by either the referring practitioner or the specialist/consultant physician.

The presentation of an unrelated illness, requiring the referral of the patient to the specialist's or the consultant physician's care would initiate a new course of treatment in which case a new referral would be required.

The receipt by a specialist or consultant physician of a new referral following the expiration of a previous referral for the same condition(s) does not necessarily indicate the commencement of a new course of treatment involving the itemisation of an initial consultation. In the continuing management/treatment situation the new referral is to facilitate the payment of benefits at the specialist or the consultant physician referred rates rather than the unreferred rates.

However, where the referring practitioner:-
(a) deems it necessary for the patient's condition to be reviewed; and
(b) the patient is seen by the specialist or the consultant physician outside the currency of the last referral; and
(c) the patient was last seen by the specialist or the consultant physician more than 9 months earlier
the attendance following the new referral initiates a new course of treatment for which Medicare benefit would be payable at the initial consultation rates.

Retention of Referral Letters
The prima facie evidence that a valid referral exists is the provision of the referral particulars on the specialist's or the consultant physician's account.

A specialist or a consultant physician is required to retain the instrument of referral (and a hospital is required to retain the patient's hospital records which show evidence of a referral) for 18 months from the date the service was rendered.

A specialist or a consultant physician is required, if requested by the Managing Director of Medicare Australia, to produce to a Medical Adviser, who is an officer of Medicare Australia, the instrument of referral within seven days after the request is received. Where the referral originates in an emergency situation or in a hospital, the specialist or consultant physician is required to produce such information as is in his or her possession or control relating to whether the patient was so treated.

Attendance for Issuing of a Referral
Medicare benefit is attracted for an attendance on a patient even where the attendance is solely for the purpose of issuing a referral letter or note. However, if a medical practitioner issues a referral without an attendance on the patient, no benefit is payable for any charge raised for issuing the referral.

Locum-tenens Arrangements
It should be noted that where a non-specialist medical practitioner acts as a locum-tenens for a specialist or consultant physician, or where a specialist acts as a locum-tenens for a consultant physician, Medicare benefit is only payable at the level appropriate for the particular locum-tenens, eg, general practitioner level for a general practitioner locum-tenens and specialist level for a referred service rendered by a specialist locum tenens.

Medicare benefits are not payable where a practitioner is not eligible to provide services attracting Medicare benefits acts as a locum-tenens for any practitioner who is eligible to provide services attracting Medicare benefits.

Fresh referrals are not required for locum-tenens acting according to accepted medical practice for the principal of a practice ie referrals to the latter are accepted as applying to the former and benefit is not payable at the initial attendance rate for an attendance by a locum-tenens if the principal has already performed an initial attendance in respect of the particular instrument of referral.

Self Referral
Medical practitioners may refer themselves to consultant physicians and specialists and Medicare benefits are payable at referred rates.

Referrals by Dentists or Optometrists
For Medicare benefit purposes, a referral may be made to

(i) a recognised specialist:
  (a) by a registered dental practitioner, where the referral arises from a dental service; or
  (b) by a registered optometrist where the specialist is an ophthalmologist; or

(ii) a consultant physician, by an approved dental practitioner (oral surgeon), where the referral arises out of a dental service.

In any other circumstances (i.e. a referral to a consultant physician by a dentist, other than an approved oral surgeon, or an optometrist, or a referral by an optometrist to a specialist other than a specialist ophthalmologist), it is not a valid referral. Any resulting consultant physician or specialist attendances will attract Medicare benefits at unreferred rates.

Registered dentists and registered optometrists may refer themselves to specialists in accordance with the criteria above, and Medicare benefits are payable at the levels which apply to their referred patients.

G.7.1. BILLING PROCEDURES

Itemised Accounts
Where the doctor bills the patient for medical services rendered, the patient needs a properly itemised account/receipt to claim Medicare benefits.

Under the provisions of the *Health Insurance Act 1973* and *Regulations*, a Medicare benefit is not payable for a professional service unless it is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of the service, the following particulars

(i) patient's name;
(ii) the date the professional service was rendered;
(iii) the amount charged for the service;
(iv) the total amount paid in respect of the service;
(v) any amount outstanding in respect of the service;
(vi) for professional services rendered to a patient as part of a privately insured episode of hospital treatment; an asterisk '*' directly after an item number where used; or a description of the professional service sufficient to identify the item that relates to that service, preceded by the word 'admitted patient' ;
(vii) for professional services rendered as part of a privately insured episode of hospital-substitute treatment and the patient who receives the treatment chooses to receive a benefit from a private health insurer, the words ‘hospital-substitute treatment’ directly after an item number where used; or a description of the professional service sufficient to identify the item that relates to that service, preceded by the words ‘hospital-substitute treatment’;
(viii) the name and practice address or name and provider number of the practitioner who actually rendered the service; (where the practitioner has more than one practice location recorded with Medicare Australia, the provider number used should be that which is applicable to the practice location at or from which the service was given);
(ix) the name and practice address or name and provider number of the practitioner claiming or receiving payment of benefits, or assignment of benefit:-
  - -for services in Groups A1 to A14, D1, T1, T4 to T9 of the General Medical Services, Groups O1 to O7 (Oral and Maxillofacial services), and Group P9 of Pathology - where the person claiming payment is NOT the person who rendered the service;
  - -for services in Groups D2, T2, T3, I2, to I5 - for every service;
(x) if the service was a Specified Simple Basic Pathology Test (listed in Category 6 - Pathology, Group P9 of the Schedule) that was determined necessary by a practitioner who is another member of the same group medical practice, the surname and initials of that other practitioner;
(xi) where a practitioner has attended the patient on more than one occasion on the same day and on each occasion rendered a professional service to which an item in Category 1 of the Medicare Benefits Schedule relates (i.e. professional attendances), the time at which each such attendance commenced; and

(xii) where the professional service was rendered by a consultant physician or a specialist in the practice of his/her speciality to a patient who has been referred:- (a) the name of the referring medical practitioner; (b) the address of the place of practice or provider number for that place of practice; (c) the date of the referral; and (d) the period of referral (where other than for 12 months) expressed in months, e.g. "3", "6" or "18" months, or "indefinitely".

NOTE: If the information required to be recorded on accounts, receipts or assignment of benefit forms is included by an employee of the practitioner, the practitioner claiming payment for the service bears responsibility for the accuracy and completeness of the information.

Practitioners should note that payment of claims could be delayed or disallowed where it is not possible from account details to clearly identify the service as one which qualifies for Medicare benefits, or the practitioner as a registered medical practitioner at the address the service was rendered. Practitioners are therefore encouraged to provide as much detail as possible on their accounts, including Medicare Benefits Schedule item number and provider number.

The *Private Health Insurance Act 2007* provides for the payment of private health insurance benefits for hospital treatment and general treatment. Hospital treatment is treatment that is intended to manage a disease, injury or condition that is provided to an insured person by a hospital or arranged with the direct involvement of a hospital. General treatment is treatment that is intended to manage or prevent a disease, injury or condition and is not hospital treatment. Hospital-substitute treatment is a sub-set of General Treatment and a direct substitute for an episode of hospital treatment. Health insurers can cover specific professional services as hospital-substitute treatment in accordance with the *Private Health Insurance (Health Insurance Business) Rules*.

Claiming of Benefits
The patient, upon receipt of a doctor's account, has three courses open for paying the account and receiving benefits.

Paid Accounts
The patient may pay the account and subsequently present the receipt at a Medicare customer service centre for assessment and payment of the Medicare benefit in cash.

In these circumstances, where a claimant personally attends a Medicare office to obtain a cash or EFT deposit for the payment of Medicare benefits, the claimant is not required to complete a Medicare Patient Claim Form (PC1).

A Medicare patient claim form (PC1) must be completed where the claimant is mailing his/her claim for a cheque or EFT payment of Medicare benefits or arranging for an agent to collect cash on the claimant's behalf at a Medicare office.

Alternatively a patient may lodge their claim electronically from the doctors' surgery using Medicare Australia's Online claiming.

Claims for professional services rendered as part of an episode of hospital-substitute treatment should be submitted to the health insurer in the first instance for the payment of private health insurance benefits. The insurer of the patient will forward the claim to Medicare Australia for the payment of Medicare benefits

Unpaid and Partially Paid Accounts
Where the patient has not paid the account, the unpaid account may be presented to Medicare with a Medicare claim form. In this case Medicare will forward to the claimant a benefit cheque made payable to the doctor.

It will be the patient's responsibility to forward the cheque to the doctor and make arrangements for payment of the balance of the account if any. "Pay doctor" cheques involving Medicare benefits, must (by law), not be sent direct to medical practitioners or to patients at a doctor's address (even when the claimant requests this). "Pay doctor" cheques are required to be forwarded to the claimant's last known address.

When issuing a receipt to a patient for an account that is being paid wholly or in part by a Medicare "pay doctor" cheque the medical practitioner should indicate on the receipt that a "Medicare" cheque for $..... was included in the payment of the account.

Where a patient has reached the relevant extended Medicare safety net threshold, the Medicare benefit payable is the Medicare rebate for the service plus 80% of the out-of-pocket cost of the service (ie difference between the fee charged by the doctor and the Medicare rebate). The patient must pay at least 20% of the out-of-pocket cost of the account before extended Medicare safety net benefits become payable for the out-of-pocket cost. Medicare will apportion the benefit accordingly.

Claims for professional services rendered as part of an episode of hospital-substitute treatment should be submitted to the

health insurer in the first instance for the payment of private health insurance benefits. The insurer of the patient will forward the claim to Medicare Australia for the payment of Medicare benefits.

Assignment of Benefit (Direct – Billing) Arrangements
Under the Health Insurance Act an Assignment of Benefit (direct-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need.

If a medical practitioner direct-bills, he/she undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient, with the exception of certain vaccines.

Under these arrangements:-

- the patient's Medicare number must be quoted on all direct-bill assignment forms for that patient;
- the assignment forms provided are loose leaf to enable the patient details to be imprinted from the Medicare Card;
- the forms include information required by Regulations under Section 19(6) of the Health Insurance Act;
- the doctor must cause the particulars relating to the professional service to be set out on the assignment form, before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it;
- where a patient is unable to sign the assignment form, the signature of the patient's parent, guardian or other responsible person (other than the doctor, doctor's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff) is acceptable. The reason the patient is unable to sign should also be stated. In the absence of a "responsible person" the patient signature section should be left blank and in the section headed 'Practitioner's Use', an explanation should be given as to why the patient was unable to sign (e.g. unconscious, injured hand etc.) and this note should be signed or initialled by the doctor. If in the opinion of the practitioner the reason is of such a "sensitive" nature that revealing it would constitute an unacceptable breach of patient confidentiality or unduly embarrass or distress the recipient of the patient's copy of the assignment of benefits form, a concessional reason "due to medical condition" to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases it is expected that the reason given will be more specific.
- Where the patient is direct-billed, an additional charge can **ONLY** be raised against the patient by the practitioner where the patient is provided with a vaccine/vaccines from the practitioner's own supply held on the practitioner's premises. This exemption only applies to general practitioners and other non-specialist practitioners in association with attendance items 3 to 96, 5000 to 5267 (inclusive) and item 10993 and only relates to vaccines that are not available to the patient free of charge through Commonwealth or State funding arrangements or available through the Pharmaceutical Benefits Scheme. The additional charge must only be to cover the supply of the vaccine.

Use of Medicare Cards in Direct Billing
The Medicare card plays an important part in direct billing as it can be used to imprint the patient details (including Medicare number) on the assignment forms. A special Medicare imprinter is used for this purpose and is available free of charge, on request, from Medicare.

The patient details can, of course, be entered on the assignment forms by hand, but the use of a card to imprint patient details assists practitioners and ensures accuracy of information. The latter is essential to ensure that the processing of a claim by Medicare is expedited.

The Medicare card number must be quoted on assignment forms. If the number is not available, then the direct-billing facility should not be used. To do so would incur a risk that the patient may not be eligible and Medicare benefits not payable.

Where a patient presents without a Medicare card and indicates that he/she has been issued with a card but does not know the details, the practitioner may contact a Medicare telephone enquiry number to obtain the number.

It is important for the practitioner to check the eligibility of patients to Medicare benefits by reference to the card, as enrolees have entitlement limited to the date shown on the card and some enrolees, eg certain visitors to Australia, have restricted access to Medicare (see paragraphs 3.4 and 3.5).

Assignment of Benefit Forms
To meet varying requirements the following types of stationery are available from Medicare Australia. Note that these are approved forms under the Health Insurance Act, and no other forms can be used to assign benefits without the approval of Medicare Australia.

(1) Form DB2-GP. This form is designed for the use of optical scanning equipment and is used to assign benefits for General Practitioner Services other than requested pathology, specialist and optometrical services. It is loose leaf for imprinting and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Practitioner copy and a Patient copy. There are 4 pre-printed items with provision for two other items. The form can also be used as an "offer to assign" when a request for pathology services is sent to an approved pathology practitioner and the patient does not attend the laboratory.

(2) Form DB2-OP. This form is designed for the use of optical scanning equipment and is used to assign benefits for optometrical services. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2-GP, except for content variations. This form may not be used as an offer to assign pathology services.

(3) Form DB2-OT. This form is designed for the use of optical scanning equipment and is used to assign benefits for all specialist services. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2-GP, except for content variations. There are no pre-printed items on this form.

(4) Form DB3. This is used to assign or offer to assign benefits for pathology tests rendered by approved pathology practitioners. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2, except for content variations. The form may not be used for services other than pathology.

(5) Form DB4. This is a continuous stationery version of the DB2, and has been designed for use on most office accounting machines.

(6) Form DB5. This is a continuous stationery form for pathology services which can be used on most office machines. It cannot be used to assign benefits and must therefore be accompanied by an offer to assign (Form DB2, DB3 or DB4) or other form approved by Medicare Australia for that purpose.

The Claim for Assigned Benefits (Form DB1N, DB1H)

Practitioners who accept assigned benefits must claim from Medicare using either Claim for Assigned Benefits form DB1N or DB1H. The DB1N form should be used where services are rendered to persons for treatment provided out of hospital or day hospital treatment. The DB1H form should be used where services are rendered to persons while hospital treatment is provided in a hospital or day hospital facility (other than public patients). Both forms have been designed to enable benefit for a claim to be directed to a practitioner other than the one who rendered the services. The facility is intended for use in situations such as where a short term locum is acting on behalf of the principal doctor and setting the locum up with a provider number and pay-group link for the principal doctor's practice is impractical. Practitioners should note that this facility cannot be used to generate payments to or through a person who does not have a provider number.

Each claim form must be accompanied by the assignment forms to which the claim relates.

The DB1N and DB1H are also loose leaf to enable imprinting of practitioner details using the special Medicare imprinter. For this purpose, practitioner cards, showing the practitioner's name, practice address and provider number are available from Medicare on request.

Direct-Bill Stationery (Forms DB6Ba & DB6Bb)

Medical practitioners wishing to direct-bill may obtain information on direct-bill stationery by telephoning 132150.

- Form DB6Ba. This form is used to order larger stocks of forms DB3, DB4 and DB5 (and where a practitioner uses these forms, DB1N and DB1H), kits for optical scanning stationery (which comprises DB2's (GP, OP and OT)), DB1's pre addressed envelopes and an instruction sheet for the use of direct-bill scanning stationery.
- Form DB6Bb. This form is used to order stocks of forms and additional products (including Medicare Safety Net forms and promotional material). These forms are available from Medicare.

Time Limits Applicable to Lodgement of Claims for Assigned Benefits

A time limit of two years applies to the lodgement of claims with Medicare under the direct-billing (assignment of benefits) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than two years earlier than the date the claim was lodged with Medicare.

Provision exists whereby in certain circumstances (eg hardship cases, third party workers' compensation cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the processing centre to which assigned claims are directed.

G.8.1. PROVISION FOR REVIEW OF INDIVIDUAL HEALTH PROFESSIONALS

The Professional Services Review (PSR) reviews and investigates service provision by health practitioners to determine if they have engaged in inappropriate practice when rendering or initiating Medicare services, or when prescribing or dispensing under the PBS.

Section 82 of the *Health Insurance Act 1973* defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude that it would be unacceptable to the general body of the members of the profession in which the practitioner was practicing when they rendered or initiated the services under review. It is also an offence under Section 82 for a person or officer of a body corporate to knowingly, recklessly or negligently cause or permit a practitioner employed by the person to engage in such conduct.

Medicare Australia monitors health practitioners' claiming patterns. Where Medicare Australia detects an anomaly, it may request the Director of PSR to review the practitioner's service provision. On receiving the request, the Director must decide whether to a conduct a review and in which manner the review will be conducted. The Director is authorized to require that documents and information be provided.

Following a review, the Director must:
(a) decide to take no further action; or
(b) enter into an agreement with the person under review (which must then be ratified by an independent Determining Authority); or
(c) refer the matter to a PSR Committee.

A PSR Committee normally comprises three medically qualified members, two of whom must be members of the same profession as the practitioner under review. However, up to two additional Committee members may be appointed to provide wider range of clinical expertise.

The Committee is authorized to:
(a) investigate any aspect of the provision of the referred services, and without being limited by the reasons given in the review request or by a Director's report following the review;
(b) hold hearings and require the person under review to attend and give evidence;
(c) require the production of documents (including clinical notes).

The methods available to a PSR Committee to investigate and quantify inappropriate practice are specified in legislation:
(a) Patterns of Services - The *Health Insurance (Professional Services Review) Regulations 1999* specify that when a general practitioner or other medical practitioner reaches or exceeds 80 or more attendances on each of 20 or more days in a 12-month period, they are deemed to have practiced inappropriately.

(i) A professional attendance means a service of a kind mentioned in group A1, A2, A5, A6, A7, A9, A11, A13, A14, A15, A16, A17, A18, A19, A20, A21, A22 or A23 of Part 3 of the General Medical Services Table.

(ii) If the practitioner can satisfy the PSR Committee that their pattern of service was as a result of exceptional circumstances, the quantum of inappropriate practice is reduce accordingly. Exceptional circumstances include, but are not limited to, those set out in the *Regulations*. These include:

a. an unusual occurrence;
b. the absence of other medical services for the practitioner's patients (having regard to the practice location); and
c. the characteristics of the patients.

(b) Sampling - A PSR Committee may use statistically valid methods to sample the clinical or practice records.

(c) Generic findings - If a PSR Committee cannot use patterns of service or sampling (for example, there are insufficient medical records), it can make a 'generic' finding of inappropriate practice.

Additional Information
A PSR Committee may not make a finding of inappropriate practice unless it has given the person under review notice of its intention to review them, the reasons for its findings, and an opportunity to respond. In reaching their decision, a PSR Committee is required to consider whether or not the practitioner has kept adequate and contemporaneous patient records (See general explanatory note G15.1 for more information on adequate and contemporaneous patient records).

The practitioner under review is permitted to make submissions to the PSR Committee before key decisions or a final report is made.

If a PSR Committee finds that the person under review has engaged in inappropriate practice, the findings will be reported to the Determining Authority to decide what action should be taken:
(i) a reprimand;
(ii) counselling;
(iii) repayment of Medicare benefits; and/or
(iv) complete or partial disqualification from Medicare benefit arrangements for up to three years.

Further information is available from the PSR website - www.psr.gov.au

G.8.2. MEDICARE PARTICIPATION REVIEW COMMITTEE

The Medicare Participation Review Committee determines what administrative action should be taken against a practitioner who:

(a) has been successfully prosecuted for relevant criminal offences;
(b) has breached an Approved Pathology Practitioner undertaking;
(c) has engaged in prohibited diagnostic imaging practices; or
(d) has been found to have engaged in inappropriate practice under the Professional Services Review scheme and has received Final Determinations on two (or more) occasions.

The Committee can take no further action, counsel or reprimand the practitioner, or determine that the practitioner be disqualified from Medicare for a particular period or in relation to particular services for up to five years.

Medicare benefits are not payable in respect of services rendered by a practitioner who has been fully disqualified, or partly disqualified in relation to relevant services under the *Health Insurance Act 1973* (Section 19B applies).

G.8.3. REFERRAL OF PROFESSIONAL ISSUES TO REGULATORY AND OTHER BODIES

The *Health Insurance Act 1973* provides for the following referral, to an appropriate regulatory body:

i. a significant threat to a person's life or health, when caused or is being caused or is likely to be caused by the conduct of the practitioner under review; or
ii. a statement of concerns of non-compliance by a practitioner with 'professional standards'.

G.8.4. MEDICARE BENEFITS CONSULTATIVE COMMITTEE

The Medicare Benefits Consultative Committee (MBCC) is an informal consultative forum established by agreement between the Department of Health and Ageing and the Australian Medical Association (AMA) to facilitate discussion on reviews of the Medicare Benefits Schedule (MBS). (Note that reviews of the Diagnostic Imaging and Pathology Services are conducted under other arrangements.) Representation is drawn from the Department of Health and Ageing, Medicare Australia, the AMA and relevant craft groups of the medical profession.

The major function of the consultative process is to review particular services or groups of services within the Schedule, including consideration of new items and appropriate fee levels, to ensure that the Schedule reflects and encourages appropriate clinical practice.

It is Government policy that reviews of Schedule items conducted under the auspices of the MBCC will be on a **cost neutral basis**, except for genuinely new items where consideration will be given to providing additional funding.

Proposals for listing of new procedures

A specific item for a new procedure is not included in the Schedule until the safety, efficacy and cost effectiveness of the procedure have been established. Through a government initiative to strengthen the evidence base of the Schedule, the Medicare Services Advisory Committee (MSAC) has been established to advise the Minister for Health and Ageing on the strength of evidence pertaining to new and emerging medical technologies and procedures in relation to their safety, effectiveness and cost effectiveness, and under what circumstances public funding should be supported for these services.

MSAC's activities complement the MBCC process. Accordingly, applications for the inclusion of new services in the MBS should be referred to MSAC for independent evaluation. The MSAC application process differs from the requirements for submissions to MBCC in that applications for evaluation of new procedures are accepted from individuals and medical industry, as well as the medical profession.

Following approval by the Minister of an MSAC recommendation for public funding of a new procedure, an appropriate MBS listing for the service will be negotiated through the MBCC process.

Proposals for revised or new item descriptors

Individual practitioners seeking changes to the MBS should seek the support of their relevant craft group or association which can pursue the matter on their behalf through the AMA to the Medicare Benefits Branch of the Department.

An MBCC submission has the capacity to impact significantly on government outlays and must provide information to allow informed decisions to be made. While this can often be seen as bureaucratic to the profession, it is a necessary part of the accountability process for public funds.

While the complexity of information provided will reflect the extent of the review being requested, submissions for amendment to items of service already listed in the MBS should generally include details as listed below.

While reviews, in the main, relate to therapeutic procedures, the Schedule items covering diagnostic and non-procedural therapeutic items on the Schedule may also require review from time to time.

Requirements for submissions

- The rationale for the change - For example, the change may be a result of developments in medical practice.
- An outline of surgical procedures to be covered - Advice should include a description of the procedure, procedural times, and duration and complexity of aftercare required.
- Supporting evidence of the safety and efficacy of procedures - Relevant journal or review articles, or literature references, should be attached. This will assist in assessing whether a particular procedure may need to be evaluated by MSAC. Identification of approval by relevant regulatory authorities where relevant must be included.
- Revised item descriptors - Suggestions for new/revised descriptors should provide an accurate description of the service covered. Definitions such as 'wide' or 'deep', 'minor' or 'major, 'short' or 'long' etc. should be avoided. Necessary restrictions between the new and existing items must be identified. Relevant clinical standards or additional specialist qualification must be identified.
- Advice as to whether surgical assistance for a procedure is warranted - The justification for a surgical assistant should be included.
- An estimate of annual utilisation of the proposed new/revised item - This should be based on expected or actual assessment of utilisation of the new item.
- A proposed fee (if a revised fee is being considered) - The derivation of the fee should be explained, eg. based on costing data or fee relativity to existing items. Any offsets should be identified, eg. other items that would not be claimed if the new/revised item was introduced.
- An outline of consultations already undertaken with other relevant craft groups.

Many areas of the Schedule are utilised by more than one craft group, and the MBCC process is designed to ensure that all relevant groups are involved in the consultative process.

Any consultation that has taken place should be outlined, and if possible, a statement indicating the level of agreement to the proposal among the relevant craft groups should be provided.

G.8.5. MEDICAL SERVICES ADVISORY COMMITTEE

The Medical Services Advisory Committee (MSAC) advises the Minister on the strength of evidence relating to the safety, effectiveness and cost effectiveness of new and emerging medical services and technologies and under what circumstances public funding, including listing on the MBS, should be supported.

MSAC members are appointed by the Minister and include specialist practitioners, general practitioners, health economists, a health consumer representative, health planning and administration experts and epidemiologists.

For more information on the MSAC refer to their website – www.msac.gov.au or email on msac.secretariat@health.gov.au or by phoning the MSAC secretariat on (02) 6289 6811.

G.8.6. PATHOLOGY SERVICES TABLE COMMITTEE

This Pathology Services Table Committee comprises six representatives from the interested professions and six from the Australian Government. Its primary role is to advise the Minister on the need for changes to the structure and content of the Pathology Services Table (except new medical services and technologies) including the level of fees.

G.8.7. MEDICARE CLAIMS REVIEW PANEL

There are MBS items which make the payment of Medicare benefits dependent on a 'demonstrated' clinical need. Services requiring prior approval are those covered by items 11222, 11225, 12207, 12215, 12217, 14124, 21965, 21997, 30214, 32501, 42771, 42783, 42786, 42789, 42792, 45019, 45020, 45528, 45557, 45558, 45559, 45585, 45586, 45588, 45639, 50125.

Claims for benefits for these services should be lodged with Medicare Australia for referral to the National Office of Medicare Australia for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable Medicare Australia to determine the eligibility of the service for the payment of benefits.

Practitioners may also apply to Medicare Australia for prospective approval for proposed surgery.

Applications for approval should be addressed to:
The MCRP Officer
PO Box 1001
Tuggeranong ACT 2901

G.9.1. PENALTIES AND LIABILITIES

Penalties of up to $10,000 or imprisonment for up to five years, or both, may be imposed on any person who makes a statement (oral or written) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used with a claim for benefits. In addition, any practitioner who is found guilty of such offences by a court shall be subject to examination by a Medicare Participation Review Committee and may be counselled or reprimanded or may have services wholly or partially disqualified from the Medicare benefit arrangements.

A penalty of up to $1,000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on a direct-billing form without the obligatory details having been entered on the form before the person signs, or who fails to cause a patient to be given a copy of the completed form.

G.10.1. SCHEDULE FEES AND MEDICARE BENEFITS

Medicare benefits are based on fees determined for each medical service. The fee is referred to in these notes as the "Schedule fee". The fee for any item listed in the MBS is that which is regarded as being reasonable on average for that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered.

In some cases two levels of fees are applied to the same service in General Medical Services, with each level of fee being allocated a separate item number. The item identified by the letter "S" applies in the case where the procedure has been rendered by a recognised specialist in the practice of his or her speciality and the patient has been referred. The item identified by the letter "G" applies in any other circumstances.

As a general rule Schedule fees are adjusted on an annual basis, usually in November.

The Schedule fee and Medicare benefit levels for the medical services contained in the MBS are located with the item descriptions. Where appropriate, the calculated benefit has been rounded to the nearest higher 5 cents. However, in no circumstances will the Medicare benefit payable exceed the fee actually charged.

There are presently three levels of Medicare benefit payable:

(a) **75% of the Schedule fee:**
   i. for professional services rendered to a privately insured patient as part of an episode of hospital treatment (other than public patients). Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '*' directly after an item number where used; or a description of the professional service, preceded by the word 'patient';
   ii. for professional services rendered as part of an episode of hospital-substitute treatment, and the patient who receives the treatment chooses to receive a benefit from a private health insurer. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service, preceded by the words 'hospital-substitute treatment'.

(b) **100% of the Schedule fee** for non-referred attendances by general practitioners to non-admitted patients and services provided by a practice nurse or registered Aboriginal Health Worker on behalf of a general practitioner.

(c) **85% of the Schedule fee,** or the Schedule fee less $69.10 (indexed annually), whichever is the greater, for all other professional services.

Public hospital services are available free of charge to eligible persons who choose to be treated as public patients.

A medical service rendered to a patient on the day of admission to, or day of discharge from hospital, *but prior to admission or subsequent to discharge*, will attract benefits at the 85% or 100% level, not 75%. This also applies to a pathology service rendered to a patient prior to admission. Attendances on patients at a hospital (other than patients covered by paragraph (i) above) attract benefits at the 85% level.

The 75% benefit level applies even though a portion of the service (eg. aftercare) may be rendered outside the hospital. With regard to obstetric items, benefits would be attracted at the 75% level where the confinement takes place in hospital.

Pathology tests performed after discharge from hospital on bodily specimens taken during hospitalisation also attract the 75% level of benefits.

It should be noted that private health insurers can cover the "patient gap" (that is, the difference between the Medicare rebate and the Schedule fee) for services attracting benefits at the 75% level. Patient's may insure with private health insurers for the gap between the 75% Medicare benefits and the Schedule fee or for amounts in excess of the Schedule fee where the doctor has an arrangement with their health insurer.

G.10.2. MEDICARE SAFETY NETS

'Out-of-pocket' expenses are the difference between the fee the practitioner charges and the Medicare benefit paid to the patient. Patients are protected against high out-of-pocket expenses for non-admitted services listed in the MBS, by the 'original' Medicare safety net and the 'extended' Medicare safety net:

(a). Under the extended Medicare safety net, Medicare rebates 80% of out-of-pocket expenses for non-admitted Medicare services, once an annual threshold of out-of-pocket expenses is reached. In 2009, concession cardholders, families receiving Family Tax Benefit (Part A) and families that qualify for notional Family Tax Benefit (Part A) are eligible for the extended Medicare safety net when their cumulative out-of-pocket expenses reach $555.70; all other singles, couples and families are eligible when their cumulative out-of-pocket expenses reach $1,111.60. The extended Medicare safety net operates with the original safety net.

(b). Under the original safety net, the Medicare benefit for non-admitted services increases to 100% of the Schedule fee, once the cumulative 'gap amounts' reach an annual threshold. In 2009 the threshold amount is $383.90. The 'gap amount' refers to the amount between the Medicare benefit and the Schedule fee. Thereafter, any remaining out-of-pocket expenses count towards meeting the extended Medicare safety net threshold.

The thresholds for the original and extended Medicare safety nets are indexed on 1 January each year.

While individuals are automatically registered with Medicare Australia for the safety nets, couples and families must register themselves to be eligible. Registration forms can be obtained from Medicare Australia offices or completed online at www.medicareaustralia.gov.au

G.11.1. SERVICES NOT LISTED IN THE MBS

Benefits are not generally payable for services not listed in the MBS. However, there are some procedural services which are not specifically listed because they are regarded as forming part of a consultation or else attract benefits on an attendance basis. For example, intramuscular injections, aspiration needle biopsy, treatment of sebhorreic keratoses and less than 10 solar keratoses by ablative techniques and closed reduction of the toe (other than the great toe).

Enquiries about services not listed or on matters of interpretation should be directed to Medicare Australia. The following telephone numbers 132 150 is reserved for MBS enquiries.

G.11.2. MINISTERIAL DETERMINATIONS

Section 3C of the *Health Insurance Act 1973* empowers the Minister to determine an item and Schedule fee (for the purposes of the Medicare benefits arrangements) for a service not included in the health insurance legislation. This provision may be used to facilitate payment of benefits for new developed procedures or techniques where close monitoring is desirable. Services which have received section 3C approval are located in their relevant Groups in the MBS with the notation "**(Ministerial Determination)**".

G.12.1. PROFESSIONAL SERVICES

Professional services which attract Medicare benefits include medical services rendered by or "on behalf of" a medical practitioner. The latter include services where a part of the service is performed by a technician employed by or, in accordance with accepted medical practice, acting under the supervision of the medical practitioner.

The H*ealth Insurance Regulations 1975* specify that the following medical services will attract benefits only if they have been personally performed by a medical practitioner on not more than one patient on the one occasion (i.e. two or more patients cannot be attended simultaneously, although patients may be seen consecutively), unless a group session is involved (i.e. Items 170-172). The requirement of "personal performance" is met whether or not assistance is provided, according to accepted medical standards:-

(a) All Category 1 (Professional Attendances) items (except 170-172, 342-346);
(b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11212, 11304, 11500, 11600, 11601, 11627, 11701, 11712, 11724, 11921, 12000, 12003;
(c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13709, 13750-13760, 13915-13948, 14050, 14053, 14218, 14221 and 14224);

(d) Item 15600 in Group T2 (Radiation Oncology);
(e) All Group T3 (Therapeutic Nuclear Medicine) items;
(f) All Group T4 (Obstetrics) items (except 16400 and 16514);
(g) All Group T6 (Anaesthetics) items;
(h) All Group T7 (Regional or Field Nerve Block) items;
(i) All Group T8 (Operations) items;
(j) All Group T9 (Assistance at Operations) items;
(k) All Group T10 (Relative Value Guide for Anaesthetics) items.

For the group psychotherapy and family group therapy services covered by Items 170, 171, 172, 342, 344 and 346, benefits are payable only if the services have been conducted personally by the medical practitioner.

Medicare benefits are not payable for these group items or any of the items listed in (a) - (k) above when the service is rendered by a medical practitioner employed by the proprietor of a hospital (not being a private hospital), except where the practitioner is exercising their right of private practice, or is performing a medical service outside the hospital. For example, benefits are not paid when a hospital intern or registrar performs a service at the request of a staff specialist or visiting medical officer.

G.12.2. SERVICES RENDERED ON BEHALF OF MEDICAL PRACTITIONERS

Medical services in Categories 2 and 3 not included in the list above and Category 5 (Diagnostic Imaging) services continue to attract Medicare benefits if the service is rendered by:-
(a) the medical practitioner in whose name the service is being claimed;
(b) a person, other than a medical practitioner, who is employed by a medical practitioner or, in accordance with accepted medical practice, acts under the supervision of a medical practitioner.

See Category 6 Notes for Guidance for arrangements relating to Pathology services.

So that a service rendered by an employee or under the supervision of a medical practitioner may attract a Medicare rebate, the service must be billed in the name of the practitioner who must accept full responsibility for the service. Medicare Australia must be satisfied with the employment and supervision arrangements. While the supervising medical practitioner need not be present for the entire service, they must have a direct involvement in at least part of the service. Although the supervision requirements will vary according to the service in question, they will, as a general rule, be satisfied where the medical practitioner has:-
(a) established consistent quality assurance procedures for the data acquisition; and
(b) personally analysed the data and written the report.

Benefits are not payable for these services when a medical practitioner refers patients to self-employed medical or paramedical personnel, such as radiographers and audiologists, who either bill the patient or the practitioner requesting the service.

G.12.3. MASS IMMUNISATION

Medicare benefits are payable for a professional attendance that includes an immunisation, provided that the actual administration of the vaccine is not specifically funded through any other Commonwealth or State Government program, nor through an international or private organisation.

The location of the service, or advertising of it, or the number of patients presenting together for it, normally do not indicate a mass immunisation.

G.13.1. SERVICES WHICH DO NOT ATTRACT MEDICARE BENEFITS

Services not attracting benefits

- telephone consultations;
- issue of repeat prescriptions when the patient does not attend the surgery in person;
- group attendances (unless otherwise specified in the item, such as items 170, 171, 172, 342, 344 and 346);
- non-therapeutic cosmetic surgery;
- euthanasia and any service directly related to the procedure. However, services rendered for counselling/assessment about euthanasia will attract benefits.

Medicare benefits are not payable where the medical expenses for the service

- are paid/payable to a public hospital;
- are for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability. (Please note that if the medical expenses relate to a compensable injury/illness for which the insurer/compensation agency is disputing liability, then Medicare benefits are payable until the liability is accepted.);

- are for a medical examination for the purposes of life insurance, superannuation, a provident account scheme, or admission to membership of a friendly society;
- are incurred in mass immunisation (see General Explanatory Note 12 for further explanation).

Unless the Minister otherwise directs
Medicare benefits are not payable where:
- the service is rendered by or on behalf of, or under an arrangement with the Australian Government, a State or Territory, a local government body or an authority established under Commonwealth, State or Territory law;
- the medical expenses are incurred by the employer of the person to whom the service is rendered;
- the person to whom the service is rendered is employed in an industrial undertaking and that service is rendered for the purposes related to the operation of the undertaking; or
- the services is a health screening service.

Current regulations preclude the payment of Medicare benefits for professional services rendered in relation to or in association with:

(a) chelation therapy (that is, the intravenous administration of ethylenediamine tetra-acetic acid or any of its salts) other than for the treatment of heavy-metal poisoning;
(b) the injection of human chorionic gonadotrophin in the management of obesity;
(c) the use of hyperbaric oxygen therapy in the treatment of multiple sclerosis;
(d) the removal of tattoos;
(e) the transplantation of a thoracic or abdominal organ, other than a kidney, or of a part of an organ of that kind; or the transplantation of a kidney in conjunction with the transplantation of a thoracic or other abdominal organ, or part of an organ of that kind;
(f) the removal from a cadaver of kidneys for transplantation;
(g) the administration of microwave (UHF radio wave) cancer therapy, including the intravenous injection of drugs used in the therapy.

Pain pumps for post-operative pain management
The cannulation and/or catheterisation of surgical sites associated with pain pumps for post-operative pain management cannot be billed under any MBS item.

The filling or re-filling of drug reservoirs of ambulatory pain pumps for post-operative pain management cannot be billed under any MBS items.

Non Medicare Services
An item in the range 1 to 10943 does not apply to the service described in that item if the service is provided at the same time as, or in connection with, any of the services specified below

(a) Endoluminal gastroplication, for the treatment of gastro-oesophageal reflux disease;
(b) Endovenous laser treatment, for varicose veins;
(c) Gamma knife surgery;
(d) Intradiscal electro thermal arthroplasty;
(e) Intravascular ultrasound (except where used in conjunction with intravascular brachytherapy);
(f) Intro-articular viscosupplementation, for the treatment of osteoarthritis of the knee;
(g) Low intensity ultrasound treatment, for the acceleration of bone fracture healing, using a bone growth stimulator;
(h) Lung volume reduction surgery, for advanced emphysema;
(i) Photodynamic therapy, for skin and mucosal cancer;
(j) Placement of artificial bowel sphincters, in the management of faecal incontinence;
(k) Sacral nerve stimulation, for urinary incontinence;
(l) Selective internal radiation therapy for any condition other than hepatic metastases that are secondary to colorectal cancer;
(m) Specific mass measurement of bone alkaline phosphatase;
(n) Transmyocardial laser revascularisation;
(o) Vertebral axial decompression therapy, for chronic back pain.

Health Screening Services
Unless the Minister otherwise directs Medicare benefits are not payable for health screening services. A health screening service is defined as a medical examination or test that is not reasonably required for the management of the medical condition of the patient. Services covered by this proscription include such items as:
- multiphasic health screening;
- mammography screening (except as provided for in Items 59300/59303);
- testing of fitness to undergo physical training program, vocational activities or weight reduction programs;
- compulsory examinations and tests to obtain a flying, commercial driving or other licence;
- entrance to schools and other educational facilities;

- for the purposes of legal proceedings;
- compulsory examinations for admission to aged persons' accommodation and pathology services associated with clinical ecology.

The Minister has directed that Medicare benefits be paid for the following categories of health screening:

- a medical examination or test on a symptomless patient by that patient's own medical practitioner in the course of normal medical practice, to ensure the patient receives any medical advice or treatment necessary to maintain their state of health. Benefits would be payable for the attendance and tests which are considered reasonably necessary according to patients individual circumstances (such as age, physical condition, past personal and family history). For example, a Papanicolaou test in a woman (see General Explanatory note 13.6.4 for more information), blood lipid estimation where a person has a family history of lipid disorder. However, such routine check up should not necessarily be accompanied by an extensive battery of diagnostic investigations;
- a pathology service requested by the National Heart Foundation of Australia, Risk Evaluation Service;
- age or health related medical examinations to obtain or renew a licence to drive a private motor vehicle;
- a medical examination of, and/or blood collection from persons occupationally exposed to sexual transmission of disease, in line with conditions determined by the relevant State or Territory health authority, (one examination or collection per person per week). Benefits are not paid for pathology tests resulting from the examination or collection;
- a medical examination being a condition of child adoption or fostering;
- a medical examination being a requisite for Social Security benefits or allowances;
- a medical or optometrical examination provided to a person who is an unemployed person (as defined by the *Social Security Act 1991)*, as the request of a prospective employer.

The National Policy on screening for the Prevention of Cervical Cancer (endorsed by the Royal Australian College of General Practitioners, the Royal Australian College of Obstetricians and Gynaecologists, the Royal College of Pathologists of Australasia, the Australian Cancer Society and the National Health and Medical Research Council) is as follows:-

- an examination interval of two years for women who have no symptoms or history suggestive of abnormal cervical cytology, commencing between the ages of 18 to 20 years, or one or two years after first sexual intercourse, whichever is later;
- cessation of cervical smears at 70 years for women who have had two normal results within the last five years. Women over 70 who have never been examined, or who request a cervical smear, should be examined.

Note 1: As separate items exist for routine examination of cervical smears, treating practitioners are asked to clearly identify on the request form to the pathologist, if the smear has been taken as a routine examination or for the management of a previously detected abnormality (see paragraph PP.11 of Pathology Services Explanatory Notes in Category 6).

Note 2: See items 2501 to 2509, and 2600 to 2616 in Group A18 and A19 of Category 1 – Professional Attendances and the associated explanatory notes for these items in Category 1 – Professional Attendances.

Services rendered to a doctor's dependants, practice partner, or practice partner's dependants

Generally, Medicare benefits are not paid for professional services rendered by a medical practitioner to dependants or partners or a partner's dependants.

A 'dependant' person is a spouse or a child. The following provides definitions of these dependant persons:

a spouse, in relation to a dependant person means:
(a) a person who is legally married to, and is not living, on a permanent basis, separately and apart from, that person; and
(b) a de facto spouse of that person.

a child, in relation to a dependant person means:
(a) a child under the age of 16 years who is in the custody, care and control of the person or the spouse of the person; and
(b) a person who:
(i) has attained the age of 16 years who is in the custody, care and control of the person of the spouse of the person; or
(ii) is receiving full time education at a school, college or university; and
(iii) is not being paid a disability support pension under the Social Security Act 1991; and
(iv) is wholly or substantially dependent on the person or on the spouse of the person.

G.14.1. PRINCIPLES OF INTERPRETATION OF THE MBS

Each professional service listed in the MBS is a complete medical service. Where a listed service is also a component of a more comprehensive service covered by another item, the benefit for the latter service will cover the former.

Where a service is rendered partly by one medical practitioner and partly by another, only the one amount of benefit is payable. For example, where a radiographic examination is started by one medical practitioner and finalised by another.

G.14.2. SERVICES ATTRACTING BENEFITS ON AN ATTENDANCE BASIS

Some services are not listed in the MBS because they are regarded as forming part of a consultation or they attract benefits on an attendance basis. Some of these services are identified in the indexes to this book with an (*).

G.14.3. CONSULTATION AND PROCEDURES RENDERED AT THE ONE ATTENDANCE

Where, during a single attendance, a consultation (under Category 1 of the MBS) and another medical service (under any other Category of the Schedule) occur, benefits are payable subject to certain exceptions, for both the consultation and the other service. Benefits are not payable for the consultation in addition to an item rendered on the same occasion where the item is qualified by words such as "each attendance", "attendance at which", “including associated attendances/consultations", and all items in Group T6 and T9. In the case of radiotherapy treatment (Group T2 of Category 3) benefits are payable for both the radiotherapy and an initial referred consultation.

Where the level of benefit for an attendance depends upon the consultation time (for example, in psychiatry), the time spent in carrying out a procedure which is covered by another item in the MBS, may not be included in the consultation time.

A consultation fee may only be charged if a consultation occurs; that is, it is not expected that consultation fee will be charged on every occasion a procedure is performed.

G.14.4. AGGREGATE ITEMS

The MBS includes a number of items which apply only in conjunction with another specified service listed in the MBS. These items provide for the application of a fixed loading or factor to the fee and benefit for the service with which they are rendered.

When these particular procedures are rendered in conjunction, the legislation provides for the procedures to be regarded as one service and for a single patient gap to apply. The Schedule fee for the service will be ascertained in accordance with the particular rules shown in the relevant items.

G.14.5. RESIDENTIAL AGED CARE FACILITY

A residential aged care facility is defined in the *Aged Care Act 1997*; the definition includes facilities formerly known as nursing homes and hostels.

G.15.1. PRACTITIONERS SHOULD MAINTAIN ADEQUATE AND CONTEMPORANEOUS RECORDS

All practitioners who provide, or initiate, a service for which a Medicare benefit is payable, should ensure they maintain **adequate** and **contemporaneous** records.
Note: 'Practitioner' is defined in Section 81 of the *Health Insurance Act 1973* and includes: medical practitioners, dentists, optometrists, chiropractors, physiotherapists, podiatrists and osteopaths.

Since 1 November 1999 PSR Committees determining issues of inappropriate practice have been obliged to consider if the practitioner kept adequate and contemporaneous records. It will be up to the peer judgement of the PSR Committee to decide if a practitioner’s records meet the prescribed standards.

The standards which determine if a record is adequate and contemporaneous are prescribed in the *Health Insurance (Professional Services Review) Regulations 1999*.

To be ***adequate***, the patient or clinical record needs to:

- clearly identify the name of the patient; and
- contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated; and
- each entry needs to provide clinical information adequate to explain the type of service rendered or initiated; and
- each entry needs to be sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the patient’s ongoing care.

To be ***contemporaneous***, the patient or clinical record should be completed at the time that the service was rendered or initiated or as soon as practicable afterwards. Records for hospital patients are usually kept by the hospital and the practitioner could rely on these records to document in-patient care.

DIAGNOSTIC IMAGING SERVICES

CATEGORY 5

SUMMARY OF CHANGES

The 1/01/2010 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

New items

58120 58121

Amended Descriptions

63464

Fee Amended

58108 58115

EMSN Change

55700 55703 55704 55705 55706 55707 55708 55709 55715 55718 55721 55723 55725 55729

55762 55764 55766 55768 55770 55722 55774

DIA... DIAGNOSTIC IMAGING SERVICES - OVERVIEW

Section 4AA of the *Health Insurance Act 1973* (the Act) enables the *Health Insurance (Diagnostic Imaging Services Table) Regulations* to prescribe a table of diagnostic imaging services that sets out rules for interpretation of the table, items of diagnostic imaging services and the amount of fees applicable to each item.

For further information on diagnostic imaging, visit the Department of Health and Ageing website at www.health.gov.au

DIB... WHAT IS A DIAGNOSTIC IMAGING SERVICE

A diagnostic imaging service is defined in the Act as meaning "an R-type diagnostic imaging service or an NR-type diagnostic imaging service to which an item in the DIST applies".

A diagnostic imaging procedure is defined in the Act as 'a procedure for the production of images (for example x-rays, computerised tomography scans, ultrasound scans, magnetic resonance imaging scans and nuclear scans) for use in the rendering of diagnostic imaging services'.

The Schedule fee for each diagnostic imaging service described in the DIST covers both the diagnostic imaging procedure and the reading and report on that procedure by the diagnostic imaging service provider. Exceptions to the reporting requirement are as follows:

(a) where the service is provided in conjunction with a surgical procedure, the findings may be noted on the operation record (items 55054, 55130, 55135, 55848, 55850, 57341, 57345, 59312, 59314, 60506, 60509 and 61109);
(b) where a service is provided in preparation of a radiological procedure (items 60918 and 60927).

As for all Medicare services, diagnostic imaging services have to be clinically relevant before they are eligible for Medicare benefits. A clinically relevant service is a service that is generally accepted in the profession as being necessary for the appropriate treatment of the patient.

For NR-type services (and R-type services provided without a request under the exemption provisions – see DID – 'Exemptions from the written request requirements for R-type diagnostic imaging services'), the clinical relevance of the service is determined by the **providing practitioner**. For R-type services rendered at the request of another practitioner, responsibility for determining the clinical relevance of the service lies with the **requesting practitioner.**

DIC... WHO MAY PROVIDE A DIAGNOSTIC IIMAGING SERVICE

Unless otherwise stated, a diagnostic imaging service specified in the DIST may be provided by:

(a) a medical practitioner; or
(b) a person, other than a medical practitioner, who:
  (i) is employed by a medical practitioner; or
  (ii) provides the service under the supervision of a medical practitioner in accordance with accepted medical practice.

For the purposes of Medicare, however, the rendering practitioner is the medical practitioner who provides the report.

Medicare benefits are not payable, for example, when a medical practitioner refers patients to self-employed paramedical personnel, such as radiographers or other persons, who either bill the patient or the practitioner requesting the service.

Reports provided by practitioners located outside Australia
Under the Act, Medicare benefits are only payable for services rendered in Australia. Where a service consists of a number of components, such as a diagnostic imaging service, all components need to be rendered in Australia in order to qualify for Medicare benefits. For diagnostic imaging services, this means that all elements of the service, including the preparation of report on the procedure, would need to be rendered in Australia.

As such, Medicare benefits are not payable for services which have been reported on by medical practitioners located outside Australia.

DID... REQUESTS FOR DIAGNOSTIC IMAGING SERVICES

Request requirements
Medicare benefits are not payable for diagnostic imaging services that are classified as R-type (requested) services unless prior to commencing the relevant service, the practitioner receives a signed and dated request from a requesting practitioner who determined the service was necessary.

Before requesting a diagnostic imaging service, the requesting practitioner must turn his or her mind to the clinical relevance of the request and determine that the service is necessary for the appropriate professional care of the patient. For example: an ultrasound to determine the sex of a foetus is not a clinically relevant service (unless there is an indication that the sex of the foetus will determine further courses of treatment, eg. a genetic background to a sex-related disease or condition).

There are exemptions to the request requirements in specified circumstances. These circumstances are detailed under DID -'Exemptions from the written request requirements for R-type diagnostic imaging services'

Who may request a diagnostic imaging service

The following practitioners may request a diagnostic imaging service:

- Specialists and consultant physicians can request any diagnostic imaging service.
- Other medical practitioners can request any service except Magnetic Resonance Imaging Services – see DIO.
- A medical practitioner, on behalf of the treating practitioner, for example, by a resident medical officer at a hospital on behalf of the patient's treating practitioner.
- Dental Practitioners, Physiotherapists, Chiropractors, Osteopaths and Podiatrists registered or licensed under State or Territory laws can request the following diagnostic imaging services:

All dental practitioners may request the following items:
57509, 57515, 57521, 57527, 57901, 57902, 57903, 57906, 57909, 57912, 57915, 57918, 57921, 57924, 57927, 57930, 57933, 57939, 57942, 57945, 57960, 57963, 57966, 57969, 58100, 58300, 58503, 58903, 59733, 59739, 59751, 60100, 60500, 60503.

In addition to these items, oral and maxillofacial surgeons, prosthodontists, dental specialists (periodontists, endodontists, pedodontists, orthodontists) and specialists in oral medicine and oral pathology are also able to request the following items:

Oral and maxillofacial surgeons
55028, 55030, 55032, 56001, 56007, 56010, 56013, 56016, 56022, 56028, 56030, 56036, 56041, 56047 56050, 56053, 56056, 56062, 56068, 56070, 56076, 56101, 56107, 56141, 56147, 56219, 56220, 56224, 56227, 56230, 56259, 56301, 56307, 56341, 56347, 56401, 56407, 56409, 56412, 56441, 56447, 56449, 56452, 56501, 56507, 56541, 56547, 56801, 56807, 56841, 56847, 57001, 57007, 57041, 57047, 57341, 57345, 57703, 57709, 57712, 57715, 58103, 58106, 58108, 58109, 58112, 58115, 58306, 58506, 58521, 58524, 58527, 58909, 59103, 59703, 60000, 60003, 60006, 60009, 60506, 60509, 61109, 61372, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 63007, 63334.

Prosthodontists
55028, 56013, 56016, 56022, 56028, 56053, 56056, 56062, 56068, 58306, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 63334.

Dental specialists (periodontists, endodontists, pedeodontists, orthodontists).
56022, 56062, 58306, 61421, 61454, 61457, 63334.

Specialists in oral medicine and/or oral pathology
55028, 55030, 55032, 56001, 56007, 56010, 56013, 56016, 56022, 56028, 56041, 56047, 56050, 56053, 56056, 56062, 56068, 56101, 56107, 56141, 56147, 56301, 56307, 56341, 56347, 56401, 56407, 56441, 56447, 57341, 57345, 58306, 58506, 58909, 59103, 59703, 60000, 60003, 60006, 60009, 60506, 60509, 61109, 61372, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 63007, 63334.

Physiotherapists, Chiropractors and Osteopaths may request:
57712, 57715, 58100 to 58106 (inclusive), 58109, 58112, 58120 and 58121.

See Para DIM of explanatory notes.

Podiatrists may request:
55836, 55840, 55844, 57521, 57527.

Form of a request

Responsibility for the adequacy of requesting details rests with the requesting practitioner. A request for a diagnostic imaging service does not have to be in a particular form. However, the legislation provides that a request must be in writing and contain sufficient information, in terms that are generally understood by the profession, to clearly identify the item/s of service requested. This includes, where relevant, noting on the request the clinical indication(s) for the requested

service. The provision of additional relevant clinical information can often assist the service provider and enhance the overall service provided to the patient. As such, this practice is actively encouraged.
A written request must be signed and dated and contain the name and address or name and provider number in respect of the place of practice of the requesting practitioner.

Referral to specified provider not required
It is not necessary that a written request for a diagnostic imaging service be addressed to a particular provider or that, if the request is addressed to a particular provider, the service must be rendered by that provider.

Request for more than one service and limit on time to render services
The requesting practitioner may use a single request to order a number of diagnostic imaging services. However, all services provided under this request must be rendered within seven days after the rendering of the first service.

Contravention of request requirements
A practitioner who, without reasonable excuse makes a request for a diagnostic imaging service that does not include the required information in his or her request or in a request made on his or her behalf is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine of $1000.

A practitioner who renders "R-type" diagnostic imaging services and who, without reasonable excuse, provides either directly or indirectly to a requesting practitioner a document to be used in the making of a request which would contravene the request information requirements is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine of $1000.

Exemptions from the written request requirements for R-type diagnostic imaging services
There are exemptions from the general written request requirements (R-type) diagnostic imaging services and these are outlined as follows:

Consultant physician or specialist
A consultant physician or specialist is a medical practitioner recognised for the purposes of the *Health Insurance Act 1973* as a specialist or consultant physician, in a particular specialty.

Except for R-type items which in their description state that a referral is required (such as most R-type items in General Ultrasound and items 59300, 59303)**,** a written request is **not** required for the payment of Medicare benefits when the diagnostic imaging service is provided by or on behalf of a consultant physician or a specialist (other than a specialist in diagnostic radiology) in his or her specialty and after clinical assessment he/she determines that the service was necessary. For details required for accounts/receipts see DIF.

However, if in the referral to the consultant physician or specialist, the referring practitioner specifically requests a diagnostic imaging service (eg to a cardiologist to perform an echocardiogram) the service provided is a requested, not self-determined service. If further services are subsequently provided, these further services are self-determined – see *"Additional services"*.

Additional services
A written request is not required for a diagnostic imaging service if that service was provided after one which has been formally requested and the providing practitioner determines that, on the basis of the results obtained from the requested service, that an additional service was necessary. However, the following services cannot be self- determined as "additional services":

- R-type items which in their description (such as most R-type items in General Ultrasound and items 59300, 59303) state that a referral is required (practitioners should claim the NR item in these circumstances);
- MRI services; and
- services not otherwise able to be requested by the original requesting practitioner.

For details required for accounts/receipts see DIF.

Substituted services
A provider may substitute a service for the service originally requested when:

- the provider determines, from the clinical information provided on the request, that the substituted service would be more appropriate for the diagnosis of the patient's condition; and
- the provider has consulted with the requesting practitioner or taken all reasonable steps to do so before providing the substituted service; and
- the substituted service was one that would be accepted as a more appropriate service in the circumstances by the practitioner's speciality group.

However, the following services cannot be substituted:

- R-type items which in their description (such as most R-type items in General Ultrasound and items 59300, 59303) state that a referral is required;
- MRI services; and
- services not otherwise able to be requested by the original requesting practitioner.

For details required for accounts/receipts see DIF.

Remote areas
A written request is not required for the payment of Medicare benefits for a R-type diagnostic imaging service rendered by a medical practitioner in a remote area provided:

- the R-type service is not one for which there is a corresponding NR-type service; and
- the medical practitioner rendering the service has been granted a remote area exemption for that service.

For details required for accounts/receipts see DIF.

Definition of remote area
The definition of a remote area is one that is more than 30 kilometres by road from:

(a) a hospital which provides a radiology service under the direction of a specialist in the specialty of diagnostic radiology; and
(b) a free-standing radiology facility under the direction of a specialist in the specialty of diagnostic radiology.

Application for remote area exemption
A medical practitioner, other than a consultant physician or specialist, who believes that he or she qualifies for exemption under the remote area definition, should obtain an application form from Medicare Australia's website www.medicareaustralia.gov.au or by contacting Medicare Australia, Provider Liaison Section, on 132150 for the cost of a local call.

Quality assurance requirement for remote area exemption
Application for, or continuation of, a remote area exemption will be contingent on practitioners being enrolled in an approved continuing medical education and quality assurance program. For further information, please contact the Australian College of Rural and Remote Medicine (ACRRM) on (07) 3105 8200.

Emergencies
The written request requirement does not apply if the providing practitioner determines that, because the need for the service arose in an emergency, the service should be performed as quickly as possible.

For details required for accounts/receipts see DIF.

Lost requests
The written request requirement does not apply where:

- the person who received the diagnostic imaging service, or someone acting on that person's behalf, claimed that a written request had been made for such a service but that the request had been lost; and
- the provider of the diagnostic imaging service or that provider's agent or employee obtained confirmation from the requesting practitioner that the request had been made.

The lost request exemption is applicable only to services that the practitioner could originally request.

For details required for accounts/receipts see DIF.

Pre-existing diagnostic imaging practices
The legislation provides for exemption from the written request requirement for services provided by practitioners who have operated pre-existing diagnostic imaging practices. The exemption applies to the services covered by the following Items: 57712, 57715, 57901, 57902, 57903, 57912, 57915, 57921, 58100, 58103, 58106, 58108, 58109, 58112, 58115, 58521, 58524, 58527, 58700, 58924 and 59103.

To qualify for this "grandparent" exemption the providing practitioner must:
(a) be treating his or her own patient;

(b) have determined that the service was necessary;
(c) have rendered between 17 October 1988 and 16 October 1990 at least 50 services (which resulted in the payment of Medicare benefits) of the kind which have been designated "R-type" services from 1 May 1991;
(d) provide the exempted services at the practice location where the services which enabled the practitioner to qualify for the "grandparent" exemption were rendered; and
(e) be enrolled in an approved continuing medical education and quality assurance program from 1 January 2001. For further information, please contact the Royal Australian College of General Practitioners (RACGP) on (03) 8699 0414 or Australian College of Rural and Remote Medicine (ACRRM) on (07) 3105 8200.

Benefits are only payable for services exempted under these provisions where the service was provided by the exempted medical practitioner at the exempted location. Exemptions are not transferable.

For details required for accounts/receipts see DIF.

Retention of requests

A practitioner who has rendered an R-type diagnostic imaging service in response to a written request must retain that request for a period of 18 months commencing on the day on which the service was rendered.

A medical practitioner must, if requested by the Managing Director, Medicare Australia, produce written requests retained by that practitioner for an R-type diagnostic imaging service as soon as practicable or by the end of the day after the day on which the Managing Director's request was made. The officer of Medicare Australia is authorised to make and retain copies of or take and retain extracts from written requests or written confirmations of lost requests.

A medical practitioner who, without reasonable excuse, fails to comply with the above requirements is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine of $1000.

DIE... REGISTRATION OF SITE UNDERTAKING DIAGNOSTIC IMAGING PROCEDURES

All sites (including hospitals) and bases for mobile equipment at or from which diagnostic imaging procedures are performed need to be registered with Medicare Australia for the purposes of Medicare.

Registered sites and bases for mobile equipment are allocated a Location Specific Practice Number (LSPN). The LSPN is a unique identifier comprising a six digit numeric and is required on all accounts, receipts and Medicare assignment of benefits forms for diagnostic imaging services before patients can receive Medicare benefits. In addition, benefits are not payable unless there is equipment of appropriate type listed on the register for the practice.

Sites or bases for mobile equipment need only register once. To maintain registration, sites are required to advise Medicare Australia of any changes to their primary information within 28 days of the change occurring. Primary information is:

- proprietor details;
- ACN (for companies);
- business name and ABN;
- address of practice site or base for mobile equipment;
- type of equipment located at the site;
- information about any health care provider not employed at, or contracted to provide services for the site or base, who has an interest in any of the equipment listed on the register.

Every 12 months, Medicare Australia will send the proprietor or authorised representative details of the information contained on the register for the practice site or base for mobile equipment. These details need to be either confirmed or updated (if necessary).

Registration will be suspended if a proprietor fails to respond to notices from Medicare Australia about registration details. . The suspension will be lifted as soon as the notices are responded to and Medicare benefits will be backdated for the period of suspension.

Registration will be cancelled after a continuous period of three months suspension. Cancellation under these circumstances is taken to have commenced from the date of suspension.

The proprietor may, at any time, request cancellation of the registration of a practice site or base for mobile equipment. Otherwise, registration may be cancelled by Medicare Australia if the registration was obtained improperly (false information supplied) or if the proprietor fails to notify Medicare Australia of primary information. A decision to cancel a

registration will only be made following due consideration of a submission by the site or base. The proprietor may apply to the Administrative Appeals Tribunal for a review of this decision. If registration is cancelled involuntarily, the proprietor may not apply to re-register the site or base for a period of 12 months unless permitted to do so.

Proprietors of unregistered practices (including where the registration is under suspension or has been cancelled) need to either advise patients in writing or display a notice that no Medicare benefits will be payable for the diagnostic imaging services.

For full details about Location Specific Practice Numbers, including how to register a practice site. A list of LSPN registrations is available on Medicare Australia's website at www.medicaraustralia.gov.au/yourhealth/our_services/lspn_search.htm and this allows practitioners and the general public to verify the registration status of practice sites eligible for Medicare benefits.

ACCREDITATION OF SITES UNDERTAKING DIAGNOSTIC IMAGING SERVICES

Stage I of the Diagnostic Imaging Accreditation Scheme (the scheme) formally commenced on **1 July 2008**. From this date certain diagnostic imaging services must be carried out at an accredited practice site or from a practice site with 'deemed accreditation' to be eligible for Medicare benefits.

Stage I of the scheme concludes on 30 June 2010. Stage II of the scheme is under development. Stage II will commence on 1 July 2010.

The scheme covers the following diagnostic imaging services in the Diagnostic Imaging Services Table (DIST) of the Medicare Benefits Scheme. From 1 July 2008 if a practice site provides any of these services that site will need to have deemed accreditation or be accredited to provide those services under Medicare.

Modality Group	**Relevant items in the Diagnostic Imaging Services Table (DIST) of the Medicare Benefits Schedule (MBS)**
Ultrasound	All items in subgroups 1, 3, 4 & 6 of Group I1
Computed Tomography	All items in Group I2
General Radiology (X-Ray)	All items in subgroups 1, 2, 4-9 of Group I3; & Items 57901 – 57945 only in subgroup 3 of Group I3; & All items in subgroups 11, 12 & 14 of Group I3
Mammography	All items in subgroup 10 of Group I3
Angiography	Items 59970 & 59974 – 60078 only in subgroup 13 of Group I3
Fluoroscopy	All items in subgroups 15 & 17 of Group I3
Orthopantomography (OPG)	Items 57960, 57963, 57966 & 57969 only in subgroup 3 of Group I3
Magnetic Resonance Imaging (MRI)	All items in Group I5

The scheme does not include the following diagnostic imaging services. If the only diagnostic imaging services a practice site provides are those which are listed below, then that site will not need to be accredited (or deemed accredited) to provide those services under Medicare.

- Cardiac Ultrasound (Group I1, Subgroup 2: 55113-55135);
- Cardiac Angiography (Group I3, Subgroup 13; 59903, 59912, 59925, 59971, 59972 and 59973. Subgroup 16; 60918 and 60927)
- Obstetric and Gynaecological Ultrasound (Group I1, Subgroup 5; 55700 – 55774); and
- Nuclear Medicine Imaging (Group I4; 61302-61650)

Becoming Accredited under Stage 1

Practice sites with deemed accreditation

Practice sites which registered for accreditation by 30 June 2008 with an approved accreditor have deemed accreditation until 30 June 2009. Sites with deemed accreditation have until 30 June 2009 to submit to an approved accreditor either:

- An application for accreditation providing written documentary evidence of compliance with the accreditation standards; or
- Written evidence of accreditation under the Medical Imaging Accreditation Program (MIAP) jointly administered by the Royal Australian and New Zealand College of Radiologists (RANZCR) and the National Association of Testing Authorities Australia (NATA).

From the acceptance of the application, the approved accreditor has up to 6 months to undertake an audit of the evidence provided and make a decision regarding the grant of accreditation. The document audit is conducted off-site from the premises of the practice. Accreditation is granted until the expiration of Stage I of the scheme which is 30 June 2010.

Approved accreditors
The four approved accreditors are:

- Australian Council on Health Care Standards (ACHS) Ph: (02) 9281 9955
- Health and Disability Auditing Australia (HDAAu) Ph: 1800 601 696
- National Association of Testing Authorities (NATA) Ph: 1800 621 666
- Quality in Practice (QIP) Ph: 1300 888 329

Practice sites without deemed accreditation including practices which commence operation after 30 June 2008
Practice sites falling into this category are not covered by the transitional arrangements and are therefore not eligible to provide diagnostic imaging services under Medicare until they obtain full accreditation.

From 1 July 2008 a site in this category can apply for Stage I accreditation by submitting their documentary evidence to an approved accreditor in support of compliance with the standards. From acceptance of the application the approved accreditor has up to 14 days to conduct an audit of the documentary evidence and make a decision regarding the grant of accreditation. The audit is conducted off-site from the premises of the practice. Accreditation is granted until the expiration of Stage I of the scheme which is 30 June 2010.

From the date of grant of accreditation the practice site can provide diagnostic imaging services under Medicare.

Choosing not to be accredited
The proprietor of a practice site may choose not to be accredited. From 1 July 2008, practice sites which are not accredited or deemed accredited may continue to provide diagnostic imaging services provided they advise patients before the service is rendered that the service will not be eligible for a Medicare rebate. From 1 July 2008 a practice site is committing an offence if the patient is not advised that the service will not attract a Medicare benefit and the reason for this.

For further information please contact the Diagnostic Imaging Section on phone: (02) 6289 8859,
email: di.accreditation@health.gov.au or visit the website: www.diagnosticimaging.health.gov.au

DIF... DETAILS REQUIRED ON ACCOUNTS, RECEIPTS AND MEDICARE ASSIGNMENT OF BENEFIT FORMS

In addition to the normal particulars of the patient, date of service, the services performed and the fees charged, the details which must be entered on accounts or receipts, and Medicare assignment of benefits forms in respect of diagnostic imaging services are as follows:

- the Location Specific Practice Number (LSPN) of the diagnostic imaging premises or mobile facility where the diagnostic imaging procedure was undertaken;

- if the professional service is provided by a specialist in diagnostic radiology the name and either the address of the place of practice, or the provider number, of that specialist;

- if the medical practitioner is not a specialist in diagnostic radiology the name and either the practice address or provider number of the practitioner who is claiming or receiving fees;

- for "R-type" (requested) services and services rendered subsequent to lost requests, the account or receipt or the Medicare assignment form must indicate the date of the request and the name and provider number, or the name and address, of the requesting practitioner.

- services that are *self-determined* must be endorsed with the letters ‘SD’ to indicate that the service was self-determined. Services are classified as self determined when rendered:
  - by a *consultant physician or specialist*, in the course of that consultant physician or specialist practicing his or her specialty (other than a specialist in diagnostic radiology), or
  - to provide *additional services* to those specified in the original request and the additional services are of the type that would have otherwise required a referral from a specialist or consultant physician; or
  - in a *remote area*, or
  - under a *pre-existing diagnostic imaging practice exemption.*

- *substituted services* the account etc. must be endorsed ‘SS’.

- *emergencies*, the account etc. must be endorsed "emergency".

- *lost requests* the account etc. must be endorsed "lost request".

DIG... MAINTAINING RECORDS OF DIAGNOSTIC IMAGING SERVICES

Providers of diagnostic imaging services must keep records of diagnostic imaging services in a manner that facilitates retrieval on the basis of the patient's name and date of service. Records of R-type diagnostic imaging services must be retained for a period of 18 months commencing on the day on which the service was rendered.

The records must include the report by the providing practitioner on the diagnostic imaging service. For ultrasound services, where the service is performed on behalf of a medical practitioner the report must record the name of the sonographer.

- Where the provider *substitutes* a service for the service originally requested, the provider's records must include:
  - words indicating that the providing practitioner has consulted with the requesting practitioner and the date of consultation; or
  - if the providing practitioner has not consulted with the requesting practitioner, sufficient information to demonstrate that he or she has taken all reasonable steps to do so.

- For services rendered after a *lost request*, the records must include words to the effect that the request was lost but confirmed by the requesting practitioner and the manner of confirmation, eg. how and when.

- For *emergency services*, the records must indicate the nature of the emergency.

If requested by the Managing Director, Medicare Australia, records retained by a providing practitioner must be produced to an officer of Medicare Australia as soon as practicable but in any event within seven days after the day the Managing Director requests the production of those records. Medicare Australia officers may make and retain copies, or take and retain extracts, of such records.

A medical practitioner who, without reasonable excuse, contravenes any of the above provisions is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine of $1000.

DIH... CONTRAVENTION OF STATE AND TERRITORY LAWS AND DISQUALIFIED PRACTITIONERS

Medicare benefits are not payable where a diagnostic imaging service is provided by, or on behalf of, a medical practitioner, and the provision of that service by that practitioner or any other person contravenes a State or Territory law which, directly or indirectly, relates to the use of diagnostic imaging procedures or equipment. The Managing Director of Medicare Australia may notify the relevant State or Territory authorities if he/she believes that a person may have contravened a law of a State or Territory relating directly or indirectly to the use of diagnostic imaging procedures or equipment.

DII... PROHIBITED PRACTICES

Changes have been made to legislation relating to diagnostic imaging services provided under Medicare.

Amendments to the Health Insurance Act 1973 (the Act) relating to diagnostic services funded under Medicare came into effect on 1 March 2008. The changes were implemented following measures introduced in the *Health Insurance Amendment (Inappropriate and Prohibited Practices and other Measures) Act 2007*.

Who might be affected?

- Anyone who can provide or request a Medicare-funded diagnostic imaging service might be affected.
- Anyone who has a relevant connection to a provider or a requester, including relatives, bodies corporate, trusts, partnerships and employees may also be affected.

What is prohibited?

- It is unlawful to ask for, accept, offer or provide a benefit, or make a threat, that is reasonably likely to induce a requester to make diagnostic imaging requests, or is related to the business of providing diagnostic imaging services.
- It is a criminal offence to ask for, accept, offer, or provide a benefit, or make a threat, that is intended to induce requests to a particular provider.
- The prohibitions apply to the provision of benefits, or the making of threats, that are directed to a requester by a provider, whether directly or through another person.

A requester of diagnostic imaging services means:

- a medical practitioner;
- a dental practitioner, a chiropractor, a physiotherapist, a podiatrist or an osteopath (in relation to certain types of services prescribed in Regulations);
- a person who employs, or engages under a contract for services, one of the people mentioned above; or
- a person who exercises control or direction over one of the people mentioned above (in his or her professional capacity).

A provider of a diagnostic imaging service means:

- a person who renders that kind of service;
- a person who carries on a business of rendering that kind of service;
- a person who employs, or engages under a contract for services, one of the people detailed above; or
- a person who exercises control or direction over a person who renders that kind of service or a person who carries on a business of rendering that kind of service.

What is permitted?

Under the Act it is permitted to:

- share the profits of a diagnostic imaging business, provided the dividend is in proportion to the beneficiary's interest in the business;
- accept or pay remuneration, including salary, wages, commission, provided the remuneration is not substantially different from the usual remuneration paid to people engaged in similar employment;
- make or accept payments for property, goods or services, provided the amount paid is not substantially different from the market value of the property, goods or services;
- make or accept payments for shared property, goods or services, provided the amount paid is proportionate to the person's share of the cost of the property, goods or services and shared staff and/or equipment are not used to provide diagnostic imaging services;
- provide or accept property, goods or services, provided the benefit exchanged is not substantially different from the market value of the property, goods or services;

Are there any benefits, other than those described in the Act, that are permitted?

- The Minister has determined that certain types of benefit are permitted. These include items to support a requester to view diagnostic imaging reports, such as specially designed computer monitors. Modest gifts and hospitality may also be permitted, under certain circumstances.

Further information on the *Health Insurance (Permitted Benefits – diagnostic imaging services) Determination 2008* can be found on the Department of Health and Ageing website at www.health.gov.au/legislativeamendments

What are the penalties for those not complying with the provisions?

- If you breach the provisions, you could potentially be subject to a range of penalties, depending on the kind of breach, including:
  - civil penalties;
  - criminal offences;
  - referral to a Medicare Participation Review Committee (MPRC), possibly resulting in loss of access to Medicare.

For further information on Prohibited Practices visit the Department of Health and Ageing website at www.health.gov.au/legislativeamendments

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DIJ... MULTIPLE SERVICES RULES

Background

There are several rules that may apply when calculating Medicare benefits payable when multiple diagnostic imaging services are provided to a patient at the same attendance (same day). These rules were developed in association with the diagnostic imaging profession representative organisations and reflect that there are efficiencies to the provider when these services are performed on the same occasion. Unless there are clinical reasons for doing so, they should be provided to the patient at the one attendance and the efficiencies from doing this reflected in the overall fee charged.

General diagnostic imaging - multiples services

The diagnostic imaging multiple services rules apply to all diagnostic imaging services. There are three rules, and more than one rule may apply in a patient episode. The rules do not apply to diagnostic imaging services rendered in a remote area by a medical practitioner who has a remote area exemption for that area - see DID.

Rule A. When a medical practitioner renders two or more diagnostic imaging services to a patient on the same day, then:

- the diagnostic imaging service with the highest Schedule fee has an unchanged Schedule fee; and
- the Schedule fee for each additional diagnostic imaging service is reduced by $5.

Rule B. When a medical practitioner renders at least one R-type diagnostic imaging service and at least one consultation to a patient on the same day, there is a deduction to the Schedule fee for the diagnostic imaging service with the highest Schedule fee as follows:

- if the Schedule fee for the consultation is $40 or more - by $35; or
- if the Schedule fee for the consultation is less than $40 but more than $15 - by $15; or
- if the Schedule fee for the consultation is less than $15 - by the amount of that fee.

The deduction under Rule B is made once only. If there is more than one consultation, the consultation with the highest Schedule fee determines the deduction amount. There is no further deduction for additional consultations.

A 'consultation' is a service rendered under an item from Category 1 of the Medicare Benefits Schedule (MBS), that is, items 1 to 10816 inclusive.

Rule C. When a medical practitioner renders an R-type diagnostic imaging service and at least one non-consultation service to the same patient on the same day, the Schedule fee for the diagnostic imaging service with the highest Schedule fee is reduced by $5.

A deduction under Rule C is made once only. There is no further deduction for any additional medical services.

For Rule C, a 'non-consultation' is defined as any following item from the MBS:
- Category 2, items 11000 to 12533;
- Category 3, items 13020 to 51318;
- Category 4, items 51700 to 53460;
- Cleft Lip and Palate services, items 75001 to 75854 (as specified in the 'Medicare Benefits for the treatment of cleft lip and cleft palate conditions' book.)

Pathology services are not included in Rule C.

When both Rules B and C apply, the sum of the deductions in the Schedule fee for the diagnostic imaging service with the highest Schedule fee is not to exceed that Schedule fee.

Ultrasound - Vascular

This rule applies to all vascular ultrasound items claimed on the same day of service ie whether performed at the same attendance by the same practitioner or at different attendances.

Where more than one vascular ultrasound service is provided to the same patient by the same practitioner on the same date of service, the following formula applies to the Schedule fee for each service:
- 100% for the item with the greatest Schedule fee
- plus 60% for the item with the next greatest Schedule fee
- plus 50% for each other item.

When the Schedule fee for some of the items are the same, the reduction is calculated in the following order:
- 100% for the item with the greatest Schedule fee and the lowest item number
- plus 60% for the item with the greatest Schedule fee and the second lowest item number
- plus 50% for each other item

Note: If 2 or more Schedule fees are equally the highest, the one with the lowest item number is taken to have the higher fee eg. Item 55238 and 55280, item 55238 would be considered the highest.

When calculating the benefit, it should be noted that despite the reduction, the collective items are treated as one service for the application of Rule A of the General Diagnostic Imaging Multiple Services rules and the patient gap. Examples can be found at: www.medicareaustralia.gov.au/providers/publications_guidelines/medical_practitioners.htm

Magnetic Resonance Imaging (MRI) - Musculoskeletal

If a medical practitioner performs 2 or more scans from subgroup 12 and 13 for the same patient on the same day, the fees specified for items that apply to the service are affected as follows:
(a) the item with the highest schedule fee retains 100% of the schedule fee; and
(b) any other fee, except the highest is reduced by 50%.

Note: If 2 or more Schedule fees are equally the highest, the one with the lowest item number is taken to have the higher fee eg. Item 63322 and 63331, item 63322 would be considered the highest.

If the reduced fee is not a multiple of 5 cents, the reduced fee is taken to be the nearest amount that is a multiple of 5 cents.

In addition, the modifying item for contrast may only be claimed once for a group of services subject to this rule.

If a medical practitioner provides:
(a) 2 or more MRI services from subgroups 12 and 13 for the same patient on the same day; and
(b) 1 or more other diagnostic imaging services for that patient on that day

the amount of the fees payable for the MRI services is taken, for the purposes of this rule, to be an amount payable for 1 diagnostic imaging service in applying Rule A of the General Diagnostic Imaging Multiple Services rules.

DIK... GROUP I1 - ULTRASOUND

Professional supervision for ultrasound services – R-type eligible services
Ultrasound services (items 55028 to 55854) marked with the symbol *(R)* with the exception of items 55600 and 55603 are not eligible for a Medicare rebate unless the diagnostic imaging procedure is performed under the professional supervision of a:
(a) specialist or a consultant physician in the practice of his or her specialty who is available to monitor and influence the conduct and diagnostic quality of the examination, and if necessary to personally attend the patient; or
(b) practitioner who is not a specialist or consultant physician who meets the requirements of A or B hereunder, and who is available to monitor and influence the conduct and diagnostic quality of the examination and, if necessary, to personally attend the patient.
   A. Between 1 September 1997 and 31 August 1999, at least 50 services were rendered by or on behalf of the practitioner at the location where the service was rendered and the rendering of those services entitled the payment of Medicare benefits.
   B. Between 1 September 1997 and 31 August 1999, at least 50 services were rendered by or on behalf of the practitioner in nursing homes or patients' residences and the rendering of those services entitled payment of Medicare benefits.

If paragraph (a) or (b) cannot be complied with, ultrasound services are eligible for a Medicare rebate:
(i) in an emergency; or
(ii) in a location that is not less than 30 kilometres by the most direct road route from another practice where services that comply with paragraph (a) or (b) are available.
Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

Sonographer accreditation
Sonographers performing medical ultrasound examinations (either R or NR type items) on behalf of a medical practitioner must be suitably qualified, involved in a relevant and appropriate Continuing Professional Development program and be Registered on the Register of Accredited Sonographers held by Medicare Australia. For further information, please contact the Medicare Australia, Provider Liaison Section, on 132150 for the cost of a local call or the Australasian Sonographer Accreditation Registry on (02) 8850 1144 or through their website at http:/www.asar.com.au

Eligibility for registration
In general, to be eligible for registration, the person must:
- hold an accredited postgraduate qualification in medical ultrasound; or
- be studying ultrasound; or
- have worked as a sonographer under the direction of a medical practitioner in Australia or New Zealand (conditions apply - for assessment of eligibility status, please contact the Australasian Sonographer Accreditation Registry).

Report requirements
The sonographer's initial and surname is to be written on the report. The name of the sonographer is not required to be included on the copy of the report given to the patient. For the purpose of this rule, the "name" means the sonographer's initial and surname.

Benefits payable
As a rule, benefit is payable **once only** for ultrasonic examination at the **one attendance**, irrespective of the areas involved.

Except as indicated in the succeeding paragraphs, *attendance* means that there is a clear separation between one service and the next. For example, where there is a short time between one ultrasound and the next, benefits will be payable for one service only. As a guide, Medicare Australia will look to a separation of three hours between services and this must be stated on accounts issued for more than one service on the one day.

Where more than one ultrasound service is rendered on the one occasion and the service relates to a non-contiguous body area, and they are "clinically relevant", (ie. the service is generally accepted in the medical profession as being necessary for the appropriate treatment or management of the patient to whom it is rendered), benefits greater than the single rate may be payable. Accounts should be marked "non-contiguous body areas".

Benefits for two contiguous areas may be payable where it is generally accepted that there are different preparation requirements for the patient and a clear difference in set-up time and scanning. Accounts should be endorsed "contiguous body area with different set-up requirements".

Subgroup 1 – General Ultrasound
Post-void residual items 55084 and 55085
When a post-void residual is the only service clinically indicated and/or rendered, it is inappropriate to report a pelvic, urinary or abdominal ultrasound, instead of or in addition to this service (55084 or 55085). Similarly, if a complete pelvic, urinary or abdominal ultrasound is billed, it is inappropriate to bill separately for a post-void residual determination, since payment of this has already been included in the payment for the complete scans.

The report must contain an entry denoting the post-void residual amount and/or bladder capacity as calculated/estimated from the ultrasound device. In addition, the medical record must contain documentation of the indication for the service and the number of times performed.

Subgroup 2 – Cardiac ultrasound
Transoesophageal echocardiography - Item 55135 and consequential amendment to Item 55130
The Medical Services Advisory Committee (MSAC) has reviewed intra-operative transoesophageal echocardiography and recommended that public funding for this procedure be supported on an interim basis and be restricted to assessment of cardiac valve competence following valve replacement or repair. Item 55135 has been developed for these indications in consultation with the Australian Society of Anaesthetists, the Australian Medical Association and the Cardiac Society of Australia and New Zealand. Indications other than those recommended by MSAC will continue to be funded under item 55130. Further research will be undertaken to assist MSAC in its future evaluation of the use of intra-operative transoesophageal echocardiography.

Subgroup 3 - Vascular ultrasound
Benefits payable
Medicare benefits are only payable for:

- a maximum of two vascular ultrasound studies in a seven-day period. A vascular ultrasound study may include one or more items. Additionally where a patient is referred for a bilateral study of both arms or both legs (eg both arms for item 55238), the account should indicate ‘bilateral’ or ‘left’ and ‘right’ to enable benefit to be paid.

- clinically relevant services, that is, the service is generally accepted in the medical profession as being necessary for the appropriate treatment or management of the patient to whom it is rendered. Any decision to have a patient return on a different day to complete a multi-area diagnostic imaging service should only be made on the basis of clinical necessity.

Multiple Vascular Ultrasound Services – *refer to DIJ*

Separation of services on the one day/contiguous and non-contiguous body areas
These rules do not apply to the vascular ultrasound items and therefore will not impact on the MVUSSR.

Examination of peripheral vessels
Vascular ultrasound services can be claimed in conjunction with item 11612.

Subgroup 4: Urological ultrasound
Transrectal ultrasound (Items 55600 and 55603)
Benefits for these items are payable where the service is rendered in the following circumstances:

- a digital rectal examination of the prostate was personally performed by the medical practitioner who also personally rendered the ultrasound service; and
- the transducer probe or probes used meets specifications of normal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz and which can obtain both axial and sagittal scans in 2 planes at right angles; and
- the patient was assessed prior to the service by a medical practitioner recognised in one or more of the specialties specified, not more than 60 days prior to the ultrasound service.

Item 55600 covers the situation where the service was rendered by a medical practitioner who **did not** assess the patient, whereas item 55603 covers the situation where the service was rendered by a medical practitioner who **did** assess the patient.

Subgroup 5: Obstetric and Gynaecological ultrasound

NR Services

Medicare benefits are not payable for more than three NR-type ultrasound services in Subgroup 5 of Group I1 (ultrasound) that are performed on the same patient in any one pregnancy.

Clinical indications

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

It should be noted that a patient must have previously had either a 55706 or 55709 ultrasound in the same pregnancy to be eligible to claim for either a 55712 or 55715 obstetric service. To be eligible to claim for either a 55721 or 55725 obstetric service, a patient must have previously had either a 55718 or 55723 ultrasound in the same pregnancy.

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

Dating of pregnancy

When dating a pregnancy for the purpose of items 55700 to 55774, a patient is:

a) "less than 12 weeks of gestation" means up to 11 weeks and 6 days of pregnancy;
b) "12 to 16 weeks of gestation" means from 12 weeks 0 days of pregnancy up to 16 weeks plus 6 days of pregnancy (inclusive);
c) "17 to 22 weeks of gestation" means from 17 weeks 0 days of pregnancy up to 22 weeks plus 6 days of pregnancy (inclusive); or
d) "after 22 weeks of gestation" means from 23 weeks 0 days of pregnancy onwards
e) "after 24 weeks of gestation" means from 25 weeks 0 days of pregnancy onwards.

Nuchal Translucency Testing

Where a nuchal translucency measurement is performed when the pregnancy is dated by a crown rump length of 45-84mm in conjunction with items 55700 (R) or 55703 (NR) or 55704 (R) or 55705 (NR), then items 55707 (R) or 55708 (NR) should be claimed. If nuchal translucency measurement for risk of foetal abnormality is performed in conjunction with any additional condition in items 55700, 55703, 55704 or 55705, only one fee is payable.

It should be noted that the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) provides a credentialling program for providers of nuchal translucency scans. It is anticipated that use of items 55707 and 55708 will be restricted to credentialed medical practitioners and sonographers in the future.

Multiple pregnancies

Obstetric ultrasound items 55759 to 55774 cover scanning of a patient who is experiencing a multiple pregnancy. The items incorporate a fee adjustment in recognition of the added complexity and costs associated with scanning multiple pregnancies. Based on the recommendations of the profession, the items apply only to patients where a multiple pregnancy has been confirmed by ultrasound. The items include identical restrictions and provisions as the second and third trimester items (55706-55725), and include items for referred and non-referred services.

Obstetric ultrasound and non-metropolitan providers (Items 55712, 55721, 55764 and 55772)

Where a practitioner has obstetric privileges at a non-metropolitan hospital and refers for items 55712, 55721 and 55764 and 55772, the practitioner must confirm his/her eligibility by stating 'non-metropolitan obstetric privileges' on the referral form.

In relation to items 55712, 55721, 55764 and 55772, non-metropolitan area includes any location outside of the Sydney, Melbourne, Brisbane, Adelaide, Perth, Greater Hobart, Darwin or Canberra major statistical divisions, as defined in the Australian Standard Geographical Classification 1999 published by the Australian Bureau of Statistics (publication number 1216.0 of 1999.

Subgroup 6: Musculoskeletal (MSK) ultrasound

Personal attendance

Medicare Benefits are only payable for a musculoskeletal ultrasound service (items 55800 to 55854) if the medical practitioner responsible for the conduct and report of the examination personally attends during the performance of the scan and personally examines the patient. Services that are performed because of medical necessity in a remote location

are exempt from this requirement – see DID for definition of remote area. Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

Equipment
Items 55800 to 55854 only apply to an ultrasound service performed using an ultrasound system which has available on-site a transducer capable of operation at, at least 7.5 megahertz.

Multiple Musculoskeletal Ultrasound Scans - items 55800 to 55846
Generally Medicare benefits are payable for more than one musculoskeletal ultrasound scan performed on the same day, however the scans are subject to Rule A of the general diagnostic imaging multiple services rules.

It is not permitted to split a bilateral scan. Where bilateral ultrasound scans are performed (or more than one area is scanned under items 55844 or 55646) the relevant item should be itemised once only on accounts and receipts or Medicare bulk billing forms. For example if both shoulders are scanned, Item 55808 (or 55810 as the case may be) should be claimed once only. This is because the item descriptor for these items covers one or both sides, or one or more areas. A patient should not be asked to make a second appointment in order to attract a benefit for multiple scans.

Shoulder and knee (Items 55808 and 55810 and 55828 and 55830)
Benefits for shoulder ultrasound items 55808 and 55810 are only payable when referral is based on the clinical indicators outlined in the item descriptions. Benefits are <u>not</u> payable when referred for non-specific shoulder pain alone.

Benefits for knee ultrasound items 55828 and 55830 are only payable when referral is based on the clinical indicators outlined in the item descriptions. Benefits are <u>not</u> payable when referred for non-specific knee pain alone or other knee conditions including:
- meniscal and cruciate ligament tears; and
- assessment of chondral surfaces.

DIL... GROUP I2 - COMPUTED TOMOGRAPHY (CT)

Capital sensitive items
A reduced Schedule fee applies to CT services provided on equipment that is 10 years old or older. This equipment must have been first installed in Australia ten or more years ago, or in the case of imported pre-used equipment, must have been first manufactured ten or more years ago. A range of items cover services provided on older equipment. These items are:

56041, 56047, 56050, 56053, 56056, 56062, 56068, 56070, 56076, 56141, 56147, 56259, 56341, 56347, 56441, 56447, 56449, 56452, 56541, 56547, 56659, 56665, 56841, 56847, 57041, 57047, 57247, 57345, 57355.

These items are identified by the addition of the letter '(NK)' at the end of the item. These items should be used where services are performed on equipment ten years old or older, except where equipment is located in a remote area when items with the letter "K", as described below, will apply.

Items 56001 to 57356 (which contain the symbol (K) at the end of the item should be used for services which are performed on a date which is less than ten years after the date on which the CT equipment used in performing the service was first installed in Australia. In the case of imported pre-used CT equipment, the services must have been performed on a date which is less than ten years from the first date of manufacture of the equipment.

For the purposes of capital sensitive items CT equipment includes the following components:
(a) a gantry;
(b) a couch;
(c) a computer; and
(d) an operator station.

Professional supervision
CT services (items 56001 to 57356) are not eligible for a Medicare rebate unless the service is performed:
(a) under the professional supervision of a specialist in the specialty of diagnostic radiology who is available:
  (i) to monitor and influence the conduct and diagnostic quality of the examination; and
  (ii) if necessary, to personally attend on the patient; or
(b) if paragraph (a) cannot be complied with
  (i) in an emergency, or
  (ii) because of medical necessity in a remote area – refer to DID.4.4 for definition of remote area.

Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

Use of a hybrid PET/CT or SPECT/CT machine
CT scans rendered on hybrid Positron Emission Tomography (PET)/CT or hybrid Single Photon Emission Computed Tomography (SPECT)/CT units are eligible for a Medicare benefit provided:

- the CT scan is not solely used for the purposes of attenuation correction and anatomical correlation of any associated PET or SPECT scan; and
- the CT scan is rendered under the same conditions as those applying to services rendered on stand-alone CT equipment. For example, the service would need to be properly requested and performed under the professional supervision of a specialist radiologist, including specialist radiologists with dual nuclear medicine qualifications.

Scan of more than one area
Items have been provided to cover the common combinations of regions – see Multiple Regions below. However, where regions are scanned on the one occasion which are not covered by a combination item, for example, item 57001 (scan of brain) and item 56619 (scan of extremities), both examinations would attract separate benefit.

Multiple regions
Items have been provided to cover the common combinations of regions. The items relating to the individual contiguous regions should not be used when scans of multiple regions are performed.

More than one attendance of the patient to complete a scan
Items 56220 to 56240 and 56619 to 56665 apply once only for a service described in any of those items, regardless of the number of patient attendances required to complete the service. For example, where a request relates to two or more regions of the spine and one region only is scanned on one occasion with the balance of regions being scanned on a subsequent occasion, benefits are payable for one combination service only upon completion.

Pre contrast scans
Pre contrast scans are included in an item of service with contrast medium only when the pre-contrast scans are of the same region.

Head
Exclusion of acoustic neuroma
If an axial scan is performed for the exclusion of acoustic neuroma, Medicare benefits are payable under item 56001 or 56007.

Assessment of headache
If the service described in item 56007 or 56047 is used for the assessment of headache of a patient, the fee mentioned in the item applies only if:
(a) a scan without intravenous contrast medium has been undertaken on the patient; and
(b) the service is required because the result of the scan is abnormal.

This rule applies to a patient who:
(i) is under 50 years; and
(ii) is (apart from the headache) otherwise well; and
(iii) has no localising symptoms or signs; and
(iv) has no history of malignancy or immunosuppression.

Spine
CT items exist which separate the examination of the spine into the cervical, thoracic and lumbosacral regions. These items are 56220 to 56240 inclusive. They include items for CT scans of two regions of the spine (56233, 56234, 56235 and 56236) and for all three regions of the spine (56237, 56238, 56239 and 56240). Restrictions apply to the following items:

(a) item 56233 is used where two examinations of the kind referred to in items 56220, 56221 and 56223 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed.
(b) item 56234 is used where two examinations of the kind referred to in items 56224, 56225 and 56226 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed.
(c) item 56235 is used where two examinations of the kind referred to in items 56227, 56228 and 56229 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed
(d) item 56236 is used where two examinations of the kind referred to in items 56230, 56231 and 56232 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed

Example: for a CT examination of the spine where the cervical and thoracic regions are to be studied (item 56233), item numbers 56220 and 56221 must be specified.

With intrathecal contrast medium (Item 56219)
The item incorporates the cost of contrast medium for intrathecal injection and associated x-rays. Benefits are not payable for this item when rendered in association with myelograms (Item 59724). Where a myelogram is rendered under item 59724 and a CT is necessary, the relevant item would be scan of spine without intravenous contrast (Item 56220, 56221 or 56223).

Upper abdomen and pelvis
Items 56501, 56507, 56541 and 56547 are not eligible for Medicare Benefits if performed for the purpose of performing a virtual colonoscopy (otherwise known as CT colonography and CT colography). CT Colonography is covered by items 56552 and 56554.

Computed Tomography of the Colon (Items 56552 and 56554)
In items 56552 and 56554 the terms 'high risk' and 'incomplete colonoscopy' are defined as follows:

High Risk
Asymptomatic people fit into this category if they have:
• three or more first-degree or a combination of first-degree and second-degree relatives on the same side of the family diagnosed with bowel cancer (suspected hereditary non-polyposis colorectal cancer or NPCC), or
• two or more first-degree or second-degree relatives on the same side of the family diagnosed with bowel cancer, including any of the following high-risk features:
– multiple bowel cancers in the one person
– bowel cancer before the age of 50 years
– at least one relative with cancer of the endometrium, ovary, stomach, small bowel, ureter, biliary tract or brain
• at least one first-degree relative with a large number of adenomas throughout the large bowel (suspected familial adenomatis polyposis or FAP), or
• somebody in the family in whom the presence of a high-risk mutation in the adenomatis polyposis coli (APC) gene or one of the mismatch repair (MMR) genes has been identified.

Source: NHMRC 2005 Clinical Practice Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer - Category 3 - those at potentially high risk.

Incomplete Colonoscopy
For audit purposes, an incomplete colonoscopy is defined as one that is not completed for technical or medical reasons and must have been performed in the preceding 3 months.

Spiral angiography
Items 57350 and 57355 and items 57351 and 57356
CT spiral angiography items 57351 and 57356 apply under certain circumstances specified in the items including where a service to which items 57350 or 57355 have been performed on the same patient within the previous 12 months, whereas items 57350 and 57355 apply under the circumstances specified in the items and where the service has **not** been performed on the same patient within the previous 12 months.

Spiral angiography/chest items not to be used to image the coronary arteries
CT coronary angiography is a technology that has not yet been assessed by the Medical Services Advisory Committee. The descriptors for CT spiral angiography items 57350, 57351, 57355 and 57356 and CT chest items 56301, 56307, 56341, 56347, 56801, 56807, 56841, 56847, 57001, 57007, 57041 and 57047 clarify that they are not to be used to image the coronary arteries.

DIM... GROUP I3 - DIAGNOSTIC RADIOLOGY

Examination and report
As for all diagnostic imaging services, the benefits allocated to each item from 57506 to 60509 inclusive cover the total service, ie. the image, reading and report. Separate benefits are not payable for individual components of the service, eg preliminary reading. Benefits are not separately payable for associated plain films involved with these items.

Exposure of more than one film
Where the radiographic examination of a specific area involves the exposure of more than one film, benefits are payable once only, except where special provision is made in the description of the item for the inclusion of all films taken for the purpose of the examination. This means that if a x-ray of the foot is requested, regardless of the number of exposures from different angles, the completed service comprises x-ray of the foot by one or more exposures and the report. The exception

to this would be the plain x-ray of the spine items (58100 to 58115) where the item number differs dependent upon the regions of the spine that are examined at the same occasion, ie. 58112 applies where two regions are examined.

Comparison X-rays
Where it is necessary for one or more films of the opposite limb to be taken for comparison purposes, benefits are payable for radiographic examination and reporting of one limb only. Comparison views are considered to be part of the examination requested.

Subgroup 4: Radiographic examination of the spine

Multiple regions
Multiple region items require that the regions of the spine to be studied must be specified on any account issued or patient assignment form completed.

Item 58112 – spine, two regions
Where item 58112 is rendered (spine, two regions), the item numbers for the regions of the spine being studied must be specified (ie from items 58100, 58103, 58106 and 58109).

Example: for a radiographic examination of the spine where the cervical and thoracic regions are to be studied, item numbers 58100 and 58103 must be specified on any account issued or patient assignment forms completed.

Item 58115 – spine, three region
Where item 58115 is rendered (spine, three regions), the item numbers for the regions of the spine being studied must be specified (items 58100, 58103, 58106 and 58109).

Example: for a radiographic examination of the spine where the cervical, the thoracic and the lumbosacral regions are to be studied, item numbers 58100, 58103 and 58106 must be specified on any accounts issued or patient assignment forms completed.

Item 58115 & 58108 – spine, three and four region

For three and four region radiographic examinations items 58115 and 58108 do not apply when requested by a physiotherapist, chiropractor or osteopath.

Item 58120 and 58121

Items 58120 and 58121 apply to physiotherapists, chiropractors and osteopaths who request a three or four region x-ray and only allow a benefit for one of the items, per patient, per calendar year.

Hand and wrist combination X-ray
An examination of the hand and the wrist on the same side should be claimed as item 57512 (NR) or 57515 (R). If items 57506 (NR) or 57509 (R) are claimed for multiple non-adjacent areas on the same side, or areas on different sides, the account should include annotation on this eg L and R hand, hand and humerus.

Images produced using Dual Energy X-ray Absorptiometry (DEXA) equipment
X-ray items of the spine 58100 to 58115 and hip 57712 and 57715 cannot be claimed when images are produced using Dual Energy X-ray Absorptiometry (DEXA) equipment.

Subgroup 8: Radiographic examination of alimentary tract and biliary system
Plain abdominal film (Items 58900/58903)
Benefits are not attracted for Items 58900/58903 in association with barium meal examinations or cholecystograms whether provided on the same day or previous day. Preliminary plain films are covered in each study.

Subgroup 10: Radiographic examination of the breasts
Request requirements (items 59300 and 59303)
Benefits under items 59300 and 59303 are attracted only where the patient has been referred in specific circumstances as indicated in the description of the items. To facilitate these provisions, the requesting medical practitioner is required to include in the request the clinical indication for the procedure. The requesting practitioner must personally sign the request.

The reference to "with or without thermography" has been removed from the item descriptor for items 59300 and 59303 with effect from 1 November 2003. The Radiology Management Committee (RMC) at its meeting of 12 August 2003,

agreed that there is no current scientific evidence to support the use of thermography in the early detection of breast cancer and in the reduction of mortality.

Professional supervision
Mammography services (items 59300 to 59318) are not eligible for a Medicare rebate unless the diagnostic imaging procedure is performed under the professional supervision of a:

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

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

Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

Subgroup 12: Radiographic examination with opaque or contrast media
Myelogram (Item 59724)
Benefits are not payable where a myelogram is rendered in association with a CT myelogram (Item 56219 - see DIL.9.1). Where it is necessary to render a CT and a myelogram, CT Items 56220, 56221 and 56223 would apply.

Subgroup 13: Angiography
Angiography services - meaning of (K) and (NK)
A reduced Schedule fees applies to cardiac angiography services provided on equipment that is 10 years old or older. This equipment must have been first installed in Australia ten or more years ago, or in the case of imported pre-used equipment, must have been first manufactured ten or more years ago.

A range of items cover services provided on older equipment. These items are 59971, 59972, 59973 and 59974, are identified by the addition of the letters '(NK)' at the end of the item and should be used where services are performed on equipment ten years old or older.

Items 59903, 59912, 59925 and 59970 have the letter '(K)' included at the end of the item. These items should be used where services are performed on equipment first installed in Australia less than ten years ago. In the case of imported pre-used equipment, the services must have been performed on a date which is less than ten years from the first date of manufacture of the equipment.

Digital subtraction angiography (DSA) (Items 60000-60078)
Benefits are payable only where these services are rendered in an angiography suite (a room that contains only equipment designed for angiography that is able to perform digital subtraction or rapid-sequence film angiography). Benefits are not payable when these services are rendered using mobile DSA imaging equipment as these services are covered by item 59970.

Each item includes all preparation and contrast injections other than for selective catheterisation. For Digital Subtraction Angiography (DSA), benefits are payable for a maximum of 1 DSA item (from Items 60000 to 60069). For selective DSA - 1 DSA item (from Items 60000 to 60069) and 1 item covering selective catheterisation (from 60072, 60075 or 60078).

If a DSA examination covers more than one of the specified regions/combinations, then the region/combination forming the major part of the examination should be selected, with itemisation to cover the total number of film runs obtained. A run is the injection of contrast, data acquisition, and the generation of a hard copy record.

Subgroup 16: Preparation for radiological procedure
Preparation items (Items 60918 and 60927)
Items 60918 and 60927 apply only to the preparation of a patient for a radiological procedure for a service to which any of items 59903 to 59974 apply. A report is not required for these services.

DIN... GROUP I4 - NUCLEAR MEDICINE IMAGING

General

Benefits for a nuclear scanning service are only payable when the service is performed by a specialist or consultant physician, or by a person acting on behalf of the specialist and the final report of the service is compiled by the specialist or consultant physician who performed the preliminary examination of the patient and the estimation and administration of the dosage.

Additional benefits will only be attracted for specialist physician or consultant physician attendance under Category 1 of the Schedule where there is a request for a full medical examination accompanied by a referral letter or note of referral.

Credentialling for nuclear medicine imaging services
Payment of Medicare rebates for nuclear medicine imaging services is limited to specialists or consultant physicians who are credentialled by the Joint Nuclear Medicine Credentialling and Accreditation Committee of the Royal Australian College of Physicians (RACP) and the Royal Australian and New Zealand College of Radiologists (RANZCR). The scheme has been developed by the profession in consultation with Government to ensure that specialists in nuclear medicine are appropriately trained and licensed, provide appropriate personal supervision of procedures and are involved in ongoing continuing medical education.

For information regarding the Scheme and for application forms, please phone the RACP or RANZCR.

Radiopharmaceuticals
The Schedule fees for nuclear medicine imaging services incorporate the costs of radiopharmaceuticals.

Single Photon Emission Computed Tomography (SPECT)
Where SPECT has been performed in conjunction with another study and is not covered under the item descriptor or is not covered under Item 61462, no Medicare benefit is payable for the SPECT study.

Single myocardialperfusion studies (Items 61302 and 61303)
Items 61302 and 61303 apply to single myocardial perfusion studies which can only be used once and cannot be used in conjunction with any other myocardial perfusion study for an individual patient referral.

Myocardialperfusion (Items 61306 and 61307)
Items 61306 and 61307 refer to all myocardial perfusion studies involving two or more sets of imaging times related to an individual patient referral. This includes stress/rest, stress/re-injection, stress/rest and re-injection thallium studies, one or two-day technetium-based perfusion agent protocols, mixed technetium-based perfusion agent/thallium protocols and the use of gated SPECT when undertaken.

Hepatobiliary study (pre-treatment) (Item 61360)
Item 61360 - the standard hepatobiliary item - also includes allowance of the pre-procedural CCK administration for preparatory emptying of the gall bladder and also morphine augmentation.

Hepatobiliary study (infusion) (Item 61361)
Item 61361 applies specifically to a standard hepatobiliary study to which has been added an infusion of sinaclide (CCK-8) following which acquisition is continued and quantification of gallbladder ejection fraction and/or common bile duct activity time curves are performed.

Whole body studies (Items 61426-61438)
"Whole body" studies must include the trunk, head and upper and lower limbs down to the elbow and knee joints respectively, whether acquired as multiple overlapping camera views or whole body sweeps (runs) with additional camera views as required. Any study that does not fulfil these criteria is a localised study.

Repeat studies (Item 61462)
Item 61462 covers repeat planar (whole body or localised) and/or SPECT imaging performed on a separate occasion using the same administration of radiopharmaceutical. The repeat planar and SPECT imaging when performed on a separate occasion using the same administration of radiopharmaceutical should be itemised as item 61462 and the original item and date of service should be indicated for reference purposes.

This item does not apply to bone scans, adrenal studies or gastro-oesophageal reflux studies, myocardial perfusion studies, colonic transit or CFS transport studies, where allowance for performance of the delayed study is incorporated into the baseline benefit fee.

Thyroid study (Item 61473)
Item 61473 incorporates the measurement of thyroid uptake on a gamma camera using a proven technique, where clinically indicated.

Positron Emission Tomography (PET) (Items 61523, 61529, 61541, 61544, 61553, 61556, 61559, 61565 and 61568 - Ministerial Determination)
Payment of Medicare rebates for PET services is limited to credentialled specialists or consultant physicians who meet eligibility requirements in *Health Insurance (Positron Emission Tomography) Determination 2008 (No. 2).* PET services must be:

1. performed by a:

    a) specialist or consultant physician credentialled under the Joint Nuclear Medicine Specialist Credentialling Program for the Recognition of the Credentials of Nuclear Medicine Specialists for Positron Emission Tomography overseen by the Joint Nuclear Medicine Credentialling and Accreditation Committee; or

    b) practitioner who is a Fellow of either RACP or RANZCR, and who has reported 400 or more studies forming part of PET services in respect of which a Medicare benefit was payable, and who holds a current license from the relevant State radiation licensing body to prescribe and administer the intended PET radiopharmaceuticals to humans;

2. provided at an accredited site for advanced training of PET, in a comprehensive facility that can provide a full range of diagnostic imaging services (including PET, CT, X-Ray and diagnostic ultrasound) and cancer treatment services (including chemotherapy, radiation oncology and surgical oncology) at the one site;

3. provided using equipment that meets each of the standards specified by ANZAPNM as detailed in the following:

    a) Interim Recommendations for PET Accreditation (Technical Aspects) dated 16 May 2001 and issued by the Australian and New Zealand Society of Nuclear Medicine; and

    b) NEMA NU 2-2001 standard published on 20 June 2001 and issued by the National Electrical Manufacturers Association.

4. only provided following referral from a recognised specialist or consultant physician.

All PET providers must complete a specific PET provider Statutory Declaration prior to being eligible to claim Medicare rebates. Statutory declarations can be obtained directly from Medicare Australia.

DIO... GROUP I5 - MAGNETIC RESONANCE IMAGING

Itemisation

MRI items in Group I5, items 63001 to 63497, are divided into subgroups defined according to the area of the body to be scanned, (ie head, spine, musculoskeletal system, cardiovascular system or body) and the number of occasions in a defined period in which Medicare benefits may be claimed by a patient. Subgroups are divided into individual items, with each item being for a specific clinical indication.

Eligible services

Group I5 items apply only to a MRI or MRA service performed:

(a) on request by a recognised specialist or consultant physician, where the request made in writing identifies the clinical indication for the service;
(b) under the professional supervision of an eligible provider; and
(c) with eligible equipment.

Requests

A referral must be in writing and identify the clinical indications for the service.

MRI services can only be requested by a recognised specialist medical practitioner or consultant physician for the purpose of the *Health Insurance Act* 1973. However, there are exceptions to this provision for a limited number of MRI:

- All dental specialists, prosthodontists, oral and maxillofacial surgeons, oral medicine specialists and oral pathology specialists may request item 63334 – scan of musculoskeletal system for derangement of the temporomandibular joint (s)
- Oral and maxillofacial surgeons and oral medicine and oral pathology specialists can also request item 63007 – scan of the head for skull base or orbital tumour.

Professional supervision

Group I5 items must be performed as follows:

(a) under the professional supervision of an eligible provider who is available to monitor and influence the conduct and diagnostic quality of the examination, including, if necessary, by personal attendance on the patient; or
(b) if paragraph (a) is not complied with:
  (i) in an emergency; or
  (ii) because of medical necessity, in a remote location (refer to DID).

Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

Eligible providers

In Group I5, an eligible provider is a specialist in diagnostic radiology who satisfies Medicare Australia that:
(a) he or she is a participant of the Royal Australian and New Zealand College of Radiologists' (RANZCR) Quality and Accreditation Program; and
(b) the equipment he or she proposes to use for providing services of the kind mentioned in Group I5 is eligible equipment.

Eligible Provider declaration

The specialist must give Medicare Australia a statutory declaration:
(a) stating that he or she is enrolled in the RANZCR Quality and Accreditation Program;
(b) specifying the location of the MRI equipment;
(c) specifying the kinds of diagnostic imaging equipment offered at the that location;
(d) stating the date of installation of the equipment (and the time of installation if this occurred on 12 May 1998); and
(e) if the equipment had not been installed before 7.30pm on 12 May 1998 (Eastern Standard Time), the specialist must also give Medicare Australia a copy of the contract for the purchase or lease of the equipment.

In addition Medicare Australia may request further supporting documentation or information. Specialists or consultant physicians are advised to contact the Provider Liaison Section, Medicare Australia on 132 150 prior to lodging a declaration.

Eligible equipment

Eligible equipment is equipment which is:

(a) equipment within the meaning of rule 31 of Part 2 of Schedule 1 to the Health Insurance (Diagnostic Imaging Services Table) Regulations 2000, as in force on 31 October 2001; or

(b) equipment that is registered under the scheme, administered by the Department, titled 'MRI Additional Units Eligibility Scheme', as in force on 27 June 2001, and in relation to which registration has not been cancelled or otherwise ceased to have effect; or

(c) equipment that is registered under the scheme, administered by the Department, titled '2004 MRI Additional Units Eligibility Scheme', as in force on 29 November 2004; or

(d) equipment located in a children's hospital described in rule 36(c) of the Health Insurance (Diagnostic Imaging Services Table) Regulations; or

(e) equipment at locations described in rule 36(d) and (e) of the Health Insurance (Diagnostic Imaging Services Table) Regulations.

The location of Medicare-eligible MRI machines is available at the Department of Health and Ageing's website at http://www.health.gov.au

Number of eligible services

- Items have been placed in subgroups according to frequency restrictions for Medicare eligibility as follows:
- Services in subgroups 1, 4, 6, 8, 11 and 18 have no frequency restriction.
- Services in subgroups 16 and 19 may be claimed on one occasion in any 12-month period.
- Services in subgroups 13, 14 and 17 may be claimed on two occasions in any 12-month period.
- Services in subgroups 2, 3, 5, 7, 9, 10, 12 and 15 may be claimed on three occasions in any 12-month period.
- Services in subgroup 20 may be claimed only once in a patient's lifetime.

- Items in subgroup 21 may only be ordered in conjunction with an eligible MRI/MRA service (see DIO.10).

Example : Item 63271 in subgroup 10 can be claimed by a patient on three occasions in any 12 month period. If the patient had claimed Medicare benefits for the following:

Item	Date of service
63271	10/12/04
63271	18/4/05
63271	16/10/05
63271	11/12/05

The following table demonstrates which dates of service would be eligible:

Date of service	Claimable?	Why?
12/3/05	No	Between 10/12/04 and 9/12/05, the patient would have had 4 x 63271 in 12 months - 10/12/04, 12/3/05, 18/4/05 and 16/10/05
4/3/06	No	Between 5/3/05 and 4/3/06, the patient would have had 4 x 63271 in 12 months - 18/4/05, 16/10/05, 11/12/05 and 4/3/06
20/4/06	Yes	Between 21/4/05 and 20/4/06, the patient would have had 3x 63271 in 12 months - 16/10/05, 11/12/05 and 20/4/06

The frequency restrictions are therefore considered to be rolling restrictions and not based on calendar or financial years.

In addition, restrictions on the number of services of the kind described in subgroup 12 apply to specific anatomical sites. Where an item description applies to more than one anatomical site the restriction on the number of services applies to each site.

- Item 63328, MRI scan for derangement of the knee or its supporting structures, applies to two specific anatomical sites, ie, right knee and left knee. Each anatomical site may be scanned up to 3 times in any 12-month period.

MRI Musculoskeletal (MSK) Multiple Services – refer to DIJ

Restrictions between MRI/MRA

When services in subgroups 1, 2, 4, 5 and 14 (MRI of the Head, Head and Cervical Spine or Cardiovascular system) and services from subgroups 3 and 15 (Magnetic Resonance Angiography) are performed on a single occasion, only the MRI rebate is claimable.

Example: Service 63064, MRI scan of head for stroke, is performed on the same occasion as service 63401, MRA scan for vascular abnormality. In this circumstance only item 63064 may be claimed.

Modifying Items

Subgroup 21 contains a number of items which modify the value of the MRI/MRA service claimed for the additional cost or complexity of performing a service on a patient who is sedated, under a general anaesthetic or is undergoing a service requiring the use of contrast. These items may only be claimed in conjunction with an eligible MRI/MRA service.

The modifying items are not considered to be services for the diagnostic imaging multiple services rules.

Contrast

- Services eligible for use with contrast are denoted by (Contrast).
- If more than one service is completed in which contrast is used, item 63491 may be claimed for each eligible service, except where restricted by another rule (see DIO.3.3).

Anaesthetic and Sedation

- The anaesthetic modifier is for use by the eligible provider performing the scan, not the Anaesthetist. Medicare benefits for Anaesthesia services are payable under Category 3 (Therapeutic Procedures), section T10 (Relative Value Guide), of the 1 November 2003 Medicare Benefits Schedule. The minimum requirements for anaesthesia (including sedation) are listed in section T10.5 of the explanatory notes in section T10.
- The modifiers for sedation and anaesthetic may not be claimed together, if a patient is both sedated and anaesthetised only the anaesthetic modifier should be claimed.
  If more than one scan is provided on a single occasion in which sedation or anaesthetic is used, either item 63494 or 63497 may only be claimed on the first scan.

DIP... MANAGEMENT OF BULK-BILLED SERVICES

Additional bulk billing payment for diagnostic imaging services (item 64990 and 64991)

Item 64990 operates in the same way as item 10990 and item 64991 operates in the same way as item 10991, apart from the following differences:

- Item 64990 and 64991 can only be used in conjunction with items in the Diagnostic Imaging Services Table of the MBS;
- Item 64990 and 64991 applies to diagnostic imaging services self determined by general practitioners and specialists with dual qualifications acting in their capacity as general practitioners;
- Specialists and consultant physicians who provide diagnostic imaging services are not able to claim item 64990 or 64991 unless, for the purposes of the *Health Insurance Act 1973*, the medical practitioner is also a general practitioner and the service provided by the medical practitioner has not been referred to that practitioner by another medical practitioner or person with referring rights.

DIQ... BULK BILLING INCENTIVE

To provide an incentive to bulk-bill, for out of hospital services that are bulk billed the schedule fee is reduced by 5% and rebates paid at 100% of this revised fee (except for item 61369).

Schedules of Services
Each professional service contained in the book has been allocated a unique item number. Located with the item number and description for each service is the Schedule fee and Medicare benefit, together with a reference to an explanatory note relating to the item (if applicable).

If the service attracts an anaesthetic, the word (Anaes.) appears following the description. Where an operation qualifies for the payment of benefits for an assistant, the relevant items are identified by the inclusion of the word (Assist.) in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

In some cases two levels of fees are applied to the same service in General Medical Services, with each level of fee being allocated a separate item number. The item identified by the letter "S" applies in the case where the procedure has been rendered by a recognised specialist in the practice of his or her specialty and the patient has been referred. The item identified by the letter "G" applies in any other circumstance.

Higher rates of benefits are also provided for consultations by a recognised consultant physician where the patient has been referred by another medical practitioner or an approved dental practitioner (oral surgeons).

Differential fees and benefits also apply to services listed in Category 5 (Diagnostic Imaging Services). The conditions relating to these services are set out in Category 5.

Explanatory Notes
Explanatory notes relating to the Medicare benefit arrangements and notes that have general application to services are located at the beginning of the schedule, while notes relating to specific items are located at the beginning of each Category. While there may be a reference following the description of an item to specific notes relating to that item, there may also be general notes relating to each Group of items.

GROUP I1 - ULTRASOUND

SUBGROUP 1 - GENERAL

55028	HEAD, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
55029	HEAD, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
55030	ORBITAL CONTENTS, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
55031	ORBITAL CONTENTS, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
55032	NECK, 1 or more structures of, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
55033	NECK, 1 or more structures of, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
55036	ABDOMEN, ultrasound scan of, including scan of urinary tract when undertaken but not being a service associated with the service described in item 55600 or item 55603, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not performed with item 55038, 55044 or 55731 on the same patient within 24 hours (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $111.30	**Benefit:** 75% = $83.50	85% = $94.65
55037	ABDOMEN, ultrasound scan of, including scan of urinary tract when undertaken but not being a service associated with the service described in item 55600 or item 55603, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
55038	URINARY TRACT, ultrasound scan of but not being a service associated with the service described in item 55600 or item 55603, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not performed with item 55036, 55044 or 55731 on the same patient within 24 hours (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75

55039	URINARY TRACT, ultrasound scan of, but not being a service associated with the service described in item 55600 or item 55603, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
55044	PELVIS, male, ultrasound scan of, by any or all approaches, but not being a service associated with the service described in item 55600 or item 55603, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not performed with item 55036 or 55038 on the same patient within 24 hours (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $111.30	**Benefit:** 75% = $83.50	85% = $94.65
55045	PELVIS, male, ultrasound scan of, by any or all approaches, but not being a service associated with the service described in item 55600 or item 55603, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
55048	SCROTUM, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.50	**Benefit:** 75% = $82.15	85% = $93.10
55049	SCROTUM, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
55054	ULTRASONIC CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this Group applies (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
55070	BREAST, one, ultrasound scan of, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $98.25	**Benefit:** 75% = $73.70	85% = $83.55
55073	BREAST, one, ultrasound scan of, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $34.05	**Benefit:** 75% = $25.55	85% = $28.95
55076	BREASTS, both, ultrasound scan of, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
55079	BREASTS, both, ultrasound scan of, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20

55084	URINARY BLADDER, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of the Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not performed with item 55600, 55603, 55036, 55038, 55044, 55731 or 11917 on the same date of service (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $98.25 **Benefit:** 75% = $73.70 85% = $83.55
55085	URINARY BLADDER, ultrasound scan of, by any or all approaches, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 applies; and the service is not performed with item 55600, 55603, 55037, 55039, 55045, 55733 or 11917 on the same date of service (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $34.05 **Benefit:** 75% = $25.55 85% = $28.95
	SUBGROUP 2 - CARDIAC
55113	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup (with the exception of items 55118 and 55130), applies, for the investigation of symptoms or signs of cardiac failure, or suspected or known ventricular hypertrophy or dysfunction, or chest pain (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $230.65 **Benefit:** 75% = $173.00 85% = $196.10
55114	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup (with the exception of items 55118 and 55130), applies, for the investigation of suspected or known acquired valvular, aortic, pericardial, thrombotic, or embolic disease, or heart tumour (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $230.65 **Benefit:** 75% = $173.00 85% = $196.10
55115	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup (with the exception of items 55118 and 55130), applies, for the investigation of symptoms or signs of congenital heart disease (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $230.65 **Benefit:** 75% = $173.00 85% = $196.10
55116	EXERCISE STRESS ECHOCARDIOGRAPHY performed in conjunction with item 11712, with two-dimensional recordings before exercise (baseline) from at least three acoustic windows and matching recordings from the same windows at, or immediately after, peak exercise, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup applies (with the exception of items 55118 and 55130). Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $261.65 **Benefit:** 75% = $196.25 85% = $222.45
55117	PHARMACOLOGICAL STRESS ECHOCARDIOGRAPHY performed in conjunction with item 11712, with two-dimensional recordings before drug infusion (baseline) from at least three acoustic windows and matching recordings from the same windows at least twice during drug infusion, including a recording at the peak drug dose not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup, applies (with the exception of items 55118 and 55130). Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $261.65 **Benefit:** 75% = $196.25 85% = $222.45

55118	HEART, 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL EXAMINATION of, from at least two levels, and in more than one plane at each level: (a) with: (i) real time colour flow mapping and, if indicated, pulsed wave Doppler examination; and (ii) recordings on video tape or digital medium; and (b) not being an intra-operative service or a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, applies (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $275.50 **Benefit:** 75% = $206.65 85% = $234.20
55130	INTRA-OPERATIVE 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL ECHOCARDIOGRAPHY incorporating Doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac surgery incorporating sequential assessment of cardiac function before and after the surgical procedure - not associated with item 55135 (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $170.00 **Benefit:** 75% = $127.50 85% = $144.50
55135	INTRA-OPERATIVE 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL ECHOCARDIOGRAPHY incorporating Doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac valve surgery (repair or replacement) incorporating sequential assessment of cardiac function and valve competence before and after the surgical procedure - not associated with item 55130 (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $353.60 **Benefit:** 75% = $265.20 85% = $300.60
	SUBGROUP 3 - VASCULAR
55238	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb OR of arteries and bypass grafts in the lower limb, below the inguinal ligament, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55244	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for acute venous thrombosis, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55246	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55248	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the upper limb OR of arteries and bypass grafts in the upper limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55252	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the upper limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55274	DUPLEX SCANNING, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of extra-cranial bilateral carotid and vertebral vessels, with or without subclavian and innominate vessels, with or without oculoplethysmography or peri-orbital Doppler examination, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Groups applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10

55276	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-abdominal, aorta and iliac arteries or inferior vena cava and iliac veins OR of intra-abdominal, aorta and iliac arteries and inferior vena cava and iliac veins, excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55278	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of renal or visceral vessels OR of renal and visceral vessels, including aorta, inferior vena cava and iliac vessels as required excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55280	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-cranial vessels, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55282	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of cavernosal artery of the penis following intracavernosal administration of a vasoactive agent, performed during the period of pharmacological activity of the injected agent, to confirm a diagnosis of vascular aetiology for impotence, where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55284	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of cavernosal tissue of the penis to confirm a diagnosis and, where indicated, assess the progress and management of: (a) priapism; or (b) fibrosis of any type; or (c) fracture of the tunica; or (d) arteriovenous malformations; where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Groups applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55292	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of surgically created arteriovenous fistula or surgically created arteriovenous access graft in the upper or lower limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55294	DUPLEX SCANNING, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or veins OR arteries and veins, for mapping of bypass conduit prior to vascular surgery, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054), 3 or 4 of this Group applies - including any associated skin marking (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
55296	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow spectral analysis and marking of veins in the lower limb below the inguinal ligament prior to varicose vein surgery, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054), 3 or 4 of this Group applies - including any associated skin marking (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $111.05 **Benefit:** 75% = $83.30 85% = $94.40

	SUBGROUP 4 - UROLOGICAL
55600	PROSTATE, bladder base and urethra, transrectal ultrasound scan of, where performed: (a) personally by a medical practitioner (not being the medical practitioner who assessed the patient as specified in (c)) using a transducer probe or probes that: (i) have a nominal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz; and (ii) can obtain both axial and sagittal scans in 2 planes at right angles; and (b) following a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology or a consultant physician in medical oncology who has: (i)examined the patient in the 60 days prior to the scan; and (ii)recommended the scan for the management of the patient's current prostatic disease (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
55603	PROSTATE, bladder base and urethra, transrectal ultrasound scan of, where performed: (a) personally by a medical practitioner who undertook the assessment referred to in (c) using a transducer probe or probes that: (i) have a nominal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz; and (ii) can obtain both axial and sagittal scans in 2 planes at right angles; and (b) following a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology or a consultant physician in medical oncology who has: (i)examined the patient in the 60 days prior to the scan; and (ii)recommended the scan for the management of the patient's current prostatic disease (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75

SUBGROUP 5 - OBSTETRIC AND GYNAECOLOGICAL

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where:

(a) the patient is referred by a medical practitioner; and

(b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and

(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and

(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and

(e) one or more of the following conditions are present:

- (i) hyperemesis gravidarum;
- (ii) diabetes mellitus;
- (iii) hypertension;
- (iv) toxaemia of pregnancy;
- (v) liver or renal disease;
- (vi) autoimmune disease;
- (vii) cardiac disease;
- (viii) alloimmunisation;
- (ix) maternal infection;
- (x) inflammatory bowel disease;
- (xi) bowel stoma;
- (xii) abdominal wall scarring;
- (xiii) previous spinal or pelvic trauma or disease;
- (xiv) drug dependency;
- (xv) thrombophilia;
- (xvi) significant maternal obesity;
- (xvii) advanced maternal age;
- (xviii) abdominal pain or mass;
- (xix) uncertain dates;
- (xx) high risk pregnancy;
- (xxi) previous post dates delivery;
- (xxii) previous caesarean section;
- (xxiii) poor obstetric history;
- (xxiv) suspicion of ectopic pregnancy;
- (xxv) risk of miscarriage;
- (xxvi) diminished symptoms of pregnancy;
- (xxvii) suspected or known cervical incompetence;
- (xxviii) suspected or known uterine abnormality;
- (xxix) pregnancy after assisted reproduction;
- (xxx) risk of fetal abnormality (R)

Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55707 (R). Fee is payable only for item 55700 or item 55707, not both items.

(See para DIQ of explanatory notes to this Category)

EMSN 55700

Fee: $60.00 **Benefit:** 75% = $45.00 85% = $51.00

Extended Medicare Safety Net Cap: $30.45

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where:

(a) the patient is not referred by a medical practitioner; and

(b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and

(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and

(d) one or more of the following conditions are present:

- (i) hyperemesis gravidarum;
- (ii) diabetes mellitus;
- (iii) hypertension;
- (iv) toxaemia of pregnancy;
- (v) liver or renal disease;
- (vi) autoimmune disease;
- (vii) cardiac disease;
- (viii) alloimmunisation;
- (ix) maternal infection;
- (x) inflammatory bowel disease;
- (xi) bowel stoma;
- (xii) abdominal wall scarring;
- (xiii) previous spinal or pelvic trauma or disease;
- (xiv) drug dependency;
- (xv) thrombophilia;
- (xvi) significant maternal obesity;
- (xvii) advanced maternal age;
- (xviii) abdominal pain or mass;
- (xix) uncertain dates;
- (xx) high risk pregnancy;
- (xxi) previous post dates delivery;
- (xxii) previous caesarean section;
- (xxiii) poor obstetric history;
- (xxiv) suspicion of ectopic pregnancy;
- (xxv) risk of miscarriage;
- (xxvi) diminished symptoms of pregnancy;
- (xxvii) suspected or known cervical incompetence;
- (xxviii) suspected or known uterine abnormality;
- (xxix) pregnancy after assisted reproduction;
- (xxx) risk of fetal abnormality (NR)

Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55708 (R). Fee is payable only for item 55703 or item 55707, not both items.

(See para DIQ of explanatory notes to this Category)

EMSN 55703

Fee: $35.00 **Benefit:** 75% = $26.25 85% = $29.75

Extended Medicare Safety Net Cap: $15.25

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where:

(a) the patient is referred by a medical practitioner; and
(b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and
(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and
(e) one or more of the following conditions are present:
- (i) hyperemesis gravidarum;
- (ii) diabetes mellitus;
- (iii) hypertension;
- (iv) toxaemia of pregnancy;
- (v) liver or renal disease;
- (vi) autoimmune disease;
- (vii) cardiac disease;
- (viii) alloimmunisation;
- (ix) maternal infection;
- (x) inflammatory bowel disease;
- (xi) bowel stoma;
- (xii) abdominal wall scarring;
- (xiii) previous spinal or pelvic trauma or disease;
- (xiv) drug dependency;
- (xv) thrombophilia;
- (xvi) significant maternal obesity;
- (xvii) advanced maternal age;
- (xviii) abdominal pain or mass;
- (xix) uncertain dates;
- (xx) high risk pregnancy;
- (xxi) previous post dates delivery;
- (xxii) previous caesarean section;
- (xxiii) poor obstetric history;
- (xxiv) suspicion of ectopic pregnancy;
- (xxv) risk of miscarriage;
- (xxvi) diminished symptoms of pregnancy;
- (xxvii) suspected or known cervical incompetence;
- (xxviii) suspected or known uterine abnormality;
- (xxix) pregnancy after assisted reproduction;
- (xxx) risk of fetal abnormality (R)

Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55707 (R). Fee is payable only for item 55704 or item 55707, not both items.

(See para DIQ of explanatory notes to this Category)

EMSN 55704

Fee: $70.00 **Benefit:** 75% = $52.50 85% = $59.50

Extended Medicare Safety Net Cap: $35.55

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where:

(a) the patient is not referred by a medical practitioner; and
(b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and
(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
(d) one or more of the following conditions are present:
- (i) hyperemesis gravidarum
- (ii) diabetes mellitus;
- (iii) hypertension;
- (iv) toxaemia of pregnancy;
- (v) liver or renal disease;
- (vi) autoimmune disease;
- (vii) cardiac disease;
- (viii) alloimmunisation;
- (ix) maternal infection;
- (x) inflammatory bowel disease;
- (xi) bowel stoma;
- (xii) abdominal wall scarring;
- (xiii) previous spinal or pelvic trauma or disease;
- (xiv) drug dependency;
- (xv) thrombophilia;
- (xvi) significant maternal obesity;
- (xvii) advanced maternal age;
- (xviii) abdominal pain or mass;
- (xix) uncertain dates;
- (xx) high risk pregnancy;
- (xxi) previous post dates delivery;
- (xxii) previous caesarean section;
- (xxiii) poor obstetric history;
- (xxiv) suspicion of ectopic pregnancy;
- (xxv) risk of miscarriage;
- (xxvi) diminished symptoms of pregnancy;
- (xxvii) suspected or known cervical incompetence;
- (xxviii) suspected or known uterine abnormality;
- (xxix) pregnancy after assisted reproduction;
- (xxx) risk of fetal abnormality (NR)

Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55708 (R). Fee is payable only for item 55705 or item 55708, not both items.

(See para DIQ of explanatory notes to this Category)

EMSN 55705 **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75
Extended Medicare Safety Net Cap: $15.25

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where:

(a) the patient is referred by a medical practitioner; and
(b) the dating for the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and
(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and
(e) the service is not performed in the same pregnancy as item 55709 (R)

(See para DIQ of explanatory notes to this Category)

EMSN 55706 **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00
Extended Medicare Safety Net Cap: $50.75

EMSN 55707	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where; (a) the patient is referred by a medical practitioner; and (b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84mm; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) one or more of the conditions mentioned in subparagraphs (e) (i) to (xxx) of item 55704 are present; and (f) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (g) the service is not performed with item 55700, 55703, 55704 or 55705 on the same patient within 24 hours (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $70.00 **Benefit:** 75% = $52.50 85% = $59.50 **Extended Medicare Safety Net Cap:** $35.55
EMSN 55708	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where; (a) the patient is not referred by a medical practitioner; and (b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84mm; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) one or more of the conditions in subparagraphs (e) (i) to (xxx) of item 55704 are present; and (e) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (f) the service is not performed in conjunction with item 55700, 55703, 55704 or 55705 on the same patient within 24 hours (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75 **Extended Medicare Safety Net Cap:** $15.25
EMSN 55709	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the service is not performed in the same pregnancy as item 55706 (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $38.00 **Benefit:** 75% = $28.50 85% = $32.30 **Extended Medicare Safety Net Cap:** $20.30
EMSN 55712	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55706 or 55709 applies (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $115.00 **Benefit:** 75% = $86.25 85% = $97.75 **Extended Medicare Safety Net Cap:** $60.90
EMSN 55715	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) further examination is clinically indicated in the same pregnancy to which item 55706 or 55709 applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $40.00 **Benefit:** 75% = $30.00 85% = $34.00 **Extended Medicare Safety Net Cap:** $20.30

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where:

(a) the patient is referred by a medical practitioner; and

(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and

(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and

(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and

(e) the service is not performed in the same pregnancy as item 55723; and

(f) one or more of the following conditions are present:

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

(See para DIQ of explanatory notes to this Category)

EMSN 55718

Fee: $100.00 **Benefit:** 75% = $75.00 85% = $85.00

Extended Medicare Safety Net Cap: $50.75

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of by any or all approaches, where:

(a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has qualifications recognised by the Royal Australian and New Zealand College of Obstericians and Gynaecologists as being equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and

(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and

(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and

(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and

(e) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (R)

(See para DIQ of explanatory notes to this Category)

EMSN 55721

Fee: $115.00 **Benefit:** 75% = $86.25 85% = $97.75

Extended Medicare Safety Net Cap: $60.90

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where:

(a) the patient is not referred by a medical practitioner; and
(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and
(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
(d) the service is not performed in the same pregnancy as item 55718; and
(e) one or more of the following conditions are present:
- (i) known or suspected fetal abnormality or fetal cardiac arrhythmia;
- (ii) fetal anatomy (late booking or incomplete mid-trimester scan);
- (iii) malpresentation;
- (iv) cervical assessment;
- (v) clinical suspicion of amniotic fluid abnormality;
- (vi) clinical suspicion of placental or umbilical cord abnormality;
- (vii) previous complicated delivery;
- (viii) uterine scar assessment;
- (ix) uterine fibroid;
- (x) previous fetal death in utero or neonatal death;
- (xi) antepartum haemorrhage;
- (xii) clinical suspicion of intrauterine growth retardation;
- (xiii) clinical suspicion of macrosomia;
- (xiv) reduced fetal movements;
- (xv) suspected fetal death;
- (xvi) abnormal cardiotocography;
- (xvii) prolonged pregnancy;
- (xviii) premature labour;
- (xix) fetal infection;
- (xx) pregnancy after assisted reproduction;
- (xxi) trauma;
- (xxii) diabetes mellitus;
- (xxiii) hypertension;
- (xxiv) toxaemia of pregnancy;
- (xxv) liver or renal disease;
- (xxvi) autoimmune disease;
- (xxvii) cardiac disease;
- (xxviii) alloimmunisation;
- (xxix) maternal infection;
- (xxx) inflammatory bowel disease;
- (xxxi) bowel stoma;
- (xxxii) abdominal wall scarring;
- (xxxiii) previous spinal or pelvic trauma or disease;
- (xxxiv) drug dependency;
- (xxxv) thrombophilia;
- (xxxvi) significant maternal obesity;
- (xxxvii) advanced maternal age;
- (xxxviii) abdominal pain or mass (NR)

(See para DIQ of explanatory notes to this Category)

EMSN 55723 **Fee:** $38.00 **Benefit:** 75% = $28.50 85% = $32.30
Extended Medicare Safety Net Cap: $20.30

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricans and Gynaecologists, where:

(a) the patient is not referred by a medical practitioner; and
(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and
(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
(d) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (NR)

(See para DIQ of explanatory notes to this Category)

EMSN 55725 **Fee:** $40.00 **Benefit:** 75% = $30.00 85% = $34.00
Extended Medicare Safety Net Cap: $20.30

Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of the umbilical artery, and measured assessment of amniotic fluid volume after the 24th week of gestation where the patient is referred by a medical practitioner for this procedure and where there is reason to suspect intrauterine growth retardation or a significant risk of foetal death, not being a service associated with a service to which an item in this Group applies - (R)

(See para DIQ of explanatory notes to this Category)

EMSN 55729 **Fee:** $27.25 **Benefit:** 75% = $20.45 85% = $23.20
Extended Medicare Safety Net Cap: $15.25

55731	PELVIS, FEMALE, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) the service is not performed with item 55036 or 55038 on the same patient within 24 hours (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $98.00 **Benefit:** 75% = $73.50 85% = $83.30
55733	PELVIS, FEMALE, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75
55736	PELVIS, FEMALE, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of medical practitioners of which the providing practitioner is a member; and (d) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $127.00 **Benefit:** 75% = $95.25 85% = $107.95
55739	PELVIS, FEMALE, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $57.00 **Benefit:** 75% = $42.75 85% = $48.45
55759	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and (f) the service is not performed in conjunction with item 55706, 55709, 55712, 55715 or 55762 during the same pregnancy (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $150.00 **Benefit:** 75% = $112.50 85% = $127.50
EMSN 55762	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not performed in conjunction with item 55706, 55709, 55712, 55715 or 55759during the same pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $60.00 **Benefit:** 75% = $45.00 85% = $51.00 **Extended Medicare Safety Net Cap:** $30.45

EMSN 55764	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstericians and Gynaecologists as equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and (f) further examination is clinically indicated in the same pregnancy to which item 55759 or 55762 has been performed; and (g) not performed in conjunction with item 55706, 55709, 55712 or 55715 during the same pregnancy (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $160.00 **Benefit:** 75% = $120.00 85% = $136.00 **Extended Medicare Safety Net Cap:** $81.20
EMSN 55766	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; (e) further examination is clinically indicated in the same pregnancy to which item 55759, or 55762 has been performed; and (f) not performed in conjunction with item 55706, 55709, 55712 or 55715 during the same pregnancy (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $65.00 **Benefit:** 75% = $48.75 85% = $55.25 **Extended Medicare Safety Net Cap:** $30.45
EMSN 55768	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where: (a) dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (b) the ultrasound confirms a multiple pregnancy; and (c) the patient is referred by a medical practitioner; and (d) the service is not performed in the same pregnancy as item 55770; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service is not performed in conjunction with item 55718, 55721, 55723 or 55725 during the same pregnancy (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $150.00 **Benefit:** 75% = $112.50 85% = $127.50 **Extended Medicare Safety Net Cap:** $76.15
EMSN 55770	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy), by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) the service is not performed in the same pregnancy as item 55768; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the service is not performed in conjunction with item 55718, 55721, 55723 or 55725 during the same pregnancy (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $60.00 **Benefit:** 75% = $45.00 85% = $51.00 **Extended Medicare Safety Net Cap:** $30.45

	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstericians and Gynaecologists as equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service is not performed in conjunction with item 55718, 55721, 55723 or 55725 during the same pregnancy (R) *(See para DIQ of explanatory notes to this Category)*
EMSN 55772	**Fee:** $160.00 **Benefit:** 75% = $120.00 85% = $136.00 **Extended Medicare Safety Net Cap:** $81.20
	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed ;and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the service is not performed in conjunction with item 55718, 55721 55723 or 55725 during the same pregnancy (NR) *(See para DIQ of explanatory notes to this Category)*
EMSN 55774	**Fee:** $65.00 **Benefit:** 75% = $48.75 85% = $55.25 **Extended Medicare Safety Net Cap:** $35.55
	SUBGROUP 6 - MUSCULOSKELETAL
	HAND OR WRIST, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)*
55800	**Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
	HAND OR WRIST, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)*
55802	**Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
	FOREARM OR ELBOW, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)*
55804	**Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
	FOREARM OR ELBOW, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)*
55806	**Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20

	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific shoulder pain alone*. SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions: - evaluation of injury to tendon, muscle or muscle/tendon junction; or - rotator cuff tear/calcification/tendinosis (biceps, subscapular, supraspinatus, infraspinatus); or - biceps subluxation; or - capsulitis and bursitis; or - evaluation of mass including ganglion; or - occult fracture; or - acromioclavicular joint pathology.(R) *(See para DIQ of explanatory notes to this Category)*
55808	**Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific shoulder pain alone*. SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions: - evaluation of injury to tendon, muscle or muscle/tendon junction; or - rotator cuff tear/calcification/tendinosis (biceps, subscapular, supraspinatus, infraspinatus); or - biceps subluxation; or - capsulitis and bursitis; or - evaluation of mass including ganglion; or - occult fracture; or - acromioclavicular joint pathology.(NR) *(See para DIQ of explanatory notes to this Category)*
55810	**Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
	CHEST OR ABDOMINAL WALL, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)*
55812	**Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
	CHEST OR ABDOMINAL WALL, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)*
55814	**Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
	HIP OR GROIN, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)*
55816	**Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
	HIP OR GROIN, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies: and (b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)*
55818	**Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
	PAEDIATRIC HIP EXAMINATION FOR DYSPLASIA, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)*
55820	**Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75

	PAEDIATRIC HIP EXAMINATION FOR DYSPLASIA, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)*		
55822	**Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
	BUTTOCK OR THIGH, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)*		
55824	**Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
	BUTTOCK OR THIGH, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)*		
55826	**Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific knee pain alone or other knee condition including:* - meniscal and cruciate ligament tears - assessment of chondral surfaces KNEE, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided for the assessment of one or more of the following conditions or suspected conditions: - abnormality of tendons or bursae about the knee; or - meniscal cyst, popliteal fossa cyst, mass or pseudomass; or - nerve entrapment, nerve or nerve sheath tumour; or - injury of collateral ligaments.(R) *(See para DIQ of explanatory notes to this Category)*		
55828	**Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific knee pain alone or other knee condition including:* - meniscal and cruciate ligament tears - assessment of chondral surfaces KNEE, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner and where the service is provided for the assessment of one or more of the following conditions or suspected conditions: - abnormality of tendons or bursae about the knee; or - meniscal cyst, popliteal fossa cyst, mass or pseudomass; or - nerve entrapment, nerve or nerve sheath tumour; or - injury of collateral ligaments.(NR) *(See para DIQ of explanatory notes to this Category)*		
55830	**Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
	LOWER LEG, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)*		
55832	**Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
	LOWER LEG, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)*		
55834	**Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
	ANKLE OR HIND FOOT, 1 or both sides, ultrasound scan of, where: (a) the services is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)*		
55836	**Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75

	ANKLE OR HIND FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)*		
55838	**Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
	MID FOOT OR FORE FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)*		
55840	**Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
	MID FOOT OR FORE FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)*		
55842	**Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
	ASSESSMENT OF A MASS ASSOCIATED WITH THE SKIN OR SUBCUTANEOUS STRUCTURES, NOT BEING A PART OF THE MUSCULOSKELETAL SYSTEM, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)*		
55844	**Fee:** $87.35	**Benefit:** 75% = $65.55	85% = $74.25
	ASSESSMENT OF A MASS ASSOCIATED WITH THE SKIN OR SUBCUTANEOUS STRUCTURES, NOT BEING A PART OF THE MUSCULOSKELETAL SYSTEM, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)*		
55846	**Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20
	MUSCULOSKELETAL CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies, and not performed in conjunction with item 55054 (R) *(See para DIQ of explanatory notes to this Category)*		
55848	**Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
	MUSCULOSKELETAL CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, inclusive of a diagnostic musculoskeletal ultrasound service, where: (a) the referring practitioner has indicated on a referral for a musculoskeletal ultrasound that a ultrasound guided intervention be performed if clinically indicated; (b) the service is not performed in conjunction with items 55054, or 55800 to 55848, and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)*		
55850	**Fee:** $152.85	**Benefit:** 75% = $114.65	85% = $129.95
	PAEDIATRIC SPINE, SPINAL CORD AND OVERLYING SUBCUTANEOUS TISSUES, Ultrasound scan of, where: a) the patient is referred by a medical practitioner b) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) *(See para DIQ of explanatory notes to this Category)*		
55852	**Fee:** $109.10	**Benefit:** 75% = $81.85	85% = $92.75
	PAEDIATRIC SPINE, SPINAL CORD AND OVERLYING SUBCUTANEOUS TISSUES, Ultrasound scan of, where: a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and b) the patient is not referred by a medical practitioner (NR) *(See para DIQ of explanatory notes to this Category)*		
55854	**Fee:** $37.85	**Benefit:** 75% = $28.40	85% = $32.20

GROUP I2 - COMPUTED TOMOGRAPHY

HEAD

56001	COMPUTED TOMOGRAPHY - scan of brain without intravenous contrast medium, not being a service to which item 57001 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $195.05	**Benefit:** 75% = $146.30	85% = $165.80
56007	COMPUTED TOMOGRAPHY - scan of brain with intravenous contrast medium and with any scans of the brain prior to intravenous contrast injection, when undertaken, not being a service to which item 57007 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $250.00	**Benefit:** 75% = $187.50	85% = $212.50
56010	COMPUTED TOMOGRAPHY - scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when undertaken (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $252.10	**Benefit:** 75% = $189.10	85% = $214.30
56013	COMPUTED TOMOGRAPHY - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $250.00	**Benefit:** 75% = $187.50	85% = $212.50
56016	COMPUTED TOMOGRAPHY - scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $290.00	**Benefit:** 75% = $217.50	85% = $246.50
56022	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $225.00	**Benefit:** 75% = $168.75	85% = $191.25
56028	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sinuses or both prior to intravenous contrast injection, when undertaken (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $336.80	**Benefit:** 75% = $252.60	85% = $286.30
56030	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $225.00	**Benefit:** 75% = $168.75	85% = $191.25
56036	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, with intravenous contrast medium, where: (a) a scan without intravenous contrast medium has been undertaken; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $336.80	**Benefit:** 75% = $252.60	85% = $286.30
56041	COMPUTED TOMOGRAPHY - scan of brain without intravenous contrast medium, not being a service to which item 57041 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $98.75	**Benefit:** 75% = $74.10	85% = $83.95
56047	COMPUTED TOMOGRAPHY - scan of brain with intravenous contrast medium and with any scans of the brain prior to intravenous contrast injection, when undertaken, not being a service to which item 57047 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $126.10	**Benefit:** 75% = $94.60	85% = $107.20
56050	COMPUTED TOMOGRAPHY - scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $128.20	**Benefit:** 75% = $96.15	85% = $109.00

	COMPUTED TOMOGRAPHY - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56053	**Fee:** $128.20	**Benefit:** 75% = $96.15	85% = $109.00
	COMPUTED TOMOGRAPHY - scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56056	**Fee:** $155.45	**Benefit:** 75% = $116.60	85% = $132.15
	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56062	**Fee:** $113.15	**Benefit:** 75% = $84.90	85% = $96.20
	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sinuses or both prior to intravenous contrast injection, when undertaken (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56068	**Fee:** $168.40	**Benefit:** 75% = $126.30	85% = $143.15
	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56070	**Fee:** $113.15	**Benefit:** 75% = $84.90	85% = $96.20
	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, with intravenous contrast medium, where: (a) a scan without intravenous contrast medium has been undertaken; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56076	**Fee:** $168.40	**Benefit:** 75% = $126.30	85% = $143.15
	NECK		
	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) without intravenous contrast medium, not being a service to which item 56801 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56101	**Fee:** $230.00	**Benefit:** 75% = $172.50	85% = $195.50
	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) - with intravenous contrast medium and with any scans of soft tissues of neck including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) prior to intravenous contrast injection, when undertaken, not being a service associated with a service to which item 56807 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56107	**Fee:** $340.00	**Benefit:** 75% = $255.00	85% = $289.00
	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) without intravenous contrast medium, not being a service to which item 56841 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56141	**Fee:** $116.45	**Benefit:** 75% = $87.35	85% = $99.00
	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) - with intravenous contrast medium and with any scans of soft tissues of neck including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) prior to intravenous contrast injection, when undertaken, not being a service associated with a service to which item 56847 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56147	**Fee:** $171.60	**Benefit:** 75% = $128.70	85% = $145.90
	SPINE		
	COMPUTED TOMOGRAPHY - scan of spine, 1 or more regions with intrathecal contrast medium, including the preparation for intrathecal injection of contrast medium and any associated plain X-rays, not being a service to which item 59724 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56219	**Fee:** $326.20	**Benefit:** 75% = $244.65	85% = $277.30

COMPUTED TOMOGRAPHY				COMPUTED TOMOGRAPHY
56220	COMPUTED TOMOGRAPHY - scan of spine, cervical region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $240.00	**Benefit:** 75% = $180.00	85% = $204.00	
56221	COMPUTED TOMOGRAPHY - scan of spine, thoracic region, without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $240.00	**Benefit:** 75% = $180.00	85% = $204.00	
56223	COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $240.00	**Benefit:** 75% = $180.00	85% = $204.00	
56224	COMPUTED TOMOGRAPHY - scan of spine, cervical region, with intravenous contrast medium and with any scans of the cervical region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $351.40	**Benefit:** 75% = $263.55	85% = $298.70	
56225	COMPUTED TOMOGRAPHY - scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine prior to intravenous contrast injection when undertaken, only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $351.40	**Benefit:** 75% = $263.55	85% = $298.70	
56226	COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, with intravenous contrast medium and with any scans of the lumbosacral region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $351.40	**Benefit:** 75% = $263.55	85% = $298.70	
56227	COMPUTED TOMOGRAPHY - scan of spine, cervical region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $122.50	**Benefit:** 75% = $91.90	85% = $104.15	
56228	COMPUTED TOMOGRAPHY - scan of spine, thoracic region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $122.50	**Benefit:** 75% = $91.90	85% = $104.15	
56229	COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $122.50	**Benefit:** 75% = $91.90	85% = $104.15	
56230	COMPUTED TOMOGRAPHY - scan of spine, cervical region, with intravenous contrast medium, and with any scans to the cerival region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $177.45	**Benefit:** 75% = $133.10	85% = $150.85	
56231	COMPUTED TOMOGRAPHY - scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $177.45	**Benefit:** 75% = $133.10	85% = $150.85	
56232	COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, with intravenous contrast medium and with any scans of the lumbosacral region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $177.45	**Benefit:** 75% = $133.10	85% = $150.85	

	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item
56233	COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56220, 56221 and 56223 without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $240.00 **Benefit:** 75% = $180.00 85% = $204.00
	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item
56234	COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56224, 56225 and 56226 with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70
	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item
56235	COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56227, 56228 and 56229 without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $122.45 **Benefit:** 75% = $91.85 85% = $104.10
	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item
56236	COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56230, 56231 and 56232 with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $177.45 **Benefit:** 75% = $133.10 85% = $150.85
56237	COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $240.00 **Benefit:** 75% = $180.00 85% = $204.00
56238	COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit, payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $351.40 **Benefit:** 75% = $263.55 85% = $298.70
56239	COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $122.45 **Benefit:** 75% = $91.85 85% = $104.10
56240	COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit, payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $177.45 **Benefit:** 75% = $133.10 85% = $150.85
56259	COMPUTED TOMOGRAPHY - scan of spine, 1 or more regions with intrathecal contrast medium, including the preparation for intrathecal injection of contrast medium and any associated plain X-rays, not being a service to which item 59724 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $164.80 **Benefit:** 75% = $123.60 85% = $140.10

	CHEST AND UPPER ABDOMEN
56301	COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56801 or 57001 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $295.00 **Benefit:** 75% = $221.25 85% = $250.75
56307	COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contrast medium and with any scans of the chest including lungs, mediastinum, chest wall or pleura and upper abdomen prior to intravenous contrast injection, when undertaken, not being a service to which item 56807 or 57007 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $340.00
56341	COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56841 or 57041 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $149.45 **Benefit:** 75% = $112.10 85% = $127.05
56347	COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contrast medium and with any scans of the chest including lungs, mediastinum, chest wall or pleura and upper abdomen prior to intravenous contrast injection, when undertaken, not being a service to which item 56847 or 57047 applies and not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $202.00 **Benefit:** 75% = $151.50 85% = $171.70
	UPPER ABDOMEN
56401	COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest) without intravenous contrast medium, not being a service to which item 56301, 56501, 56801 or 57001 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50
56407	COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest) with intravenous contrast medium and with any scans of upper abdomen (diaphragm to iliac crest) prior to intravenous contrast injection, when undertaken, not being a service to which item 56307, 56507, 56807 or 57007 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $360.00 **Benefit:** 75% = $270.00 85% = $306.00
56409	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) without intravenous contrast medium not being a service associated with a service to which item 56401 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50
56412	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) with intravenous contrast medium and with any scans of pelvis (iliac crest to pubic symphysis) prior to intravenous contrast injection, when undertaken, not being a service to which item 56407 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $360.00 **Benefit:** 75% = $270.00 85% = $306.00
56441	COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest), without intravenous contrast medium, not being a service to which item 56341, 56541, 56841 or 57041 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $126.80 **Benefit:** 75% = $95.10 85% = $107.80
56447	COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest) with intravenous contrast medium, and with any scans of upper abdomen (diaphragm to iliac crest) prior to intravenous contrast injection, when undertaken, not being a service to which item 56347, 56547, 56847 or 57047 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $181.50 **Benefit:** 75% = $136.15 85% = $154.30

	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) without intravenous contrast medium, not being a service to which item 56441 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56449	**Fee:** $126.80	**Benefit:** 75% = $95.10	85% = $107.80
	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) with intravenous contrast medium, and with any scans of pelvis (iliac crest to pubic symphysis) prior to intravenous contrast injection, when undertaken, not being a service to which item 56447 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56452	**Fee:** $181.50	**Benefit:** 75% = $136.15	85% = $154.30
	UPPER ABDOMEN AND PELVIS COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis without intravenous contrast medium, not for the purposes of virtual colonoscopy, not being a service to which item 56801 or 57001 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56501	**Fee:** $385.00	**Benefit:** 75% = $288.75	85% = $327.25
	COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis with intravenous contrast medium and with any scans of upper abdomen and pelvis prior to intravenous contrast injection, when undertaken, not for the purposes of virtual colonoscopy, not being a service to which item 56807 or 57007 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56507	**Fee:** $480.05	**Benefit:** 75% = $360.05	85% = $410.95
	COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis without intravenous contrast medium, not for the purposes of virtual colonoscopy, not being a service to which item 56841 or 57041 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56541	**Fee:** $193.15	**Benefit:** 75% = $144.90	85% = $164.20
	COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis with intravenous contrast medium, and with any scans of upper abdomen and pelvis prior to intravenous contrast injection, when undertaken, not for the purposes of virtual colonoscopy, not being a service to which item 56847 or 57047 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56547	**Fee:** $243.75	**Benefit:** 75% = $182.85	85% = $207.20
	COMPUTED TOMOGRAPHY OF COLON for exclusion of colorectal neoplasia in symptomatic or high risk patients if: (a) the patient has had an incomplete colonoscopy in the 3 months before the scan; and (b) the date of incomplete colonoscopy is set out on the request for scan; and (c) the service is not a service to which items 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies (R) (K) (Anaes.) *(See para DIL and DIQ of explanatory notes to this Category)*		
56552	**Fee:** $600.00	**Benefit:** 75% = $450.00	85% = $530.90
	COMPUTED TOMOGRAPHY OF COLON for exclusion of colorectal neoplasia in symptomatic or high risk patients if: (a) the request for scan states that one of the following contraindications to colonoscopy is present: (i) suspected perforation of the colon; (ii) complete or high-grade obstruction that will not allow passage of the scope; and (b) the service must not be a service to which item 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies (R) (K) (Anaes.) *(See para DIL and DIQ of explanatory notes to this Category)*		
56554	**Fee:** $600.00	**Benefit:** 75% = $450.00	85% = $530.90
	EXTREMITIES COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions without intravenous contrast medium, payable once only whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56619	**Fee:** $220.00	**Benefit:** 75% = $165.00	85% = $187.00
	COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions with intravenous contrast medium and with any scans of extremities prior to intravenous contrast injection, when undertaken; only 1 benefit is payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56625	**Fee:** $334.65	**Benefit:** 75% = $251.00	85% = $284.50

	COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions without intravenous contrast medium, payable once only whether 1 or more attendances are required to complete (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56659	**Fee:** $112.10	**Benefit:** 75% = $84.10	85% = $95.30
	COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions with intravenous contrast medium, and with any scans of extremities prior to intravenous contrast injection, when undertaken; only 1 benefit is payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56665	**Fee:** $167.40	**Benefit:** 75% = $125.55	85% = $142.30
	CHEST, ABDOMEN, PELVIS AND NECK COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56801	**Fee:** $466.55	**Benefit:** 75% = $349.95	85% = $397.45
	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56807	**Fee:** $560.00	**Benefit:** 75% = $420.00	85% = $490.90
	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56841	**Fee:** $233.35	**Benefit:** 75% = $175.05	85% = $198.35
	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
56847	**Fee:** $283.85	**Benefit:** 75% = $212.90	85% = $241.30
	BRAIN, CHEST AND UPPER ABDOMEN COMPUTED TOMOGRAPHY - scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
57001	**Fee:** $466.65	**Benefit:** 75% = $350.00	85% = $397.55
	COMPUTED TOMOGRAPHY- scan of brain and chest with or without scans of upper abdomen with intravenous contrast medium and with any scans of brain and chest and upper abdomen prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
57007	**Fee:** $567.75	**Benefit:** 75% = $425.85	85% = $498.65
	COMPUTED TOMOGRAPHY- scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
57041	**Fee:** $233.40	**Benefit:** 75% = $175.05	85% = $198.40
	COMPUTED TOMOGRAPHY- scan of brain and chest with or without scans of upper abdomen with intravenous contrast medium and with any scans of brain and chest and upper abdomen prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification or image the coronary arteries (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
57047	**Fee:** $283.90	**Benefit:** 75% = $212.95	85% = $241.35

	PELVIMETRY
57201	COMPUTED TOMOGRAPHY - PELVIMETRY (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $155.20 **Benefit:** 75% = $116.40 85% = $131.95
57247	COMPUTED TOMOGRAPHY - PELVIMETRY (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $77.55 **Benefit:** 75% = $58.20 85% = $65.95
	INTERVENTIONAL TECHNIQUES
57341	COMPUTED TOMOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $470.00 **Benefit:** 75% = $352.50 85% = $400.90
57345	COMPUTED TOMOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $241.60 **Benefit:** 75% = $181.20 85% = $205.40
	SPIRAL ANGIOGRAPHY
57350	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (c) the service has not been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $510.00 **Benefit:** 75% = $382.50 85% = $440.90
57351	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of acute or recurrent pulmonary embolism; acute symptomatic arterial occlusion; post operative complication of arterial surgery; acute ruptured aneurysm; or acute dissection of the aorta, carotid or vertebral artery; and (c) the services to which 57350 or 57355 apply have been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $510.00 **Benefit:** 75% = $382.50 85% = $440.90
57355	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (c) the service has not been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $264.15 **Benefit:** 75% = $198.15 85% = $224.55

COMPUTED TOMOGRAPHY				COMPUTED TOMOGRAPHY
	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: a) the service is not a service to which another item in this group applies; and b) the service is performed for the exclusion of acute or recurrent pulmonary embolism; acute symptomatic arterial occlusion; post operative complication of arterial surgery; or acute ruptured aneurysm; acute dissection of the aorta, carotid or vertebral artery; and (c) the services to which 57350 or 57355 apply have been performed on the same patient within the previous 12 months; and (d) the service is not a study performed to image the coronary arteries (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)*			
57356	**Fee:** $264.15	**Benefit:** 75% = $198.15	85% = $224.55	

	GROUP I3 - DIAGNOSTIC RADIOLOGY		
	SUBGROUP 1 - RADIOGRAPHIC EXAMINATION OF EXTREMITIES		
57506	HAND, WRIST, FOREARM, ELBOW OR HUMERUS (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $29.75	**Benefit:** 75% = $22.35	85% = $25.30
57509	HAND, WRIST, FOREARM, ELBOW OR HUMERUS (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $39.75	**Benefit:** 75% = $29.85	85% = $33.80
57512	HAND AND WRIST OR HAND, WRIST AND FOREARM OR FOREARM AND ELBOW OR ELBOW AND HUMERUS (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $40.50	**Benefit:** 75% = $30.40	85% = $34.45
57515	HAND AND WRIST OR HAND, WRIST AND FOREARM OR FOREARM AND ELBOW OR ELBOW AND HUMERUS (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.00	**Benefit:** 75% = $40.50	85% = $45.90
57518	FOOT, ANKLE, LEG, KNEE OR FEMUR (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $32.50	**Benefit:** 75% = $24.40	85% = $27.65
57521	FOOT, ANKLE, LEG, KNEE OR FEMUR (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $43.40	**Benefit:** 75% = $32.55	85% = $36.90
57524	FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $49.40	**Benefit:** 75% = $37.05	85% = $42.00
57527	FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $65.75	**Benefit:** 75% = $49.35	85% = $55.90
	SUBGROUP 2 - RADIOGRAPHIC EXAMINATION OF SHOULDER OR PELVIS		
57700	SHOULDER OR SCAPULA (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $40.50	**Benefit:** 75% = $30.40	85% = $34.45
57703	SHOULDER OR SCAPULA (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.00	**Benefit:** 75% = $40.50	85% = $45.90
57706	CLAVICLE (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $32.50	**Benefit:** 75% = $24.40	85% = $27.65
57709	CLAVICLE (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $43.40	**Benefit:** 75% = $32.55	85% = $36.90
57712	HIP JOINT (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10
57715	PELVIC GIRDLE (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $60.90	**Benefit:** 75% = $45.70	85% = $51.80
57721	FEMUR, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $99.25	**Benefit:** 75% = $74.45	85% = $84.40

DIAGNOSTIC RADIOLOGY				HEAD
	SUBGROUP 3 - RADIOGRAPHIC EXAMINATION OF HEAD			
57901	SKULL, not in association with item 57902 (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $64.50	**Benefit:** 75% = $48.40	85% = $54.85	
57902	CEPHALOMETRY, not in association with item 57901 (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $64.50	**Benefit:** 75% = $48.40	85% = $54.85	
57903	SINUSES (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.30	**Benefit:** 75% = $35.50	85% = $40.25	
57906	MASTOIDS (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $64.50	**Benefit:** 75% = $48.40	85% = $54.85	
57909	PETROUS TEMPORAL BONES (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $64.50	**Benefit:** 75% = $48.40	85% = $54.85	
57912	FACIAL BONES orbit, maxilla or malar, any or all (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10	
57915	MANDIBLE, not by orthopantomography technique (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10	
57918	SALIVARY CALCULUS (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10	
57921	NOSE (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10	
57924	EYE (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10	
57927	TEMPOROMANDIBULAR JOINTS (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $49.65	**Benefit:** 75% = $37.25	85% = $42.25	
57930	TEETH SINGLE AREA (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $32.90	**Benefit:** 75% = $24.70	85% = $28.00	
57933	TEETH FULL MOUTH (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $78.25	**Benefit:** 75% = $58.70	85% = $66.55	
57939	PALATOPHARYNGEAL STUDIES with fluoroscopic screening (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $64.50	**Benefit:** 75% = $48.40	85% = $54.85	
57942	PALATOPHARYNGEAL STUDIES without fluoroscopic screening (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $49.65	**Benefit:** 75% = $37.25	85% = $42.25	
57945	LARYNX, LATERAL AIRWAYS AND SOFT TISSUES OF THE NECK, not being a service associated with a service to which item 57939 or 57942 applies (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $43.40	**Benefit:** 75% = $32.55	85% = $36.90	

57960	Orthopantomography, for diagnosis and/or management of trauma, infection, tumours, congenital conditions or surgical conditions of the teeth or maxillofacial region (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.40	**Benefit:** 75% = $35.55	85% = $40.30
57963	Orthopantomography, for diagnosis and/or management of impacted teeth, caries, periodontal or peripical pathology where signs or symptoms of those conditions are evident (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.40	**Benefit:** 75% = $35.55	85% = $40.30
57966	Orthopantomography, for diagnosis and/or management of missing or crowded teeth, or developmental anomalies of the teeth or jaws (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.40	**Benefit:** 75% = $35.55	85% = $40.30
57969	Orthopantomography, for diagnosis and/or management of temporomandibular joint arthroses or dysfunction (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.40	**Benefit:** 75% = $35.55	85% = $40.30
	SUBGROUP 4 - RADIOGRAPHIC EXAMINATION OF SPINE		
58100	SPINE CERVICAL (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $67.15	**Benefit:** 75% = $50.40	85% = $57.10
58103	SPINE THORACIC (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $55.10	**Benefit:** 75% = $41.35	85% = $46.85
58106	SPINE LUMBOSACRAL (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $77.00	**Benefit:** 75% = $57.75	85% = $65.45
Fee 58108	Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $110.00	**Benefit:** 75% = $82.50	85% = $93.50
58109	SPINE SACROCOCCYGEAL (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.00	**Benefit:** 75% = $35.25	85% = $39.95
58112	*NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item* Spine, two examinations of the kind referred to in items 58100, 58103, 58106 and 58109 (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $97.25	**Benefit:** 75% = $72.95	85% = $82.70
Fee 58115	*NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item* Spine, three examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $110.00	**Benefit:** 75% = $82.50	85% = $93.50
New 58120	Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal (R), if the service to which item 58120 or 58121 applies has not been performed on the same patient within the same calendar year **Fee:** $110.00	**Benefit:** 75% = $82.50	85% = $93.50
New 58121	*NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item* Spine, three examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R), if the service to which item 58120 or 58121 applies has not been performed on the same patient within the same calendar year **Fee:** $110.00	**Benefit:** 75% = $82.50	85% = $93.50

	SUBGROUP 5 - BONE AGE STUDY AND SKELETAL SURVEYS		
58300	BONE AGE STUDY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $40.10	**Benefit:** 75% = $30.10	85% = $34.10
58306	SKELETAL SURVEY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $89.40	**Benefit:** 75% = $67.05	85% = $76.00

	SUBGROUP 6 - RADIOGRAPHIC EXAMINATION OF THORACIC REGION		
58500	CHEST (lung fields) by direct radiography (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $35.35	**Benefit:** 75% = $26.55	85% = $30.05
58503	CHEST (lung fields) by direct radiography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.15	**Benefit:** 75% = $35.40	85% = $40.10
58506	CHEST (lung fields) by direct radiography with fluoroscopic screening (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $60.75	**Benefit:** 75% = $45.60	85% = $51.65
58509	THORACIC INLET OR TRACHEA (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $39.75	**Benefit:** 75% = $29.85	85% = $33.80
58521	LEFT RIBS, RIGHT RIBS OR STERNUM (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $43.40	**Benefit:** 75% = $32.55	85% = $36.90
58524	LEFT AND RIGHT RIBS, LEFT RIBS AND STERNUM, OR RIGHT RIBS AND STERNUM (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $56.50	**Benefit:** 75% = $42.40	85% = $48.05
58527	LEFT RIBS, RIGHT RIBS AND STERNUM (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $69.40	**Benefit:** 75% = $52.05	85% = $59.00
	SUBGROUP 7 - RADIOGRAPHIC EXAMINATION OF URINARY TRACT		
58700	PLAIN RENAL ONLY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $46.05	**Benefit:** 75% = $34.55	85% = $39.15
58706	INTRAVENOUS PYELOGRAPHY, with or without preliminary plain films and with or without tomography - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $157.90	**Benefit:** 75% = $118.45	85% = $134.25
58715	ANTEGRADE OR RETROGRADE PYELOGRAPHY, with or without preliminary plain films and with preparation and contrast injection - 1 side - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $151.55	**Benefit:** 75% = $113.70	85% = $128.85
58718	RETROGRADE CYSTOGRAPHY OR RETROGRADE URETHROGRAPHY with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $126.10	**Benefit:** 75% = $94.60	85% = $107.20
58721	RETROGRADE MICTURATING CYSTOURETHROGRAPHY, with preparation and contrast injection - (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $138.25	**Benefit:** 75% = $103.70	85% = $117.55
	SUBGROUP 8 - RADIOGRAPHIC EXAMINATION OF ALIMENTARY TRACT AND BILIARY SYSTEM		
58900	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909, 58912, 58915 or 58924 applies (NR) *(See para DIQ of explanatory notes to this Category)* **Fee:** $35.70	**Benefit:** 75% = $26.80	85% = $30.35
58903	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909, 58912, 58915 or 58924 applies (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.60	**Benefit:** 75% = $35.70	85% = $40.50

	BARIUM or other opaque meal of 1 or more of PHARYNX, OESOPHAGUS, STOMACH OR DUODENUM, with or without preliminary plain films of pharynx, chest or duodenum, not being a service associated with a service to which item 57939 or 57942 or 57945 applies - (R) *(See para DIQ of explanatory notes to this Category)*		
58909	**Fee:** $89.95	**Benefit:** 75% = $67.50	85% = $76.50
	BARIUM or other opaque meal OF OESOPHAGUS, STOMACH, DUODENUM AND FOLLOW THROUGH TO COLON, with or without screening of chest, with or without preliminary plain film (R) *(See para DIQ of explanatory notes to this Category)*		
58912	**Fee:** $110.25	**Benefit:** 75% = $82.70	85% = $93.75
	BARIUM or other opaque meal, SMALL BOWEL SERIES ONLY, with or without preliminary plain film (R) *(See para DIQ of explanatory notes to this Category)*		
58915	**Fee:** $78.95	**Benefit:** 75% = $59.25	85% = $67.15
	SMALL BOWEL ENEMA, barium or other opaque study of the small bowel, including DUODENAL INTUBATION, with or without preliminary plain films, not being a service associated with a service to which item 30488 applies - (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
58916	**Fee:** $138.50	**Benefit:** 75% = $103.90	85% = $117.75
	OPAQUE ENEMA, with or without air contrast study and with or without preliminary plain films - (R) *(See para DIQ of explanatory notes to this Category)*		
58921	**Fee:** $135.25	**Benefit:** 75% = $101.45	85% = $115.00
	GRAHAM'S TEST (cholecystography), with preliminary plain films and with or without tomography - (R) *(See para DIQ of explanatory notes to this Category)*		
58924	**Fee:** $84.05	**Benefit:** 75% = $63.05	85% = $71.45
	CHOLEGRAPHY DIRECT, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 30439 applies - (R) *(See para DIQ of explanatory notes to this Category)*		
58927	**Fee:** $76.45	**Benefit:** 75% = $57.35	85% = $65.00
	CHOLEGRAPHY, percutaneous transhepatic, with or without preliminary plain films and with preparation and contrast injection - (R) *(See para DIQ of explanatory notes to this Category)*		
58933	**Fee:** $205.60	**Benefit:** 75% = $154.20	85% = $174.80
	CHOLEGRAPHY, drip infusion, with or without preliminary plain films, with preparation and contrast injection and with or without tomography - (R) *(See para DIQ of explanatory notes to this Category)*		
58936	**Fee:** $195.95	**Benefit:** 75% = $147.00	85% = $166.60
	DEFAECOGRAM (R) *(See para DIQ of explanatory notes to this Category)*		
58939	**Fee:** $139.30	**Benefit:** 75% = $104.50	85% = $118.45
	SUBGROUP 9 - RADIOGRAPHIC EXAMINATION FOR LOCALISATION OF FOREIGN BODIES		
	Localisation of foreign body, if provided in conjunction with a service described in Subgroups 1 to 12 of Group I3 (R) *(See para DIQ of explanatory notes to this Category)*		
59103	**Fee:** $21.30	**Benefit:** 75% = $16.00	85% = $18.15
	SUBGROUP 10 - RADIOGRAPHIC EXAMINATION OF BREASTS		
	(Note: These items are intended for use in the investigation of a clinical abnormality of the breast/s and NOT for individual, group or opportunistic screening of asymptomatic patients) MAMMOGRAPHY OF BOTH BREASTS, if there is a reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner. Unless otherwise indicated, mammography includes both breasts (R) *(See para DIQ of explanatory notes to this Category)*		
59300	**Fee:** $89.50	**Benefit:** 75% = $67.15	85% = $76.10

	MAMMOGRAPHY OF ONE BREAST, if: (a) the patient is referred with a specific request for a unilateral mammogram; and (b) there is reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner (R) *(See para DIQ of explanatory notes to this Category)*		
59303	**Fee:** $53.95	**Benefit:** 75% = $40.50	85% = $45.90
	MAMMARY DUCTOGRAM (galactography) - 1 breast (R) *(See para DIQ of explanatory notes to this Category)*		
59306	**Fee:** $100.30	**Benefit:** 75% = $75.25	85% = $85.30
	MAMMARY DUCTOGRAM (galactography) - 2 breasts (R) *(See para DIQ of explanatory notes to this Category)*		
59309	**Fee:** $200.60	**Benefit:** 75% = $150.45	85% = $170.55
	RADIOGRAPHIC EXAMINATION OF BOTH BREASTS, in conjunction with a surgical procedure on each breast, using interventional techniques - (R) *(See para DIQ of explanatory notes to this Category)*		
59312	**Fee:** $87.00	**Benefit:** 75% = $65.25	85% = $73.95
	RADIOGRAPHIC EXAMINATION OF 1 BREAST, in conjunction with a surgical procedure using interventional techniques - (R) *(See para DIQ of explanatory notes to this Category)*		
59314	**Fee:** $52.50	**Benefit:** 75% = $39.40	85% = $44.65
	RADIOGRAPHIC EXAMINATION OF EXCISED BREAST TISSUE to confirm satisfactory excision of 1 or more lesions in 1 breast or both following pre-operative localisation in conjunction with a service under item 31536 - (R) *(See para DIQ of explanatory notes to this Category)*		
59318	**Fee:** $47.05	**Benefit:** 75% = $35.30	85% = $40.00
	SUBGROUP 11 - RADIOGRAPHIC EXAMINATION IN CONNECTION WITH PREGNANCY		
	PELVIMETRY, not being a service associated with a service to which item 57201 applies (R) *(See para DIQ of explanatory notes to this Category)*		
59503	**Fee:** $89.40	**Benefit:** 75% = $67.05	85% = $76.00
	SUBGROUP 12 - RADIOGRAPHIC EXAMINATION WITH OPAQUE OR CONTRAST MEDIA		
	DISCOGRAPHY, each disc, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
59700	**Fee:** $96.55	**Benefit:** 75% = $72.45	85% = $82.10
	DACRYOCYSTOGRAPHY, 1 side, with or without preliminary plain film and with preparation and contrast injection - (R) *(See para DIQ of explanatory notes to this Category)*		
59703	**Fee:** $75.90	**Benefit:** 75% = $56.95	85% = $64.55
	HYSTEROSALPINGOGRAPHY, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
59712	**Fee:** $113.70	**Benefit:** 75% = $85.30	85% = $96.65
	BRONCHOGRAPHY, 1 side, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
59715	**Fee:** $143.55	**Benefit:** 75% = $107.70	85% = $122.05
	PHLEBOGRAPHY, 1 side, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
59718	**Fee:** $134.65	**Benefit:** 75% = $101.00	85% = $114.50
	MYELOGRAPHY, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 56219 applies - (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
59724	**Fee:** $226.45	**Benefit:** 75% = $169.85	85% = $192.50

59733	SIALOGRAPHY, 1 side, with preparation and contrast injection, not being a service associated with a service to which item 57918 applies - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $107.70	**Benefit:** 75% = $80.80	85% = $91.55
59736	VASOEPIDIDYMOGRAPHY, 1 side, - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $62.00	**Benefit:** 75% = $46.50	85% = $52.70
59739	SINOGRAM OR FISTULOGRAM, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $73.75	**Benefit:** 75% = $55.35	85% = $62.70
59751	ARTHROGRAPHY, each joint, excluding the facet (zygapophyseal) joints of the spine, single or double contrast study, with or without preliminary plain films and with preparation and contrast injection - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $139.15	**Benefit:** 75% = $104.40	85% = $118.30
59754	LYMPHANGIOGRAPHY, one or both sides, with preliminary plain films and follow-up radiography and with preparation and contrast injection - (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $219.35	**Benefit:** 75% = $164.55	85% = $186.45
59760	PERITONEOGRAM (herniography) with or without contrast medium including preparation - performed on a person over 14 years of age (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $115.15	**Benefit:** 75% = $86.40	85% = $97.90
59763	AIR INSUFFLATION during video - fluoroscopic imaging including associated consultation (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $133.90	**Benefit:** 75% = $100.45	85% = $113.85
	SUBGROUP 13 - ANGIOGRAPHY		
59903	ANGIOCARDIOGRAPHY including the service described in item 59970, 59974 or 61109, not being a service to which item 59912 or 59925 applies (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $114.55	**Benefit:** 75% = $85.95	85% = $97.40
59912	SELECTIVE CORONARY ARTERIOGRAPHY (R) (K), including the services described in item 59970, 59974 or 61109, not being a service to which item 59903 or 59925 applies (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $305.20	**Benefit:** 75% = $228.90	85% = $259.45
59925	SELECTIVE CORONARY ARTERIOGRAPHY AND ANGIOCARDIOGRAPHY, including the services described in items 59903, 59912, 59970, 59974 or 61109 (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $362.45	**Benefit:** 75% = $271.85	85% = $308.10
59970	ANGIOGRAPHY AND/OR DIGITAL SUBTRACTION ANGIOGRAPHY with fluoroscopy and image acquisition using a mobile image intensifier, 1 or more regions including any preliminary plain films, preparation and contrast injection (R) (K) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $168.30	**Benefit:** 75% = $126.25	85% = $143.10
59971	ANGIOCARDIOGRAPHY including the service described in item 59970, 59974 or 61109, not being a service to which item 59972 or 59973 applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $57.30	**Benefit:** 75% = $43.00	85% = $48.75
59972	SELECTIVE CORONARY ARTERIOGRAPHY (R) (NK), including the service described in item 59970, 59974 or 61109, not being a service to which item 59971 or 59973 applies (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $152.60	**Benefit:** 75% = $114.45	85% = $129.75

59973	SELECTIVE CORONARY ARTERIOGRAPHY AND ANGIOCARDIOGRAPHY, including the services described in items 59970, 59971, 59972, 59974 or 61109 (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $181.25	**Benefit:** 75% = $135.95	85% = $154.10
59974	ANGIOGRAPHY AND/OR DIGITAL SUBTRACTION ANGIOGRAPHY with fluoroscopy and image acquisition using a mobile image intensifier, 1 or more regions including any preliminary plain films, preparation and contrast injection (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.20	**Benefit:** 75% = $63.15	85% = $71.60
	BY DIGITAL SUBTRACTION TECHNIQUE		
60000	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography - 1 to 3 data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $564.00	**Benefit:** 75% = $423.00	85% = $494.90
60003	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography - 4 to 6 data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $827.10	**Benefit:** 75% = $620.35	85% = $758.00
60006	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography - 7 to 9 data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,176.10	**Benefit:** 75% = $882.10	85% = $1,107.00
60009	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography - 10 or more data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,376.30	**Benefit:** 75% = $1,032.25	85% = $1,307.20
60012	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 1 to 3 data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $564.00	**Benefit:** 75% = $423.00	85% = $494.90
60015	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 4 to 6 data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $827.10	**Benefit:** 75% = $620.35	85% = $758.00
60018	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 7 to 9 data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,176.10	**Benefit:** 75% = $882.10	85% = $1,107.00
60021	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 10 or more data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,376.30	**Benefit:** 75% = $1,032.25	85% = $1,307.20
60024	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 1 to 3 data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $564.00	**Benefit:** 75% = $423.00	85% = $494.90
60027	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 4 to 6 data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $827.10	**Benefit:** 75% = $620.35	85% = $758.00
60030	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 7 to 9 data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,176.10	**Benefit:** 75% = $882.10	85% = $1,107.00
60033	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 10 or more data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,376.30	**Benefit:** 75% = $1,032.25	85% = $1,307.20

60036	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 1 to 3 data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $564.00	**Benefit:** 75% = $423.00	85% = $494.90
60039	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 4 to 6 data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $827.10	**Benefit:** 75% = $620.35	85% = $758.00
60042	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 7 to 9 data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,176.10	**Benefit:** 75% = $882.10	85% = $1,107.00
60045	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 10 or more data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,376.30	**Benefit:** 75% = $1,032.25	85% = $1,307.20
60048	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 1 to 3 data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $564.00	**Benefit:** 75% = $423.00	85% = $494.90
60051	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 4 to 6 data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $827.10	**Benefit:** 75% = $620.35	85% = $758.00
60054	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 7 to 9 data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,176.10	**Benefit:** 75% = $882.10	85% = $1,107.00
60057	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 10 or more data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,376.30	**Benefit:** 75% = $1,032.25	85% = $1,307.20
60060	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 1 to 3 data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $564.00	**Benefit:** 75% = $423.00	85% = $494.90
60063	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 4 to 6 data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $827.10	**Benefit:** 75% = $620.35	85% = $758.00
60066	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 7 to 9 data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,176.10	**Benefit:** 75% = $882.10	85% = $1,107.00
60069	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 10 or more data acquisition runs (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,376.30	**Benefit:** 75% = $1,032.25	85% = $1,307.20
60072	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique - 1 vessel (NR) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $48.10	**Benefit:** 75% = $36.10	85% = $40.90
60075	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique - 2 vessels (NR) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $96.10	**Benefit:** 75% = $72.10	85% = $81.70

60078	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique - 3 or more vessels (NR) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $144.25 **Benefit:** 75% = $108.20 85% = $122.65
	SUBGROUP 14 - TOMOGRAPHY
60100	TOMOGRAPHY OF ANY REGION (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $60.75 **Benefit:** 75% = $45.60 85% = $51.65
	SUBGROUP 15 - FLUOROSCOPIC EXAMINATION
60500	FLUOROSCOPY, with general anaesthesia (not being a service associated with a radiographic examination) (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $43.40 **Benefit:** 75% = $32.55 85% = $36.90
60503	FLUOROSCOPY, without general anaesthesia (not being a service associated with a radiographic examination) (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $29.75 **Benefit:** 75% = $22.35 85% = $25.30
60506	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting less than 1 hour, not being a service associated with a service to which another item in this Table applies (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $63.75 **Benefit:** 75% = $47.85 85% = $54.20
60509	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting 1 hour or more, not being a service associated with a service to which another item in this Table applies (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $98.90 **Benefit:** 75% = $74.20 85% = $84.10
	SUBGROUP 16 - PREPARATION FOR RADIOLOGICAL PROCEDURE
60918	ARTERIOGRAPHY (peripheral) or PHLEBOGRAPHY 1 vessel, when used in association with a service to which items 59903, 59912, 59925, 59970, 59971 59972, 59973 or 59974 applies, not being a service associated with a service to which items 60000 to 60078 inclusive apply (NR) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10
60927	SELECTIVE ARTERIOGRAM or PHLEBOGRAM, when used in association with a service to which items 59903, 59912, 59925, 59970, 59971 59972, 59973 or 59974 applies, not being a service associated with a service to which items 60000 to 60078 inclusive apply (NR) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $38.05 **Benefit:** 75% = $28.55 85% = $32.35
	SUBGROUP 17 - INTERVENTIONAL TECHNIQUES
61109	FLUOROSCOPY in an ANGIOGRAPHY SUITE with image intensification, in conjunction with a surgical procedure, using interventional techniques, not being a service associated with a service to which another item in this Table applies (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $258.90 **Benefit:** 75% = $194.20 85% = $220.10

GROUP I4 - NUCLEAR MEDICINE IMAGING

61302	SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - planar imaging (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $448.85	**Benefit:** 75% = $336.65	85% = $381.55
61303	SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - with single photon emission tomography and with planar imaging when undertaken (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $565.30	**Benefit:** 75% = $424.00	85% = $496.20
61306	COMBINED STRESS AND REST, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - planar imaging (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $709.70	**Benefit:** 75% = $532.30	85% = $640.60
61307	COMBINED STRESS AND REST, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - with single photon emission tomography and with planar imaging when undertaken (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $834.90	**Benefit:** 75% = $626.20	85% = $765.80
61310	MYOCARDIAL INFARCT-AVID-STUDY, with planar imaging and single photon emission tomography, OR planar imaging or single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $367.30	**Benefit:** 75% = $275.50	85% = $312.25
61313	GATED CARDIAC BLOOD POOL STUDY, (equilibrium), with planar imaging and single photon emission tomography OR planar imaging or single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $303.35	**Benefit:** 75% = $227.55	85% = $257.85
61314	GATED CARDIAC BLOOD POOL STUDY, and first pass blood flow or cardiac shunt study, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $420.00	**Benefit:** 75% = $315.00	85% = $357.00
61316	GATED CARDIAC BLOOD POOL STUDY, with intervention, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $381.15	**Benefit:** 75% = $285.90	85% = $324.00
61317	GATED CARDIAC BLOOD POOL STUDY, with intervention and first pass blood flow study or cardiac shunt study, with planar imaging and single photon emission tomography OR planar imaging, or single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $492.40	**Benefit:** 75% = $369.30	85% = $423.30
61320	CARDIAC FIRST PASS BLOOD FLOW STUDY OR CARDIAC SHUNT STUDY, not being a service to which another item in this Group applies (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $228.90	**Benefit:** 75% = $171.70	85% = $194.60
61328	LUNG PERFUSION STUDY, with planar imaging and single photon emission tomography OR planar imaging, or single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $227.65	**Benefit:** 75% = $170.75	85% = $193.55
61340	LUNG VENTILATION STUDY using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography OR planar imaging or single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $253.00	**Benefit:** 75% = $189.75	85% = $215.05
61348	LUNG PERFUSION STUDY AND LUNG VENTILATION STUDY using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $443.35	**Benefit:** 75% = $332.55	85% = $376.85

61352	LIVER AND SPLEEN STUDY (colloid) - planar imaging (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $259.35	**Benefit:** 75% = $194.55	85% = $220.45
61353	LIVER AND SPLEEN STUDY (colloid), with single photon emission tomography and with planar imaging when undertaken (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $386.60	**Benefit:** 75% = $289.95	85% = $328.65
61356	RED BLOOD CELL SPLEEN OR LIVER STUDY, including single photon emission tomography when undertaken (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $392.80	**Benefit:** 75% = $294.60	85% = $333.90
61360	HEPATOBILIARY STUDY, including morphine administration or pre-treatment with cholecystokinin (CCK) when undertaken (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $403.35	**Benefit:** 75% = $302.55	85% = $342.85
61361	HEPATOBILIARY STUDY with formal quantification following baseline imaging, using an infusion of cholecystokinin (CCK) (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $461.40	**Benefit:** 75% = $346.05	85% = $392.30
61364	BOWEL HAEMORRHAGE STUDY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $496.95	**Benefit:** 75% = $372.75	85% = $427.85
61368	MECKEL'S DIVERTICULUM STUDY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $223.10	**Benefit:** 75% = $167.35	85% = $189.65
61369	INDIUM-LABELLED OCTREOTIDE STUDY - including single photon emission tomography when undertaken, where: (a) there is a suspected gastro-entero-pancreatic endocrine tumour, based on biochemical evidence, with negative or equivocal conventional imaging; or (b) a surgically amenable gastro-entero-pancreatic endocrine tumour has been identified based on conventional techniques, in order to exclude additional disease sites. (Ministerial Determination) (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $2,015.75	**Benefit:** 75% = $1,511.85	85% = $1,946.65
61372	SALIVARY STUDY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $223.10	**Benefit:** 75% = $167.35	85% = $189.65
61373	GASTRO-OESOPHAGEAL REFLUX STUDY, including delayed imaging on a separate occasion when undertaken (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $489.70	**Benefit:** 75% = $367.30	85% = $420.60
61376	OESOPHAGEAL CLEARANCE STUDY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $143.35	**Benefit:** 75% = $107.55	85% = $121.85
61381	GASTRIC EMPTYING STUDY, using single tracer (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $574.35	**Benefit:** 75% = $430.80	85% = $505.25
61383	COMBINED SOLID AND LIQUID GASTRIC EMPTYING STUDY using dual isotope technique or the same isotope on separate days (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $624.95	**Benefit:** 75% = $468.75	85% = $555.85
61384	RADIONUCLIDE COLONIC TRANSIT STUDY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $687.70	**Benefit:** 75% = $515.80	85% = $618.60
61386	RENAL STUDY, including perfusion and renogram images and computer analysis OR cortical study with planar imaging (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $332.50	**Benefit:** 75% = $249.40	85% = $282.65

	RENAL CORTICAL STUDY, with single photon emission tomography and planar quantification (R) *(See para DIQ of explanatory notes to this Category)*		
61387	**Fee:** $430.75	**Benefit:** 75% = $323.10	85% = $366.15
	SINGLE RENAL STUDY with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R) *(See para DIQ of explanatory notes to this Category)*		
61389	**Fee:** $370.55	**Benefit:** 75% = $277.95	85% = $315.00
	RENAL STUDY with diuretic administration following a baseline study (R) *(See para DIQ of explanatory notes to this Category)*		
61390	**Fee:** $409.95	**Benefit:** 75% = $307.50	85% = $348.50
	COMBINED EXAMINATION INVOLVING A RENAL STUDY following angiotensin converting enzyme (ACE) inhibitor provocation and a baseline study, in either order and related to a single referral episode (R) *(See para DIQ of explanatory notes to this Category)*		
61393	**Fee:** $605.50	**Benefit:** 75% = $454.15	85% = $536.40
	CYSTOURETEROGRAM (R) *(See para DIQ of explanatory notes to this Category)*		
61397	**Fee:** $246.85	**Benefit:** 75% = $185.15	85% = $209.85
	TESTICULAR STUDY (R) *(See para DIQ of explanatory notes to this Category)*		
61401	**Fee:** $162.30	**Benefit:** 75% = $121.75	85% = $138.00
	CEREBRAL PERFUSION STUDY, with single photon emission tomography and with planar imaging when undertaken (R) *(See para DIQ of explanatory notes to this Category)*		
61402	**Fee:** $605.05	**Benefit:** 75% = $453.80	85% = $535.95
	BRAIN STUDY WITH BLOOD BRAIN BARRIER AGENT, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)*		
61405	**Fee:** $346.00	**Benefit:** 75% = $259.50	85% = $294.10
	CEREBRO-SPINAL FLUID TRANSPORT STUDY, with imaging on 2 or more separate occasions (R) *(See para DIQ of explanatory notes to this Category)*		
61409	**Fee:** $873.50	**Benefit:** 75% = $655.15	85% = $804.40
	CEREBRO-SPINAL FLUID SHUNT PATENCY STUDY (R) *(See para DIQ of explanatory notes to this Category)*		
61413	**Fee:** $225.95	**Benefit:** 75% = $169.50	85% = $192.10
	DYNAMIC BLOOD FLOW STUDY OR REGIONAL BLOOD VOLUME QUANTITATIVE STUDY, not being a service associated with a service to which another item in this Group applies (R) *(See para DIQ of explanatory notes to this Category)*		
61417	**Fee:** $118.85	**Benefit:** 75% = $89.15	85% = $101.05
	BONE STUDY - whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) *(See para DIQ of explanatory notes to this Category)*		
61421	**Fee:** $479.80	**Benefit:** 75% = $359.85	85% = $410.70
	BONE STUDY - whole body and single photon emission tomography, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) *(See para DIQ of explanatory notes to this Category)*		
61425	**Fee:** $600.70	**Benefit:** 75% = $450.55	85% = $531.60
	WHOLE BODY STUDY using iodine (R) *(See para DIQ of explanatory notes to this Category)*		
61426	**Fee:** $554.80	**Benefit:** 75% = $416.10	85% = $485.70
	WHOLE BODY STUDY using gallium (R) *(See para DIQ of explanatory notes to this Category)*		
61429	**Fee:** $543.00	**Benefit:** 75% = $407.25	85% = $473.90
	WHOLE BODY STUDY using gallium, with single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)*		
61430	**Fee:** $659.45	**Benefit:** 75% = $494.60	85% = $590.35

61433	WHOLE BODY STUDY using cells labelled with technetium (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $496.95	**Benefit:** 75% = $372.75	85% = $427.85
61434	WHOLE BODY STUDY using cells labelled with technetium, with single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $615.40	**Benefit:** 75% = $461.55	85% = $546.30
61437	WHOLE BODY STUDY using thallium (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $542.75	**Benefit:** 75% = $407.10	85% = $473.65
61438	WHOLE BODY STUDY using thallium, with single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $672.95	**Benefit:** 75% = $504.75	85% = $603.85
61441	BONE MARROW STUDY - whole body using technetium labelled bone marrow agents (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $489.70	**Benefit:** 75% = $367.30	85% = $420.60
61442	WHOLE BODY STUDY, using gallium - with single photon emission tomography of 2 or more body regions acquired separately (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $752.35	**Benefit:** 75% = $564.30	85% = $683.25
61445	BONE MARROW STUDY - localised using technetium labelled agent (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $286.80	**Benefit:** 75% = $215.10	85% = $243.80
61446	LOCALISED BONE OR JOINT STUDY, including when undertaken, blood flow, blood pool and repeat imaging on a separate occasion (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $333.55	**Benefit:** 75% = $250.20	85% = $283.55
61449	LOCALISED BONE OR JOINT STUDY and single photon emission tomography, including when undertaken, blood flow, blood pool and imaging on a separate occasion (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $456.20	**Benefit:** 75% = $342.15	85% = $387.80
61450	LOCALISED STUDY using gallium (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $397.55	**Benefit:** 75% = $298.20	85% = $337.95
61453	LOCALISED STUDY using gallium, with single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $514.70	**Benefit:** 75% = $386.05	85% = $445.60
61454	LOCALISED STUDY using cells labelled with technetium (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $348.10	**Benefit:** 75% = $261.10	85% = $295.90
61457	LOCALISED STUDY using cells labelled with technetium, with single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $470.45	**Benefit:** 75% = $352.85	85% = $401.35
61458	LOCALISED STUDY using thallium (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $396.95	**Benefit:** 75% = $297.75	85% = $337.45
61461	LOCALISED STUDY using thallium, with single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $527.85	**Benefit:** 75% = $395.90	85% = $458.75

61462	REPEAT PLANAR AND SINGLE PHOTON EMISSION TOMOGRAPHY IMAGING, OR REPEAT PLANAR IMAGING OR SINGLE PHOTON EMISSION TOMOGRAPHY IMAGING on an occasion subsequent to the performance of any one of items 61364, 61426, 61429, 61430, 61442, 61450, 61453, 61469, 61484 or 61485 where there is no additional administration of radiopharmaceutical and where the previous radionuclide scan was abnormal or equivocal. (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $129.00	**Benefit:** 75% = $96.75	85% = $109.65
61465	VENOGRAPHY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $265.50	**Benefit:** 75% = $199.15	85% = $225.70
61469	LYMPHOSCINTIGRAPHY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $348.10	**Benefit:** 75% = $261.10	85% = $295.90
61473	THYROID STUDY including uptake measurement when undertaken (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $175.40	**Benefit:** 75% = $131.55	85% = $149.10
61480	PARATHYROID STUDY, planar imaging and single photon emission tomography when undertaken (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $386.85	**Benefit:** 75% = $290.15	85% = $328.85
61484	ADRENAL STUDY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $880.85	**Benefit:** 75% = $660.65	85% = $811.75
61485	ADRENAL STUDY, with single photon emission tomography (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $999.20	**Benefit:** 75% = $749.40	85% = $930.10
61495	TEAR DUCT STUDY (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $223.10	**Benefit:** 75% = $167.35	85% = $189.65
61499	PARTICLE PERFUSION STUDY (intra-arterial) or Le Veen shunt study (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $253.00	**Benefit:** 75% = $189.75	85% = $215.05
61505	CT scan performed at the same time and covering the same body area as single photon emission tomography for the purpose of anatomic localisation or attenuation correction where no separate diagnostic CT report is issued and only in association with items 61302 - 61650 (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $100.00	**Benefit:** 75% = $75.00	85% = $85.00
61523	Whole body FDG PET study, performed for evaluation of a solitary pulmonary nodule where the lesion is considered unsuitable for transthoracic fine needle aspiration biopsy, or for which an attempt at pathological characterisation has failed.(R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $953.00	**Benefit:** 75% = $714.75	85% = $883.90
61529	Whole body FDG PET study, performed for the staging of proven non-small cell lung cancer, where curative surgery or radiotherapy is planned (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $953.00	**Benefit:** 75% = $714.75	85% = $883.90
61541	Whole body FDG PET study, following initial therapy, performed for the evaluation of suspected residual, metastatic or recurrent colorectal carcinoma in patients considered suitable for active therapy *(See para DIQ of explanatory notes to this Category)* **Fee:** $953.00	**Benefit:** 75% = $714.75	85% = $883.90
61544	Whole body FDG PET study, following initial therapy, performed for the evaluation of suspected residual, metastatic or recurrent colorectal carcinoma in patients considered suitable for active therapy, with catheterisation of the bladder. *(See para DIQ of explanatory notes to this Category)* **Fee:** $975.00	**Benefit:** 75% = $731.25	85% = $905.90

	Whole body FDG PET study, following initial therapy, performed for the evaluation of suspected metastatic or recurrent malignant melanoma in patients considered suitable for active therapy *(See para DIQ of explanatory notes to this Category)*		
61553	**Fee:** $999.00	**Benefit:** 75% = $749.25	85% = $929.90
	Whole body FDG PET study, following initial therapy, performed for the evaluation of suspected metastatic or recurrent malignant melanoma in patients considered suitable for active therapy, with catheterisation of the bladder *(See para DIQ of explanatory notes to this Category)*		
61556	**Fee:** $1,021.00	**Benefit:** 75% = $765.75	85% = $951.90
	FDG PET study of the brain, performed for the evaluation of refractory epilepsy which is being evaluated for surgery (R) *(See para DIQ of explanatory notes to this Category)*		
61559	**Fee:** $918.00	**Benefit:** 75% = $688.50	85% = $848.90
	Whole body FDG PET study, following initial therapy, performed for the evaluation of suspected residual, metastatic or recurrent ovarian carcinoma in patients considered suitable for active therapy. *(See para DIQ of explanatory notes to this Category)*		
61565	**Fee:** $953.00	**Benefit:** 75% = $714.75	85% = $883.90
	Whole body FDG PET study, following initial therapy, performed for the evaluation of suspected residual, metastatic or recurrent ovarian carcinoma in patients considered suitable for active therapy with curative intent, with catheterisation of the bladder. *(See para DIQ of explanatory notes to this Category)*		
61568	**Fee:** $975.00	**Benefit:** 75% = $731.25	85% = $905.90
	Whole body FDG PET study, performed for the staging of proven oesophageal or GEJ carcinoma, in patients considered suitable for active therapy (R).		
61577	**Fee:** $953.00	**Benefit:** 75% = $714.75	85% = $883.90
	Whole body FDG PET study, performed for the staging of proven oesophageal or GEJ carcinoma, in patients considered suitable for active therapy, with catheterisation of the bladder (R).		
61580	**Fee:** $975.00	**Benefit:** 75% = $731.25	85% = $905.90
	Whole body FDG PET study performed for the staging of biopsy-proven newly diagnosed or recurrent head and neck cancer (R).		
61598	**Fee:** $953.00	**Benefit:** 75% = $714.75	85% = $883.90
	Whole body FDG PET study performed for the evaluation of patients with suspected residual head and neck cancer after definitive treatment, and who are suitable for active therapy (R).		
61604	**Fee:** $953.00	**Benefit:** 75% = $714.75	85% = $883.90
	Whole body FDG PET study performed for the evaluation of metastatic squamous cell carcinoma of unknown primary site involving cervical nodes (R).		
61610	**Fee:** $953.00	**Benefit:** 75% = $714.75	85% = $883.90
	Whole body FDG PET study performed for the evaluation of metastatic squamous cell carcinoma from an unknown primary site involving cervical nodes, with catherterisation of the bladder (R).		
61613	**Fee:** $975.00	**Benefit:** 75% = $731.25	85% = $905.90
	LEUKOSCAN STUDY, for use in diagnostic imaging of the long bones and feet in patients with suspected osteomyelitis, and where patients do not have access to *ex-vivo WBC scanning.* (Ministerial Determination) *Note* LeukoScan is only indicated for diagnostic imaging in patients suspected of infection in the long bones and feet, including those with diabetic ulcers. The descriptor does not cover patients who are being investigated for other sites of infection *(See para DIQ of explanatory notes to this Category)*		
61650	**Fee:** $878.70	**Benefit:** 75% = $659.05	85% = $809.60

GROUP I5 - MAGNETIC RESONANCE IMAGING

SUBGROUP 1 - SCAN OF HEAD - FOR SPECIFIED CONDITIONS

MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head** for:

- tumour of the brain or meninges (R) (Contrast) (Anaes.)
(See para DIQ of explanatory notes to this Category)

63001	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75

- inflammation of the brain or meninges (R) (Contrast) (Anaes.)
(See para DIQ of explanatory notes to this Category)

63004	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75

- skull base or orbital tumour (R) (Contrast) (Anaes.)
(See para DIQ of explanatory notes to this Category)

63007	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75

- stereotactic scan of brain, with Fiducials in place, for the sole purpose to allow planning for stereotactic neurosurgery (R) (Contrast) (Anaes.)
(See para DIQ of explanatory notes to this Category)

63010	**Fee:** $336.00	**Benefit:** 75% = $252.00	85% = $285.60

SUBGROUP 2 - SCAN OF HEAD - FOR SPECIFIED CONDITIONS

NOTE: Benefits are payable for each service included by Subgroup 2 on three occasions only in any 12 month period

MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head** for:

- acoustic neuroma (R) (Contrast) (Anaes.)
(See para DIQ of explanatory notes to this Category)

63040	**Fee:** $336.00	**Benefit:** 75% = $252.00	85% = $285.60

- pituitary tumour (R) (Contrast) (Anaes.)
(See para DIQ of explanatory notes to this Category)

63043	**Fee:** $358.40	**Benefit:** 75% = $268.80	85% = $304.65

- toxic or metabolic or ischaemic encephalopathy (R) (Contrast) (Anaes.)
(See para DIQ of explanatory notes to this Category)

63046	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75

- demyelinating disease of the brain (R) (Contrast) (Anaes.)
(See para DIQ of explanatory notes to this Category)

63049	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75

- congenital malformation of the brain or meninges (R) (Contrast) (Anaes.)
(See para DIQ of explanatory notes to this Category)

63052	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75

- venous sinus thrombosis (R) (Contrast) (Anaes.)
(See para DIQ of explanatory notes to this Category)

63055	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75

- head trauma (R) (Contrast) (Anaes.)
(See para DIQ of explanatory notes to this Category)

63058	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75

- epilepsy (R) (Contrast) (Anaes.)
(See para DIQ of explanatory notes to this Category)

63061	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75

	- stroke (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63064	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75
	- carotid or vertebral artery desection (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63067	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75
	- intracranial aneurysm (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63070	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75
	- intracranial arteriovenous malformation (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63073	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75
	SUBGROUP 3 - SCAN OF HEAD AND NECK VESSELS - FOR SPECIFIED CONDITIONS		
	NOTE: Benefits are payable for each service included by Subgroup 3 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING AND MAGNETIC RESONANCE ANGIOGRAPHY of extra and/or intracranial circulation, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head and neck vessls** for: - stroke (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63101	**Fee:** $492.80	**Benefit:** 75% = $369.60	85% = $423.70
	SUBGROUP 4 - SCAN OF HEAD AND CERVICAL SPINE - FOR SPECIFIED CONDITIONS		
	MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head and cervical spine** for: - tumour of the central nervous system or meninges (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63111	**Fee:** $492.80	**Benefit:** 75% = $369.60	85% = $423.70
	- inflammation of the central nervous system or meninges (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63114	**Fee:** $492.80	**Benefit:** 75% = $369.60	85% = $423.70
	SUBGROUP 5 - SCAN OF HEAD AND CERVICAL SPINE - FOR SPECIFIED CONDITIONS		
	NOTE: Benefits are payable for each service included by Subgroup 5 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head and cervical spine** for: - demyelinating disease of the central nervous system (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63125	**Fee:** $492.80	**Benefit:** 75% = $369.60	85% = $423.70
	- congenital malformation of the central nervous system or meninges (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63128	**Fee:** $492.80	**Benefit:** 75% = $369.60	85% = $423.70
	- syrinx (congenital or aquired) (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*		
63131	**Fee:** $492.80	**Benefit:** 75% = $369.60	85% = $423.70

	SUBGROUP 6 - SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS
63151	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of one region or two contiguous regions of the spine** for: - infection (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63154	- tumour (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
	SUBGROUP 7 - SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS
63161	**NOTE: Benefits are payable for each service included by Subgroup 7 on three occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of one region or two contiguous regions of the spine** for: - demyelinating (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63164	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63167	myelopathy (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63170	- syrinx (congenital or aquired) (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63173	- cervical radiculopathy (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63176	- sciatica (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63179	- spinal canal stenosis (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63182	- previous spinal surgery (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65
63185	- trauma (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $358.40 **Benefit:** 75% = $268.80 85% = $304.65

	SUBGROUP 8 - SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS
	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of three contiguous regions or two non contiguous regions of the spine** for: - infection (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63201	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- tumour (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63204	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	SUBGROUP 9 - SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS
	NOTE: Benefits are payable for each service included by Subgroup 9 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of three contiguous regions or two non contiguous regions of the spine** for: - demyelinating disease (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63219	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63222	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- myelopathy (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63225	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- syrinx (congenital or aquired) (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63228	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- cervical radiculopathy (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63231	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- sciatica (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63234	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- spinal canal stenosis (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63237	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- previous spinal surgery (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63240	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- trauma (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63243	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80

	SUBGROUP 10 - SCAN OF CERVICAL SPINE AND BRACHIAL PLEXUS - FOR SPECIFIED CONDITIONS
	NOTE: Benefits are payable for each service included by Subgroup 10 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of cervcial spine and brachial plexus** for:
63271	- tumour (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $423.70
63274	- trauma (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $423.70
63277	- cervical radiculopathy (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $423.70
63280	- previous surgery (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $423.70
	SUBGROUP 11 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS
	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of musculoskeletal system** for:
63301	- tumour arising in bone or musculoskeletal system, this excludes tumours arising in breast, prostate or rectum (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $380.80 **Benefit:** 75% = $285.60 85% = $323.70
63304	- infection arising in bone or musculoskeletal system, this excludes infection arising in breast, prostate or rectum (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $380.80 **Benefit:** 75% = $285.60 85% = $323.70
63307	- osteonecrosis (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $380.80 **Benefit:** 75% = $285.60 85% = $323.70
	SUBGROUP 12 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS
	NOTE: Benefits are payable for each service included by Subgroup 12 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of musculoskeletal system** for:
63322	- derangement of hip or its supporting structures (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63325	- derangment of shoulder or its supporting structures (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63328	- derangment of knee or its supporting structures (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
63331	- derangment of ankle and/or foot or its supporting structures (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

	- derangment of one or both temporomandibular joints or their supporting structures (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63334	**Fee:** $336.00 **Benefit:** 75% = $252.00 85% = $285.60
	- derangment of wrist and/or hand or its supporting structures (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63337	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- derangment of elbow or its supporting structures (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63340	**Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	SUBGROUP 13 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS
	NOTE: Benefits are payable for each service included by Subgroup 13 on two occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician **- scan of musculoskeletal system** for: - Gaucher disease (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63361	**Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	SUBGROUP 14 - SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS
	NOTE: Benefits are payable for each service included by Subgroup 14 on two occasions only in any 12 month period MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician **- scan of cardiovascular system** for: - congenital disease of the heart or a great vessel (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63385	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- tumour of the heart or a great vessel (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63388	**Fee:** $448.00 **Benefit:** 75% = $336.00 85% = $380.80
	- abnormality of thoracic aorta (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63391	**Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	SUBGROUP 15 - MAGNETIC RESONANCE ANGIOGRAPHY - SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS
	NOTE: Benefits are payable for each service included by Subgroup 15 on three occasions only in any 12 month period MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan **- scan of cardiovascular system** for: - vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63401	**Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75
	- obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*
63404	**Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

MAGNETIC RESONANCE IMAGING				MRI
	SUBGROUP 16 - MAGNETIC RESONANCE ANGIOGRAPHY - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS			
	NOTE: Benefits are payable for each service included by Subgroup 16 on one occasion only in any 12 month period MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of person under the age of 16** for: - the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*			
63416	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75	
	SUBGROUP 17 - MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS			
	NOTE: Benefits are payable for each service included by Subgroup 17 on two occasions only in any 12 month period, for previously diagnosed conditions MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of person under the age of 16** for: - post-inflammatory or post-traumatic physeal fusion (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)*			
63425	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75	
	- Gaucher disease (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)*			
63428	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75	
	SUBGROUP 18 - MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS			
	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of person under the age of 16** for: - pelvic or abdominal mass (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*			
63440	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75	
	- mediastinal mass (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*			
63443	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75	
	- congenital uterine or anorectal abnormality (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*			
63446	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75	
	SUBGROUP 19 - SCAN OF BODY - FOR SPECIFIED CONDITIONS			
	NOTE: Benefits are payable for each service included by Subgroup 19 on one occasion only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of body** for: - adrenal mass in a patient with malignancy which is otherwise resecetable (R) (Anaes.) *(See para DIQ of explanatory notes to this Category)*			
63461	**Fee:** $358.40	**Benefit:** 75% = $268.80	85% = $304.65	

MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where:
(a) a dedicated breast coil is used; and
(b) the request for scan identifies that the woman is asymptomatic and is less than 50 years of age; and
(c) the request for scan identifies either:
(i) that the patient is at high risk of developing breast cancer, due to 1 of the following:
(A) 3 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer;
(B) 2 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer, if any of the following applies to at least 1 of the relatives:
- has been diagnosed with bilateral breast cancer;
- had onset of breast cancer before the age of 40 years;
- had onset of ovarian cancer before the age of 50 years;
- has been diagnosed with breast and ovarian cancer, at the same time or at different times;
- has Ashkenazi Jewish ancestry;
- is a male relative who has been diagnosed with breast cancer;

(C) 1 first or second degree relative diagnosed with breast cancer at age 45 years or younger, plus another first or second degree relative on the same side of the family with bone or soft tissue sarcoma at age 45 years or younger; or

(ii) that genetic testing has identified the presence of a high risk breast cancer gene mutation.

Scan of both breasts for:

- detection of cancer (R)

NOTE: Benefits are payable on one occasion only in any 12 month period
(Anaes.)
Amend *(See para DIQ of explanatory notes to this Category)*
63464 **Fee:** $690.00 **Benefit:** 75% = $517.50 85% = $620.90

MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where:
(a) a dedicated breast coil is used; and
(b) the woman has had an abnormality detected as a result of a service described in item 63464 performed in the previous 12 months

Scan of both breasts for:

- detection of cancer (R)

NOTE 1: Benefits are payable on one occasion only in any 12 month period

NOTE 2: This item is intended for follow-up imaging of abnormalities diagnosed on a scan described by item 63464

(Anaes.)
(See para DIQ of explanatory notes to this Category)
63467 **Fee:** $690.00 **Benefit:** 75% = $517.50 85% = $620.90

SUBGROUP 20 - SCAN OF PELVIS AND UPPER ABDOMEN - FOR SPECIFIED CONDITIONS

NOTE: Benefits are payable for a service included by Subgroup 20 on one occasion only.
MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where:
(a) the patient is referred by a specialist or by a consultant physician and
(b) the request for scan identifies that (i) a histological diagnosis of carcinoma of the cervix has been made and (ii) the patient has been diagnosed with cervical cancer at FIGO stage 1B or greater

Scan of:

- Pelvis for the staging of histologically diagnosed cervical cancer at FIGO stages 1B or greater (R) (Contrast) (Anaes.)
(See para DIQ of explanatory notes to this Category)
63470 **Fee:** $403.20 **Benefit:** 75% = $302.40 85% = $342.75

- Pelvis and upper abdomen, in a single examination, for the staging of histologically diagnosed cervical cancer at FIGO stages 1B or greater (R) (Contrast) (Anaes.)
(See para DIQ of explanatory notes to this Category)
63473 **Fee:** $627.20 **Benefit:** 75% = $470.40 85% = $558.10

MAGNETIC RESONANCE IMAGING				MRI
	NOTE: benefits are payable for a service included by Subgroup 20 on one occasion only. MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a phased array body coil is used, and (b) the request for scan identifies that the indication is for the initial staging of rectal cancer (including cancer of the rectosigmoid and anorectum). Scan of: - Pelvis for the initial staging of rectal cancer (R) (contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*			
63476	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75	
	SUBGROUP 21 - SCAN OF BODY - FOR SPECIFIED CONDITIONS			
	NOTE: Benefits are only payable for each service included by Subgroup 21 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician **- scan of pancreas and biliary tree** for: - suspected biliary or pancreatic pathology (R) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)*			
63482	**Fee:** $403.20	**Benefit:** 75% = $302.40	85% = $342.75	
	SUBGROUP 22 - MODIFYING ITEMS			
	NOTE: Benefits in Subgroup 22 are only payable for modifying items where claimed simultaneously with MRI services. Modifiers for sedation and anaesthesia may not be claimed for the same service. Modifying items for use with MAGNETIC RESONANCE IMAGING or MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician. **Scan performed**: - involves the use of contrast agent for eligible Magnetic Resonance Imaging items (Note: (Contrast) denotes an item eligible for use with this item) *(See para DIQ of explanatory notes to this Category)*			
63491	**Fee:** $44.80	**Benefit:** 75% = $33.60	85% = $38.10	
	- involves use of intravenous or intramuscular sedation on a patient *(See para DIQ of explanatory notes to this Category)*			
63494	**Fee:** $44.80	**Benefit:** 75% = $33.60	85% = $38.10	
	- on a patient under anaesthetic in the presence of a medical practitioner qualified to perform an anaesthetic *(See para DIQ of explanatory notes to this Category)*			
63497	**Fee:** $156.80	**Benefit:** 75% = $117.60	85% = $133.30	

GROUP I6 - MANAGEMENT OF BULK-BILLED SERVICES

A diagnostic imaging service to which an item in this table (other than this item or item 64991) applies if:
(a) the service is an unreferred service; and
(b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and
(c) the person is not an admitted patient of a hospital; and
(d) the service is bulk-billed in respect of the fees for:
(i) this item; and
(ii) the other item in this table applying to the service
(See para DIP and DIQ of explanatory notes to this Category)

64990 **Fee:** $6.65 **Benefit:** 85% = $5.70

A diagnostic imaging service to which an item in this table (other than this item or item 64990) applies if:
(a) the service is an unreferred service; and
(b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and
(c) the person is not an admitted patient of a hospital; and
(d) the service is bulk-billed in respect of the fees for:
(i) this item; and
(ii) the other item in this table applying to the service; and
(e) the service is provided at, or from, a practice location in:
(i) a regional, rural or remote area; or
(ii) Tasmania; or
(iii) A geographical area included in any of the following SSD spatial units:
(A) Beaudesert Shire Part A
(B) Belconnen
(C) Darwin City
(D) Eastern Outer Melbourne
(E) East Metropolitan
(F) Frankston City
(G) Gosford-Wyong
(H) Greater Geelong City Part A
(I) Gungahlin-Hall
(J) Ipswich City (part in BSD)
(K) Litchfield Shire
(L) Melton-Wyndham
(M) Mornington Peninsula Shire
(N) Newcastle
(O) North Canberra
(P) Palmerston-East Arm
(Q) Pine Rivers Shire
(R) Queanbeyan
(S) South Canberra
(T) South Eastern Outer Melbourne
(U) Southern Adelaide
(V) South West Metropolitan
(W) Thuringowa City Part A
(X) Townsville City Part A
(Y) Tuggeranong
(Z) Weston Creek-Stromlo
(ZA) Woden Valley
(ZB) Yarra Ranges Shire Part A; or
(iv) the geographical area included in the SLA spatial unit of Palm Island (AC)
(See para DIP and DIQ of explanatory notes to this Category)

64991 **Fee:** $10.05 **Benefit:** 85% = $8.55

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