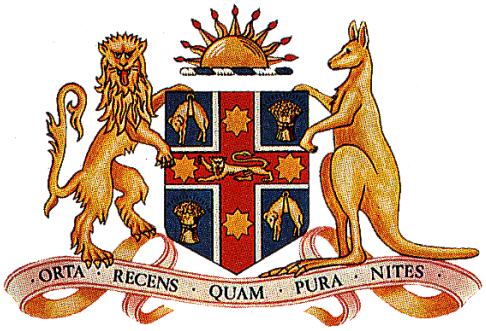

Government Gazette

of the State of

New South Wales

Number 606–Other
Friday, 26 November 2021

The New South Wales Government Gazette is the permanent public record of official NSW Government notices. It also contains local council, non-government and other notices.

Each notice in the Government Gazette has a unique reference number that appears in parentheses at the end of the notice and can be used as a reference for that notice (for example, (n2019-14)).

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To submit a notice for gazettal, see the Gazette page.

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By Authority
Government Printer

CO-OPERATIVES NATIONAL LAW (NSW)

Section 601AA(4) of the Corporations Act 2001 as applied by
section 453 of the Co-operatives National Law (NSW)

NOTICE OF PROPOSED DEREGISTRATION - Voluntary

CO-OPERATIVE DETAILS

Co-operative: Maroubra R.S.L. Memorial Bowling Club Co-operative Limited
Co-operative Number: NSWC00416

NOTICE

The Registrar has received an application to deregister the Co-operative under section 601AA of the *Corporations Act 2001* as applied by section 453 of the *Co-Operatives National* Law (NSW).

The Registrar may deregister the Co-operative when two months have passed since publication of this Notice in the NSW Government Gazette

Dated this 19th day of November 2021 at Bathurst.

Robyne Lunney
Manager, Regulatory Services, Registry & Accreditation
DELEGATE OF THE REGISTRAR OF CO-OPERATIVES

District Court Criminal Practice Note 26

Walama List Sentencing Procedure

Preamble

1. This Practice Note establishes an alternative procedure for managing cases involving eligible Aboriginal and Torres Strait Islander persons charged with criminal offences before the District Court of New South Wales, to be known as the "**Walama List**".

Commencement

2. This Practice Note commences at Sydney District Court on 31 January 2022.

Application

3. This Practice Note applies to matters committed for sentence or where a plea of guilty has been entered upon Arraignment after 1 December 2021.

Introduction

4. The aims of the Walama List are to:
   (a) reduce the risk factors related to re-offending by Aboriginal and Torres Strait Islander offenders;
   (b) reduce the rate of breaches of court orders by Aboriginal and Torres Strait Islander offenders;
   (c) increase compliance with court orders by Aboriginal and Torres Strait Islander offenders;
   (d) reduce the overrepresentation of Aboriginal and Torres Strait Islander persons in custody in NSW;
   (e) increase Aboriginal and Torres Strait Islander community participation and confidence in the criminal justice system; and
   (f) facilitate a better understanding of any underlying issues which may increase the likelihood of re-offending.

5. The Walama List will seek to achieve these aims by:
   (a) enabling Aboriginal and Torres Strait Islander community participation in the court process and embedding Aboriginal and Torres Strait Islander narratives in the sentencing process;
   (b) utilising culturally appropriate programs and supports to address needs and risk factors that may impact on an offender's continued involvement with the criminal justice system; and
   (c) facilitating continuous court monitoring of appropriate therapeutic interventions to address identified needs and risk factors.

Nomination of Walama List Judge(s)

6. The Chief Judge of the District Court will nominate at least one Judge as the "**Walama List Judge**".

Sittings of the Walama List

7. The Walama List will operate at Sydney District Court.

8. The Walama List Judge will hear all Walama List matters during one week per calendar month. All Walama List matters are to be listed in the same week during the relevant month.

Eligibility Criteria

9. To be referred to the Walama List, an offender must:
   (a) have pleaded guilty to the offence either before the Local Court or upon Arraignment in the District Court;
   (b) have signed an Agreed Statement of Facts;
   (c) be descended from an Aboriginal person or Torres Strait Islander person, identify as an Aboriginal person or Torres Strait Islander person, and be accepted as such by the relevant community; and
   (d) be willing to participate in the Walama List sentencing procedure.

10. An offender is not eligible for referral to the Walama List if he or she is charged with an offence set out in the Schedule to this Practice Note.

11. Only matters listed for sentence at District Court venues in the Greater Sydney Area (namely, Sydney District Court, Parramatta District Court, Campbelltown District Court and Penrith District Court) are eligible for referral to the Walama List.

12. Notwithstanding that an offender is otherwise assessed as suitable, the Court may decline to accept him or her into the Walama List.

Listing of Cases Referred to the Walama List

13. Where a matter has been committed for sentence to the District Court, and the offender meets the eligibility criteria, the legal representative for the offender is to make an **Application for Referral to the Walama List** on the date of First Mention in the District Court. Where an eligible offender has made an Application for Referral, the presiding Judge must adjourn the proceedings for mention to the Walama List, after consultation with the Walama List Judge to ascertain availability.

14. Where an offender has entered a plea of guilty after committal to the District Court and an Application for Referral is made by the offender, the presiding Judge must adjourn the proceedings for mention to the Walama List, after consultation with the Walama List Judge to ascertain availability.

15. In the ordinary course, and subject to available listings, the matters are to be listed for mention on the next available Walama List mention date using the Walama List Diary.

Stage 1: First Mention in the Walama List

16. The **first mention** in the Walama List is to be attended by a representative for the Prosecution, the legal representative(s) for the offender, the offender, a Senior Aboriginal Client and Community Support Officer ("**SACCSO**") from the Aboriginal Services Unit, DCJ Strategy, Policy and Commission Division, and the Walama List Judge.

17. At the first mention in the Walama List, case management orders will be made as follows:
    (a) the Prosecution is to serve and file the Crown bundle no later than 3 business days prior to the second mention date in the Walama List.

18. The matter will then be adjourned for a **second mention** during the next Walama List hearing week.

Stage 2: Completion of Intake Documentation

19. Between the first mention in the Walama List and the second mention in the Walama List, the **SACCSO** assisting the Walama List is to interview the offender and complete the "**initial intake documentation**".

Stage 3: Second Mention in the Walama List

20. At the second mention in the Walama List, the prosecution bundle will be formally tendered, and case management orders made as follows:
    (a) the Defence bundle, including any psychiatric or psychological material, is to be served and filed no later than 7 business days prior to the Sentencing Conversation.

21. The matter will then be adjourned for "**Sentencing Conversation**" during the next Walama List hearing week.

22. A release application may be made on either the first or second mention date subject to notice being given to the DPP and the Court.

Stage 4: The Sentencing Conversation

23. The **Sentencing Conversation** will be facilitated by the Walama List Judge, and is to be attended by:
    (a) the offender and the offender's legal representative(s);
    (b) the Prosecution;
    (c) an allocated Community Corrections Officer and/or caseworkers from other nominated government and non-government support services;

(d) two Aboriginal or Torres Strait Islander Elders or Respected Persons nominated by the Walama List Judge in consultation with the **SACCSO** where the Walama List Judge considers they are likely to be of significant assistance to him or her;
(e) a support person for the offender at the discretion of the Walama List Judge;
(f) the **SACCSO**; and
(g) any other person the Walama List Judge considers appropriate, including but not limited to any victim(s) and their support person.

24. The proceedings are to be open to the public unless a closed court is required by law.

25. The purpose of the **Sentencing Conversation** is to discuss:
(a) the nature of the offending behaviour;
(b) the implications of that offending behaviour on the victim(s), the offender's family and community;
(c) the offender's background;
(d) the offender's need for treatment and/or a rehabilitation program, and the availability of a suitable program/s;
(e) the offender's willingness to comply with a **Walama Case Plan**; and
(f) any other matter relevant to sentencing.

26. At the **Sentencing Conversation** the Walama List Judge may:
(a) impose conditions on the offender's bail requiring the offender to submit to assessments for a rehabilitation program as required;
(b) impose conditions on the offender's bail requiring the offender to commence participation in any rehabilitation program and/or submit to drug and/or alcohol testing;
(c) nominate support agencies and/or caseworkers to work with the offender as required;
(d) make orders for further reports and updated reports; and
(e) make any other orders necessary to facilitate the formulation of the **Walama Case Plan**, to be finalised at the next court date.

Stage 5: Preparation of draft Walama Case Plan

27. A "**Walama Case Plan**" will be formulated to meet the particular needs and risk factors relevant to the individual offender, and may include a combination of culturally appropriate rehabilitation programs; counselling, physical and mental health therapies; and/or other programs and support services as appropriate.

28. Between the **Sentencing Conversation** and the first **Case Plan Conversation**, the participant's case worker/Community Corrections Officer will facilitate the preparation of a draft **Walama Case Plan**. This may involve interviewing the offender and their legal representative, identifying any existing caseworkers and other supports (including treatment providers) that the offender wishes to continue to engage with, and obtaining contact details to notify existing service providers of the offender's next court date in the Walama List.

29. A case worker may be a NSW Community Corrections Officer or a caseworker from a community organisation.

Stage 6: Case Plan Conversation

30. At the first **Case Plan Conversation**, the draft **Walama Case Plan** will be discussed and finalised subject to any required modifications identified. **Case Plan Conversations** are to be conducted by the Walama List Judge with as little formality as possible, in the presence of:
    (a) the offender and the offender's legal representative(s);
    (b) the Prosecution;
    (c) an allocated Community Corrections Officer and/or caseworkers from other nominated government and non-government support services;
    (d) two Aboriginal or Torres Strait Islander Elders or Respected Persons nominated by the Walama List Judge in consultation with the **SACCSO** where the Walama List Judge considers they are likely to be of significant assistance to him or her;

(e) a support person for the offender at the discretion of the Walama List Judge;
(f) the **SACCSO**; and
(g) any other person the Walama List Judge considers appropriate, including but not limited to any victim(s) and their support person.

31. The Walama List Judge may successively adjourn the proceedings part-heard for a period of up to 12 months for the purpose of ongoing **Case Plan Conversations**.

32. The purpose of ongoing **Case Plan Conversations** is to:
(a) monitor the suitability and effectiveness of the offender's **Walama Case Plan**;
(b) monitor the offender's participation in the **Walama Case Plan** to ensure compliance; and
(c) determine whether the **Walama Case Plan** requires modification.

33. The frequency of the **Case Plan Conversations** will be determined by the Walama List Judge in consultation with the offender's legal representatives, the Prosecution, community Elders or Respected Persons and case worker(s)/supports with whom the offender is engaged.

34. Where an offender breaches a condition of their **Walama Case Plan**, the offender is to be called up before the Walama List Judge. Without limiting the penalties available at law, the Walama List Judge may:
(a) take no action on the breach;
(b) make changes to the offender's **Walama Case Plan**;
(c) discharge the offender from the Walama List sentencing procedure; or
(d) proceed to sentence the offender or adjourn the case for sentence to a later date.

35. Before an offender may be discharged from the Walama List sentencing procedure, the Walama List Judge is to convene for the purpose of a

further **Case Plan Conversation** in the presence of the community Elders or Respected Persons who attended the initial Sentencing Conversation.

36. If the offender informs the Walama List Judge that he or she wishes to cease participation in the Walama List sentencing procedure, the Walama List Judge may:
    (a) note on the court file that consent to participate in the Walama List sentencing procedure has been withdrawn;
    (b) adjourn the case for sentence; and
    (c) direct the preparation of a Sentencing Assessment Report if such a report has not previously been ordered.

Stage 7: Sentencing

37. Upon the offender's completion of the **Walama Case Plan**, the Walama List Judge is to sentence the offender in open court (unless a closed court is required by law) in the presence of:
    (a) the offender and the offender's legal representative(s);
    (b) the Prosecution;
    (c) an allocated Community Corrections Officer and/or caseworkers from other nominated government and non-government support agencies;
    (d) two Aboriginal or Torres Strait Islander Elders or Respected Persons nominated by the Walama List Judge in consultation with the **SACCSO** where the Walama List Judge considers they are likely to be of significant assistance to him or her;
    (e) a support person for the offender at the discretion of the Walama List Judge;
    (f) the **SACCSO**; and
    (g) any other person the Walama List Judge considers appropriate, including but not limited to any victim(s) and their support person.

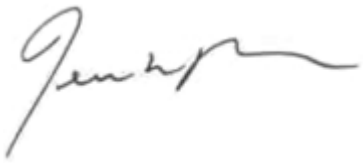
38. The sentencing options available to the Walama List Judge are those available at law.

Role of Elders and Respected Persons

39. In order to significantly assist the Walama List Judge in sentencing, the Walama List Judge may grant the applications of Aboriginal and Torres Strait Islander Elders and Respected Persons to act as *amici curiae* in Sentencing and **Case Plan Conversations**.

40. Aboriginal and Torres Strait Islander Elders and Respected Persons may:
    (a) provide cultural and community advice to the Walama List Judge;
    (b) assist the Walama List Judge to understand the offender's cultural heritage, history and norms;
    (c) offer support and advice to the Walama List Judge on how the offender could improve connections with his or her culture and community; and
    (d) assist the Walama List Judge to identify culturally significant issues and culturally appropriate programs or supports that might be included in the **Walama Case Plan**.

41. Elders and Respected Persons will not participate in the determination of the sentence to be imposed.



The Honourable Justice D M Price AO
Chief Judge of the District Court
22 November 2021

Schedule of offences not eligible for referral to the Walama List:

i) A prescribed sexual offence as defined by s 3 of the *Criminal Procedure Act 1986* (NSW);
ii) An offence contrary to s 33 of the *Crimes Act 1900* (NSW);
iii) An offence contrary to s 37 of the *Crimes Act 1900* (NSW);
iv) An offence contrary to ss 26, 27, 28, 29 and 30 of the *Crimes Act 1900* (NSW).

CHURCHES OF CHRIST IN NEW SOUTH WALES INCORPORATION ACT 1947

Declaration of Trusts Certificate No. 2021-01

IN accordance with section 29B of Part 5 of the abovementioned Act it is certified that:

1. the Church of Christ at Nowra has by special resolution of 26 July 2020 directed that The Churches of Christ Property Trust ("Property Trust") hold the real property known as 15 Crest Avenue, North Nowra described as Lot 172 in Deposited Plan 751258 (the, "Land") on trust for and for the benefit of Churches of Christ Community Care ABN 41 041 851 866 (also known as "Fresh Hope Care") subject to –

    - Fresh Hope Care by resolution agreeing to accept that the Land be held by the Property Trust on trust for and for the benefit of Fresh Hope Care; and
    - Conference Executive by resolution agreeing that the Land be held by the Property Trust on trust for and for the benefit of Fresh Hope Care;

2. Fresh Hope Care has by resolution of 19 August 2020 agreed to accept the Land and to request that Conference Executive agree to direct the Trust from 1 December 2020 to hold the Land on trust for and for the benefit of Fresh Hope Care; and

3. Conference Executive has by resolution of 26 November 2020 directed the Trust to hold the Land on trust for and for the benefit of Fresh Hope Care from 1 December 2020,

and, therefore, noting the:

- special resolution of Church of Christ at Nowra of 26 July 2020;
- resolution of Fresh Hope Care of 19 August 2020; and
- resolution of Conference Executive of 26 November 2020 directing the Trust,

the Trust resolved on 10 December 2020 to hold the real property known as 15 Crest Avenue, North Nowra and which is described as Lot 172 in Deposited Plan 751258 on trust for and for the benefit of Churches of Christ Community Care ABN 41 041 851 866 also known as Fresh Hope Care, from 1 December 2020.

Dated at Jannali this 22nd Day of March 2021

SHAMUS TOOMEY
Registrar

NSW SPORTING INJURIES

5th November 2021

SPORTING INJURIES INSURANCE ACT, 1978

Order of Declaration under Section 5

In pursuance of Section 5 of the Sporting Injuries Insurance Act, 1978, I declare by this order the

Corndale Cricket and Sport Inc

to be a sporting organisation, for the purposes of the provisions of the Act, in respect of the activity Cricket

Jason McLaughlin
General Manager
Workers Compensation Underwriting

Date: 5 November 2021

ASSOCIATIONS INCORPORATION ACT 2009

Cancellation of registration pursuant to section 80

TAKE NOTICE that **SADAQCARE AUSTRALIA INC - INC2000999** became registered under the Corporations Act 2001 as **SADAQCARE AUSTRALIA LTD - ACN 654 120 671** a company limited by guarantee, on 26 October 2021, and accordingly its registration under the Associations Incorporation Act 2009 is cancelled as of that date.

Terri McArthur
Delegate of the Commissioner,
NSW Fair Trading
23 November 2021

WORKERS COMPENSATION (MEDICAL PRACTITIONER FEES) ORDER 2021 No.2

under the

Workers Compensation Act 1987

I, Adam Dent, Chief Executive, State Insurance Regulatory Authority, make thefollowing Order pursuant to section 61(2) of the *Workers Compensation Act 1987*.

Dated this 22nd day of November 2021

Adam Dent
Chief Executive
State Insurance Regulatory Authority

Explanatory Note

Treatment by a Medical Practitioner is medical or related treatment covered under the *Workers Compensation Act 1987*. This Order sets the maximum fees for which an employer is liable under the Act for any medical or related treatment provided to a NSW worker. The fee for the treatment or service must not exceed the maximum fee for the treatment or service as specified in this Order. Workers are not liable for the cost of any medical or related treatment covered by this Order. The effect of this Order is to prevent a Medical Practitioner from recovering from the worker or employer any extra charge for treatments covered by this Order.

Under section 60(2A)(a) of the *Workers Compensation Act 1987,* medical or related treatment requires prior insurer approval unless treatment is provided within 48 hours of the injury happening or treatment is exempt from pre-approval under the *Workers Compensation Act 1987* or the State Insurance Regulatory Authority's *Workers Compensation Guidelines* in effect at the time.

This Order adopts the *List of Medical Services and Fees* issued by the Australian Medical Association (AMA), except where specified in this Order. To bill an AMA item, a Medical Practitioner must have fulfilled the service requirements as specified in the item descriptor. Medical Specialists must utilise AMA item numbers relevant to the type of consultation/service provided (e.g. a dually qualified Pain medicine specialist/anaesthetist cannot bill time based anaesthetic item numbers where pain medicine consultations/services apply; etc). Where a comprehensive item is used, separate items cannot be claimed for any of the individual items included in the comprehensive service.

The incorrect use of any item referred to in this Order can result in penalties, including the Medical Practitioner being required to repay monies that the Medical Practitioner has incorrectly received.

Consulting Surgeons should also refer to the *Workers Compensation (Surgeon Fees) Order* or, if an Orthopaedic Surgeon, the *Workers Compensation (Orthopaedic Surgeon Fees) Order .*

Workers Compensation (Medical Practitioner Fees) Order 2021 No.2

1. Name of Order

This Order is the *Workers Compensation (Medical Practitioner Fees) Order 2021 No.2.*

2. Commencement

This Order commences on 1 December 2021.

3. Definitions

In this Order:

the Act means the *Workers Compensation Act 1987.*

the Authority means the State Insurance Regulatory Authority as constituted under section 17 of the *State Insurance and Care Governance Act 2015*.

Aftercare visits are covered by the surgical procedure fee during the first six weeks following the date of surgery or until wound healing has occurred. Unrelated visits or incidental reasons for visits that are not regarded as routine aftercare must be explained with accounts rendered.

AMA List means the document entitled *List of Medical Services and Fees* as amended or replaced, from time to time, published by the Australian Medical Association, that is the current edition on the AMA website at the date of service delivery.

Assistance at Operation means assistance provided by a Medical Practitioner, but only where an assistant's fee is allowed for in the Commonwealth Medical Benefits Schedule (MBS). An assistant fee may only be applicable for surgical procedures EA015 – MY330 and MZ731 to MZ871.

Assistance at Operation is only payable once per eligible item number performed by the principal Surgeon/Medical Practitioner irrespective of the number of Medical Practitioners providing Assistance at Operation.

Note: *Assistance at Operation* fees are not payable to health practitioners who are not a Medical Practitioner e.g. perioperative nurses.

In accordance with NSW Health policy directive *Employment Arrangements for Medical Officers in the NSW Public Health Service* (**Doc No**: PD2019_027), Assistance at Operation fees cannot be charged for workers compensation cases performed in a public hospital when the assistant is a resident medical officer or registrar. If a resident medical officer or registrar is on rotation to an accredited private hospital, the relevant Assistance at Operation fee may be charged. Payment of these fees are to be directed into a hospital or departmental trust fund account and the invoice should include details of this account. The Authority reserves the

right to conduct an audit of Assistance at Operation fee payments to ensure their proper distribution into the named trust fund.

Case conference means a face-to-face meeting, video conference or teleconference with any or all of the following parties – worker (including a support person, if requested by the worker), employer, workplace rehabilitation provider, insurer or other treatment practitioner/s delivering services to the worker. Discussion must seek to clarify the worker's capacity for work, barriers to return to work and strategies to overcome these barriers via an open forum to ensure parties are aligned with respect to expectations and direction of the worker's recovery at work/return to suitable employment. If the discussion you have is with the worker and their chosen support person, it must include another third party to be considered a Case conference. Discussions between the worker's nominated treating doctor and other treating practitioners (e.g. allied health practitioners, medical specialists/surgeons) relating to treatment are considered a normal interaction between referring doctor and practitioner. This is not to be charged as a Case conference.

File notes of Case conferences are to be documented in the Medical Practitioner's records indicating the person/s spoken to, details of discussions, duration of the discussion and outcomes. This information may be required for invoicing purposes.

Consulting Surgeon means a Medical Practitioner who is recognised by the Medical Board of Australia or by Medicare Australia as a Specialist Surgeon or Specialist in orthopaedic surgery and who is registered with the Australian Health Practitioner Regulation Authority as a Specialist in surgery in their chosen field. It also includes a Surgeon or Orthopaedic Surgeon who is a staff member at a public hospital providing services at that public hospital. In accordance with section 60(2A)(d) of the Act, the employer will not be liable for the treatment provided if the treatment or service is provided by a Medical Practitioner who is suspended or disqualified from practice under any relevant law or the Medical Practitioner's registration is limited or subject to any condition imposed as a result of a disciplinary process.

General Practitioner is a Medical Practitioner and has the meaning given by subsection 3(1) of the *Health Insurance Act 1973 (Cth).* In accordance with section 60(2A)(d) of the Act, the employer will not be liable for the treatment provided if the treatment or service is provided by a Medical Practitioner who is suspended or disqualified from practice under any relevant law or the Medical Practitioner's registration is limited or subject to any condition imposed as a result of a disciplinary process.

GST means the Goods and Services Tax payable under the GST Law.

GST Law has the same meaning as in the *A New Tax System (Goods and Services Tax) Act 1999 (Cth).*

Insurer means the employer's workers compensation insurer.

Medical Practitioner means a person registered in the medical profession under the *Health Practitioner Regulation National Law (NSW) No.86a*, or equivalent in their jurisdiction with the Australian Health Practitioner Regulation Agency. In

accordance with section 60(2A)(d) of the Act, the employer will not be liable for the treatment provided if the treatment or service is provided by a Medical Practitioner who is suspended or disqualified from practice under any relevant law or the Medical Practitioner's registration is limited or subject to any condition imposed as a result of a disciplinary process.

Medical Specialist means a Medical Practitioner recognised as a specialist in accordance with the *Health Insurance Regulations 2018 (Cth)*, Part 2, Division 4, who is remunerated at specialist rates under Medicare. In accordance with section 60(2A)(d) of the Act, the employer will not be liable for the treatment provided if the treatment or service is provided by a Medical Practitioner who is suspended or disqualified from practice under any relevant law or the Medical Practitioner's registration is limited or subject to any condition imposed as a result of a disciplinary process.

Multiple operations or injuries refer to situations that require two or more operations or for the treatment of two or more injuries carried out at the same time. It applies to the AMA items EA015 to MY330 and MZ731 to MZ871, with the exception of items specifically listed as a multiple procedure item in the AMA List, or where Schedules in the *Workers Compensation (Orthopaedic Surgeon Fees) Order* or *Workers Compensation (Surgeon Fees) Order* prevent combining of items.

Out-of-hours services only apply in an emergency where the clinic is not normally open at that time, and urgent treatment is provided. This fee is not to be utilised in the situation where a consultation is conducted within the advertised hours of a clinic.

Telehealth means delivery of consultations via video or telephone by a Medical Practitioner. Consultations would be inclusive of any electronic communication to support the delivery of the consultation service. Medical Practitioners must consider the appropriateness of this mode of service delivery for each worker on a case-by-case basis and be satisfied worker outcomes are not compromised. Telehealth consultations must be consented to by the worker. Medical Practitioners are responsible for delivering Telehealth consultations in accordance with the principles of professional conduct and the relevant professional and practice guidelines to ensure that all care is taken to ensure the safety, appropriateness and effectiveness of the service. Telehealth consultations are to be paid in accordance with this Order (noting those items specifically excluded in Clause 7 of this Order). Medical Practitioners are to bill for Telehealth consultations using the same AMA List item number normally billed for a face to face consultation, with the addition of a 'T' as a suffix to the item number e.g. AA020T (Level B consultation delivered via telehealth) versus AA020 (Level B consultation delivered face to face). The fee payable remains the same. No additional fee (e.g. facility fees) can be charged in relation to the consultation.

Workers Compensation (Orthopaedic Surgeon Fees) Order means the *Workers Compensation (Orthopaedic Surgeon Fees) Order* in force on the date the service is provided.

Workers Compensation (Surgeon Fees) Order means the *Workers Compensation (Surgeon Fees) Order* in force on the date the service is provided.

Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order means the *Workplace Injury*

Management and Workers Compensation (Medical Examinations and Reports Fees) Order in force on the date the service is provided.

4. Application of Order

This Order applies to treatment provided on or after the commencement date of this Order, whether it relates to an injury received before, on, or after that date.

5. Maximum fees for Medical Practitioners

(1) This clause applies to medical and related treatment provided by a Medical Practitioner in respect of which a fee is specified in the AMA List, except:

- Medical services identified in the AMA List by AMA numbers AC500/AC500T, AC510/AC510T, AC520, AC530, AC600/AC600T and AC610/AC610T (Professional Attendances by a Specialist), if these medical services are provided by a Specialist Surgeon;
- Medical services identified in the AMA List by AMA Numbers EA015 to MZ871 (Surgical Operations) if these medical services are provided by a Specialist Surgeon;
- Medical services identified in the AMA List by AMA Number MZ900 (Assistance at Operation fee);
- Medical services identified in the AMA List by AMA numbers OP200 and OP210 (magnetic resonance imaging – MRI).

(2) The maximum amount payable for magnetic resonance imaging (MRI) is:

- OP200 - $700 for one region of the body or two contiguous regions of the body
- OP210 - $1050 for three or more contiguous regions of the body, or two or more entirely **separate** regions of the body (e.g. wrist and ankle).

(3) The maximum amount payable for a certificate of capacity is $48.40. This fee is payable only once per claim for completion of the initial certificate of capacity and is invoiced under payment classification code **WCO001**.

(4) A General Practitioner, Medical Specialist and Consulting Surgeon may be remunerated for time spent in addition to the usual medical management to assist a worker recover at/return to work. This time may include discussions with employers, Case conferences, visits to work sites, time spent reviewing injury management or recovery at/return to work plans and providing additional reports (where pre-approved by the insurer).

The time taken for these services must be billed under payment classification code **WCO002** (with the exception of some reports – see explanation below) and reflect the time taken (to the nearest 5 minutes) to deliver the service.

The following maximum hourly rates are payable:

- General Practitioner: $296.40 or $24.70 per 5 minutes
- Medical Specialist: $411.60 or $34.30 per 5 minutes
- Consulting Surgeon: $543.60 or $45.30 per 5 minutes.

Note: No fee is payable for liaising with other health providers involved in the treatment of the worker (e.g. Medical Specialists/Surgeons, allied health practitioners) unless the communication is additional to that required for the management of patients with comparable injuries/conditions that are not work related.

Where a report is requested regarding the management of a worker's injury and is additional to any report routinely provided as part of a specialist consultation (refer to clause 6 'Specialist consultations' below) it should be billed under **WCO002** at the above 5-minute pro-rata rates to reflect the time taken to prepare the report. These reports may answer questions to assist the insurer determine prognosis for recovery and timeframes for returning to work. The medical practitioner requires pre-approval from the insurer for provision of these reports.

If the report is requested as part of a current or potential dispute (for example, when there is lack of agreement regarding liability, causation, capacity for work or treatment between key parties) and the treating Medical Practitioner is requested to provide their opinion, the *Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order* applies.

(5) Where medical records are maintained electronically by a Medical Practitioner/practice a flat fee of $60 is payable (for provision of all requested medical records held by the medical practice) inclusive of postage and handling. A Medical Practitioner/practice should not provide or bill for hard copy medical records if they are maintained electronically.

Where medical records are not maintained electronically the maximum fee for providing hard copies of medical records is $38 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages. This fee is inclusive of postage and handling.

Provision of electronic or hard copy medical records is to be billed under State Insurance Regulatory Authority payment classification code **WCO005**.

Where a Medical Practitioner has been requested to provide medical records and the doctor needs to review the records prior to provision (to redact non-work-related injury information), the time taken to review the records is to be billed under **WCO002** at the pro-rata rates specified above at 5(4). This fee can be billed in addition to the fees stated above for provision of medical records by hard copy or electronically.

(6) Fees for Assistance at Operation are calculated at 20% of the principal Surgeon/Medical Practitioner's fee for the surgical procedure/s performed, but only those surgical procedure/s where an assistance fee is allowed for in the MBS, or $393.20, whichever is the greater. Assistance at Operation is only payable once per eligible item number performed by the principal Surgeon irrespective of the number of Medical Practitioners providing Assistance at Operation.

(7) Telehealth consultations are to be paid in accordance with this Order (noting those items specifically excluded in Clause 7 of this Order). Medical Practitioners are to bill for Telehealth consultations using the same AMA Fees List item number normally billed for a face-to-face consultation, with the addition of a 'T' as a suffix to the item number e.g. AA020T (Level B consultation delivered via telehealth) versus AA020 (Level B consultation

delivered face to face). The fee payable remains the same. No additional fee (e.g. facility fees) can be charged in relation to the consultation.

(8) Fees for Multiple operations or injuries are to be paid in accordance with the AMA List '*Multiple Operations Rule*' with the exception of:

- items specifically listed as a multiple procedure item in the AMA List or where Schedules in the *Workers Compensation (Surgeon Fees) Order* or the *Workers Compensation (Orthopaedic Surgeon Fees) Order* prevent combining of items.

- Medical Practitioners who meet the definition of Surgeon or Orthopaedic surgeon as defined in the *Workers Compensation (Surgeons Fees) Order* or *Workers Compensation (Orthopaedic Surgeons Fees) Order* are to be paid in accordance with the provisions specified in the *Workers Compensation (Surgeon Fees) Order* or, if an Orthopaedic Surgeon, the *Workers Compensation (Orthopaedic Surgeon Fees) Order*.

(9) Subject to subclauses (1), (2), (3), (4), (5), (6), (7), (8) and clause 7 (Nil fee for certain medical services) and clause 8 (Nil payment for cancellation or non-attendance) of this Order, the maximum amount for which an employer is liable under the Act for any claim for medical or related treatment is the fee listed, in respect of the medical or related treatment concerned, in the AMA List.

6. Specialist consultations

The initial Medical Specialist/Consulting Surgeon consultation fee includes the first consultation, the report to the referring Medical Practitioner and copy of the report to the insurer.

The report will contain:

- The worker's diagnosis and present condition;
- An outline of the mechanism of injury;
- The worker's capacity for work;
- The need for treatment or additional rehabilitation; and
- Medical co-morbidities that are likely to impact on the management of the worker's condition (subject to relevant privacy considerations).

A subsequent Medical Specialist/Consulting Surgeon consultation fee includes a consultation with a Medical Specialist/Consulting Surgeon subsequent to the first in a single course of treatment, the report from the subsequent consultation to the referring Medical Practitioner and copy of the report to the insurer.

A subsequent consultation fee is not to be billed if conducted on the same day as surgery or in the normal aftercare that applies following surgery. The cost of these consultations is included in the fee for the surgical procedure**.**

Consultations with Medical Specialists/Consultant Surgeons require prior approval by the insurer, unless exempt from pre-approval by the Act or the Authority's *Workers Compensation Guidelines.*

7. Nil fee for certain medical services

The AMA List includes items that are not relevant to medical services provided to

workers. As such, the fee set for the following items is nil:

- General Practitioner - Urgent attendances after hours item (Medical services identified in the AMA List by AMA number AA007)

- All time-based General Practitioner fees items (Medical services identified in the AMA List by AMA numbers AA190 – AA320)

- Enhanced primary care items (Medical services identified in the AMA List by AMA numbers AA501 – AA670, AA850)

- All shared health summary items (Medical services identified in the AMA List by AMA numbers AA340 – AA343)

- Telehealth items (Medical services identified in the AMA List by AMA numbers AA170 – AA210, AA584 – AA670, AF070 – AF180, AF260 – AF370, AJ051 – AJ200, AM210 – AM 240, AP040, and AP050 – AP105).

- Imaging/radiology – Professional attendance items billed in conjunction with imaging /radiology services where an interventional procedure/s has not been provided by the attending radiologist.

8. Nil payment for cancellation or non-attendance

No fee is payable for cancellation or non-attendance by a worker for treatment services with a Medical Practitioner/Medical Specialist/Consulting Surgeon.

9. No pre-payment of fees

Pre-payment of fees for reports and services is not permitted.

10. Goods and Services Tax

An amount fixed by this Order is exclusive of GST. An amount fixed by this Order may be increased by the amount of any GST payable in respect of the service to which the cost relates, and the cost so increased is taken to be the amount fixed by this Order. This clause does not permit a Medical Practitioner/Medical Specialist/Consulting Surgeon to charge or recover more than the amount of GST payable in respect of the service to which the cost relates.

11. Requirements for invoices

All invoices should be submitted to the insurer within 30 calendar days of the service provided and must comply with the Authority's itemised invoicing requirements for the invoice to be processed. Refer to the Doctors in workers compensation webpage on the SIRA website at www.sira.nsw.gov.au

WORKERS COMPENSATION
(ORTHOPAEDIC SURGEON FEES) ORDER 2021 No.2

under the

Workers Compensation Act 1987

I, Adam Dent, Chief Executive, State Insurance Regulatory Authority, make the following Order pursuant to section 61(2) of the *Workers Compensation Act 1987*.

Dated this 22nd day of November 2021

Adam Dent
Chief Executive
State Insurance Regulatory Authority

Explanatory Note

Treatment by a Medical Practitioner who is an Orthopaedic Surgeon is medical or related treatment covered under the *Workers Compensation Act 1987*. This Order sets the maximum fees for which an employer is liable under the Act for treatment by an Orthopaedic Surgeon provided to a NSW worker. It must not exceed the maximum fee for the treatment or service as specified in this Order. Workers are not liable for the cost of any medical or related treatment covered by this Order. The effect of this Order is to prevent an Orthopaedic Surgeon from recovering from the worker or employer any extra charge for treatments covered by this Order.

Under section 60(2A)(a) of the *Workers Compensation Act 1987,* medical or related treatment requires prior insurer approval unless treatment is provided within 48 hours of the injury happening or treatment is exempt from pre-approval under the *Workers Compensation Act 1987* or the State Insurance Regulatory Authority's *Workers Compensation Guidelines* in effect at the time.

Treatment by a Surgeon other than an Orthopaedic Surgeon is covered by the *Workers Compensation (Surgeon Fees) Order.* However, maximum fees under this Order may apply to procedures carried out by a Surgeon which are covered by the *Workers Compensation (Surgeon Fees) Order.*

Orthopaedic Surgeons should also refer to the *Workers Compensation (Medical Practitioner Fees) Order.*

This Order adopts the items listed as Orthopaedic Procedures in the *List of Medical Services and Fees* issued by the Australian Medical Association (AMA).

To bill an AMA item number an Orthopaedic Surgeon must have fulfilled the service requirements as specified in the item descriptor.

Where only one service is rendered, only one item should be billed. Where more than one service is rendered on one occasion of service, the appropriate item for each discrete service may be billed, provided that each item fully meets the item descriptor. Where an operation comprises a

combination of procedures which are commonly performed together, and for which there is an AMA item that specifically describes the combination of procedures, then only that item should be billed. Where a comprehensive item number is used, separate items must not be claimed for any of the individual items included in the comprehensive service. The invoice should cover the total episode of treatment.

The incorrect use of any items referred to in this Order can result in penalties, including the Medical Practitioner being required to repay monies that the Medical Practitioner has incorrectly received.

Workers Compensation (Orthopaedic Surgeon Fees) Order 2021 No.2

1. Name of Order

This Order is the *Workers Compensation (Orthopaedic Surgeon Fees) Order 2021* No.2.

2. Commencement

This Order commences on 1 December 2021.

3. Definitions

In this Order (including Schedules A, B, C and D):

the Act means the *Workers Compensation Act 1987*.

the Authority means the State Insurance Regulatory Authority as constituted under section 17 of the *State Insurance and Care Governance Act 2015.*

Aftercare visits are covered by the surgical procedure fee during the first six weeks following the date of surgery or until wound healing has occurred. Unrelated visits or incidental reasons for visits that are not regarded as routine aftercare must be explained with accounts rendered.

Assistance at Operation means a Medical Practitioner, but only where an assistant's fee is allowed for in the Commonwealth Medicare Benefits Schedule (MBS). An assistant fee may only be applicable for surgical procedures EA015 to MY330 and MZ731 to MZ871. Assistance at Operation is only payable once per item number performed by the principal Orthopaedic Surgeon irrespective of the number of Medical Practitioners providing Assistance at Operation. Assistance at Operation fees are to be billed by the Medical Practitioner who provides the assistance (not the Surgeon), using the AMA item code MZ900.

Note: Assistance at Operation fees are not payable to health practitioners who are not a Medical Practitioner eg. perioperative nurses.

In accordance with NSW Health policy directive *Employment Arrangements for Medical Officers in the NSW Public Health Service* (**Doc No:** PD2019_027), Assistance at Operation fees cannot be charged for workers compensation cases performed in a public hospital when the assistant is a resident medical officer or registrar. If a resident medical officer or registrar is on rotation to an accredited private hospital, the relevant Assistant at Operation fee may be charged. Payment of these fees are to be directed into a hospital or departmental trust fund account and the invoice should include details of this account. The

Authority reserves the right to conduct an audit of Assistance at Operation fee payments to ensure their proper distribution into the named trust fund.

AMA List means the document entitled *List of Medical Services and Fees* as amended or replaced, from time to time published by the Australian Medical Association, that is the current edition on the AMA website at the date of service delivery.

Compound (open) wound refers to a situation where an Orthopaedic Surgeon is treating a fracture and the injury is associated with a compound (open) wound. In an open fracture wound that requires debridement, a 50% loading for open fracture fixation can be applied. Debridement item EA075/30023 is not to be billed when applying this loading.

Extended initial consultation means a consultation involving significant multiple trauma or complex "red flag" spinal conditions (systemic pathology, carcinoma, infection, fracture or nerve impingement) involving a lengthy consultation and extensive physical examination.

GST means the Goods and Services Tax payable under the GST Law.

GST Law has the same meaning as in the *A New Tax System (Goods and Services Tax) Act 1999* of the Commonwealth.

Initial consultation and report covers the first consultation, the report to the referring Medical Practitioner and the copy of the report to the insurer.

The report will contain:

- the worker's diagnosis and present condition;
- an outline of the mechanism of injury;
- the worker's capacity for work;
- the need for treatment or additional rehabilitation; and
- medical co-morbidities that are likely to impact on the management of the worker's condition (in accordance with privacy considerations).

The receipt of this report and any certificates of capacity under section 44B of the Act post-treatment will provide sufficient information for insurers, employers and workplace rehabilitation providers to develop recovery at/return to work plans.

Instrument fee covers procedures where the Orthopaedic Surgeon supplies all the equipment or a substantial number of specialised instruments in exceptional circumstances and must be justified. This fee does not apply for all operations or if only incidental instruments (non-critical) are supplied by the Orthopaedic Surgeon. Routine items such as loupes are not included.

Insurer means the employer's workers compensation insurer

Medical Practitioner means a person registered in the medical profession under the *Health Practitioner Regulation National Law (NSW) No 86a,* or equivalent in their jurisdiction with the Australian Health Practitioner Regulation Agency. In accordance with section 60(2A)(d) of the Act, the employer will not be liable for the treatment provided if the treatment or service is provided by a Medical Practitioner who is suspended or disqualified from practice under any relevant law or the Medical Practitioner's registration is limited or subject to any condition imposed as a result of a disciplinary process.

Multiple operations or injuries refer to situations that require two or more operations or for the treatment of two or more injuries carried out at the same time. It applies to the AMA items EA015 to MY330 and MZ731 to MZ871, with the exception of items specifically listed as a multiple procedure item in the AMA List, or where Schedules in this Order prevent combining of items. The fee for the main procedure or injury is to be paid in full as per Schedule A (1.5 x AMA List fee), and for each additional item or injury at 1.125 x AMA List Fee specified in Schedule A.

Opinion on file request includes retrieval of a file from whatever source, reading time, and reporting where a request for such an opinion has been made in writing to the Orthopaedic Surgeon and in accordance with privacy principles.

Orthopaedic procedures are those listed in the AMA List but do not include the cost of bandages, dressings, plaster of Paris bandages, splints, metallic fixation agents, and prosthetic implants which may be charged in addition to the fee set out in Schedules in this Order, if purchased by the Orthopaedic Surgeon. The fee for Orthopaedic procedures includes pre-surgery consultations conducted on the same day of surgery and aftercare visits.

Orthopaedic Surgeon means a Medical Practitioner who is recognised by the Medical Board of Australia or by Medicare Australia as a Specialist in orthopaedic surgery and who is registered with the Australian Health Practitioner Regulation Agency as a Specialist in surgery, in the field of orthopaedic surgery. It includes an Orthopaedic Surgeon who is a staff member at a public hospital providing services at the hospital.

Out-of-hours consultation means a call-out to a public or private hospital or a private home for an urgent case before 8.00am or after 6:00pm Monday to Friday, or anytime on the weekend and public holidays. This fee is not to be utilised where a consultation is conducted for non-urgent cases.

Out-of-hours loading only applies when an Orthopaedic Surgeon is called back to perform a procedure(s) in isolation, rather than for cases scheduled before 8.00am or after 6.00pm on a weekday or a routine weekend operating list. Loading to be calculated at 20% of the total procedure fee. Item must be reflected in the invoice as a separate entry against code WCO008.

Revision surgery refers to a procedure carried out to correct earlier surgery. Only where the revision surgery is performed by an Orthopaedic Surgeon other than the original Orthopaedic Surgeon, shall it attract a fee of 50% of the amount for the principal procedure in the initial surgery, in addition to the fee payable for the new procedure. Where the new procedure is specified as a revision procedure in the AMA List, the 50% loading does not apply.

Spinal surgical rules and conditions provided in the Medicare Benefits Schedule at the time the service was provided apply to spinal surgical items MZ731 (MBS 51011) to MZ871 (MBS 51171).

Subsequent consultation and report is each attendance subsequent to the first in a single course of treatment. A subsequent consultation fee is not to be billed if conducted on the same day as surgery or in the normal aftercare that applies following surgery. The cost of these consultations is included in the fee for the Orthopaedic procedure**.**

The subsequent Orthopaedic Surgeon consultation fee includes a subsequent consultation, a report from the subsequent consultation to the referring General Practitioner and copy of the report to the insurer. Providing copies of these reports does not attract a fee.

Telehealth means delivery of consultations via video or telephone by an Orthopaedic Surgeon. Consultations would be inclusive of any electronic communication to support the delivery of the service. Orthopaedic Surgeons must consider the appropriateness of this mode of service delivery for each worker on a case-by-case basis and be satisfied worker outcomes are not compromised. Telehealth consultations must be consented to by the worker. Orthopaedic Surgeons are responsible for delivering Telehealth consultations in accordance with the principles of professional conduct and the relevant professional and practice guidelines to ensure the safety, appropriateness and effectiveness of the service. Telehealth consultations are to be paid in accordance with this Order (noting those items specifically excluded in Clause 7 of the *Workers Compensation (Medical Practitioner Fees) Order)*. Orthopaedic Surgeons are to bill for Telehealth consultations using thesame AMA Fees List item number normally billed for a face-to-face consultation, with the addition of a 'T' as a suffix to the item number e.g. AC510T (Subsequent consultation and report delivered via telehealth) versus AC510 (Subsequent consultation and report delivered face to face). The fee payable remains the same. No additional fee (e.g. facility fees) can be charged in relation to the consultation.

Workers Compensation (Medical Practitioner Fees) Order means the *Workers Compensation (Medical Practitioner Fees) Order* in force on the date the service is provided.

Workers Compensation (Surgeon Fees) Order means the *Workers Compensation (Surgeon Fees) Order* in force on the date the service is provided.

Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order means the *Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order* in force on the date the service is provided.

4. Application of Order

This Order applies to treatment provided on or after the commencement date of this Order, whether it relates to an injury received before, on, or after that date.

5. Maximum fees for treatment by Orthopaedic Surgeon

The maximum fee amount for which an employer is liable under the Act for treatment of a worker by an Orthopaedic Surgeon, being treatment of a type specified in Column 1 of Schedule A to this Order, is the corresponding amount specified in Column 3 of that Schedule.

A fee charged by an Orthopaedic Surgeon for a patient's treatment (including the management of fractures and other conditions) will be in addition to the fee in Schedule A for the initial consultation and report.

6. Billing items for hand surgery (Schedule B)

Schedule B provides mandatory guidelines for billing items used in hand and wrist surgery only.

Table 1 details items that are not billable for hand surgery procedures.

Table 2 details items with restricted application for hand surgery and where clinical justification is required that they are reasonably necessary given the circumstances of the case.

7. Billing items for shoulder and elbow surgery (Schedule C)

Schedule C provides mandatory guidelines for billing items used in shoulder and elbow surgery only.

Any item number where the term "flag" is used in the Clinical Indication column highlights a potential exception that will require further justification. Should an Orthopaedic Surgeon seek an exception to the guidelines, the Orthopaedic Surgeon must provide a written explanation to support the request.

8. Billing items for general upper limb surgery (Schedule D)

Schedule D provides mandatory guidelines for billing items used in general upper limb surgery.

Any item number where the term "flag" is used in the Clinical Indication column highlights a potential exception that will require further justification. Should an Orthopaedic Surgeon seek an exception to the guidelines, the Orthopaedic Surgeon must provide a written explanation to support the request.

9. GST

An amount fixed by this Order is exclusive of GST. An amount fixed by this Order may be increased by the amount of any GST payable in respect of the service to which the cost relates, and the cost so increased is taken to be the amount fixed by this Order. This clause does not permit a Medical Practitioner or an Orthopaedic Surgeon to charge or recover more than the amount of GST payable in respect of the service to which the cost relates.

10. Requirements for invoices

All invoices should be submitted to the insurer within 30 calendar days of the service provided and must comply with the Authority's itemised invoicing requirements for the invoice to be processed. Refer to the Doctors in workers compensation webpage on the SIRA website at www.sira.nsw.gov.au.

All invoices with surgical items must also be accompanied by the following:

(1) Detailed operation report including a description of the initial injury and an outline of the mechanism of injury, time surgery commenced and finished, intra-operative findings and the procedures performed, including structures that were repaired (stating the anatomic location) and technique of repair.

(2) Usage of any of the restricted item numbers (Schedule B, Table 2, Schedule C and Schedule D) must be accompanied by clinical justification in order to process the claim.

Note: A Medical Practitioner who provides Assistance at Operation is to invoice for their services separately to the principal Orthopaedic Surgeon/Medical Practitioner.

11. Surgery requests

For any proposed surgery – a list of proposed applicable AMA item numbers will need to be provided prior to approval being given.

Where questions arise in individual clinical situations, supply of additional information may be required to assist in determinations.

12. No pre-payment of fees

Pre-payment of fees for reports and services is not permitted.

13. Nil payment for cancellation or non-attendance

No fee is payable for cancellation or non-attendance by a worker for treatment services with an Orthopaedic Surgeon.

SCHEDULE A
MAXIMUM FEES FOR ORTHOPAEDIC SURGEONS

Item	Column 1 Type of service	Column 2 AMA Item(s)	Column 3 Maximum amount
Consultations			
1.	Initial consultation and report (AC500T to be utilised when consultation delivered via telehealth)	AC500/AC500T (MBS 104)	$340.40
2.	Extended initial consultation and report	WCO006	$468.90
3.	Subsequent consultation and report (AC510T to be utilised when consultation delivered via telehealth)	AC510/AC510T (MBS 105)	$234.50
4.	Out-of-hours consultation	WCO007	$196.70 in addition to consultation fee.
Procedures			
5.	Orthopaedic procedure(s)	ML005 (MBS 46300) to MY330 (MBS 50239) and MZ731 (MBS 50950) to MZ871 (MBS 51171)	1.5 x AMA List Fee for the primary item number. (For any additional item numbers refer to item 8 of this Schedule).
6.	Instrument fee	WCO003	$234.50
7.	Assistance at Operation (*Assistance at Operation* fees are only payable to Medical Practitioners, not other health practitioners eg. perioperative nurses). Assistance at Operation fees are to be billed by the MedicalPractitioner who provides the assistance (not the Surgeon). Note: Assistance at Operation is only payable once per eligible item number performed by the principal Orthopaedic Surgeon irrespective ofthe number of Medical Practitioners providing Assistance at Operation.	MZ900	A fee of 20% of the Orthopaedic Surgeon's fee for surgical procedure/s performed, but only those surgical procedure/s where an assistant is allowed for in the MBS, or $393.20, whichever is the greater.

Item	Column 1 Type of service	Column 2 AMA Item(s)	Column 3 Maximum amount
8.	Multiple operations or injuries		Primary item number to be paid in full (1.5 x AMA List Fee) and additional AMA item number(s) at 1.125 x AMA List Fee.
9.	Aftercare visits (As defined in this Order)		As per AMA List.
10.	Compound (open) wound		In an open fracture wound that requires debridement, a 50% loading for open fracture fixation can be applied. Debridement item EA075/30023 is not to be billed when applying this loading.
11.	Out of hours loading	WCO008	20% of total procedure fee.
Insurer/lawyer requests			
12.	Opinion on file request	WCO009	$234.50
13.	Telephone requests including Case conferences (refer to the definition within the *Workers Compensation (Medical Practitioner Fees) Order)* or where there is a request to provide medical records and the Medical Practitioner needs to reviewthe records prior to provision (to redact non-work-related injury information)	WCO002	$45.30 per 5 minutes.
14.	Lost reports and reprints		$158.90 per report.
15.	Consulting Orthopaedic Surgeon reports (where additional information that is not related to the routine injury management of the patient is requested by either party to a potential or current dispute) Note: The party requesting a report must agree on the category of report with the Medical Practitioner in advance and confirm the request in writing at the time of referral.	Relevant IMS/WIS code	Please refer to the *Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order,* Schedule 2.

16.	Fees for providing copies of clinical notes and records	WCO005	Where medical records are maintained electronically by a Medical Practitioner/practice a flat fee of $60 is payable (for provision of all requested medical records held by the medical practice) inclusive of postage and handling. A Medical Practitioner/practice should not provide or bill for hard copy medical records if they are maintained electronically. Where medical records are not maintained electronically the maximum fee for providing hard copies of medical records (including Consulting Orthopaedic Surgeon's notes and reports) is $38 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages. This fee is inclusive of postage and handling. Where a Medical Practitioner has been requested to provide medicalrecords and the doctor needs to review the records prior to provision (to redact non-work-related injury information), the timetaken to review the records is to be billed under **WCO002** at the rate specified at item 13, Schedule A. This fee can be billed in addition tothe fees stated above for provisionof medical records by hard copy or electronically.

SCHEDULE B
BILLING ITEMS USED IN HAND SURGERY

Table 1: Item numbers and descriptors not applicable to hand surgery procedures

AMA/MBS item number	Descriptor	Reason for decline
CV233/18266 CV082/Nil	INJECTION OF AN ANAESTHETIC AGENT, ulnar, radial or median nerve of main trunk, one or more of, not being associated with a brachial plexus block MINOR NERVE BLOCK (specify type) to provide post-operative pain relief (this does not include subcutaneous infiltration)	The MBS does not allow a claim for nerve blocks performed as a method of postoperative analgesia. Infiltration is included in both the anaesthetic schedule AND in the surgical item number fee if performed by the Surgeon. This item can only be billed in circumstances where a formal nerve block is performed by the Surgeon as the only form of anaesthesia and no charge is raised for another anaesthetic service.
MG540/45051	CONTOUR RECONSTRUCTION for open repair of contour defects, due to deformity, requiring insertion of a non-biological implant, if it can be demonstrated that contour reconstructive surgery is indicated because the deformity is secondary to congenital absence of tissue or has arisen from trauma (other than trauma from previous cosmetic surgery), excluding the following: (a) insertion of a non-biological implant that is a component of another service listed in Surgical Operations; (b) injection of liquid or semisolid material; and (c) services to insert mesh	This relates to the insertion of foreign implant for pathological deformity by an open operation i.e. facial reconstruction and was not intended for usage in hand surgery.
MH480/45445	FREE GRAFTING (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of and removal of mould)	The appropriate item is MH490/45448.
MR170/47954	Repair of traumatic tear or rupture of tendon, other than a service associated with: (a) a service to which item LN810 applies; or (b) a service to which another item in the List applies if the service described in the other item is for the purpose of repairing peripheral nerve items in the same region	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MS005/48400	Osteotomy of phalanx or metatarsal of foot, for correction of deformity, excision of accessory bone or sesamoid bone, including any of the following (if performed):	This item is from the orthopaedic group of items and relates to foot surgery only. There already exist appropriate items in the hand surgery section.

AMA/MBS item number	Descriptor	Reason for decline
	(a) removal of bone (b) excision of surrounding osteophytes (c) synovectomy (d) joint release - one bone	
MS015/48403	Osteotomy of phalanx or metatarsal, osteotomy or osteectomy of first toe of foot, for correction of deformity, with internal fixation, including any of the following (if performed): (a) removal of bone; (b) excision of surrounding osteophytes; (c) synovectomy; (d) joint release; - one bone	This item is from the orthopaedic group of items and relates to foot surgery only. There already exist appropriate items in the hand surgery section.
OF812/60500, OF816/60503, OF820/60506, OF824/60509 and OF952/61109	FLUOROSCOPY	Fluoroscopy items (OF812 – OF824 and OF952) can only be billed by a medical practitioner who, at the date they deliver the service, holds a relevant Radiation User Licence. Note: These items are not billable by more than one provider per occasion of service and only billable by the provider who delivers the service.

Table 2: Item numbers with restricted application for hand surgery – clinical justification required

AMA/MBS item number	Descriptor	Clinical indication
AC510/30105 Note: If consultation is undertaken via telehealth, code AC510T applies	Each attendance SUBSEQUENT to the first in a single course of treatment	Follow up consultations will not be paid within the 6-week period following a procedure as this is included in normal aftercare.

AMA/MBS item number	Descriptor	Clinical indication
EA075/30023	WOUND OF SOFT TISSUE, traumatic, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Assist.)	The repair of wound must be undertaken by suture, tissue adhesive resin (such as methyl methacrylate) or clips. These items are not to be billed for the closure of surgical wound, as such closure is part of a surgical procedure and not additional. Item EA075/30023 covers debridement of traumatic, "deep or extensively contaminated" wound. Benefits are not billable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures. Debridements are also not billable when removing percutaneous wire fixation. This item can be billed for deep chronic wounds or in combination with open fractures requiring debridement. This item is not to be billed in combination with EA215/30068. Limit of one debridement per episode of care or per limb. This item cannot be billed when a surgeon applies the 50% loading for open fracture fixation. Flag if this procedure is requested more than once per episode of care or per limb.
EA095/30029	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7CM IN LENGTH), involving deeper tissue, not being a service to which another item in Group 3.4 applies.	This item is for use in wound suture when no other vital tissue is involved. It cannot be billed in conjunction with item EA075/30023 for the same wound/zone of injury, nor when repair of a performed and deeper structure is also claimed for.
EA755/30223	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS OR SIMILAR LESION, requiring admission to hospital or day-hospital facility, INCISION WITH DRAINAGE OF (excluding aftercare)	This item cannot be billed in conjunction with item EA075/30023 for the same wound/zone of injury.
EA825/30238	FASCIA, DEEP, repair of, FOR HERNIATED MUSCLE	This item is rarely indicated and cannot be billed in conjunction with items EA075/30023 MR240/47975, MR250/47978, MR260/47981.
ET560/33815	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture	This item is applicable for repair of radial, ulnar or brachial arteries proximal to wrist crease.

AMA/MBS item number	Descriptor	Clinical indication
ET570/33818	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis	This item is applicable for repair of radial, ulnar or brachial arteries proximal to wrist crease.
LN740/39312	NEUROLYSIS, internal (interfascicular) neurolysis of, using microsurgical techniques, other than a service associated with a service to which EA075 applies.	This item is never indicated in acute trauma. It is rarely indicated in elective surgery and is reserved for use in revision nerve decompression surgery. This item is not to be billed in conjunction with item MU400 or MU410: Wrist carpal tunnel release (division of transverse carpal ligament), unless for a revision procedure. Not billable with EA075 or LN810.
LN750/39315	NERVE TRUNK, nerve graft to, (cable graft) by cable graft, using microsurgical techniques, including any of the following (if performed): (a) harvesting of nerve graft using microsurgical graft; (b) proximal and distal anastomosis of nerve graft; (c) transposition of nerve to facilitate grafting; (d) neurolysis; other than a service associated with a service to which item EA075 or LN810 applies	This item can only be billed once per named nerve trunk, regardless of the number and distal distribution of individual cables. This item cannot be billed in conjunction with EA075, LN790, LN800, LN804, LN806 or LN810.
LN760/39318	Nerve, digital or cutaneous, nerve graft to, using microsurgical techniques, including either or both of the following (if performed): (a) harvesting of nerve graft from separate donor site; (b) proximal and distal anastomosis of nerve graft. - other than a service associated with a service to which item LN810 applies	This item cannot be billed in conjunction with items LN790, LN800, LN804, LN806 or LN810. This item cannot be billed for prosthetic neural tubes or wraps. In this setting, items LN700 or LN710 are applicable.
LN790/39324	NEURECTOMY or removal of tumour or neuroma from superficial peripheral nerve	This item cannot be billed in conjunction with item LN810.
LN800/39327	NEURECTOMY, NEUROTOMY or removal of tumour from deep peripheral nerve, by open operation	This item cannot be billed in conjunction with item LN810.
LN810/39330	NEUROLYSIS by open operation without transposition, not being a service associated with a service to which items EA075, LN740, LN770, LN804, LN806, LN826, LN829, LN832, LN835, MU402, MX474 or MX475 applies	This item is not for the identification of nerves during surgical exposure. It is not to be billed in combination with item LN700. This item cannot be billed in combination with EA075, LN740, LN770, LN804, LN806, LN826, LN829, LN832, LN835, MU402, MX474 or MX475 This item is not to be billed in conjunction with item MU400 or MU410.However, items LN810 and MU400 can be billed together for combined carpal tunnel release and cubital tunnel release surgery. This item is not to be billed in conjunction with

AMA/MBS item number	Descriptor	Clinical indication
		item ML235 tendon sheath of hand/wrist open operation for stenosing tenovaginitis.
MH115/45203	SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, complicated or large, and excluding flap for male pattern baldness and excluding H-flap or double advancement flap, not in association with any of items EN036 to EN084	This item is rarely indicated in the hand and wrist as a large defect will not be readily amenable to a local flap reconstruction. It is not to be billed for suturing of traumatic skin flaps.
MH125/45206	SINGLE STAGE LOCAL FLAP where indicated to repair 1 defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excluding H-flap or double advancement flap, not in association with any of items EN036 to EN084	This item can only be billed once for a z-plasty.
MJ025/45500	MICROVASCULAR REPAIR using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit	This item relates to microvascular repair of an artery or vein. This item cannot be billed for repair of dorsal veins with volar skin intact, branches of digital arteries, branches of radial/ulnar vessels and venae comitantes of major arteries. Microvascular repairs distal to the metacarpophalangeal joint will also require clinical documentation of appropriate surgical technique utilising an operating microscope.
MJ030/45501 MJ035/45502	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of limb or digit/ MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for reimplantation of limb or digit	These items specifically relate to replantation of limb and digit. i.e., the amputated portion must be completely detached.
MJ045/45503	MICRO-ARTERIAL or MICRO-VENOUS graft using microsurgical techniques	This item includes the remuneration for harvesting the graft and performing any microvascular anastomoses to the graft.
MJ075/45515	SCAR, other than on face or neck, NOT MORE THAN 7 CMS IN LENGTH, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or approved day hospital facility, or where performed by a Specialist in the practice of his or her specialty	This item cannot be billed in conjunction with other items e.g., nerve repair, tendon repair, flap repair (i.e., intended to be an independent procedure).
MJ245/45563	NEUROVASCULAR ISLAND FLAP, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness	This item is for a true island flap, elevated on a neurovascular pedicle for an existing traumatic defect. This item is not to be billed for VY advancement flaps where item MH125/45206 is applicable.

AMA/MBS item number	Descriptor	Clinical indication
ML105/46325	Excisional arthroplasty of CARPOMETACARPAL JOINT OF THUMB, with excision of adjacent trapezoid, including either or both of the following (if performed): (a) ligament and tendon transfers (b) realignment procedures	This item is primarily intended for use in reconstruction for basal thumb arthritis. It is not approved for excision of the pisiform.
ML125/46330	Ligamentous or capsular repair or reconstruction of INTERPHALANGEAL OR METACARPOPHALANGEAL JOINT OF HAND, including any of the following (if performed): (a) arthrotomy (b) joint stabilisation (c) synovectomy; - one joint	This item is only billable for repair of named ligaments where preoperative or intraoperative findings document significant joint instability.
ML135/46333	Ligamentous or capsular repair or reconstruction of INTERPHALANGEAL OR METACARPOPHALANGEAL JOINT OF HAND with graft, using graft or implant, including any of the following (if performed): (a) arthrotomy (b) harvest of graft (c) joint stabilisation (d) synovectomy, other than a service associated with a service to which item MR645, MR650, MR655, MR660 or MR665 apply - one joint	Cannot be billed with MR645, MR650, MR655, MR660 or MR665. This item is only billable for repair of named ligaments using free grafts or alloplast where preoperative or intraoperative findings document significant joint instability. This item cannot be billed for reattachment of ligament using a bone anchor. Item ML125/46330 is the approved number.
ML145/46336	Synovectomy of INTERPHALANGEAL, METACARPOPHALANGEAL OR CARPOMETACARPAL JOINT OF HAND, including any of the following (if performed): (a) capsulectomy (b) debridement (c) ligament or tendon realignment (or both), other than a service combined with a service to which item ML705 applies—one joint	This item cannot be billed in conjunction with any other item or procedure related to the joint. This item cannot be billed in conjunction with item EA075/30023 or ML705.
ML155/46339	Synovectomy of digital flexor tendons at wrist level, for diagnosed inflammatory arthritis, including either or both of the following (if performed):	Rare in a workers' compensation setting. Not for use for De Quervain's (refer to ML247/46367). Note: If performing a complete flexor tenosynovectomy, a release of the Carpal Tunnel

AMA/MBS item number	Descriptor	Clinical indication
	(a) tenolysis (b) release of median nerve and carpal tunnel, other than a service associated with a service to which item EA075, LN810 or MU400 applies—applicable only once per occasion on which the service is performed	is part of the operation and therefore MU400 or MU410 should not be billed. If this item is requested in conjunction with MU400 or MU410 (Wrist carpal tunnel release) or ML237/46367 (De Quervain's), clinical documentation of gross synovitis is required, preferably with histological confirmation. Flag if this procedure is requested two or more times.
ML185/46348 – ML225/46360	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules (b) tenolysis (c) tenoplasty, other than a service associated with a service to which item EA075 or ML235 applies.	ML185/46348 – 1 digit ML195/46351 – 2 digits ML205/46354 – 3 digits ML215/46357 – 4 digits ML225/46360 – 5 digits Not in combination with EA075, ML235 orML155/46339.
ML235/46363	Trigger finger release, for stenosing tenosynovitis, including either or both of the following (if performed): (a) synovectomy (b) synovial biopsy - one ray	This item is not to be billed in combination with LN810/39330. Item used for Trigger Finger Release.
ML247/46367	De Quervain's release, including any of the following (if performed): (a) synovectomy of extensor pollicis brevis (b) synovectomy of abductor pollicis longus tendons (c) retinaculum reconstruction, other than a service associated with a service to which item ML155 applies	Not to be billed with ML155. De Quervain's tenosynovitis - can only be billed once per side (ie. includes both APL and EPB tendons).
ML260/46370 – ML340/46395	Dupuytren's contracture, fasciectomy	Flag if this procedure is requested for an acute injury or trauma.
ML405/46414	Insertion of artificial tendon prosthesis in preparation for grafting of tendon of hand or wrist, including tenolysis (if performed), other than a service associated with a service to which item EA075 applies	Tenolysis items ML535/ 46450 and ML545/46453) or EA075 cannot be billed with this item.
ML425/46420	Primary repair of EXTENSOR TENDON OF HAND OR WRIST—one tendon	Item ML425 is for an acutely injured tendon as a primary procedure. This item should not be billed for repair of extensor tendon split as part of an access to phalangeal fractures/osteotomies.
ML445/46426	Primary repair of FLEXOR TENDON OF HAND OR WRIST, proximal to A1 pulley, other than a service to repair a tendon of a digit if 2 tendons of the same digit have been repaired during the same procedure - one tendon	Not to be billed more than once to repair FDS tendon in a digit. This item can only be billed a maximum of twice per digit.

AMA/MBS item number	Descriptor	Clinical indication
ML465/46432	Primary repair of FLEXOR TENDON OF HAND OR WRIST, distal to A1 pulley, other than a service to repair a tendon of a digit if 2 tendons of the same digit have been repaired during the same procedure - one tendon	This item is only to be billed for acute injuries. This item can only be billed a maximum of twice per digit.
ML535/46450	Tenolysis of EXTENSOR TENDON OF HAND OR WRIST, following tendon injury or graft, other than a service: (a) for acute, traumatic injury; or (b) associated with a service to which item EA075 applies —one ray	This item is applicable for freeing tendons from scar following previous surgery or trauma. It is not indicated in an acute hand injury. Item ML535 cannot be billed in conjunction with release of trigger finger or for release of De Quervians' (see ML235/46363 and ML247/46367). Item ML535 cannot be billed with EA075.
ML545/46453	Tenolysis of FLEXOR TENDON OF HAND OR WRIST, following tendon injury, repair or graft, other than a service: (a) for acute, traumatic injury; or (b) associated with a service to which item EA075 applies	This item is applicable for freeing tendons from scar following previous surgery or trauma. It is not indicated in an acute hand injury. Item ML545 cannot be billed in conjunction with release of trigger finger or for release of De Quervain's (see ML235/46363 and ML247/46367). Item ML545 cannot be billed with EA075.
ML705/46495	Complete excision of one or more ganglia or mucous cysts of INTERPHALANGEAL, METACARPOPHALANGEAL OR CARPOMETACARPAL JOINT OF HAND, including any of the following (if performed): (a) arthrotomy (b) osteophyte resections (c) synovectomy, other than a service associated with a service to which item EA355 or ML145 applies—one joint	Not being a service associated with a service to which item EA355/30107 or ML145/46336 applies.
ML715/46498	Excision of GANGLION OF FLEXOR TENDON SHEATH OF HAND, including any of the following (if performed): (a) flexor tenosynovectomy (b) sheath excision (c) skin closure by any method, other than a service associated with a service to which item EA355 or ML235 applies	Not being a service associated with a service to which item EA355/30107 or ML235/46363 applies.
ML725/46500	Excision of GANGLION OF DORSAL WRIST JOINT OF HAND, including any of the following (if performed): (a) arthrotomy (b) capsular or ligament repair (or both) (c) synovectomy,	This item is not to be billed in combination with EA355/30107.

AMA/MBS item number	Descriptor	Clinical indication
	other than a service associated with a service to which item EA355 applies	
ML735/46501	Excision of GANGLION OF VOLAR WRIST JOINT OF HAND, including any of the following (if performed): (a) arthrotomy (b) capsular or ligament repair (or both) (c) synovectomy, other than a service associated with a service to which item EA355 or ML105 applies	This item is not to be billed in combination with EA355/30107 or ML105/46325.
ML745/46502	Excision of RECURRENT GANGLION OF DORSAL WRIST JOINT OF HAND, including any of the following (if performed): (a) arthrotomy (b) capsular or ligament repair (or both) (c) synovectomy	This item is not to be billed in combination with EA355/30107.
ML755/46503	Excision of RECURRENT GANGLION OF VOLAR WRIST JOINT OF HAND, including any of the following (if performed): (a) arthrotomy (b) capsular or ligament repair (or both) (c) synovectomy, other than a service associated with a service to which item EA355 applies	This item is not to be billed in combination with EA355/30107.
ML765/46504	NEUROVASCULAR ISLAND FLAP, heterodigital, for pulp re-innervation and soft tissue cover	These items are only to be billed for a heterodigital neurovascular island flap used to resurface pulp loss (e.g. Littler flap, first dorsal metacarpal artery or Kite flap). There is a limit of one flap per digit. Flag if this procedure is requested two or more times.
ML795/46513	Removal of nail of finger or thumb—one nail	This item should not be billed in association with nailbed repair (items ML665/46486 or ML675/46489).
ML825/46522	Open operation and drainage of infection for FLEXOR TENDON SHEATH OF FINGER OR THUMB, including either or both of the following (if performed): (a) synovectomy (b) tenolysis, other than a service associated with a service to which item EA075 applies -	This item is applicable only for drainage of suppurative flexor tenosynovitis. It does not apply to washout of flexor sheath in acute injury. ML825 cannot be billed in combination with EA075.

AMA/MBS item number	Descriptor	Clinical indication
	one digit	
MR090/47921	ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure	This item cannot be billed when the k-wire has been used as part of fracture fixation. Can be billed for the insertion of a temporary pin in association with a ligament/tendon repair.
MR110/47927	Removal of one or more buried wires, pins or screws (inserted for internal fixation purposes) - one bone	This item applies for removal of *buried* k-wire. Where a k-wire or wires cross more than 2 bones, only 1 item number is billable.
MS025/48406	Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, for correction of deformity, including any of the following (if performed): (a) removal of bone (b) excision of surrounding osteophytes (c) synovectomy (d) joint release - one bone	This item is not appropriate for simple removal of bone prominence, osteophytes or small quantities of excess bone.
MU400 and MU410	Carpal tunnel release (division of transverse carpal ligament), by any approach (MU400) or endoscopic (MU410) approach	These are the appropriate item numbers for a primary carpal tunnel release. These items cannot be billed together. Either of these items cannot be used in combination with ML155/46339 or EA075/30023. Ultrasound costs are not billable in conjunction with these surgical procedures. Nerve Conduction Studies (NCS) are preferable prior to surgical consideration, other than in acute cases.
MU460/49209	Prosthetic replacement of WRIST or distal radioulnar joint, including either or both of the following (if performed): (a) ligament realignment (b) tendon realignment	Flag if this procedure is requested.
MU462/49210	Revision of total replacement arthroplasty of WRIST or distal radioulnar joint, including any of the following (if performed): (a) ligament rebalancing (b) removal of prosthesis (c) tendon rebalancing	Flag if this procedure is requested.
MU470/49212	Arthrotomy of WRIST or distal radioulnar joint, for infection, including any of the following (if performed): (a) joint debridement	This item is not to be billed in conjunction with excision of primary or recurrent wrist ganglia (items ML725/46500, ML735/46501, ML745/46502 and ML755/46503).

AMA/MBS item number	Descriptor	Clinical indication
	(b) removal of loose bodies (c) synovectomy	
MU480/49215	Reconstruction of single or multiple ligaments or capsules of WRIST, by open procedure, including any of the following (if performed): (a) arthrotomy (b) ligament harvesting and grafting (c) synovectomy (d) tendon harvesting and grafting (e) insertion of synthetic ligament substitute	Including repair of single or multiple ligaments or capsules, including associated arthrotomy.
MU490/49218	WRIST, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy)—other than a service associated with another arthroscopic procedure of the wrist joint	Not being a service associated with any other arthroscopic procedure of the wrist joint.
MU500/49221	Treatment of WRIST, by arthroscopic means, including any of the following (if performed): (a) drilling of defect (b) removal of loose bodies (c) release of adhesions (d) synovectomy (e) debridement (f) resection of dorsal or volar ganglia, other than a service associated with a service to which another item in the List applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint	Not being a service associated with any other arthroscopic procedure of the wrist joint.
MU510/49224	Osteoplasty of WRIST, by arthroscopic means, including either or both of the following (if performed): (a) excision of the distal ulna (b) total synovectomy, other than a service associated with a service to which another item in the List applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint—2 or more distinct areas	Not being a service associated with any other arthroscopic procedure of the wrist.
MU520/49227	Treatment of WRIST by one of the following: (a) pinning of osteochondral fragment, by arthroscopic means (b) stabilisation procedure for	Not being a service associated with any other arthroscopic procedure of the wrist joint.

AMA/MBS item number	Descriptor	Clinical indication
	ligamentous disruption (c) partial wrist fusion or carpectomy, by arthroscopic means (d) fracture management, other than a service associated with a service to which another item in the List applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint	

SCHEDULE C

BILLING ITEMS USED IN SHOULDER AND ELBOW SURGERY

This Order adopts the *WorkCover Queensland Upper Limb Surgery Guidelines (July 2021)* with minor modifications. Relevant items from the *WorkCover Queensland Upper Limb Surgery* Guidelines are provided within Schedule C and their use is mandatory when billing for shoulder and elbow surgery.

AMA/MBS item number	Descriptor	Clinical indication
BONE GRAFTS		
MS025/48406	Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, for correction of deformity, including any of the following (if performed): (a) removal of bone (b) excision of surrounding osteophytes (c) synovectomy (d) joint release - one bone	Not to be billed in combination with item MT770/48951. **Flag if this item is used in combination with any other shoulder items (MT600/48900 to MT800/48960).**
MS035/48409	Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, for correction of deformity, with internal fixation, including any of the following (if performed): (a) removal of bone (b) excision of surrounding osteophytes (c) synovectomy (d) joint release, - one bone	Not to be billed in combination with item MT770/48951. **Flag if this item is billed in combination with any other shoulder items (MT600/48900 to MT800/48960).**
MS045/48412	Osteotomy of humerus, without internal fixation	Can be billed with item MR020/47903 (tennis elbow release) if a lateral or medial epicondylectomy is performed. Can be billed with LN810/39330 if ulna nerve neuritis or compression has been diagnosed requiring formal surgical decompression.
SHOULDERS		
MT600/48900	SHOULDER, excision or coraco-acromial ligament or removal of calcium deposit from cuff or both	Open operation not arthroscopic. Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed twice or more.**
MT610/48903	SHOULDER, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any other combination	Open operation, also known as open acromioplasty or subacromial decompression (SAD).

AMA/MBS item number	Descriptor	Clinical indication
MT620/48906	SHOULDER, repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff, or both - other than a service associated with a service to which Item MT600 applies	Known as open cuff repair without acromioplasty. Not to be billed in combination with item MT600/48900. If MS025 is performed it cannot be billed with item MT770. Can be billed in combination with arthroscopic code MT770/48951 Note: If MT620/48906 is performed arthroscopically it cannot be billed with item MT770/48951.
MT630/48909	SHOULDER, repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination, other than a service associated with a service to which item MT610 applies	Known as open rotator cuff repair with acromioplasty with excision of AC joint. Not being a service to which item MT610/48903 applies. **Not to be billed with item MX670/49851.** Not to be billed with MT770/48951 or in combination with MT610/48903. This item is not to be billed with services associated with any other **arthroscopic** procedure of the shoulder region.
MT650/48915	SHOULDER, Hemi-arthroplasty	Use of this item rarely seen in State Insurance Regulatory Authority claims. Maybe appropriate for shoulder trauma/fractures only.
MT660/48918	Anatomic or reverse total shoulder replacement, including any of the following (if performed): (a) associated rotator cuff repair (b) biceps tenodesis (c) tuberosity osteotomy other than a service associated with a service to which another item in the List applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by open or arthroscopic means	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT670/48921	SHOULDER, total replacement arthroplasty, revision of	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT680/48924	Revision of total shoulder replacement, including either or both of the following (if performed): (a) bone graft to humerus (b) bone graft to scapula	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT690/48927	Shoulder prosthesis, removal of	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT730/48939	SHOULDER, arthrodesis of, with synovectomy if performed	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed once or more.**
MT740/48942	Arthrodesis of shoulder, with bone grafting or internal fixation, including either or both of the following (if performed): (a) removal of prosthesis (b) synovectomy	Not to be billed with a service to which item MR645, MR650, MR655, MR660 or MR665 applies Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed once or more.**

AMA/MBS item number	Descriptor	Clinical indication
	other than a service associated with a service to which item MR645, MR650, MR655, MR660 or MR665 applies	
MT750/48945	SHOULDER, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region	Not to be billed with any **arthroscopic** procedure of the shoulder region. May be billed with open surgery i.e. items MT630/48909, MT620/48906.
MT760/48948	SHOULDER, arthroscopic surgery of, involving any 1 or more of: removal of loose bodies; decompression of calcium deposit; debridement of labrum, synovium or rotator cuff; or chondroplasty - not being a service associated with any other arthroscopic procedure of the shoulder region	Not to be billed with any other **arthroscopic** procedure of the shoulder region. Preparatory for an open procedure. Appropriate with items MT620/48906 and MT630/48909.
MT770/48951	SHOULDER, arthroscopic division of coraco-acromial ligament including acromioplasty - not being a service associated with any other arthroscopic procedure of the shoulder region	Not to be billed with any other **arthroscopic** procedure of the shoulder region. Not to be billed in combination with items EA365/30111 or MT780/48954. Can be billed in combination with MT620/48906 if MT620 is performed as an open rotator cuff repair procedure.
MT780/48954	Synovectomy of shoulder, performed as an independent procedure, including release of contracture (if performed), other than a service associated with a service to which another item in the List applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by arthroscopic means	Known as frozen shoulder release; stand-alone item code. Not to be billed with any other **arthroscopic** procedure of the shoulder region. Not to be billed in combination with item MT770/48951. **Flag if this item is billed with any other item for shoulder surgery.**
MT798/48958	Joint stabilisation procedure for multi-directional instability of shoulder, anterior or posterior repair, by open or arthroscopic means, including labral repair or attachment (if performed), excluding bone grafting and removal of hardware. Other than a service associated with a service to which another item in this List applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by arthroscopic means.	If item is requested for recurrent dislocations, it is highly recommended to look at worker history to determine if surgery is to treat the aggravation or a pre-existing condition. Not to be used with any other arthroscopic procedure of the shoulder region.
MT800/48960	SHOULDER, reconstruction or repair of, including repair of rotator cuff by	Not to be billed with any other procedure of the shoulder region.

AMA/MBS item number	Descriptor	Clinical indication
	arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by separate approach when performed - not being a service associated with any other procedure of the shoulder region	Not to be billed with item **EA365/30111, MT770/48951 or MT798/48958.** **Flag if practitioner requesting a Superior Capsular Reconstruction (SCR) procedure.**
ELBOW		
LN770/39321	Transposition of NERVE, excluding the ulnar nerve at the elbow, other than a service associated with a service to which item LN810 applies	Not appropriate for use in epicondylitis surgery – refer to item LN810/39330 (this item applies to transposition of ulna nerve anterior to medial epicondyle to submuscular or subcutaneous site). Not to be combined with MS045/48412 or LN810/39330 or LN730.
MU035/49100	ELBOW, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture	Not to be billed for tennis elbow surgery.
MU055/49106	ELBOW, arthrodesis of, with synovectomy if performed	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed.**
MU065/49109	Elbow, total synovectomy of	Known as **common contracture release**. Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if billed.**
MU075/49112	Radial head replacement of elbow, other than a service associated with a service to which item MU085 applies	Seen with fractures, dislocations and acute trauma. Not to be billed in combination with item MU065/49109 or MU085**.** **Flag if billed.**
MU085/49115	Total or hemi humeral arthroplasty of elbow, excluding isolated radial head replacement and ligament stabilisation procedures, other than a service associated with a service to which item MU075 applies	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if billed.**
MU086/49116	ELBOW, total replacement arthroplasty of, revision procedure, including removal of prosthesis	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if billed.**
MU087/49117	Revision of total replacement arthroplasty of elbow, including bone grafting and removal of prosthesis	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if billed.**
MU095/49118	ELBOW, diagnostic arthroscopy of, including biopsy and lavage, not being a service associated with any other arthroscopic procedure of the elbow	Not to be billed with any other **arthroscopic** procedure of the elbow region. Appropriate for use with open elbow surgery.
MU105/49121	Surgery of the elbow, by	Not to be billed with any other **arthroscopic** procedure of the elbow.

AMA/MBS item number	Descriptor	Clinical indication
	arthroscopic means, including any of the following (if performed): (a) chondroplasty (b) drilling of defect (c) osteoplasty (d) removal of loose bodies (e) release of contracture or adhesions (f) treatment of epicondylitis, other than a service associated with a service to which another item in the List applies if the service described in the other item is for the purpose of an arthroscopic procedure of the elbow	
OTHER		
EA365/30111	Bursa (large) including olecranon, calcaneum or patella, excision of	**Flag if used in combination with any shoulder surgery.** Not to be billed in combination with item MT800/48960 or MU108/49124.
LN810/39330	Neurolysis by open operation without transposition, other than a service associated with a service to which Item EA075, LN770, LN804, LN806, LN826, LN829, LN832, LN835, MU402, MX474 or MX475 applies	Not being a service associated with a service to which item LN740/39312 EA075, LN770, LN804, LN806, LN826, LN829, LN832, LN835, MU402, MX474 or MX475 applies. Can be billed in combination with elbow surgery (eg: MS045/48412 if performing an ulna nerve release with medial epicondylectomy or MR020/47903 lateral or medial epicondylitis debridement). Not to be billed in combination with item MT760/48948. **Flag if billed in combination with any item codes for shoulder surgery or in acute trauma.**
OTHER JOINTS		
MY055/50112	CICATRICIAL FLEXION or EXTENSION CONTRACTION of JOINT, correction of, involving tissues deeper than skin and subcutaneous tissue, not being a service to which another item in this Group 9 Surgical Operations applies	Not being a service to which another item in group 9 Surgical Operations applies. Not to be billed with any other **arthroscopic** procedure of the shoulder region. Not to be billed in combination with item MT780/48954. **Flag if billed in combination with any item code for elbow and shoulder surgery.** Implies a release for stiffness after injury or surgery. May occur with other numbers in relation to a large release of a stiff elbow. Three to five item numbers should be in association with an operation that took two to three hours and is usually a revision situation or after serious trauma. The complexity should be reflected in the history of injury, number of prior operations, duration of surgery, complexity of the operation.
MY065/50115	Manipulation of one or more joints, excluding spine, other t	Code used for adhesive capsulitis (frozen shoulder) manipulation under anaesthetic (MAU).

AMA/MBS item number	Descriptor	Clinical indication
	associated with a service to which another item in group 9 Surgical Operations applies.	Not to be billed for an 'examination' of a joint under general anaesthetic prior to an operation, where the general anaesthetic is for the operation itself. Not being a service associated with a service to which another item in Group 9, Surgical operations applies. **Flag if this item is used two or more times.**
GENERAL		
MR020/47903	Epicondylitis, open operation for	This is the only item number appropriate for Tennis or Golfers Elbow Debridement (Lateral or Medial Epicondylitis). Can be combined with MS045/48412 where a formal excision of the epicondyle is justified, not just for debridement of epicondyle. Can also be combined with LN810/39330 if ulna nerve neuritis or compression has been diagnosed which requires formal surgical decompression. **Flag if billed in combination with any other item numbers.**
MR110/47927	Removal of one or more buried wires, pins, or screws (inserted for internal fixation purposes) - one bone	This item applies for removal of one or more buried k-wire per bone. Where fixation crosses two or more bones, only one item number is claimable. Cannot be billed in combination with MR100/47924
MR170/47954	Repair of traumatic tear or rupture of tendon, other than a service associated with: (a) a service to which item LN810 applies; or (b) a service to which another item in the List applies if the service described in the other item is for the purpose of repairing peripheral nerve items in the same region	Cannot be billed in combination with LN810 or a service to which another item in the List applies if the service described in the other item is for the purpose of repairing peripheral nerve items in the same region. **Flag if billed with any other item code.**

SCHEDULE D

ADDITIONAL ITEMS USED IN UPPER LIMB SURGERY

This Order adopts the *WorkCover Queensland Upper Limb Surgery Guidelines (July 2021) with minor modifications*. The relevant items from the *WorkCover Queensland Upper Limb Surgery Guidelines*are provided in Schedule D and their use is mandatory when billing for upper limb surgery.

AMA/MBS item number	Descriptor	Clinical indication
EA075/30023 – EA155 / 30049	Repair of Wounds	These items are not to be billed for the closure of surgical wound, as such closure is part of a surgical procedure and not additional. The repair of wound referred to in these items must be undertaken by suture, tissue adhesive resin (such as methyl methacrylate) or clips. The term 'superficial' means affecting skin and subcutaneous tissue including fat and the term 'deeper tissue' means all tissues deep to but not including subcutaneous tissue such as fascia and muscle.
EA355/30107	GANGLION OR SMALL BURSA, excision of, other than a service associated with a service to which an item in this Group applies	Not being a service associated with a service to which another item in this Group applies.
MS055/48415	Humerus, osteotomy, with internal fixation	Not to be billed with item LN810/47903 (tennis elbow release) unless a lateral epicondylectomy is performed. Flag if this item is requested, particularly if requested for tennis elbow surgery.

ASSOCIATIONS INCORPORATION ACT 2009

Cancellation of registration pursuant to section 80

TAKE NOTICE that **AUSTRALASIAN INSTITUTE OF MARINE SURVEYORS INC - Y0257339** became registered under the Corporations Act 2001 as **AUSTRALASIAN INSTITUTE OF MARINE SURVEYORS LTD - ACN 615 920 397** a company limited by guarantee, on 19 August 2021, and accordingly its registration under the Associations Incorporation Act 2009 is cancelled as of that date.

Terri McArthur
Delegate of the Commissioner,
NSW Fair Trading
23 November 2021

WORKERS COMPENSATION
(SURGEON FEES) ORDER 2021 No.2

under the

Workers Compensation Act 1987

I, Adam Dent, Chief Executive, State Insurance Regulatory Authority, make the following Order pursuant to section 61(2) of the *Workers Compensation Act 1987*.

Dated this 22nd day of November 2021

Adam Dent
Chief Executive
State Insurance Regulatory Authority

Explanatory Note

Treatment by a Medical Practitioner who is a Surgeon is medical or related treatment covered under the *Workers Compensation Act 1987*. This Order sets the maximum fees for which an employer is liable under the Act for treatment by a Surgeon provided to a NSW worker. It must not exceed the maximum fee for the treatment or service as specified in this Order. Workers are not liable for the cost of any medical or related treatment covered by this Order. The effect of this Order is to prevent a Surgeon from recovering from the worker or employer any extra charge for treatments covered by this Order.

Under section 60(2A)(a) of the *Workers Compensation Act 1987,* medical or related treatment requires prior insurer approval unless treatment is provided within 48 hours of the injury happening or treatment is exempt from pre-approval under the *Workers Compensation Act 1987* or the State Insurance Regulatory Authority's *Workers Compensation Guidelines* in effect at the time.

Treatment by an Orthopaedic Surgeon is covered by the *Workers Compensation (Orthopaedic Surgeon Fees) Order.* However, maximum fees under this Order may apply to procedures carried out by an Orthopaedic Surgeon which are covered by the *Workers Compensation (Surgeon Fees) Order.*

Surgeons should also refer to the *Workers Compensation (Medical Practitioner Fees) Order.*

This Order adopts the items listed as Surgical Procedures in the *List of Medical Services and Fees* issued by the Australian Medical Association (AMA).

To bill an AMA item number a Surgeon must have fulfilled the service requirements as specified in the item descriptor.

Where only one service is rendered, only one item should be billed. Where more than one service is rendered on one occasion of service, the appropriate item for each discrete service may be billed, provided that each item fully meets the item descriptor. Where an operation comprises a combination of procedures, which are commonly performed together, and for which there is an

AMA item that specifically describes the combination of procedures, then only that item should be billed. Where a comprehensive item number is used, separate items must not be claimed for any of the individual items included in the comprehensive service. The invoice should cover the total episode of treatment.

The incorrect use of any items referred to in this Order can result in penalties, including the Medical Practitioner being required to repay monies that the Medical Practitioner has incorrectly received.

Workers Compensation (Surgeon Fees) Order 2021 No.2

1. Name of Order

This Order is the *Workers Compensation (Surgeon Fees) Order 2021* No.2.

2. Commencement

This Order commences on 1 December 2021.

3. Definitions

In this Order (including Schedules A, B, C and D):

the Act means the *Workers Compensation Act 1987*.

the Authority **means** the State Insurance Regulatory Authority as constituted under section 17 of the *State Insurance and Care Governance Act 2015.*

Aftercare visits are covered by the surgical procedure fee during the first six weeks following the date of surgery or until wound healing has occurred. Unrelated visits or incidental reasons for visits that are not regarded as routine aftercare must be explained with accounts rendered.

Assistance at Operation means a Medical Practitioner, but only where an assistant's fee is allowed for in the Commonwealth Medicare Benefits Schedule (MBS). An assistant fee may only be applicable for surgical procedures EA015 to MY330 and MZ731 to MZ871. Assistance at Operation is only payable once per item number performed by the principal Surgeon irrespective of the number of Medical Practitioners providing Assistance at Operation. Assistance at Operation fees are to be billed by the Medical Practitioner who provides the assistance (not the Surgeon), using the AMA item code MZ900.

Note: *Assistance at Operation* fees are not payable to health practitioners who are not a Medical Practitioner e.g. perioperative nurses.

In accordance with NSW Health policy directive *Employment Arrangements for Medical Officers in the NSW Public Health Service* (**Doc No:** PD2019_027), Assistance at Operation fees cannot be charged for workers compensation cases performed in a public hospital when the assistant is a resident medical officer or registrar. If a resident medical officer or registrar is on rotation to an accredited private hospital, the relevant Assistance at Operation fee may be charged. Payment of these fees are to be directed into a hospital or departmental trust fund account and the invoice should include details of this account. The Authority reserves the right to conduct an audit of Assistance at Operation fee payments to ensure their proper distribution into the named trust fund.

AMA List means the document entitled *List of Medical Services and Fees* as amended or replaced, from time to time published by the Australian Medical Association, that is the current edition on the AMA website at the date of service delivery.

Compound (open) wound refers to a situation where a Surgeon is treating a fracture and the injury is associated with a compound (open) wound. In an open fracture wound that requires debridement, a 50% loading for open fracture fixation can be applied. Debridement item EA075/30023 is not to be billed when applying this loading.

Extended initial consultation means a consultation involving significant multiple trauma or complex "red flag" spinal conditions (systemic pathology, carcinoma, infection, fracture or nerve impingement) involving a lengthy consultation and extensive physical examination.

GST means the Goods and Services Tax payable under the GST Law.

GST Law has the same meaning as in the *A New Tax System (Goods and Services Tax) Act 1999* of the Commonwealth.

Initial consultation and report covers the first consultation, the report to the referring Medical Practitioner and the copy of the report to the insurer.

The report will contain:

- the worker's diagnosis and present condition;
- an outline of the mechanism of injury
- the worker's capacity for work
- the need for treatment or additional rehabilitation; and
- medical co-morbidities that are likely to impact on the management of the worker's condition (in accordance with privacy considerations).

The receipt of this report and any certificates of capacity under section 44B of the Act post-treatment will provide sufficient information for insurers, employers and workplace rehabilitation providers to develop recovery at/return to work plans.

Instrument fee covers procedures where the Surgeon supplies all the equipment or a substantial number of specialised instruments in exceptional circumstances and must be justified. This fee does not apply for all operations or if only incidental instruments (non-critical) are supplied by the Surgeon. Routine items such as loupes are not included.

Insurer means the employer's workers compensation insurer.

Medical Practitioner means a person registered in the medical profession under the *Health Practitioner Regulation National Law (NSW) No 86a,* or equivalent in their jurisdiction with the Australian Health Practitioner Regulation Agency. In accordance with section 60(2A)(d) of the Act, the employer will not be liable for the treatment provided if the treatment or service is provided by a Medical Practitioner who is suspended or disqualified from practice under any relevant law or the Medical Practitioner's registrationis limited or subject to any condition imposed as a result of a disciplinary process.

Multiple operations or injuries refer to situations that require two or more operations or for the treatment of two or more injuries carried out at the same time. It applies to the AMA items EA015 to MY330 and MZ731 to MZ871, with the exception of items specifically listed as a multiple procedure item in the AMA List, or where Schedules in this Order prevent combining of items. The fee for the main procedure or injury is to be paid in full as per

Schedule A (1.5 x of AMA List fee), and for each additional item or injury at 1.125 x AMA List Fee specified in Schedule A.

Opinion on file request includes retrieval of a file from whatever source, reading time, and reporting where a request for such an opinion has been made in writing to the Surgeon and in accordance with privacy principles.

Out-of-hours consultation means a call-out to a public or private hospital or a private home for an urgent case before 8.00am or after 6:00pm Monday to Friday, or anytime on the weekend and public holidays. This fee is not to be utilised where a consultation is conducted for non-urgent cases.

Out-of-hours loading only applies when a Surgeon is called back to perform a procedure(s) in isolation rather than for cases scheduled before 8.00am or after 6.00 pm on a weekday or a routine weekend operating list. Loading is to be calculated at 20% of the total procedure fee. The item must be reflected in the invoice as a separate entry against code WCO008.

Revision surgery refers to a procedure carried out to correct earlier surgery. Only where the revision surgery is performed by a Surgeon other than the original Surgeon, shall it attract a fee of 50% of the amount for the principal procedure in the initial surgery, in addition to the fee payable for the new procedure. Where the new procedure is specified as a revision procedure in the AMA List, the 50% loading does not apply.

Spinal surgical rules and conditions provided in the Medicare Benefits Schedule at the time the service was provided apply to spinal surgical items MZ731 (MBS 51011) to MZ871 (MBS 51171).

Surgical procedures are those listed in the AMA List but do not include the cost of bandages, dressings, plaster of Paris bandages, splints, metallic fixation agents, and prosthetic implants which may be charged in addition to the fee set out in Schedule A, if purchased by the Surgeon. The fee for surgical procedures includes pre-surgery consultations conducted on the same day of surgery and aftercare visits.

Subsequent consultation and report is each attendance subsequent to the first in a single course of treatment. A subsequent consultation fee is not to be billed if conducted on the same day as surgery or in the normal aftercare that applies following surgery. The cost of these consultations is included in the fee for the surgical procedure.

The subsequent consultation fee includes a subsequent consultation, a report from the subsequent consultation to the referring General Practitioner and copy of the report to the insurer. Providing copies of these reports does not attract a fee.

Surgeon means a Medical Practitioner who is currently a Fellow of the Royal Australasian College of Surgeons or who is recognised by Medicare Australia as a Specialist Surgeon. It includes a Surgeon who is a staff member at a public hospitalproviding services at that hospital.

Telehealth means delivery of consultations via video or telephone by a Surgeon. Consultations would be inclusive of any electronic communication to support the delivery

of the service. Surgeons must consider the appropriateness of this mode of service delivery for each worker on a case-by-case basis and be satisfied worker outcomes arenot compromised. Telehealth consultations must be consented to by the worker.
Surgeons are responsible for delivering Telehealth consultations in accordance with the principles of professional conduct and the relevant professional and practice guidelines to ensure the safety, appropriateness and effectiveness of the service. Telehealth consultations are to be paid in accordance with this Order (noting those items specifically excluded in Clause 7 of the *Workers Compensation (Medical Practitioner Fees) Order)*.
Surgeons are to bill for Telehealth consultations using the same AMA Fees List item number normally billed for a face-to-face consultation, with the addition of a 'T' as a suffix to the item number e.g. AC510T (Subsequent consultation and report delivered via telehealth) versus AC510 (Subsequent consultation and report delivered face to face).
The fee payable remains the same. No additional fee (e.g. facilityfees) can be charged in relation to the consultation.

Workers Compensation (Medical Practitioner Fees) Order means the *Workers Compensation (Medical Practitioner Fees) Order* in force on the date the service is provided.

Workers Compensation (Orthopaedic Surgeon Fees) Order means the *Workers Compensation (Orthopaedic Surgeon Fees) Order* in force on the date the service is provided.

Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order means the *Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order* in force on the date the service is provided.

4. Application of Order

This Order applies to treatment provided on or after the commencement date of this Order, whether it relates to an injury received before, on, or after that date.

5. Maximum fees for treatment by Surgeon

The maximum fee amount for which an employer is liable under the Act for treatment of a worker by a Surgeon, being treatment of a type specified in Column 1 of Schedule A to this Order, is the corresponding amount specified in Column 3 of that Schedule.

A fee charged by a Surgeon for a patient's treatment (including the management of fractures and other conditions) will be in addition to the fee in Schedule A for the initial consultation and report.

6. Billing items for hand surgery (Schedule B)

Schedule B provides mandatory guidelines for billing items used in hand and wrist surgery only.

Table 1 details items that are not billable for hand surgery procedures.

Table 2 details items with restricted application for hand surgery and where clinical justification is required that they are reasonably necessary given the circumstances of the case.

7. Billing items for shoulder and elbow surgery (Schedule C)

Schedule C provides mandatory guidelines for billing items used in shoulder and elbow surgery only.

Any item number where the term "flag" is used in the "Clinical Indication" column highlights a potential exception that will require further justification. Should a Surgeon seek an exception to the mandatory guidelines the Surgeon must provide a written explanation to

support the request.

8. Billing items for general upper limb surgery (Schedule D)

Schedule D provides mandatory guidelines for billing items used in general upper limb surgery.

Any item number where the term "flag" is used in the Clinical Indication column highlights a potential exception that will require further justification. Should a Surgeon seek an exception to the guidelines, the Surgeon must provide a written explanation to support the request.

9. GST

An amount fixed by this Order is exclusive of GST. An amount fixed by this Order may be increased by the amount of any GST payable in respect of the service to which the cost relates, and the cost so increased is taken to be the amount fixed by this Order. This clause does not permit a Surgeon to charge or recover more than the amount of GST payable in respect of the service to which the cost relates.

10. Requirements for invoices

All invoices should be submitted to the insurer within 30 calendar days of the service provided and must comply with the Authority's itemised invoicing requirements for the invoice to be processed. Refer to the Doctors in workers compensation webpage on the SIRA website at www.sira.nsw.gov.au

All invoices with surgical items must also be accompanied by the following:

(1) Detailed operation report including a description of the initial injury and an outline of the mechanism of injury, time surgery commenced and finished, intra-operative findings and the procedures performed, including structures that were repaired (stating the anatomic location) and technique of repair.

(2) Usage of any of the restricted item numbers (Schedule B, Table 2, Schedule C and Schedule D) must be accompanied by clinical justification in order to process the claim.

Note: A Medical Practitioner who provides Assistance at Operation is to invoice for their services separately to the principal Surgeon/Medical Practitioner.

11. Surgery requests

For any proposed surgery – a list of proposed applicable AMA item numbers will need to be provided prior to approval being given.

Where questions arise in individual clinical situations, supply of additional information may be required to assist in determinations.

12. No pre-payment of fees

Pre-payment of fees for reports and services is not permitted.

13. Nil payment for cancellation or non - attendance

No fee is payable for cancellation or non-attendance by a worker for treatment services with a Surgeon.

SCHEDULE A
MAXIMUM FEES FOR SURGEONS

Item	Column 1 Type of service	Column 2 AMA Item(s)	Column 3 Maximum amount
Consultations			
1.	Initial consultation and report (AC500T/AC600T to be utilised when consultation delivered via telehealth)	AC500/AC500T (MBS 104) AC600 /AC600T (MBS 6007)	$340.40
2.	Extended initial consultation and report	WCO006	$468.90
3.	Subsequent consultation and report (AC510T/AC610T to be utilised when consultation delivered via telehealth)	AC510/AC510T (MBS 105) AC610/AC610T (MBS 6009)	$234.50
4.	Out of hours consultation	WCO007	$196.70 in addition to consultation fee.
Procedures			
5.	Surgical procedure(s)	EA015 (MBS 30001) to MY330 (MBS 50239) and MZ731 (MBS 51011) to MZ871 (MBS 51171)	1.5 x AMA List Fee for the primary item number. (For any additional item numbers refer to item 8 of this Schedule).
6.	Instrument fee	WCO003	$234.50
7.	Assistance at Operation (*Assistance at Operation* fees are only payable to Medical Practitioners, not other health practitioners e.g. perioperative nurses). Assistance at Operation fees are to be billed by the Medical Practitioner who provides the assistance (not the Surgeon). Note: Assistance at Operation is only payable once per item number performed by the principal Surgeon irrespective of	MZ900	A fee of 20% of the Surgeon's fee for surgical procedure/s performed, but only those surgical procedure/s where an assistant is allowed for in the MBS, or $393.20, whichever is the greater.

Item	Column 1 Type of service	Column 2 AMA Item(s)	Column 3 Maximum amount
	the number of Medical Practitioners providing Assistance at Operation.		
8.	Multiple operations or injuries		Primary item number to be paid in full (1.5 x AMA List Fee) and additional AMA item number(s) at 1.125 x AMA List Fee.
9.	Aftercare visits (As defined in this Order)		As per AMA List.
10.	Compound (open) wound		In an open fracture wound that requires debridement, a 50% loading for open fracture fixation can be applied. Debridement item EA075/30023 is not to be billed when applying this loading.
11.	Out of hours loading	WCO008	20% of total procedure fee.
Insurer/lawyer requests			
12.	Opinion on file request	WCO009	$234.50
13.	Telephone requests including Case conferences (refer to the definition within the *Workers Compensation (Medical Practitioner Fees) Order)* or where there is a request to provide medical records and the Medical Practitioner needs to review the records prior to provision (to redact non-work-related injury information)	WCO002	$45.30 per 5 minutes.
14.	Lost reports and reprints		$158.90 per report
15.	Consulting Surgeon reports (where additional information that is not related to the routine injury management of the patient is requested by either party to a potential or current dispute). Note: The party requesting a report must agree the category of report with the Medical Practitioner in advance and confirm the request in writing at the time of referral.	Relevant IMS/WIS code	Please refer to the *Workplace Injury Management and Workers Compensation (Medical Examinations and Reports Fees) Order* Schedule 2.
16.	Fees for providing copies of clinical notes and records	WCO005	Where medical records are maintained electronically by a Medical Practitioner/practice a flat fee of $60 is payable (for provision of all requested medical records

Item	Column 1 Type of service	Column 2 AMA Item(s)	Column 3 Maximum amount
			held by the medical practice) inclusive of postage and handling. A Medical Practitioner/practice should not provide or bill for hard copy medical records if they are maintained electronically. Where medical records are not maintained electronically the maximum fee for providing hard copies of medical records (including Consulting Surgeon's notes and reports) is $38 (for 33 pages or less) and an additional $1.40 per page if more than 33 pages. This fee is inclusive of postage and handling. Where a Medical Practitioner has been requested to provide medical records and the doctor needs to review the records prior to provision (to redact non-work-related injury information), the time taken to review the records is to be billed under **WCO002** at the rate specified at item 13, Schedule A. This fee can be billed in addition to the fees stated above for provision of medical records by hard copy or electronically.

SCHEDULE B
BILLING ITEMS USED IN HAND SURGERY

Table 1: Item numbers and descriptors not applicable to hand surgery procedures

AMA/MBS item number	Descriptor	Reason for decline
CV233/18266 CV082/Nil	INJECTION OF AN ANAESTHETIC AGENT, ulnar, radial or median nerve of main trunk, one or more of, not being associated with a brachial plexus block MINOR NERVE BLOCK (specify type) to provide post-operative pain relief (this does not include subcutaneous infiltration)	The MBS does not allow a claim for nerve blocks performed as a method of postoperative analgesia. Infiltration is included in both the anaesthetic schedule AND in the surgical item number fee if performed by the Surgeon. This item can only be billed in circumstances where a formal nerve block is performed by the Surgeon as the only form of anaesthesia and no charge is raised for another anaesthetic service.
MG540/45051	CONTOUR RECONSTRUCTION for open repair of contour defects, due to deformity, requiring insertion of a non-biological implant, if it can be demonstrated that contour reconstructive surgery is indicated because the deformity is secondary to congenital absence of tissue or has arisen from trauma (other than trauma from previous cosmetic surgery), excluding the following: (a) insertion of a non-biological implant that is a component of another service listed in Surgical Operations; (b) injection of liquid or semisolid material; and (c) services to insert mesh	This relates to the insertion of foreign implant for pathological deformity by an open operation i.e. facial reconstruction and was not intended for usage in hand surgery.
MH480/45445	FREE GRAFTING (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of and removal of mould)	The appropriate item is MH490/45448.
MR170/47954	Repair of traumatic tear or rupture of tendon, other than a service associated with: (a) a service to which item LN810 applies; or (b) a service to which another item in the List applies if the service described in the other item is for the purpose of repairing peripheral nerve items in the same region	This item is from the orthopaedic group of items. There already exist appropriate items in the hand surgery section.
MS005/48400	Osteotomy of phalanx or metatarsal of foot, for correction of deformity, excision of accessory bone or sesamoid bone, including any of the following (if performed):	This item is from the orthopaedic group of items and relates to foot surgery only. There already exist appropriate items in the hand surgery section.

AMA/MBS item number	Descriptor	Reason for decline
	(a) removal of bone (b) excision of surrounding osteophytes (c) synovectomy (d) joint release - one bone	
MS015/48403	Osteotomy of phalanx or metatarsal, osteotomy or osteectomy of first toe of foot, for correction of deformity, with internal fixation, including any of the following (if performed): (a) removal of bone; (b) excision of surrounding osteophytes; (c) synovectomy; (d) joint release; - one bone	This item is from the orthopaedic group of items and relates to foot surgery only. There already exist appropriate items in the hand surgery section.
OF812/60500, OF816/60503, OF820/60506, OF824/60509 and OF952/61109	FLUOROSCOPY	Fluoroscopy items (OF812 – OF824 and OF952) can only be billed by a medical practitioner who, at the date they deliver the service, holds a relevant Radiation User Licence. Note: These items are not billable by more than one provider per occasion of service and only billable by the provider who delivers the service.

Table 2: Item numbers with restricted application for hand surgery – clinical justification required

AMA/MBS item number	Descriptor	Clinical indication
AC510/30105 Note: If consultation is undertaken via telehealth, code AC510T applies	Each attendance SUBSEQUENT to the first in a single course of treatment	Follow up consultations will not be paid within the 6-week period following a procedure as this is included in normal aftercare.

AMA/MBS item number	Descriptor	Clinical indication
EA075/30023	WOUND OF SOFT TISSUE, traumatic, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Assist.)	The repair of wound must be undertaken by suture, tissue adhesive resin (such as methyl methacrylate) or clips. These items are not to be billed for the closure of surgical wound, as such closure is part of a surgical procedure and not additional. Item EA075/30023 covers debridement of traumatic, "deep or extensively contaminated" wound. Benefits are not billable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures. Debridements are also not billable when removing percutaneous wire fixation. This item can be billed for deep chronic wounds or in combination with open fractures requiring debridement. This item is not to be billed in combination with EA215/30068. Limit of one debridement per episode of care or per limb. This item cannot be billed when a surgeon applies the 50% loading for open fracture fixation. Flag if this procedure is requested more than once per episode of care or per limb.
EA095/30029	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7CM IN LENGTH), involving deeper tissue, not being a service to which another item in Group 3.4 applies.	This item is for use in wound suture when no other vital tissue is involved. It cannot be billed in conjunction with item EA075/30023 for the same wound/zone of injury, nor when repair of a performed and deeper structure is also claimed for.
EA755/30223	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS OR SIMILAR LESION, requiring admission to hospital or day-hospital facility, INCISION WITH DRAINAGE OF (excluding aftercare)	This item cannot be billed in conjunction with item EA075/30023 for the same wound/zone of injury.
EA825/30238	FASCIA, DEEP, repair of, FOR HERNIATED MUSCLE	This item is rarely indicated and cannot be billed in conjunction with items EA075/30023 MR240/47975, MR250/47978, MR260/47981.
ET560/33815	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture	This item is applicable for repair of radial, ulnar or brachial arteries proximal to wrist crease.

AMA/MBS item number	Descriptor	Clinical indication
ET570/33818	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis	This item is applicable for repair of radial, ulnar or brachial arteries proximal to wrist crease.
LN740/39312	NEUROLYSIS, internal (interfascicular) neurolysis of, using microsurgical techniques, other than a service associated with a service to which EA075 applies.	This item is never indicated in acute trauma. It is rarely indicated in elective surgery and is reserved for use in revision nerve decompression surgery. This item is not to be billed in conjunction with item MU400 or MU410: Wrist carpal tunnel release (division of transverse carpal ligament), unless for a revision procedure. Not billable with EA075 or LN810
LN750/39315	NERVE TRUNK, nerve graft to, (cable graft) by cable graft, using microsurgical techniques, including any of the following (if performed): (a) harvesting of nerve graft using microsurgical graft; (b) proximal and distal anastomosis of nerve graft; (c) transposition of nerve to facilitate grafting; (d) neurolysis; other than a service associated with a service to which item EA075 or LN810 applies	This item can only be billed once per named nerve trunk, regardless of the number and distal distribution of individual cables. This item cannot be billed in conjunction with EA075, LN790, LN800, LN804, LN806 or LN810.
LN760/39318	Nerve, digital or cutaneous, nerve graft to, using microsurgical techniques, including either or both of the following (if performed): (a) harvesting of nerve graft from separate donor site; (b) proximal and distal anastomosis of nerve graft. - other than a service associated with a service to which item LN810 applies	This item cannot be billed in conjunction with items LN790, LN800, LN804, LN806 or LN810. This item cannot be billed for prosthetic neural tubes or wraps. In this setting, items LN700 or LN710 are applicable.
LN790/39324	NEURECTOMY or removal of tumour or neuroma from superficial peripheral nerve	This item cannot be billed in conjunction with item LN810.
LN800/39327	NEURECTOMY, NEUROTOMY or removal of tumour from deep peripheral nerve, by open operation	This item cannot be billed in conjunction with item LN810.
LN810/39330	NEUROLYSIS by open operation without transposition, not being a service associated with a service to which items EA075, LN740, LN770, LN804, LN806, LN826, LN829, LN832, LN835, MU402, MX474 or MX475 applies	This item is not for the identification of nerves during surgical exposure. It is not to be billed in combination with item LN700. This item cannot be billed in combination with EA075, LN740, LN770, LN804, LN806, LN826, LN829, LN832, LN835, MU402, MX474 or MX475 This item is not to be billed in conjunction with item MU400 or MU410.However, items LN810 and MU400 can be billed together for combined carpal tunnel release and cubital tunnel release surgery.

AMA/MBS item number	Descriptor	Clinical indication
		This item is not to be billed in conjunction with item ML235 tendon sheath of hand/wrist open operation for stenosing tenovaginitis.
MH115/45203	SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, complicated or large, and excluding flap for male pattern baldness and excluding H-flap or double advancement flap, not in association with any of items EN036 to EN084	This item is rarely indicated in the hand and wrist as a large defect will not be readily amenable to a local flap reconstruction. It is not to be billed for suturing of traumatic skin flaps.
MH125/45206	SINGLE STAGE LOCAL FLAP where indicated to repair 1 defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excluding H-flap or double advancement flap, not in association with any of items EN036 to EN084	This item can only be billed once for a z-plasty.
MJ025/45500	MICROVASCULAR REPAIR using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit	This item relates to microvascular repair of an artery or vein. This item cannot be billed for repair of dorsal veins with volar skin intact, branches of digital arteries, branches of radial/ulnar vessels and venae comitantes of major arteries. Microvascular repairs distal to the metacarpophalangeal joint will also require clinical documentation of appropriate surgical technique utilising an operating microscope.
MJ030/45501 MJ035/45502	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of limb or digit/ MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for reimplantation of limb or digit	These items specifically relate to replantation of limb and digit. i.e., the amputated portion must be completely detached.
MJ045/45503	MICRO-ARTERIAL or MICRO-VENOUS graft using microsurgical techniques	This item includes the remuneration for harvesting the graft and performing any microvascular anastomoses to the graft.
MJ075/45515	SCAR, other than on face or neck, NOT MORE THAN 7 CMS IN LENGTH, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or approved day hospital facility, or where performed by a Specialist in the practice of his or her specialty	This item cannot be billed in conjunction with other items e.g., nerve repair, tendon repair, flap repair (i.e., intended to be an independent procedure).
MJ245/45563	NEUROVASCULAR ISLAND FLAP, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness	This item is for a true island flap, elevated on a neurovascular pedicle for an existing traumatic defect. This item is not to be billed for VY advancement flaps where item MH125/45206 is applicable.

AMA/MBS item number	Descriptor	Clinical indication
ML105/46325	Excisional arthroplasty of CARPOMETACARPAL JOINT OF THUMB, with excision of adjacent trapezoid, including either or both of the following (if performed): (a) ligament and tendon transfers (b) realignment procedures	This item is primarily intended for use in reconstruction for basal thumb arthritis. It is not approved for excision of the pisiform.
ML125/46330	Ligamentous or capsular repair or reconstruction of INTERPHALANGEAL OR METACARPOPHALANGEAL JOINT OF HAND, including any of the following (if performed): (a) arthrotomy (b) joint stabilisation (c) synovectomy; - one joint	This item is only billable for repair of named ligaments where preoperative or intraoperative findings document significant joint instability.
ML135/46333	Ligamentous or capsular repair or reconstruction of INTERPHALANGEAL OR METACARPOPHALANGEAL JOINT OF HAND with graft, using graft or implant, including any of the following (if performed): (a) arthrotomy (b) harvest of graft (c) joint stabilisation (d) synovectomy, other than a service associated with a service to which item MR645, MR650, MR655, MR660 or MR665 apply - one joint	Cannot be billed with MR645, MR650, MR655, MR660 or MR665. This item is only billable for repair of named ligaments using free grafts or alloplast where preoperative or intraoperative findings document significant joint instability. This item cannot be billed for reattachment of ligament using a bone anchor. Item ML125/46330 is the approved number.
ML145/46336	Synovectomy of INTERPHALANGEAL, METACARPOPHALANGEAL OR CARPOMETACARPAL JOINT OF HAND, including any of the following (if performed): (a) capsulectomy (b) debridement (c) ligament or tendon realignment (or both), other than a service combined with a service to which item ML705 applies—one joint	This item cannot be billed in conjunction with any other item or procedure related to the joint. This item cannot be billed in conjunction with item EA075/30023 or ML705.
ML155/46339	Synovectomy of digital flexor tendons at wrist level, for diagnosed inflammatory arthritis, including either or both of the following (if performed):	Rare in a workers' compensation setting. Not for use for De Quervain's (refer to ML247/46367). Note: If performing a complete flexor tenosynovectomy, a release of the Carpal Tunnel

AMA/MBS item number	Descriptor	Clinical indication
	(a) tenolysis (b) release of median nerve and carpal tunnel, other than a service associated with a service to which item EA075, LN810 or MU400 applies—applicable only once per occasion on which the service is performed	is part of the operation and therefore MU400 or MU410 should not be billed. If this item is requested in conjunction with MU400 or MU410 (Wrist carpal tunnel release) or ML237/46367 (De Quervain's), clinical documentation of gross synovitis is required, preferably with histological confirmation. Flag if this procedure is requested two or more times.
ML185/46348 – ML225/46360	Flexor tenosynovectomy of hand, distal to lumbrical origin, including any of the following (if performed): (a) removal of intratendinous nodules (b) tenolysis (c) tenoplasty, other than a service associated with a service to which item EA075 or ML235 applies.	ML185/46348 – 1 digit ML195/46351 – 2 digits ML205/46354 – 3 digits ML215/46357 – 4 digits ML225/46360 – 5 digits Not in combination with EA075, ML235 orML155/46339.
ML235/46363	Trigger finger release, for stenosing tenosynovitis, including either or both of the following (if performed): (a) synovectomy (b) synovial biopsy - one ray	This item is not to be billed in combination with LN810/39330. Item used for Trigger Finger Release.
ML247/46367	De Quervain's release, including any of the following (if performed): (a) synovectomy of extensor pollicis brevis (b) synovectomy of abductor pollicis longus tendons (c) retinaculum reconstruction, other than a service associated with a service to which item ML155 applies	Not to be billed with ML155. De Quervain's tenosynovitis - can only be billed once per side (ie. includes both APL and EPB tendons).
ML260/46370 – ML340/46395	Dupuytren's contracture, fasciectomy	Flag if this procedure is requested for an acute injury or trauma.
ML405/46414	Insertion of artificial tendon prosthesis in preparation for grafting of tendon of hand or wrist, including tenolysis (if performed), other than a service associated with a service to which item EA075 applies	Tenolysis items ML535/ 46450 and ML545/46453) or EA075 cannot be billed with this item.
ML425/46420	Primary repair of EXTENSOR TENDON OF HAND OR WRIST—one tendon	Item ML425 is for an acutely injured tendon as a primary procedure. This item should not be billed for repair of extensor tendon split as part of an access to phalangeal fractures/osteotomies.
ML445/46426	Primary repair of FLEXOR TENDON OF HAND OR WRIST, proximal to A1 pulley, other than a service to repair a tendon of a digit if 2 tendons of the same digit have been repaired during	Not to be billed more than once to repair FDS tendon in a digit. This item can only be billed a maximum of twice per digit.

AMA/MBS item number	Descriptor	Clinical indication
	the same procedure - one tendon	
ML465/46432	Primary repair of FLEXOR TENDON OF HAND OR WRIST, distal to A1 pulley, other than a service to repair a tendon of a digit if 2 tendons of the same digit have been repaired during the same procedure - one tendon	This item is only to be billed for acute injuries. This item can only be billed a maximum of twice per digit.
ML535/46450	Tenolysis of EXTENSOR TENDON OF HAND OR WRIST, following tendon injury or graft, other than a service: (a) for acute, traumatic injury; or (b) associated with a service to which item EA075 applies —one ray	This item is applicable for freeing tendons from scar following previous surgery or trauma. It is not indicated in an acute hand injury. Item ML535 cannot be billed in conjunction with release of trigger finger or for release of De Quervians' (see ML235/46363 and ML247/46367). Item ML535 cannot be billed with EA075.
ML545/46453	Tenolysis of FLEXOR TENDON OF HAND OR WRIST, following tendon injury, repair or graft, other than a service: (a) for acute, traumatic injury; or (b) associated with a service to which item EA075 applies	This item is applicable for freeing tendons from scar following previous surgery or trauma. It is not indicated in an acute hand injury. Item ML545 cannot be billed in conjunction with release of trigger finger or for release of De Quervain's (see ML235/46363 and ML247/46367). Item ML545 cannot be billed with EA075.
ML705/46495	Complete excision of one or more ganglia or mucous cysts of INTERPHALANGEAL, METACARPOPHALANGEAL OR CARPOMETACARPAL JOINT OF HAND, including any of the following (if performed): (a) arthrotomy (b) osteophyte resections (c) synovectomy, other than a service associated with a service to which item EA355 or ML145 applies—one joint	Not being a service associated with a service to which item EA355/30107 or ML145/46336 applies.
ML715/46498	Excision of GANGLION OF FLEXOR TENDON SHEATH OF HAND, including any of the following (if performed): (a) flexor tenosynovectomy (b) sheath excision (c) skin closure by any method, other than a service associated with a service to which item EA355 or ML235 applies	Not being a service associated with a service to which item EA355/30107 or ML235/46363 applies.
ML725/46500	Excision of GANGLION OF DORSAL WRIST JOINT OF HAND, including any of the following (if performed): (a) arthrotomy	This item is not to be billed in combination with EA355/30107.

AMA/MBS item number	Descriptor	Clinical indication
	(b) capsular or ligament repair (or both) (c) synovectomy, other than a service associated with a service to which item EA355 applies	
ML735/46501	Excision of GANGLION OF VOLAR WRIST JOINT OF HAND, including any of the following (if performed): (a) arthrotomy (b) capsular or ligament repair (or both) (c) synovectomy, other than a service associated with a service to which item EA355 or ML105 applies	This item is not to be billed in combination with EA355/30107 or ML105/46325.
ML745/46502	Excision of RECURRENT GANGLION OF DORSAL WRIST JOINT OF HAND, including any of the following (if performed): (a) arthrotomy (b) capsular or ligament repair (or both) (c) synovectomy	This item is not to be billed in combination with EA355/30107.
ML755/46503	Excision of RECURRENT GANGLION OF VOLAR WRIST JOINT OF HAND, including any of the following (if performed): (a) arthrotomy (b) capsular or ligament repair (or both) (c) synovectomy, other than a service associated with a service to which item EA355 applies	This item is not to be billed in combination with EA355/30107.
ML765/46504	NEUROVASCULAR ISLAND FLAP, heterodigital, for pulp re-innervation and soft tissue cover	These items are only to be billed for a heterodigital neurovascular island flap used to resurface pulp loss (e.g. Littler flap, first dorsal metacarpal artery or Kite flap). There is a limit of one flap per digit. Flag if this procedure is requested two or more times.
ML795/46513	Removal of nail of finger or thumb—one nail	This item should not be billed in association with nailbed repair (items ML665/46486 or ML675/46489).
ML825/46522	Open operation and drainage of infection for FLEXOR TENDON SHEATH OF FINGER OR THUMB, including either or both of the following (if performed): (a) synovectomy	This item is applicable only for drainage of suppurative flexor tenosynovitis. It does not apply to washout of flexor sheath in acute injury. ML825 cannot be billed in combination with EA075.

AMA/MBS item number	Descriptor	Clinical indication
	(b) tenolysis, other than a service associated with a service to which item EA075 applies - one digit	
MR090/47921	ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure	This item cannot be billed when the k-wire has been used as part of fracture fixation. Can be billed for the insertion of a temporary pin in association with a ligament/tendon repair.
MR110/47927	Removal of one or more buried wires, pins or screws (inserted for internal fixation purposes) - one bone	This item applies for removal of *buried* k-wire. Where a k-wire or wires cross more than 2 bones, only 1 item number is billable.
MS025/48406	Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, for correction of deformity, including any of the following (if performed): (a) removal of bone (b) excision of surrounding osteophytes (c) synovectomy (d) joint release - one bone	This item is not appropriate for simple removal of bone prominence, osteophytes or small quantities of excess bone.
MU400 and MU410	Carpal tunnel release (division of transverse carpal ligament), by any approach (MU400) or endoscopic (MU410) approach	These are the appropriate item numbers for a primary carpal tunnel release. These items cannot be billed together. Either of these items cannot be used in combination with ML155/46339 or EA075/30023. Ultrasound costs are not billable in conjunction with these surgical procedures. Nerve Conduction Studies (NCS) are preferable prior to surgical consideration, other than in acute cases.
MU460/49209	Prosthetic replacement of WRIST or distal radioulnar joint, including either or both of the following (if performed): (a) ligament realignment (b) tendon realignment	Flag if this procedure is requested.
MU462/49210	Revision of total replacement arthroplasty of WRIST or distal radioulnar joint, including any of the following (if performed): (a) ligament rebalancing (b) removal of prosthesis (c) tendon rebalancing	Flag if this procedure is requested.

AMA/MBS item number	Descriptor	Clinical indication
MU470/49212	Arthrotomy of WRIST or distal radioulnar joint, for infection, including any of the following (if performed): (a) joint debridement (b) removal of loose bodies (c) synovectomy	This item is not to be billed in conjunction with excision of primary or recurrent wrist ganglia (items ML725/46500, ML735/46501, ML745/46502 and ML755/46503).
MU480/49215	Reconstruction of single or multiple ligaments or capsules of WRIST, by open procedure, including any of the following (if performed): (a) arthrotomy (b) ligament harvesting and grafting (c) synovectomy (d) tendon harvesting and grafting (e) insertion of synthetic ligament substitute	Including repair of single or multiple ligaments or capsules, including associated arthrotomy.
MU490/49218	WRIST, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy)—other than a service associated with another arthroscopic procedure of the wrist joint	Not being a service associated with any other arthroscopic procedure of the wrist joint.
MU500/49221	Treatment of WRIST, by arthroscopic means, including any of the following (if performed): (a) drilling of defect (b) removal of loose bodies (c) release of adhesions (d) synovectomy (e) debridement (f) resection of dorsal or volar ganglia, other than a service associated with a service to which another item in the List applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint	Not being a service associated with any other arthroscopic procedure of the wrist joint.
MU510/49224	Osteoplasty of WRIST, by arthroscopic means, including either or both of the following (if performed): (a) excision of the distal ulna (b) total synovectomy, other than a service associated with a service to which another item in the List applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint—2 or more distinct areas	Not being a service associated with any other arthroscopic procedure of the wrist.

AMA/MBS item number	Descriptor	Clinical indication
MU520/49227	Treatment of WRIST by one of the following: (a) pinning of osteochondral fragment, by arthroscopic means (b) stabilisation procedure for ligamentous disruption (c) partial wrist fusion or carpectomy, by arthroscopic means (d) fracture management, other than a service associated with a service to which another item in the List applies if the service described in the other item is for the purpose of performing an arthroscopic procedure of the wrist joint	Not being a service associated with any other arthroscopic procedure of the wrist joint.

SCHEDULE C

BILLING ITEMS USED IN SHOULDER AND ELBOW SURGERY

This Order adopts the *WorkCover Queensland Upper Limb Surgery Guidelines (July 2021)* with minor modifications. Relevant items from the *WorkCover Queensland Upper Limb Surgery* Guidelines are provided within Schedule C and their use is mandatory when billing for shoulder and elbow surgery.

AMA/MBS item number	Descriptor	Clinical indication
BONE GRAFTS		
MS025/48406	Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, for correction of deformity, including any of the following (if performed): (a) removal of bone (b) excision of surrounding osteophytes (c) synovectomy (d) joint release - one bone	Not to be billed in combination with item MT770/48951. **Flag if this item is used in combination with any other shoulder items (MT600/48900 to MT800/48960).**
MS035/48409	Osteotomy of fibula, radius, ulna, clavicle, scapula (other than acromion), rib, tarsus or carpus, for correction of deformity, with internal fixation, including any of the following (if performed): (a) removal of bone (b) excision of surrounding osteophytes (c) synovectomy (d) joint release, - one bone	Not to be billed in combination with item MT770/48951. **Flag if this item is billed in combination with any other shoulder items (MT600/48900 to MT800/48960).**
MS045/48412	Osteotomy of humerus, without internal fixation	Can be billed with item MR020/47903 (tennis elbow release) if a lateral or medial epicondylectomy is performed. Can be billed with LN810/39330 if ulna nerve neuritis or compression has been diagnosed requiring formal surgical decompression.
SHOULDERS		
MT600/48900	SHOULDER, excision or coraco-acromial ligament or removal of calcium deposit from cuff or both	Open operation not arthroscopic. Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed twice or more.**
MT610/48903	SHOULDER, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any other combination	Open operation, also known as open acromioplasty or subacromial decompression (SAD).

AMA/MBS item number	Descriptor	Clinical indication
MT620/48906	SHOULDER, repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff, or both - other than a service associated with a service to which Item MT600 applies	Known as open cuff repair without acromioplasty. Not to be billed in combination with item MT600/48900. If MS025 is performed it cannot be billed with item MT770. Can be billed in combination with arthroscopic code MT770/48951 Note: If MT620/48906 is performed arthroscopically it cannot be billed with item MT770/48951.
MT630/48909	SHOULDER, repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination, other than a service associated with a service to which item MT610 applies	Known as open rotator cuff repair with acromioplasty with excision of AC joint. Not being a service to which item MT610/48903 applies. **Not to be billed with item MX670/49851.** Not to be billed with MT770/48951 or in combination with MT610/48903. This item is not to be billed with services associated with any other **arthroscopic** procedure of the shoulder region.
MT650/48915	SHOULDER, Hemi-arthroplasty	Use of this item rarely seen in State Insurance Regulatory Authority claims. Maybe appropriate for shoulder trauma/fractures only.
MT660/48918	Anatomic or reverse total shoulder replacement, including any of the following (if performed): (a) associated rotator cuff repair (b) biceps tenodesis (c) tuberosity osteotomy other than a service associated with a service to which another item in the List applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by open or arthroscopic means	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT670/48921	SHOULDER, total replacement arthroplasty, revision of	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT680/48924	Revision of total shoulder replacement, including either or both of the following (if performed): (a) bone graft to humerus (b) bone graft to scapula	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT690/48927	Shoulder prosthesis, removal of	Use of this item rarely seen in State Insurance Regulatory Authority claims.
MT730/48939	SHOULDER, arthrodesis of, with synovectomy if performed	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed once or more.**

AMA/MBS item number	Descriptor	Clinical indication
MT740/48942	Arthrodesis of shoulder, with bone grafting or internal fixation, including either or both of the following (if performed): (a) removal of prosthesis (b) synovectomy other than a service associated with a service to which item MR645, MR650, MR655, MR660 or MR665 applies	Not to be billed with a service to which item MR645, MR650, MR655, MR660 or MR665 applies. Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed once or more.**
MT750/48945	SHOULDER, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region	Not to be billed with any **arthroscopic** procedure of the shoulder region. May be billed with open surgery i.e. items MT630/48909, MT620/48906
MT760/48948	SHOULDER, arthroscopic surgery of, involving any 1 or more of: removal of loose bodies; decompression of calcium deposit; debridement of labrum, synovium or rotator cuff; or chondroplasty - not being a service associated with any other arthroscopic procedure of the shoulder region	Not to be billed with any other **arthroscopic** procedure of the shoulder region. Preparatory for an open procedure. Appropriate with items MT620/48906 and MT630/48909.
MT770/48951	SHOULDER, arthroscopic division of coraco-acromial ligament including acromioplasty - not being a service associated with any other arthroscopic procedure of the shoulder region	Not to be billed with any other **arthroscopic** procedure of the shoulder region. Not to be billed in combination with items EA365/30111 or MT780/48954. Can be billed in combination with MT620/48906 if MT620 is performed as an open rotator cuff repair procedure
MT780/48954	Synovectomy of shoulder, performed as an independent procedure, including release of contracture (if performed), other than a service associated with a service to which another item in the List applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by arthroscopic means	Known as frozen shoulder release; stand-alone item code. Not to be billed with any other **arthroscopic** procedure of the shoulder region. Not to be billed in combination with item MT770/48951. **Flag if this item is billed with any other item for shoulder surgery.**
MT798/48958	Joint stabilisation procedure for multi-directional instability of shoulder, anterior or posterior repair, by open or arthroscopic means, including labral repair or attachment (if performed), excluding bone grafting and removal of hardware. Other than a service associated with a service to which another item in	If item is requested for recurrent dislocations, it is highly recommended to look at worker history to determine if surgery is to treat the aggravation or a pre-existing condition. Not to be used with any other arthroscopic procedure of the shoulder region.

AMA/MBS item number	Descriptor	Clinical indication
	this List applies if the service described in the other item is for the purpose of performing a procedure on the shoulder region by arthroscopic means.	
MT800/48960	SHOULDER, reconstruction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by separate approach when performed - not being a service associated with any other procedure of the shoulder region	Not to be billed with any other procedure of the shoulder region. Not to be billed with item **EA365/30111, MT770/48951 or MT798/48958.** **Flag if practitioner requesting a Superior Capsular Reconstruction (SCR) procedure.**
ELBOW		
LN770/39321	Transposition of NERVE, excluding the ulnar nerve at the elbow, other than a service associated with a service to which item LN810 applies	Not appropriate for use in epicondylitis surgery – refer to item LN810/39330 (this item applies to transposition of ulna nerve anterior to medial epicondyle to submuscular or subcutaneous site). Not to be combined with MS045/48412 or LN810/39330 or LN730.
MU035/49100	ELBOW, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture	Not to be billed for tennis elbow surgery.
MU055/49106	ELBOW, arthrodesis of, with synovectomy if performed	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if this item is billed.**
MU065/49109	Elbow, total synovectomy of	Known as **common contracture release**. Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if billed.**
MU075/49112	Radial head replacement of elbow, other than a service associated with a service to which item MU085 applies	Seen with fractures, dislocations and acute trauma. Not to be billed in combination with item MU065/49109 or MU085**.** **Flag if billed.**
MU085/49115	Total or hemi humeral arthroplasty of elbow, excluding isolated radial head replacement and ligament stabilisation procedures, other than a service associated with a service to which item MU075 applies	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if billed.**
MU086/49116	ELBOW, total replacement arthroplasty of, revision procedure, including removal of prosthesis	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if billed.**

AMA/MBS item number	Descriptor	Clinical indication
MU087/49117	Revision of total replacement arthroplasty of elbow, including bone grafting and removal of prosthesis	Use of this item rarely seen in State Insurance Regulatory Authority claims. **Flag if billed.**
MU095/49118	ELBOW, diagnostic arthroscopy of, including biopsy and lavage, not being a service associated with any other arthroscopic procedure of the elbow	Not to be billed with any other **arthroscopic** procedure of the elbow region. Appropriate for use with open elbow surgery.
MU105/49121	Surgery of the elbow, by arthroscopic means, including any of the following (if performed): (a) chondroplasty (b) drilling of defect (c) osteoplasty (d) removal of loose bodies (e) release of contracture or adhesions (f) treatment of epicondylitis, other than a service associated with a service to which another item in the List applies if the service described in the other item is for the purpose of an arthroscopic procedure of the elbow	Not to be billed with any other **arthroscopic** procedure of the elbow.
OTHER		
EA365/30111	Bursa (large) including olecranon, calcaneum or patella, excision of	**Flag if used in combination with any shoulder surgery.** Not to be billed in combination with item MT800/48960 or MU108/49124.
LN810/39330	Neurolysis by open operation without transposition, other than a service associated with a service to which Item EA075, LN770, LN804, LN806, LN826, LN829, LN832, LN835, MU402, MX474 or MX475 applies	Not being a service associated with a service to which item LN740/39312 EA075, LN770, LN804, LN806, LN826, LN829, LN832, LN835, MU402, MX474 or MX475 applies. Can be billed in combination with elbow surgery (eg: MS045/48412 if performing an ulna nerve release with medial epicondylectomy or MR020/47903 lateral or medial epicondylitis debridement). Not to be billed in combination with item MT760/48948. **Flag if billed in combination with any item codes for shoulder surgery or in acute trauma.**
OTHER JOINTS		
MY055/50112	CICATRICIAL FLEXION or EXTENSION CONTRACTION of JOINT, correction of, involving tissues deeper than skin and subcutaneous tissue, not being a service to which another item in this Group 9 Surgical Operations applies	Not being a service to which another item in group 9 Surgical Operations applies. Not to be billed with any other **arthroscopic** procedure of the shoulder region. Not to be billed in combination with item MT780/48954. **Flag if billed in combination with any item**

AMA/MBS item number	Descriptor	Clinical indication
		code for elbow and shoulder surgery. Implies a release for stiffness after injury or surgery. May occur with other numbers in relation to a large release of a stiff elbow. Three to five item numbers should be in association with an operation that took two to three hours and is usually a revision situation or after serious trauma. The complexity should be reflected in the history of injury, number of prior operations, duration of surgery, complexity of the operation.
MY065/50115	Manipulation of one or more joints, excluding spine, other than a service associated with a service to which another item in group 9 Surgical Operations applies.	Code used for adhesive capsulitis (frozen shoulder) manipulation under anaesthetic (MAU). Not to be billed for an 'examination' of a joint under general anaesthetic prior to an operation, where the general anaesthetic is for the operation itself. Not being a service associated with a service to which another item in Group 9, Surgical operations applies. **Flag if this item is used two or more times.**
GENERAL		
MR020/47903	Epicondylitis, open operation for	This is the only item number appropriate for Tennis or Golfers Elbow Debridement (Lateral or Medial Epicondylitis). Can be combined with MS045/48412 where a formal excision of the epicondyle is justified, not just for debridement of epicondyle. Can also be combined with LN810/39330 if ulna nerve neuritis or compression has been diagnosed which requires formal surgical decompression. **Flag if billed in combination with any other item numbers.**
MR110/47927	Removal of one or more buried wires, pins, or screws (inserted for internal fixation purposes) - one bone	This item applies for removal of one or more buried k-wire per bone. Where fixation crosses two or more bones, only one item number is claimable. Cannot be billed in combination with MR100/47924
MR170/47954	Repair of traumatic tear or rupture of tendon, other than a service associated with: (a) a service to which item LN810 applies; or (b) a service to which another item in the List applies if the service described in the other item is for the purpose of repairing peripheral nerve items in the same region	Cannot be billed in combination with LN810 or a service to which another item in the List applies if the service described in the other item is for the purpose of repairing peripheral nerve items in the same region. **Flag if billed with any other item code.**

SCHEDULE D

ADDITIONAL ITEMS USED IN UPPER LIMB SURGERY

This Order adopts the *WorkCover Queensland Upper Limb Surgery Guidelines (July 2021) with minor modifications*. The relevant items from the *WorkCover Queensland Upper Limb Surgery Guidelines* are provided in Schedule D and their use is mandatory when billing for upper limb surgery.

AMA/MBS item number	Descriptor	Clinical indication
EA075/30023 – EA155/30049	Repair of Wounds	These items are not to be billed for the closure of surgical wound, as such closure is part of a surgical procedure and not additional. The repair of wound referred to in these items must be undertaken by suture, tissue adhesive resin (such as methyl methacrylate) or clips. The term 'superficial' means affecting skin and subcutaneous tissue including fat and the term 'deeper tissue' means all tissues deep to but not including subcutaneous tissue such as fascia and muscle.
EA355/30107	GANGLION OR SMALL BURSA, excision of, other than a service associated with a service to which an item in this Group applies	Not being a service associated with a service to which another item in this Group applies.
MS055/48415	Humerus, osteotomy, with internal fixation	Not to be billed with item LN810/47903 (tennis elbow release) unless a lateral epicondylectomy is performed. Flag if this item is requested, particularly if requested for tennis elbow surgery.

GEOGRAPHICAL NAMES ACT 1966

PURSUANT to the provisions of Section 10 of the *Geographical Names Act 1966*, the Geographical Names Board has this day assigned the name listed hereunder as a geographical name.

Wiyingay for a creek connecting Wheeny Lagoon on the east with a series of unnamed lagoons/chain of ponds on the west, in the suburb of Cattai, The Hills Shire LGA.

The position and extent for this feature is recorded and shown within the Geographical Names Register of New South Wales. This information can be accessed through the Board's website at www.gnb.nsw.gov.au

NARELLE UNDERWOOD
Chair

Geographical Names Board
346 Panorama Ave
BATHURST NSW 2795

ASSOCIATIONS INCORPORATION ACT 2009

Cancellation of incorporation pursuant to section 74

TAKE NOTICE that the incorporation of the following associations is cancelled by this notice pursuant to section 74 of the Associations Incorporation Act, 2009.

ULLADULLA WOMANS SHED INCORPORATED	**INC1500382**
ALBION/ARCTIC INDIGENOUS ALLIANCE INC	**INC2100797**
SOUTH WEST VIDEO CLUB INCORPORATED	**INC9881393**
BATHURST ARTS COUNCIL INC	**Y0537234**

Cancellation is effective as at the date of gazettal.

Dated this 25th Day of November 2021

Megan Green
Delegate of the Commissioner for Fair Trading
Department of Customer Service

GEOGRAPHICAL NAMES ACT 1966

PURSUANT to the provisions of Section 10 of the *Geographical Names Act 1966*, the Geographical Names Board has this day assigned the names listed hereunder as geographical names.

Gulaga as a dual name for the geographical feature already named Mount Dromedary, a prominent mountain about 4.5 km west by north of Tilba Tilba, located in Gulaga National Park, Eurobodalla LGA.

Barunguba as a dual name for the geographical feature already named Montague Island, an island in the Tasman Sea about 9 km east south east of the town of Narooma, and about 7 km east of the Narooma coastline, Eurobodalla LGA.

Najanuka as a dual name for the geographical feature already named Little Dromedary Mountain, a hill, a large rocky outcrop protruding straight up, at a 90-degree angle from the ground, located about 2 km south of Central Tilba, Eurobodalla LGA.

Biamanga as a dual name for the geographical feature already named Mumbulla Mountain, a mountain located in the Biamanga National Park, 27km east of Bega and 25km north west of Tathra in the suburb of Mumbulla Mountain, Bega Valley LGA.

Both names are recorded in the Geographical Names Register as dual names and neither name will have precedence over the other.

The position and extent for these features is recorded and shown within the Geographical Names Register of New South Wales. This information can be accessed through the Board's website at www.gnb.nsw.gov.au

NARELLE UNDERWOOD
Chair

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