Government of **Western Australia**
Department of **Health**

WESTERN AUSTRALIAN GOVERNMENT MEDICAL SERVICES SCHEDULE

for use by

INDEPENDENT CONTRACTED MEDICAL PRACTITIONERS

treating

PUBLIC PATIENTS

VALID FROM 1st December 2022

INDEX

Please note: Descriptions of MBS items included in WAGMSS are **not included in this document**, but can be found in the latest Medicare Benefits Schedule Book or downloaded from the Commonwealth Department of Health and Aged Care website http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home

Fee Schedule: an Excel-based interactive fees schedule can be found on the Government of Western Australia Department of Health Contracted Medical Practitioners website.

1.0 WESTERN AUSTRALIAN GOVERNMENT MEDICAL SERVICES SCHEDULE (WAGMSS)

1.1 INTRODUCTION

THE SCHEDULE OF SERVICES

This Schedule of medical services is produced by the Department of Health, Western Australia, and updates the Western Australian Government Medical Services Schedule of 1st December 2021 with effect from 1st December 2022.

The Schedule defines medical procedures and the fee payable and is intended for use by private medical practitioners to define and charge for medical services they provide to public patients admitted to government non-teaching hospitals. For a charge to be raised against a medical procedure, it must be listed in the Schedule.

For the most part, service items and their descriptions included in WAGMSS are identical to the Medicare Benefits Schedule (MBS). Descriptions for MBS items included in the WAGMSS can be found online on the Commonwealth Department of Health and Aged Care website.
http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1

Where an item description includes a phrase in brackets such as (*See para T8.49 of explanatory notes to this Category)* the explanatory notes can be found in the MBS Book and apply to that WAGMSS item.

There are also a number of service items unique to WAGMSS for attendances, obstetrics and anaesthetics. Descriptions and numbers for these are given in this document.

CAUTION

Although WAGMSS is based upon the Medicare Benefits Schedule (MBS), it should be noted that not all item numbers and descriptions are included. An MBS item number cannot be used unless it is published in the WAGMS Schedule.

The following MBS items are **not** included in this version of the Schedule:

Category 1 Attendance items relating to surgery, consulting rooms or home visits as CMP services, and all MBS items in groups

- A1 General Practitioner Attendances
- A2 Other Non-Referred Attendances
- A3 Specialist Attendances
- A10 Optometric Services
- A11 Urgent Attendance After Hours
- A14 Health Assessments
- A17 Domiciliary and Residential Medication Management Reviews
- A21 Professional Attendances at Recognised Emergency Departments of Private Hospitals
- A22 GP After Hours Attendances to Which No Other Item Applies
- A23 Other Non-Referred After-Hours Attendances to Which No Other Item Applies
- A27 Pregnancy Support Counselling
- A33 Transcatheter Aortic Valve Implantation Case Conference
- A35 Services for Patients in Residential Aged Care Facilities
- A40 Telehealth and Phone Attendance Services
- A41 Additional Focussed Psychological Strategies
- A42 Mental Health Planning for Care Recipients of a Residential Aged Care facility
- A45 Nicotine and Smoking Cessation Counselling

Category 3 Therapeutic Procedures – all items in

- T2 Radiation Oncology

Category 5 Diagnostic imaging services – all items in

- I4 Nuclear Medicine Imaging
- I5 Magnetic Resonance Imaging (MRI) Magnetic Resonance Angiography (MRA)
- I6 Management of Bulk-Billed Services

Category 6 Pathology Services – all items with the exception of Simple Basic Tests (performed by a medical practitioner)

Category 7 Cleft Lip & Palate Services – all items

Category 8 Miscellaneous Services

PRINCIPLES OF INTERPRETATION

Each professional service listed in the Schedule is a complete medical service in itself. However, a service may also form part of a more comprehensive service covered by another scheduled item, in which case, the fee payable for the comprehensive service covers all individual elements. For example, benefit is not payable for a bronchoscopy where a foreign body is removed from the bronchus since the bronchoscopy is an integral part of the removal operation.

Where a service is rendered partly by one medical practitioner and partly by another, only the one fee is payable. This may be instanced by the case in which a radiographic examination is partly completed by one medical practitioner and finalised by another, the only fee payable being that for the total examination.

Where different medical practitioners render separate services covered by individual items in the Schedule, the individual items apply. For example, if antenatal care in the hospital is provided by one medical practitioner, and the confinement and postnatal care are provided by another medical practitioner, the fee for the first practitioner's services are payable under Item 16500 while the fee for the latter practitioner's services are payable under item 16519.

SERVICES ELIGIBLE FOR PAYMENT OF FEES

Professional services include medical services rendered by or on behalf of a medical practitioner. Medical services, which may be rendered 'on behalf of' a medical practitioner, include services where a portion 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.

With the exception of telephone consultations and obstetric deliveries claimed in accordance with the Midwifery Group Practice arrangements at Bunbury Hospital – (management of labour, incomplete), medical services will attract benefits only if they have been physically performed by a medical practitioner on not more than one patient on the one occasion for the purpose of billing. Although two or more patients may be managed simultaneously, billing should be apportioned in a manner that reflects the time taken to manage each patient. The requirement of 'physical performance'

- Needs to be met whether or not assistance is provided in the performance of the service according to accepted medical standards, or
- Where a consultant, supervising a registrar as part of that registrar's approved training programme, is
    a. physically present for all or part of the time the service is provided by the registrar; and
    b. during such time that the consultant is not physically present, is positioned to immediately attend the patient in person within a medically appropriate time frame.

For X-rays, except where there is a specific contract for the provision of these services, the fee paid will depend upon the involvement of hospital staff and/or

equipment. (See section 1.3 for more details)

For family group therapy and group psychotherapy services covered, fees are payable only if the services have been conducted in a public hospital by the medical practitioner. Fees are not payable for these group items when a medical practitioner employed by the Government of Western Australia renders the service.

SERVICES WHICH ARE NOT ELIGIBLE FOR THE PAYMENT OF FEES

Fees are not payable in respect of a professional service in the following circumstances:

1. Nontherapeutic cosmetic surgery.
2. Other services, such as manipulations performed by physiotherapists, even though they may be undertaken/provided on the advice of a medical practitioner.
3. Where the service was rendered on premises other than a public hospital, EXCEPT for telephone consultations (Items WA05 or WA06) or in cases where a public patient is referred by the hospital for specialist services.
4. Where the medical expenses for the service are for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability.
5. Where the service is a medical examination for the purposes of life insurance, superannuation, or provident account scheme, or admission to membership of a friendly society.
6. Where the service was rendered in the course of the carrying out of a mass immunisation programme.
7. Where public outpatient services are not provided by the hospital.
8. Where the employer of the person to whom the service was rendered incurred the medical expenses.
9. Where the person to whom that service was rendered was employed in an industrial undertaking and that service was rendered for the purposes connected with the operation of that undertaking.
10. Where the service was a health screening service.
11. Where the services were rendered in association with the following:
    - injection of human chorionic gonadotrophin (HCG) in the management of obesity
    - chelation therapy
    - hyperbaric oxygen therapy in the treatment of multiple sclerosis
    - removal of tattoos
    - 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
    - the removal from a cadaver of kidneys for transplantation
    - the administration of microwave (UHF radio wave) cancer therapy, including the intravenous injection of drugs used in the therapy.

1.2 GENERAL - EXPLANATORY NOTES

DEFINITIONS

Public Patient	**is an 'eligible' person who receives or elects to receive free of charge to them, a public hospital service, and includes an involuntary patient detained in authorised portions of the hospital.**
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.**

MEDICAL SERVICE AGREEMENT

In order to provide hospital services, the medical practitioner must have a current Medical Service Agreement (MSA) with the Health Service. Fees are only paid for services where there is a valid MSA.

RECOGNITION AS SPECIALIST OR CONSULTANT PHYSICIAN

Where a medical practitioner has been recognised as a specialist or consultant physician for the purposes of the *Health Insurance Act 1973,* fees are payable at a higher rate in respect of certain services rendered by him or her in the practice of the speciality in which he or she is so recognised. All enquiries concerning the recognition of specialists and consultant physicians should be directed to the appropriate Commonwealth Department.

SCHEDULE OF FEES

The fees for each item number in the Western Australian Government Medical Services Schedule are not included in this description but are shown separately as an Excel interactive spreadsheet. The fees do **not** include the item number description.

CONTRACT FEE RATE

A medical practitioner may elect for fees to be paid at other than 100%. In these cases, the manner in which fees are calculated is as follows.

The fee paid for any item in the Western Australian Government Medical Services Schedule (WAGMSS) is the base fee for that item, multiplied by the contracted percentage.

For example, assuming the contracted rate is 71%

E.g.	**Step 1** - WA0045	= $49.25
	Step 2 - $49.25 x 71%	= $34.97

For derived fees, the base from which the fee is to be derived must be calculated **BEFORE** the contract percentage is applied. An example of how to calculate the anaesthetic fees, all of which are derived, is shown below.

E.g.	**Step I** – CA020	= 4 RVG units	
		= 4 x $35.90	= $143.60
	Step 2 - $143.60 x 71%		= $101.96

1.3 DIAGNOSTIC IMAGING CHARGES (DI)

Where there is no separate contract specifically for the provision of DI services, DI charges fall into three categories:

- **Full Service Fee - where the CMP provides the service, facilities and reports on the film,** payment will be 100% of the MBS fee for that item.
- **Reporting Fee - where the CMP simply reports on the film, the hospital providing the equipment and staff,** a reading fee is paid that is 42% of the MBS fee for that item. Where a CMP has signed a CMP contract which stipulates a fee rate other than 100%, reporting payments will be made as 42% of the stipulated fee rate for that item.
- **Facility Charge - by the hospital against the CMP for the use of hospital equipment/staff for DI services provided to private patients,** a facility charge will be raised that is 42% of the MBS fee for that item.

Before invoicing the hospital for payment of either the full service and/or reporting fee, please check with the hospital to determine whether these charges can be included as part of an invoice containing other fee for service charges, or whether they need to be separately invoiced.
Note: All Diagnostic Imaging (DI) charges in WAGMSS are identical to the Medicare Benefit Schedule (MBS) valid at the date of service.

1.4 BUSINESS RULES

Business rules are used to assess every account submitted for payment. These rules cover – age and sex related items, Aftercare, Restrictives, Composites, Time dependencies, Multiple procedures.

1.4.1 - After-care; see section 5.0 Operations
1.4.2 - Restrictives; see section 5.0 Operations
1.4.3 - Multiple Operations Rule; see section 5.0 Operations
1.4.4 - Composites
The Schedule includes a number of items, which apply only in conjunction with another specified service listed in the Schedule. These items provide for the application of a fixed loading or factor to the fee for the service with which they are rendered.

When these particular procedures are rendered in conjunction, the procedures are to be regarded as one service. The fee for the service will be ascertained in accordance with the composite business rules.

1.4.5 - Time Dependencies

The description of certain items includes phrases such as 'maximum of 6 sessions in any 12-month period'. These are classified as time dependencies and restrict the use of these items during that time period.

1.5 CORRECTION, ADDITIONS, DELETIONS OR FEE CHANGES

From 1st December 2022 the following changes will be made to the WAGMSS: - All descriptive changes, deletions and new items introduced in the Commonwealth Medical Benefit Schedule between 1st November 2021 to the 31st October 2022, **where relevant to WAGMSS**, have been incorporated. Details of these changes can be found in the MBS books and supplements. These can be viewed and downloaded from the Commonwealth Department of Health and Aged Care website https://www.health.gov.au/

1. *Deleted are items*

00253,00255,00257,00260,00262,00264,00266,00269,00271,00364,00366,00367, 00369,00370,11903,11906,11909,11915,11921,13206,13292,14209,18274,32029, 32099,32102,32103,32104,32111,32112,32114,32115,32120,32126,32132,32138, 32142,32145,32153,32168,32177,32180,32200,32203,32206,32209,32210,32214, 32217,32220,35502,35520,35523,35530,35542,35572,35602,35605,35613,35618, 35627,35634,35638,35646,35664,35670,35677,35678,35684,35688,35706,35709, 35710,35713,37043,39115,91285, 91287,91723,91727.

2. *New items to be added are*

2.1 Attendances – 93660,93661,93666

2.2. Diagnostic Procedures and Investigations– 11342,11345,11736,11737

2.3 *Therapeutic Procedures* – 13241,13761,13762,30175,30661,30662,31377,31378,31379,31380,31381,31382, 31383,32118,32231,32232,32233,32234,32235,32236,32237,35591,35592,35609, 35610,35631,35632,35668,35669,35671,35721,35724,35751,36530,38514,38522, 38523,39014,39110,39111,39116,39117,39119,39129,39141,40863,47790, 47791,47792, CK1215

2.4 Diagnostic Imaging – 55068, 55740,55741,55742,55743,55757,55758

3. Over the past 12 months Medicare has made adjustments to the descriptions of a range of items in their schedule. Where these items are also used in WAGMSS, the new descriptions have been adopted from 1st December 2022.

4. From 1st December 2022 the anaesthetic RVG Base Unit Value will be $43.70

Please note MBS **derived** fees in the WAGMSS are paid at the MBS value and adjusted with MBS updates.

5. Due to the COVID-19 pandemic, there are 32 WA specific items that cover GP Attendances, Specialist Attendances and Consultant Physician Attendances delivered via telehealth. The fees for these items mirror their physical attendance counterparts and are effective from 13/03/2020 until further notice. These item numbers can be claimed from home, practice or elsewhere.

You are advised to check the summary of changes listed on
http://www.mbsonline.gov.au

Every care is taken in the preparation of this schedule. However, should you notice an error it will be appreciated if you would inform your local hospital of the error, so that a correction can be made with the next issue.

RULINGS
Where changes or new circumstances arise in response to the Schedule, the Department of Health WA will issue Rulings on their interpretation or application as necessary.

2.0 BILLING PROCEDURES

2.1 SERVICE DETAILS

Practitioners should claim for services rendered by submitting their own private account forms to the relevant public hospital. Separate invoices are required for each CMP provider number. (i.e. no invoice to have services provided under different CMP provider numbers or by multiple medical practitioners.)

2.2 CMP PROVIDER NUMBERS

Each contracted medical practitioner is allocated a hospital specific CMP Provider Number (CMPPN). The CMPPN is for WA CMP payment purposes only and cannot be used for Medicare, as the provider number does NOT confer any eligibility for Medicare benefits.

The purpose of the CMPPN is to determine

1. The method of payment selected. (EFT or cheque)
2. The correct method of communication is used.
3. The fee rate applying to the services provided and the period of the contract under which the medical practitioner is operating.

A separate CMPPN is required for each hospital location and each contract (irrespective of location) under which a medical practitioner provides services.

The medical practitioner must have a current Medical Service Agreement(s) covering hospital(s) at which they provide a service.

Note: It is essential that the appropriate CMPPN be shown on each invoice, especially where a medical practitioner holds multiple CMPPN at one location, otherwise the invoice may be paid against the wrong contract, payment made to the account attached to the incorrect contract, and the remittance communicated to the wrong payee.
A medical practitioner providing services to a hospital under different contracts will require a separate CMPPN for each contract. Each contract is likely to have a different ABN form. Further details are outlined on the CMP website https://ww2.health.wa.gov.au/Articles/A_E/Contracted-Medical-Practitioners.

2.3 GST REQUIREMENTS

The Commonwealth Government introduced a Goods and Services Tax (GST) on 1 July 2000. All services rendered to public patients in public hospitals on or after 1 July 2000 by Medical Practitioners who are independent contractors, are subject to GST.

CATEGORIES OF MEDICAL PRACTITIONER

For the purposes of the CMP Medical Account Assessment System, medical practitioners can fall into one of the following GST categories:

- does not have an Australian Business Number (ABN)

- has an ABN, is registered for GST and invoice is GST compliant
- has an ABN, is not registered for GST and invoice is compliant but cannot charge GST.

WITHOLDING TAX (WHT)

Where a Medical Practitioner does not have an ABN, the invoice will be subject to a Withholding Tax of 47% and GST will not be applied to these services.
WHT is calculated on the assessed amount of the service.

GST COMPLIANT INVOICE

Invoices submitted for payment by medical practitioners must conform to Australian Taxation Office requirement for a tax invoice.

Fees will not be paid in respect to a professional service unless there is recorded on the invoice setting out the fee for the service, the following details. These details are also required to be shown on an invoice in order for it to be GST compliant:

1. **The invoice must clearly state:**
   - ⇒ The words *Tax Invoice*
   - ⇒ Supplier's identity
   - ⇒ Supplier's Trading Address

2. **Australian Business Number (ABN)**
   - ⇒ If you do not have an ABN, contact MAAS Support on MAAS_Support@health.wa.gov.au

3. **Invoice Number and Invoice Date**
   - ⇒ The Invoice Number must not exceed 50 characters
   - ⇒ The Invoice Number can only include alpha numeric characters plus the following special characters: * - / _
   - ⇒ One invoice (only) per file in PDF format is preferred

4. **CMP Provider Number** (for the purposes of invoicing on a Fee for Service basis)
   - ⇒ Your CMP Provider Number consists of your MPO number, site code and contract number. For example, 500000-BY1-1
   - ⇒ Your CMP Provider Number is specific to the hospital referenced in your MSA
   - ⇒ If you have more than one MSA, you will have more than one CMP Provider Number
   - ⇒ A tax compliant invoice must include the CMP Provider Number applicable to the hospital where the medical services were provided
   - ⇒ Separate invoices must be supplied for each CMP Provider Number

5. **Date the relevant service was provided**
   - ⇒ The date of service cited on the invoice will be verified against the hospital's records

6. **Item number for the relevant service**
   - ⇒ Each service that is invoiced must include the correct item number from the Western Australian Government Medical Services Schedules Policy (WAGMSS) and the correct applicable fee from the WAGMSS Fee Schedule

7. Patient Details

⇒ The Unique Medical Record Number (UMRN) is assigned to the patient by the hospital. The UMRN as well as the patient's name and date of birth should be referenced in the invoice

⇒ If a patient is attended multiple times on the same or on different invoices, you must state the times of each attendance and state why multiple attendances were required

⇒ Invoices may include items for more than one patient

8. Any applicable service qualifiers (item description)

⇒ Each service item must include a description of the service

⇒ If the same item number is claimed on the same day (this only applies for surgical items) for the same patient more than once, the description must include the body position of the service

⇒ Service qualifiers are factors stipulated in the WAGMSS that affect the agreed fee for a given service

⇒ Service qualifiers include:

- Where the service was provided more than once on the same day, the number of occasions and the time each service was provided
- Where the service was provided after hours, or if it is an emergency procedure, the time the service was provided
- Where the service was surgical assistance, the base item and which doctor they assisted
- In the case of an anaesthetist, the account should also show the name of the Medical Practitioner who performed the operation
- Where travel costs are claimed, the number of kilometres travelled

9. The Health Service Provider name

⇒ Invoices must show which Health Service Provider is being invoiced, e.g. WA Country Health Service; East Metropolitan Health Service etc, and the hospital name

⇒ In the case of an anaesthetist, the account must also show the name of the Medical Practitioner who performed the operation.

10. Agreed fee, exclusive of GST, for the relevant service

⇒ The fee must be sourced for the relevant service item from the current WAGMSS Fee Schedule

⇒ Invoices with fees that do not match the current WAGMSS fee for the relevant service item will be rejected and returned to the CMP to correct. There is a $2 over and $10 under tolerance built into the system

⇒ WAGMSS is updated on 1st December each year and the updated fee must be applied to invoices for services provided on and after that date

11. GST payable

⇒ The GST payable must be specified

Invoices for Relative Value Guide (RVG) anaesthetic procedures must include three components from the WAGMSS Anaesthetic Items Fee Schedule.
Together, these components give the total RVG derived value for that service:

⇒ The Base RVG Units that relate to the procedure item number

⇒ The start and end times (in a 24-hour clock) of the procedure and the corresponding Time Units

- ⇒ The Modifying Units that relate to the physical status and other factors that relate to the patient
- ⇒ In addition, the invoice must specify any applicable afterhours loading (EAHA). **Note EAHA loading MAY NOT BE CLAIMED for any anaesthetic item where the M2 modifier is claimed.**

Where payment is sought for reading an X-ray, the item number for the total procedure should be listed and endorsed 'reading only'.

Where a consultant physician or a specialist in the practice of his/her speciality rendered the professional service to a patient, the Health Service must confirm that the medical practitioner is accredited to provide specialist services at that hospital. For account processing purposes, to confirm the medical practitioner's accreditation, the Health Service will provide to clerks processing CMP accounts, a correctly authorised list of registered CMPs indicating the specialties that they are accredited to provide. The clerk will then treat this as a service with a 'valid referral' when processing the account.

Practitioners should be aware that claims for payment will be returned or disallowed where the Schedule item number is not provided.

The medical practitioner claiming payment for the service bears responsibility for the accuracy and completeness of the information.

Other than in exceptional circumstances, no account will be accepted for payment by a public hospital if a period of 90 days has elapsed since the service was rendered, or as otherwise specified in the applicable Medical Services Agreement.

2.4 PAYMENTS

The previous Medical Account Assessment System (MAAS), commonly known as the 'VMP system' was used to assess and certify CMP accounts against the Medicare Benefit Scheme (MBS) and Western Australian Government Medical Services Schedules Policy (WAGMSS) rules and rates. This MAAS was provided to WA Health by the Commonwealth Department of Human Services (Medicare) under a long-standing services contract.

This contract expired on 30 June 2019 and in its place, WA Health implemented a replacement MAAS which went live on **1 July 2019**. The new MAAS streamlined and improved the way CMP accounts are processed.

As part of the transition to the new MAAS, any Recipient Created Tax Invoice (RCTI) Agreements currently in place ceased for all claims, including for other payments to CMPs such as 'Special Arrangements', 'On call minimum' etc, on **1 July 2019**. CMPs will be expected to submit a tax compliant invoice for their claims from this date.

Payments of invoices are made to the bank account nominated by you on your *Application for a CMP Registration Number*

- ⇒ It is not mandatory to include payment instructions on your invoice
- ⇒ If you wish to update your payment details, you should contact MAAS Support via MAAS_Support@health.wa.gov.au

Ad hoc CMP Payment Statements will no longer be available and CMPs will only be sent Remittance Advices following payments to nominated bank accounts.

Examples of GST compliant invoices for anaesthetic and other services can be found on the Government of Western Australian Department of Health Contracted Medical Practitioners (CMP) website
https://ww2.health.wa.gov.au/Articles/A_E/Contracted-Medical-Practitioners

2.5 SPECIAL CONSIDERATIONS

DEPARTMENT OF VETERANS AFFAIRS (DVA)
All patients with DVA entitlements should be admitted to public hospitals with the financial classification shown as DVA. Medical practitioners have the option to submit DVA accounts to the hospital for payment by the CMP system, instead of the Department of Veterans' Affairs. The hospital will pay the medical practitioner. Annual recovery of these costs from DVA is undertaken by Cash Management in System Finance.

DEAD ON ARRIVAL
In circumstances where the patient was taken to a hospital emergency department and the Medical Practitioner called in to certify death, the hospital is responsible for payment.

2.6 AUDIT REQUIREMENTS

Claims for medical services rendered must be supported by adequate notation/documentation in the hospital's patient medical records to support the claim.
For medical records documentation to be considered 'adequate', notations must include the following detail

- **Time**
- **Date**
- **Sufficient detail to describe the care provided, particularly level of consultation and complexity of care given. (see page 18 for guidelines for attendances)**
- **Notes to be written in legible handwriting**
- **Signature of medical practitioner**

If the medical practitioner does not provide sufficient documentary evidence in the patient's medical record, the account will be returned unpaid.

Medical practitioners are not permitted to amend hospital documents (patient records) after the account/invoice for the service has been presented UNLESS special circumstances exist. Those special circumstances are to be documented and presented to the Hospital Executive for approval to amend.
Documentation of patient care is the property of the hospital and is **NOT** to be removed from the hospital premises.
Services in excess of the approved standard must have satisfactory explanations attached to claims for payment. If not, the account WILL be returned unpaid.

APPEALS
Appeals against assessments made in accordance with the above principles should be referred through the Health Service General Manager for consideration by the Director General of Health.

3.0 MAINTENANCE OF HOSPITAL PATIENT RECORDS

RECORDING OF MEDICAL SERVICES

A sufficient standard of detail recorded in patient's medical records to support medical practitioner's accounts for services rendered, is essential.

GUIDELINES FOR PATIENT RECORDS

The attending medical practitioner shall keep a legible record in the hospital file of the essential features of the patient's condition and instructions for treatment. These records are the property of the hospital. The medical practitioner shall endeavour to fulfil the following guidelines to good practice:

Admission Data

1. Identification of patient
2. Admission diagnosis, other significant diagnosis and a clear statement of anticipated treatment.
3. Record of requests for investigations
4. Therapeutic orders
5. Medication with known adverse drug reactions
6. Consent form(s) [where applicable]

Process Data

1. Changes to current therapy
2. Diagnostic procedures
3. Operation report and anaesthetic record. Drugs and dosages used during anaesthesia
4. Notation of reports of all investigations
5. Record of progress
6. Intravenous fluid orders

Outcome Data

1. Final diagnosis.

Medical practitioners are to provide written orders for drugs. Where appropriate forms are provided by the hospital these should be used.

Notwithstanding above, the present practices concerning:

I. the administration of verbally-ordered drugs without written prescription and
II. the admission of patients in the absence of adequate verbal orders for treatment,

shall be permitted to continue, both in emergency situations or when the medical practitioner is not on the hospital premises at the time in question, **PROVIDED** always that the practitioner must supply a retrospective written authorisation at the first opportunity, and in any event **WITHIN 24 HOURS OF THE ORDER BEING GIVEN.**

4.0 ATTENDANCES

The complete explanatory notes for professional attendances can be found in the current Medical Benefits Schedule Book issued by the Commonwealth Department of Health and Aged Care.

The following guidelines address specific WAGMSS issues:

FEE FOR HOSPITAL VISIT
Professional attendance by the Medical Practitioner upon the patient is necessary before a consultation may be regarded as a professional attendance.

A fee for a hospital visit should only be raised where the attendance on the patient involves:

a) An evaluation by examination of the patient's physical or psychological condition, or:
b) Where there is significant alteration in management ordered and documented.

For payment of a visit, documentary evidence is required in the hospital's patient records.

The circumstances in which an 'initial patient/attendance' charge may be raised, vary between General Practitioners, Consultant Physicians and Specialists.

For a GP the 'initial patient' refers to the first patient seen on any occasion of service. An occasion of service is an attendance by the GP at the hospital during which one or more patients are seen.

For Consultant Physicians and Specialists, the 'initial attendance' refers to the first time the patient is seen for a single course of treatment, so that all other visits by that patient over the treatment period, are to be charged as subsequent or follow ups.

There are four categories that apply to GP attendances, which relate to the level of complexity of that attendance. The following notes are intended to help in the selection of the most appropriate category.

Level A – These items are for the obvious and straightforward cases and this should be reflected in the practitioner's records. In this context, the practitioner should undertake the necessary examination of the affected part if required, and note the action taken.

Level B – A Level B item will be used for a consultation lasting less than 20 minutes for cases that are not obvious or straightforward in relation to one or more health related issues. The medical practitioner may undertake all or some of the tasks set out in the item descriptor as clinically relevant, and this should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.

Level C - A Level C item will be used for a consultation lasting at least 20 minutes for cases in relation to one or more health related issues. The medical practitioner may undertake all or some of the tasks set out in the item descriptor as clinically relevant, and this should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.

Level D – A Level D item will be used for a consultation lasting at least 40 minutes for cases in relation to one or more health related issues. The medical practitioner may undertake all or some of the tasks set out in the item descriptor as clinically relevant, and this should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.

FREQUENCY OF FEES FOR VISIT

Departmental guidelines for maximum payments for medical practitioner's visits are:

ACUTE PERIOD	Daily visit for a period of 10 days
SUB-ACUTE	Three times a week
NON-ACUTE PERIOD	Three times a week
NURSING HOME TYPE	Long stay patients (over 35 days) e.g. Care Awaiting Placement - one visit a week. This does not apply to Residential Care, where normal standards of patient care should be applied as for any patient in his/her own home.
RESPITE/REHABILITATIVE	One weekly visit

Patients in hospital (may also include previous hospitalisation) for a period of 35 days will automatically be classified Nursing Home Type unless an Acute Care Certificate s is issued by the attending medical practitioner.

Where a medical practitioner considers that more visits were necessary than provided in these guidelines, an explanation should be attached to the account. Should the management of an acute inpatient require more than one (1) visit per day, there should be a reasonable lapse of time between visits, and the times of such visits should be entered on the account.

CONSULTATION AND PROCEDURE RENDERED AT THE ONE ATTENDANCE

Where a consultation and another medical service are rendered during the course of a single attendance, benefits are payable for both subject to certain exceptions. The exceptions are:

1) Items with descriptions qualified by the words.
    a) 'Each Attendance' 'At an Attendance' or 'Attendance at which'.

Where a service listed in this sub-paragraph 1.a is performed in conjunction with a consultation a fee is payable for either the consultation or the service **but not for both:**

    b) 'including all related attendances'
    c) 'including associated consultation'

2) Those items which cover or include a component for antenatal or postnatal care.
3) Those items which provide separate benefit for special services for the treatment of obstetrical complications.
4) Those items where the attendance is an integral part of the service.

For those services covered by sub-paragraphs 1.b, 1.c, 2, 3 and 4 above, fees are payable only for the procedure specified in the scheduled item.

In cases where the fee for an attendance depends upon consultation time, the time spent in carrying out a procedure, which is covered by another item in the Schedule, must not be included in calculating the consultation time.

Medical practitioners should ensure that a fee for a consultation is charged only when a consultation actually takes place. It is not expected that a consultation fee will be charged on every occasion a procedure is performed.

NOTE:

- **Only when the hospital has initiated the attendance may a medical practitioner claim a 'hospital initiated' attendance item. For a fee to be raised, evidence of 'hospital initiation' must be recorded in the patient medical record.**
- **Where a medical practitioner having completed the 'hospital initiated' attendance, elects to conduct other routine patient visits, these only attract 'routine attendance' fees other than in exceptional circumstances.**
- **Payment of 'after hours' and 'after midnight' fees is dependent upon the hospital initiating the attendance, and applies only to that attendance**
- Advice rendered by telephone or letter is **NOT PAYABLE** except as provided in items WA0005 or WA0006 for certain telephone consultations.
- The cost of travel between neighbouring towns is **NOT PAYABLE** except as provided in items WA0032 or WA0033.
- Where medical practitioners have made arrangements with the hospital concerned to use outpatient facilities, or lease premises situated within the hospital to see their private patients, the fee to be raised is a matter between the patient and the practitioner. The hospital is not responsible for payment.

UNIQUE WAGMSS CONSULTATION ITEM DESCRIPTIONS

PROLONGED PROFESSIONAL ATTENDANCES

Professional attendance on a patient requiring continuous attendance on the patient to the exclusion of all other patients, whether or not the patient is in imminent danger of death.

Claims for these attendances should be made using Medical Benefits Schedule Group A5 Prolonged Attendances, items 160, 161, 162, 163 or 164

SPECIAL CONSULTATIONS & TRAVEL COSTS

TELEPHONE CONSULTATIONS

NOTE: This 'consultation fee' is payable only when a nurse at a public hospital, in a 'single–doctor' town, telephones a medical practitioner for urgent medical advice and/or patient management instructions, in relation to a non-inpatient or the inpatient of another medical practitioner who is unavailable. This item is not payable in association with an attendance by that doctor on that patient on the same occasion.

WA0005 In Hours

WA0006 After Hours

TRAVEL COSTS

WA0032 Where a medical practitioner from an adjacent town travels to a "one–doctor" town to assist with a procedure

WA0033 Travel costs associated with the provision of medical services to the public hospital of a neighbouring town, where the local practitioner is absent or sick and when approved by the relevant Hospital Administrator

GENERAL PRACTITIONER ATTENDANCES		LEVEL 'A'	LEVEL 'B'	LEVEL 'C'	LEVEL 'D'
ATTENDANCE AT A PUBLIC HOSPITAL AS PART OF A ROUTINE VISIT TO THE HOSPITAL	**Initial patient seen on the 1 occasion of service**	WA0045	WA0050	WA0055	WA0060
	Each subsequent patient seen on the 1 occasion of service	WA0046	WA0051	WA0056	WA0061
HOSPITAL INITIATED ATTENDANCE AT A PUBLIC HOSPITAL **IN–HOURS** An attendance that occurs between 8am and 6pm on any weekday that is not a public holiday	**Initial patient seen on the 1 occasion of service**	WA0045H/T	WA0050H/T	WA0055H/T	WA0060H
	Each subsequent patient seen on the 1 occasion of service	WA0046H/T	WA0051H/T	WA0056H/T	WA0061H
HOSPITAL INITIATED ATTENDANCE AT A PUBLIC HOSPITAL **AFTER–HOURS but PRIOR TO MIDNIGHT** An attendance that occurs between 6pm and 12 midnight on any weekday, or at any time after 8am on a Saturday, Sunday or a public holiday.	**Initial patient seen on the 1 occasion of service**	WA0045P/T	WA0050P/T	WA0055P/T	WA0060P
	Each subsequent patient seen on the 1 occasion of service	WA0046P/T	WA0051P/T	WA0056P/T	WA0061P
HOSPITAL INITIATED ATTENDANCE AT A PUBLIC HOSPITAL **AFTER MIDNIGHT** An attendance that occurs on any day between 12 midnight and 8am	**Initial patient seen on the 1 occasion of service**	WA0045M/T	WA0050M/T	WA0055M/T	WA0060M
	Each subsequent patient seen on the 1 occasion of service	WA0046M/T	WA0051M/T	WA0056M/T	WA0061M

SPECIALIST ATTENDANCES (OTHER THAN CONSULTANT PHYSICIAN)	**Initial attendance (single patient) in a single course of treatment**	**Each attendance subsequent to the first attendance in a single course of treatment**
ATTENDANCE AT A PUBLIC HOSPITAL AS PART OF A ROUTINE VISIT TO THE HOSPITAL	WA0150/T	WA0151/T
HOSPITAL INITIATED ATTENDANCE AT A PUBLIC HOSPITAL– **IN HOURS -** An attendance that occurs between 8am and 6pm on any weekday that is not a public holiday	WA0150H/T	WA0151H/T
HOSPITAL INITIATED ATTENDANCE AT A PUBLIC HOSPITAL – **AFTER–HOURS** - After hours are defined as between 6pm and 12 midnight on any weekday, or at any time after 8am on a Saturday, Sunday or a public holiday.	WA0150P/T	WA0151P/T
HOSPITAL INITIATED ATTENDANCE AT A PUBLIC HOSPITAL – **AFTER MIDNIGHT** - An attendance that occurs on any day between 12 midnight and 8am	WA0150M/T	WA0151M/T

CONSULTANT PHYSICIAN ATTENDANCES (OTHER THAN IN PSYCHIATRY) Professional attendance at a public hospital by a consultant physician in the practice of his or her specialty (other than in psychiatry) where the patient is referred to him or her by a medical practitioner. (referred consultations are regarded as hospital initiated)	**Initial attendance (single patient) in a single course of treatment**	**Each attendance subsequent to the first attendance in a single course of treatment**
REFERRED CONSULTATION IN A PUBLIC HOSPITAL IN HOURS - An attendance that occurs between 8am and 6pm on any weekday that is not a public holiday	WA0170H/T	WA0171H/T
REFERRED CONSULTATION IN A PUBLIC HOSPITAL AFTER–HOURS - After hours are defined as between 6pm and 12 midnight on any weekday, or at any time after 8am on a Saturday, Sunday or a public holiday.	WA0170P/T	WA0171P/T
REFERRED CONSULTATION IN A PUBLIC HOSPITAL AFTER MIDNIGHT - An attendance that occurs on any day between 12 midnight and 8am	WA0170M/T	WA0171M/T

5.0 OPERATIONS

The complete explanatory notes for operations can be found in the current Medical Benefits Schedule Book issued by the Commonwealth Department of Health & Aged Care.

ATTENDANCES
Pre-operative visits in hospital by the surgeon shortly before surgery and normal after-care post-operative visits are included in the fee and not payable as separate items.

A fee for a pre-operative visit will only be paid if the surgeon does a formal admission i.e. documents history, examination findings and investigations in the hospital medical record and writes up treatment orders.

Payment of fees for surgical operations are subject to the following business rules

- restrictives
- multiple operations rules.
- aftercare

RESTRICTIVES
Many items in this group are qualified by one of the following 'restrictive' phrases:

'as an independent procedure';
'not being a service to which another item in this Group/Subgroup applies'; or
'not being a service to which item ***** applies'

An explanation of each of these phrases is as follows:

'as an independent procedure' - The inclusion of this phrase in the description of an item precludes payment of fees when:

I. A procedure so qualified is associated with another procedure that is performed through the same incision, e.g. nephrostomy (Item 36552) in the course of an open operation on the kidney for another purpose.
II. Such procedure is combined with another in the same body area, e.g. direct examination of larynx with another operation on the larynx or trachea.
III. The procedure is an integral part of the performance of another procedure, e.g. removal of foreign body in conjunction with debridement of deep or extensive contaminated wound or soft tissue, including suturing of that wound when performed under general anaesthetic.

''not being a service associated with a service to which another item in this Group/Subgroup applies' - means that fee is not payable for any other item in that group when it is performed on the same occasion as this item.

'not being a service to which item *** applies'** - means that when this item is performed on the same occasion as the reference item, no fee is payable.

'not being a service to which another item in this group applies' – means that this item may be itemised if there is no specific item relating to the service performed in the Schedule, (e.g. Laparotomy involving operation on abdominal viscera, not covered by any other item in this group). Fees may be attracted for an item with this qualification as well as a fee for another service during the course of the same operation.

MULTIPLE OPERATIONS RULE

The fees for two or more operations, other than those listed in subgroup 12 'Amputations' of the MBS, performed on a patient on the one occasion are calculated by the following rules:-

100% for the item with the greatest Schedule fee

plus

75% for the item with the next greatest Schedule fee (50% for lens extraction or insertion)

plus

50% for each other item (25% for lens extraction or insertion).

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 when applying the multiple operation rule.

There are a number of items in the Schedule where the description indicates that the item applies only when rendered in association with another procedure. The Schedule fees for such items have therefore been determined on the basis that the "multiple operation rule" will always apply.

Where two medical practitioners operate independently and either performs more than one operation, the rule would apply in respect of the services performed by each practitioner.

The multiple operations rule does NOT apply

- To an operation which is one of two or more operations performed under the one anaesthetic on the same patient if the medical practitioner who performed the operation did not also perform or assist at the other operation or any of the other operations, or administer the anaesthetic. In such cases the fees specified in the Schedule apply.
- In the case of emergency patients when each procedure is paid the 100% benefit.

- Where the need arises for the patient to be returned to the operating theatre on the same day as the original procedure for further surgery due to post-operative complications, which would not be considered as normal aftercare. Accounts should be endorsed to the effect that they are separate procedures so that a separate benefit may be paid.

AFTER CARE

Aftercare is the term generally used to refer to professional attendances necessary for the postoperative treatment of a patient. It is deemed to include all post operative treatment rendered by medical practitioners (not necessarily the provider that performed the operation) up until the patient's recovery from the operation, plus the final check or examination.

The fee for the surgical procedures includes normal after-care whether the surgery is routine or urgent. This includes attendances, associated documentation, and the discharge summary. If additional attendances are necessary, the medical practitioner should provide written reasons in the hospital medical record if he/she is to receive remuneration.

Most aftercare treatment will be consultations/attendances.

Generally, the fees specified for operations contains a component for the consequential after-care customarily provided. After-care for the purposes of this Schedule is deemed to include all postoperative treatment provided in the hospital.

The amount and duration of after-care consequent on an operation may vary between patients for the same operation, as well as between different operations which range from minor procedures performed during consultation or as day surgery, to major surgery carried out in hospital. As a guide to interpretation, after-care includes all normal post-operative attendances up to the healing of the wound or normal union of a fracture plus the final check or examination.

As a general rule, post-operative complications, which necessitate recourse to the operating theatre, would not be regarded as coming within the concept of normal after-care.

Attendances, which form part of normal after-care, should not be shown on the medical practitioner's account. Only those attendances, which do not form part of normal after-care; i.e. those services attracting separate fees, should be itemised. When additional services are itemised, the medical practitioner should show against those services on the account the words **'not normal after-care'.**

Subject to the approval of the local hospital, fees may be paid for professional services for the treatment 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.

Attendances subsequent to such operations should not be regarded as after-care but rather as a continuation of the treatment of the original condition and attract fees.

Generally, when a surgeon delegates aftercare to a local medical practitioner, the subdivision of the fee is a matter between the medical practitioners, and only the one fee is payable. This also applies in respect of fractures. A health service may decide to transfer patients to smaller local hospitals for a patient's aftercare period, and agree to pay the local medical practitioner for providing the aftercare service. In these cases, the medical practitioner should show against these aftercare services on the account the words **'not normal after-care – transferred patient'.**

The hospital is not responsible for aftercare payments where the hospital staff treat a patient who is subsequently referred to a private medical practitioner.

The following table shows the time period, which has been adopted as reasonable for the after-care of fractures:

Treatment of Fracture of	**Aftercare Period**
Terminal phalanx of finger or thumb	6 weeks
Proximal phalanx of finger or thumb	6 weeks
Middle phalanx of finger	6 weeks
One or more metacarpals not involving base of first carpometacarpal joint	6 weeks
First metacarpal involving carpometacarpal joint (Bennett's fracture)	8 weeks
Carpus (excluding navicular)	6 weeks
Navicular or carpal scaphoid	3 months
Colles/Smith/Barton's fracture of wrist 3 months	3 months
Distal end of radius or ulna, involving wrist	8 weeks
Radius	8 weeks
Ulna	8 weeks
Both shafts of forearm or humerus	3 months
Clavicle or sternum	4 weeks
Scapula	6 weeks
Pelvis (excluding symphysis pubis) or sacrum	4 months
Symphysis pubis	4 months
Femur	6 months
Fibula or tarsus (excepting os calis or os talus)	8 weeks
Tibia or patella	4 months
Both shafts of leg, ankle (Potts fracture with or without dislocation, os calcis (calcaneus) or os talus)	4 months
Metatarsals – one or more	6 weeks
Phalanx of toe (other than great toe)	6 weeks
More than one phalanx of toe (other than great toe)	6 weeks
Distal phalanx of great toe	8 weeks
Proximal phalanx of great toe	8 weeks
Nasal bones, requiring reduction	4 weeks
Nasal bones, requiring reduction and involving osteotomies	4 weeks

Maxilla or mandible, unilateral or bilateral, not requiring splinting	6 weeks
Maxilla or mandible, requiring splinting or wiring of teeth	3 months
Maxilla or mandible, circumosseous fixation of	3 months
Maxilla or mandible, external skeletal fixation of	3 months
Zygoma	6 weeks
Spine (excluding sacrum), transverse process or bone other than vertebral body requiring immobilisation in plaster or traction by skull callipers	3 months
Spine (excluding sacrum), vertebral body without involvement of cord, requiring immobilisation in plaster or traction by skull callipers	6 months
Spine (excluding sacrum), vertebral body, with involvement of cord	6 months

AFTER CARE – Where the patient is referred to an intensive care unit

Fees are payable for post-operative attendances by an intensivist in an intensive care unit, provided the intensivist, or the surgeon, who referred the surgical patient to the unit, supplies a brief explanation (to be submitted with the medical account covering the patient's treatment in the intensive care unit) of the intercurrent condition, or the unusual complication or an account of why the post-operative care was not regarded as normal after-care.

Routine admissions to an intensive care unit after major surgery in the absence of significant complications, do not attract additional fees.

ASSISTANCE AT OPERATION

General

Items covering operations, which are eligible for benefits for surgical assistance, have been identified by the inclusion of the word "Assist." in the item description. The assistant fee is only payable for surgical procedures, which have been so identified.

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

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

Assistance at Multiple Operations

Where surgical 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 surgeon's fee. The multi-operation formula is then applied to those items at which assistance was rendered and for which benefits for surgical assistance are payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (i.e. either Items 51300 or 51303).

The derived fee applicable to Item 51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery which attracts an assistance rebate.

6.0 OBSTETRICS

The complete explanatory notes for obstetrics can be found in the current Medical Benefits Schedule Book issued by the Commonwealth Department of Health and Aged Care The following notes clarify specific use of items in the WAGMSS.

FEES & CONDITIONS

In order to receive approval by a hospital board to practice obstetrics at a Government hospital under the direction of that board, a Medical Practitioner should meet one of the following requirements:

a) Hold a Diploma of Obstetrics of the RACOG
b) Hold an equivalent qualification to (a) as determined by the Clinical Privileges Advisory Committee
c) Demonstrate he or she has an equivalent period of supervised training and experience in accordance with RACGP and RACOG guidelines
d) In extraordinary circumstances, can demonstrate competence in obstetrics at an equivalent level to (c) above

Specific endorsement from the hospital Clinical Privileges Advisory Committee is required for a medical practitioner to use item 16522.

ANTENATAL CARE

Antenatal care items are only chargeable for public patients, when the antenatal care is provided **in the hospital**.

MANAGEMENT OF LABOUR & DELIVERY

Antenatal checks in hospital by the obstetrician will only be paid when performed on a separate occasion to the commencement of labour (natural, induced or caesarean). Normal after-care post-delivery visits are included in the fee and not payable as separate items.

Fees for management of labour and delivery covered by Items 16515, 16518, 16519, include:

- Surgical and/or intravenous infusion induction of labour
- Forceps or vacuum extraction
- Evacuation of products of conception by manual removal (not being an independent procedure)
- Episiotomy or repair of tears

In some instances, the obstetrician may not be able to be present at all stages of confinement. In these circumstances, a fee is payable under item 16519 provided that the doctor attends the patient as soon as possible during the confinement and assumes full responsibility for the mother and baby.

Item 16519 covers delivery by any means including Caesarean section. If, however, a patient is referred, or her care is transferred to another medical practitioner for the specific purpose of delivery by Caesarean section, whether because of an emergency situation or otherwise, then the Caesarean section would be claimed under item 16520.

Where, during labour, a general practitioner hands the patient over to another medical practitioner, fees are payable for the incomplete confinement under item 16518 for the referring practitioners services. The second practitioner's services would be payable under items 16515 or 16520 or 16522 (i.e. confinement as an independent procedure by a specialist).

If the handover occurs at the time of the confinement but before the general practitioner has commenced the actual confinement, fees for the general practitioner's services should be assessed under item 16500 for the antenatal attendances given in the hospital, and on consultation basis for the postnatal attendances.

Where an Obstetrician, contacted to provide clinical support to midwives in accordance with the Midwifery Group Practice arrangements at Bunbury Hospital, is not required to be present during labour, but is immediately available from a remote site to provide advice and support, fees are payable under item RH6518 (management of labour, incomplete). In this circumstance the item applies from the time the GP Obstetrician is alerted by the midwife that labour is imminent or has commenced through to the completion of post-natal care, for up to 5 days. It is not payable if any other 'management of labour & delivery' item is claimed for the same delivery. (RH6515 to RH6528)

At a high-risk delivery, fees will be payable for the attendance of any medical practitioner (called in by the medical practitioner in charge of the delivery) for the purposes of resuscitation and subsequent supervision of the neonate. Examples of high-risk deliveries include cases of difficult vaginal delivery, Caesarean section or the delivery of babies with Rhesus (Rh) problems and babies of toxaemic mothers. After hours attendance at a caesarean section (WA0195) may only be claimed by a Consultant Paediatrician.

As a rule, 24 weeks would be the period distinguishing a miscarriage from a premature confinement. However, if a live birth has taken place before 24 weeks and the foetus survives for a reasonable period, fees would be payable under the appropriate confinement item.

Management of labour & delivery items can be claimed using the following MBS item numbers.

Metropolitan Hospital Item Numbers	Country Hospital Item Numbers
16515	RH6515
16518	RH6518
16519	RH6519
16520	RH6520
16522	RH6522
16527	RH6527
16528	RH6528
51306	RH1306
51309	RH1309

The fees payable in country hospitals vary from those payable in the metropolitan area.

POSTNATAL CARE

The fees payable for those delivery items which include the words, `confinement and postnatal care for five days,' cover all attendances on the **mother and the baby** during that period. Normal postnatal care by a medical practitioner would include:-

(i) uncomplicated care and check of
- lochia
- fundus
- perineum and vulva/episiotomy site
- temperature
- bladder/urination
- bowels

(ii) advice and support for establishment of breast feeding

(iii) psychological assessment and support

(iv) Rhesus status

(v) Rubella status and immunisation

(vi) contraception advice/management

Procedures not included in normal postnatal care are:

- Where the medical services rendered are outside those covered by a consultation, e.g. repair of third-degree tear, blood transfusion, etc.
- Where the condition of the mother and/or baby during the five-day postnatal period is such as to require the services of a consultant (e.g. paediatrician, specialist gynaecologist, etc).
- Where it is necessary during the postnatal period to treat a condition not directly related to the pregnancy or the confinement or the neonatal condition of the baby; or
- In the management of premature babies (i.e. babies born prior to the end of the 37th week of pregnancy or where the birth weight of the baby is less than 2500 grams) during the period that close supervision is necessary.
- Where a patient is transferred at arm's length to another practitioner for routine postpartum care (e.g. Mother and/or baby returning from a larger centre to a country town, or transferring between hospitals following confinement); in such cases routine postnatal attendances attract benefits on an attendance basis.

Routine examination by paediatricians and general practitioners of normal newborn infants are not to be remunerated, except when:

(a) Where the obstetrician has requested the presence of the paediatrician or general practitioner (must be documented in the hospital medical record) because the delivery is high risk e.g. difficult vaginal delivery, Caesarean section. The paediatrician or general practitioner would be present to assist with resuscitation of the newborn if necessary.

(b) The newborn infant has a significant medical condition or is `at risk' premature.

UNIQUE WAGMSS OBSTETRIC ITEM DESCRIPTIONS

MANAGEMENT OF LABOUR AND DELIVERY

WA0195 Out of hours attendance by a Consultant Paediatrician at an urgent and potentially complex Caesarean Section including observation of foetal monitoring, attendance at the subsequent operation and resuscitation of the infant as required. The out of hours period is defined as between 6pm to 8am on a weekday, 8am Saturday to 8am Monday for weekends, and for public holidays 8am to 8am the following day.

7.0 ANAESTHETICS

The complete explanatory notes for anaesthetics can be found in the current Medical Benefits Schedule Book issued by the Commonwealth Department of Health and Aged Care. The following notes clarify specific use of items in the WAGMSS.

ANAESTHETIC GROUPING
In the WAGMSS, anaesthetic items are held in three groups:

Group T6 Attendances and Consultations

Group T7 Regional and Field Nerve Blocks - A nerve block is interpreted as the anaesthetising of a substantial segment of the body innervated by a large nerve, or an area supplied by a smaller nerve where the technique demands expert anatomical knowledge and a high degree of precision.

Group T10 RVG anaesthetic procedures - these items are all RVG derived and prefixed CA to CT and CV to CX.

ASSOCIATED BUSINESS RULES
As there is a procedural overlap between groups T7 and T10, the following "rules" are intended to help you in assessing CMP anaesthetic accounts, and to ensure that items invoiced for payment are from the correct anaesthetic group.

1: Group 10 anaesthetic procedures pre-fixed CA to CT are only payable where the anaesthetic is administered by a medical practitioner other than the medical practitioner rendering the medical service requiring anaesthesia.

2: Group 7 regional and field nerve block items **may** be claimed
- when the item is administered by a medical practitioner, in the course of a surgical procedure undertaken by her/him.
- Where a block is carried out in cases not associated with an operation, such as intractable pain and during labour, regardless of whether more than one medical practitioner is involved

3: Group 7 regional and field nerve block items **may not** be claimed
- Where anaesthesia combines a regional nerve block with general anaesthesia for an operative procedure, or where a regional or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation. A fee for these procedures will only be paid under relevant anaesthesia items set out in group T10.
- Digital ring analgesia, local infiltration into tissue surrounding a lesion or paracervical (uterine) analgesia as these items form part of any procedure in which they are used.

GROUP T7 – REGIONAL OR FIELD NERVE BLOCKS

NOTE **EPIDURAL SERVICES TO PATIENTS IN LABOUR.**

Items 18216 & 18219 should be used when claiming for **in-hours** epidural services to a patient in labour.
For a patient requiring **emergency** labour services provided in the **after-hours** period, these items will attract emergency after-hours loadings.

Items 18226 & 18227 should be used when claiming **after-hours** epidural services for a patient in normal labour.

18216 Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner Applicable once per presentation, per medical practitioner, per complete new procedure (Anaes.)

18219 Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, where continuous attendance by the medical practitioner extends beyond the first hour (Anaes)

18226 Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner, for **a patient in normal labour**, where the service is provided in the after-hours period. being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday Applicable once per presentation, per medical practitioner, per complete new procedure

18227 Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, where continuous attendance by the medical practitioner extends beyond the first hour, for **a patient in normal labour**, where the service is provided in the after-hours period. being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday.

ACCOUNTING NOTE

When, for derived epidural items 18216 and 18226, attendance extends beyond the first hour and warrants claiming for the extended period using items 18219 and 18227 respectively, both the items must be shown on the account (18216 and 18219 or 18226 and 18227). When a payment statement arrives for the claim it will show $0 against 18216 or 18226, with the total amount owed against either 18219 or 18227.

RVG CALCULATIONS

RVG procedures have three components which together give the total RVG derived value for that anaesthetic service. The three components are

1: BASIC UNIT VALUE

- A Basic RVG Unit Value is listed for each procedure and relates to difficulty of that particular anaesthetic technique.
- It includes usual postoperative visits and such items as intravenous induction, endotracheal intubation, intravenous infusions and transfusions, local and regional anaesthesia and usual monitoring procedures, all of which are part of the whole anaesthetic.
- It excludes pre-anaesthesia consultations, specialised forms of catheterisation and monitoring (e.g. intra-arterial, central venous and pulmonary artery), and perioperative nerve blocks for postoperative analgesia.
- Where anaesthesia is provided for services covered by multiple items in the RVG, a fee is only payable for the RVG item with the highest basic unit value. However, the time component should include the total anaesthesia time taken for all services.
- A local regional nerve block in association with a general anaesthetic is regarded as part of the anaesthetic and will not have added value except by reason of the time value involved.

2: TIME UNITS

- Each 15 minutes (or part thereof) of anaesthetic time counts as one time unit. Time begins when the anaesthetist begins to prepare the patient for anaesthetic care in the operating room or equivalent area and ends when the anaesthetist is no longer in personal attendance; that is when the patient may be safely placed under the supervision of other personnel.
- For anaesthetic procedures with dates of service 1st December 2005 or later, where a procedure exceeds **2 hours,** time units are 15 minutes for the first two hours, and 10 minutes thereafter.
- In the case of medical management of cardio-pulmonary bypass perfusion time for the perfusionist begins with induction of anaesthesia and finishes with the closure of the chest.

3: MODIFYING UNITS

There are two groups of modifiers:

PHYSICAL STATUS

P1 – normal healthy patient – 0 RVG

P2 – patient with mild systemic disease – 0 RVG

P3 – patient with severe systemic disease that severely limits activity – 1 RVG

P4 – patient with severe systemic disease that is a constant threat to life – 2 RVG

P5 – moribund patient who is not expected to survive for 24 hours with or without the operation – 3 RVG

P6 – declared brain-dead patient whose organs are being removed for donor purposes – 0 RVG

OTHER

M1 – anaesthesia for a patient under four years or over 75 years old – 1 RVG

M2 – anaesthesia for emergency surgery; an emergency exists when a delay in treatment of the patient would lead to a significant threat to life or body part. – 2 RVG

M2 may not be included in any EAHA claim

When applying modifiers, only one modifier from each group may be selected.

CONSULTATIONS

RVG derived items for anaesthetic consultations and attendances; these can be found on pages 40 and 41.

- A consultation may only be charged for, when a formal consultation was performed. The administration of anaesthesia also includes the pre-anaesthetic consultation, except where the consultation is undertaken as a separate attendance at a place other than an operating theatre or an anaesthesia induction room. When charged separately, the consultation will only be paid in association with an operative procedure. **If, following the pre-anaesthetic consultation, the procedure is delayed or cancelled, this consultation and any subsequent consultation during the delay are to be treated as normal consultation.**
- Where therapeutic or diagnostic procedures, are instituted following formal referred consultation, then it is appropriate to charge for both the consultation and the procedure. If subsequent attendances include further therapeutic procedures and the procedural items are charged, it is not appropriate to charge a consultation fee, unless a formal subsequent consultation occurs.
- Consultation time only applies to the period of active attendance on the patient and does not include time spent in discussion with other health professionals.
- Consultation services covered by pain specialists' items in the range 2801-3000 cannot be claimed in conjunction with items CA7610-CA7625
- Acute Pain Management – where the anaesthetist is requested to manage the patient's acute pain at a time subsequent and separate to the patient's anaesthesia and surgery, and makes a formal initial assessment of the patient, this can be classified as a referred consultation.
- It would be expected that in the vast majority of cases, the insertion of a peripheral venous cannula (other than in association with anaesthesia) where the patient is referred, would attract benefit under item CA7640. However, in exceptional clinical circumstances, where the procedure is considerably more difficult and exceeds 15 minutes, such as for patients with chronic disease undergoing long term intravenous therapy, paediatric patients or patients having chemotherapy, item CA7645 would apply.
- A consultation occurring immediately before the institution of major regional blockade for a patient in labour is covered by item CA7680.
- CA0070 is applicable for call backs at any time, from home, office or places other than the hospital.

MISCELLANEOUS

- The item number descriptions in WAGMSS and MBS, with the exception of CA0070, are the same. However, as the MBS calculation process and RVG rate differ from that used in the WAGMSS it has been necessary to replace the first digit of the MBS item number with one of the following combination of letters

CA, CB, CC, CD, CE, CF, CG, CH, CJ, CK, CL, CM, CN, CQ, CR, CS, CT, CV, or CX.

- No payment will be made for intravenous infusion or electrocardiographic monitoring when performed as part of an anaesthetic procedure as provision has already been made for these in the item value.
- IV Drip Insertion items are not payable in association with anaesthesia or where consultation or attendance fee is charged.
- The value paid for an anaesthetic item remains the same regardless of whether more than one medical practitioner is involved in the administration of it. Where the second practitioner is not the surgeon or assistant surgeon, a claim may be made as an 'assistant anaesthetist' using items from Group T10.26.
- Where anaesthesia is required for an aftercare procedure, only an anaesthetic charge may be raised. For example, perioperative nerve blocks that are done for the provision of postoperative analgesia are entitled to an additional charge. However, if the service is performed by the operating surgeon during the post-operative period of an operation it is considered to be part of the normal aftercare.
- Where anaesthesia is administered to a patient, the premedication of the patient in preparation for anaesthesia is deemed to form part of the anaesthetic and is not separately chargeable.

ANAESTHETIC ASSISTANCE

When it is necessary to have a second attending anaesthetist to assist with the anaesthetic, the circumstances must be documented. Such services will have a Basic Value of 5 units plus Time Units. See items CW5200 and CW5205. The time period eligible for payment is that during which the assistant is in active attendance on the patient during anaesthesia.

(EAHA) EMERGENCY AFTER HOURS LOADING

- Only where an anaesthetic service meets the definition of emergency, and where more than 50% of the time for the emergency anaesthesia service is provided in the afterhours period, is the emergency after hours loading to be applied.
- Emergency anaesthesia is defined as where a patient requires immediate treatment without which there would be significant threat to life or body part. In the case of obstetric anaesthesia, this applies to urgent epidural insertion for pain relief or management of pregnancy related problems such as pre-eclampsia, and the management of higher risk pregnancies such as vaginal birth after caesarean section and multiple birth. It would **not** apply to routine non-urgent epidural insertion associated with induction of labour where significant pain is not established.
- After hours are defined as between 6pm and 8am on any weekday, or at any time on a Saturday, Sunday or a public holiday.
- For EAHA loadings to be claimed, an anaesthetic procedure must have been performed.
- **EAHA loadings CANNOT BE CLAIMED for anaesthetic procedures with M2 modifiers (MBS equivalent item 25020)**

- EAHA loadings only apply to Group T6 anaesthetic attendances & consultations items CA0070, CA7610, CA7615, CA7620, CA7625 & CA7680; all other Group T6 items are ineligible.
- Anaesthetic attendances and consultation items will only be paid at the EAHA rate where an anaesthetic procedure is performed during the attendance, and both items are charged on the same invoice.
- EAHA loadings only apply to Group T7 regional & field nerve block items 18216, 18219, 18222 & 18225, all other Group T7 items are ineligible.
- For nerve blocks used in association with an obstetric delivery please note, EAHA loadings may only be claimed when used in the afterhours period in association with an emergency delivery. Claims for the administration of nerve blocks for a routine obstetric delivery, where over 50% of the time is in the afterhours period, should be made using items 18226 and 18227.
- EAHA loadings apply to all Group T10 RVG derived anaesthetic items.

UNIQUE WAGMSS RVG DERIVED ANAESTHETIC ITEM DESCRIPTIONS

Please note that although generally descriptions for items will match the MBS equivalent item, some descriptions have been adjusted for clarification or to better suit WA hospital situations.

GROUP T6 - ATTENDANCES AND CONSULTATIONS

CA0070 Call back from home, office or other distant location of an anaesthetist for the provision of emergency services. Item is separate from and additional to any service provided by the anaesthetist including consultations.

PRE-ANAESTHETIC CONSULTATION IN PREPARATION FOR THE ADMINISTRATION OF AN ANAESTHETIC BY A MEDICAL PRACTITIONER IN THE PRACTICE OF ANAESTHESIA, not being a service associated with a service to which items 2801 – 3000 apply (see para T6.1 of MBS explanatory notes to this Category)

CA7610 Brief consultation involving targeted history and limited examination (including the cardio-respiratory system) and of not more than 15 minutes duration

CA7615 Consultation on a patient undergoing advanced surgery or who has complex medical problems, involving a selective history and an extensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes - and of more than 15 minutes but not more than 30 minutes duration.

CA7620 Consultation on a patient undergoing advanced surgery or who has complex medical problems, involving a detailed history and a comprehensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes - and of more than 30 minutes but not more than 45 minutes duration.

CA7625 Consultation on a patient undergoing advanced surgery or who has complex medical problems, involving an exhaustive history and a comprehensive examination of multiple systems, the formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of a high complexity documented in the patient notes - and of more than 45 minutes duration.

REFERRED ANAESTHETIC CONSULTATION BY A SPECIALIST ANAESTHETIST, not being a service associated with a service to which items 2801 – 3000 apply (see para T6.2 of MBS explanatory notes to this Category)

CA7640 Brief consultation involving short history and limited examination and of not more than 15 minutes duration

CA7645 Consultation involving a selective history and examination of multiple systems and the formulation of a written patient management plan - and of more than 15 minutes but not more than 30 minutes duration.

CA7650 Consultation involving a detailed history and comprehensive examination of multiple systems and the formulation of a written patient management plan - and of more than 30 minutes but not more than 45 minutes duration.

CA7655 Consultation involving an exhaustive history and a comprehensive examination of multiple systems, the formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of a high complexity - and of more than 45 minutes duration.

OTHER ANAESTHETIC CONSULTATION BY AN ANAESTHETIST IN THE PRACTICE OF ANAESTHESIA, not being a service associated with a service to which items 2801 – 3000 apply (see para T6.3 of MBS explanatory notes to this Category)

CA7680 A consultation immediately prior to the institution of a major regional blockade of a patient in labour, where no previous consultation has occurred.

CA7690 Where a pre-anaesthesia consultation covered by an item in the range CA7615 - CA7625 is performed in rooms if:

(a) the service is provided to a patient prior to an admitted patient episode of care involving anaesthesia, and

(b) the service is not provided to an admitted patient of a hospital, and

(c) the service is not provided on the day of admission to hospital for the subsequent episode of care involving anaesthesia

(d) the service is of more than 15 minutes duration

not being a service associated with a service to which items 2801 – 3000 apply. *(See para T6.3 of explanatory notes to this category)*

GROUP T10 – RELATIVE VALUE GUIDE FOR ANAESTHESIA

SUBGROUP T10.01 – HEAD

Initiation of management of anaesthesia:

CA0100 -for all procedures on the skin, subcutaneous tissue, muscles, salivary glands, or superficial vessels of the head including biopsy not being the service to which another item in this subgroup applies.

CA0102 – for plastic repair of cleft palate

CA0104 – for electroconvulsive therapy

CA0120 -for all procedures on external, middle or inner ear, including biopsy, not being a service to which another item in this subgroup applies.

CA0124 – for otoscopy

CA0140 - for all procedures on eye, not being a service to which another item in this subgroup applies.

CA0142 – for lens surgery

CA0143 – for retinal surgery

CA0144 – for corneal transplant

CA0145 – for vitrectomy

CA0146 – for biopsy of conjunctiva

CA0147 – for squint repair

CA0148 – for ophthalmoscopy

CA0160 -for internasal or accessory sinuses, not being a service to which another item in this subgroup applies.

CA0162 – for internasal surgery for malignancy or for internasal ablation

CA0164 – for biopsy, soft tissue on the nose and accessory sinuses.

CA0170 -for all intraoral procedures, including biopsy, not being a service to which another item in this subgroup applies.

CA0172 – for repair of cleft palate

CA0174 – for excision of retropharyngeal tumour

CA0176 – for radical intraoral surgery

CA0190 - for all procedures on facial bones, not being a service to which another item in this subgroup applies

CA0192 – for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction)

CA0210 - for all intracranial procedures, not being a service to which another item in this subgroup applies

CA0212 – for subdural taps

CA0214 – for burr holes of the cranium

CA0216 – for intracranial vascular procedures including those for aneurysms and arterio–venous abnormalities

CA0220 – for spinal fluid shunt procedures

CA0222 – for ablation of an intracranial nerve

CA0225 – for all cranial bone procedures

CA0230 – for microvascular free tissue flap surgery involving the head or face

(See para T10.28 of explanatory notes to this Category)

SUBGROUP T10.02 – NECK

Initiation of management of anaesthesia:

CB0300 -for all procedures on the skin or subcutaneous tissue of the neck, not being a service to which another item in this subgroup applies

CB0305 – for incision and drainage of large haematoma, large abscess, cellulitis or similar lesion or epiglottitis causing life threatening airway obstruction

CB0320 - for all procedures on oesophagus, thyroid, larynx, trachea, lymphatic system, muscles, nerves or other deep tissues of the neck, not being a service to which another item in this subgroup applies

CB0321 – for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy

CB0330 – for laser surgery to the airway (excluding nose and mouth)

CB0350 -for all procedures on major vessels of neck, not being a service to which another item in this subgroup applies

CB0352 – for simple ligation of major vessels of the neck

CB0355 – for microvascular free tissue flap surgery involving the neck

(See para T10.28 of explanatory notes to this Category)

SUBGROUP T10.03 – THORAX

Initiation of management of anaesthesia:

CC0400 - for all procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this subgroup applies

CC0401 - for procedures on the breast, not being a service to which another item in this subgroup applies

CC0402 – for reconstructive procedures on breast, including implant reconstruction and exchange

CC0403 – for axillary dissection or sentinel node biopsy

CC0404 – for mastectomy

CC0405 – for reconstructive procedures on the breast using myocutaneous flaps

CC0406 – for radical or modified radical procedures on breast with internal mammary node dissection

CC0410 – for electrical conversion of arrhythmias

CC0420 - for all procedures on the skin or subcutaneous tissue of the posterior part of the chest, not being a service to which another item in this subgroup applies

CC0440 – for percutaneous bone marrow biopsy of the sternum

CC0450 - for all procedures on clavicle, scapula or sternum, not being a service to which another item in this subgroup applies

CC0452 – for radical surgery on clavicle, scapula or sternum

CC0470 – for partial rib resection, not being a service to which another item in this subgroup applies

CC0472 – for thoracoplasty

CC0474 – for radical procedures on chest wall

(see para T10.22 of explanatory notes to this Category)

CC0475 ─ for microvascular free tissue flap surgery involving the anterior or posterior thorax

(See para T10.28 of explanatory notes to this Category)

SUBGROUP T10.04 – INTRATHORACIC

Initiation of management of anaesthesia:

CD0500 -for open procedures on the oesophagus

CD0520 - for all closed chest procedures (including rigid oesophagoscopy, bronchoscopy), not being a service to which another item in this subgroup applies

CD0522 – for needle biopsy of pleura

CD0524 – for pneumocentesis

CD0526 – for thoracoscopy

CD0528 – for mediastinoscopy

CD0540 - for all thoracotomy procedures involving lungs, pleura, diaphragm, or mediastinum, not being a service to which another item in this subgroup applies

CD0542 – for pulmonary decortication

CD0546 – for pulmonary resection with thoracoplasty

CD0548 – for intrathoracic repair of trauma to trachea and bronchi

CD0560 – for (a) open procedures on heart, pericardium, or great vessels of chest

(b) percutaneous insertion of a vuvular prosthesis

SUBGROUP T10.05 - SPINE AND SPINAL CORD

Initiation of management of anaesthesia:

CE0600 - for all procedures on cervical spine and/or cord, not being a service to which another item in this subgroup applies (for myelography and discography see items CS1906 and CS1914)

CE0604 – for posterior cervical laminectomy with the patient in the sitting position

CE0620 - for all procedures on thoracic spine and/or cord, not being a service to which another item in this subgroup applies

CE0622 – for thoracolumbar sympathectomy

CE0630 - for all procedures in lumbar region, not being a service to which another item in this subgroup applies

CE0632 – for lumbar sympathectomy

CE0634 – for chemonucleolysis

CE0670 - for extensive spine and/or spinal cord procedures

(see para T10.23 of explanatory notes to this Category)

CE0680 - for manipulation of spine when performed in the operating theatre of a hospital or day hospital facility

CE0690 - for percutaneous spinal procedures, not being a service to which another item in this subgroup applies

SUBGROUP T10.06 - UPPER ABDOMEN

Initiation of management of anaesthesia:

CF0700 - for all procedures on the skin or subcutaneous tissue of the upper anterior abdominal wall, not being a service to which another item in this subgroup applies

CF0702 – for percutaneous liver biopsy

CF0703 – for all procedures on the nerves, muscles, tendons and fascia of the upper abdominal wall, not being a service to which another item in this subgroup applies

CF0704 – for microvascular free tissue flap surgery involving the anterior or posterior upper abdomen *(See para T10.28 of explanatory notes to this Category)*

CF0706 - for laparoscopic procedures in the upper abdomen, including laparoscopic cholecystectomy, not being a service to which another item in this subgroup applies

CF0730 - for all procedures on the skin or subcutaneous tissue of the upper posterior abdominal wall, not being a service to which another item in this subgroup applies

CF0740 – for upper gastrointestinal endoscopic procedures

CF0745 for: (a) upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage;(b) endoscopic retrograde cholangiopancreatography;(c) upper gastrointestinal endoscopic ultrasound;(d) percutaneous endoscopic gastrostomy;(e) upper gastrointestinal endoscopic mucosal resection of tumour. (7 basic units)

CF0750 - for all hernia repairs in upper abdominal wall, not being a service to which another item in this subgroup applies

CF0752 – for repair of incisional hernia and/or wound dehiscence

CF0754 – for omphalocele

CF0756 – for transabdominal repair of diaphragmatic hernia

CF0770 – for all procedures on major abdominal blood vessels

CF0790 – for all procedures within the peritoneal cavity in upper abdomen including any of the following
- **(a)** open cholecystectomy,
- **(b)** gastrectomy,
- **(c)** laparoscopically assisted nephrectomy, or
- **(d)** bowel shunts

CF0791 –for bariatric surgery in a patient with clinically severe obesity

CF0792 – for partial hepatectomy (excluding liver biopsy)

CF0793 – for extended or trisegmental hepatectomy

CF0794 – for pancreatectomy, partial or total

CF0798 – for neuro endocrine tumour removal, in the upper abdomen

CF0799 – for percutaneous procedures on an intra-abdominal organ, in the upper abdomen

SUBGROUP T10.07 - LOWER ABDOMEN

Initiation of management of anaesthesia:

CG0800 - for all procedures on the skin or subcutaneous tissue of the lower anterior abdominal wall, not being a service to which another item in this subgroup applies

CG0802 – for lipectomy of the lower abdomen

CG0803 – for all procedures on the nerves, muscles, tendons and fascia of the lower abdominal wall, not being a service to which another item in this subgroup applies.

CG0804 – for microvascular free tissue flap surgery involving the anterior or posterior lower abdomen

(See para T10.28 of explanatory notes to this Category)

CG0806 – for laparoscopic procedures in the lower abdomen

CG0810 – for lower intestinal endoscopic procedures

CG0815 – for extracorporeal shock wave lithotripsy to urinary tract

CG0820 – for all procedures on the skin, its derivatives or subcutaneous tissue of the lower posterior abdominal wall

CG0830 - for all hernia repairs in lower abdomen, not being a service to which another item in this subgroup applies

CG0832 – for repair of incisional herniae and/or wound dehiscence of the lower abdomen

CG0840 - for all open procedures within the peritoneal cavity in lower abdomen, including appendicectomy, not being a service for which another item in this subgroup applies

(See para TN.10.27 of explanatory notes to this Category)

CG0841 - for bowel resection, including laparoscopic bowel resection, not being a service for which another item in this subgroup applies

CG0842 – for amniocentesis

CG0844 – for abdominoperineal resection, including pull–through procedures, ultra-low anterior resection and formation of bowel reservoir

CG0845 – for radical prostatectomy

CG0846 – for radical hysterectomy

CG0847 – for ovarian malignancy

CG0848 – for pelvic exenteration

CG0850 – for caesarean section

CG0855 – for caesarean hysterectomy or hysterectomy within 24 hours of delivery

CG0860 - for all extraperitoneal procedures in lower abdomen, including urinary tract not being a service to which another item of this subgroup applies

CG0862 – for renal procedures, including upper 1/3 of ureter

CG0863 – for nephrectomy

CG0864 – for total cystectomy

CG0866 – for adrenalectomy

CG0867 – for neuro endocrine tumour removal in the lower abdomen

CG0868 – for renal transplantation (donor or recipient)

CG0880 - for all procedures on major lower abdominal vessels, not being a service to which another item in this subgroup applies

CG0882 – for inferior vena cava ligation

CG0884 – for percutaneous umbrella insertion

CG0886 – for percutaneous procedures on an intra-abdominal organ in the lower abdomen

SUBGROUP T10.08 – PERINEUM

Initiation of management of anaesthesia:

CH0900 -for procedures on the skin or subcutaneous tissue of the perineum, not being a service to which another item in this subgroup applies

CH0902 – for anorectal procedures (including surgical haemorrhoidectomy, but not banding of haemorrhoids)

CH0904 – for radical perineal procedure including radical perineal prostatectomy or radial vulvectomy

CH0905 – for microvascular free tissue flap surgery involving the perineum

(See para T10.28 of explanatory notes to this Category)

CH0906 – for vulvectomy

CH0910 Initiation of management of anaesthesia- for all transurethral procedures (including urethrocystoscopy), not being a service to which another item in this subgroup applies

CH0911 – for endoscopic ureteroscopic surgery including laser procedures

(See para T10.29 of explanatory notes to this Category)

CH0912 – for transurethral resection of bladder tumour(s)

CH0914 – for transurethral resection of prostate

CH0916 – for bleeding post–transurethral resection

CH0920 for all procedures on external genitalia, not being a service to which another item in this subgroup applies

CH0924 – for procedures on undescended testis, unilateral or bilateral

CH0926 – for radical orchidectomy, inguinal approach

CH0928 – for radical orchidectomy, abdominal approach

CH0930 – for orchiopexy, unilateral or bilateral

CH0932 – for complete amputation of penis

CH0934 – for complete amputation of penis with bilateral inguinal lymphadenectomy

CH0936 – for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy

CH0938 – for insertion of penile prosthesis

CH0940 - for per vagina and vaginal procedures (including biopsy of vagina, cervix or endometrium), not being a service to which another item in this subgroup applies

CH0942 – for vaginal procedures including repair operations and urinary incontinence procedures (perineal)

CH0943 – for transvaginal assisted reproductive services

CH0944 – for vaginal hysterectomy

CH0946 – for vaginal birth

CH0948 – for purse string ligation of cervix, or removal of purse string ligature

CH0950 – for culdoscopy

CH0952 – for hysteroscopy

CH0954 – for correction of inverted uterus

CH0956 – for evacuation of the retained products of conception, as a complication of confinement

CH0958 – for manual removal of retained placenta or for repair of vaginal or perineal tear following delivery

CH0960 – for vaginal procedures in the management of postpartum haemorrhage (blood loss>500mls)

SUBGROUP T10.09 - PELVIS – EXCEPT HIP

Initiation of management of anaesthesia:

CJ1100 - for all procedures on the skin or subcutaneous tissue of the anterior pelvic region (anterior to iliac crest), except external genitalia

CJ1110 – for all procedures on the skin and its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum

CJ1112 – for percutaneous bone marrow biopsy of the anterior iliac crest

CJ1114 – for percutaneous bone marrow biopsy of the posterior iliac crest

CJ1116 – for percutaneous bone marrow harvesting from the pelvis

CJ1120 – for procedures on bony pelvis

CJ1130 – for body cast application or revision when performed in the operating theatre of a hospital.

CJ1140 – for interpelviabdominal (hindquarter) amputation

CJ1150 – for radical procedures for tumour of pelvis, except hindquarter amputation

CJ1155 – for microvascular free tissue flap surgery involving the anterior or posterior pelvis

(See para T10.28 of explanatory notes to this Category)

CJ1160 – for closed procedures involving symphysis pubis or sacroiliac joint when performed in the operating theatre of a hospital.

CJ1170 – for open procedures involving symphysis pubis or sacroiliac joint

SUBGROUP T10.10 - UPPER LEG – EXCEPT KNEE

Initiation of management of anaesthesia:

CK1195 - for all procedures on the skin or subcutaneous tissue of the upper leg

CK1199 – for all procedures on nerves, muscles, tendons, fascia, or bursae of upper leg

CK1200 – for all closed procedures involving hip joint when performed in an operating theatre of a hospital

CK1202 – for arthroscopic procedures of hip joint

CK1210 -for all open procedures involving hip joint, not being a service to which another item in this subgroup applies

CK1212 – for hip disarticulation

CK1214 – for primary total hip replacement

CK1215 **-** for revision of total hip replacement

CK1216 – for bilateral total hip replacement

CK1220 – for all closed procedures involving upper 2/3 of femur when performed in an operating theatre of a hospital or day hospital facility

CK1230 - for all open procedures involving upper 2/3 of femur, not being a service to which another item in this subgroup applies.

CK1232 – for above knee amputation

CK1234 – for radical resection of the upper 2/3 of femur

CK1260 – for all procedures involving veins of upper leg, including exploration

CK1270 - for all procedures involving arteries of upper leg, including bypass graft, not being a service to which another item in this subgroup applies.

CK1272 – for femoral artery ligation

CK1274 – for femoral artery embolectomy

(see para T10.24 of explanatory notes to this Category)

CK1275 – for microvascular free tissue flap surgery involving the upper leg

(See para T10.28 of explanatory notes to this Category)

CK1280 – for microsurgical reimplantation of upper leg

SUBGROUP T10.11 - KNEE AND POPLITEAL AREA

Initiation of management of anaesthesia:

CL1300 - for all procedures on the skin or subcutaneous tissue of the knee and/or popliteal area

CL1321 – for all procedures on nerves, muscles, tendons, fascia or bursae of knee and/or popliteal area

CL1340 – for all closed procedures on lower 1/3 of femur when performed in an operating theatre of a hospital

CL1360 – for all open procedures on lower 1/3 of femur

CL1380 – for all closed procedures on knee joint when performed in an operating theatre of a hospital

CL1382 – for arthroscopic procedures of knee joint

CL1390 – for all closed procedures on upper ends of tibia and fibula, and/or patella when performed in an operating theatre of a hospital

CL1392 – for all open procedures on upper ends of tibia and fibula and/or patella

CL1400 - for open procedures on knee joint, not being a service to which another item in this subgroup applies.

CL1402 – for knee replacement

CL1403 – for bilateral knee replacement

CL1404 – for disarticulation of knee

CL1420 – for all cast applications, removal, or repair involving knee joint when performed in an operating theatre of a hospital

CL1430 - for all procedures on veins of knee and popliteal area, not being a service to which another item in this subgroup applies.

CL1432 – for repair of arteriovenous fistula of knee or popliteal area

CL1440 - for all procedures on arteries of knee and popliteal area, not being a service to which another item in this subgroup applies.

CL1445 – for microvascular free tissue flap surgery involving the knee and/or popliteal area

(See para T10.28 of explanatory notes to this Category)

SUBGROUP T10.12 - LOWER LEG – BELOW KNEE

Initiation of management of anaesthesia:

CM1460 - for all procedures on the skin or subcutaneous tissue of lower leg, ankle, or foot

CM1461 -for all procedures on nerves, muscles, tendons, or fascia of lower leg, ankle, or foot, not being a service to which another item in this subgroup applies.

CM1462 – for all closed procedures on lower leg, ankle, and foot

CM1464 – for arthroscopic procedure of ankle joint

CM1472 – for repair of Achilles tendon

CM1474 – for gastrocnemius recession

CM1480 - for all open procedures on bones of lower leg, ankle, or foot, including amputation, not being a service to which another item in this subgroup applies.

CM1482 – for radical resection of bone involving lower leg, ankle or foot

CM1484 – for osteotomy or osteoplasty of tibia or fibula

CM1486 – for total ankle replacement

CM1490 – for lower leg cast application, removal or repair when undertaken in a hospital.

CM1500 - for all procedures on arteries of lower leg, including bypass graft, not being a service to which another item in this subgroup applies.

CM1502 – for embolectomy of the lower leg

CM1520 - for all procedures on veins of lower leg, not being a service to which another item in this subgroup applies.

CM1522 – for venous thrombectomy of the lower leg

CM1530 – for microsurgical reimplantation of lower leg, ankle or foot

CM1532 – for microsurgical reimplantation of toe

CM1535 – for microvascular free tissue flap surgery involving the lower leg

(See para T10.28 of explanatory notes to this Category)

SUBGROUP T10.13 - SHOULDER AND AXILLA

Initiation of management of anaesthesia:

CN1600 - for all procedures on the skin or subcutaneous tissue of the shoulder and axilla

CN1610 – for all procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla including axillary dissection

CN1620 – for all closed procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, or the shoulder joint when performed in an operating theatre of a hospital

CN1622 – for all arthroscopic procedures of the shoulder joint

CN1630 - for all open procedures on humeral and neck, sternoclavicular joint, acromioclavicular joint, or shoulder joint, not being a service to which another item in this subgroup applies.

CN1632 – for radical resection involving humeral head and neck, sternoclavicular joint, acromioclavicular joint, or shoulder joint

CN1634 – for shoulder disarticulation

CN1636 – for interscapulothoracic (forequarter) amputation

CN1638 – for total shoulder replacement

CN1650 - for all procedures on arteries of shoulder or axilla, not being a service to which another item in this subgroup applies.

CN1652 – for procedures for axillary–brachial aneurysm

CN1654 – for bypass graft of arteries of shoulder or axilla

CN1656 – for axillary–femoral bypass graft

CN1670 – for all procedures on veins of shoulder or axilla

CN1680 - for all shoulder cast application, removal or repair, not being a service to which another item in this subgroup applies, when undertaken in a hospital

CN1682 – for shoulder spica application when undertaken in a hospital

CN1685 – for microvascular free tissue flap surgery involving the shoulder or the axilla

(See para T10.28 of explanatory notes to this Category)

SUBGROUP T10.14 - UPPER ARM AND ELBOW

Initiation of management of anaesthesia

CQ1700 -for all procedures on the skin or subcutaneous tissue of the upper arm or elbow

CQ1710 - for all procedures on nerves, muscles, tendons, fascia or bursae of upper arm or elbow, not being a service to which another item in this subgroup applies

CQ1712 – for open tenotomy of the upper arm or elbow

CQ1714 – for tenoplasty of the upper arm or elbow

CQ1716 – for tenodesis, rupture of long tendon of biceps

CQ1730 – for all closed procedures on the upper arm or elbow when performed in an operating theatre of a hospital

CQ1732 – for arthroscopic procedures of elbow joint

CQ1740 - for open procedures on the upper arm or elbow not being a service to which another item in this subgroup applies.

CQ1756 – for radical procedures on the upper arm or elbow

CQ1760 – for total elbow replacement

CQ1770 - for all procedures on arteries of upper arm, not being a service to which another item in this subgroup applies.

CQ1772 – for embolectomy of the arteries of the upper arm.

CQ1780 - for all procedures on veins of upper arm, not being a service to which another item in this subgroup applies.

CQ1785 – for microvascular free tissue flap surgery involving the upper arm or elbow

(See para T10.28 of explanatory notes to this Category)

CQ1790 – for microsurgical reimplantation of upper arm

SUBGROUP T10.15 - FOREARM, WRIST AND HAND

Initiation of management of anaesthesia:

CR1800 - for all procedures on the skin or subcutaneous tissue of the forearm, wrist or hand

CR1810 – for all procedures on nerves, muscles, tendons, fascia or bursae of forearm, wrist or hand

CR1820 – for all closed procedures on radius, ulna, wrist or hand bones when performed in an operating theatre of a hospital

CR1830 Initiation of management of anaesthesia for all open procedures on radius, ulna, wrist or hand bones, not being a service to which another item in this subgroup applies.

CR1832 – for total wrist replacement

CR1834 – for arthroscopic procedures of the wrist joint

CR1840 - for all procedures on arteries of forearm, wrist or hand, not being a service to which another item in this subgroup applies.

CR1842 – for embolectomy of arteries of forearm, wrist or hand.

CR1850 -for all procedures on veins of forearm, wrist or hand, not being a service to which another item in this subgroup applies.

CR1860 – for forearm, wrist or hand cost application, removal, or repair when rendered to a patient as part of an episode of hospital treatment

CR1865 – for microvascular free tissue flap surgery involving the forearm, wrist or hand

(See para T10.28 of explanatory notes to this Category)

CR1870 – for microsurgical reimplantation of forearm, wrist or hand

CR1872 – for microsurgical reimplantation of finger

SUBGROUP T10.16 - ANAESTHESIA FOR BURNS

Initiation of management of anaesthesia:

CR1878 - for excision or debridement of burns, with or without skin grafting where the area of burn involves not more than 3% of total body surface

CR1879 – for excision or debridement of burns, with or without skin grafting where the area of burn involves more than 3% but less than 10% of total body surface

CR1880 – for excision or debridement of burns, with or without skin grafting where the area of burn involves more than 10% but less than 20% of total body surface

CR1881 – for excision or debridement of burns, with or without skin grafting where the area of burn involves more than 20% but less than 30% of total body surface

CR1882 – for excision or debridement of burns, with or without skin grafting where the area of burn involves more than 30% but less than 40% of total body surface

CR1883 – for excision or debridement of burns, with or without skin grafting where the area of burn involves more than 40% but less than 50% of total body surface

CR1884 – for excision or debridement of burns, with or without skin grafting where the area of burn involves more than 50% but less than 60% of total body surface

CR1885 – for excision or debridement of burns, with or without skin grafting where the area of burn involves more than 60% but less than 70% of total body surface

CR1886 – for excision or debridement of burns, with or without skin grafting where the area of burn involves more than 70% but less than 80% of total body surface

CR1887 – for excision or debridement of burns, with or without skin grafting where the area of burn involves more than 80% or more of total body surface

SUBGROUP T10.17 - ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES

Initiation of management of anaesthesia:

CS1900 - for injection procedure for hysterosalpingography

CS1906 – for injection procedure for myelography; lumbar or thoracic

CS1908 – for injection procedure for myelography; cervical

CS1910 – for injection procedure for myelography; posterior fossa

CS1912 – for injection procedure for discography: lumbar or thoracic

CS1914 – for injection procedure for discography: cervical

CS1915 – for peripheral arteriogram

CS1916 – for arteriograms; cerebral, carotid or vertebral

CS1918 – retrograde arteriograms, brachial or femoral

CS1922 – for computerised axial tomography scanning, magnetic resonance scanning, or digital subtraction angiography scanning

CS1925 – for retrograde cystography, retrograde urethrography or retrograde cystourethrography

CS1926 – for fluoroscopy

CS1930 – for bronchography

CS1935 – for phlebography

CS1936 – for heart, 2-dimensional real time transoesophageal examination
(see para T10.26 of explanatory notes to this Category)

CS1939 – for peripheral venous cannulation

CS1941 – for cardiac catheterisation including coronary arteriography ventriculography and cardiac mapping, insertion of automatic defibrillator or transvenous pacemaker

(see para T10.25 of explanatory notes to this Category)

CS1942 – for cardiac electrophysiological procedures including radio frequency ablation

CS1943 – for central venous cannulation or insertion of right heart balloon catheter (via jugular, subclavian or femoral vein) by percutaneous or open exposure.

CS1945 – for lumbar puncture, cisternal puncture, or epidural injection

CS1949 – for harvesting of bone marrow for the purpose of transplantation

CS1952 – for diagnostic muscle biopsy to assess for malignant hyperpyrexia

CS1955 – for electroencephalography

CS1959 – for brain stem evoked response audiometry.

CS1962 – for electrocochleography by extratympanic method or transtympanic membrane insertion method

CS1965 – as a therapeutic procedure if there is a clinical need for anaesthesia, not for a headache of any aetiology

CS1969 – during hyperbaric therapy, where the medical practitioner is not confined in the chamber (including the administration of oxygen)

CS1970 – during hyperbaric therapy, where the medical practitioner is confined in the chamber (including the administration of oxygen)

CS1973 – for brachytherapy using radioactive sealed sources

CS1976 – for therapeutic nuclear medicine

CS1980 – for radiotherapy

SUBGROUP T10.18 – MISCELLANEOUS

Initiation of management of anaesthesia:

CT1990 - when no procedure ensues

(see para T10.12 of explanatory notes to this Category)

CT1992 - performed on a person under the age of 10 years in connection with a procedure covered by an item, which has not been identified as attracting an anaesthetic

CT1997 - in connection with a procedure covered by an item that does not include the word "(Anaes)", other than a service to which item CT1992 or CS1965 applies **if there is a clinical need for anaesthesia**

(see para T10.13 of explanatory notes to this Category)

SUBGROUP T10.19 – THERAPEUTIC AND DIAGNOSTIC SERVICES

CV2002 Administration of homologous blood or bone marrow already collected, **when performed in association with the administration of anaesthesia**

(see para T10.8 of explanatory notes to this Category)

CV2007 endotracheal intubation with flexible fibreoptic scope associated with difficult airway, **when performed in association with the administration of anaesthesia**

CV2008 Double lumen endobronchial tube or bronchial blocker, insertion of, **when performed in association with the administration of anaesthesia**

CV2012 Central venous, pulmonary arterial, systemic arterial or cardiac intracavity, blood pressure monitoring by indwelling catheter – once a day for each type of pressure for a patient

(a) when performed in association with the management of anaesthesia for the patient, and
(b) Other than a service to which item 13876 applies
(c) Who is categorised as having a high risk of complication or develops during the current procedure either complications or a high risk of complications

(see para T10.8 of explanatory notes to this Category)

CV2014 Central venous, pulmonary arterial, systemic arterial or cardiac intracavity, blood pressure monitoring, by indwelling catheter – once a day for each for each type of pressure for a patient

(a) when performed in association with the management of anaesthesia for the patient, and
(b) relating to another discrete operation on the same day for the patient, and
(c) Other than a service to which item 13876 applies

(d) Who is categorised as having a high risk of complication or develops during the current procedure either complications or a high risk of complications

(see para T10.8 of explanatory notes to this Category)

CV2015 Right heart balloon catheter, insertion of, including pulmonary wedge pressure and cardiac output measurement, when performed in association with the administration of anaesthesia

(see para T10.8 of explanatory notes to this Category)

CV2020 Central vein catheterisation, by percutaneous or open exposure, not being a service to which item 13318 applies, when performed in association with the administration of anaesthesia

(See para TN.1.6, para T10.8 of explanatory notes to this Category)

CV2025 Intra-arterial cannulation, when performed in association with the management of anaesthesia in a patient who;
(a) Is categorised as having a high risk of complication or
(b) Develops a high risk of complication during the procedure

(see para T10.8 of explanatory notes to this Category)

CV2031 Intrathecal or Epidural injection (initial) of a therapeutic substance or substances, with or without insertion of a catheter**, in association with anaesthesia and surgery**, for post-operative pain management, not being a service associated with a service to which CV2036 applies.

(See para TN.10.17 of explanatory notes to this Category)

CV2036 Intrathecal or Epidural injection (subsequent) of a therapeutic substance or substances, using an in-situ catheter**, in association with anaesthesia and surgery**, for pain management, not being a service associated with a service to which CV2031 applies.

(See para TN.10.17 of explanatory notes to this Category)

CV2041 Perioperative introduction of a plexus or nerve block proximal to the lower leg or forearm for post-operative pain management

(See para TN.10.17 of explanatory notes to this Category)

CV2042 Introduction of a nerve block performed via a retrobulbar, peribulbar, or sun Tenon's approach, or other complex eye block, when administered by an anaesthetist perioperatively

(see para T10.8 of explanatory notes to this Category)

CV2051 Intra-operative transoesophogeal echocardiography – monitoring in real time of the structure and function of the heart chambers, valves and surrounding structures, including assessment of blood flow, with appropriate permanent recording during procedures on the heart, pericardium or great vessels of the chest (not in association with items 55130, 55135 or CS1936)

(see para T10.30 of explanatory notes to this Category)

CV2055 Perfusion of limb or organ using heart lung machine or equivalent, not being a service associated with anaesthesia to which an item in subgroup 21 applies

(see para T10.10 of explanatory notes to this Category)

CV2060 Whole body perfusion, cardiac bypass, using heart–lung machine or equivalent is continuously operated by a medical perfusionist, other than a service associated with anaesthesia to which an item in Subgroup 21 applies

(see para T10.10 of explanatory notes to this Category)

CV2065 Induced controlled hypothermia, total body, being a service to which item CV2060 applies, not being a service associated with anaesthesia to which an item in Subgroup 21 applies

(see para T10.10 of explanatory notes to this Category)

CV2075 Deep Hypothermic circulatory arrest, to a core temperature of less than 22 ‘C, including management of retrograde cerebral perfusion if performed. not being a service associated with anaesthesia to which an item in Subgroup 21 applies

(see para T10.10 of explanatory notes to this Category)

SUBGROUP T10.20 – ADMINISTRATION OF AN ANAESTHETIC IN CONNECTION WITH A DENTAL SERVICE

Initiation of management of anaesthesia:

CX2900 - by a medical practitioner, of anaesthesia for extraction of tooth or teeth with or without incision of soft tissue or removal of bone.

(see para T10.14 of explanatory notes to this Category)

CX2905 - restorative dental work.

(see para T10.14 of explanatory notes to this Category)

SUBGROUP T10.26 – ASSISTANCE AT ANAESTHESIA

CW5200 Assistance in the administration of anaesthesia on a patient in imminent danger of death requiring continuous lifesaving emergency treatment, to the exclusion of all patients

(see para T10.9 of explanatory notes to this Category)

CW5205 Assistance in the administration of elective anaesthesia where

i. the patient has complex airway problems; or
ii. the patient is a neonate or a complex paediatric case; or
iii. there is anticipated to be massive blood loss (greater than 50% of blood volume) during the procedure; or
iv. the patient is critically ill, with multiple organ failure; or
v. where the anaesthesia time exceeds 6 hours

and the assistance is provided to the exclusion of all other patients.

(see para T10.9 of explanatory notes to this Category)