Australian Government

Department of Health

Medicare Benefits Schedule Book

Category 4

Operating from 1 November 2018

Title: Medicare Benefits Schedule Book
ISBN: 978-76007-376-3
Publications Number: 12289

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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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GENERAL EXPLANATORY NOTES

GENERAL EXPLANATORY NOTES

GN.1.1 The Medicare Benefits Schedule - Introduction

Schedules of Services

Each professional service contained in the Schedule 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.

Higher rates of benefits are 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.

GN.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. The Department of Human Services 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 Aboriginal and Torres Strait Islander health practitioner;
    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, the Department of Human Services may request its return from the practitioner concerned.

GN.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 the Department of Human Services 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, the Department of Human Services will take recovery action.

The Department of Human Services (DHS) has developed a Health Practitioner Guideline for responding to a request to substantiate that a patient attended a service. There is also a Health Practitioner Guideline for substantiating that a specific treatment was performed. These guidelines are located on the DHS website.

GN.2.4 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 80000-88000 and 82100-82140 and 82200-82215, allied health professionals, dentists, and dental specialists, participating midwives and participating nurse practitioners 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 the Department of Human Services to provide these services.

GN.2.5 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 the Department of Human Services for a Medicare provider number for the locations where these services/referrals/requests will be provided. The form may be downloaded from the Department of Human Services website.

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.

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.

GN.2.6 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 the Department of Human Services (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.

GN.2.7 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 will vary from case 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.

GN.2.8 Contact details for the Department of Human Services

Changes to Provider Contact Details

It is important that you contact the Department of Human Services promptly of any changes to your preferred contact details. Your preferred mailing address is used to contact you about Medicare provider matters. We require requests for changes to your preferred contact details to be made by the provider in writing to the Department of Human Services at:

Medicare

GPO Box 9822

in your capital city

or

By email: medicare.prov@medicareaustralia.gov.au

You may also be able to update some provider details through HPOS
http://www.medicareaustralia.gov.au/hpos/index.jsp

MBS Interpretations

The day-to-day administration and payment of benefits under the Medicare arrangements is the responsibility of the Department of Human Services. Inquiries concerning matters of interpretation of MBS items should be directed to the Department of Human Services at Email: askmbs@humanservices.gov.au

or by phone on 132 150

GN.3.9 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.

GN.3.10 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"

GN.3.11 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.

GN.3.12 Reciprocal Health Care Agreements

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

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 enroll with the Department of Human Services to receive benefits. A passport is sufficient for public hospital care and PBS drugs.

Exceptions:

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

· 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.

GN.4.13 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 the Department of Human Services, having completed an application form available from the Department of Human Services'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 the Department of Human Services when a placement is approved. General practitioner trainees need to apply for a provider number using the appropriate provider number application form available on the Department of Human Services'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:

QI&CPD Program Administrator, RACGP

Tel: 1800 472 247 Email at: qicpd@racgp.org.au

Secretary, General Practice Recognition Eligibility Committee:

Email at gprec@health.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 the Department of Human Services using the approved Application Form available on the the Department of Human Services website: www.humanservices.gov.au. Applicants should forward their applications, as appropriate, to

The Secretariat

The General Practice Recognition Eligibility Committee

National Registration and Accreditation Scheme Policy Section

MDP 152

Department of Health

GPO Box 9848

CANBERRA ACT 2601

email address: gprec@health.gov.au

The Secretariat

The General Practice Recognition Appeal Committee

National Registration and Accreditation Scheme Policy Section

MDP 152

Department of Health

GPO Box 9848

CANBERRA ACT 2601

email address: gprac@health.gov.au

The relevant body will forward the application together with its certification of eligibility to the Department of Human Services 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 Secretariat, General Practice Recognition Appeal Committee (GPRAC), National Registration and Accreditation Scheme Policy Section, MDP 152, Department of Health, GPO Box 9848, Canberra, ACT, 2601.

Removal of vocational recognition status

A medical practitioner may at any time request the Department of Human Services 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 the Department of Human Services 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.

GN.5.14 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 the Department of Human Services' 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 the Department of Human Services' Medicare website.

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 the Department of Human Services' Medicare website.

The Department of Human Services (DHS) has developed an Health Practitioner Guideline to substantiate that a valid referral existed (specialist or consultant physician) which is located on the DHS website.

GN.5.15 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.

GN.6.16 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 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 by Dentists or Optometrists or Participating Midwives or Participating Nurse Practitioners

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

(c) by a participating midwife where the specialist is an obstetrician or a paediatrician, as clinical needs dictate. A referral given by a participating midwife is valid until 12 months after the first service given in accordance with the referral and for I pregnancy only or

(d) by a participating nurse practitioner to specialists and consultant physicians. A referral given by a participating nurse practitioner is valid until 12 months after the first service given in accordance with the referral.

(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 <u>not</u> 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.

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 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

State and Territory Governments are responsible for the provision of public hospital services to eligible persons in accordance with the National Healthcare Agreement.

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 2 years from the date the service was rendered.

A specialist or a consultant physician is required, if requested by the Department of Human Services CEO, to produce to a medical practitioner who is an employee of the Department of Human Services, 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.

GN.7.17 Billing procedures

The Department of Human Services website contains information on Medicare billing and claiming options. Please visit the Department of Human Services website for further information.

Bulk billing

Under the *Health Insurance Act 1973*, a bulk billing facility for professional services is available to all persons in Australia who are eligible for a benefit under the Medicare program. If a practitioner bulk bills for a service the practitioner undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service cannot be raised. This includes but is not limited to:

- any consumables that would be reasonably necessary to perform the service, including bandages and/or dressings;
- record keeping fees;
- a booking fee to be paid before each service, or;
- an annual administration or registration fee.

Where the patient is bulk billed, an additional charge can **only** be raised against the patient by the practitioner where the patient is provided with a vaccine or 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**, **179 to 212**, **733 to 789** and **5000 to 5267** (inclusive) 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.

Where a practitioner provides a number of services (excluding operations) on the one occasion, they can choose to bulk bill some or all of those services and privately charge a fee for the other service (or services), in excess of the Medicare rebate. The privately charged fee can only be charged in relation to said service (or services). Where two or more operations are provided on the one occasion, all services must be either bulk billed or privately charged.

It should be noted that, where a service is not bulk billed, a practitioner may privately raise an additional charge against a patient, such as for a consumable. An additional charge can also be raised where a practitioner does not bulk bill a patient but instead charges a fee that is equal to the rebate for the Medicare service. For example, where a general practitioner provides a professional service to which item 23 relates the practitioner could, in place of bulk billing the patient, charge the rebate for the service and then also raise an additional charge (such as for a consumable).

GN.8.18 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.

The Department of Human Services monitors health practitioners' claiming patterns. Where the Department of Human Services 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:

decide to take no further action; or

enter into an agreement with the person under review (which must then be ratified by an independent Determining Authority); or

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:

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;

hold hearings and require the person under review to attend and give evidence;

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.

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.

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:

an unusual occurrence;

the absence of other medical services for the practitioner's patients (having regard to the practice location); and

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

GN.8.19 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).

GN.8.20 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'.

GN.8.21 Comprehensive Management Framework for the MBS

The Government announced the Comprehensive Management Framework for the MBS in the 2011-12 Budget to improve MBS management and governance into the future. As part of this framework, the Medical Services Advisory Committee (MSAC) Terms of Reference and membership have been expanded to provide the Government with independent expert advice on all new proposed services to be funded through the MBS, as well as on all proposed amendments to existing MBS items. Processes developed under the previously funded MBS Quality Framework are now being integrated with MSAC processes under the Comprehensive Management Framework for the MBS.

GN.8.22 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 7550.

GN.8.23 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.

GN.9.25 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.

GN.10.26 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.

Schedule fees are usually adjusted on an annual basis except for Pathology, Diagnostic Imaging and certain other items.

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 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 '*' or the letter 'H' directly after an item number where used; or a description of the professional service and an indication the service was rendered as an episode of hospital treatment (for example, 'in hospital', 'admitted' or 'in 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 Aboriginal and Torres Strait Islander health practitioner on behalf of a general practitioner.
c. 85% of the Schedule fee, or the Schedule fee less $83.40 (indexed annually in November), whichever is the greater, for all other professional services.

Public hospital services are to be provided free of charge to eligible persons who choose to be treated as public patients in accordance with the National Healthcare Agreement.

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.

GN.10.27 Medicare safety nets

The Medicare Safety Nets provide families and singles with an additional rebate for out-of-hospital Medicare services, once annual thresholds are reached. There are two safety nets: the original Medicare safety net and the extended Medicare safety net.

Original Medicare Safety Net:

Under the original Medicare safety net, the Medicare benefit for out-of-hospital services is increased to 100% of the Schedule Fee (up from 85%) once an annual threshold in gap costs is reached. Gap costs refer to the difference between the Medicare benefit (85%) and the Schedule Fee. The threshold from 1 January 2018 is $461.30. This threshold applies to all Medicare-eligible singles and families.

Extended Medicare Safety Net:

Under the extended Medicare safety net (EMSN), once an annual threshold in out-of-pocket costs for out-of-hospital Medicare services is reached, Medicare will pay for 80% of any future out-of-pocket costs for out-of-hospital Medicare services for the remainder of the calendar year. However, where the item has an EMSN benefit cap, there is a maximum limit on the EMSN benefit that will be paid for that item. Further explanation about EMSN benefit caps is provided below. Out-of-pocket costs refer to the difference between the Medicare benefit and the fee charged by the practitioner.

In 2018, the threshold for singles and families that hold Commonwealth concession card, families that received Family Tax Benefit Part (A) (FTB(A)) and families that qualify for notional FTB (A) is $668.10. The threshold for all other singles and families in 2018 is $2,093.30.

The thresholds for both safety nets are usually indexed on 1 January each year.

Individuals are automatically registered with the Department of Human Services for the safety nets; however couples and families are required to register in order to be recognised as a family for the purposes on the safety nets. In most cases, registered families have their expenses combined to reach the safety net thresholds. This may help to qualify for safety net benefits more quickly. Registration forms can be obtained from the Department of Human Services offices, or completed online at http://www.humanservices.gov.au/customer/services/medicare/medicare-safety-net.

EMSN Benefit Caps:

The EMSN benefit cap is the maximum EMSN benefit payable for that item and is paid in addition to the standard Medicare rebate. Where there is an EMSN benefit cap in place for the item, the amount of the EMSN cap is displayed in the item descriptor.

Once the EMSN threshold is reached, each time the item is claimed the patient is eligible to receive up to the EMSN benefit cap. As with the safety nets, the EMSN benefit cap only applies to out-of-hospital services.

Where the item has an EMSN benefit cap, the EMSN benefit is calculated as 80% of the out-of-pocket cost for the service. If the calculated EMSN benefit is less than the EMSN benefit cap; then calculated EMSN rebate is paid. If the calculated EMSN benefit is greater than the EMSN benefit cap; the EMSN benefit cap is paid.

For example: Item A has a Schedule fee of $100, the out-of-hospital benefit is $85 (85% of the Schedule fee). The EMSN benefit cap is $30. Assuming that the patient has reached the EMSN threshold:

o If the fee charged by the doctor for Item A is $125, the standard Medicare rebate is $85, with an out-of-pocket cost of $40. The EMSN benefit is calculated as $40 x 80% = $32. However, as the EMSN benefit cap is $30, only $30 will be paid.

o If the fee charged by the doctor for Item A is $110, the standard Medicare rebate is $85, with an out-of-pocket cost of $25. The EMSN benefit is calculated as $25 x 80% = $20. As this is less than the EMSN benefit cap, the full $20 is paid.

GN.11.28 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 the Department of Human Services on 132 150.

GN.11.29 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)**".

GN.12.30 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 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, 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 14245);

(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.

Medicare benefits are only payable for items 12306 - 12322 (Bone Densitometry) when the service is performed by a specialist or consultant physician in the practice of his or her specialty where the patient is referred by another medical practitioner.

GN.12.31 Services rendered on behalf of medical practitioners

Medical services in Categories 2 and 3 not included in GN.12.30 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. All practitioners should ensure they maintain adequate and contemporaneous records. All elements of the service must be performed in accordance with accepted medical practice.

Supervision from outside of Australia is not acceptable.

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.

GN.12.32 Medicare benefits and vaccinations

Where a medical practitioner administers an injection for immunisation purposes on his or her own patient, Medicare benefits for that service would be payable on a consultation basis, that is, for the attendance at which the injection is given. However, the cost of the vaccine itself does not attract a Medicare rebate. The Medicare benefits arrangements cover only the professional component of the medical practitioner's service. There are some circumstances where a Medicare benefit is not payable when a medical practitioner administers an injection for immunisation purposes – please refer to example 3 below for further details.

Example 1

A patient presents to a GP to receive the influenza vaccination. The patient is not in the cohort of patients which is covered for the influenza vaccine under the NIP.

After taking a short patient history, the GP administers the vaccine to the patient. The GP has met the requirements of a level A consultation and claims item 3. The GP can bulk bill the patient for the cost of the MBS service and can charge a separate amount for the cost of the vaccine, which is not covered under the NIP.

If a patient presented to a GP to receive a vaccine and to enquire about a medical condition, the GP may claim the appropriate item (such as item 23).

Example 2

A patient presents to a GP to receive the influenza vaccination. The patient is in the cohort of patients which is covered for the influenza vaccine under the NIP.

After taking a short patient history, the GP administers the vaccine to the patient. The GP has met the requirements of a level A consultation and claims item 3. The GP can bulk bill the patient but does not need to charge a separate amount for the cost of the vaccine, which is covered under the NIP.

If a patient presented to a GP to receive a vaccine and to enquire about a medical condition, the GP may claim the appropriate item (such as item 23).

Example 3

A GP is employed by a State or Territory community health centre to administer vaccines and provides no additional medical services.

A Medicare benefit is not payable as the GP is providing the service under an arrangement with the State or Territory, which is prohibited under subsection 19(2) of the Health Insurance Act 1973. The service is also prohibited on the basis that it is a mass immunisation which is prohibited under subsection 19(4).

A mass immunisation is a program to inoculate people that is funded by the Commonwealth or State Government, or through an international or private organisation.

GN.13.33 Services which do not attract Medicare benefits

Services not attracting benefits

(a) telephone consultations;

(b) issue of repeat prescriptions when the patient does not attend the surgery in person;

(c) group attendances (unless otherwise specified in the item, such as items 170, 171, 172, 342, 344 and 346);

(d) non-therapeutic cosmetic surgery;

(e) 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

(a) are paid/payable to a public hospital;

(b) 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.);

(c) are for a medical examination for the purposes of life insurance, superannuation, a provident account scheme, or admission to membership of a friendly society;

(d) are incurred in mass immunisation (see General Explanatory Note 12.3 for further explanation).

Unless the Minister otherwise directs

Medicare benefits are not payable where:

(a) 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;

(b) the medical expenses are incurred by the employer of the person to whom the service is rendered;

(c) 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

(d) the service is a health screening service.

(e) the service is a pre-employment 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

No MBS item applies to a service mentioned in the item if the service is provided to a patient at the same time as, or in connection with, an injection of blood or a blood product that is autologous.

No MBS item applies to a service mentioned in the item if the service is provided to a patient at the same time as, or in connection with, the harvesting, storage, in vitro processing or injection of non-haematopoietic stem cells.

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) gamma knife surgery;

(c) intradiscal electro thermal arthroplasty;

(d) intravascular ultrasound (except where used in conjunction with intravascular brachytherapy);

(e) intro-articular viscosupplementation, for the treatment of osteoarthritis of the knee;

(f) low intensity ultrasound treatment, for the acceleration of bone fracture healing, using a bone growth stimulator;

(g) lung volume reduction surgery, for advanced emphysema;

(h) photodynamic therapy, for skin and mucosal cancer;

(i) placement of artificial bowel sphincters, in the management of faecal incontinence;

(j) selective internal radiation therapy for any condition other than hepatic metastases that are secondary to colorectal cancer;

(k) specific mass measurement of bone alkaline phosphatase;

(l) transmyocardial laser revascularisation;

(m) vertebral axial decompression therapy, for chronic back pain.

(n) autologous chondrocyte implantation and matrix-induced autologous chondrocyte implantation.

(o) vertebroplasty

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:

(a) multiphasic health screening;

(b) mammography screening (except as provided for in Items 59300/59303);

(c) testing of fitness to undergo physical training program, vocational activities or weight reduction programs;

(d) compulsory examinations and tests to obtain a flying, commercial driving or other licence;

(e) entrance to schools and other educational facilities;

(f) for the purposes of legal proceedings;

(g) 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) 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 cervical screening test in a person (see General Explanatory note 12.3 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;

(b) a pathology service requested by the National Heart Foundation of Australia, Risk Evaluation Service;

(c) age or health related medical examinations to obtain or renew a licence to drive a private motor vehicle;

(d) 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;

(e) a medical examination for a person as a prerequisite of that person becoming eligible to foster a child or children;

(f) a medical examination being a requisite for Social Security benefits or allowances;

(g) 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 for the National Cervical Screening Program (NCSP) is as follows:

(a) Cervical screening should be undertaken every five years in asymptomatic persons, using a primary human papillomavirus (HPV) test with partial genotyping and reflex liquid based cytology (LBC) triage;

(b) Persons who have ever been sexually active should commence cervical screening at 25 years of age;

(c) Persons aged 25 years or older and less than 70 years will receive invitations and reminders to participate in the program;

(d) Persons will be invited to exit the program by having a HPV test between 70 years or older and less than 75 years of age and may cease cervical screening if their test result is low risk;

(e) Persons 75 years of age or older who have either never had a cervical screening test or have not had one in the previous five years, may request a cervical screening test and can be screened;

(f) All persons, both HPV vaccinated and unvaccinated, are included in the program;

(g) Self collection of a sample for testing is available for persons who are aged 30 years and over and has never participated in the NCSP; or is overdue for cervical screening by two years or longer.

· Self collection must be facilitated and requested by a healthcare professional who also routinely offers cervical screening services;

· The self collection device and the HPV test, when used together, must meet the requirements of the National Pathology Accreditation Advisory Council (NPAAC) Requirements for Laboratories Reporting Tests for the NCSP; and

(h) Persons with intermediate and higher risk screening test results should be followed up in accordance with the cervical screening pathway and the NCSP: Guidelines for the management of screen detected abnormalities, screening women in specific populations and investigation of women with abnormal vaginal bleeding (2016 Guidelines) – endorsed by the Royal Australian College of General Practitioners, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Royal College of Pathologists of Australasia, the Australian Society of Gynaecologic Oncologists and the Australian Society for Colposcopy and Cervical Pathology.

Note 1: As separate items exist for routine screening, screening in specific population and investigation of persons with abnormal vaginal bleeding, treating practitioners are asked to clearly identify on the request form, if the sample is collected as part of routine screening or for another purpose (see paragraph PP.16.11 of Pathology Services Explanatory Notes in Category 6).

Note 2: Where reflex cytology is performed following the detection of HPV in routine screening, the HPV test and the LBC test results must be issued as a combined report with the overall risk rating.

Note 3: 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

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) 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.

(b) 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.

GN.14.34 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.

GN.14.35 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.

GN.14.36 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.

GN.14.37 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.

GN.14.38 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.

GN.15.39 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.

The Department of Human Services (DHS) has developed an Health Practitioner Guideline to substantiate that a specific treatment was performed which is located on the DHS website.

CATEGORY 4: ORAL AND MAXILLOFACIAL SERVICES

SUMMARY OF CHANGES FROM 01/11/2018

The 01/11/2018 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

Deleted Items

53600

Changes as a result of MBS Taskforce Review of Dermatology, Allergy and Immunology

As part of the 2018-19 Budget, the Government announced changes to Medical Benefts Schedule (MBS) items for dermatology, allergy and immunology to take effect from 1 November 2018.

These changes are the result of a review by the Dermatology, Allergy and Immunology Clinical Committee (DAICC) working under the MBS Review Taskforce.

The changes delete 12 items and change 28 items to remove unnecessary tests from the MBS, focus on encouraging best practice, and improve patient care and safety.

ORAL AND MAXILLOFACIAL SERVICES NOTES

ON.1.1 Benefits for Medical Services Performed by Approved Dental Practitioners

Under the provisions of the *Health Insurance Act 1973* (the Act), Medicare benefits are payable where an eligible person incurs medical expenses in respect of certain professional services rendered by a approved dental practitioner approved before 1 November 2004.

Category 4 is restricted to those dental practitioners who were approved by the Minister prior to 1November2004 for the provision of oral and maxillofacial surgery services and relevant attendances.

Approved dental practitioners may also request certain diagnostic imaging services - refer to Category 5 - Diagnostic Imaging Services for more information.

ON.1.2 Changes to the Scheme Effective from 1 November 2004

From 1 November 2004, access to Category 4 is restricted to those dental practitioners who were approved by the Minister prior to 1 November 2004. No new approvals will be granted after that date.

Background

Since 2000, practitioners performing oral and maxillofacial surgery in Australia are required to have both dental and medical qualifications in order to sit for their FRACDS(OMS) exam. This effectively means that since then, any practitioner who has obtained an FRACDS(OMS) or equivalent can access Category 3 of the MBS because they are medically qualified. The Government, in consultation with the Australian and New Zealand Association of Oral and Maxillofacial Surgeons, the Australian Dental Association, the Royal Australian College of Surgeons, the Royal Australian College of Dental Surgeons and the Australian Medical Association, has agreed that access by new practitioners to Category 4 will be withdrawn from 1November2004. Practitioners who were approved prior to that date will continue to have access to Category 4. The long-term proposal is that once all practitioners who currently access Category 4 have left the workforce, Category 4 will be removed from the Medicare Benefits Schedule.

Details of the services attracting Medicare benefits are set out in the Medicare Benefits Schedule.

ON.2.1 Definition of Oral and Maxillofacial Surgery

Oral and Maxillofacial Surgery is defined as the surgical specialty which deals with the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects of the oral and maxillofacial region.

ON.2.2 Services That Can Be Provided

Dental practitioners holding the FRACDS (OMS) or equivalent who were approved by the Minister prior to 1November2004 may perform prescribed oral and maxillofacial services listed in this category. All dental practitioners approved for the purposes of subsection 3(1) of the Act are also recognised to perform those items of oral and maxillofacial surgery listed in Group C2 of the booklet "Medicare Benefits for Treatment of Cleft Lip and Cleft Palate Conditions".

It is emphasised that -

- the sole purpose of granting approval to dental practitioners is to enable payment of Medicare benefits;

- the services set out in Groups 01 to 011 of the Medicare Benefits Schedule book, and in the Cleft Lip and Cleft Palate Schedule are the only ones for which Medicare benefits are payable when the services are performed by an eligible dental practitioner.

ON.3.1 Principles of Interpretation

Each professional service listed in the Schedule is a complete medical service in itself. Where a service is rendered partly by one practitioner and partly by another, only the one amount of benefit is payable.

ON.3.2 Multiple Operation Rule

The Schedule fees for two or more operations performed on a patient on the one occasion are calculated by the following rule:-

100% for the item with the greatest Schedule fee, plus 50% for the item with the next greatest Schedule fee, plus 25% for each other item.

NOTE:

1. Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents

2. Where two or more operations performed on the one occasion have fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.

3. The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

The above rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient by different dental practitioners unless either practitioner assists the other. In this case, the fees and benefits specified in the Schedule apply. For these purposes the term "operation" includes all services in Groups O3 to O9.

If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

ON.3.3 After Care (Post-operative Treatment)

The fee specified for each of the operations listed in the Schedule contains a component for the consequential after-care customarily provided unless otherwise indicated. After-care is deemed to include all post-operative treatment rendered by practitioners and need not necessarily be limited to treatment given by the approved dental practitioner or to treatment given by any one practitioner. This does not preclude, however, the payment of benefit for professional services for the treatment by a dental practitioner of an intercurrent condition or an unusual complication arising from the operation.

Some minor operations are merely stages in the treatment of a particular condition. Professional services by dental practitioners subsequent to such operations should not be regarded as after-care but rather as continuation of the treatment of the original condition and should attract benefit. Item 52057 is a service to which this policy applies.

ON.3.4 Administration of Anaesthetics by Medical Practitioners

When a medical practitioner administers an anaesthetic in connection with a procedure prescribed for the payment of Medicare benefits (and the procedure has been performed by an approved dental practitioner), Medicare benefits are payable for the administration of the anaesthetic on the same basis as if the procedure had been rendered by a medical practitioner.

The Schedule fee for anaesthesia is established using the RVG schedule at Category 3 - Group T10.

Before the payment of benefits for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of additional details are required on the anaesthetist's account:

- The anaesthetist's account must show the name/s of the medical practitioner/s who performed the associated operation/s. Also, where the after hours emergency modifier applies to the anaesthesia service, the account must include the start time, the end time and the total time of the anaesthesia;

- The assistant anaesthetist's account must show the name/s of the medical practitioners who performed the associated operation/s, as well as the name of the principle anaesthetist. In addition, where the after hours emergency modifier applies, the assistant anaesthetist's account must record the start time, the end time and the total time for which he or she was providing professional attention to the patient during the anaesthesia.

ON.4.1 Consultations - (Items 51700 and 51703)

The consultation item numbers (51700 and 51703) are to be used by approved dental practitioners in the practice of oral and maxillofacial surgery.

The referral must be from a registered dental practitioner or a medical practitioner.

ON.4.2 Assistance at Operations - (Items 51800 and 51803)

Items covering operations which are eligible for benefits for assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery or surgical assistance have been 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.

The assistance must be rendered by a practitioner other than the surgeon, the anaesthetist or the assistant anaesthetist.

Where more than one practitioner provides assistance to an approved dental practitioner no additional benefits are payable. The assistance benefit is the same irrespective of the number of practitioners providing assistance.

<u>Benefits payable under item 51800</u>

Medicare benefits are payable under Item 51800 for assistance rendered at the following procedures:

51900, 51904, 52010, 52018, 52039, 52048, 52051, 52062, 52063, 52066, 52078, 52090, 52092, 52095, 52105, 52108, 52111, 52130, 52138, 52141, 52144, 52147, 52182, 52300, 52303, 52312, 52315, 52321, 52324, 52336, 52339, 52424, 52440, 52452, 52480, 52482, 52600, 52603, 52609, 52612, 52615, 52624, 52626, 52627, 52800, 52803, 52806, 52809, 52818, 52824, 52828, 52830, 53006, 53009, 53016, 53215, 53220, 53225, 53226, 53236, 53239, 53242, 53406, 53409, 53412, 53413, 53415, 53416, 53453, 53460.

Where assistance with any of the above procedures is provided by a medical practitioner, benefits are payable under item 51300.

<u>Benefits payable under Item 51803</u>

Medicare benefits are payable under Item 51803 for assistance rendered at the following procedures:

51906, 52054, 52094, 52114, 52117, 52120, 52122, 52123, 52126, 52129, 52131, 52148, 52158, 52184, 52186, 52306, 52330, 52333, 52337, 52342, 52345, 52348, 52351, 52354, 52357, 52360, 52363, 52366, 52369, 52372, 52375, 52378, 52379, 52380, 52382, 52430, 52442, 52444, 52446, 52456, 52484, 52618, 52621, 52812, 52815, 52821, 52832, 53015, 53017, 53019, 53209, 53212, 53218, 53221, 53224, 53227, 53230, 53233, 53414, 53418, 53419, 53422, 53423, 53424, 53425, 53427, 53429, 53455.

or at a combination of procedures (including those identified as payable under item 51800 above) for which the aggregate fee exceeds the amount specified in the item.

Where assistance with any of the above procedures is provided by a medical practitioner, benefits are payable under Item 51303.

<u>Assistance at multiple operations</u>

Where assistance is provided at two or more operations performed on a patient on the one occasion the multi operation formula is applied to all the operations to determine the surgical fee payable to each approved dental

practitioner. The multi-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Items 51800/51300 or 51803/51303).

The derived fee applicable to Item 51803/51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery.

ON.4.3 Repair of Wound - (Item 51900)

Item 51900 covers debridement of "deep and extensively contaminated" wound. Benefits are not payable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures.

ON.4.4 Lipectomy, Wedge Excision - Two or More Excisions - (Item 51906)

Multiple lipectomies attract benefits under Item 51906 once only, i.e. the multiple operation rule does not apply.

Medicare benefits are not payable in respect of liposuction.

ON.4.5 Upper Aerodigestive Tract Endoscopic Procedure - (Item 52035)

The following are guidelines of appropriate minimum standards for the performance of GI endoscopy in relation to (a) cleaning, disinfection and sterilisation procedures, and (b) anaesthetic and resuscitation equipment. These guidelines are based on the advice of the Gastroenterological Society of Australia, the Sections of HPB and Upper GI and of Colon and Rectal Surgery of the Royal Australasian College of Surgeons, and the Colorectal Surgical Society of Australia.

Cleaning, disinfection and sterilisation procedures

Endoscopic procedures should be performed in facilities where endoscope and accessory reprocessing protocols follow procedures outlined in:-

(i) 'Infection and Endoscopy' (3rd edition), Gastroenterological Society of Australia;

(ii) 'Infection control in the health care setting - Guidelines for the prevention of transmission of infectious diseases', National Health and Medical Research Council; and

(iii) Australian Standard AS 4187-1994 (and Amendments), Standards Association of Australia.

Anaesthetic and resuscitation equipment

Where the patient is anaesthetised, anaesthetic equipment, administration and monitoring, and post operative and resuscitation facilities should conform to the standards outlined in 'Sedation for Endoscopy', Australian & New Zealand College of Anaesthetists, Gastroenterological Society of Australia and Royal Australasian College of Surgeons. These guidelines will be taken into account in determining appropriate practice in the context of the Professional Services Review process.

ON.4.6 Tumour, cyst, Ulcer or Scar - (Items 52036 to 52054)

It is recognised that odontogenic keratocysts, although not neoplastic, often require the surgical management of benign tumours.

ON.4.7 Aspiration of Haematoma - (Item 52056)

Aspiration of haematoma is indicated in clinical situations where incision may leave an unsightly scar or where access is difficult for conventional drainage.

ON.4.8 Osteotomy of Jaw - (Items 52342 to 52375)

The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site.

Bone grafts taken from a separate site, e.g. iliac crest, would attract additional benefit under Item 52318 or 52319 for the harvesting, plus item 52130 or 52131 for the grafting.

Where the site of grafting under item 52131 requires closure by single stage local flap, item 52300 may be claimed where clinically appropriate. Clinically appropriate in this instance means that the flap is required to close defects because the defect cannot be closed directly.

A local skin flap is an area of skin or subcutaneous tissue designed to be elevated from the skin adjoining a defect requiring closure. The flap remains partially attached by pedicle and is moved to the defect by rotation, advancement or transposition, or a combination of these manoeuvres.

Benefits are only payable where the flap is required for adequate wound closure. A secondary defect will be created which may be closed by direct suture, skin grafting or sometimes a further local skin flap. This latter procedure will also attract benefit if closed by graft or flap repair but not been closed by direct suture.

By definition, direct wound closure (e.g. by suture) does not constitute skin flap. Similarly, angled, curved or trapdoor incisions which are used for exposure and which are sutured back into the same position relative to the adjacent tissues are not skin flap repairs. Undermining of the edges of the wound prior to suturing is considered a normal part of wound closure and is not considered to skin flap repair.

For the purposes of these items, a reference to maxilla includes the zygoma.

ON.4.9 Genioplasty - (Item 52378)

Genioplasty attracts benefit once only although a section is made on both sides of the symphysis of the mandible.

ON.4.10 Fracture of Mandible or Maxilla - (Items 53400 to 53439)

There are two maxillae in the skull and for the purpose of these items the mandible is regarded as comprising two bones.

Hence a bilateral fracture of the mandible would be assessed as:

· Item 53409 x 1½;

· two maxillae and one side of the mandible as Item 53406 x 1½ + 53409 x ¼.

Splinting in Item 53406 or 53409 refers to cap splints, arch bars, silver (cast metal) or acrylic splints.

ON.4.12 Destruction of Nerve Branch by Neurolytic Agent - (Item 53706)

Item 53706 includes the use of botulinum toxin as a neurolytic agent.

ORAL AND MAXILLOFACIAL SERVICES ITEMS

O1. CONSULTATIONS	
	Group O1. Consultations
	APPROVED DENTAL PRACTITIONER, REFERRED CONSULTATION - SURGERY, HOSPITAL OR RESIDENTIAL AGED CARE FACILITY
51700	Professional attendance (other than a second or subsequent attendance in a single course of treatment) by an approved dental practitioner, at consulting rooms, hospital or residential aged care facility where the patient is referred to him or her (See para ON.4.1 of explanatory notes to this Category) **Fee:** $85.55 **Benefit:** 75% = $64.20 85% = $72.75
51703	Professional attendance by an approved dental practitioner, each attendance subsequent to the first in a single course of treatment at consulting rooms, hospital or residential aged care facility where the patient is referred to him or her (See para ON.4.1 of explanatory notes to this Category) **Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55
O2. ASSISTANCE AT OPERATION	
	Group O2. Assistance At Operation
51800	Assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery at any operation identified by the word "Assist." for which the fee does not exceed $558.30 or at a series or combination of operations identified by the word "Assist." where the fee for the series or combination of operations identified by the word "Assist." does not exceed $558.30 (See para ON.4.2 of explanatory notes to this Category) **Fee:** $86.30 **Benefit:** 75% = $64.75 85% = $73.40
51803	Assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery at any operation identified by the word "Assist." for which the fee exceeds $558.30 or at a series or combination of operations identified by the word "Assist." where the aggregate fee exceeds $558.30 (See para ON.4.2 of explanatory notes to this Category) **Derived Fee:** one fifth of the established fee for the operation or combination of operations
O3. GENERAL SURGERY	
	Group O3. General Surgery
51900	WOUND OF SOFT TISSUE, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.) (See para ON.4.3 of explanatory notes to this Category) **Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15
51902	WOUNDS, DRESSING OF, under general anaesthesia, with or without removal of sutures, not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.) **Fee:** $73.90 **Benefit:** 75% = $55.45 85% = $62.85
51904	LIPECTOMY - wedge excision of skin or fat - 1 EXCISION (Anaes.) (Assist.) **Fee:** $454.85 **Benefit:** 75% = $341.15 85% = $386.65
51906	LIPECTOMY - wedge excision of skin or fat - 2 OR MORE EXCISIONS (Anaes.) (Assist.) (See para ON.4.4 of explanatory notes to this Category)

O3. GENERAL SURGERY	
	Fee: $691.75 **Benefit:** 75% = $518.85 85% = $608.35
52000	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes.) **Fee:** $82.50 **Benefit:** 75% = $61.90 85% = $70.15
52003	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) **Fee:** $117.55 **Benefit:** 75% = $88.20 85% = $99.95
52006	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes.) **Fee:** $117.55 **Benefit:** 75% = $88.20 85% = $99.95
52009	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) **Fee:** $185.60 **Benefit:** 75% = $139.20 85% = $157.80
52010	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.) **Fee:** $254.00 **Benefit:** 75% = $190.50 85% = $215.90
52012	SUPERFICIAL FOREIGN BODY, removal of, as an independent procedure (Anaes.) **Fee:** $23.50 **Benefit:** 75% = $17.65 85% = $20.00
52015	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and suture, as an independent procedure (Anaes.) **Fee:** $109.90 **Benefit:** 75% = $82.45 85% = $93.45
52018	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.) **Fee:** $276.80 **Benefit:** 75% = $207.60 85% = $235.30
52021	ASPIRATION BIOPSY of 1 or MORE JAW CYSTS as an independent procedure to obtain material for diagnostic purposes and not being a service associated with an operative procedure on the same day (Anaes.) **Fee:** $29.45 **Benefit:** 75% = $22.10 85% = $25.05
52024	BIOPSY OF SKIN OR MUCOUS MEMBRANE, as an independent procedure (Anaes.) **Fee:** $52.20 **Benefit:** 75% = $39.15 85% = $44.40
52025	LYMPH NODE OF NECK, biopsy of (Anaes.) **Fee:** $183.90 **Benefit:** 75% = $137.95 85% = $156.35
52027	BIOPSY OF LYMPH GLAND, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure and not being a service to which item 52025 applies (Anaes.) **Fee:** $149.75 **Benefit:** 75% = $112.35 85% = $127.30
52030	SINUS, excision of, involving superficial tissue only (Anaes.) **Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50
52033	SINUS, excision of, involving muscle and deep tissue (Anaes.) **Fee:** $183.90 **Benefit:** 75% = $137.95 85% = $156.35
52034	PREMALIGNANT LESIONS of the oral mucous, treatment by cryotherapy, diathermy or carbon

O3. GENERAL SURGERY	
	dioxide laser **Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55
52035	ENDOSCOPIC LASER THERAPY for neoplasia and benign vascular lesions of the oral cavity (Anaes.) (See para ON.4.5 of explanatory notes to this Category) **Fee:** $476.10 **Benefit:** 75% = $357.10 85% = $404.70
52036	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 52039 applies (Anaes.) (See para ON.4.6 of explanatory notes to this Category) **Fee:** $126.90 **Benefit:** 75% = $95.20 85% = $107.90
52039	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Anaes.) (Assist.) (See para ON.4.6 of explanatory notes to this Category) **Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15
52042	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.) (See para ON.4.6 of explanatory notes to this Category) **Fee:** $172.50 **Benefit:** 75% = $129.40 85% = $146.65
52045	TUMOUR, CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), removal of, not being a service to which another item in Groups O3 to O9 applies, involving muscle, bone, or other deep tissue (Anaes.) (See para ON.4.6 of explanatory notes to this Category) **Fee:** $246.50 **Benefit:** 75% = $184.90 85% = $209.55
52048	TUMOUR OR DEEP CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), removal of, requiring wide excision, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) (See para ON.4.6 of explanatory notes to this Category) **Fee:** $371.50 **Benefit:** 75% = $278.65 85% = $315.80
52051	TUMOUR, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.) (See para ON.4.6 of explanatory notes to this Category) **Fee:** $502.25 **Benefit:** 75% = $376.70 85% = $426.95
52054	TUMOUR, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.) (See para ON.4.6 of explanatory notes to this Category) **Fee:** $587.60 **Benefit:** 75% = $440.70 85% = $504.20
52055	HAEMATOMA, SMALL ABSCESS OR CELLULITIS, not requiring admission to a hospital,

O3. GENERAL SURGERY	
	INCISION WITH DRAINAGE OF (excluding after care) **Fee:** $27.35 **Benefit:** 75% = $20.55 85% = $23.25
52056	HAEMATOMA, aspiration of (Anaes.) (See para ON.4.7 of explanatory notes to this Category) **Fee:** $27.35 **Benefit:** 75% = $20.55 85% = $23.25
52057	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.) (See para ON.3.3 of explanatory notes to this Category) **Fee:** $162.95 **Benefit:** 75% = $122.25 85% = $138.55
52058	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS, using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $237.60 **Benefit:** 75% = $178.20 85% = $202.00
52059	ABSCESS, DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $267.65 **Benefit:** 75% = $200.75 85% = $227.55
52060	MUSCLE, excision of (Anaes.) **Fee:** $189.40 **Benefit:** 75% = $142.05 85% = $161.00
52061	MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes.) **Fee:** $223.60 **Benefit:** 75% = $167.70 85% = $190.10
52062	MUSCLE, RUPTURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.) **Fee:** $295.70 **Benefit:** 75% = $221.80 85% = $251.35
52063	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) **Fee:** $356.35 **Benefit:** 75% = $267.30 85% = $302.90
52064	BONE CYST, injection into or aspiration of (Anaes.) **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
52066	SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.) **Fee:** $445.40 **Benefit:** 75% = $334.05 85% = $378.60
52069	SUBLINGUAL GLAND, extirpation of (Anaes.) **Fee:** $198.50 **Benefit:** 75% = $148.90 85% = $168.75
52072	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes.) **Fee:** $58.80 **Benefit:** 75% = $44.10 85% = $50.00
52073	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes.) **Fee:** $149.75 **Benefit:** 75% = $112.35 85% = $127.30
52075	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures (Anaes.) **Fee:** $149.75 **Benefit:** 75% = $112.35 85% = $127.30
52078	TONGUE, partial excision of (Anaes.) (Assist.) **Fee:** $295.70 **Benefit:** 75% = $221.80 85% = $251.35

O3. GENERAL SURGERY	
52081	TONGUE TIE, division or excision of frenulum (Anaes.) **Fee:** $46.50 **Benefit:** 75% = $34.90 85% = $39.55
52084	TONGUE TIE, MANDIBULAR FRENULUM OR MAXILLARY FRENULUM, division or excision of frenulum, in a person aged not less than 2 years (Anaes.) **Fee:** $119.50 **Benefit:** 75% = $89.65 85% = $101.60
52087	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.) **Fee:** $204.70 **Benefit:** 75% = $153.55 85% = $174.00
52090	OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes.) (Assist.) **Fee:** $356.35 **Benefit:** 75% = $267.30 85% = $302.90
52092	OPERATION on SKULL for OSTEOMYELITIS (Anaes.) (Assist.) **Fee:** $464.50 **Benefit:** 75% = $348.40 85% = $394.85
52094	OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 52092 (Anaes.) (Assist.) **Fee:** $587.55 **Benefit:** 75% = $440.70 85% = $504.15
52095	BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.) **Fee:** $380.80 **Benefit:** 75% = $285.60 85% = $323.70
52096	ORTHOPAEDIC PIN OR WIRE, insertion of, into maxilla or mandible or zygoma, as an independent procedure (Anaes.) **Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95
52097	EXTERNAL FIXATION, removal of, in the operating theatre of a hospital (Anaes.) **Fee:** $160.05 **Benefit:** 75% = $120.05
52098	EXTERNAL FIXATION, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.) **Fee:** $188.20 **Benefit:** 75% = $141.15 85% = $160.00
52099	BURIED WIRE, PIN or SCREW, 1 or more, which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, per bone, not being a service associated with a service to which item 52102 or 52105 applies (Anaes.) **Fee:** $141.25 **Benefit:** 75% = $105.95 85% = $120.10
52102	BURIED WIRE, PIN or SCREW, 1 or more, which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, where undertaken in the operating theatre of a hospital, per bone (Anaes.) **Fee:** $141.25 **Benefit:** 75% = $105.95 85% = $120.10
52105	PLATE, 1 or more of, and associated screw and wire which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, per bone, not being a service associated with a service to which item 52099 or 52102 applies (Anaes.) (Assist.) **Fee:** $263.60 **Benefit:** 75% = $197.70 85% = $224.10
52106	ARCH BARS, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia where undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $108.90 **Benefit:** 75% = $81.70

O3. GENERAL SURGERY	
52108	LIP, full thickness wedge excision of, with repair by direct sutures (Anaes.) (Assist.) **Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15
52111	VERMILIONECTOMY (Anaes.) (Assist.) **Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15
52114	MANDIBLE or MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.) **Fee:** $587.60 **Benefit:** 75% = $440.70 85% = $504.20
52117	MANDIBLE, including lower border, or MAXILLA, sub-total resection of (Anaes.) (Assist.) **Fee:** $699.45 **Benefit:** 75% = $524.60 85% = $616.05
52120	MANDIBLE, hemimandiblectomy of, including condylectomy where performed (Anaes.) (Assist.) **Fee:** $827.30 **Benefit:** 75% = $620.50 85% = $743.90
52122	MANDIBLE, hemi-mandibular reconstruction of, OR MAXILLA, reconstruction of, with BONE GRAFT, PLATE, TRAY OR ALLOPLAST, not being a service associated with a service to which item 52123 applies (Anaes.) (Assist.) **Fee:** $827.30 **Benefit:** 75% = $620.50 85% = $743.90
52123	MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.) **Fee:** $936.55 **Benefit:** 75% = $702.45 85% = $853.15
52126	MAXILLA, total resection of (Anaes.) (Assist.) **Fee:** $900.45 **Benefit:** 75% = $675.35 85% = $817.05
52129	MAXILLA, total resection of both maxillae (Anaes.) (Assist.) **Fee:** $1,205.40 **Benefit:** 75% = $904.05 85% = $1122.00
52130	BONE GRAFT, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) **Fee:** $442.45 **Benefit:** 75% = $331.85 85% = $376.10
52131	BONE GRAFT WITH INTERNAL FIXATION, not being a service to which an item in the range (a) 51900 to 52186; or (b) 52303 to 53460 applies (Anaes.) (Assist.) **Fee:** $611.90 **Benefit:** 75% = $458.95 85% = $528.50
52132	TRACHEOSTOMY (Anaes.) **Fee:** $248.95 **Benefit:** 75% = $186.75 85% = $211.65
52133	CRICOTHYROSTOMY by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.) **Fee:** $91.05 **Benefit:** 75% = $68.30 85% = $77.40
52135	POST-OPERATIVE or POST-NASAL HAEMORRHAGE, or both, control of, where undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $144.35 **Benefit:** 75% = $108.30
52138	MAXILLARY ARTERY, ligation of (Anaes.) (Assist.) **Fee:** $448.55 **Benefit:** 75% = $336.45 85% = $381.30
52141	FACIAL, MANDIBULAR or LINGUAL ARTERY or VEIN or ARTERY and VEIN, ligation of, not

O3. GENERAL SURGERY	
	being a service to which item 52138 applies (Anaes.) (Assist.) **Fee:** $443.70 **Benefit:** 75% = $332.80 85% = $377.15
52144	FOREIGN BODY, deep, removal of using interventional imaging techniques (Anaes.) (Assist.) **Fee:** $413.55 **Benefit:** 75% = $310.20 85% = $351.55
52147	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.) **Fee:** $390.25 **Benefit:** 75% = $292.70 85% = $331.75
52148	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.) **Fee:** $689.80 **Benefit:** 75% = $517.35 85% = $606.40
52158	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.) **Fee:** $1,110.65 **Benefit:** 75% = $833.00 85% = $1027.25
	MALIGNANT DISEASE
52180	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, biopsy of (not including aftercare) (Anaes.) **Fee:** $188.20 **Benefit:** 75% = $141.15 85% = $160.00
52182	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (Anaes.) (Assist.) **Fee:** $414.25 **Benefit:** 75% = $310.70 85% = $352.15
52184	BONE TUMOUR, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) **Fee:** $611.90 **Benefit:** 75% = $458.95 85% = $528.50
52186	BONE TUMOUR, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) **Fee:** $753.25 **Benefit:** 75% = $564.95 85% = $669.85
O4. PLASTIC & RECONSTRUCTIVE	
	Group O4. Plastic & Reconstructive
52300	SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, with skin or mucosa (Anaes.) (Assist.) **Fee:** $284.35 **Benefit:** 75% = $213.30 85% = $241.70
52303	SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, with buccal pad of fat (Anaes.) (Assist.) **Fee:** $406.05 **Benefit:** 75% = $304.55 85% = $345.15
52306	SINGLE-STAGE LOCAL FLAP, where indicated, repair to 1 defect, using temporalis muscle (Anaes.) (Assist.) **Fee:** $602.45 **Benefit:** 75% = $451.85 85% = $519.05
52309	FREE GRAFTING (mucosa or split skin) of a granulating area (Anaes.) **Fee:** $204.70 **Benefit:** 75% = $153.55 85% = $174.00
52312	FREE GRAFTING (mucosa, split skin or connective tissue) to 1 defect, including elective dissection (Anaes.) (Assist.)

O4. PLASTIC & RECONSTRUCTIVE	
	Fee: $284.35 **Benefit:** 75% = $213.30 85% = $241.70
52315	FREE GRAFTING, FULL THICKNESS, to 1 defect (mucosa or skin) (Anaes.) (Assist.) **Fee:** $473.75 **Benefit:** 75% = $355.35 85% = $402.70
52318	BONE GRAFT, harvesting of, via separate incision, being a service associated with a service to which another item in Groups O3 to O9 applies - Autogenous - small quantity (Anaes.) **Fee:** $141.25 **Benefit:** 75% = $105.95 85% = $120.10
52319	BONE GRAFT, harvesting of, via separate incision, being a service associated with a service to which another item in Groups O3 to O9 applies - Autogenous - large quantity (Anaes.) **Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20
52321	FOREIGN IMPLANT (NON-BIOLOGICAL), insertion of, for CONTOUR RECONSTRUCTION of pathological deformity, not being a service associated with a service to which item 52624 applies (Anaes.) (Assist.) **Fee:** $473.75 **Benefit:** 75% = $355.35 85% = $402.70
52324	DIRECT FLAP REPAIR, using tongue, first stage (Anaes.) (Assist.) **Fee:** $473.75 **Benefit:** 75% = $355.35 85% = $402.70
52327	DIRECT FLAP REPAIR, using tongue, second stage (Anaes.) **Fee:** $235.05 **Benefit:** 75% = $176.30 85% = $199.80
52330	PALATAL DEFECT (oro-nasal fistula), plastic closure of, including services to which item 52300, 52303, 52306 or 52324 applies (Anaes.) (Assist.) **Fee:** $781.95 **Benefit:** 75% = $586.50 85% = $698.55
52333	CLEFT PALATE, primary repair (Anaes.) (Assist.) **Fee:** $781.95 **Benefit:** 75% = $586.50 85% = $698.55
52336	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.) (Assist.) **Fee:** $488.75 **Benefit:** 75% = $366.60 85% = $415.45
52337	ALVEOLAR CLEFT (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes.) (Assist.) **Fee:** $1,069.10 **Benefit:** 75% = $801.85 85% = $985.70
52339	CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.) **Fee:** $556.60 **Benefit:** 75% = $417.45 85% = $473.20
52342	MANDIBLE or MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $966.80 **Benefit:** 75% = $725.10
52345	MANDIBLE or MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,090.35 **Benefit:** 75% = $817.80
52348	MANDIBLE or MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,232.05 **Benefit:** 75% = $924.05

O4. PLASTIC & RECONSTRUCTIVE	
52351	MANDIBLE or MAXILLA, bilateral osteotomy of osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,383.65 **Benefit:** 75% = $1037.75
52354	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,402.70 **Benefit:** 75% = $1052.05
52357	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,579.20 **Benefit:** 75% = $1184.40
52360	MANDIBLE and MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,611.05 **Benefit:** 75% = $1208.30
52363	MANDIBLE and MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,812.40 **Benefit:** 75% = $1359.30
52366	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,772.30 **Benefit:** 75% = $1329.25
52369	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,992.70 **Benefit:** 75% = $1494.55
52372	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $1,933.55 **Benefit:** 75% = $1450.20
52375	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (H) (Anaes.) (Assist.) (See para ON.4.8 of explanatory notes to this Category) **Fee:** $2,165.75 **Benefit:** 75% = $1624.35
52378	GENIOPLASTY including transposition of nerves and vessels and bone grafts taken from the same site

O4. PLASTIC & RECONSTRUCTIVE	
	(Anaes.) (Assist.) (See para ON.4.9 of explanatory notes to this Category) **Fee:** $748.65 **Benefit:** 75% = $561.50 85% = $665.25
52379	FACE, contour reconstruction of 1 region, using autogenous bone or cartilage graft (Anaes.) (Assist.) **Fee:** $1,279.45 **Benefit:** 75% = $959.60 85% = $1196.05
52380	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) **Fee:** $2,178.60 **Benefit:** 75% = $1633.95 85% = $2095.20
52382	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) **Fee:** $2,611.60 **Benefit:** 75% = $1958.70 85% = $2528.20
52420	MANDIBLE, fixation by intermaxillary wiring, excluding wiring for obesity **Fee:** $241.15 **Benefit:** 75% = $180.90 85% = $205.00
52424	DERMIS, DERMOFAT OR FASCIA GRAFT (excluding transfer of fat by injection) (Anaes.) (Assist.) **Fee:** $473.65 **Benefit:** 75% = $355.25 85% = $402.65
52430	MICROVASCULAR REPAIR OF, using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.) **Fee:** $1,090.35 **Benefit:** 75% = $817.80 85% = $1006.95
52440	CLEFT LIP, unilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) **Fee:** $541.35 **Benefit:** 75% = $406.05 85% = $460.15
52442	CLEFT LIP, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) **Fee:** $676.80 **Benefit:** 75% = $507.60 85% = $593.40
52444	CLEFT LIP, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) **Fee:** $751.85 **Benefit:** 75% = $563.90 85% = $668.45
52446	CLEFT LIP, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) **Fee:** $887.50 **Benefit:** 75% = $665.65 85% = $804.10
52450	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.) **Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65
52452	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.) **Fee:** $488.75 **Benefit:** 75% = $366.60 85% = $415.45
52456	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) **Fee:** $827.30 **Benefit:** 75% = $620.50 85% = $743.90
52458	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) **Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65

O4. PLASTIC & RECONSTRUCTIVE	
52460	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.) **Fee:** $781.95 **Benefit:** 75% = $586.50 85% = $698.55
52480	COMPOSITE GRAFT (Chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (Anaes.) (Assist.) **Fee:** $502.25 **Benefit:** 75% = $376.70 85% = $426.95
52482	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.) **Fee:** $483.25 **Benefit:** 75% = $362.45 85% = $410.80
52484	MACROSTOMIA, operation for (Anaes.) (Assist.) **Fee:** $575.30 **Benefit:** 75% = $431.50 85% = $491.90
O5. PREPROSTHETIC	
	Group O5. Preprosthetic
52600	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.) **Fee:** $338.35 **Benefit:** 75% = $253.80 85% = $287.60
52603	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.) **Fee:** $323.40 **Benefit:** 75% = $242.55 85% = $274.90
52606	MAXILLARY TUBEROSITY, reduction of (Anaes.) **Fee:** $246.70 **Benefit:** 75% = $185.05 85% = $209.70
52609	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes.) (Assist.) **Fee:** $323.40 **Benefit:** 75% = $242.55 85% = $274.90
52612	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes.) (Assist.) **Fee:** $406.05 **Benefit:** 75% = $304.55 85% = $345.15
52615	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - more than 20 lesions (Anaes.) (Assist.) **Fee:** $503.85 **Benefit:** 75% = $377.90 85% = $428.30
52618	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.) **Fee:** $586.50 **Benefit:** 75% = $439.90 85% = $503.10
52621	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes.) (Assist.) **Fee:** $586.50 **Benefit:** 75% = $439.90 85% = $503.10
52624	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.) **Fee:** $473.65 **Benefit:** 75% = $355.25 85% = $402.65
52626	ALVEOLAR RIDGE AUGMENTATION - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.) **Fee:** $290.50 **Benefit:** 75% = $217.90 85% = $246.95
52627	OSSEO-INTEGRATION PROCEDURE - in the practice of oral and maxillofacial surgery, extra oral implantation of titanium fixture (Anaes.) (Assist.) **Fee:** $503.85 **Benefit:** 75% = $377.90 85% = $428.30
52630	OSSEO-INTEGRATION PROCEDURE - in the practice of oral and maxillofacial surgery, fixation of transcutaneous abutment (Anaes.) **Fee:** $186.50 **Benefit:** 75% = $139.90 85% = $158.55

O5. PREPROSTHETIC	
52633	OSSEO-INTEGRATION PROCEDURE - intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) **Fee:** $503.85 **Benefit:** 75% = $377.90 85% = $428.30
52636	OSSEO-INTEGRATION PROCEDURE - fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) **Fee:** $186.50 **Benefit:** 75% = $139.90 85% = $158.55
O6. NEUROSURGICAL	
	Group O6. Neurosurgical
52800	NEUROLYSIS BY OPEN OPERATION, without transposition, not being a service associated with a service to which item 52803 applies (Anaes.) (Assist.) **Fee:** $276.80 **Benefit:** 75% = $207.60 85% = $235.30
52803	NERVE TRUNK, internal (interfascicular), NEUROLYSIS of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $398.55 **Benefit:** 75% = $298.95 85% = $338.80
52806	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from superficial peripheral nerve (Anaes.) (Assist.) **Fee:** $276.80 **Benefit:** 75% = $207.60 85% = $235.30
52809	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from deep peripheral nerve (Anaes.) (Assist.) **Fee:** $473.75 **Benefit:** 75% = $355.35 85% = $402.70
52812	NERVE TRUNK, PRIMARY repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $676.80 **Benefit:** 75% = $507.60 85% = $593.40
52815	NERVE TRUNK, SECONDARY repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $714.35 **Benefit:** 75% = $535.80 85% = $630.95
52818	NERVE, TRANSPOSITION OF (Anaes.) (Assist.) **Fee:** $473.75 **Benefit:** 75% = $355.35 85% = $402.70
52821	NERVE GRAFT TO NERVE TRUNK, (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,030.20 **Benefit:** 75% = $772.65 85% = $946.80
52824	PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.) (Assist.) **Fee:** $443.70 **Benefit:** 75% = $332.80 85% = $377.15
52826	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.) **Fee:** $237.60 **Benefit:** 75% = $178.20 85% = $202.00
52828	CUTANEOUS NERVE, primary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $353.35 **Benefit:** 75% = $265.05 85% = $300.35
52830	CUTANEOUS NERVE, secondary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $466.10 **Benefit:** 75% = $349.60 85% = $396.20

O6. NEUROSURGICAL	
52832	CUTANEOUS NERVE, nerve graft to, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $639.20 **Benefit:** 75% = $479.40 85% = $555.80
O7. EAR, NOSE & THROAT	
	Group O7. Ear, Nose & Throat
53000	MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.) **Fee:** $32.55 **Benefit:** 75% = $24.45 85% = $27.70
53003	MAXILLARY ANTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission to hospital) not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.) **Fee:** $91.90 **Benefit:** 75% = $68.95 85% = $78.15
53004	MAXILLARY ANTRUM, LAVAGE OF - each attendance at which the procedure is performed, including any associated consultation (Anaes.) **Fee:** $35.60 **Benefit:** 75% = $26.70 85% = $30.30
53006	ANTROSTOMY (RADICAL) (Anaes.) (Assist.) **Fee:** $521.25 **Benefit:** 75% = $390.95 85% = $443.10
53009	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.) **Fee:** $295.70 **Benefit:** 75% = $221.80 85% = $251.35
53012	ANTRUM, drainage of, through tooth socket (Anaes.) **Fee:** $117.55 **Benefit:** 75% = $88.20 85% = $99.95
53015	ORO-ANTRAL FISTULA, plastic closure of (Anaes.) (Assist.) **Fee:** $587.60 **Benefit:** 75% = $440.70 85% = $504.20
53016	NASAL SEPTUM, septoplasty, submucous resection or closure of septal perforation (Anaes.) (Assist.) **Fee:** $483.25 **Benefit:** 75% = $362.45 85% = $410.80
53017	NASAL SEPTUM, reconstruction of (Anaes.) (Assist.) **Fee:** $602.85 **Benefit:** 75% = $452.15 85% = $519.45
53019	MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.) **Fee:** $580.90 **Benefit:** 75% = $435.70 85% = $497.50
53052	POST-NASAL SPACE, direct examination of, with or without biopsy (Anaes.) **Fee:** $122.85 **Benefit:** 75% = $92.15 85% = $104.45
53054	NASENDOSCOPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX one or more of these procedures (Anaes.) **Fee:** $122.85 **Benefit:** 75% = $92.15 85% = $104.45
53056	EXAMINATION OF NASAL CAVITY or POST-NASAL SPACE, or NASAL CAVITY AND POST-NASAL SPACE, UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $71.95 **Benefit:** 75% = $54.00 85% = $61.20
53058	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.) **Fee:** $122.85 **Benefit:** 75% = $92.15 85% = $104.45

O7. EAR, NOSE & THROAT	
53060	CAUTERISATION (other than by chemical means) OR CAUTERISATION by chemical means when performed under general anaesthesia OR DIATHERMY OF SEPTUM, TURBINATES FOR OBSTRUCTION OR HAEMORRHAGE SECONDARY TO SURGERY (OR TRAUMA) - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes.) **Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45
53062	POST SURGICAL NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.) **Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50
53064	CRYOTHERAPY TO NOSE in the treatment of nasal haemorrhage (Anaes.) **Fee:** $162.95 **Benefit:** 75% = $122.25 85% = $138.55
53068	TURBINECTOMY or TURBINECTOMIES, partial or total, unilateral (Anaes.) **Fee:** $136.50 **Benefit:** 75% = $102.40 85% = $116.05
53070	TURBINATES, submucous resection of, unilateral (Anaes.) **Fee:** $178.05 **Benefit:** 75% = $133.55 85% = $151.35
O8. TEMPOROMANDIBULAR JOINT	
	Group O8. Temporomandibular Joint
53200	MANDIBLE, treatment of a dislocation of, not requiring open reduction (Anaes.) **Fee:** $70.65 **Benefit:** 75% = $53.00 85% = $60.10
53203	MANDIBLE, treatment of a dislocation of, requiring open reduction (Anaes.) **Fee:** $118.70 **Benefit:** 75% = $89.05 85% = $100.90
53206	TEMPOROMANDIBULAR JOINT, manipulation of, performed in the operating theatre of a hospital, not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.) **Fee:** $142.95 **Benefit:** 75% = $107.25
53209	GLENOID FOSSA, ZYGOMATIC ARCH and TEMPORAL BONE, reconstruction of (Obwegeser technique) (Anaes.) (Assist.) **Fee:** $1,649.10 **Benefit:** 75% = $1236.85 85% = $1565.70
53212	ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.) **Fee:** $890.85 **Benefit:** 75% = $668.15 85% = $807.45
53215	TEMPOROMANDIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes.) (Assist.) **Fee:** $408.70 **Benefit:** 75% = $306.55 85% = $347.40
53218	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more such procedures (Anaes.) (Assist.) **Fee:** $653.80 **Benefit:** 75% = $490.35 85% = $570.40
53220	TEMPOROMANDIBULAR JOINT, arthrotomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $329.60 **Benefit:** 75% = $247.20 85% = $280.20
53221	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.)

O8. TEMPOROMANDIBULAR JOINT	
	Fee: $872.30 **Benefit:** 75% = $654.25 85% = $788.90
53224	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $967.00 **Benefit:** 75% = $725.25 85% = $883.60
53225	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.) **Fee:** $290.50 **Benefit:** 75% = $217.90 85% = $246.95
53226	TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $312.30 **Benefit:** 75% = $234.25 85% = $265.50
53227	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without meniscus or capsular surgery, including meniscectomy when performed, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,188.20 **Benefit:** 75% = $891.15 85% = $1104.80
53230	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,338.45 **Benefit:** 75% = $1003.85 85% = $1255.05
53233	TEMPOROMANDIBULAR JOINT, surgery of, involving procedures to which items 53224, 53226, 53227 and 53230 apply and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,504.05 **Benefit:** 75% = $1128.05 85% = $1420.65
53236	TEMPOROMANDIBULAR JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $470.70 **Benefit:** 75% = $353.05 85% = $400.10
53239	TEMPOROMANDIBULAR JOINT, arthrodesis of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $470.70 **Benefit:** 75% = $353.05 85% = $400.10
53242	TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) **Fee:** $312.30 **Benefit:** 75% = $234.25 85% = $265.50

O9. TREATMENT OF FRACTURES	
	Group O9. Treatment Of Fractures
53400	MAXILLA, unilateral or bilateral, treatment of fracture of, not requiring splinting (See para ON.4.10 of explanatory notes to this Category) **Fee:** $129.20 **Benefit:** 75% = $96.90 85% = $109.85
53403	MANDIBLE, treatment of fracture of, not requiring splinting (See para ON.4.10 of explanatory notes to this Category) **Fee:** $157.85 **Benefit:** 75% = $118.40 85% = $134.20
53406	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $406.65 **Benefit:** 75% = $305.00 85% = $345.70

O9. TREATMENT OF FRACTURES	
53409	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $406.65 **Benefit:** 75% = $305.00 85% = $345.70
53410	ZYGOMATIC BONE, treatment of fracture of, not requiring surgical reduction (See para ON.4.10 of explanatory notes to this Category) **Fee:** $85.65 **Benefit:** 75% = $64.25 85% = $72.85
53411	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $238.80 **Benefit:** 75% = $179.10 85% = $203.00
53412	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $392.10 **Benefit:** 75% = $294.10 85% = $333.30
53413	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $480.35 **Benefit:** 75% = $360.30 85% = $408.30
53414	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $551.85 **Benefit:** 75% = $413.90 85% = $469.10
53415	MAXILLA, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $435.65 **Benefit:** 75% = $326.75 85% = $370.35
53416	MANDIBLE, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $435.65 **Benefit:** 75% = $326.75 85% = $370.35
53418	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $566.35 **Benefit:** 75% = $424.80 85% = $482.95
53419	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $566.35 **Benefit:** 75% = $424.80 85% = $482.95
53422	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $718.75 **Benefit:** 75% = $539.10 85% = $635.35
53423	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $718.75 **Benefit:** 75% = $539.10 85% = $635.35

O9. TREATMENT OF FRACTURES	
53424	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $616.65 **Benefit:** 75% = $462.50 85% = $533.25
53425	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $616.65 **Benefit:** 75% = $462.50 85% = $533.25
53427	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $842.25 **Benefit:** 75% = $631.70 85% = $758.85
53429	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $842.25 **Benefit:** 75% = $631.70 85% = $758.85
53439	MANDIBLE, treatment of a closed fracture of, involving a joint surface (Anaes.) (See para ON.4.10 of explanatory notes to this Category) **Fee:** $238.80 **Benefit:** 75% = $179.10 85% = $203.00
53453	ORBITAL CAVITY, reconstruction of a wall or floor with or without foreign implant (Anaes.) (Assist.) **Fee:** $483.25 **Benefit:** 75% = $362.45 85% = $410.80
53455	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.) **Fee:** $567.65 **Benefit:** 75% = $425.75 85% = $484.25
53458	NASAL BONES, treatment of fracture of, not being a service to which item 53459 or 53460 applies **Fee:** $43.05 **Benefit:** 75% = $32.30 85% = $36.60
53459	NASAL BONES, treatment of fracture of, by reduction (Anaes.) **Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20
53460	NASAL BONES, treatment of fractures of, by open reduction involving osteotomies (Anaes.) (Assist.) **Fee:** $480.35 **Benefit:** 75% = $360.30 85% = $408.30
O11. REGIONAL OR FIELD NERVE BLOCKS	
	Group O11. Regional Or Field Nerve Blocks
53700	(Note. Where an anaesthetic combines a regional nerve block with a general anaesthetic for an operative procedure, benefits will be paid only under the anaesthetic item relevant to the operation. The items in this Group are to be used in the practice of oral and maxillofacial surgery and are not to be used for dental procedures (eg. restorative dentistry or dental extraction.)) TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent **Fee:** $124.85 **Benefit:** 75% = $93.65 85% = $106.15
53702	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent **Fee:** $62.50 **Benefit:** 75% = $46.90 85% = $53.15
53704	FACIAL NERVE, injection of an anaesthetic agent **Fee:** $37.65 **Benefit:** 75% = $28.25 85% = $32.05

O11. REGIONAL OR FIELD NERVE BLOCKS	
	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies (See para ON.4.12 of explanatory notes to this Category)
53706	**Fee:** $124.85 **Benefit:** 75% = $93.65 85% = $106.15

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