Australian Government Department of Health

Medicare Benefits Schedule Book Category 3 Operating from 1 March 2019

Title: Medicare Benefits Schedule Book

ISBN: 978-1-76007-375-3 Publications Number: 12289

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

The latest Medicare Benefits Schedule information is available from MBS Online at

http://www.health.gov.au/mbsonline

TABLE OF CONTENTS GENERAL EXPLANATORY NOTES......

GENERAL EXPLANATORY NOTES	
GENERAL EXPLANATORY NOTES	7
CATEGORY 3: THERAPEUTIC PROCEDURES	33
SUMMARY OF CHANGES FROM 01/03/2019	34
THERAPEUTIC PROCEDURES NOTES	35
Group T1. Miscellaneous Therapeutic Procedures	
Subgroup 1. Hyperbaric Oxygen Therapy	
Subgroup 2. Dialysis	
Subgroup 3. Assisted Reproductive Services	
Subgroup 4. Paediatric & Neonatal	
Subgroup 5. Cardiovascular	
Subgroup 6. Gastroenterology	
Subgroup 8. Haematology	
Subgroup 9. Procedures Associated With Intensive Care And Cardiopulmonary Support	
Subgroup 10. Management And Procedures Undertaken In An Intensive Care Unit	110
Subgroup 11. Chemotherapeutic Procedures	
Subgroup 12. Dermatology	
Subgroup 13. Other Therapeutic Procedures	
Group T2. Radiation Oncology	
Subgroup 1. Superficial	
Subgroup 2. Orthovoltage	
Subgroup 3. Megavoltage	
Subgroup 4. Brachytherapy	120
Subgroup 5. Computerised Planning	
Subgroup 6. Stereotactic Radiosurgery	
Subgroup 7. Radiation Oncology Treatment Verification	
Subgroup 8. Brachytherapy Planning And Verification	
Subgroup 10. Targetted Intraoperative Radiotherapy	129
Group T4. Obstetrics	
Group T6. Anaesthetics	
Subgroup 1. Anaesthesia Consultations	
Group T7. Regional Or Field Nerve Blocks	
Group T8. Surgical Operations	
Subgroup 1. General	
Subgroup 2. Colorectal	
Subgroup 3. Vascular	
Subgroup 4. Gynaecological	
Subgroup 5. Urological	
Subgroup 6. Cardio-Thoracic	
Subgroup 7. Neurosurgical	
Subgroup 8. Ear, Nose And Throat	283
Subgroup 9. Ophthalmology	294
Subgroup 10. Operations For Osteomyelitis	
Subgroup 11. Paediatric	
Subgroup 12. Amputations	
Subgroup 13. Plastic And Reconstructive Surgery	
Subgroup 14. Hand Surgery	
Subgroup 15. Orthopaedic	
Subgroup 16. Radiofrequency And Microwave Tissue Ablation	
Subgroup 17. Spinal Surgery	390
Group T9. Assistance At Operations	397
Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia	
Performed In Association With An Eligible Service	
Subgroup 1. Head	
Subgroup 2. Neck	
Subgroup 3. Thorax	
Subgroup 4. Intrathoracic	
Subgroup 5. Spine And Spinal Cord	
Subgroup 6. Upper Abdomen	406

Subgroup 7. Lower Abdomen	408
Subgroup 8. Perineum	
Subgroup 9. Pelvis (Except Hip)	414
Subgroup 10. Upper Leg (Except Knee)	
Subgroup 11. Knee And Popliteal Area	
Subgroup 12. Lower Leg (Below Knee)	
Subgroup 13. Shoulder And Axilla	
Subgroup 14. Upper Arm And Elbow	422
Subgroup 15. Forearm Wrist And Hand	423
Subgroup 16. Anaesthesia For Burns	
Subgroup 17. Anaesthesia For Radiological Or Other Diagnostic Or Therapeutic Procedures	
Subgroup 18. Miscellaneous	428
Subgroup 19. Therapeutic And Diagnostic Services	429
Subgroup 20. Administration Of Anaesthesia In Connection With A Dental Service	432
Subgroup 21. Anaesthesia/Perfusion Time Units	
Subgroup 22. Anaesthesia/Perfusion Modifying Units - Physical Status	443
Subgroup 23. Anaesthesia/Perfusion Modifying Units - Other	444
Subgroup 24. Anaesthesia After Hours Emergency Modifier	444
Subgroup 25. Perfusion After Hours Emergency Modifier	
Subgroup 26. Assistance At Anaesthesia	
Group T11. Botulinum Toxin Injections.	446
INDEX	451

GENERAL EXPLANATORY NOTES

GENERAL EXPLANATORY NOTES

GN.1.1 The Medicare Benefits Schedule - Introduction Schedules of Services

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

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

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

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

Explanatory Notes

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

GN.1.2 Medicare - an outline

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

- a. Free treatment for public patients in public hospitals.
- b. The payment of 'benefits', or rebates, for professional services listed in the Medicare Benefits Schedule (MBS). In general, the Medicare benefit is 85% of the Schedule fee, otherwise the benefits are
 - i. 100% of the Schedule fee for services provided by a general practitioner to non-referred, non-admitted patients;
 - ii. 100% of the Schedule fee for services provided on behalf of a general practitioner by a practice nurse or Aboriginal and Torres Strait Islander health practitioner;
 - iii. 75% of the Schedule fee for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients);
 - iv. 75% of the Schedule fee for professional services rendered as part of a privately insured episode of hospital-substitute treatment.

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

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

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

Where a Medicare benefit has been inappropriately paid, the Department of Human Services may request its return from the practitioner concerned.

GN.1.3 Medicare benefits and billing practices

Key information on Medicare benefits and billing practices

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

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

Billing practices contrary to the Act

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

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

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

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

Potential consequence of improperly issuing an account

The potential consequences for improperly issuing an account are

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

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

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

GN.2.4 Provider eligibility for Medicare

To be eligible to provide medical service which will attract Medicare benefits, or to provide services for or on behalf of another practitioner, practitioners must meet one of the following criteria:

- (a) be a recognised specialist, consultant physician or general practitioner; or
- (b) be in an approved placement under section 3GA of the Health Insurance Act 1973; or
- (c) be a temporary resident doctor with an exemption under section 19AB of the *Health Insurance Act 1973*, and working in accord with that exemption.

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

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

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

Non-medical practitioners

To be eligible to provide services which will attract Medicare benefits under MBS items 10950-10977 and MBS items 80000-88000 and 82100-82140 and 82200-82215, allied health professionals, dentists, and dental specialists, participating midwives and participating nurse practitioners must be

- (a) registered according to State or Territory law or, absent such law, be members of a professional association with uniform national registration requirements; and
- (b) registered with the Department of Human Services to provide these services.

GN.2.5 Provider Numbers

Practitioners eligible to have Medicare benefits payable for their services and/or who for Medicare purposes wish to raise referrals for specialist services and requests for pathology or diagnostic imaging services, may apply *in writing* to the Department of Human Services for a Medicare provider number for the locations where these services/referrals/requests will be provided. The form may be downloaded from the Department of Human Services website.

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

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

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

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

GN.2.6 Locum tenens

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

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

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

GN.2.7 Overseas trained doctor

Ten year moratorium

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

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

Exclusions - Practitioners who before 1 January 1997 had

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

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

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

GN.2.8 Contact details for the Department of Human Services Changes to Provider Contact Details

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

Medicare

GPO Box 9822

in your capital city

or

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

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

MBS Interpretations

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

or by phone on 132 150

GN.3.9 Patient eligibility for Medicare

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

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

GN.3.10 Medicare cards

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

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

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

GN.3.11 Visitors to Australia and temporary residents

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

GN.3.12 Reciprocal Health Care Agreements

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

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

Exceptions:

- · Visitors from Ireland and New Zealand are entitled to public hospital care and PBS drugs, and should present their passports before treatment as they are not issued with Medicare cards.
- · Visitors from Italy and Malta are covered for a period of six months only.

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

GN.4.13 General Practice

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

- (a) vocationally registered under section 3F of the *Health Insurance Act 1973* (see General Explanatory Note below); or
- (b) a Fellow of the Royal Australian College of General Practitioners (FRACGP), who participates in, and meets the requirements for the RACGP Quality Assurance and Continuing Medical Education Program; or
- (c) a Fellow of the Australian College of Rural and Remote Medicine (FACRRM) who participates in, and meets the requirements for the ACRRM Quality Assurance and Continuing Medical Education Program; or
- (d) is undertaking an approved general practice placement in a training program for *either* the award of FRACGP *or* a training program recognised by the RACGP being of an equivalent standard; or
- (e) is undertaking an approved general practice placement in a training program for *either* the award of FACRRM *or* a training program recognised by ACRRM as being of an equivalent standard.

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

Vocational recognition of general practitioners

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

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

In assessing whether a practitioner's medical practice is predominantly in general practice, the practitioner must have at least 50% of clinical time and services claimed against Medicare. Regard will also be given as to whether the

practitioner provides a comprehensive primary medical service, including treating a wide range of patients and conditions using a variety of accepted medical skills and techniques, providing services away from the practitioner's surgery on request, for example, home visits and making appropriate provision for the practitioner's patients to have access to after hours medical care.

Further information on eligibility for recognition should be directed to:

OI&CPD Program Administrator, RACGP

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

Secretary, General Practice Recognition Eligibility Committee:

Email at gprec@health.gov.au

Executive Assistant, ACRRM:

Tel: (07) 3105 8200 Email at acrrm@acrrm.org.au

How to apply for vocational recognition

Medical practitioners seeking vocational recognition should apply to the Department of Human Services using the approved Application Form available on the Department of Human Services website: www.humanservices.gov.au. Applicants should forward their applications, as appropriate, to

The Secretariat
The General Practice Recognition Eligibility Committee
National Registration and Accreditation Scheme Policy Section
MDP 152
Department of Health
GPO Box 9848
CANBERRA ACT 2601
email address: gprec@health.gov.au

The Secretariat
The General Practice Recognition Appeal Committee
National Registration and Accreditation Scheme Policy Section
MDP 152
Department of Health
GPO Box 9848
CANBERRA ACT 2601
email address: gprac@health.gov.au

The relevant body will forward the application together with its certification of eligibility to the Department of Human Services CEO for processing.

Continued vocational recognition is dependent upon:

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

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

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

Medical practitioners refused certification by the RACGP, the ACRRM or GPREC may appeal in writing to The Secretariat, General Practice Recognition Appeal Committee (GPRAC), National Registration and Accreditation Scheme Policy Section, MDP 152, Department of Health, GPO Box 9848, Canberra, ACT, 2601.

Removal of vocational recognition status

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

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

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

GN.5.14 Recognition as a Specialist or Consultant Physician

A medical practitioner who:

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

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

A relevant specialist College may also give the Department of Human Services' Chief Executive Officer a written notice stating that a medical practitioner meets the criteria for recognition.

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

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

Further information about applying for recognition is available at the <u>Department of Human Services' Medicare</u> website.

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

GN.5.15 Emergency Medicine

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

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

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

GN.6.16 Referral Of Patients To Specialists Or Consultant Physicians

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

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

What is a Referral?

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

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

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

The exceptions to the requirements in paragraph above are that

- (a) sub-paragraphs (i), (ii) and (iii) do not apply to
- a pre-anaesthesia consultation by a specialist anaesthetist (items 16710-17625);
- (b) sub-paragraphs (ii) and (iii) do not apply to
- a referral generated during an episode of hospital treatment, for a service provided or arranged by that hospital, where the hospital records provide evidence of a referral (including the referring practitioner's signature); or

- an emergency where the referring practitioner or the specialist or the consultant physician was of the opinion that the service be rendered as quickly as possible; and
- (c) sub-paragraph (iii) does not apply to instances where a written referral was completed by a referring practitioner but was lost, stolen or destroyed.

Examination by Specialist Anaesthetists

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

Who can Refer?

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

Referrals by Dentists or Optometrists or Participating Midwives or Participating Nurse Practitioners

For Medicare benefit purposes, a referral may be made to

- (i) a recognised specialist:
- (a) by a registered dental practitioner, where the referral arises from a dental service; or
- (b) by a registered optometrist where the specialist is an ophthalmologist; or
- (c) by a participating midwife where the specialist is an obstetrician or a paediatrician, as clinical needs dictate. A referral given by a participating midwife is valid until 12 months after the first service given in accordance with the referral and for I pregnancy only or
- (d) by a participating nurse practitioner to specialists and consultant physicians. A referral given by a participating nurse practitioner is valid until 12 months after the first service given in accordance with the referral.
- (ii) a consultant physician, by an approved dental practitioner (oral surgeon), where the referral arises out of a dental service.

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

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

Billing

Routine Referrals

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

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

Special Circumstances

(i) Lost, stolen or destroyed referrals.

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

(ii) Emergencies

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

(iii) Hospital referrals.

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

Public Hospital Patients

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

Bulk Billing

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

Period for which Referral is Valid

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

Specialist Referrals

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

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

Referrals by other Practitioners

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

Definition of a Single Course of Treatment

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

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

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

However, where the referring practitioner:-

- (a) deems it necessary for the patient's condition to be reviewed; and
- (b) the patient is seen by the specialist or the consultant physician outside the currency of the last referral; and
- (c) the patient was last seen by the specialist or the consultant physician more than 9 months earlier

the attendance following the new referral initiates a new course of treatment for which Medicare benefit would be payable at the initial consultation rates.

Retention of Referral Letters

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

A specialist or a consultant physician is required to retain the instrument of referral (and a hospital is required to retain the patient's hospital records which show evidence of a referral) for 2 years from the date the service was rendered.

A specialist or a consultant physician is required, if requested by the Department of Human Services CEO, to produce to a medical practitioner who is an employee of the Department of Human Services, the instrument of referral within seven days after the request is received. Where the referral originates in an emergency situation or in a hospital, the specialist or consultant physician is required to produce such information as is in his or her possession or control relating to whether the patient was so treated.

Attendance for Issuing of a Referral

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

Locum-tenens Arrangements

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

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

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

Self Referral

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

GN.7.17 Billing procedures

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

Bulk billing

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

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

Where the patient is bulk billed, an additional charge can **only** be raised against the patient by the practitioner where the patient is provided with a vaccine or vaccines from the practitioner's own supply held on the practitioner's premises. This exemption only applies to general practitioners and other non-specialist practitioners in association with attendance items **3** to **96**, **179** to **212**, **733** to **789** and **5000** to **5267** (inclusive) and only relates to vaccines that are not available to the patient free of charge through Commonwealth or State funding arrangements or available through the Pharmaceutical Benefits Scheme. The additional charge must only be to cover the supply of the vaccine.

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

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

GN.8.18 Provision for review of individual health professionals

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

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

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

Following a review, the Director must:

decide to take no further action; or

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

refer the matter to a PSR Committee.

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

The Committee is authorized to:

investigate any aspect of the provision of the referred services, and without being limited by the reasons given in the review request or by a Director's report following the review;

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

require the production of documents (including clinical notes).

The methods available to a PSR Committee to investigate and quantify inappropriate practice are specified in legislation:

(a) Patterns of Services - The Health Insurance (Professional Services Review) Regulations 1999 specify that when a general practitioner or other medical practitioner reaches or exceeds 80 or more attendances on each of 20 or more days in a 12-month period, they are deemed to have practiced inappropriately.

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

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

an unusual occurrence;

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

- **Sampling** A PSR Committee may use statistically valid methods to sample the clinical or practice records.
- **(c) Generic findings** If a PSR Committee cannot use patterns of service or sampling (for example, there are insufficient medical records), it can make a 'generic' finding of inappropriate practice.

Additional Information

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

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

If a PSR Committee finds that the person under review has engaged in inappropriate practice, the findings will be reported to the Determining Authority to decide what action should be taken:

- (i) a reprimand;
- (ii) counselling;
- (iii) repayment of Medicare benefits; and/or
- (iv) complete or partial disqualification from Medicare benefit arrangements for up to three years.

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

GN.8.19 Medicare Participation Review Committee

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

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

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

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

GN.8.20 Referral of professional issues to regulatory and other bodies

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

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

GN.8.21 Comprehensive Management Framework for the MBS

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

GN.8.22 Medical Services Advisory Committee

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

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

For more information on the MSAC refer to their website - www.msac.gov.au or email on msac.secretariat@health.gov.au or by phoning the MSAC secretariat on (02) 6289 7550.

GN.8.23 Pathology Services Table Committee

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

GN.9.25 Penalties and Liabilities

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

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

GN.10.26 Schedule fees and Medicare benefits

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

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

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

There are presently three levels of Medicare benefit payable:

a. 75% of the Schedule fee:

- i. for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients). Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '*' or the letter 'H' directly after an item number where used; or a description of the professional service and an indication the service was rendered as an episode of hospital treatment (for example, 'in hospital', 'admitted' or 'in patient');
- ii. for professional services rendered as part of an episode of hospital-substitute treatment, and the patient who receives the treatment chooses to receive a benefit from a private health insurer. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service, preceded by the words 'hospital-substitute treatment'
- b. 100% of the Schedule fee for non-referred attendances by general practitioners to non-admitted patients and services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a general practitioner.
- c. 85% of the Schedule fee, or the Schedule fee less \$83.40 (indexed annually in November), whichever is the greater, for all other professional services.

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

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

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

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

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

GN.10.27 Medicare safety nets

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

Original Medicare Safety Net:

Under the original Medicare safety net, the Medicare benefit for out-of-hospital services is increased to 100% of the Schedule Fee (up from 85%) once an annual threshold in gap costs is reached. Gap costs refer to the difference between the Medicare benefit (85%) and the Schedule Fee. The threshold from 1 January 2019 is \$470.00. This threshold applies to all Medicare-eligible singles and families.

Extended Medicare Safety Net:

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

caps is provided below. Out-of-pocket costs refer to the difference between the Medicare benefit and the fee charged by the practitioner.

In 2019, the threshold for singles and families that hold Commonwealth concession card, families that received Family Tax Benefit Part (A) (FTB(A)) and families that qualify for notional FTB (A) is \$680.70. The threshold for all other singles and families in 2019 is \$2,133.00.

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

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

EMSN Benefit Caps:

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

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

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

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

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

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

GN.11.28 Services not listed in the MBS

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

Enquiries about services not listed or on matters of interpretation should be directed to the Department of Human Services on 132 150.

GN.11.29 Ministerial Determinations

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

GN.12.30 Professional services

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

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

- (a) Category 1 (Professional Attendances) items except 170-172, 342-346, 820-880, 6029-6042, 6064-6075;
- (b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11304, 11600, 11627, 11701, 11712, 11722, 11724, 11728, 11921, 12000, 12003;
- (c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13709, 13750-13760, 13915-13948, 14050, 14053, 14218, 14221 and 14245);
- (d) Item 15600 in Group T2 (Radiation Oncology);
- (e) All Group T3 (Therapeutic Nuclear Medicine) items;
- (f) All Group T4 (Obstetrics) items (except 16400 and 16514);
- (g) All Group T6 (Anaesthetics) items;
- (h) All Group T7 (Regional or Field Nerve Block) items;
- (i) All Group T8 (Operations) items;
- (j) All Group T9 (Assistance at Operations) items;
- (k) All Group T10 (Relative Value Guide for Anaesthetics) items.

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

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

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

GN.12.31 Services rendered on behalf of medical practitioners

Medical services in Categories 2 and 3 not included in GN.12.30 and Category 5 (Diagnostic Imaging) services continue to attract Medicare benefits if the service is rendered by:-

- (a) the medical practitioner in whose name the service is being claimed;
- (b) a person, other than a medical practitioner, who is employed by a medical practitioner or, in accordance with accepted medical practice, acts under the supervision of a medical practitioner.

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

So that a service rendered by an employee or under the supervision of a medical practitioner may attract a Medicare rebate, the service must be billed in the name of the practitioner who must accept full responsibility for the service. All practitioners should ensure they maintain adequate and contemporaneous records. All elements of the service must be performed in accordance with accepted medical practice.

Supervision from outside of Australia is not acceptable.

While the supervising medical practitioner need not be present for the entire service, they must have a direct involvement in at least part of the service. Although the supervision requirements will vary according to the service in question, they will, as a general rule, be satisfied where the medical practitioner has:-

- (a) established consistent quality assurance procedures for the data acquisition; and
- (b) personally analysed the data and written the report.

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

GN.12.32 Medicare benefits and vaccinations

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

Example 1

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

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

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

Example 2

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

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

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

Example 3

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

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

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

GN.13.33 Services which do not attract Medicare benefits Services not attracting benefits

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

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

- (a) are paid/payable to a public hospital;
- (b) are for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability. (Please note that if the medical expenses relate to a compensable injury/illness for which the insurer/compensation agency is disputing liability, then Medicare benefits are payable until the liability is accepted.);
- (c) are for a medical examination for the purposes of life insurance, superannuation, a provident account scheme, or admission to membership of a friendly society;
- (d) are incurred in mass immunisation (see General Explanatory Note 12.3 for further explanation).

Unless the Minister otherwise directs

Medicare benefits are not payable where:

- (a) the service is rendered by or on behalf of, or under an arrangement with the Australian Government, a State or Territory, a local government body or an authority established under Commonwealth, State or Territory law;
- (b) the medical expenses are incurred by the employer of the person to whom the service is rendered;
- (c) the person to whom the service is rendered is employed in an industrial undertaking and that service is rendered for the purposes related to the operation of the undertaking; or
- (d) the service is a health screening service.
- (e) the service is a pre-employment screening service

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

- (a) chelation therapy (that is, the intravenous administration of ethylenediamine tetra-acetic acid or any of its salts) other than for the treatment of heavy-metal poisoning;
- (b) the injection of human chorionic gonadotrophin in the management of obesity;

- (c) the use of hyperbaric oxygen therapy in the treatment of multiple sclerosis;
- (d) the removal of tattoos;
- (e) the transplantation of a thoracic or abdominal organ, other than a kidney, or of a part of an organ of that kind; or the transplantation of a kidney in conjunction with the transplantation of a thoracic or other abdominal organ, or part of an organ of that kind;
- (f) the removal from a cadaver of kidneys for transplantation;
- (g) the administration of microwave (UHF radio wave) cancer therapy, including the intravenous injection of drugs used in the therapy.

Pain pumps for post-operative pain management

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

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

Non Medicare Services

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

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

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

- (a) endoluminal gastroplication, for the treatment of gastro-oesophageal reflux disease;
- (b) gamma knife surgery;
- (c) intradiscal electro thermal arthroplasty;
- (d) intravascular ultrasound (except where used in conjunction with intravascular brachytherapy);
- (e) intro-articular viscosupplementation, for the treatment of osteoarthritis of the knee;
- (f) low intensity ultrasound treatment, for the acceleration of bone fracture healing, using a bone growth stimulator;
- (g) lung volume reduction surgery, for advanced emphysema;
- (h) photodynamic therapy, for skin and mucosal cancer;
- (i) placement of artificial bowel sphincters, in the management of faecal incontinence;
- (j) selective internal radiation therapy for any condition other than hepatic metastases that are secondary to colorectal cancer;
- (k) specific mass measurement of bone alkaline phosphatase;
- (1) transmyocardial laser revascularisation;
- (m) vertebral axial decompression therapy, for chronic back pain.

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

Health Screening Services

Unless the Minister otherwise directs Medicare benefits are not payable for health screening services. A health screening service is defined as a medical examination or test that is not reasonably required for the management of the medical condition of the patient. Services covered by this proscription include such items as:

- (a) multiphasic health screening;
- (b) mammography screening (except as provided for in Items 59300/59303);
- (c) testing of fitness to undergo physical training program, vocational activities or weight reduction programs;
- (d) compulsory examinations and tests to obtain a flying, commercial driving or other licence;
- (e) entrance to schools and other educational facilities;
- (f) for the purposes of legal proceedings;
- (g) compulsory examinations for admission to aged persons' accommodation and pathology services associated with clinical ecology.

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

- (a) a medical examination or test on a symptomless patient by that patient's own medical practitioner in the course of normal medical practice, to ensure the patient receives any medical advice or treatment necessary to maintain their state of health. Benefits would be payable for the attendance and tests which are considered reasonably necessary according to patients individual circumstances (such as age, physical condition, past personal and family history). For example, a cervical screening test in a person (see General Explanatory note 12.3 for more information), blood lipid estimation where a person has a family history of lipid disorder. However, such routine check-up should not necessarily be accompanied by an extensive battery of diagnostic investigations;
- (b) a pathology service requested by the National Heart Foundation of Australia, Risk Evaluation Service;
- (c) age or health related medical examinations to obtain or renew a licence to drive a private motor vehicle;
- (d) a medical examination of, and/or blood collection from persons occupationally exposed to sexual transmission of disease, in line with conditions determined by the relevant State or Territory health authority, (one examination or collection per person per week). Benefits are not paid for pathology tests resulting from the examination or collection;
- (e) a medical examination for a person as a prerequisite of that person becoming eligible to foster a child or children;
- (f) a medical examination being a requisite for Social Security benefits or allowances;
- (g) a medical or optometrical examination provided to a person who is an unemployed person (as defined by the Social Security Act 1991), as the request of a prospective employer.

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

- (a) Cervical screening should be undertaken every five years in asymptomatic persons, using a primary human papillomavirus (HPV) test with partial genotyping and reflex liquid based cytology (LBC) triage;
- (b) Persons who have ever been sexually active should commence cervical screening at 25 years of age;

- (c) Persons aged 25 years or older and less than 70 years will receive invitations and reminders to participate in the program;
- (d) Persons will be invited to exit the program by having a HPV test between 70 years or older and less than 75 years of age and may cease cervical screening if their test result is low risk;
- (e) Persons 75 years of age or older who have either never had a cervical screening test or have not had one in the previous five years, may request a cervical screening test and can be screened;
- (f) All persons, both HPV vaccinated and unvaccinated, are included in the program;
- (g) Self collection of a sample for testing is available for persons who are aged 30 years and over and has never participated in the NCSP; or is overdue for cervical screening by two years or longer.
- Self collection must be facilitated and requested by a healthcare professional who also routinely offers cervical screening services;
- The self collection device and the HPV test, when used together, must meet the requirements of the National Pathology Accreditation Advisory Council (NPAAC) Requirements for Laboratories Reporting Tests for the NCSP; and
- (h) Persons with intermediate and higher risk screening test results should be followed up in accordance with the cervical screening pathway and the NCSP: Guidelines for the management of screen detected abnormalities, screening women in specific populations and investigation of women with abnormal vaginal bleeding (2016 Guidelines) endorsed by the Royal Australian College of General Practitioners, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Royal College of Pathologists of Australasia, the Australian Society of Gynaecologic Oncologists and the Australian Society for Colposcopy and Cervical Pathology.
- Note 1: As separate items exist for routine screening, screening in specific population and investigation of persons with abnormal vaginal bleeding, treating practitioners are asked to clearly identify on the request form, if the sample is collected as part of routine screening or for another purpose (see paragraph PP.16.11 of Pathology Services Explanatory Notes in Category 6).
- Note 2: Where reflex cytology is performed following the detection of HPV in routine screening, the HPV test and the LBC test results must be issued as a combined report with the overall risk rating.
- Note 3: See items 2501 to 2509, and 2600 to 2616 in Group A18 and A19 of Category 1 Professional Attendances and the associated explanatory notes for these items in Category 1 Professional Attendances.

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

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

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

- (a) a spouse, in relation to a dependant person means:
- a. a person who is legally married to, and is not living, on a permanent basis, separately and apart from, that person; and
- b. a de facto spouse of that person.
- (b) a child, in relation to a dependant person means:
- a. a child under the age of 16 years who is in the custody, care and control of the person or the spouse of the person; and

b. a person who:

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

GN.14.34 Principles of interpretation of the MBS

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

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

GN.14.35 Services attracting benefits on an attendance basis

Some services are not listed in the MBS because they are regarded as forming part of a consultation or they attract benefits on an attendance basis.

GN.14.36 Consultation and procedures rendered at the one attendance

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

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

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

GN.14.37 Aggregate items

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

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

GN.14.38 Residential aged care facility

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

GN.15.39 Practitioners should maintain adequate and contemporaneous records

All practitioners who provide, or initiate, a service for which a Medicare benefit is payable, should ensure they maintain **adequate** and **contemporaneous** records.

Note: 'Practitioner' is defined in Section 81 of the *Health Insurance Act 1973* and includes: medical practitioners, dentists, optometrists, chiropractors, physiotherapists, podiatrists and osteopaths.

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

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

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

clearly identify the name of the patient; and

contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated; and

each entry needs to provide clinical information adequate to explain the type of service rendered or initiated; and

each entry needs to be sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the patient's ongoing care.

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

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

CATEGORY 3: THERAPEUTIC PROCEDURES

SUMMARY OF CHANGES FROM 01/03/2019

The 01/03/2019 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

(a) new itemNew(b) amended descriptionAmend(c) fee amendedFee(d) item number changedRenum(e) EMSN changedEMSN

Amended Fee effective 8 March 2019

51011

Amended Notes

GN.2.8 GN.12.30 TN.7.4

Correct fee on MBS online from \$1,435.30 to \$1,435.50

The fee for item 51011 on MBS online does not match the fee outlined in the Health Insurance (General Medical Services Tables) Regulations 2018, or the fee administered by the Department of Human Services. This change will align MBS Online with the legislation.

THERAPEUTIC PROCEDURES NOTES

TN.1.1 Hyperbaric Oxygen Therapy - (Items 13015, 13020, 13025 and 13030)

Hyperbaric Oxygen Therapy not covered by these items would attract benefits on an attendance basis. For the purposes of these items, a comprehensive hyperbaric medicine facility means a separate hospital area that, on a 24 hour basis:

- (a) is equipped and staffed so that it is capable of providing to a patient:
- (i) hyperbaric oxygen therapy at a treatment pressure of at least 2.8 atmospheric pressure absolute (180 kilopascal gauge pressure); and
- (ii) mechanical ventilation and invasive cardiovascular monitoring within a monoplace or multiplace chamber for the duration of the hyperbaric treatment; and
- (b) is under the direction of at least 1 medical practitioner who is rostered, and immediately available, to the facility during the facility's ordinary working hours if the practitioner:
- (i) is a specialist with training in diving and hyperbaric medicine; or
- (ii) holds a Diploma of Diving and Hyperbaric Medicine of the South Pacific Underwater Medicine Society; and
- (c) is staffed by:
- (i) at least 1 medical practitioner with training in diving and hyperbaric medicine who is present in the facility and immediately available at all times when patients are being treated at the facility; and
- (ii) at least 1 registered nurse with specific training in hyperbaric patient care to the published standards of the Hyperbaric Technicians and Nurses Association, who is present during hyperbaric oxygen therapy; and
- (d) has admission and discharge policies in operation.

TN.1.2 Haemodialysis - (Items 13100 and 13103)

Item 13100 covers the supervision in hospital by a medical specialist for the management of dialysis, haemofiltration, haemoperfusion or peritoneal dialysis in the patient who is not stabilised where the total attendance time by the supervising medical specialist exceeds 45 minutes.

Item 13103 covers the supervision in hospital by a medical specialist for the management of dialysis, haemofiltration, haemoperfusion or peritoneal dialysis in a stabilised patient, or in the case of an unstabilised patient, where the total attendance time by the supervising medical specialist does not exceed 45 minutes.

TN.1.3 Consultant Physician Supervision of Home Dialysis - (Item 13104)

Item 13104 covers the planning and management of dialysis and the supervision of a patient on home dialysis by a consultant physician in the practice of his or her specialty of renal medicine. Planning and management would cover the consultant physician participating in patient management discussions coordinated by renal centres. Supervision of the patient at home can be undertaken by telephone or other electronic medium, and includes:

- Regular ordering, performance and interpretation of appropriate biochemical and haematological studies (generally monthly);
- Feed-back of results to the home patient and his or her treating general physician;
- Adjustments to medications and dialysis therapies based upon these results;

- Co-ordination of regular investigations required to keep patient on active transplantation lists, where relevant:
- Referral to, and communication with, other specialists involved in the care of the patient; and
- Being available to advise the patient or the patient's agent.

A record of the services provided should be made in the patient's clinical notes.

The schedule fee equates to one hour of time spent undertaking these activities. It is expected that the item will be claimed once per month, to a maximum of 12 claims per year. The patient should be informed that he or she will incur a charge for which a Medicare rebate will be payable.

This item includes dialysis conducted in a residential aged care facility. In remote areas, where a patient's home is an unsuitable environment for home dialysis due to a lack of space, or the absence of telecommunication, electricity and water utilities, the item includes dialysis in a community facility such as the local primary health care clinic.

TN.1.4 Assisted Reproductive Technology ART Services - (Items 13200 to 13221)

Medicare benefits are not payable in respect of ANY other item in the Medicare Benefits Schedule (including Pathology and Diagnostic Imaging) in lieu of or in connection with items 13200 - 13221. Specifically, Medicare benefits are not payable for these items in association with items 104, 105, 14203, 14206, 35637, pathology tests or diagnostic imaging.

A treatment cycle that is a series of treatments for the purposes of ART services is defined as beginning either on the day on which treatment by superovulatory drugs is commenced or on the first day of the patient's menstrual cycle, and ending either; not more than 30 days later, or if a service mentioned in item 13212, 13215 or 13321 is provided in connection with the series of treatments-on the day after the day on which the last of those services is provided.

The date of service in respect of treatment covered by Items 13200, 13201, 13203, 13206, 13209 and 13218 is **DEEMED** to be the **FIRST DAY** of the treatment cycle.

Items 13200, 13201, 13202 and 13203 are linked to the supply of hormones under the Section 100 (National Health Act) arrangements. Providers must notify the Department of Human Services of Medicare card numbers of patients using hormones under this program, and hormones are only supplied for patients claiming one of these four items.

Medicare benefits are not payable for assisted reproductive services rendered in conjunction with surrogacy arrangements where surrogacy is defined as 'an arrangement whereby a woman agrees to become pregnant and to bear a child for another person or persons to whom she will transfer guardianship and custodial rights at or shortly after birth'.

NOTE: Items 14203 and 14206 are not payable for artificial insemination.

TN.1.5 Intracytoplasmic Sperm Injection - (Item 13251)

Item 13251 provides for intracytoplasmic sperm injection for male factor infertility under the following circumstances:

- where fertilisation with standard IVF is highly unlikely to be successful; or
- where in a previous cycle of IVF, the fertilisation rate has failed due to low or no fertilisation.

Item 13251 excludes a service to which item 13218 applies. Sperm retrieval procedures associated with intracytoplasmic sperm injection are covered under items 37605 and 37606.

Items 13251, 37605, 37606 do not include services provided in relation to artificial insemination using the husband's or donated sperm.

TN.1.6 Peripherally Inserted Central Catheters

Peripherally inserted central catheters (PICC) are an alternative to standard percutaneous central venous catheter placement or surgically placed intravenous catheters where long-term venous access is required for ongoing patient therapy.

Medicare benefits for PICC can be claimed under central vein catheterisation items 13318, 13319, 13815 and 22020.

These items are for central vein catheterisation (where the tip of the catheter is positioned in a central vein) and cannot be used for venous catheters where the tip is positioned in a peripheral vein.

TN.1.7 Administration of Blood or Bone Marrow already Collected (Item 13706)

Item 13706 is payable for the transfusion of blood, or platelets or white blood cells or bone marrow or gamma globulins. This item is not payable when gamma globulin is administered intramuscularly.

TN.1.8 Collection of Blood - (Item 13709)

Medicare benefits are payable under Item 13709 for collection of blood for autologous transfusions in respect of an impending operation (whether or not the blood is used), or when homologous blood is required in an emergency situation.

Medicare benefits are not payable under Item 13709 for collection of blood for long-term storage for possible future autologous transfusion, or for other forms of directed blood donation.

TN.1.9 Intensive Care Units - (Items 13870 to 13888)

'Intensive Care Unit' means a separate hospital area that:

- (a) is equipped and staffed so as to be capable of providing to a patient:
- (i) mechanical ventilation for a period of several days; and
- (ii) invasive cardiovascular monitoring; and
- (b) is supported by:
- (i) at least one specialist or consultant physician in the specialty of intensive care who is immediately available and exclusively rostered to the ICU during normal working hours; and
- (ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and
- (iii) a registered nurse for at least 18 hours in each day; and
- (c) has defined admission and discharge policies.

"**immediately available**" means that the intensivist must be predominantly present in the ICU during normal working hours. Reasonable absences from the ICU would be acceptable to attend conferences, meetings and other commitments which might involve absences of up to 2 hours during the working day.

"exclusively rostered" means that the specialist's sole clinical commitment is to intensive care associated activities and is not involved in any other duties that may preclude immediate availability to intensive care if required.

For Neonatal Intensive Care Units an 'Intensive Care Unit' means a separate hospital area that:

- (a) is equipped and staffed so as to be capable of providing to a patient, being a newly-born child:
- (i) mechanical ventilation for a period of several days; and

- (ii) invasive cardiovascular monitoring; and
- (b) is supported by:
- (i) at least one consultant physician in the specialty of paediatric medicine, appointed to manage the unit, and who is immediately available and exclusively rostered to the ICU during normal working hours; and
- (ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and
- (iii) a registered nurse for at least 18 hours in each day; and
- (c) has defined admission and discharge policies.

Medicare benefits are payable under the 'management' items only once per day irrespective of the number of intensivists involved with the patient on that day. However, benefits are also payable for an attendance by another specialist/consultant physician who is not managing the patient but who has been asked to attend the patient. Where appropriate, accounts should be endorsed to the effect that the consultation was not part of the patient's intensive care management in order to identify which consultations should attract benefits in addition to the intensive care items.

In respect of Neonatal Intensive Care Units, as defined above, benefits are payable for admissions of babies who meet the following criteria:-

- (i) all babies weighing less than 1000gms;
- (ii) all babies with an endotracheal tube, and for the 24 hours following endotracheal tube removal;
- (iii) all babies requiring Constant Positive Airway Pressure (CPAP) for acute respiratory instability;
- (iv) all babies requiring more than 40% oxygen for more than 4 hours;
- (v) all babies requiring an arterial line for blood gas or pressure monitoring; or
- (vi) all babies having frequent seizures.

Cases may arise where babies admitted to a Neonatal Intensive Care Unit under the above criteria who, because they no longer satisfy the criteria are ready for discharge, in accordance with accepted discharge policies, but who are physically retained in the Neonatal Intensive Care Unit for other reasons. For benefit purposes such babies must be deemed as being discharged from the Neonatal Intensive Care Unit and not eligible for benefits under items 13870, 13873, 13876, 13881, 13882, 13885 and 13888.

Likewise, Medicare benefits are not payable under items 13870, 13873, 13876, 13881 13882, 13885 and 13888 in respect of babies not meeting the above criteria, but who, for whatever other reasons, are physically located in a Neonatal Intensive Care Unit.

Medicare benefits are payable for admissions to an Intensive Care Unit following surgery only where clear clinical justification for post-operative intensive care exists.

TN.1.10 Procedures Associated with Intensive Care - (Items 13818, 13842, 13847, 13848 and 13857) Item 13818 covers the insertion of a right heart balloon catheter (Swan-Ganz catheter). Benefits are payable under this item only once per day except where a second discrete operation is performed on that day.

Benefits are payable under items 13876 (within an ICU) and 11600 (outside an ICU) once only for each type of pressure, up to a maximum of 4 pressures per patient per calendar day, and irrespective of the number of the practitioners involoved in monitoring the pressures.

If a service covered by Item 13842 is provided outside of an ICU, in association with, for example, an anaesthetic, benefits are payable for Item 13842 in addition to Item 13870 where the services are performed on the same day. Where this occurs, accounts should be endorsed "performed outside of an Intensive Care Unit" against Item 13842.

Items 13847 and 13848

Item 13847 covers management of counterpulsation by intraaortic balloon on the first day and includes initial and subsequent consultations and monitoring of parameters. Insertion of the intraaortic balloon is covered under item 38609 Management on each day subsequent to the first is covered under item 13848.

"management" of counterpulsation of intraaortic balloon means full heamodynamic assessment and management on several occasions during the day.

Item 13857 covers the establishment of airway access and initiation of ventilation on a patient outside intensive care for the purpose of subsequent ventilatory support in intensive care. Benefits are not payable under Item 13857 where airway access and ventilation is initiated in the context of an anaesthetic for surgery even if it is likely that following surgery the patient will be ventilated in an ICU. In such cases the appropriate anaesthetic item/s should be itemised.

Medicare benefits are not payable for sampling by arterial puncture under Item 13839 in addition to Item 13870 (and 13873) on the same day. Benefits are payable under Item 13842 (Intra-arterial cannulation) in addition to Item 13870 (and 13873) when performed on the same day.

TN.1.11 Management and Procedures in Intensive Care Unit - (Items 13870, 13873, 13876)

Medicare benefits are only payable for management and procedures in intensive care covered by items 13870, 13873, 13876, 13882, 13885 and 13888 where the service is provided by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care.

Items 13870 and 13873

Medicare Benefits Schedule fees for Items 13870 and 13873 represent global daily fees covering all attendances by the intensivist in the ICU (and attendances provided by support medical personnel) and all electrocardiographic monitoring, arterial sampling and, bladder catheterisation.performed on the patient on the one day. If a patient is transferred from one ICU to another it would be necessary for an arrangement to be made between the two ICUs regarding the billing of the patient.

Items 13870 and 13873 should be itemised on accounts according to each calendar day and not per 24 hour period. For periods when patients are in an ICU for very short periods (say less than 2 hours) with minimal ICU management during that time, a fee should not be raised.

Item 13876

Item 13876 covers the monitoring of pressures in an ICU. Benefits are paid only once for each type of pressure, up to a maximum of 4 pressures per patient per calendar day and irrespective of the number of medical practitioners involved in the monitoring of pressures in an ICU.

Item 11600

Item 11600 covers the monitoring of pressures outside the ICU by practitioners not associated with the ICU. Benefits are paid only once for each type of pressure, up to a maximum of 4 pressures per patient per calendar day and irrespective of the number of practitioners involved in monitoring the pressures.

TN.1.12 Cytotoxic Chemotherapy Administration - (Item 13915)

Following a recommendation of a National Health and Medical Research Council review committee in 2005, Medicare benefits are no longer payable for professional services rendered for the purpose of administering microwave (UHF radiowave) cancer therapy, including the intravenous injection of drugs used in the therapy.

TN.1.13 Implanted Pump or Reservoir/Drug Delivery Device - (Items 13939 and 13942)

The schedule fee for Items 13939 and 13942 includes a component to cover accessing of the drug delivery device. Accordingly, benefits are not payable under Item 13945 (Long-term implanted drug delivery device, accessing of) in addition to Items 13939 and 13942.

TN.1.14 PUVA or UVB Therapy - (Item 14050)

A component for any necessary subsequent consultation has been included in the Schedule fee for this item. However, the initial consultation preceding commencement of a course of therapy would attract benefits.

Phototherapy should only be used when:

- Topical therapy has failed or is inappropriate.
- The severity of the condition as assessed by specialist opinion (including symptoms, extent of involvement and quality of life impairment) warrants its use.

Narrow band UVB should be the preferred option for phototherapy unless there is documented evidence of superior efficacy of UVA phototherapy for the condition being treated.

Phototherapy treatment for psoriasis and palmoplantar pustulosis should consider the National Institute of Health and Care Excellence's Guidelines at https://pathways.nice.org.uk/pathways/psoriasis

Involvement by a specialist in the specialty of dermatology at a minimum should include a letter stating the diagnosis, need for phototherapy, estimated time of treatment and review date.

TN.1.15 Laser Photocoagulation - (Items 14100 to 14124)

All laser equipment used for services under items 14100-14124 must be listed on the Australian Register of Therapeutic Goods.

The Australasian College of Dermatologists has advised that the following ranges (applicable to an average 4 year old child and an adult) should be used as a reference to the treatment areas specified in Items 14106 - 14124:

Entire forehead	50 -75 cm ²
Cheek	55 - 85 cm ²
Nose	10 -25 cm ²
Chin	10 - 30 cm ²
Unilateral midline anterior - posterior neck	60 - 220 cm ²
Dorsum of hand	25 - 80 cm ²
Forearm	100 - 250 cm ²
Upper arm	$105 - 320 \text{ cm}^2$

TN.1.16 Facial Injections of Poly-L-Lactic Acid - (Items 14201 and 14202)

Poly-L-lactic acid is listed within the standard arrangements on the Pharmaceutical Benefits Scheme (PBS) as an Authority Required listing for initial and maintenance treatments, for facial administration only, of severe facial lipoatrophy caused by therapy for HIV infection.

TN.1.17 Hormone and Living Tissue Implantation - (Items 14203 and 14206)

Items 14203 and 14206 are not payable for artificial insemination.

TN.1.18 Implantable Drug Delivery System for the Treatment of Severe Chronic Spasticity - (Items 14227 to 14242)

Baclofen is provided under Section 100 of the Pharmaceutical Benefits Scheme for the following indications: Severe chronic spasticity, where oral agents have failed or have caused unacceptable side effects, in patients with chronic spasticity:

- (a) of cerebral origin; or
- (b) due to multiple sclerosis; or
- (c) due to spinal cord injury; or
- (d) due to spinal cord disease.

Items 14227 to 14242 should be used in accordance with these restrictions.

TN.1.19 Immunomodulating Agent - (Item 14245)

Item 14245 applies only to a service provided by a medical practitioner who is registered by the Department of Human Services CEO to participate in the arrangements made, under paragraph 100 (1) (b) of the National Health Act 1953, for the purpose of providing an adequate pharmaceutical service for persons requiring treatment with an immunomodulating agent.

These drugs are associated with risk of anaphylaxis which must be treated by a medical practitioner. For this reason a medical practitioner needs to be available at all times during the infusion in case of an emergency.

TN.1.20 Therapeutic procedures may be provided by a specialist trainee (Items 13015 to 51318)

- (1) Items 13015 to 51318 (excluding 13209 (T1) 16400 to 16500 (T4), 16590 to 16591 (T4), 17610 to 17690 (T6) and 18350 to 18373 (T11) apply to a medical service provided by;
 - (a) A medical practitioner, or;
 - (b) A specialist trainee under the direct supervision of a medical practitioner.
- (2) For paragraph (1) (b), a medical service provided by a specialist trainee is taken to have been provided by the supervising medical practitioner.
- (3) In this rule: Specialist trainee means a medical practitioner who is undertaking an Australian Medical Council (AMC) accredited Medical College Training Program. Direct Supervision means personal and continuous attendance for the duration of the service.

TN.1.21 Telehealth Specialist Services

These notes provide information on the telehealth MBS video consultation items by specialists, consultant physicians and psychiatrists. A video consultation involves a single specialist, consultant physician or psychiatrist attending a patient, with the possible support of another medical practitioner, a participating optometrist, a participating nurse practitioner, a participating midwife, practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker at the patient end of the video conference. The decision as to whether the patient requires clinical support at the patient end of the specialist service is based on whether the support is necessary for the provision of the specialist service. Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

MBS items numbers 99, 112, 149, 288, 389, 2820, 3015, 6016, 13210, 16399 and 17609 allow a range of existing MBS attendance items to be provided via video conferencing. These items have a derived fee which is equal to 50% of the schedule fee for the consultation item claimed (e.g. 50% of the schedule fee for item 104) when billed with one of the associated consultation items (such as 104). A patient rebate of 85% for the derived fee is payable.

Six MBS item numbers (113, 114, 384, 2799, 3003 and 6004) provide for an initial attendance via videoconferencing by a specialist, consultant physician, consultant occupational physician, pain medicine specialist/consultant physician, palliative medicine specialist/consultant physician or neurosurgeon where the service is 10 minutes or less. The items are stand-alone items and do not have a derived fee.

Where an attendance is more than 10 minutes, practitioners should use the existing item numbers consistent with the current arrangements. Normal restrictions which apply for initial consultations will also apply for these items. For example, if a patient has an initial consultation via telehealth, they cannot also claim an initial face-to-face consultation as part of the same course of treatment.

Clinical indications

The specialist, consultant physician or psychiatrist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the specialist, consultant physician or psychiatrist.

Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

Restrictions

The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes hospital in the home patients). Benefits are not payable for telephone or email consultations. In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Billing Requirements

All video consultations provided by specialists, consultant physicians or psychiatrists must be **separately billed**. That is, only the relevant telehealth MBS consultation item and the associated derived item are to be itemised on the account/bill/voucher. Any other service/item billed should be itemised on a separate account/bill/voucher. This will ensure the claim is accurately assessed as being a video consultation and paid accordingly.

Practitioners should not use the notation 'telehealth', 'verbal consent' or 'Patient unable to sign' to overcome administrative difficulties to obtaining a patient signature for bulk billed claims (for further information see mbsonline.gov.au/telehealth).

Eligible Geographical Areas

Geographic eligibility for telehealth services funded under Medicare are determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are areas that are outside a Major City (RA1) according to ASGC-RA (RA2-5). Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

This rule will not apply to specialist video consultation with patients who are a care recipient in a residential care service; or at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the *Health Insurance Act 1973* as these patients are able to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at www.mbsonline.gov.au/ telehealth eligible areas

Record Keeping

Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Extended Medicare Safety Net (EMSN)

All telehealth consultations (with the exception of the participating optometrist telehealth items) are subject to EMSN caps. The EMSN caps for ART and Obstetric telehealth items 13210 and 16399 were set in reference to the EMSN caps applying to the base ART and Obstetric consultation items.

The EMSN caps for all other telehealth consultation items are equal to 300% of the schedule fee (to a maximum of \$500). The maximum EMSN benefit for a telehealth consultation is equal to the sum of the EMSN cap for the base item and the EMSN cap for the telehealth items.

Aftercare Rule

Video consultations are subject to the same aftercare rules as practitioners providing face-to-face consultations.

Multiple attendances on the same day

In some situations a patient may receive a telehealth consultation and a face to face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Referrals

The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Technical requirements

In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

TN.1.22 Cryopreservation of semen (Item 13260)

A semen cycle collection process involves obtaining up to 3 semen samples on alternate days producing up to 50 cryopreserved straws of frozen sperm.

Maximum of two semen collection cycles, one cycle collected prior to a patient undergoing the first cytotoxic/radiation treatment and the second cycle to be collected if the patient has relapsed and requires treatment.

TN.1.23 MBS Item 13105 - Haemodialysis in very remote areas

The purpose of item 13105 is for the management of haemodialysis to a person with end-stage renal disease. The service is provided in very remote areas (defined as Modified Monash 7) by a registered nurse, an Aboriginal health

worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner. The service is supervised by a medical practitioner (either in person or remotely).

As a condition of receiving the Medicare-funded dialysis treatment, the patient's care must be managed by a nephrologist, with the patient being treated or reviewed by the nephrologist every 3 to 6 months (either in person or remotely).

The patient is not an admitted patient of a hospital and the service is provided in a primary care setting.

Item 13104 should not be claimed if item 13105 is claimed.

TN.2.1 Radiation Oncology - General

The level of benefits for radiotherapy depends on the number of fields irradiated and the number of times treatment is given.

Treatment by rotational therapy (including rotational therapy using volumetric modulated arc therapy or intensity modulated arc therapy) is considered to be equivalent to the irradiation of three fields (i.e., irradiation of one field plus two additional fields). For example, each attendance for orthovoltage rotational therapy at the rate of 3 or more treatments per week would attract benefit under Item 15100 plus twice Item 15103. Similarly, each attendance for arc therapy of the prostate using a dual photon linear accelerator would attract benefits under 15248 plus twice 15263. Benefits are payable once only per attendance for treatment irrespective of whether one or more arcs are involved.

Benefits for consultations rendered on the same day as treatment and/or planning services are only payable where they are clinically relevant. A clinically relevant service is one that is generally accepted by the relevant profession as being necessary for the appropriate treatment of the patient.

From 1 January 2016, separate items were listed for intensity-modulated radiotherapy (IMRT) and image-guided radiotherapy (IGRT). Previously, these services were delivered and billed against the existing MBS three-dimensional radiotherapy items.

Definitions have been inserted into the Health Insurance (General Medical Services Table) Regulation as follows:

In items 15275, 15555, 15565 and 15715:

IMRT means intensity modulated radiation therapy, being a form of external beam radiation therapy that uses high energy megavoltage x rays to allow the radiation dose to conform more closely to the shape of a tumour by changing the intensity of the radiation beam.

In item 15275:

IGRT means image guided radiation therapy, being a process in which frequent 2 and 3 dimensional imaging is captured as close as possible to the time of treatment by using x rays and scans (similar to CT scans) before and during radiotherapy treatment, in order to show the size, shape and position of a cancer as well as the surrounding tissues and bones.

TN.2.2 Brachytherapy of the Prostate - (Item 15338)

One of the requirements of item 15338 is that patients have a Gleason score of less than or equal to 7. However, where the patient has a score of 7, comprising a primary score of 4 and a secondary score of 3 (ie. 4+3=7), it is recommended that low dose rate brachytherapy form part of a combined modality treatment.

Low dose brachytherapy of the prostate should be performed in patients with favourable anatomy allowing adequate access to the prostate without pubic arch interference and who have a life expectancy of at least greater than 10 years.

An 'approved site' for the purposes of this item is one at which radiation oncology services may be performed lawfully under the law of the State or Territory in which the site is located.

TN.2.3 Planning Services - (Items 15500 to 15565 and 15850)

A planning episode involves field setting and dosimetry. One plan only will attract Medicare benefits in a course of treatment. However, benefits are payable for a plan for brachytherapy and a plan for megavoltage or teletherapy treatment, when rendered in the same course of treatment.

- further planning items where planning is undertaken in respect of a different tumour site to that (or those) specified in the original prescription by the radiation oncologist; and
- a plan for brachytherapy and a plan for megavoltage or teletherapy treatment, when rendered in the same course of treatment.

Items 15500 to 15533 (inclusive) are for a planning episode for 2D conformal radiotherapy. Items 15550 to 15562 (excluding item 15555) are for a planning episode for 3D conformal radiotherapy. Items 15555 and 15565 are for a planning episode for intensity modulated radiotherapy (IMRT).

It is expected that the 2D simulation items (15500, 15503, and 15506) would be used in association with the 2D planning items (15518, 15521, and 15524) in a planning episode. However there may be instances where it may be appropriate to use the 3D Planning items (15556, 15559, and 15562) in association with the 2D simulation items (15500, 15503, and 15506) in a planning episode. The 3D simulation items (15550 and 15553) can only be billed in association with the 3D planning items (15556, 15559, and 15562) in a planning episode. However there may be instances where it may be appropriate to use the 3D Planning items (15556, 15559, and 15562) in association with the 2D simulation items (15500, 15503, and 15506) in a planning episode. The 3D simulation items (15550 and 15553) can only be billed in association with the 3D planning items (15556, 15559, and 15562) in a planning episode. The IMRT simulation item (15555) and IMRT dosimetry item (15565) can only be billed in association with each other and only for IMRT (i.e. neither IMRT simulation items for an episode of care).

Item 15850 covers radiation source localisation for high dose brachytherapy treatment. Item 15850 applies to brachytherapy provided to any part of the body.

TN.2.4 Treatment Verification - (Items 15700 to 15705, 15710, 15715 and 15800)

In these items, 'treatment verification' means:

A quality assurance procedure designed to facilitate accurate and reproducible delivery of the radiotherapy/brachytherapy to the prescribed site(s) or region(s) of the body as defined in the treatment prescription and/or associated dose plan(s) and which utilises the capture and assessment of appropriate images using:

- (a) x-rays (this includes portal imaging, either megavoltage or kilovoltage, using a linear accelerator)
- (b) computed tomography; or
- (c) ultrasound, where the ultrasound equipment is capable of producing images in at least three dimensions (unidimensional ultrasound is not covered); together with a record of the assessment(s) and any correction(s) of significant treatment delivery inaccuracies detected.

Item 15700 covers the acquisition of images in one plane and incorporates both single or double exposures. The item may be itemised once only per attendance for treatment, irrespective of the number of treatment sites verified at that attendance.

Item 15705 (multiple projections) applies where images in more that one plane are taken, for example orthogonal views to confirm the isocentre. It can be itemised only where verification is undertaken of treatments involving three or more fields. It can be itemised where single projections are acquired for multiple sites, eg multiple

metastases for palliative patients. Item 15705 can be itemized only once per attendance for treatment, irrespective of the number of treatment sites verified at that attendance.

15710 applies to volumetric verification imaging using acquisition by computed tomography. It can be itemised only where verification is undertaken of treatments involving three or more fields and only once per attendance for treatment, irrespective of the number of treatment sites verified at that attendance.

Items 15700, 15705, 15710 and 15715:

- may not claimed together for the same attendance at which treatment is rendered
- must only be itemised when the verification procedure has been prescribed in the treatment plan and the image has been reviewed by a radiation oncologist

Item 15800 - Benefits are payable once only per attendance at which treatment is verified.

TN.3.1 Therapeutic Dose of Yttrium 90 - (Item 16003)

This item cannot be claimed for selective internal radiation therapy (SIRT).

See items 35404, 35406 and 35408 for SIRT using SIR_Spheres (yttrium-90 microspheres).

TN.4.1 Antenatal Service Provided by a Nurse, Midwife or an Aboriginal and Torres Strait Islander health practitioner - (Item 16400)

Item 16400 can only be claimed by a medical practitioner (including a vocationally registered or non-vocationally registered GP, a specialist or a consultant physician) where an antenatal service is provided to a patient by a midwife, nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of the medical practitioner at, or from an eligible practice location in a regional, rural or remote area.

A regional, rural or remote area is classified as a RRMA 3-7 area under the Rural Remote Metropolitan Areas classification system.

Evidence based national or regional guidelines should be used in the delivery of this antenatal service.

An eligible practice location is the place associated with the medical practitioner's Medicare provider number from which the service has been provided. If you are unsure if the location is in an eligible area you can call the Department of Human Services on 132 150.

A midwife means a registered midwife who holds a current practising certificate as a midwife issued by a State or Territory regulatory authority and who is employed by, or whose services are otherwise retained by, the medical practitioner or their practice.

A nurse means a registered or enrolled nurse who holds a current practising certificate as a nurse issued by a State or Territory regulatory authority and who is employed by, or whose services are otherwise retained by, the medical practitioner or their practice. The nurse must have appropriate training and skills to provide an antenatal service.

An Aboriginal and Torres Strait Islander health practitioner means a person who has been registered as an Aboriginal and Torres Strait Islander health practitioner by the Aboriginal and Torres Strait Islander Health Practice Board of Australia and meets the Board's registration standards. The Aboriginal and Torres Strait Islander health practitioner must be employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under subsection 19(2) of the Health Insurance Act 1973.

An Aboriginal and Torres Strait Islander health practitioner may use any of the titles authorised by the Aboriginal and Torres Strait Islander Health Practice Board: Aboriginal health practitioner; Aboriginal and Torres Strait Islander health practitioner; or Torres Strait Islander health practitioner.

The midwife, nurse or Aboriginal and Torres Strait Islander health practitioner must also comply with any relevant legislative or regulatory requirements regarding the provision of the antenatal service.

The medical practitioner under whose supervision the antenatal service is provided retains responsibility for the health, safety and clinical outcomes of the patient. The medical practitioner must be satisfied that the midwife, nurse or Aboriginal and Torres Strait Islander health practitioner is appropriately registered, qualified and trained, and covered by indemnity insurance to undertake antenatal services.

Supervision at a distance is recognised as an acceptable form of supervision. This means that the medical practitioner does not have to be physically present at the time the service is provided. However, the medical practitioner should be able to be contacted if required.

The medical practitioner is not required to see the patient or to be present while the antenatal service is being provided by the midwife, nurse or Aboriginal and Torres Strait Islander health practitioner. It is up to the medical practitioner to decide whether they need to see the patient. Where a consultation with the medical practitioner has taken place prior to or following the antenatal service, the medical practitioner is entitled to claim for their own professional service, but item 16400 cannot be claimed in these circumstances.

Item 16400 cannot be claimed in conjunction with another antenatal attendance item for the same patient, on the same day by the same practitioner.

A bulk billing incentive item (10990, 10991 or 10992) cannot be claimed in conjunction with item 16400. An incentive payment is incorporated into the schedule fee.

Item 16400 can only be claimed 10 times per pregnancy.

Item 16400 cannot be claimed for an admitted patient of a hospital.

TN.4.2 Items for Initial and Subsequent Obstetric Attendances (Items 16401 and 16404)

16401 and 16404 replace items 104 and 105 for any specialist obstetric attendance relating to pregnancy. This includes any initial and subsequent attendance with a specialist obstetrician for discussion of pregnancy or pregnancy related conditions or complications, or any postnatal care provided to the patient subsequent to the expiration of normal aftercare period. Item 16500 is still claimed for routine antenatal attendances. These items are subject to Extended Medicare Safety Net caps.

TN.4.3 Antenatal Care - (Item 16500)

In addition to routine antenatal attendances covered by Item 16500 the following services, where rendered during the antenatal period, attract benefits:-

- (a) Items 16501, 16502, 16505, 16508, 16509 (but not normally before the 24th week of pregnancy), 16511, 16512, 16514, 16533, 16534 and 16600 to 16627.
- (b) The initial consultation at which pregnancy is diagnosed.
- (c) The first referred consultation by a specialist obstetrician when called in to advise on the pregnancy.
- (d) All other services, excluding those in Category 1 and Group T4 of Category 3 not mentioned above.
- (e) Treatment of an intercurrent condition not directly related to the pregnancy.

Item 16514 relates to antenatal cardiotocography in the management of high risk pregnancy. Benefits for this service are not attracted when performed during the course of the labour and birth.

TN.4.4 External Cephalic Version for Breech Presentation - (Item 16501)

Contraindications for this item are as follows:

- antepartum haemorrhage (APH)
- multiple pregnancy,
- fetal anomaly,
- fetal growth restriction,
- caesarean section scar,
- uterine anomalies,
- obvious cephalopelvic disproportion,
- isoimmunization,
- premature rupture of the membranes.

TN.4.5 Labour and Birth - (Items 16515, 16518, 16519, 16530 and 16531)

Benefits for management of labour and birth covered by Items 16515, 16518, 16519, 16530 and 16531 includes the following (where indicated):-

- surgical and/or intravenous infusion induction of labour;
- forceps or vacuum extraction;
- evacuation of products of conception by manual removal (not being an independent procedure);
- episiotomy or repair of tears.

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

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

Two items in Group T9 provide benefits for assistance by a medical practitioner at a Caesarean section. Item 51306 relates to those instances where the Caesarean section is the only procedure performed, while Item 51309 applies when other operative procedures are performed at the same time.

Where, during labour, a medical practitioner hands the patient over to another medical practitioner, benefits are payable under Item 16518 for the referring practitioner's services. The second practitioner's services would attract benefits under Item 16515 (i.e., management of vaginal birth) or Item 16520 (Caesarean section). If another medical practitioner is called in for the management of the labour and birth, benefits for the referring practitioner's services should be assessed under Item 16500 for the routine antenatal attendances and on a consultation basis for the postnatal attendances, if performed.

At a high risk birth benefits will be payable for the attendance of any medical practitioner (called in by the doctor in charge of the birth) for the purposes of resuscitation and subsequent supervision of the neonate. Examples of high risk births include cases of difficult vaginal birth, Caesarean section or the birth of babies with Rh problems and babies of toxaemic mothers.

TN.4.6 Caesarean Section - (Item 16520)

Benefits under this item are attracted only where the patient has been specifically referred to another medical practitioner for the management of the birth by Caesarean section and the practitioner carrying out the procedure has not rendered any antenatal care. Caesarean sections performed in any other circumstances attract benefits under Item 16519.

TN.4.7 Complicated Confinement - (Item 16522)

A record of the clinical indication/s that constitute billing under item 16522 should be retained on the patient's medical record.

TN.4.8 Labour and Birth Where Care is Transferred by a Participating Midwife - (Items 16527 to 16528)

Where the intrapartum care of a patient is transferred to a medical practitioner by a participating midwife for the management of birth, item 16527 or 16528 would apply depending on the service provided.

Where care is transferred by a participating midwife prior to the commencement of labour, items 16519 or 16522 would apply.

TN.4.9 Items for Planning and Management of a Pregnancy (Item 16590 and 16591)

Item 16590 is intended to provide for the planning and management of pregnancy that has progressed beyond 28 weeks, where the medical practitioner is intending to undertake the birth for a privately admitted patient.

Item 16591 is for the planning and management of a pregnancy that has progressed beyond 28 weeks and the medical practitioner is providing shared antenatal care and is not intending to undertake the birth.

Items 16590 and 16591 are to include the provision of a mental health assessment of the patient. Both items are subject to Extended Medicare Safety Net caps and should only be claimed by a patient once per pregnancy.

TN.4.10 Post-Partum Care - (Items 16515 to 16520 and 16564 to 16573)

The Schedule fees and benefits payable for Items 16519 and 16520 cover all postnatal attendances on the mother and the baby, except in the following circumstances:-

- (i) where the medical services rendered are outside those covered by a consultation, e.g., blood transfusion;
- (ii) where the condition of the mother and/or baby is such as to require the services of another practitioner (e.g., paediatrician, gynaecologist, etc);
- (iii) where the patient is transferred, at arms length, to another medical practitioner for routine post-partum, care (eg mother and/or baby returning from a larger centre to a country town or transferring between hospitals following confinement). In such cases routine postnatal attendances attract benefits on an attendance basis. The transfer of a patient within a group practice would not qualify for benefits under this arrangement except in the case of Items 16515 and 16518. These items cover those occasions when a patient is handed over while in labour from the practitioner who under normal circumstances would have delivered the baby, but because of compelling circumstances decides to transfer the patient to another practitioner for the birth;
- (iv) where during the postnatal period a condition occurs which requires treatment outside the scope of normal postnatal care;
- (v) in the management of premature babies (i.e. babies born prior to the end of the 37th week of pregnancy or where the birth weight of the baby is less than 2500 grams) during the period that close supervision is necessary.

Normal postnatal care by a medical practitioner would include:-

(i) uncomplicated care and check of

- lochia
- fundus
- perineum and vulva/episiotomy site
- temperature
- bladder/urination
- bowels
- (ii) advice and support for establishment of breast feeding
- (iii) psychological assessment and support
- (iv) Rhesus status
- (v) Rubella status and immunisation
- (vi) contraception advice/management

Examinations of apparently normal newborn infants by consultant or specialist paediatricians do not attract benefits

Items 16564 to 16573 relate to postnatal complications and should not be itemised in respect of a normal birth. To qualify for benefits under these items, the patient is required to be transferred to theatre, or be administered general anaesthesia or epidural injection for the performance of the procedure. Utilisation of the items will be closely monitored to ensure appropriate usage.

TN.4.11 Interventional Techniques - (Items 16600 to 16627, 35518 and 35674)

For Items 16600 to 16627, 35518 and 35674 there is no component in the Schedule fee for the associated ultrasound. Benefits are attracted for the ultrasound under the appropriate items in Group I1 of the Diagnostic Imaging Services Table. If diagnostic ultrasound is performed on a separate occasion to the procedure, benefits would be payable under the appropriate ultrasound item.

Item 51312 provides a benefit for assistance by a medical practitioner at interventional techniques covered by Items 16606, 16609, 16612, 16615, and 16627.

TN.4.12 Telehealth Specialist Services

These notes provide information on the telehealth MBS video consultation items by specialists, consultant physicians and psychiatrists. A video consultation involves a single specialist, consultant physician or psychiatrist attending a patient, with the possible support of another medical practitioner, a participating optometrist, a participating nurse practitioner, a participating midwife, practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker at the patient end of the video conference. The decision as to whether the patient requires clinical support at the patient end of the specialist service is based on whether the support is necessary for the provision of the specialist service. Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

MBS items numbers 99, 112, 149, 288, 389, 2820, 3015, 6016, 13210, 16399 and 17609 allow a range of existing MBS attendance items to be provided via video conferencing. These items have a derived fee which is equal to 50% of the schedule fee for the consultation item claimed (e.g. 50% of the schedule fee for item 104) when billed with one of the associated consultation items (such as 104). A patient rebate of 85% for the derived fee is payable.

Six MBS item numbers (113, 114, 384, 2799, 3003 and 6004) provide for an initial attendance via videoconferencing by a specialist, consultant physician, consultant occupational physician, pain medicine

specialist/consultant physician, palliative medicine specialist/consultant physician or neurosurgeon where the service is 10 minutes or less. The items are stand alone items and do not have a derived fee.

Where an attendance is more than 10 minutes, practitioners should use the existing item numbers consistent with the current arrangements. Normal restrictions which apply for initial consultations will also apply for these items. For example, if a patient has an initial consultation via telehealth, they cannot also claim an initial face-to-face consultation as part of the same course of treatment.

Clinical indications

The specialist, consultant physician or psychiatrist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the specialist, consultant physician or psychiatrist.

Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

Restrictions

The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes hospital in the home patients). Benefits are not payable for telephone or email consultations. In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Billing Requirements

All video consultations provided by specialists, consultant physicians or psychiatrists must be **separately billed**. That is, only the relevant telehealth MBS consultation item and the associated derived item are to be itemised on the account/bill/voucher. Any other service/item billed should be itemised on a separate account/bill/voucher. This will ensure the claim is accurately assessed as being a video consultation and paid accordingly.

Practitioners should not use the notation 'telehealth', 'verbal consent' or 'Patient unable to sign' to overcome administrative difficulties to obtaining a patient signature for bulk billed claims (for further information see mbsonline.gov.au/telehealth).

Eligible Geographical Areas

Geographic eligibility for telehealth services funded under Medicare are determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are areas that are outside a Major City (RA1) according to ASGC-RA (RA2-5). Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

This rule will not apply to specialist video consultation with patients who are a care recipient in a residential care service; or at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the *Health Insurance Act 197*, as these patients are able to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at www.mbsonline.gov.au/ telehealth eligible areas

Record Keeping

Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Extended Medicare Safety Net (EMSN)

All telehealth consultations (with the exceptions of the participating optometrist telehealth items) are subject to EMSN caps. The EMSN caps for ART and Obstetric telehealth items 13210 and 16399 were set in reference to the EMSN caps applying to the base ART and Obstetric consultation items.

The EMSN caps for all other telehealth consultation items are equal to 300% of the schedule fee (to a maximum of \$500). The maximum EMSN benefit for a telehealth consultation is equal to the sum of the EMSN cap for the base item and the EMSN cap for the telehealth items.

Aftercare Rule

Video consultations are subject to the same aftercare rules as practitioners providing face-to-face consultations.

Multiple attendances on the same day

In some situations a patient may receive a telehealth consultation and a face to face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Referrals

The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Technical requirements

In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

TN.4.13 Mental Health Assessments for Obstetric Patients (Items 16590, 16591, 16407)

Items for the planning and management of pregnancy (16590 and 16591) and for a postnatal attendance between 4 and 8 weeks after birth (16407), include a mental health assessment of the patient, including screening for drug and alcohol use and domestic violence, to be performed by the clinician or another suitably qualified health professional on behalf of the clinician. A mental health assessment must be offered to each patient, however, if the patient chooses not to undertake the assessment, this does not preclude a rebate being payable for these items.

It is recommended that mental health assessments associated with items 16590, 16591, and 16407 be conducted in accordance with the National Health and Medical Research Council (NHMRC) endorsed guideline: *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline* – October 2017, Centre for Perinatal Excellence.

Results of the mental health assessment must be recorded in the patient's medical record. A record of a patient's decision not to undergo a mental health assessment must be recorded in the patient's clinical notes.

TN.4.14 Extended Medicare Safety Net (EMSN) for Obstetric Services (Items 16531, 16533 and 16534)

The Extended Medicare Safety Net (EMSN) benefit is capped at 65% of the schedule fee for obstetric items 16531, 16533, and 16534. However, as these items are for in-hospital services only, the EMSN does not apply

TN.6.1 Pre-anaesthesia Consultations by an Anaesthetist - (Items 17610 to 17625)

Pre-anaesthesia consultations are covered by items in the range 17610 - 17625.

Pre-anaesthesia consultations comprise 4 time-based items utilising 15 minute increments up to and exceeding 45 minutes, in conjunction with content-based descriptors. A pre-anaesthesia consultation will attract benefits under the appropriate items based on **BOTH** the duration of the consultation **AND** the complexity of the consultation in accordance with the requirements outlined in the content-based item descriptions.

Whether or not the proposed procedure proceeds, the pre-anaesthetic attendance will attract benefits under the appropriate consultation item in the range 17610 - 17625, as determined by the duration and content of the consultation.

The following provides further guidance on utilisation of the appropriate items in common clinical situations:

- (i) Item 17610 (15 mins or less) a pre-anaesthesia consultation of a straightforward nature occurring prior to investigative procedures and other routine surgery. This item covers routine pre-anaesthesia consultation services including the taking of a brief history, a limited examination of the patient including the cardio-respiratory system and brief discussion of an anaesthesia plan with the patient.
- (ii) Item 17615 (16-30 mins) a pre-anaesthesia consultation of between 16 to 30 minutes duration AND of significantly greater complexity than that required under item 17610. To qualify for benefits patients will be undergoing advanced surgery or will have complex medical problems. The consultation will involve a more extensive examination of the patient, for example: the cardio-respiratory system, the upper airway, anatomy relevant to regional anaesthesia and invasive monitoring. An anaesthesia plan of management should be formulated, of which there should be a written record included in the patient notes.
- (iii) Item 17620 (31-45 mins) a pre-anaesthesia consultation of high complexity involving all of the requirements of item 17615 and of between 31 to 45 minutes duration. The pre-anaesthesia consultation will also involve evaluation of relevant patient investigations and the formulation of an anaesthesia plan of management of which there should be a written record in the patient notes.
- (iv) Item 17625 (more than 45 mins) a pre-anaesthesia consultation of high complexity involving all of the requirements of item 17615 and item 17620 and of more than 45 minutes duration. The pre-anaesthesia consultation will also involve evaluation of relevant patient investigations as well as discussion of the patient's medical condition and/or anaesthesia plan of management with other relevant healthcare professionals. An anaesthesia plan of management should be formulated, of which there should be a written record included in the patient notes.

Some examples of advanced surgery that may require a longer consultation under items 17615-17625 would include:

- · Bowel resection
- · Caesarean section
- · Neonatal surgery
- · Major laparotomies
- · Radical cancer resection
- · Major reconstructive surgery eg free flap transfers, breast reconstruction

- · major joint arthroplasty
- · joint reconstruction
- · Thoracotomy
- · Craniotomy
- · Spinal surgery eg spinal fusion, discectomy
- · Major vascular surgery eg aortic aneurysm repair, arterial bypass surgery, carotid artery endarterectomy

Some examples of complex medical problems in relation to items 17615-17625 would include:

- · Major cardiac problems e.g cardiomyopathy, unstable ischaemic heart disease, heart failure
- · Major respiratory disease e.g COPD, respiratory failure, acute lung conditions eg. infection and asthma,
- · Major neurological conditions CVA, intra/extra cerebral haemorrhage, cerebral palsy and/or major intellectual disability, degenerative conditions of the CNS
- · Major metabolic conditions e.g unstable diabetes, uncontrolled hyperthyroidism, renal failure, liver failure, immune deficiency
- · Anaesthetic problems eg past history of awareness, known or anticipated difficulty with securing the airway, malignant hyperpyrexia, drug allergy,
- · Other conditions -
- patients with history of stroke/TIA's presenting for vascular surgery
- patients on anti-platelet agents presenting for major surgery requiring management of anticoagulant status
- patients with poor respiratory/cardiac function presenting for major surgery requiring management of perioperative medications, analgaesia and monitoring

NOTE I:

It is important to note that:

- · patients undergoing the types of advanced surgery listed above but who are otherwise of reasonable health and who, therefore, do not require a longer pre-anaesthesia consultation as provided for under items 17615-17625, would qualify for benefits under item 17610; and
- · not all patients with complex medical problems will qualify for a longer consultation under items 17615-17625. For example, patients who have reasonably stable diabetes may only require a short consultation, covered under item 17610. Similarly, patients with reasonably well controlled emphysema (COPD) undergoing minor surgery may only require a short pre-anaesthesia consultation (item 17610), whereas the same patient scheduled for an upper abdominal laparotomy and with recent onset angina with the possible need for ICU postoperatively may require a longer consultation.

NOTE II:

- · Consultation services covered by pain specialists items in the range 2801-3000 cannot be claimed in conjunction with items 17610-17625
- The consultation time under items 17610 17625 only applies to the period of active attendance on the patient and does not include time spent in discussion with other health care practitioners.

• The requirement of a written patient management plan in items 17615-17625 or the discussion of the management plan with other health care professions, where this occurs, does not relate to and cannot be claimed in conjunction GP Management Plans, Team Care Arrangements, Multidisciplinary Care Plans or Case Conference items in Group A15 of the MBS

TN.6.2 Referred Anaesthesia Consultations - (Items 17640 to 17655)

Referred anaesthesia consultations (other than pre-anaesthesia attendances) where the patient is referred will be covered by new items in the range 17640 - 17655. These new items replace the use of specialist referred items 104 and 105. Items 104 and 105 will no longer apply to referred anaesthesia consultations provided by specialist anaesthetists.

Referred anaesthesia consultations comprise 4 time-based items utilising 15 minute increments up to and exceeding 45 minutes, in conjunction with content-based descriptors. Services covered by these specialist referred items include consultations in association with the following:

- (i) Acute pain management
- · Postoperative, utilising specialised techniques eg Patient Controlled Analgesia System (PCAS)
- · as an independent service eg pain control following fractured ribs requiring nerve blocks
- · obstetric pain management
- (ii) Perioperative management of patients
- · postoperative management of cardiac, respiratory and fluid balance problems following major surgery
- · vascular access procedures (other than intra-operative peripheral vascular access procedures)

Items 17645 - 17655 will involve the examination of multiple systems and the formulation of a written management plan. Items 17650 and 17655 would also entail the ordering and/or evaluation of relevant patient investigations.

NOTE:

- · It should be noted that the consultation time under items 17640 17655 only applies to the period of active attendance on the patient and does not include time spent in discussion with other health care practitioners.
- \cdot Consultation services covered by pain medicine specialist items in the range 2801-3000 cannot be claimed in conjunction with items 17640 17655.
- · The requirement of a written patient management plan in items 17645-17655 or the discussion of the management plan with other health care professions, where this occurs, does not relate to and cannot be claimed in conjunction GP Management Plans, Team Care Arrangements, Multidisciplinary Care Plans or Case Conference items in Group A15 of the MBS.

It would be expected that in the vast majority of cases, the insertion of a peripheral venous cannula (other than in association with anaesthesia) where the patient is referred, would attract benefit under item 17640. However, in exceptional clinical circumstances, where the procedure is considerably more difficult and exceeds 15 minutes, such as for patients with chronic disease undergoing long term intravenous therapy, paediatric patients or patients having chemotherapy, item 17645 would apply.

TN.6.3 Anaesthetist Consultations - Other - (Items 17680, 17690)

A consultation occurring immediately before the institution of major regional blockade for a patient in labour is covered by item 17680.

Item 17690 can only be claimed where all of the conditions set out in (a) to (d) of item 17690 have been met.

Item 17690 can only be claimed in conjunction with a service covered by items 17615, 17620, or 17625.

Item 17690 cannot be claimed where the pre-anaesthesia consultation covered by items 17615, 17620 or 17625 is provided on the same day as admission to hospital for the subsequent episode of care involving anaesthesia services.

NOTE: Consultation services covered by pain medicine specialist items in the range 2801-3000 cannot be claimed in conjunction with anaesthesia consultation items 17610 - 17690.

TN.6.4 Telehealth Specialist Services

These notes provide information on the telehealth MBS video consultation items by specialists, consultant physicians and psychiatrists. A video consultation involves a single specialist, consultant physician or psychiatrist attending a patient, with the possible support of another medical practitioner, a participating optometrist, a participating nurse practitioner, a participating midwife, practice nurse or Aboriginal health worker at the patient end of the video conference. The decision as to whether the patient requires clinical support at the patient end of the specialist service is based on whether the support is necessary for the provision of the specialist service. Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

MBS items numbers 99, 112, 149, 288, 389, 2820, 3015, 6016, 13210, 16399 and 17609 allow a range of existing MBS attendance items to be provided via video conferencing. These items have a derived fee which is equal to 50% of the schedule fee for the consultation item claimed (e.g. 50% of the schedule fee for item 104) when billed with one of the associated consultation items (such as 104). A patient rebate of 85% for the derived fee is payable.

Six MBS item numbers (113, 114, 384, 2799, 3003 and 6004) provide for an initial attendance via videoconferencing by a specialist, consultant physician, consultant occupational physician, pain medicine specialist/consultant physician, palliative medicine specialist/consultant physician or neurosurgeon where the service is 10 minutes or less. The items are stand-alone items and do not have a derived fee.

Where an attendance is more than 10 minutes, practitioners should use the existing item numbers consistent with the current arrangements. Normal restrictions which apply for initial consultations will also apply for these items. For example, if a patient has an initial consultation via telehealth, they cannot also claim an initial face-to-face consultation as part of the same course of treatment.

Clinical indications

The specialist, consultant physician or psychiatrist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the specialist, consultant physician or psychiatrist.

Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

Restrictions

The MBS telehealth attendance items are not payable for services to an admitted hospital patient (this includes hospital in the home patients). Benefits are not payable for telephone or email consultations. In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Billing Requirements

All video consultations provided by specialists, consultant physicians or psychiatrists must be **separately billed**. That is, only the relevant telehealth MBS consultation item and the associated derived item are to be itemised on the account/bill/voucher. Any other service/item billed should be itemised on a separate account/bill/voucher. This will ensure the claim is accurately assessed as being a video consultation and paid accordingly.

Practitioners should not use the notation 'telehealth', 'verbal consent' or 'Patient unable to sign' to overcome administrative difficulties to obtaining a patient signature for bulk billed claims (for further information see mbsonline.gov.au/telehealth).

Eligible Geographical Areas

Geographic eligibility for telehealth services funded under Medicareare determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are areas that are outside a Major City (RA1) according to ASGC-RA (RA2-5). Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

This rule will not apply to specialist video consultation with patients who are a care recipient in a residential care service; or at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the *Health Insurance Act 1973* as these patients are able to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at www.mbsonline.gov.au/ telehealth eligible areas

Record Keeping

Participating telehealth practitioners must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date, time and the people who participated.

Only clinical details recorded at the time of the attendance count towards the time of the consultation. It does not include information added at a later time, such as reports of investigations.

Extended Medicare Safety Net (EMSN)

All telehealth consultations (with the exceptions of the participating optometrist telehealth items) are subject to EMSN caps. The EMSN caps for ART and Obstetric telehealth items 13210 and 16399 were set in reference to the EMSN caps applying to the base ART and Obstetric consultation items.

The EMSN caps for all other telehealth consultation items are equal to 300% of the schedule fee (to a maximum of \$500). The maximum EMSN benefit for a telehealth consultation is equal to the sum of the EMSN cap for the base item and the EMSN cap for the telehealth items.

Aftercare Rule

Video consultations are subject to the same aftercare rules as practitioners providing face-to-face consultations.

Multiple attendances on the same day

In some situations a patient may receive a telehealth consultation and a face to face consultation by the same or different practitioner on the same day.

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Referrals

The referral procedure for a video consultation is the same as for conventional face-to-face consultations.

Technical requirements

In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

Individual clinicians must be confident that the technology used is able to satisfy the item descriptor and that software and hardware used to deliver a videoconference meets the applicable laws for security and privacy.

TN.7.1 Regional or Field Nerve Blocks - General

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

Where anaesthesia combines a regional nerve block with general anaesthesia for an operative procedure, benefit will be paid only under the relevant anaesthesia item as set out in Group T10.

Where a regional or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block attracts benefits under the Group T10 anaesthesia item and not the block item in Group T7.

Where a regional or field nerve block which is covered by an item in Group T7 is administered by a medical practitioner in the course of a surgical procedure undertaken by that practitioner, then such a block will attract benefit under the appropriate Group T7 item.

When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.

Digital ring analgesia, local infiltration into tissue surrounding a lesion or paracervical (uterine) analgesia are not eligible for the payment of Medicare benefits under items within Group T7. Where procedures are carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure.

TN.7.2 Maintenance of Regional or Field Nerve Block - (Items 18222 and 18225)

Medicare benefit is attracted under these items only when the service is performed other than by the operating surgeon. This does not preclude benefits for an obstetrician performing an epidural block during labour.

When the service is performed by the operating surgeon during the post-operative period of an operation it is considered to be part of the normal aftercare. In these circumstances a Medicare benefit is not attracted.

TN.7.3 Intrathecal or Epidural Injection - (Item 18232)

This items covers caudal infusion/injection.

TN.7.4 Intrathecal or Epidural Infusion - (Items 18226 and 18227)

Items 18226 and 18227 apply where intrathecal or epidural analgesia is required for obstetric patients in the after hours period. For these items, the after hours period is defined as the period from 8pm to 8am on any weekday, or any time on a Saturday, Sunday or a public holiday.

Medicare benefits are only payable under item 18227 where more than 50% of the service is provided in the after hours period, otherwise benefits would be payable under item 18219.

TN.7.5 Regional or Field Nerve Blocks - (Items 18234 to 18298)

Items in the range 18234 - 18298 are intended to cover the injection of anaesthetic into the nerve or nerve sheath and not for the treatment of carpal tunnel or similar compression syndromes.

Paravertebral nerve block items 18274 and 18276 cover the provision of regional anaesthesia for surgical and related procedures for the management acute pain or of chronic pain related to radiculopathy. Infiltration of the soft tissue of the paravertebral area for the treatment of other pain symptoms does not attract benefit under these items. Additionally, items 18274 and 18276 do not cover facet joint blocks/injections. This procedure is covered under item 39013.

Item 18292 may not be claimed for the injection of botulinum toxin, but may be claimed where a neurolytic agent (such as phenol) is used to treat the obturator nerve in patients receiving botulinum toxin injections under item 18354 for a dynamic foot deformity.

TN.8.1 Surgical Operations

Many items in Group T8 of the Schedule are qualified by one of the following phrases:

- · "as an independent procedure";
- · "not being a service associated with a service to which another item in this Group applies"; or
- · "not being a service to which another item in this Group applies"

An explanation of each of these phrases is as follows.

As an Independent Procedure

The inclusion of this phrase in the description of an item precludes payment of benefits when:-

- (i) a procedure so qualified is associated with another procedure that is performed through the same incision, e.g. nephrostomy (Item 36552) in the course of an open operation on the kidney for another purpose;
- (ii) such procedure is combined with another in the same body area, e.g. direct examination of larynx (Item 41846) with another operation on the larynx or trachea;
- (iii) the procedure is an integral part of the performance of another procedure, e.g. removal of foreign body (Item 30067/30068) in conjunction with debridement of deep or extensive contaminated wound of soft tissue, including suturing of that wound when performed under general anaesthetic (Item 30023).

Not Being a Service Associated with a Service to which another Item in this Group Applies

"Not being a service associated with a service to which another item in this Group applies" means that benefit is not payable for any other item in that Group when it is performed on the same occasion as this item. eg item 30106.

"Not being a service associated with a service to which Item applies" means that when this item is performed on the same occasion as the reference item no benefit is payable. eg item 39330.

Not Being a Service to which another Item in this Group Applies

"Not being a service to which another item in this Group applies" means that this item may be itemised if there is no specific item relating to the service performed, e.g. Item 30387 (Laparotomy involving operation on abdominal viscera (including pelvic viscera), not being a service to which another item in this Group applies). Benefits may be attracted for an item with this qualification as well as benefits for another service during the course of the same operation.

TN.8.2 Multiple Operation Rule

The fees for two or more operations, listed in Group T8 (other than Subgroup 12 of that Group), performed on a patient on the one occasion (except as provided in paragraph T8.2.3) are calculated by the following rule:-

- 100% for the item with the greatest Schedule fee

plus 50% for the item with the next greatest Schedule fee

plus 25% for each other item.

Note:

- (a) Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents.
- (b) Where two or more operations performed on the one occasion have Schedule fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.
- (c) The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.
- (d) For these purposes the term "operation" only refers to all items in Group T8 (other than Subgroup 12 of that Group).

This rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient if the medical practitioner who performed the operation did not also perform or assist at the other operation or any of the other operations, or administer the anaesthetic. In such cases the fees specified in the Schedule apply.

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

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

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

Where the need arises for the patient to be returned to the operating theatre on the same day as the original procedure for further surgery due to post-operative complications, which would not be considered as normal aftercare - see paragraph T8.2, such procedures would generally not be subject to the "multiple operation rule". Accounts should be endorsed to the effect that they are separate procedures so that a separate benefit may be paid.

Extended Medicare Safety Net Cap

The Extended Medicare Safety Net (EMSN) benefit cap for items subject to the multiple operations rule, where all items in that claim are subject to a cap are calculated from the abated (reduced) schedule fee.

For example, if an item has a Schedule fee of \$100 and an EMSN benefit cap equal to 80 per cent of the schedule fee, the calculated EMSN benefit cap would be \$80. However, if the schedule fee for the item is reduced by 50 per cent in accordance with the multiple operations rule provisions, and all items in that claim carry a cap, the calculated EMSN benefit cap for the item is \$40 (50% of \$100*80%).

TN.8.3 Procedure Performed with Local Infiltration or Digital Block

It is to be noted that where a procedure is carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure and an additional benefit is therefore not payable.

TN.8.4 Aftercare (Post-operative Treatment) Definition

Section 3(5) of the Health Insurance Act 1973 states that services included in the Schedule (other than attendances) include all professional attendances necessary for the purposes of post-operative treatment of the patient. For the purposes of this book, post-operative treatment is generally referred to as "aftercare".

Aftercare is deemed to include all post-operative treatment rendered by medical specialists and consultant physicians, and includes all attendances until recovery from the operation, the final check or examination, regardless of whether the attendances are at the hospital, private rooms, or the patient's home. Aftercare need not necessarily be limited to treatment given by the surgeon or to treatment given by any one medical practitioner.

If the initial procedure is performed by a general practitioner, normal aftercare rules apply to any post-operative service provided by the same practitioner.

The medical practitioner determines each individual aftercare period depending on the needs of the patient as the amount and duration of aftercare following an operation may vary between patients for the same operation, as well as between different operations.

Private Patients

Medicare will not normally pay for any consultations during an aftercare period as the Schedule fee for most operations, procedures, fractures and dislocations listed in the MBS item includes a component of aftercare.

There are some instances where the aftercare component has been excluded from the MBS item and this is clearly indicated in the item description.

There are also some minor operations that are merely stages in the treatment of a particular condition. As such, attendances subsequent to these services should not be regarded as aftercare but rather as a continuation of the treatment of the original condition and attract benefits. Likewise, there are a number of services which may be performed during the aftercare period for pain relief which would also attract benefits. This includes all items in Groups T6 and T7, and items 39013, 39100, 39115, 39118, 39121, 39127, 39130, 39133, 39136, 39324 and 39327.

Where there may be doubt as to whether an item actually does include the aftercare, the item description includes the words "including aftercare".

If a service is provided during the aftercare phase for a condition not related to the operation, then this can be claimed, provided the account identifies the service as 'Not normal aftercare', with a brief explanation of the reason for the additional services.

If a patient was admitted as a private patient in a public hospital, then unless the MBS item does not include aftercare, no Medicare benefits are payable for aftercare.

Medicare benefits are not payable for surgical procedures performed primarily for cosmetic reasons. However, benefits are payable for certain procedures when performed for specific medical reasons, such as breast reconstruction following mastectomy. Surgical procedures not listed on the MBS do not attract a Medicare benefit.

Where an initial or subsequent consultation relates to the assessment and discussion of options for treatment and, a cosmetic or other non-rebatable service are discussed, this would be considered a rebatable service under Medicare. Where a consultation relates entirely to a cosmetic or other non-Medicare rebatable service (either before or after that service has taken place), then that consultation is not rebatable under Medicare. Any aftercare associated with a cosmetic or non-Medicare rebatable service is also not rebatable under Medicare.

Public Patients

All care directly related to a public in-patient's care should be provided free of charge. Where a patient has received in-patient treatment in a hospital as a public patient (as defined in Section 3(1) of the Health Insurance Act 1973), routine and non-routine aftercare directly related to that episode of admitted care will be provided free of charge as part of the public hospital service, regardless of where it is provided, on behalf of the state or territory as required by the National Healthcare Agreement. In this case no Medicare benefit is payable.

Notwithstanding this, where a public patient independently chooses to consult a private medical practitioner for aftercare, then the clinically relevant service provided during this professional attendance will attract Medicare benefits.

Where a public patient independently chooses to consult a private medical practitioner for aftercare following treatment from a public hospital emergency department, then the clinically relevant service provided during this professional attendance will attract Medicare benefits.

Fractures

Where the aftercare for fractures is delegated to a doctor at a place other than where the initial reduction was carried out, then Medicare benefits may be apportioned on a 50:50 basis rather than on the 75:25 basis for surgical operations.

Where the reduction of a fracture is carried out by hospital staff in the out-patient or emergency department of a public hospital, and the patient is then referred to a private practitioner for aftercare, Medicare benefits are payable for the aftercare on an attendance basis.

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

Treatment of fracture of	After-care Period
Terminal phalanx of finger or thumb	6 weeks
Proximal phalanx of finger or thumb	6 weeks
Middle phalanx of finger	6 weeks
One or more metacarpals not involving base of first carpometacarpal joint	6 weeks
First metacarpal involving carpometacarpal joint (Bennett's fracture)	8 weeks
Carpus (excluding navicular)	6 weeks
Navicular or carpal scaphoid	3 months
Colles'/Smith/Barton's fracture of wrist	3 months
Distal end of radius or ulna, involving wrist	8 weeks
Radius	8 weeks
Ulna	8 weeks
Both shafts of forearm or humerus	3 months
Clavicle or sternum	4 weeks
Scapula	6 weeks
Pelvis (excluding symphysis pubis) or sacrum	4 months
Symphysis pubis	4 months
Femur	6 months
Fibula or tarsus (excepting os calcis or os talus)	8 weeks
Tibia or patella	4 months

Both shafts of leg, ankle (Potts fracture) with or without dislocation, os calcis (calcaneus) or os talus	4 months
Metatarsals - one or more	6 weeks
Phalanx of toe (other than great toe)	6 weeks
More than one phalanx of toe (other than great toe)	6 weeks
Distal phalanx of great toe	8 weeks
Proximal phalanx of great toe	8 weeks
Nasal bones, requiring reduction	4 weeks
Nasal bones, requiring reduction and involving osteotomies	4 weeks
Maxilla or mandible, unilateral or bilateral, not requiring splinting	6 weeks
Maxilla or mandible, requiring splinting or wiring of teeth	3 months
Maxilla or mandible, circumosseous fixation of	3 months
Maxilla or mandible, external skeletal fixation of	3 months
Zygoma	6 weeks
Spine (excluding sacrum), transverse process or bone other than vertebral body requiring immobilisation in plaster or traction by skull calipers	3 months
Spine (excluding sacrum), vertebral body, without involvement of cord, requiring immobilisation in plaster or traction by skull calipers	6 months
Spine (excluding sacrum), vertebral body, with involvement of cord	6 months

Note: This list is a guide only and each case should be judged on individual merits.

TN.8.5 Abandoned surgery - (Item 30001)

Item 30001 applies where the procedure has been commenced but is then discontinued for medical reasons or for other reasons which are beyond the surgeon's control (eg equipment failure).

An operative procedure commences when the:

- a) patient is in the procedure room or on the bed or operation table where the procedure is to be performed; and
- b) patient is anaesthetised or operative site is sufficiently anaesthetised for the procedure to commence; and
- c) patient is positioned or the operative site is prepared with antiseptic or draping.

Where an abandoned procedure eligible for a benefit under item 30001 attracts an assistant under the provisions of the items listed in Group T9 (Assistance at Operations), the fee for the surgical assistant is calculated as 50% of the assistance fee that would have applied under the relevant item from Group T9.

Practitioners claiming an assistant fee for abandoned surgery should itemise their accounts with the relevant item from group T9. Such claims should include an account endorsement "assistance at abandoned surgery" or similar and should be accompanied by details of the surgery proposed and the reasons for the operation being discontinued or abandoned.

TN.8.6 Repair of Wound - (Items 30023 to 30049)

The repair of wound referred to in these items must be undertaken by suture, tissue adhesive resin (such as methyl methacrylate) or clips. These items do not cover repair of wound at time of surgery.

Item 30023 covers debridement of traumatic, "deep or extensively contaminated" wound. Benefits are not payable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures.

For the purpose of items 30026 to 30049 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.

TN.8.7 Biopsy for Diagnostic Purposes - (Items 30071 to 30096)

Needle aspiration biopsy attracts benefits on an attendance basis and not under item 30078.

Item 30071 (diagnostic biopsy of the skin) or 30072 (diagnostic biopsy of mucous membrane) should be used when a biopsy (including shave) of a lesion is required to confirm a diagnosis and would facilitate the appropriate management of that lesion. If the shave biopsy results in a definitive excision of the lesion, only 30071 or 30072 can be claimed.

Items 30071-30096 require that the specimen be sent for pathological examination.

The aftercare period for item 30071 or 30072 is 2 days rather than the standard aftercare period for skin excision of 10 days.

TN.8.8 Lipectomy - (Items 30165 to 30179)

Lipectomy is not intended as a primary bariatric procedure to correct obesity. MBS benefits are not available for surgery performed for cosmetic purposes.

For the purpose of informing patient eligibility for lipectomy items (30165-30172, 30177, 30179) that are for the management of significant weight loss (SWL), SWL is defined as a weight loss equivalent of at least five BMI units. Weight must be stable for at least six months following significant weight loss prior to lipectomy. For significant weight loss that has occurred following pregnancy, the products of conception must not be included in the calculation of baseline weight to measure weight loss against.

Multiple lipectomies of redundant non-abdominal skin and fat as a direct consequence of mass weight loss (for example on both buttocks and both thighs), attracts a Medicare benefit only once against the relevant item (30171 or 30172). The schedule fee for multiple lipectomies for excision of redundant non-abdominal skin and fat following massive weight loss is the same regardless of the number of excisions.

The lipectomy items cannot be claimed in association with items 45564, 45565 or 45530. Where the abdomen requires surgical closure with reconstruction of the umbilicus following free tissue transfer (45564, 45565) or breast reconstruction (45530), item 45569 is to be claimed.

TN.8.9 Treatment of Keratoses, Warts etc (Items 30187, 30189, 30192 and 36815)

Treatment of seborrheic keratoses by any means, attracts benefits on an attendance basis only.

Treatment of fewer than 10 solar keratoses by ablative techniques such as cryotherapy attracts benefits on an attendance basis only. Where 10 or more solar keratoses are treated by ablative techniques, benefits are payable under item 30192.

Warts and molluscum contagiosum where treated by any means attract benefits on an attendance basis except where:

- (a) admission for treatment in an operating theatre of an accredited day surgery facility or hospital is required. In this circumstance, benefits are paid under item 30189 where a definitive removal of the wart or molluscum contagiosum is to be undertaken.
- (b) benefits have been paid under item 30189, and recurrence occurs.

(c) palmar and plantar warts are treated by laser and require treatment in an operating theatre of an accredited day surgery facility or hospital. In this circumstance, benefits are paid under item 30187.

TN.8.10 Cryotherapy and Serial Curettage Excision - (Items 30196 and 30202)

In item 30196, serial curettage excision, as opposed to simple curettage, refers to the technique where the margin having been defined, the lesion is carefully excised by a skin curette using a series of dissections and cauterisations so that all extensions and infiltrations of the lesion are removed.

For the purposes of items 30196 and 30202, the requirement for histopathological proof of malignancy is satisfied where multiple lesions are to be removed from the one anatomical region if a single lesion from that region is histologically tested and proven for malignancy.

For the purposes of items 30196 and 30202, an anatomical region is defined as: hand, forearm, upper arm, shoulder, upper trunk or chest (anterior and posterior), lower trunk (anterior or posterior) or abdomen (anterior lower trunk), buttock, genital area/perineum, upper leg, lower leg and foot, neck, face (six sections: left/right lower, left/right mid and left/right upper third) and scalp.

For Medicare benefits to be payable for item 30196, the provider performing the service must also retain documented evidence that malignancy has been proven by histopathology.

For Medicare benefits to be payable for item 30202, the provider performing the service must also retain documented evidence that malignancy has either been proven by histopathology or confirmed by opinion of a specialist in the specialty of dermatology.

The Department of Human Services (DHS) has developed a <u>Health Practitioner Guideline to substantiate proof of</u> malignancy where required for MBS items which is located on the DHS website.

TN.8.12 Sentinel Node Biopsy for Breast Cancer - (Items 30299 to 30303)

The Medical Services Advisory Committee (MSAC) evaluated the available evidence and found that sentinel lymph node biopsy is safe and effective in identifying sentinel lymph nodes, but that the long term outcomes of sentinel lymph node biopsy compared to lymph node clearance are uncertain. As a result, interim Medicare funding is available for these items pending the outcome of clinical trials and further consideration by the MSAC.

For items 30299 and 30300, both lymphoscintigraphy and lymphotropic dye injection must be used, unless the patient has an allergy to the lymphotropic dye.

For the purposes of these items, the axillary lymph node levels referred to are as follows:

- **Level I** axillary lymph nodes up to the inferior border of pectoralis minor.
- Level II -axillary lymph nodes up to the superior border of pectoralis minor.
- Level III axillary lymph nodes extending above the superior border of pectoralis minor.

TN.8.13 Dissection of Axillary Lymph Nodes - (Items 30335 and 30336)

For the purposes of Items 30335 and 30336, the definitions of lymph node levels referred to are set out below.

Anatomically, the dissection extends from below upwards as follows:

- Level I dissection of axillary lymph nodes up to the inferior border of pectoralis minor.
- Level II dissection of axillary lymph nodes up to the superior border of pectoralis minor.
- Level III dissection of axillary lymph nodes extending above the superior border of pectoralis minor.

TN.8.14 Laparotomy and Other Procedures on the Abdominal Viscera - (Items 30375 and 30622)

Procedures on the abdominal viscera may be performed by laparotomy or laparoscopically. Both items 30375 and 30622 cover several operations on abdominal viscera. Where more than one of the procedures referrec to in these items are performed during the one operation, each procedure may be itemised according to the multiple operation formula.

TN.8.15 Diagnostic Laparoscopy - (Items 30390 and 30627)

If a diagnostic laparoscopy procedure is performed at a different time on the same day to another laparoscopic service, the procedures are considered to be un-associated services. The claim for benefits should be annotated to indicate that the two services were performed on separate occasions, otherwise the claims will be considered to be a single service.

TN.8.16 Major Abdominal Incision - (Item 30396)

A major abdominal incision is one that gives access through an open wound to all compartments of the abdominal cavity. Item 30396 is intended for open surgical incisions only and not those performed laparoscopically.

TN.8.17 Gastrointestinal Endoscopic Procedures - (Items 30473 to 30481, 30484, 30485, 30490 to 30494, 30680 to 32023, 32084 to 32095, 32103, 32104 and 32106)

The following are guidelines for appropriate minimum standards for the performance of GI endoscopy in relation to (a) cleaning, disinfection and sterilisation procedures, and (b) anaesthetic and resuscitation equipment.

These guidelines are based on the advice of the Gastroenterological Society of Australia, the Sections of HPB and Upper GI and of Colon and Rectal Surgery of the Royal Australasian College of Surgeons, and the Colorectal Surgical Society of Australia.

Cleaning, disinfection and sterilisation procedures

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

- i. Infection Control in Endoscopy, Gastroenterological Society of Australia and Gastroenterological Nurses College of Australia , 2011;
- ii. Australian Guidelines for the Prevention and Control of Infection in Healthcare (NHMRC, 2010);
- iii. Australian Standard AS 4187-2014 (and Amendments), Standards Association of Australia.

Anaesthetic and resuscitation equipment

Where the patient is anaesthetised, anaesthetic equipment, administration and monitoring, and post-operative and resuscitation facilities should conform to the standards outlined in 'Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures' (PS09), Australian & New Zealand College of Anaesthetists, Gastroenterological Society of Australia and Royal Australasian College of Surgeons.

Conjoint Committee

For the purposes of Item 32023, the procedure is to be performed by a colorectal surgeon or gastroenterologist with endoscopic training who is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy.

TN.8.18 Gastrectomy, Sub-total Radical - (Item 30523)

The item differs from total radical Gastrectomy (Item 30524) in that a small part of the stomach is left behind. It involves resection of the greater omentum and posterior abdominal wall lymph nodes with or without splenectomy.

TN.8.19 Anti reflux Operations - (Items 30527 to 30533, 31464 and 31466)

These items cover various operations for reflux oesophagitis. Where the only procedure performed is the simple closure of a diaphragmatic hiatus benefit would be attracted under Item 30387 (Laparotomy involving operation on abdominal viscera, including pelvic viscera, not being a service to which another item in this Group applies).

TN.8.20 Radiofrequency ablation of mucosal metaplasia for the treatment of Barrett's Oesophagus (Item 30687)

The diagnosis of high grade dysplasia is recommended to be confirmed by two expert pathologists with experience in upper gastrointestinal pathology.

A multidisciplinary team should review treatment options for patients with high grade dysplasia and would typically include upper gastrointestinal surgeons and/or interventional gastroenterologists.

TN.8.21 Endoscopic or Endobronchial Ultrasound +/- Fine Needle Aspiration - (Items 30688 - 30710)

For the purposes of these items the following definitions apply:

Biopsy means the removal of solid tissue by core sampling or forceps

FNA means aspiration of cellular material from solid tissue via a small gauge needle.

The provider should make a record of the findings of the ultrasound imaging in the patient's notes for any service claimed against items 30688 to 30710.

Endoscopic ultrasound is an appropriate investigation for patients in whom there is a strong clinical suspicion of pancreatic neoplasia with negative imaging (such as CT scanning). Scenarios include, but are not restricted to:

- A middle aged or elderly patient with a first attack of otherwise unexplained (eg negative abdominal CT) first episode of acute pancreatitis; or
- A patient with biochemical evidence of a neuroendocrine tumour.

The procedure is not claimable for periodic surveillance of patients at increased risk of pancreatic cancer, such as chronic pancreatitis. However, EUS would be appropriate for a patient with chronic pancreatitis in whom there was a clinical suspicion of pancreatic cancer (eg. a pancreatic mass occurring on a background of chronic pancreatitis).

TN.8.22 Removal of Skin Lesions - (Items 31356 to 31376)

The excision of warts and seborrheic keratoses attracts benefits on an attendance basis with the exceptions outlined in T8.13 of the explanatory notes to this category. Excision of pre-malignant lesions including solar keratoses where clinically indicated are covered by items 31357, 31360, 31362, 31364, 31366, 31368 and 31370.

The excision of suspicious pigmented lesions for diagnostic purposes attract benefits under items 31357, 31360, 31362, 31364, 31366, 31368 and 31370.

Malignant tumours are covered by items 31356, 31358, 31359, 31361, 31363, 31365, 31367, 31369 and 31371 to 31376.

Items 31357, 31360, 31362, 31364, 31366, 31368, 31370 *require*that the specimen be sent for histological examination. Items 31356, 31358, 31359, 31361, 31363, 31365, 31367, 31369, 31371-31376 also *require*that a specimen has been sent for histological confirmation of malignancy, and any subsequent specimens are sent for histological examination. Confirmation of malignancy*must* be received before itemisation of accounts for Medicare benefits purposes.

Where histological results are available at the time of issuing accounts, the histological diagnosis will decide the appropriate itemisation. If the histological report shows the lesion to be benign, items 31357, 31360, 31362, 31364, 31366, 31368 or 31370 should be used.

It will be necessary for practitioners to retain copies of histological reports.

TN.8.23 Removal of Skin Lesion From Face - (Items 31245, 31361 to 31364, 31372 and 31373)

For the purposes of these items, the face is defined as that portion of the head anterior to the hairline and above the jawline.

TN.8.24 Dissection of Lymph Nodes of Neck - (Items 30618, 31423 to 31438)

For the purposes of these items, the lymph node levels referred to are as follows:

Level I	Submandibular and submental lymph nodes
Level II	Lymph nodes of the upper aspect of the neck including the jugulodigastric node, upper jugular chain nodes and upper spinal accessory nodes
Level III	Lymph nodes deep to the middle third of the sternomastoid muscle consisting of mid jugular chain nodes, the lower most of which is the jugulo-omohyoid node, lying at the level where the omohyoid muscle crosses the internal jugular vein
Level IV	Lower jugular chain nodes, including those nodes overlying the scalenus anterior muscle
Level V	Posterior triangle nodes, which are usually distributed along the spinal accessory nerve in the posterior triangle

Comprehensive dissection involves all 5 neck levels while *selective* dissection involves the removal of only certain lymph node groups, for example:-

Item 31426 (removal of 3 lymph node levels) - e.g. supraomohyoid neck dissection (levels I-III) or lateral neck dissection (levels II-IV).

Item 31429 (removal of 4 lymph node levels) - e.g. posterolateral neck dissection (levels II-V) or anterolateral neck dissection (levels I-IV)

Other combinations of node levels may be removed according to clinical circumstances.

TN.8.25 Excision of Breast Lesions, Abnormalities or Tumours - Malignant or Benign - (Items 31500 to 31515)

Therapeutic biopsy or excision of breast lesions, abnormalities or tumours under Items: 31500, 31503, 31506, 31509, 31512, 31515 either singularly or in combination should not be claimed when using the Advanced Breast Biopsy Instrumentation (ABBI) procedure, or any other large core breast biopsy device.

TN.8.26 Fine Needle Aspiration of Breast Lesion - (Item 31533)

An impalpable lesion includes those lesions that clinically require definition by ultrasound or mammography for accurate or safe sampling, eg. lesions in association with breast prostheses or in areas of breast thickening.

TN.8.27 Diagnostic Biopsy of Breast using Advanced Breast Biopsy Instrumentation - (Items 31539 and 31545)

For the purposes of Items 31539 and 31545, surgeons performing this procedure should have evidence of appropriate training via a course approved by the Breast Section of the Royal Australasian College of Surgeons, have experience in the procedure, and the Department of Human Services notified of their eligibility to perform this procedure.

The ABBI procedure is contraindicated and should not be performed on the following subset of patients:

- Patients with mass, asymmetry or clustered microcalcifications that cannot be targeted using digital imaging equipment;
- Patients unable to lie prone and still for 30 to 60 minutes;
- Breasts less than 20mm in thickness when compressed;
- Women on anticoagulants;
- Lesions that are too close to the chest wall to allow cannula access;
- Patients weighing more than 135kg;
- Women with prosthetic breast implants.

TN.8.28 Preoperative Localisation of Breast Lesion Prior to the Use of Advanced Breast Biopsy Instrumentation - (Item 31542)

For the purposes of item 31542, radiologists eligible to perform the procedure must have been identified by the Royal Australian and New Zealand College of Radiologists as having sufficient training and experience in this procedure, and the Department of Human Services notified of their eligibility to perform this procedure.

TN.8.29 Bariatric Procedures - (Items 31569 to 31581, anaesthesia item 20791)

Items 31569 to 31581 and item 20791 provide for surgical treatment of clinically severe obesity and the accompanying anaesthesia service (or similar). The term clinically severe obesity generally refers to a patient with a Body Mass Index (BMI) of 40kg/m^2 or more, or a patient with a BMI of 35kg/m^2 or more with other major medical co-morbidities (such as diabetes, cardiovascular disease, cancer). The BMI values in different population groups may vary due, in part, to different body proportions which affect the percentage of body fat and body fat distribution. Consequently, different ethnic groups may experience major health risks at a BMI that is below the 35-40 kg/m² provided for in the definition. The decision to undertake obesity surgery remains a matter for the clinical judgment of the surgeon.

If crural repair taking 45 minutes or less is performed in association with the bariatric procedure, additional hernia repair items cannot be claimed for the same service.

TN.8.30 Reversal of a Bariatric Procedure (item 31584)

If a revisional procedure requires the reversal of the existing bariatric procedure, item 31584 can be claimed with items 31569 to 31581 for the new procedure for the same patient on the same occasion. For example, item 31584 could be claimed for the reversal of a gastric band, and 31572 for conversion to gastric bypass or 31575 for conversion to sleeve gastrectomy.

TN.8.31 Per Anal Excision of Rectal Tumour using Rectoscopy - (Items 32103, 32104 and 32106)

Surgeons performing these procedures should be colorectal surgeons and have undergone appropriate training which is recognised by the Colorectal Surgical Society of Australasia.

Items 32103, 32104 and 32106 cannot be claimed in conjunction with each other or with anterior resection items 32024 or 32025 for the same patient, on the same day, by any practitioner.

TN.8.32 Varicose veins - (Items 32500 to 32517)

In relation to endovenous laser therapy (ELT) and/or radiofrequency diathermy/ablation, Rule 2.44.14 of the *Health Insurance (General Medical Services Table) Regulations* (GMST) means the following:

- ELT and/or radiofrequency diathermy/ablation are not payable if they are billed under any varicose vein items (32500 to 32517) or vascular item 35321.
- If ELT and/or radiofrequency diathermy/ablation are provided on the same occasion as these MBS items, the ELT and radiofrequency diathermy/ablation services must be itemised separately on the invoice, showing the full fees for each service separately to the fees billed against the MBS items.
- We strongly recommend that a practitioner who intends to bill ELT and/or radiofrequency diathermy/ablation on the same occasion as providing MBS services contact Department of Human Services' provider information line on 132 150 to confirm the Department of Human Services' requirements for correct itemisation of MBS and non-MBS services on a single invoice.
- The Department of Human Services monitors billing practices associated with MBS items and any billing which stands out as being out of line with most practitioners may warrant the attention of the Department of Human Services.
- In light of the policy clarification of GMST Rule 2.44.14, with effect from 1 May 2009, the Department of Human Services will be able to track any apparent cost-shifting (of ELT and/or radiofrequency diathermy/ablation) to the MBS items detailed in GMST Rule 2.44.14 or to other MBS items.

TN.8.33 Cyanoacrylate Embolisation (Items 32528 and 32529), Endovenous Laser Therapy (Items 32520 and 32522) and Radiofrequency Ablation (Items 32523 and 32526)

It is recommended that the medical practitioner performing cyanoacrylate embolisation (CAE), endovenous laser therapy (ELT) or radiofrequency ablation (RFA) has successfully completed a substantial course of study and training in the management of venous disease, which has been endorsed by their relevant professional organisation.

Medicare-funded CAE, ELT and RFA can only be performed in cases where it is documented by duplex ultrasound that the great or small saphenous vein (and major tributaries of saphenous veins as necessary) demonstrates reflux of 0.5 seconds or longer.

TN.8.34 Uterine Artery Embolisation - (Item 35410)

This item was introduced on an interim basis in November 2006 following a recommendation of the Medical Services Advisory Committee (MSAC), pending the outcome of clinical trials and further consideration by the MSAC. The requirement for specialist referral by a gynaecologist for uterine artery embolisation was a MSAC recommendation. Providers should retain the instrument of specialist referral for each patient from the date of the procedure, as this may be subject to audit by the Department of Human Services.

TN.8.35 Endovascular Coiling of Intracranial Aneurysms - (Item 35412)

This service includes balloon angioplasty and insertion of stents (assisted coiling) associated with intracranial aneurysm coiling. The use of liquid embolics alone is not covered by this item. Digital Subtraction Angiography (DSA) done to diagnose the aneurysm (items 60009 and either 60072, 60075 or 60078) is claimable, however this must be clearly noted on the claim and in the clinical notes as separate from the intra-operative DSA done with the coiling procedure.

TN.8.36 Arterial and Venous Patches - (Items 33545 to 33551 and 34815)

Vascular surgery items have been constructed on the basis that arteriotomy and venotomy wounds are closed by simple suture without the use of a patch.

Where a patch angioplasty is used to enlarge a narrowed vein, artery or arteriovenous fistula, the correct item would be 34815 or 34518. If the vein is harvested for the patch through a separate incision, Item 33551 would also apply, in accordance with the multiple operation rule.

If a patch graft is involved in conjunction with an operative procedure included in Items 33500 - 33542, 33803, 33806, 33815, 33833 or 34142, the patch graft would attract benefits under Item 33545 or 33548 in addition to the item for the primary operation (under the multiple operation rule). Where vein is harvested for the patch through a separate incision Item 33551 would also apply.

TN.8.37 Carotid Disease - (Item 32700, 32703, 32760, 33500, 33545, 33548, 33551, 33554, 35303, 35307)

Interventional procedures for the management of carotid disease should be performed in accordance with the NHMRC endorsed *Clinical Guidelines for Stroke Management 2010*.

Carotid Percutaneous Transluminal Angioplasty with Stenting (CPTAS), under item 35307 is only funded under the MBS for patients who meet the criteria for carotid endarterectomy but are unfit for open surgery.

TN.8.38 Peripheral Arterial or Venous Catheterisation - (Item 35317)

Item 35317 is restricted to the regional delivery of thrombolytic, vasoactive or chemotherapeutic oncologic agents in association with a radiological service. This item in not intended for infusions with systemic affect.

TN.8.39 Peripheral Arterial or Venous Embolisation - (Item 35321)

As set out in Rule 2.44.14 in the *Health Insurance (General Medical Services Table) Regulations,* item 35321 does not apply to the service described in that item if the service is provided at the same time as, or in connection with, endovenous laser treatment for varicose veins.

TN.8.40 Selective Internal Radiation Therapy (SIRT) using SIR-Spheres - (Items 35404, 35406 and 35408)

These items were introduced into the Schedule on an interim basis in May 2006 following a recommendation of the Medical Services Advisory Committee (MSAC) pending the outcome of clinical trials and further consideration by the MSAC. SIRT should not be performed in an outpatient or day patient setting to ensure patient and radiation safety requirements are met.

TN.8.41 Percutaneous Transluminal Coronary Angioplasty - (Items 38309, 38312, 38315 and 38318)

A coronary artery lesion is considered to be complex when the lesion is a chronic total occlusion, located at an ostial site, angulated, tortuous or greater than 1cm in length. Percutaneous transluminal coronary rotational atherectomy is suitable for revascularisation of complex and heavily calcified coronary artery stenoses in patients for whom coronary artery bypass graft surgery is contraindicated.

Each of the items 38309, 38312, 38315 and 38318 describes an episode of service. As such, only one item in this range can be claimed in a single episode.

TN.8.42 Colposcopic Examination - (Item 35614)

It should be noted that colposcopic examination (screening) of a person during the course of a consultation does not attract Medicare benefits under Item 35614 except in the following circumstances:

- (a) where the patient has had an abnormal cervical screen result;
- (b) where there is a history of ingestion of oestrogen by the patient's mother during their pregnancy; or
- (c) where the patient has been referred by another medical practitioner because of suspicious signs of genital cancer.

TN.8.43 Hysteroscopy - (Item 35626)

Hysteroscopy undertaken in the office/consulting rooms can be claimed under this item where the conditions set out in the description of the item are met.

TN.8.44 Curettage of Uterus under GA or Major Nerve Block - (Items 35639 and 35640)

Uterine scraping or biopsy using small curettes (e.g. Sharman's or Zeppelin's) and requiring minimal dilatation of the cervix, not necessitating a general anaesthesia, does not attract benefits under these items but would be paid under Item 35620 where malignancy is suspected, or otherwise on an attendance basis.

TN.8.45 Neoplastic Changes of the Cervix - (Items 35644-35648)

The term "previously confirmed intraepithelial neoplastic changes of the cervix" in these items refers to diagnosis made by either cytologic, colposcopic or histologic methods. This may also include persistent human papilloma virus (HPV) changes of the cervix.

TN.8.46 Sterilisation of Minors - Legal Requirements - (Items 35657, 35687, 35688, 35691, 37622 and 37623)

- (i) It is unlawful throughout Australia to conduct a sterilisation procedure on a minor which is not a byproduct of surgery appropriately carried out to treat malfunction or disease (eg malignancies of the reproductive tract) unless legal authorisation has been obtained.
- (ii) Practitioners are liable to be subject to criminal and civil action if such a sterilisation procedure is performed on a minor (a person under 18 years of age) which is not authorised by the Family Court of Australia or another court or tribunal with jurisdiction to give such authorisation.
- (iii) Parents/guardians have no legal authority to consent on behalf of minors to such sterilisation procedures. Medicare Benefits are only payable for sterilisation procedures that are clinically relevant professional services as defined in Section 3 (1) of the *Health Insurance Act 1973*.

TN.8.47 Debulking of Uterus - (Item 35658)

Benefits are payable under Item 35658, using the multiple operation rule, in addition to vaginal hysterectomy.

TN.8.48 Nephrectomy - (Items 36526 and 36527)

Items 36526 and 36527 are only claimable where the practitioner has a high index of suspicion of malignancy which cannot be confirmed by biopsy prior to surgery being performed, due to the biopsy being either clinically inappropriate, or the specimen provided showing an inconclusive diagnosis.

TN.8.50 Sacral Nerve Stimulation (items 36663-36668)

A two-stage process of testing and treatment is required to ensure suitability for Sacral Nerve Stimulation for detrusor overactivity or non obstructive urinary retention where urethral obstruction has been urodynamically excluded. The testing phase involves acute and sub-chronic testing. The first stage includes peripheral nerve evaluation and patients who achieve greater than 50% improvement in urinary incontinence or retention episodes during testing will be eligible to receive permanent SNS treatment.

TN.8.51 Ureteroscopy - (Item 36803)

Item 36803 refers to ureteroscopy of one ureter when performed for the purpose of inspection alone. It may not be used when one of the other ureteroscopy numbers (Items 36806 or 36809) or pyeloscopy numbers (Items 36652, 36654 or 36656) is used for a ureteroscopic procedure performed in the same ureter or collecting system. It may be used when inspection alone is carried out in one ureter independently from a ureteroscopic or pyeloscopic procedure in another ureter or collecting system. If Item number 36803 is used with one of the other above 5 numbers, it must be specified that item number 36803 refers to ureteroscopy performed in another ureter eg 36654 (Right side) and 36803 (Left side). 36803 may also be used in this way if there is a partial or complete duplex collecting system eg 36809 (Lower pole moiety ureter, Left side) and 36803 (Upper pole moiety ureter, Left side).

Item numbers 36806 and 36809 may only be used together when 2 independent ureteroscopic procedures are performed in separate ureters. These separate ureters may be components of a complete or partial duplex system. If both these numbers are used together, the Regulations require qualification of these item numbers by the site, as is necessary with 36803 eg 36806 (Right side) and 36809 (Left side).

TN.8.52 Selective Coronary Angiography - (Items 38215 to 38246)

Each item in the range 38215-38240 describes an episode of service. As such, only one item in this range can be claimed in a single episode.

Item 38243 may be billed once only immediately prior to any coronary interventional procedure, including situations where a second operator performs any coronary interventional procedure after diagnostic angiography by the first operator.

Item 38246 may be billed when the same operator performs diagnostic coronary angiography and then proceeds directly with any coronary interventional procedure during the same occasion of service. Consequently, it may not be billed in conjunction with items 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38243. In the event that the same operator performed any coronary interventional procedure immediately after the diagnostic procedure described by item 38231, 38237 or 38240, that item may be billed as an alternative to item 38246.

Items in the range 38215 - 38246 cannot be claimed for any intravascular ultrasound (IVUS) procedure therefore Medicare Benefits are not payable for IVUS.

TN.8.53 Transurethral Needle Ablation (TUNA) of the Prostate - (Items 37201 and 37202)

Moderate to severe lower urinary tract symptoms are defined using the American Urological Association (AUA) Symptom Score or the International Prostate Symptom Score (IPSS).

Patients not medically fit for transurethral resection of the prostate (TURP) can be defined as:

- (i) Those patients who have a high risk of developing a serious complication from the surgery. Retrograde ejaculation is **not** considered to be a serious complication of TURP.
- (ii) Those patients with a co-morbidity which may substantially increase the risk of TURP or the risk of the anaesthetic necessary for TURP.

TN.8.54 Gold Fiducial Markers into the Prostate - (item 37217)

Item 37217 is for the insertion of gold fiducial markers into the prostate or prostate surgical bed as markers for radiotherapy. The service can not be claimed under item 37218 or any other surgical item.

This item is introduced into the Schedule on an interim basis pending the outcome of an evaluation being undertaken by the Medical Services Advisory Committee (MSAC).

Further information on the review of this service is available from the MSAC Secretariat.

TN.8.55 Brachytherapy of the Prostate - (Item 37220)

One of the requirements of item 37220 is that patients have a Gleason score of less than or equal to 7. However, where the patient has a score of 7, comprising a primary score of 4 and a secondary score of 3 (ie. 4+3=7), it is recommended that low dose rate brachytherapy form part of a combined modality treatment.

Low dose rate brachytherapy of the prostate should be performed in patients, with favourable anatomy allowing adequate access to the prostate without pubic arch interference, and who have a life expectancy of greater than 10 years.

An 'approved site' for the purposes of this item is one at which radiation oncology services may be performed lawfully under the law of the State or Territory in which the site is located.

TN.8.56 High Dose Rate Brachytherapy - (Item 37227)

Item 37227 covers the service undertaken by an urologist or radiation oncologist as part of the High Dose Rate Brachytherapy procedure, in association with a radiation oncologist. If the service is undertaken by an urologist, a

radiation oncologist must be present in person at the time of the service. The removal of the catheters following completion of the Brachytherapy is also covered under this item.

TN.8.57 Radical or Debulking Operation for Ovarian Tumour - (Item 35720)

This item refers to the operation for carcinoma of the ovary where the bulk of the tumour and the omentum are removed. Where this procedure is undertaken in association with hysterectomy benefits are payable under both item numbers with the application of the multiple operation formula.

TN.8.58 Transcutaneous Sperm Retrieval - (Item 37605)

Item 37605 covers transcutaneous sperm retrieval for the purposes of intracytoplasmic sperm injection (item 13251) for male factor infertility, in association with assisted reproductive technologies.

Item 37605 provides for the procedure to be performed unilaterally. Where it is clinically necessary to perform the service bilaterally, the multiple operation rule would apply, in accordance with point T8.5 of these Explanatory Notes.

Where the procedure is carried out under local infiltration as the means of anaesthesia, additional benefit is not payable for the anaesthesia component as this is considered to be part of the procedure.

TN.8.59 Surgical Sperm Retrieval, by Open Approach - (Item 37606)

Item 37606 covers open sperm retrieval for the purposes of intracytoplasmic sperm injection (item 13251) for male factor infertility, in association with assisted reproductive technologies. Item 37606 provides for the procedure to be performed unilaterally. Where it is clinically necessary to perform the service bilaterally, the multiple operation rule would apply.

Benefits for item 37606 may be claimed in conjunction with a service or services provided under item 37605, where an open approach is clinically necessary following an unsuccessful percutaneous approach. Likewise, such services would be subject to the multiple operation rule.

Benefit is not payable for item 37606 in conjunction with item 37604.

TN.8.60 Cardiac Pacemaker Insertion - (Items 38209, 38212, 38350, 38353 and 38356)

The fees for the insertion of a pacemaker (Items 38350, 38353 and 38356) cover the testing of cardiac conduction or conduction threshold, etc related to the pacemaker and pacemaker function.

Accordingly, additional benefits are not payable for such routine testing under Item 38209 or 38212 (Cardiac electrophysiological studies).

TN.8.61 Implantable ECG Loop Recorder - (Item 38285)

The fee for implantation of the loop recorder (item 38285) covers the initial programming and testing of the device for satisfactory rhythm capture. Benefits are payable only once per day.

The term "recurrent" refers to more than one episode of syncope, where events occur at intervals of 1 week or longer. The term "other available cardiac investigations" includes the following:

- a complete history and physical examination that excludes a primary neurological cause of syncope and does not exclude a cardiac cause;
- electrocardiography (ECG) (items 1170-11702);
- echocardiography (items 55113-55115);
- continuous ECG recording or ambulatory ECG monitoring (items 11708-11711);

- up-right tilt table test (item 11724); and
- cardiac electrophysiological study, unless there is reasonable medical reason to waive this requirement (item 38209).

TN.8.62 Transluminal Insertion of Stent or Stents - (Item 38306)

Item 38306 should only be billed once per occlusional site. It is not appropriate to bill item 38306 multiple times for the insertion of more than one stent at the same occlusional site in the same artery. However, it would be appropriate to claim this item multiple times for insertion of stents into the same artery at different occlusional sites or into another artery or occlusional site. It is expected that the practitioner will note the details of the artery or site into which the stents were placed, in order for the Department of Human Services to process the claims.

TN.8.63 Permanent Cardiac Synchronisation Device (Items 38365, 38368 and 38654)

Items 38365, 38368 and 38654 apply only to patients who meet the criteria listed in the item descriptor, and to patients who do not meet the criteria listed in the descriptor but have previously had a CRT device and transvenous left ventricular electrode inserted and who prior to its insertion met the criteria and now need the device replaced.

TN.8.64 Intravascular Extraction of Permanent Pacing Leads - (Item 38358)

For the purposes of Item 38358 specialists or consultant physicians claiming this item must have training recognised by the Lead Extraction Advisory Committee of the Cardiac Society of Australia and New Zealand, and the Department of Human Services notified of that recognition. The procedure should only be undertaken in a hospital capable of providing cardiac surgery.

TN.8.65 Cardiac Resynchronisation Therapy - (Item 38371)

Item 38371 applies only to patients who meet the criteria listed in the item descriptor, and to patients who do not meet the criteria listed in the descriptor but have previously had an CRT device capable of defibrillation inserted and who prior to its insertion met the criteria and now need the device replaced.

TN.8.66 Implantable Cardioverter Defibrillator - (Items 38384 and 38387)

Items 38384 and 38387 apply only to patients who meet the criteria listed in the item descriptor, and to patients who do not meet the criteria listed in the descriptor but have previously had an ICD device inserted and who prior to its insertion met the criteria and now need the device replaced.

TN.8.67 Cardiac and Thoracic Surgical Items - (Items 38470 to 38766)

Items 38470 to 38766 must be performed using open exposure or minimally invasive surgery which excludes percutaneous and transcatheter techniques unless otherwise stated in the item.

TN.8.68 Coronary Artery Bypass - (Items 38497 to 38504)

The fees for Items 38497 and 38498 include the harvesting of vein graft material. Harvesting of internal mammary artery and/or vein graft material is covered in the fees for Items 38500, 38501, 38503 and 38504. Where harvesting of an artery other than the internal mammary artery is undertaken, benefits are payable under Item 38496 on the multiple operation basis. The procedure of coronary artery bypass grafting using arterial graft is covered by Item 38500, 38501, 38503 or 38504 irrespective of the origin of the arterial graft.

Items 38498, 38501 and 38504 require that either a clinical or medical perfusionist are present in the operating theatre throughout the procedure in case it is necessary to convert to an on-pump procedure and cardiopulmonary bypass is required.

If it is necessary to provide cardiopulmonary bypass items 38498, 38501 and 38504 cannot be claimed. The procedure should be claimed under items 38497, 38500 or 38503 as appropriate in conjunction with the relevant cardiopulmonary bypass procedures.

TN.8.69 Re-operation via Median Sternotomy - (Item 38640)

Medicare benefits are payable for Item 38640 plus the item/s covering the major surgical procedure/s performed at the time of the re-operation, using the multiple operation formula. Benefits are not payable for Item 38640 in association with Item 38656, 38643 or 38647.

TN.8.70 Skull Base Surgery - (Items 39640 to 39662)

The surgical management of lesions involving the skull base (base of anterior, middle and posterior fossae) often requires the skills of several surgeons or a number of surgeons from different surgical specialties working together or in tandem during the operative session. These operations are usually not staged because of the need for definitive closure of the dura, subcutaneous tissues, and skin to avoid serious infections such as osteomyelitis and/or meningitis.

Items 39640 to 39662 cover the removal of the tumour, which would normally be performed by a neurosurgeon. Other items are available to cover procedures performed as a part of skull base surgery by practitioners in other specialities, such as ENT and plastic and reconstructive surgery.

TN.8.71 Intradiscal Injection of Chymopapain - (Item 40336)

The fee for this item includes routine post-operative care. Associated radiological services attract benefits under the appropriate item in Group I3.

TN.8.72 Removal of Ventilating Tube from Ear - (Item 41500)

Benefits are not payable under Item 41500 for removal of ventilating tube. This service attracts benefits on an attendance basis.

TN.8.73 Meatoplasty - (Item 41515)

When this procedure is associated with Item 41530, 41548, 41557, 41560 or 41563 the multiple operation rule applies.

TN.8.74 Reconstruction of Auditory Canal - (Item 41524)

When associated with Item 41557, 41560 or 41563 the multiple operation rule applies.

TN.8.75 Removal of Nasal Polyp or Polypi - (Items 41662 and 41668)

Where such polyps are removed in association with another intranasal procedure, Medicare benefit is paid under Item 41662. However where the associated procedure is of lesser value than Item 41668, benefit for removal of polypi would be paid under Item 41668.

Services performed under item 41668 require admission to hospital.

TN.8.76 Larynx, Direct Examination - (Item 41846)

Benefit is not attracted under this item when an anaesthetist examines the larynx during the course of administration of a general anaesthetic.

TN.8.77 Microlaryngoscopy - (Item 41858)

This item covers the removal of "juvenile papillomata" by mechanical means, e.g. cup forceps. Item 41861 refers to the removal by laser surgery.

TN.8.78 Imbedded Foreign Body - (Item 42644)

For the purpose of item 42644, an imbedded foreign body is one that is sub-epithelial or intra-epithelial and is completely removed using a hypodermic needle, foreign body gouge or similar surgical instrument with magnification provided by a slit lamp biomicroscope, loupe or similar device.

Item 42644 also provides for the removal of rust rings from the cornea, which requires the use of a dental burr, foreign body gouge or similar instrument with magnification by a slit lamp biomicroscope.

Where the imbedded foreign body is not completely removed, benefits are payable under the relevant attendance item

TN.8.79 Corneal Incisions - (Item 42672)

The description of this item refers to two sets of calculations, one performed some time prior to the operation, the other during the course of the operation. Both of these measurements are included in the Schedule fee and benefit for Item 42672.

TN.8.80 Cataract surgery (Items 42698 and 42701)

Items 42698 and 42701 provide for intraocular lens extraction and replacement as a separate procedure to be used in instances when lens removal and replacements are contraindicated at the same operation, such as in patients presenting with proliferative diabetic retinopathy or recurrent uveitis.

TN.8.81 Posterior Juxtascleral Depot injection - (Item 42741)

For the purpose of item 42741, the therapeutic substance must be registered with the Therapeutic Goods Administration (or listed on the Pharmaceutical Benefits Schedule, if so listed) as being suitable for injection for the treatment of predominantly (greater than or equal to 50%) classic, subfoveal choroidal neovascularisation due to age-related macular degeneration, as diagnosed by fluorescein angiography, in a patient with a baseline visual acuity equal to or better than 6/60.

TN.8.82 Cyclodestructive Procedures - (Items 42770)

Item 42770 is restricted to a maximum of 2 treatments in a 2 year period.

TN.8.83 Insertion of drainage device for glaucoma (Item 42752)

Item 42752 provides for the insertion of a drainage device for the treatment of glaucoma patients who are at high risk of failure of trabeculectomy (such as patients who have aggressive neovascular glaucoma or extensive conjunctival scarring); have iridocorneal endothelial syndrome; inflammatory (uveitic) glaucoma; or aphakic glaucoma.

TN.8.84 Laser Trabeculoplasty - (Item 42782)

Item 42782 is restricted to a maximum of 4 treatments in a 2 year period.

TN.8.85 Laser Iridotomy - (Item 42785)

Item 42785 is restricted to a maximum of 3 treatments in a 2 year period.

TN.8.86 Laser Capsulotomy - (Items 42788)

Item 42788 is restricted to a maximum of 2 treatments in a 2 year period.

TN.8.87 Laser Vitreolysis or Corticolysis of Lens Material or Fibrinolysis - (Item 42791)

Item 42791 is restricted to a maximum of 3 treatments in a 2 year period.

TN.8.88 Division of Suture by Laser - (Item 42794)

Benefits under this item are restricted to a maximum of 2 treatments in a 2 year period. There is no provision for additional treatments in that period.

TN.8.89 Ophthalmic Sutures - (Item 42845)

This item refers to the occasion when readjustment has to be made to the sutures to vary the angle of deviation of the eye. It does not cover the mere tightening of the loosely tied sutures without repositioning, or adjustment performed prior to the patient leaving the operating theatre.

TN.8.91 Abrasive Therapy/Resurfacing - (Items 45021 to 45026)

For the purposes of the above items, one aesthetic area is any of the following of the whole face (considered to be divided into six segments):- forehead; right cheek; left cheek; nose; upper lip; and chin.

Items 45021 and 45024 cover abrasive therapy only. For the purposes of these items, abrasive therapy requires the removal of the epidermis and into the deeper papillary dermis. Services performed using a laser are not eligible for benefits under these items.

Items 45025 and 45026 do not cover the use of fractional (Fraxel[®]) laser therapy.

TN.8.92 Escharotomy - (Item 45054)

Benefits are payable once only under Item 45054 for each limb (or chest) regardless of the number of incisions to each of these areas.

TN.8.93 Local Skin Flap - Definition

Medicare benefits for flaps are only payable when clinically appropriate. Clinically appropriate in this instance means that the flap or graft is required to close the defect because the defect cannot be closed directly, or because the flap is required to adapt scar position optimally with regard to skin creases or landmarks, maintain contour on the face or neck, or prevent distortion of adjacent structures or apertures.

A local skin flap is an area of skin and subcutaneous tissue designed to be elevated from the skin adjoining a defect requiring closure. The flap remains partially attached by its pedicle and is moved into the defect by rotation, advancement or transposition, or a combination of these manoeuvres. A benefit is only payable when the flap is required for adequate wound closure. A secondary defect will be created which may be closed by direct suture, skin grafting or sometimes a further local skin flap. This later procedure will also attract benefit if closed by graft or flap repair but not when closed by direct suture.

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

A "Z" plasty is a particular type of transposition flap repair. Although 2 flaps are created, benefit will be paid on the basis of Item 45201, claimable once per defect. Additional flaps are to be claimed under Item 45202, if clinically indicated.

Note: refer to T8.128 for MBS item 45202 for circumstances where other services might involve flap repair.

TN.8.94 Free Grafting to Burns - (Items 45406 to 45418)

Items 45406 to 45418 cover split skin grafting using autografts, homografts or xenografts.

TN.8.95 Revision of Scar - (Items 45506 to 45518)

For the purposes of items 45506 to 45518, revision of scar refers to modification of existing scars (traumatic, surgical or pathological) that is designed to decrease scar width, adapt scar position with regard to skin creases and landmarks, release scars from adhering to underlying structures, improve scar contour in keeping with undamaged skin or restore the shape of facial aperture.

Items 45506 to 45518 are only claimable when performed by a specialist in the practice of his or her specialty or where undertaken in the operating theatre of a hospital.

Only items 45506 and 45512, for the face and neck, can be claimed in association with items providing for graft or flap services.

For excision of scar services which do not meet the requirements of the revision of scar items as defined, the appropriate item in the range 31206 to 31225 should be claimed.

TN.8.96 Augmentation Mammaplasty - (Items 45524, 45527 and 45528)

A Medicare benefit is generally not attracted under item 45524 unless the asymmetry in breast size is greater than 10%. Augmentation of a second breast sometime after an initial augmentation of one side would not attract benefits. Benefits are not payable for augmentation mammaplasty services performed using fat transfer to the breast.

Item 45528 applies where bilateral mammaplasty is indicated because of malformation of breast tissue, disease or trauma of the breast, (but not as a result of previous cosmetic surgery) other than covered under item 45524 or 45527.

Volumetric measurement of the breasts should be performed using a technique which has been reported in a published study.

TN.8.97 Breast Reconstruction, Myocutaneous Flap - (Item 45530)

When a prosthesis is inserted in conjunction with this operation, benefit would be attracted under Item 45527, the multiple operation rule applying. Benefits would also be payable for nipple reconstruction (Item 45545) when performed.

When claiming item 45530 for a rectus abdominis flap; item 45569 should be claimed for closure of the abdomen and reconstruction of the umbilicus, and item 45570 may be claimed if repair of the musculoaponeurotic layer is required. When claiming item 45530 for a latissimus dorsi flap, no item for the closure of the musculoaponeurotic layer should be claimed as it is expected that repair will be by direct suture. In the small number of cases, when a latissimus dorsi flap is used, and repair by means other than direct suture is required, use of item 45203 would be appropriate.

Items 30165-30179 (lipectomy items) should not be claimed in association with item 45530 as stated in the Health Insurance (General Medical Services Table) Regulations.

TN.8.98 Breast Prosthesis, Removal and Replacement of - (Items 45553 and 45554)

It is generally expected that the replacement prosthesis will be the same size as the prosthesis that is removed. Medicare benefits are not payable for services under items 45553-45554 where the procedure is performed solely to increase breast size.

Where the original implant was not inserted in the context of breast cancer or developmental abnormality, intraoperative photographs need to demonstrate significant evidence of substantial skin laxity to justify replacement of the prosthesis.

In the context of eligibility for item 45553 and 45554, an unacceptable deformity would not include asymmetry caused as a result of implant removal.

Where a rupture has been established through imaging and reported, items 45553 and 45554 will still apply even if intra-operatively the implant is found to be structurally intact.

Full clinical details must be documented in patient notes, including pre-operative photographic and / or diagnostic imaging evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.99 Breast Ptosis - (Items 45556 and 45558)

For the purposes of item 45556, Medicare benefit is only payable for the correction of breast ptosis when performed unilaterally, in the context of breast cancer or developmental breast abnormality to match the position of the contralateral breast. This item is payable only once per patient. Additional benefit is not payable if this procedure is also performed on the contralateral breast.

Item 45558 applies where correction of breast ptosis is indicated because at least two-thirds of the breast tissue, including the nipple, lies inferior to the infra-mammary fold where the nipple is located at the most dependent, inferior part of the breast contour.

Full clinical details must be documented in patient notes, including pre-operative photographic evidence (including anterior, left lateral and right lateral views) as specified in the item descriptor which demonstrates the clinical need for the service, as this may be subject to audit.

TN.8.100 Nipple and/or Areola Reconstruction - (Items 45545 and 45546)

Item 45545 involves the taking of tissue from, for example, the other breast, the ear lobe and the inside of the upper thigh with or without local flap.

Item 45546 covers the non-surgical creation of nipple or areola by intradermal colouration.

TN.8.101 Liposuction - (Items 45584 and 45585)

Medicare benefits for liposuction are generally attracted under item 45584, that is for the treatment of post-traumatic pseudolipoma. Such trauma must be significant and result in large haematoma and localised swelling. Only on very rare occasions would benefits be payable for bilateral liposuction.

Where liposuction is indicated for the treatment of Barraquer-Simons Syndrome, lymphoedema or macrodystrophia lipomatosa, or the reduction of buffalo hump, item 45585 applies. One regional area is defined as one limb or trunk. If liposuction is required on more than one limb, item 45585 can be claimed once per limb.

Full clinical details must be documented in patient notes, including pre-operative photographic and / or diagnostic imaging evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.102 Meloplasty for Correction of Facial Asymmetry - (Items 45587 and 45588)

Benefits are payable under items 45587 and 45588 for face lift operations performed in hospital to correct soft tissue abnormalities of the face due to causes other than the ageing process, including trauma, a congenital condition or disease.

Where bilateral meloplasty is indicated because of congenital malformation for conditions such as drooling from the angles of the mouth and deep pitting of the skin resulting from severe acne scarring, disease or trauma (but not as a result of previous cosmetic surgery), item 45588 applies.

Full clinical details must be documented in patient notes, including pre-operative photographic and/or diagnostic imaging evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.103 Reduction of Eyelids - (Items 45617 and 45620)

Where a reduction is performed for a medical condition of one eyelid, it may be necessary to undertake a similar compensating procedure on the other eyelid to restore symmetry. The latter operation would also attract benefits.

Medicare benefits are not payable for non-therapeutic cosmetic services. Full clinical details must be documented in patient notes, including pre-operative photographic and / or diagnostic evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.104 Rhinoplasty - (Items 45632 to 45644, and 45650)

Benefits are payable for septoplasty (item 41671) where performed in conjunction with rhinoplasty.

A Medicare benefit for items 45632 – 45644 and 45650 is payable where the indication for surgery is for:

- (i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or
- (ii) significant acquired, congenital or developmental deformity.

The NOSE Scale refers to the Nasal Obstruction Symptom Evaluation Scale, developed by Stewart et al, as published in the Otolaryngology-Head and Neck Surgery, 130: 2.

The NOSE Scale can be accessed here: https://www.entnet.org//content/facial-plasticsrhinology-outcome-tool-nose-scale

Full clinical details must be documented in patient notes, including pre-operative photographic and / or NOSE Scale evidence demonstrating the clinical need for the service as this may be subject to audit.

TN.8.105 Contour Restoration - (Item 45647)

For the purpose of item 45647, a region in relation to the face is defined as either being upper left or right, mid left or right or lower left or right. Accounts should be annotated with region/s to which the service applies.

TN.8.106 Vermilionectomy - (Item 45669)

Item 45669 covers treatment of the entire lip.

TN.8.107 Osteotomy of Jaw - (Items 45720 to 45752)

The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site. Bone grafts taken from a separate site, eg iliac crest, would attract additional benefit under Item 47726 or 47729 for the harvesting, plus Item 48239 or 48242 for the grafting.

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

Item 75621 for the provision of fitting of surgical templates may be claimed in association with the appropriate orthognathic surgical items in the range of 45720 to 45754 for prescribed dental patients registered under the Cleft Lip and Cleft Palate Scheme.

TN.8.108 Genioplasty - (Item 45761)

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

TN.8.109 Tumour, Cyst, Ulcer or Scar - (Items 45801 to 45813)

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

TN.8.110 Fracture of Mandible or Maxilla - (Items 45975 to 45996)

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

TN.8.111 Reduction of Dislocation or Fracture

Closed reduction means treatment of a dislocation or fracture by non-operative reduction, and includes the use of percutaneous fixation or external splintage by cast or splints.

Open reduction means treatment of a dislocation or fracture by either operative exposure including the use of any internal or external fixation; or non-operative (closed reduction) where intra-medullary or external fixation is used.

Where the treatment of a fracture requires reduction on more than one occasion to achieve an adequate alignment, benefits are payable for each separate occasion at which reduction is performed under the appropriate item covering the fracture being treated.

The treatment of fractures/dislocations not specifically covered by an item in Subgroup 15 (Orthopaedic) attracts benefits on an attendance basis.

TN.8.112 Removal of Multiple Exostoses (Items 47933 and 47936)

Items 47933 and 47936 provide for removal of multiple exostoses when undertaken via the same incision.

TN.8.116 Wrist Surgery - (Items 49200 to 49227)

For the purposes of these items, the wrist includes both the radiocarpal joint and the midcarpal joint.

TN.8.117 Diagnostic Arthroscopy and Arthroscopic Surgery of the Knee (Items 49557 and 49563)

The Medical Services Advisory Committee (MSAC) evaluated the available evidence and did not support public funding for matrix-induced autologous chondrocyte implantation (MACI) or autologous chondrocyte implantation (ACI) for the treatment of chondral defects in the knee and other joints, due to the increased cost compared to existing procedures and the lack of evidence showing short term or long-term improvements in clinical outcomes. Medicare benefits are not payable in association with this technology.

TN.8.118 Paediatric Patients - (Items 50450 to 50658)

For the purpose of Medicare benefits a paediatric patient is considered to be a patient under the age of eighteen years, except in those instances where an item provides further specifications (i.e. fracture items for paediatric patients which state "with open growth plates").

TN.8.119 Treatment of Fractures in Paediatric Patients - (Items 50500 to 50588)

Items 50552 and 50560 apply to fractures that may arise during delivery and at an age when anaesthesia poses a significant risk and thus reduction is usually performed in the neonatal unit or nursery.

Item 50576 provides for closed reduction in the skeletally immature patient and will require application of a hip spica cast and related aftercare.

Medicare benefits are payable for services that specify reduction with or without internal fixation by open or percutaneous means, where reduction is carried out on the growth plate or joint surface or both.

TN.8.120 Unresectable primary malignant tumour of the liver destruction of by open or laparoscopic radiofrequency ablation or microwave tissue ablation- (Item 50952)

A multi-disciplinary team for the purposes of item 50952 would include a hepatobilliary surgeon, interventional radiologist and a gastroenterologist or oncologist.

TN.8.121 Paracentesis of anterior chamber or vitreous cavity and/or intravitreal injection - (Items 42738 to 42740)

Items 42738 and 42739 provide for paracentesis for the injection of therapeutic substances and/or the removal of aqueous or vitreous, when undertaken as an independent procedure. That is, not in conjunction with other intraocular surgery.

Item 42739 should be claimed for patients requiring anaesthetic services for the procedure. Advice from the Royal Australian and New Zealand College of Ophthalmologists is that independent injections require only topical anaesthesia, with or without subconjunctival anaesthesia, except in specific circumstances as outlined below where additional anaesthetic services may be indicated:

- nystagmus or eye movement disorder;
- cognitive impairment precluding safe intravitreal injection without sedation;
- a patient under the age of 18 years;
- a patient unable to tolerate intravitreal injection under local anaesthetic without sedation; or
- endophthalmitis or other inflammation requiring more extensive anaesthesia (eg peribulbar).

Practitioners billing item 42739 must keep clinical notes outlining the basis for the use of anaesthetic.

Item 42740 provides for intravitreal injection of therapeutic substances and/or the removal of vitreous for diagnostic purposes when performed in conjunction with other intraocular surgery including with a service to which Item 42809 (retinal photocoagulation) applies.

TN.8.122 Bone Graft (Items 48200-48242 and 48642-48651)

Bone graft substitute materials can be used for the purpose of bone graft for items 48200-48242 and 48642-48651.

TN.8.123 Vulvoplasty and Labioplasty - (Items 35533 and 35534)

Item 35533 is intended to cover the surgical repair of female genital mutilation or a major congenital anomaly of the uro-gynaecological tract which is not covered by existing MBS items. For example, this item would apply where a patient who has previously received treatment for cloacal extrophy, bladder exstrophy or congenital adrenal hyperplasia requires additional or follow-up treatment.

Item 35534 is intended to cover services for a structural abnormality causing significant functional impairment and is restricted to patients aged 18 years and over.

A detailed clinical history outlining the structural abnormality and the medical need for surgery of the vulva and/or labia must be included in patient notes, as this may be subject to audit.

Medicare benefits are not payable for non-therapeutic cosmetic services.

TN.8.124 Treatment of Wrist and Finger Fractures - (Items 47301 to 47319, and 47361 to 47373)

- For the purposes of these items, fixation includes internal and external.
- Regarding item 47362, major regional anaesthesia includes bier block.

TN.8.125 Removal of Skin Lesions - Necessary Excision Diameter - (Items 31356 to 31376)

The necessary excision diameter (or defect size) refers to the lesion size plus a clinically appropriate margin of healthy tissue required with the intent of complete surgical excision. Measurements should be taken prior to excision. Margin size should be determined in line with NHMRC guidelines:

Clinical practice guide - Basal cell carcinoma, squamous cell carcinoma(and related lesions)-a guide to clinical management in Australia. November 2008. Cancer Council Australia and; Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand (2008).

For the purpose of Items 31356 to 31376 the defect size is calculated by the average of the width and the length of the skin lesion and an appropriate margin. The necessary excision diameter is calculated as shown in the Factsheet at this link: Determining lesion size for MBS item selection.

Practitioners must retain copies of histological reports and any other supporting evidence (patient notes, photographs etc). Photographs should include scale.

An episode of care includes both the excision and closure for the same defect, even when excision and closure occur at separate attendances.

Definitive surgical excision for items 31371 to 31376 means surgical removal with adequate margins as part of the curative management of the malignancies specified in these items.

An incomplete surgical excision of a malignant skin lesion with curative intent should be billed as a malignant skin lesion excision item even when further surgery is needed. Wide excision of the primary tumour bed following local excision of a primary melanoma, appendageal carcinoma, malignant connective tissue or merkel cell carcinoma of the skin may be claimed using item 31371, 31372, 31373, 31374, 31375 or 31376, depending on the location of the malignancy and the size of the excision diameter.

For Items 31356 to 31370, a malignant skin lesion is defined as a basal cell carcinoma; a squamous cell carcinoma (including keratoacanthoma); a cutaneous deposit of lymphoma; or a cutaneous metastasis from an internal malignancy.

TN.8.126 Flap Repair - (Item 45202)

Practitioners must only perform a muscle or skin flap repair where clinical need can be clearly evidenced (i.e. where a patient hassevere pre-existing scarring, severe skin atrophy, sclerodermoid changes or where the defect is contiguous witha free margin).

Clinical evidence may be supported by patient notes, photographs of the affected area and pathology reports.

TN.8.127 Interpretation of femoroacetabular impingement (FAI) restriction (items 48424, 49303,49366)

Patients presenting with hip dysplasia, Perthes Disease and Slipped Upper Femoral Epiphysis (SUFE) are eligible for treatment under items 49366, 49303 and 48424.

TN.8.132 Transcatheter occlusion of left atrial appendage for stroke prevention (item 38276) Explanatory Note

A contraindication to lifelong anticoagulation is defined as:

- i) a previous major bleeding complication experienced whilst undergoing treatment with oral anticoagulation therapy,
- ii) a blood dyscrasia, or
- iii) a vascular abnormality predisposing to potentially life threatening haemorrhage

The procedure is performed as a hospital service.

TN.8.133 Endoscopic upper gastrointestinal strictures (item 30475)

Endoscopic upper GI stricture services 41819 and 41820 have been consolidated under item 30475. This consolidated item will allow any endoscopic technique to be performed for oesophageal through to gastroduodenal procedures and will include imaging intensification if done. The fee is the same as item 41819 which higher than item 30475 but lower than 41820.

TN.8.134 Application of items 32084, 32087, 32090 and 32093

If a service to which item 32084, 32087, 32090 or 32093 applies is provided by a practitioner to a patient on more than one occasion on a day, the second service is taken to be a separate service for the purposes of the item if the second service is provided under a second episode of anaesthesia or other sedation.

TN.8.135 Transcatheter Aortic Valve Implantation (Item 38495)

Item 38495 applies only to a service for Transcatheter Aortic Valve Implantation (TAVI) for the treatment of symptomatic severe aortic stenosis, that is to be provided in a TAVI Hospital by a TAVI Practitioner on a patient who has been assessed as suitable to receive the procedure.

TAVI Practitioner

For item 38495 a TAVI Practitioner is either a cardiothoracic surgeon or interventional cardiologist who is accredited by Cardiac Accreditation Services Limited.

Accreditation by Cardiac Accreditation Services Limited must be valid prior to the service being undertaken in order for benefits to be payable under item 38495.

The process for accreditation and re-accreditation is outlined in the *Transcatheter Aortic Valve Implantation - Rules* for the Accreditation of TAVI Practitioners, issued by Cardiac Accreditation Services Limited, and is available on the Cardiac Accreditation Services Limited website, www.tavi.org.au.

Cardiac Accreditation Services Limited is a national body comprising representatives from the Australian & New Zealand Society of Cardiac & Thoracic Surgeons (ANZSCTS) and the Cardiac Society of Australia and New Zealand (CSANZ).

TAVI Hospital

For item 38495 a TAVI Hospital means a hospital, as defined by subsection 121-5(5) of the *Private Health Insurance Act 2007*, that is clinically accepted as being a facility that is suitable for TAVI procedures to be performed at.

The *Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners* developed by Cardiac Accreditation Services Limited provides guidance on what are considered by the sector as minimum requirements that must be met in order to be a clinically acceptable facility that is suitable for TAVI procedures to be performed at.

Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners can be accessed via www.tavi.org.au.

TAVI Patient

For item 38495 a TAVI Patient is a patient who, as a result of a TAVI Case Conference, has been recommended as being suitable to receive the service described in item 38495.

A TAVI Case Conference is a process by which:

- (a) there is a team of 3 or more participants, where:
 - (i) the first participant is a cardiothoracic surgeon; and

- (ii) the second participant is an interventional cardiologist; and
- (iii) the third participant is a specialist or consultant physician who does not perform a service described in Item 38495 for the patient being assessed; and
 - (iv) either the first or the second participant is also a TAVI Practitioner; and
- (b) the team assesses a patient's risk and technical suitability to receive the service described in Item 38495, taking into account matters such as:
 - (i) the patient's risk and technical suitability for a surgical aortic valve replacement; and
 - (ii) the patient's cognitive function and frailty; and
- (c) the result of the assessment is that the team makes a recommendation about whether or not the patient is suitable to receive the service described in Item 38495; and
- (d) the particulars of the assessment and recommendation are recorded in writing.

While benefits are payable for an eligible TAVI Case Conference under Items 6080 and 6081, a claim for these services does not have to be made in order for a benefit to be paid under Item 38495. Item 38495 is only payable once per patient in a five year period.

TN.8.136 Corneal Collagen Cross Linking (Item 42652)

Evidence of progression in patients over the age of twenty five is determined by the patient history including an objective change in tomography or refraction over time. Evidence of progression in patients aged twenty five years or younger is determined by patient history including an objective change in tomography or refraction over time and/or posterior elevation data and objective documented progression at a subclinical level.

TN.8.137 Thyroidectomy and hemithyroidectomy procedures (items 30296, 30306, and 30310)

Total thyroidectomy or total hemithyroidectomy are the most appropriate procedures in the majority of circumstances when a thyroidectomy is required. The preferred procedure for thyrotoxicosis is total thyroidectomy (item 30296). Item 30310 is to be used only in uncommon circumstances where a subtotal or partial thyroidectomy is indicated and includes a subtotal lobectomy, nodulectomy, or isthmusectomy or equivalent partial thyroidectomy.

TN.8.138 Re-exploratory thyroid surgery (item 30297)

Item 30297 is for re-exploratory thyroid surgery where prior thyroid surgery and associated scar tissue increases the complexity of surgery. For completion hemithyroidectomy on the contralateral side to a previous hemithyroidectomy for thyroid cancer, item 30306 is the appropriate item.

TN.8.139 Personal performance of a Synacthen Stimulation Test (item 30097)

A 0900h serum cortisol (0830-0930) less than 100 nmol/L indicates adrenal deficiency and a Synacthen Test is not required.

A 0900h serum cortisol (0830-0930) greater than 400 nmol/L indicates adrenal sufficiency and a Synacthen Test is not required. An exception to this is when testing women on oral contraception where cortisol levels may be higher due to increases in cortisol-binding globulin and this threshold may not exclude women with adrenal insufficiency.

TN.8.140 Excision of graft material - Items 35581 and 35582

For items 35581 and 35582 the size of the excised graft material must be histologically tested and confirmed.

TN.8.141 Application of items 51011 to 51171 (Sub-group 17)

Spinal surgery items 51011 to 51171 cannot be performed in conjunction with any other item (outside of subgroup 17) in Group T8 of the MBS (surgical operation items 30001 to 50952), when that surgical item is related to spinal surgery.

Meaning of Motion Segment

Motion segment is defined as including all anatomical structures (including traversing and exiting nerve roots) between and including the top of the pedicle above to the bottom of the pedicle below.

Combined Anterior and Posterior Surgery

Combined anterior/ posterior surgery items 51061, 51062, 51063, 51064, 51065 and 51066 cannot be claimed with any item between 51020 and 51045 (i.e. items for spinal instrumentation, posterior bone graft and/or anterior column fusion).

Interpretation of Spinal Fusion

Lumbar spinal fusion may not be claimed for chronic low back pain for which a diagnosis has not been made.

TN.8.142 Spinal Decompression - Items 51011 to 51015

Items 51011 to 51015 are for services which include discectomy, decompression of central spinal canal by laminectomy or partial corpectomy (vertebral spurs and osteophytes; less than 50% of the vertebral body), and decompression of the subfacetal recess, the exit foramen and far lateral (intertransverse) space.

For decompression procedures, only one item is selected from 51011 to 51015.

For posterolateral spinal fusion without instrumentation, if a decompression procedure is combined with the fusion, two items numbers can be selected: one from 51011 to 51015 and one from 51031 to 51036.

For posterolateral spinal fusion with instrumentation, two item numbers can be selected: one from 51020 to 51026 and one from 51031 to 51036. If decompression is also performed, three items can be selected: one from 51011 to 51015, one from 51020 to 51026 and one from 51031 to 51036.

For instrumented spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers can be selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

If more than 50% of a vertebral body is resected (piecemeal vertebrectomy) an item from 51051 to 51059 can be selected in addition to an item from 51011 to 51015.

Items 51011 to 51015 can be used when the purpose of the laminectomy is exposure or posterior spinal release.

TN.8.143 Spinal Instrumentation (cervical, thoracic and lumbar) - Items 51020 to 51026

Items 51020 to 51026 are intended for spinal instrumentation at any level. The appropriate item is determined by the number of motion segments instrumented, barring item 51020 which applies to one vertebra.

For posterolateral spinal fusion with instrumentation, two item numbers are selected: one from 51020 to 51026 and one from 51031 to 51036. If decompression is also performed, three items are selected: one from 51011 to 51015, one from 51020 to 51026 and one from 51031 to 51036.

For instrumented spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers are selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

TN.8.144 Posterior and/or Posterolateral (intertransverse or facet joint) bone graft (cervical, thoracic and lumbar) - Items 51031 to 51036

Items 51031 to 51036 are for services which include local morcellized, artificial or harvested bone graft with or without bone morphogenic protein (BMP).

For posterolateral spinal fusion without instrumentation, if a decompression is combined with the fusion, two items numbers are selected; one from 51011 to 51015 and one from 51031 to 51036.

For posterolateral spinal fusion with instrumentation, two item numbers are selected: one from 51020 to 51026 and one from 51031 to 51036. If decompression is also performed, three items are selected: one from 51011 to 51015, one from 51020 to 51026 and one from 51031 to 51036.

For instrumental spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers are selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

TN.8.145 Anterior column fusion, with or without implant, or limited vertebrectomy (less than 50%) and anterior fusion (cervical, thoracic and lumbar) - Items 51041 to 51045

Items 51041 to 51045 are for services which include placement of local morcellized, artificial, harvested bone graft, bone morphogenic protein (BMP) and prosthetic devices into the invertebral space. Artificial bone grafting materials must be used in accordance with the manufacturer's instructions.

Items 51041 to 51045 are to be selected irrespective of surgical approach (anterior, direct lateral or posterior via open or minimally invasive techniques).

For instrumented spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers are selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

For and instrumented anterior cervical decompression and fusion, (with or without cage) three items are selected: one from 51011 to 51015, one from 51020 to 51026, and one from 51041 to 51045.

Items 51041 to 51045 cannot be claimed with any item between 51051 and 51059 if performed at the same motion segment.

If an assisting surgeon is used at any time during the procedure, then 51160 or 51165 should be used in isolation by the assisting surgeon. If the assisting surgeon needs to perform complex non-spinal surgery, they may use a more appropriate item from outside the spinal surgery schedule.

TN.8.146 Spinal Osteotomy and/or vertebrectomy - Items 51051 to 51059

Items 51051 to 51059 are intended for spinal osteotomy and/or vertebrectomy at any level.

For the purpose of items 51054, 51055 and 51056, the definition of piecemeal or subtotal excision is the removal of at least 50% of the vertebral body.

Items 51051 to 51059 cannot be claimed with any item between 51041 and 51045 if performed at the same motion segment.

TN.8.147 Anterior and Posterior (combined) Spinal fusion under one anaesthetic via separate incisions - Items 51061 to 51066

Only one of these items should be billed for any appropriate combined anterior and posterior surgeries which are completed under one anaesthetic. The appropriate item is determined by the number of motion segments to which grafting and fusion occur.

These items cannot be claimed with any item between 51020 to 51026, 51031 to 51036 and 51041 to 51045.

If a laminectomy is included, an item from 51011 to 51015 can also be used appropriate to the level of decompression.

If spinal osteotomy or vertebrectomy (>50%) is performed as part of the combined anterior/posterior approach, it is appropriate to claim one item between 51051 to 51056 in addition to an item between 51061 to 51066.

TN.8.148 Odontoid Screw fixation - Item 51103

This item is not for use when another item is claimed for the management of the odontoid fracture.

TN.8.149 Application of items 51160 and 51166

If the spine surgeon performs their own exposure to the thoracic or lumbar spine then 51160 or 51165 can be added to the claim for the overall surgery. If an assisting surgeon is used at any time during the procedure, then 51160 or 51165 should be used in isolation by the assisting surgeon. If the assisting surgeon needs to perform complex non-spinal surgery, they may use a more appropriate item but not in combination with 51160 or 51165. If an exposure surgeon claims a number from any section of the MBS schedule, the spinal surgeon cannot claim 51160 or 51165.

TN.8.150 Correction of Developmental Breast Abnormality - (Items 45060 to 45062)

Full clinical details must be documented in patient notes, including pre-operative photographic and / or diagnostic imaging evidence as specified in the item descriptor which demonstrates the clinical need for the service, as this may be subject to audit.

Volumetric measurement of the breasts should be performed using a technique which has been reported in a published study.

TN.8.151 Mohs surgery service caseload

Services under items 31000, 31001 and 31002 should make up at least 90% of a Mohs surgeon's caseload of items 31000-31005 annually.

TN.9.1 Assistance at Operations - (Items 51300 to 51318)

Items covering operations which are eligible for benefits for surgical assistance have been identified by the inclusion of the word "Assist." in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

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

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

NOTE: The Benefit in respect of assistance at an operation is not payable unless the assistance is rendered by a medical practitioner other than the anaesthetist or assistant anaesthetist. The amount specified is the amount payable whether the assistance is rendered by one or more medical practitioners.

Assistance at Multiple Operations

Where surgical assistance is provided at two or more operations performed on a patient on the one occasion the multiple operation formula is applied to all the operations to determine the surgeon's fee for Medicare benefits purposes. The multiple-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for surgical assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Item 51300 or 51303).

Multiple Operation Rule - Surgeon	Multiple Operation Rule - Assistant
Item A - \$300@100%	Item A (Assist.) - \$300@100%
Item B - \$250@50%	Item B (No Assist.)
Item C - \$200@25%	Item C (Assist.) - \$200@50%
Item D - \$150@25%	Item D (Assist.) - \$150@25%

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

Surgeons Operating Independently

Where two surgeons operate independently (ie neither assists the other or administers the anaesthetic) the procedures they perform are considered as two separate operations, and therefore, where a surgical assistant is engaged by each, or one of the surgeons, benefits for surgical assistance are payable in the same manner as if the surgeons were operating separately.

TN.9.2 Benefits Payable under Item 51300

Medicare benefits are payable under item 51300 for assistance rendered at any operation identified by the word "Assist." for which the fee does not exceed the fee threshold specified in the item descriptor, or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee threshold specified in the item descriptor has not been exceeded.

TN.9.3 Benefits Payable Under Item 51303

Medicare benefits are payable under item 51303 for assistance rendered at any operation identified by the word "Assist." for which the fee exceeds the fee threshold specified in the item descriptor or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee exceeds the threshold specified in the item descriptor.

TN.9.4 Benefits Payable Under Item 51309

Medicare benefits are payable under item 51309 for assistance rendered at any operation identified by the word "Assist." or a series or combination of operations identified by the word "Assist." and assistance at a birth involving Caesarean section.

Where assistance is provided at a Caesarean section birth and at a procedure or procedures which have not been identified by the word "Assist.", benefits are payable under item 51306.

TN.9.5 Assistance at Cataract and Intraocular Lens Surgery - (Item 51318)

The reference to "previous significant surgical complication" covers vitreous loss, rupture of posterior capsule, loss of nuclear material into the vitreous, intraocular haemorrhage, intraocular infection (endophthalmitis), cystoid macular oedema, corneal decompensation or retinal detachment.

TN.10.1 Relative Value Guide For Anaesthetics - (Group T10) Overview of the RVG

The RVG groups anaesthesia services within anatomical regions. These items are listed in the MBS under Group T10, Subgroups 1-16 Anaesthesia for radiological and other therapeutic and diagnostic services are grouped separately under Subgroup 17. Also included in the RVG format are certain additional monitoring and therapeutic services, such as blood pressure monitoring (item 22012) and central vein catheterisation (item 22020) when performed in association with the administration of anaesthesia. These services are listed at subgroup 19. The RVG also provides for assistance at anaesthesia under certain circumstances. These items are listed at subgroup 26.

Details of the billing requirements for the RVG are available from the Department of Human Services website.

The RVG is based on an anaesthesia unit system reflecting the complexity of the service and the total time taken for the service. Each unit has been assigned a dollar value.

Under the RVG, the MBS fee for anaesthesia in connection with a procedure is comprised of up to three components:

- 1. The basic units allocated to each anaesthetic procedure, reflecting the complexity of the procedure (an item in the range 20100-21997);
- 2. The time unit allocation reflecting the total time of the anaesthesia (an item in the range 23010-24136); and
- 3. Where appropriate, modifying units recognising certain added complexities in anaesthesia (an item/s in the range 25000-25020).

Assistance at anaesthesia

To establish the fee for the assistant service items 25200 and 25205, both services have been allocated a number of base units. The total time that the assistant anaesthetist was in active attendance on the patient is then added, along with modifiers as appropriate to determine the MBS fee.

Whole body perfusion

Where whole body perfusion is performed, the MBS fee is determined by adding together the following:

- 1. The base units allocated to the service (item 22060);
- 2. The time unit allocation reflecting the total time of the perfusion (an item in the range 23010 24136); and
- 3. Where appropriate, modifying units recognising certain added complexities in perfusion (an item/s in the range 25000 25020).

TN.10.2 Eligible Services

Generally, a Medicare benefit is only payable for anaesthesia which is performed in connection with an "eligible" service. An "eligible" service is defined as a clinically relevant professional service which is listed in the Schedule and which has been identified as attracting an anaesthetic fee.

TN.10.3 RVG Unit Values

Basic Units

The RVG basic unit allocation represents the complexity of the anaesthetic procedure relative to the anatomical site and physiological impact of the surgery.

Time Units

The number of time units is calculated from the total time of the anaesthesia service, the assistant at anaesthesia service or the whole body perfusion service:

- for anaesthesia, time is considered to begin when the anaesthetist commences exclusive and continuous care of the patient for anaesthesia. Time ends when the anaesthetist is no longer in professional attendance, that is, when the patient is safely placed under the supervision of other personnel;
- for assistance at anaesthesia, time is taken to be the period that the assistant anaesthetist is in active attendance on the patient during anaesthesia; and

• for perfusion, perfusion time begins with the commencement of anaesthesia and finishes with the closure of the chest.

For up to and including the first - 2 hours of time, each 15 minutes (or part thereof) constitutes 1 time unit. For time beyond 2 hours, each time unit equates to 10 minutes (or part thereof).

For statistical purposes, a separate MBS item applies to every 5 minute increment for anaesthetic services between 15 minutes and 2 hours duration. For or these services, the appropriate 5 minute item number should be included on accounts.

Modifying Units (25000 - 25050)

Modifying units have been included in the RVG to recognise added complexities in anaesthesia or perfusion, associated with the patient's age, physical status or the requirement for emergency surgery. These cover the following clinical situations:

ASA physical status indicator 3 - A patient with severe systemic disease that significantly limits activity (item 25000). This would include: severely limiting heart disease; severe diabetes with vascular complications or moderate to severe degrees of pulmonary insufficiency.

Some examples of clinical situations to which ASA 3 would apply are:

- a patient with ischaemic heart disease such that they encounter angina frequently on exertion thus significantly limiting activities;
- a patient with chronic airflow limitation who gets short of breath such that the patient cannot complete one flight of stairs without pausing;
- a patient who has suffered a stroke and is left with a residual neurological deficit to the extent that is significantly limits normal activity, such as hemiparesis; or
- a patient who has renal failure requiring regular dialysis.

ASA physical status indicator 4 - A patient with severe systemic disease which is a constant threat to life (item 25005). This covers patients with severe systemic disorders that are already life-threatening, not always correctable by an operation. This would include: patients with heart disease showing marked signs of cardiac failure; persistent angina or advanced degrees of pulmonary, hepatic, renal or endocrine insufficiency.

ASA physical status indicator 4 would be characterised by the following clinical examples:

- a person with coronary disease such that they get angina daily on minimum exertion thus severely curtailing their normal activities;
- a person with end stage emphysema who is breathless on minimum exertion such as brushing their hair or walking less than 20 metres; or
- a person with severe diabetes which affects multiple organ systems where they may have one or more of the following examples:
- severe visual impairment or significant peripheral vascular disease such that they may get intermittent claudication on walking less than 20 metres; or
- severe coronary artery disease such that they suffer from cardiac failure and/or angina whereby they are limited to minimal activity.

ASA physical status indicator 5 - a moribund patient who is not expected to survive for 24 hours with or without the operation (item 25010). This would include: a burst abdominal aneurysm with profound shock; major cerebral trauma with rapidly increasing intracranial pressure or massive pulmonary embolus.

The following are some examples that would equate to ASA physical status indicator 5

- a burst abdominal aneurysm with profound shock;
- major cerebral trauma with increasing intracranial pressure; or
- massive pulmonary embolus.
- **NOTE:** It should be noted that the Medicare Benefits Schedule does NOT include modifying units for patients assessed as ASA physical status indicator 2. Some examples of ASA 2 would include:
- a patient with controlled hypertension which has no affect on the patient's normal lifestyle;
- a patient with coronary artery disease that results in angina occurring on substantial exertion but not limiting normal activity; or
- a patient with insulin dependant diabetes which is well controlled and has minimal effect on normal lifestyle.
- Where the patient is less than 12 months or age or 70 years or greater (item 25015).
- For anaesthesia, assistance at anaesthesia or a perfusion service in association with an *emergency procedure (item 25020).
- For anaesthesia or assistance at anaesthesia in association with an *after hours emergency procedure (items 25025 and 25030).
- For a perfusion service in association with *after hours emergency surgery (item 25050).
- * **NOTE:** It should be noted that the emergency modifier and the after hours emergency modifiers cannot both be claimed in the one anaesthesia assistance at anaesthesia or perfusion episode.

It should also be noted that modifiers are not stand alone services and can only be claimed in association with anaesthesia, assistance at anaesthesia or with a perfusion service covered by item 22060.

Definition of Emergency

For the purposes of both the emergency modifier and the after hours emergency modifiers, emergency is defined as existing where the patient requires immediate treatment without which there would be significant threat to life or body part.

Definition of After Hours

For the purposes of the after hours emergency modifier items, the after hours period is defined as being the period from 8pm to 8am on any weekday or at any time on a Saturday, a Sunday or a public holiday. Benefit for the After Hours Emergency Modifiers is only payable where more than 50% of the time for the emergency anaesthesia, the assistance at emergency anaesthesia or the perfusion service is provided in the after hours period. In situations where less than the 50% of the time for the service falls in the after hours period, the emergency modifier rather than the after hours emergency modifier applies. For information about deriving the fee for the service where the after hours emergency modifier applies.

TN.10.4 Deriving the Schedule Fee under the RVG

The Schedule fee for each component of anaesthesia (base items, time items and modifier items) in the RVG Schedule is derived by applying the unit value to the total number of anaesthesia units for each component. For example:

ITEM	DESCRIPTION		SCHEDULE FEE
RVG	Anaesthesia Service		SCHEDULE FEE (Units x \$ 19.45)
20840	Anaesthesia for resection of perforated bowel		\$116.70
23200	Time - 4 hours 40 minutes		\$466.80
25000	Modifier - Physical status		\$19.45
22012	2 Central Venous Pressure Monitoring		\$58.35

After Hours Emergency Services

When deriving the fee for the after hours emergency modifier for anaesthesia or assistance at anaesthesia, the 50% loading applies to the anaesthesia or assistance service from Group T10 and to any additional clinically relevant therapeutic or diagnostic service from Group T10, Subgroup 18, provided during the anaesthesia episode. For example:

ITEM	DESCRIPTION	UNITS	SCHEDULE FEE (Units x \$19.45)
20840	Anaesthesia for resection of perforated bowel	6	\$ 116.70
23190	Time - 4 hours 40 minutes	24	\$466.80
25000	Modifier - Physical status	1	\$19.45
22012	22012 Central Venous Pressure Monitoring		\$58.35
	TOTAL UNITS		Schedule fee = \$661.30
25025	Anaesthesia After Hours Emergency Modifier		Schedule Fee \$661.30 x 50% = \$330.65

Definition of Radical Surgery for the RVG

Where the term radical appears in an item description, it refers to an extensive surgical procedure, performed for the treatment of malignancy. It usually denotes extensive block dissection not only of the malignant tissue, but also of the surrounding tissue, particularly fat and lymphatic drainage systems. See notes T10.18 and T10.22 which clarify the definitions of the words "extensive" and "radical" used in items 20192 and 20474.

Multiple Anaesthesia Services

Where anaesthesia is provided for services covered by multiple items in the RVG, Medicare benefit is only payable for the RVG item with the highest basic unit value. However, the time component should include the total anaesthesia time taken for all services. For example:

ITEM	DESCRIPTION	UNITS	SCHEDULE FEE
20790	Anaesthesia for Cholecystectomy	8	\$155.60
20752	Incisional Hernia	6	(lower value - fee not payable) \$116.70
23111	Time - 2hrs 30mins	11	\$213.95
25015	Physical Status - Over 70	1	\$19.45

Prolonged Anaesthesia

Under the RVG, the previous rules that related to prolonged anaesthesia no longer apply. Where anaesthesia is prolonged beyond that which an anaesthetist would normally encounter for a particular service, the RVG provides for the anaesthetist to claim the total anaesthesia time for the procedure/s.

TN.10.5 Minimum Requirements for Claiming Benefits under Items in the RVG (including sedation) Medicare benefits for RVG services (including sedation) are only payable where both the staffing and the facility in which the service was rendered meets the following minimum guidelines. These guidelines are based on protocols established by the Australian and New Zealand College of Anaesthetists (ANZCA).

Staffing

- Techniques intended to produce loss of consciousness must not be used unless an anaesthetist is present to care exclusively for the patient;
- Where the patient is a young child, is elderly or has any serious medical condition (such as significant cardio-respiratory disease or danger of airway compromise), an anaesthetist should be present to administer sedation and monitor the patient;
- In all other cases, an appropriately trained medical practitioner, other than the proceduralist, is required to be in exclusive attendance on the patient during the procedure, to administer sedation and to monitor the patient; and
- There must be sufficient equipment (including oxygen, suction and appropriate medication), to enable resuscitation should it become necessary.

Facilities

The procedure must be performed in a location which is adequate in size and staffed and equipped to deal with a cardiopulmonary emergency. This must include:

- An operating table, trolley or chair which can be readily tilted;
- Adequate uncluttered floor space to perform resuscitation, should this become necessary;
- Adequate suction and room lighting;
- A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient;
- A self inflating bag suitable for artificial ventilation together with a range of equipment for advance airway management;
- Appropriate drugs for cardiopulmonary resuscitation;
- A pulse oximeter; and
- Ready access to a defibrillator.

These requirements apply equally to dental anaesthesia or sedation services provided under items in Group T10, Subgroup 20 of the RVG.

TN.10.6 Account Requirements

Before a benefit will be paid for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of details additional to those set out at paragraph 7.1 of the General Explanatory Notes of the Medicare Benefits Schedule are required on the anaesthetist's account:

- **the anaesthetist's account** must show the name/s of the medical practitioner/s who performed the associated operation/s. In addition, where the after hours emergency modifier applies to the anaesthesia service, the account must include the start time, the end time and total time of the anaesthetic.
- **the assistant anaesthetist's account** must show the names/s of the medical practitioners who performed the associated operation/s, as well as the name of the principal anaesthetist. In addition, where the after hours emergency modifier applies, the assistant anaesthetist's account must record the start time, the end time and the total time for which he or she was providing professional attention to the patient during the anaesthetic.
- **the perfusionist's account** must record the start time, end time and total time of the perfusion service where the after hours emergency modifier is claimed.

TN.10.7 General Information

The Health Insurance Act provides that where anaesthesia is administered to a patient, the premedication of the patient in preparation for anaesthesia is deemed to form part of the administration of anaesthesia. The administration of anaesthesia also includes the pre-anaesthesia consultation with the patient in preparation for that administration, except where such consultation entails a separate attendance carried out at a place other than an operating theatre or an anaesthesia induction room. The pre-anaesthesia consultation for a patient should be performed in association with a clinically relevant service.

Except in special circumstances, benefit is not payable for the administration of anaesthesia listed in Subgroups 1-18, unless the anaesthesia is administered by a medical practitioner other than the medical practitioner who renders the medical service in connection with which anaesthesia is administered.

Fees and benefits for anaesthesia services under the RVG cover all essential components in the administration of the anaesthesia service. Separate benefit may be attracted, however, for complementary services such as central venous pressure and direct arterial pressure monitoring (see note T10.9).

It should be noted that additional benefit is not payable for intravenous infusion or electrocardiographic monitoring, provision for which has been made in the value determined for the anaesthetic units.

The Medicare benefit derived under the RVG for the administration of anaesthesia is the benefit payable for that service irrespective of whether one or more than one medical practitioner administers it. However, benefit is provided under Subgroup 24 for the services of one assistant anaesthetist (who must not be either the surgeon or assistant surgeon (see Note 10.9)

Where a regional nerve block or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block is assessed as an anaesthesia item according to the advice in paragraph T10.4. When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.

When a regional nerve block or field nerve block covered by an item in Group T7 of the Schedule is administered by a medical practitioner in the course of a surgical procedure undertaken by him/her, then such a block will attract benefit under the appropriate item in Group T7.

It should be noted that where a procedure is carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure and an additional benefit is therefore not payable.

It may happen that the professional service for which the anaesthesia is administered does not itself attract a benefit because it is part of the after-care of an operation. This does not, however, affect the benefit payable for the anaesthesia service. Benefit is payable for anaesthesia administered in connection with such a professional service (or combination of services) even though no benefit is payable for the associated professional service.

The administration of epidural anaesthesia during labour is covered by Item 18216 or 18219 in Group T7 of the Schedule whether administered by the medical practitioner undertaking the confinement or by another medical practitioner. Subsequent "top-ups" are covered by Item 18222 or 18225.

TN.10.8 Additional Services Performed in Connection with Anaesthesia - Subgroup 19

Included in the RVG format are a number of additional or complimentary services which may be provided in connection with anaesthesia such as pulmonary artery pressure monitoring (item 22012) and intra-arterial cannulation (item 22025).

These items (with the exception of peri-operative nerve blocks (22030-22050)) and perfusion services (22055-22075) have also been retained in the MBS in the non-RVG format, for use by practitioners who provide these services other than in association with anaesthesia.

Where an anaesthetist provides an additional (clinically relevant) service during anaesthesia that is not one listed in Subgroup 19 (excluding intravenous infusion or electrocardiographic monitoring) the relevant non-RVG item should be claimed.

Items 22012 and 22014

Benefits are payable under items 22012 and 22014 only once for each type of pressure, up to a maximum of 4 pressures per patient per calendar day, and irrespective of the number of practitioners involved in monitoring the pressures.

TN.10.9 Assistance in the Administration of Anaesthesia

The RVG provides for a separate benefit to be paid for the services of an assistant anaesthetist in connection with an operation or series of operations in specified circumstances, as outlined below. This benefit is payable only in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

Therapeutic and Diagnostic services covered by Subgroup 19 items (such as blood transfusion, pressure monitoring, insertion of CVC, etc) are payable only once per patient per anaesthetic episode. Where these services are provided by the assistant anaesthetist these services are eligible for Medicare benefits only where the same service is not also claimed by the primary anaesthetist.

Assistance at anaesthesia in connection with emergency treatment (Item 25200)

Item 25200 provides for assistance at anaesthesia where the patient is in imminent danger of death. Situations where imminent danger of death requiring an assistant anaesthetist might arise include: complex airway problems, anaphylaxis or allergic reactions, malignant hyperpyrexia, neonatal and complicated paediatric anaesthesia, massive blood loss and subsequent resuscitation, intra-operative cardiac arrest, critically ill patients from intensive care units or inability to wean critically ill patients from pulmonary bypass.

Assistance in the administration of elective anaesthesia (Item 25205)

A separate benefit is payable under Item 25205 for the services of an assistant anaesthetist in connection with elective anaesthesia in the circumstances outlined in the item descriptor. This benefit is only payable in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

For the purposes of Item 25205, a 'complex paediatric case' involves one or more of the following:-

- (i) the need for invasive monitoring (intravascular or transoesophageal); or
- (ii) organ transplantation; or
- (iii) craniofacial surgery; or
- (iv) major tumour resection; or

(v) separation of conjoint twins.

TN.10.10 Perfusion Services - (Items 22055 to 22075)

Perfusion services covered by items 22055-22075 have been included in the RVG format.

As with anaesthesia, where whole body perfusion is performed, the Schedule fee is determined on the base units allocated to the service (item 22060), the total time for the perfusion, and modifying units, as appropriate, i.e.

(a) the basic units allocated to whole body perfusion under item 22060:

22060 WHOLE BODY PERFUSION, CARDIAC BYPASS, where the heart-lung machine or equivalent is continuously operated by a medical perfusionist, other than a service associated with anaesthesia to which an item in Subgroup 21 applies. (20 basic units) (See para T10.10 of explanatory notes to this Category)

(b) plus, the time unit allocation reflecting the total time of the perfusion (an item in the range 23010 - 24136), for example:

23033	41 MINUTES TO 45 MINUTES (3 basic units)
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plus, where appropriate

(c) modifying units recognising certain added complexities in perfusion (an item/s in the range 25000 - 25020), for example:

25015	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA - where the patient's age is up to one year or 70 years or greater (1 basic unit)
23013	the patient's age is up to one year or 70 years or greater (1 basic unit)

The time component for item 22060 is defined as beginning with the commencement of anaesthesia and finishing with the closure of the chest.

Items 22065 and 22070 may only be used in association with item 22060.

Medicare benefits are not payable for perfusion unless the perfusion is performed by a medical practitioner other than the medical practitioner who renders the associated medical service in Group T8 or the medical practitioner who administers the anaesthesia listed in the RVG in Group T10.

The medical practitioner providing the service must comply with the training requirements in the Australian and New Zealand College of Anaesthetists (ANZCA) *Guidelines for Major Extracorporeal Perfusion* (PS27 2015).

Benefits are not payable if another person primarily and/or continuously operates the HLM.

TN.10.12 Discontinued Procedure - (Item 21990)

Claims for benefits under Item 21990 should be submitted to Medicare for approval of benefits. Claims should include details of the surgery/procedure which had been proposed and the reason for it being discontinued or abandoned.

TN.10.13 Anaesthesia in Connection with a Procedure not Identified as Attracting a Medicare Benefit for Anaesthesia - (Item 21997)

Payment of benefit for Item 21997 is not restricted to the service being performed in connection with a surgical service in Group T8. Item 21997 may be performed with any item in the Medicare Benefits Schedule that has not been identified as attracting a Medicare benefit for anaesthesia (including attendances) in circumstances where anaesthesia is considered clinically necessary.

TN.10.14 Anaesthesia in Connection with a Dental Service - (Items 22900 and 22905)

Items 22900 and 22905 cover the administration of anaesthesia in connection with a dental service that is not a service covered by an item in the Medicare Benefits Schedule i.e removal of teeth and restorative dental work. Therefore, the requirement that anaesthesia be performed in association with an 'eligible' service (as defined in point T10.2) does not apply to dental anaesthesia items 22900 and 22905.

TN.10.15 Anaesthesia in Connection with Cleft Lip and Cleft Palate Repair - (Items 20102 and 20172)

Anaesthesia associated with cleft lip and cleft palate repair is covered in Subgroup 1 of the RVG Schedule, under items 20102 and 20172.

TN.10.16 Anaesthesia in Connection with an Oral and Maxillofacial Service - (Category 4 of the Medicare Benefits Schedule)

Benefit for anaesthesia provided by a medical practitioner in association with an Oral and Maxillofacial service (Category 4 of the Medicare Benefits Schedule) is derived using the RVG. Benefit for anaesthesia for oral and maxillofacial services should be claimed under the appropriate RVG item from Subgroup 1 or 2.

TN.10.17 Intra-operative Blocks for Post Operative Pain - (Items 22031 to 22050)

Benefits are only payable for intra-operative nerve blocks performed for the management of post-operative pain that are specifically catered for under items 22031 to 22050.

TN.10.18 Anaesthesia in Connection with Extensive Surgery on Facial Bones - (Item 20192)

The term 'extensive' in relation to this item is defined as major facial bone surgery or reconstruction including major resection or osteotomies or osteotomies of mandibles and/or maxillae, surgery for prognathism or surgery for Le Fort II or III fractures.

TN.10.19 Intrathecal or Epidural Injection for Control of Post-operative Pain - Initial - (Item 22031)

Benefits are payable under item 22031 for the initial intrathecal or epidural injection of a therapeutic substance/s, in association with anaesthesia and surgery, for the control of post-operative pain. Benefit is not payable for subsequent intra-operative intrathecal and epidural injection (item 22036) in the same anaesthetic episode. Where subsequent infusion is provided post operatively, to maintain analgesia, benefit would be payable under items 18222 or 18225.

TN.10.20 Intrathecal or Epidural Injection for Control of Post-operative Pain - Subsequent - (Item 22036)

Benefits are payable under item 22036 for subsequent intrathecal or epidural injection of a therapeutic substance/s, in association with anaesthesia and surgery, performed intra-operatively, for postoperative pain management, where the catheter is already in-situ. Benefits are not payable under this item where the initial injection was performed intra-operatively, under item 22031, in the same anaesthetic episode.

TN.10.21 Regional or Field Nerve Blocks for Post-operative Pain - (Items 22040 - 22050)

Benefits are payable under Items 22040 to 22050 in addition to the general anaesthesia for the related procedure.

TN.10.22 Anaesthesia for Radical Procedures on the Chest Wall - (Item 20474)

Radical procedures on the chest wall referred to in item 20474 would include procedures such as pectus excavatum.

TN.10.23 Anaesthesia for Extensive Spine or Spinal Cord Procedures - (Item 20670)

This item covers major spinal surgery involving multiple levels of the spinal cord and spinal fusion where performed. Procedures covered under this item would include the Harrington Rod technique. Surgery on individual spinal levels would be covered under items 20600, 20620 and 20630.

TN.10.24 Anaesthesia for Femoral Artery Embolectomy - (Item 21274)

Item 21274 covers anaesthesia for femoral artery embolectomy. Grafts involving intra-abdominal vessels would be covered under item 20880.

TN.10.25 Anaesthesia for Cardiac Catheterisation - (Item 21941)

Item 21941 does not include either central vein catheterisation or insertion of right heart balloon catheter. Anaesthesia for these procedures is covered under item 21943.

TN.10.26 Anaesthesia for 2 Dimensional Real Time Transoesophageal Echocardiography - (Item 21936)

Benefits are payable for anaesthesia in connection with 2 dimensional real time transoesophageal echocardiography, (including intra-operative echocardiography) which includes doppler techniques, real time colour flow mapping and recording onto video tape or digital medium.

TN.10.27 Anaesthesia for Services on the Upper and Lower Abdomen - (Subgroups 6 and7)

Establishing whether an RVG anaesthetic item pertains to the upper or lower abdomen, depends on whether the majority of the associated surgery was performed in the region above or below the umbilicus.

Some examples of upper abdomen would be:

- laparoscopy on upper abdominal viscera;
- laparoscopy with operative focus superior to the umbilical port;
- surgery to the liver, gallbladder and ducts, stomach, pancreas, small bowel to DJ flexure;
- the kidneys in their normal location (as opposed to pelvic kidney); or
- spleen or bowel (where it involves a diaphragmatic hernia or adhesions to gallbladder bed).

Some examples of lower abdomen would be:

- abdominal wall below the umbilicus;
- laparoscopy on lower abdominal viscera;
- laparoscopy with operative focus inferior to the umbilical port;
- surgery on the jejunum, ileum, or colon;
- surgery on the appendix; or
- surgery associated with the female reproductive system.

TN.10.28 Anaesthesia for Microvascular Free Tissue Flap Surgery - (Items 20230, 20355, 20475, 20704, 20804, 20905, 21155, 21275, 21455, 21535, 21685, 21785 and 21865)

Benefits are only payable where complete free tissue flap surgery is undertaken involving microsurgical arterial and venous anastomoses. Benefits do not apply for microsurgical rotation flaps or for re-implementation of digits or either the hand or the foot.

TN.10.29 Anaesthesia for Endoscopic Ureteric Surgery - Including Laser Procedure - (Item 20911) Benefits are not payable under item 20911 for diagnostic ureteroscopy.

TN.11.1 Botulinum Toxin - (Items 18350 to 18379)

The Therapeutic Goods Administration (TGA) assesses each indication for the therapeutic use of botulinum toxin on an individual basis. There are currently three botulinum toxin agents with TGA registration (Botox®, Dysport® and Xeomin®). Each has undergone a separate evaluation of its safety and efficacy by the TGA as they are neither bioequivalent, nor dose equivalent. When claiming under an item for the injection of botulinum toxin, only the botulinum toxin agent specified in the item can be used. Benefits are not payable where an agent other than that specified in the item is used.

The TGA assesses each indication for the therapeutic use of botulinum toxin by assessment of clinical evidence for its use in paediatric or adult patients. Where an indication has been assessed for adult use, data has generally been assessed using patients over 12 years of age. Paediatric indications have been assessed using data from patients under 18 years of age. Botulinum toxin should only be administered to patients under the age of 18 where an item is for a paediatric indication, and patients over 12 years of age where the item is for an adult indication, unless otherwise specified.

Items for the administration of botulinum toxin can only be claimed by a medical practitioner who is recognised as an eligible medical practitioner for the relevant indication under the arrangements under Section 100 of the *National Health Act 1953* (the Act) relating to the use and supply of botulinum toxin. The specialist qualifications required to administer botulinum toxin vary across the indications for which the medicine is listed on the PBS, and are detailed within the relevant PBS restrictions available at: www.pbs.gov.au/browse/section100-mf

Item 18354 for the treatment of equinus, equinovarus or equinovalgus is limited to a maximum of 4 injections per patient on any day (2 per limb). Accounts should be annotated with the limb which has been treated. Item 18292 may not be claimed for the injection of botulinum toxin, but may be claimed where a neurolytic agent (such as phenol) is used, in addition to botulinum toxin injection(s), to treat the obturator nerve in patients with a dynamic foot deformity.

Treatment under item 18375 or 18379 can only continue if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline from the start of week 6 through to the end of week 12 after the first treatment. The term 'continue' means the patient can be retreated under item 18375 or 18379 at some point after the 12 week period (for example; 6 to 12 months after the first treatment). This requirement is in line with the PBS listing for the supply of the medicine for this indication under Section 100 of the *Act*.

Item 18362 for the treatment of severe primary axillary hyperhidrosis allows for a maximum number of 3 treatments per patient in a 12 month period, with no less than 4 months to elapse between treatments.

Botulinum toxin which is not supplied and administered in accordance with the arrangements under Section 100 of the *Act* is not required to be provided free of charge to patients. Where a charge is made for the botulinum toxin administered, it must be separately listed on the account and not billed to Medicare. Since 1 September 2015, PBS patient co-payments have applied to botulinum toxin supplied and administered in accordance with the arrangements under Section 100 of the Act.

The Department of Human Services (DHS) has developed a <u>Health Practitioner Guideline to substantiate that a patient had a pre-existing condition at the time of the service</u> which is located on the DHS website.

TR.8.1 Mechanical thrombectomy - (Item 35414)

For the purposes of this item, *eligible stroke centre* means a facility that:

- (a) has a designated stroke unit;
- (b) is equipped and has staff available or on call so that it is capable of providing the following to a patient on a 24-hour basis:
 - (i) the services of a specialist or consultant physician who has the training required under paragraph (b) of item 35414;
 - (ii) diagnostic imaging services using advanced imaging techniques, which must include computed tomography, computed tomography angiography, digital subtraction angiography, magnetic resonance imaging, and magnetic resonance angiography; and
 - (iii) care from a team of health practitioners which includes a stroke physician, a neurologist, a neurosurgeon, a radiologist, an anaesthetist, an intensive care unit specialist, a medical imaging technologist, and a nurse;
- (c) has dedicated endovascular angiography facilities; and
- (d) has written procedures for assessing and treating patients who have, or may have, experienced a stroke.

Note: A health practitioner may fulfil the role of more than one of the types of health practitioner specified in paragraph (b)(iii). For example, a neurologist may also be a stroke physician.

Conjoint Committee for Recognition of Training in Interventional Neuroradiology (CCINR)

CCINR comprises representatives from the Australian and New Zealand Society of Neuroradiology (ANZSNR), the Neurosurgical Society of Australasia (NSA) and the Australian and New Zealand Association of Neurologists (ANZAN). For the purposes of this item, specialists or consultant physicians performing this procedure must have training recognised by CCINR, and the Department of Human Services notified of that recognition.

THERAPEUTIC PROCEDURES ITEMS

	CELLANEOUS THERAPEUTIC DURES 1. HYPERBARIC OXYGEN THERAPY
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 1. Hyperbaric Oxygen Therapy
	HYPERBARIC, OXYGEN THERAPY, for treatment of localised non-neurological soft tissue radiation injuries excluding radiation-induced soft tissue lymphoedema of the arm after treatment for breast cancer, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance.
13015	(See para TN.1.1 of explanatory notes to this Category) Fee: \$254.75 Benefit: 75% = \$191.10 85% = \$216.55
	HYPERBARIC OXYGEN THERAPY, for treatment of decompression illness, gas gangrene, air or gas embolism; diabetic wounds including diabetic gangrene and diabetic foot ulcers; necrotising soft tissue infections including necrotising fasciitis or Fournier's gangrene; or for the prevention and treatment of osteoradionecrosis, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance
13020	(See para TN.1.1 of explanatory notes to this Category) Fee: \$258.85 Benefit: 75% = \$194.15 85% = \$220.05
	HYPERBARIC OXYGEN THERAPY for treatment of decompression illness, air or gas embolism, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber greater than 3 hours, including any associated attendance - per hour (or part of an hour)
13025	(See para TN.1.1 of explanatory notes to this Category) Fee: \$115.70 Benefit: 75% = \$86.80 85% = \$98.35
	HYPERBARIC OXYGEN THERAPY performed in a comprehensive hyperbaric medicine facility where the medical practitioner is pressurised in the hyperbaric chamber for the purpose of providing continuous life saving emergency treatment, including any associated attendance - per hour (or part of an hour)
13030	(See para TN.1.1 of explanatory notes to this Category) Fee: \$163.45 Benefit: 75% = \$122.60 85% = \$138.95
	CELLANEOUS THERAPEUTIC DURES 2. DIALYSIS
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 2. Dialysis
	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist exceeds 45 minutes in 1 day
13100	(See para TN.1.2 of explanatory notes to this Category) Fee: \$136.65 Benefit: 75% = \$102.50 85% = \$116.20
13103	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance

T1. MISC	CELLANEOUS THERAPEUTIC DURES 2. DIALYSIS
	time on the patient by the supervising medical specialist does not exceed 45 minutes in 1 day
	(See para TN.1.2 of explanatory notes to this Category) Fee: $\$71.20$ Benefit: $75\% = \$53.40$ $85\% = \$60.55$
	Planning and management of home dialysis (either haemodialysis or peritoneal dialysis), by a consultant physician in the practice of his or her specialty of renal medicine, for a patient with end-stage renal disease, and supervision of that patient on self-administered dialysis, to a maximum of 12 claims per year
13104	(See para TN.1.3, TN.1.23 of explanatory notes to this Category) Fee: \$147.95 Benefit: 85% = \$125.80
	Haemodialysis for a patient with end-stage renal disease if:
	(a) the service is provided by a registered nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner; and
	(b) the service is supervised by the medical practitioner (either in person or remotely); and
	(c) the patient's care is managed by a nephrologist; and
	(d) the patient is treated or reviewed by the nephrologist every 3 to 6 months (either in person or remotely); and
	(e) the patient is not an admitted patient of a hospital; and
	(f) the service is provided in a Modified Monash 7 area
13105 G	Fee: \$592.00 Benefit: 100% = \$592.00
	DECLOTTING OF AN ARTERIOVENOUS SHUNT
13106	Fee: \$121.35 Benefit: 75% = \$91.05 85% = \$103.15
	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS INSERTION AND FIXATION OF (Anaes.)
13109	Fee: \$227.75 Benefit: 75% = \$170.85 85% = \$193.60
	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS, removal of (including catheter cuffs) (Anaes.)
13110	Fee: \$228.50 Benefit: 75% = \$171.40 85% = \$194.25
T1. MISC PROCE	CELLANEOUS THERAPEUTIC DURES 3. ASSISTED REPRODUCTIVE SERVICES
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 3. Assisted Reproductive Services
13200	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE PROCEEDING TO OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13201, 13202, 13203, 13206, 13218 applies - being services rendered during 1 treatment cycle - INITIAL cycle in a single

PROCE	CELLANEOUS THERAPEUTIC DURES 3. ASSISTED REPRODUCTIVE SERVICES
	calendar year
	(See para TN.1.4 of explanatory notes to this Category) Fee: \$3,110.75 Benefit: 75% = \$2333.10 85% = \$3027.35 Extended Medicare Safety Net Cap: \$1,675.50
	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE PROCEEDING TO OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13200, 13202, 13203, 13206, 13218 applies - being services rendered during 1 treatment cycle - each cycle SUBSEQUENT to the first in a single calendar year
13201	(See para TN.1.4 of explanatory notes to this Category) Fee: \$2,909.75 Benefit: 75% = \$2182.35 Extended Medicare Safety Net Cap: \$2,432.15
	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE THAT IS CANCELLED BEFORE OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation and including quantitative estimation of hormones, semen preparation, ultrasound examinations, but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which Item 13200, 13201, 13203, 13206, 13218, applies being services rendered during 1 treatment cycle
13202	(See para TN.1.4 of explanatory notes to this Category) Fee: \$465.55 Benefit: 75% = \$349.20 85% = \$395.75 Extended Medicare Safety Net Cap: \$64.95
	OVULATION MONITORING SERVICES, for artificial insemination - including quantitative estimation of hormones and ultrasound examinations, being services rendered during 1 treatment cycle but excluding a service to which Item 13200, 13201, 13202, 13206, 13212, 13215, 13218, applies
13203	(See para TN.1.4 of explanatory notes to this Category) Fee: \$486.75 Benefit: 75% = \$365.10 85% = \$413.75 Extended Medicare Safety Net Cap: \$108.15
	ASSISTED REPRODUCTIVE TECHNOLOGIES TREATMENT CYCLE using either the natural cycle or oral medication only to induce oocyte growth and development, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, frozen embryo transfer or donated embryos or ova or treatment involving the use of injectable drugs to induce superovulation being services rendered during 1 treatment cycle but only if rendered in conjunction with a service to which item 13212 applies
13206	(See para TN.1.4 of explanatory notes to this Category) Fee: \$465.55 Benefit: 75% = \$349.20 85% = \$395.75 Extended Medicare Safety Net Cap: \$64.95
	PLANNING and MANAGEMENT of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies or for artificial insemination payable once only during 1 treatment cycle
13209	(See para TN.1.4 of explanatory notes to this Category) Fee: \$84.70 Benefit: 75% = \$63.55 85% = \$72.00 Extended Medicare Safety Net Cap: \$10.90
13210	Professional attendance on a patient by a specialist practising in his or her specialty if:

T1. MIS	CELLANEOUS THERAPEUTIC DURES 3. ASSISTED REPRODUCTIVE SERVICES
	(a) the attendance is by video conference; and
	(b) item 13209 applies to the attendance; and
	(c) the patient is not an admitted patient; and
	(d) the patient:
	(i) is located both:
	(A) within a telehealth eligible area; and
	(B) at the time of the attendance-at least 15 kms by road from the specialist; or
	(ii) is a care recipient in a residential care service; or
	(iii) is a patient of:
	(A) an Aboriginal Medical Service; or
	(B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies
	(See para TN.1.21 of explanatory notes to this Category) Derived Fee: 50% of the fee for item 13209. Benefit: 85% of the derived fee Extended Medicare Safety Net Cap: \$5.30
	Oocyte retrieval for the purpose of assisted reproductive technologies-only if rendered in connection with a service to which item 13200, 13201 or 13206 applies (Anaes.)
13212	(See para TN.1.4 of explanatory notes to this Category) Fee: \$354.45 Benefit: 75% = \$265.85 Extended Medicare Safety Net Cap: \$70.35
	Transfer of embryos or both ova and sperm to the uterus or fallopian tubes, excluding artificial insemination-only if rendered in connection with a service to which item 13200, 13201, 13206 or 13218 applies, being services rendered in one treatment cycle (Anaes.)
13215	(See para TN.1.4 of explanatory notes to this Category) Fee: \$111.10 Benefit: 75% = \$83.35 85% = \$94.45 Extended Medicare Safety Net Cap: \$48.70
	PREPARATION of frozen or donated embryos or donated oocytes for transfer to the uterus or fallopian tubes, by any means and including quantitative estimation of hormones and all treatment counselling but excluding artificial insemination services rendered in 1 treatment cycle and excluding a service to which item 13200, 13201, 13202, 13203, 13206, 13212 applies (Anaes.)
13218	(See para TN.1.4, TN.1.5 of explanatory notes to this Category) Fee: \$793.55 Benefit: 75% = \$595.20 85% = \$710.15 Extended Medicare Safety Net Cap: \$702.65
	Preparation of semen for the purpose of artificial insemination-only if rendered in connection with a service to which item 13203 applies
13221	(See para TN.1.4 of explanatory notes to this Category) Fee: \$50.80 Benefit: 75% = \$38.10 Extended Medicare Safety Net Cap: \$21.70
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PROCE	CELLANEOUS THERAPEUTIC DURES 3. ASSISTED REPRODUCTIVE SERVICE
	INTRACYTOPLASMIC SPERM INJECTION for the purposes of assisted reproductive technologies, for male factor infertility, excluding a service to which Item 13203 or 13218 applies
13251	(See para TN.1.5 of explanatory notes to this Category) Fee: \$417.95 Benefit: 75% = \$313.50 85% = \$355.30 Extended Medicare Safety Net Cap: \$108.15
	Processing and cryopreservation of semen for fertility preservation treatment before or after completion of gonadotoxic treatment for malignant or non-malignant conditions, in a post-pubertal male in Tanner stages II-V, up to 60 years old, if the patient is referred by a specialist or consultant physician, initial cryopreservation of semen (not including storage) - one of a maximum of two semen collection cycles per patient in a lifetime.
13260	(See para TN.1.22 of explanatory notes to this Category) Fee: \$415.00 Benefit: 75% = \$311.25 85% = \$352.75 Extended Medicare Safety Net Cap: \$269.75
	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required
13290	Fee: \$204.25 Benefit: 75% = \$153.20 85% = \$173.65
	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required, under
	general anaesthetic, in a hospital (Anaes.)
13292	
T1. MIS	general anaesthetic, in a hospital (Anaes.) Fee: \$408.70 Benefit: 75% = \$306.55 85% = \$347.40 CELLANEOUS THERAPEUTIC
T1. MIS	general anaesthetic, in a hospital (Anaes.) Fee: \$408.70 Benefit: 75% = \$306.55 85% = \$347.40 CELLANEOUS THERAPEUTIC
T1. MIS	general anaesthetic, in a hospital (Anaes.) Fee: \$408.70 Benefit: 75% = \$306.55 85% = \$347.40 CELLANEOUS THERAPEUTIC DURES 4. PAEDIATRIC & NEONATA
T1. MIS	general anaesthetic, in a hospital (Anaes.) Fee: \$408.70 Benefit: 75% = \$306.55 85% = \$347.40 CELLANEOUS THERAPEUTIC DURES 4. PAEDIATRIC & NEONATA Group T1. Miscellaneous Therapeutic Procedures
T1. MIS	general anaesthetic, in a hospital (Anaes.) Fee: \$408.70 Benefit: 75% = \$306.55 85% = \$347.40 CELLANEOUS THERAPEUTIC DURES 4. PAEDIATRIC & NEONATA Group T1. Miscellaneous Therapeutic Procedures Subgroup 4. Paediatric & Neonatal UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or
T1. MIS	general anaesthetic, in a hospital (Anaes.) Fee: \$408.70 Benefit: 75% = \$306.55 85% = \$347.40 CELLANEOUS THERAPEUTIC DURES 4. PAEDIATRIC & NEONATA Group T1. Miscellaneous Therapeutic Procedures Subgroup 4. Paediatric & Neonatal UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate
T1. MISPROCE	general anaesthetic, in a hospital (Anaes.) Fee: \$408.70 Benefit: 75% = \$306.55 85% = \$347.40 CELLANEOUS THERAPEUTIC DURES 4. PAEDIATRIC & NEONATA Group T1. Miscellaneous Therapeutic Procedures Subgroup 4. Paediatric & Neonatal UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate Fee: \$56.95 Benefit: 75% = \$42.75 85% = \$48.45
T1. MIS PROCE	general anaesthetic, in a hospital (Anaes.) Fee: \$408.70 Benefit: 75% = \$306.55 85% = \$347.40 CELLANEOUS THERAPEUTIC DURES 4. PAEDIATRIC & NEONATA Group T1. Miscellaneous Therapeutic Procedures Subgroup 4. Paediatric & Neonatal UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate Fee: \$56.95 Benefit: 75% = \$42.75 85% = \$48.45 UMBILICAL ARTERY CATHETERISATION with or without infusion
13300	general anaesthetic, in a hospital (Anaes.) Fee: \$408.70 Benefit: 75% = \$306.55 85% = \$347.40 CELLANEOUS THERAPEUTIC DURES 4. PAEDIATRIC & NEONATA Group T1. Miscellaneous Therapeutic Procedures Subgroup 4. Paediatric & Neonatal UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate Fee: \$56.95 Benefit: 75% = \$42.75 85% = \$48.45 UMBILICAL ARTERY CATHETERISATION with or without infusion Fee: \$84.40 Benefit: 75% = \$63.30 85% = \$71.75 BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection
13300	general anaesthetic, in a hospital (Anaes.) Fee: \$408.70 Benefit: 75% = \$306.55 85% = \$347.40 CELLANEOUS THERAPEUTIC DURES 4. PAEDIATRIC & NEONATA Group T1. Miscellaneous Therapeutic Procedures Subgroup 4. Paediatric & Neonatal UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate Fee: \$56.95 Benefit: 75% = \$42.75 85% = \$48.45 UMBILICAL ARTERY CATHETERISATION with or without infusion Fee: \$84.40 Benefit: 75% = \$63.30 85% = \$71.75 BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor
13292 T1. MIS PROCE 13300 13303	general anaesthetic, in a hospital (Anaes.) Fee: \$408.70 Benefit: 75% = \$306.55 85% = \$347.40 CELLANEOUS THERAPEUTIC DURES 4. PAEDIATRIC & NEONATA Group T1. Miscellaneous Therapeutic Procedures Subgroup 4. Paediatric & Neonatal UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate Fee: \$56.95 Benefit: 75% = \$42.75 85% = \$48.45 UMBILICAL ARTERY CATHETERISATION with or without infusion Fee: \$84.40 Benefit: 75% = \$63.30 85% = \$71.75 BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor Fee: \$334.10 Benefit: 75% = \$250.60 85% = \$284.00 BLOOD TRANSFUSION with venesection and complete replacement of blood, using blood already

_	CELLANEOUS T DURES	IERAPEUTIC 4. PAEDIATRIC & NEONATA
	Fee: \$28.45	Benefit: 75% = \$21.35 85% = \$24.20
	CENTRAL VEI	CATHETERISATION - by open exposure in a person under 12 years of age (Anaes.)
13318	(See para TN.1.6 o Fee: \$227.45	explanatory notes to this Category) Benefit: 75% = \$170.60 85% = \$193.35
	CENTRAL VEI	CATHETERISATION in a neonate via peripheral vein (Anaes.)
13319	Fee: \$227.45	Benefit: 75% = \$170.60 85% = \$193.35
	CELLANEOUS T DURES	ERAPEUTIC 5. CARDIOVASCULAI
	Group T1. Misc	llaneous Therapeutic Procedures
		Subgroup 5. Cardiovascular
	RESTORATION course of cardiac	OF CARDIAC RHYTHM by electrical stimulation (cardioversion), other than in the surgery (Anaes.)
13400	Fee: \$96.80	Benefit: 75% = \$72.60 85% = \$82.30
	CELLANEOUS T DURES	ERAPEUTIC 6. GASTROENTEROLOG
	Group T1. Misc	llaneous Therapeutic Procedures
		Subgroup 6. Gastroenterology
	GASTRO-OESO	PHAGEAL balloon intubation, for control of bleeding from gastric oesophageal varice
13506	Fee: \$184.50	Benefit: 75% = \$138.40 85% = \$156.85
	CELLANEOUS T DURES	ERAPEUTIC 8. HAEMATOLOG
	Group T1. Misc	llaneous Therapeutic Procedures
		Subgroup 8. Haematology
	HARVESTING	OF HOMOLOGOUS (including allogeneic) or AUTOLOGOUS bone marrow for the
	purpose of transp	antation (Anaes.)
13700	Fee: \$333.25	Benefit: 75% = \$249.95 85% = \$283.30
	TRANSFUSION	OF BLOOD, including collection from donor
13703	Fee: \$119.50	Benefit: 75% = \$89.65 85% = \$101.60
	TRANSFUSION	OF BLOOD or bone marrow already collected
13706	(See para TN.1.7 o Fee: \$83.35	explanatory notes to this Category) Benefit: 75% = \$62.55 85% = \$70.85
		F BLOOD for autologous transfusion or when homologous blood is required for sion in emergency situation
		explanatory notes to this Category)

	DURES		8. HAEMATOLOGY	
	Fee: \$48.45	Benefit: 75% = \$36.35	85% = \$41.20	
	utilising continu viability studies, other parameters	ous or intermittent flow tech if performed; continuous n with continuous registered	ne removal of plasma or cellular (or both) elements of blood, hniques; including morphological tests for cell counts and nonitoring of vital signs, fluid balance, blood volume and nurse attendance under the supervision of a consultant th a service to which item 13755 applies -payable once per	
13750	Fee: \$136.65	Benefit: 75% = \$102.50	85% = \$116.20	
	intermittent flow continuous mon registered nurse	techniques; including mor toring of vital signs, fluid battendance under the superv	etion of blood products for transfusion, utilising continuous or phological tests for cell counts and viability studies; valance, blood volume and other parameters; with continuous vision of a consultant physician; not being a service 50 applies - payable once per day	
13755	Fee: \$136.65	Benefit: 75% = \$102.50	85% = \$116.20	
	THERAPEUTIC porphyria cutane		nanagement of haemochromatosis, polycythemia vera or	
13757	Fee: \$72.95	Benefit: 75% = \$54.75	85% = \$62.05	
	IN VITRO PROCESSING (and cryopreservation) of bone marrow or peripheral blood for autologous stem cell transplantation as an adjunct to high dose chemotherapy for:			
	. chemosensitive intermediate or high grade non-Hodgkin's lymphoma at high risk of relapse following first line chemotherapy; or			
	. Hodgkin's disease which has relapsed following, or is refractory to, chemotherapy; or			
	. acute myelogenous leukaemia in first remission, where suitable genotypically matched sibling donor is not available for allogeneic bone marrow transplant; or			
	. multiple myeloma in remission (complete or partial) following standard dose chemotherapy; or			
	. small round cell sarcomas; or			
	. primitive neuroectodermal tumour; or			
	. germ cell tumours which have relapsed following, or are refractory to, chemotherapy;			
	. germ cell tumours which have had an incomplete response to first line therapy.			
	- performed under the supervision of a consultant physician - each day.			
13760	Fee: \$762.60	Benefit: 75% = \$571.95	85% = \$679.20	
	CELLANEOUS T DURES	HERAPEUTIC	9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT	
	Group T1. Miscellaneous Therapeutic Procedures			
	Subgroup 9. Procedures Associated With Intensive Care And Cardiopulmonary Support			
13815	CENTRAL VEIN CATHETERISATION by percutaneous or open exposure not being a service to			

	CELLANEOUS THERAPEUTIC DURES	9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT	
	which item 13318 applies (Anaes.)		
	(See para TN.1.6 of explanatory notes to this Car Fee: \$85.25 Benefit: 75% = \$63.95		
	RIGHT HEART BALLOON CATHETER, cardiac output measurement (Anaes.)	insertion of, including pulmonary wedge pressure and	
13818	(See para TN.1.10 of explanatory notes to this Ca Fee: \$113.70 Benefit: 75% = \$85.30	-	
	INTRACRANIAL PRESSURE, monitoring bolt or similar, by a specialist or consultant	g of, by intraventricular or subdural catheter, subarachnoid physician - each day	
13830	Fee: \$75.35 Benefit: 75% = \$56.55	85% = \$64.05	
	ARTERIAL PUNCTURE and collection of	blood for diagnostic purposes	
13839	Fee: \$23.05 Benefit: 75% = \$17.30	85% = \$19.60	
	INTRAARTERIAL CANNULATION for to blood gas analysis	he purpose of taking multiple arterial blood samples for	
13842	(See para TN.1.10 of explanatory notes to this Ca Fee: \$69.30 Benefit: 75% = \$52.00		
	COUNTERPULSATION BY INTRAAOR initial and subsequent consultations and mo	ΓΙC BALLOON management on the first day including nitoring of parameters (Anaes.)	
13847	(See para TN.1.10 of explanatory notes to this Ca Fee: \$156.10 Benefit: 75% = \$117.10		
	COUNTERPULSATION BY INTRAAOR first, including associated consultations and	TIC BALLOON management on each day subsequent to the monitoring of parameters	
13848	(See para TN.1.10 of explanatory notes to this Ca Fee: \$131.05 Benefit: 75% = \$98.30		
	CIRCULATORY SUPPORT DEVICE, management of, on first day		
13851	Fee: \$493.65 Benefit: 75% = \$370.25	85% = \$419.65	
	CIRCULATORY SUPPORT DEVICE, man	nagement of, on each day subsequent to the first	
13854	Fee: \$114.85 Benefit: 75% = \$86.15	85% = \$97.65	
	AIRWAY ACCESS, ESTABLISHMENT OF AND INITIATION OF MECHANICAL VENTILATIO (other than in the context of an anaesthetic for surgery), outside an Intensive Care Unit, for the purpose of subsequent ventilatory support in an Intensive Care Unit		
13857	(See para TN.1.10 of explanatory notes to this Ca Fee: \$146.40 Benefit: 75% = \$109.80		
	CELLANEOUS THERAPEUTIC DURES	10. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT	
	Group T1. Miscellaneous Therapeutic Pro	ocedures	
	Subgroup 10. Management And	d Procedures Undertaken In An Intensive Care Unit	
	1 1 2		

T1. MIS PROCE	CELLANEOUS THERAPEUTIC DURES	10. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT
	(Note: See para T1	.8 of Explanatory Notes to this
	Category for defini	tion of an Intensive Care Unit)
13870	Fee: \$362.10 Benefit: 75% = \$271.60	inces to this Category)
	immediately available and exclusively rostered	Care Unit by a specialist or consultant physician who is for intensive care - including all attendances, ing and bladder catheterisation - management on each
13873	(See para TN.1.9, TN.1.11 of explanatory notes to the Fee: \$268.60 Benefit: 75% = \$201.45	nis Category)
	intracavity pressure, continuous monitoring by by a specialist or consultant physician who is in	r arterial pressure, systemic arterial pressure or cardiac indwelling catheter in an intensive care unit and managed mmediately available and exclusively rostered for sure on any calendar day (up to a maximum of 4
13876	(See para TN.1.9, TN.1.11, TN.1.10 of explanatory pages \$76.90 Benefit: 75% = \$57.70	notes to this Category)
	AIRWAY ACCESS, ESTABLISHMENT OF A VENTILATION, in an Intensive Care Unit, no specialist or consultant physician for the purpose	t in association with any anaesthetic service, by a
13881	(See para TN.1.9, TN.1.11 of explanatory notes to the Fee: \$146.40 Benefit: 75% = \$109.80	nis Category)
	invasive means where the only alternative to no	are Unit, management of, by invasive means, or by non- on-invasive ventilatory support would be invasive at physician who is immediately available and exclusively
13882	(See para TN.1.9, TN.1.11 of explanatory notes to the Fee: \$115.25 Benefit: 75% = \$86.45	nis Category)
		NO VENOUS HAEMOFILTRATION, in an intensive ltant physician who is immediately available and first day (H)
13885	(See para TN.1.9, TN.1.11 of explanatory notes to the Fee: \$153.65 Benefit: 75% = \$115.25	nis Category)
13888		NO VENOUS HAEMOFILTRATION, in an intensive ltant physician who is immediately available and

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES		HERAPEUTIC	10. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT	
	exclusively rosts	ered for intensive care - on	each day subsequent to the first day (H)	
	(See para TN.1.9, Fee: \$76.90	TN.1.11 of explanatory notes Benefit: 75% = \$57.70		
	IISCELLANEOUS THERAPEUTIC CEDURES 11. CHEMOTHERAPEUTIC PROCEDURES			
	Group T1. Misc	ellaneous Therapeutic Pro	ocedures	
		Subgroup 1	1. Chemotherapeutic Procedures	
	into a vein, or a than 1 hours dur photodynamic th	butterfly needle, or the side ation - payable once only or	istration of, either by intravenous push technique (directly e-arm of an infusion) or by intravenous infusion of not more in the same day, not being a service associated with for the administration of drugs used immediately prior to, or herapy alone	
13915	(See para TN.1.12 Fee: \$65.05	of explanatory notes to this C Benefit: 75% = \$48.80		
			istration of, by intravenous infusion of more than 1 hours a - payable once only on the same day	
13918	Fee: \$97.95	Benefit: 75% = \$73.50	85% = \$83.30	
		CHEMOTHERAPY, adminite first day of treatment	istration of, by intravenous infusion of more than 6 hours	
13921	Fee: \$110.80	Benefit: 75% = \$83.10	85% = \$94.20	
	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode			
13924	Fee: \$65.25	Benefit: 75% = \$48.95	85% = \$55.50	
	CYTOTOXIC CHEMOTHERAPY, administration of, either by intra-arterial push technique (directly into an artery, a butterfly needle or the side-arm of an infusion) or by intra-arterial infusion of not morthan 1 hours duration - payable once only on the same day			
13927	Fee: \$84.40	Benefit: 75% = \$63.30	85% = \$71.75	
	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day			
13930	Fee: \$117.80	Benefit: 75% = \$88.35	85% = \$100.15	
	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - for the first day of treatment			
13933	Fee: \$130.70	Benefit: 75% = \$98.05	85% = \$111.10	
		· · · · · · · · · · · · · · · · · · ·	istration of, by intra-arterial infusion of more than 6 hours st in the same continuous treatment episode	
13936	Fee: \$85.15	Benefit: 75% = \$63.90	85% = \$72.40	
13939			pading of, with a cytotoxic agent or agents, not being a service 15, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or	

	CELLANEOUS THERAPEUTIC
PROCE	DURES 11. CHEMOTHERAPEUTIC PROCEDURES
	13945 applies
	(See para TN.1.13 of explanatory notes to this Category) Fee: \$97.95 Benefit: 75% = \$73.50 85% = \$83.30
	AMBULATORY DRUG DELIVERY DEVICE, loading of, with a cytotoxic agent or agents for the infusion of the agent or agents via the intravenous, intra-arterial or spinal routes, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies
13942	(See para TN.1.13 of explanatory notes to this Category) Fee: \$65.25 Benefit: 75% = \$48.95 85% = \$55.50
	LONG-TERM IMPLANTED DRUG DELIVERY DEVICE FOR CYTOTOXIC CHEMOTHERAPY, accessing of
13945	Fee: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65
	CYTOTOXIC AGENT, instillation of, into a body cavity
13948	Fee: \$65.25 Benefit: 75% = \$48.95 85% = \$55.50
	CELLANEOUS THERAPEUTIC DURES 12. DERMATOLOGY
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 12. Dermatology
	UVA or UVB phototherapy administered in a whole body cabinet or hand and foot cabinet including associated consultations other than the initial consultation, if treatment is initiated and supervised by a specialist in the specialty of dermatology
	Applicable not more than 150 times in a 12 month period
14050	(See para TN.1.14 of explanatory notes to this Category) Fee: \$52.75 Benefit: 75% = \$39.60 85% = \$44.85
	Laser photocoagulation using laser radiation in the treatment of vascular abnormalities of the head or neck, including any associated consultation, if:
	(a) the abnormality is visible from 3 metres; and
	(b) photographic evidence demonstrating the need for this service is documented in the patient notes;
	to a maximum of 4 sessions (including any sessions to which this item or any of items 14106 to 14118 apply) in any 12 month period (Anaes.)
14100	(See para TN.1.15 of explanatory notes to this Category) Fee: \$152.50 Benefit: 75% = \$114.40 85% = \$129.65 Extended Medicare Safety Net Cap: \$122.00
	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), if the abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12
	month period—area of treatment less than 150 cm ² (Anaes.)

	CELLANEOUS THERAPEUTIC DURES 12. DERMATOLOG		
	(See para TN.1.15 of explanatory notes to this Category) Fee: \$160.15		
	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12 month period—area of treatment 150 cm ² to 300 cm ² (Anaes.)		
14115	(See para TN.1.15 of explanatory notes to this Category) Fee: \$256.50 Benefit: 75% = \$192.40 85% = \$218.05		
	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14115 apply) in any 12 month period—area of treatment more than 300 cm ² (Anaes.)		
14118	(See para TN.1.15 of explanatory notes to this Category) Fee: \$325.75 Benefit: 75% = \$244.35 85% = \$276.90		
	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, if:		
	(a) a seventh or subsequent session (including any sessions to which this item or any of items 14100 to 14118 apply) is indicated in a 12 month period commencing on the day of the first session; and		
	(b) photographic evidence demonstrating the need for this service is documented in the patient notes (Anaes.)		
14124	(See para TN.1.15 of explanatory notes to this Category) Fee: \$152.50 Benefit: 75% = \$114.40 85% = \$129.65		
	CELLANEOUS THERAPEUTIC DURES 13. OTHER THERAPEUTIC PROCEDURE		
	Group T1. Miscellaneous Therapeutic Procedures		
	Subgroup 13. Other Therapeutic Procedures		
	GASTRIC LAVAGE in the treatment of ingested poison		
14200	Fee: \$59.80 Benefit: 75% = \$44.85 85% = \$50.85		
	POLY-L-LACTIC ACID, one or more injections of, for the initial session only, for the treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the National Health Act 1953 - once per patient		
14201	(See para TN.1.16 of explanatory notes to this Category) Fee: \$236.85		
	POLY-L-LACTIC ACID, one or more injections of (subsequent sessions), for the continuation of treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the National Health Act 1953		
14202			

T1. MIS PROCE	CELLANEOUS THERAPEUTIC DURES 13. OTHER THERAPEUTIC PROCEDURES
	(See para TN.1.16 of explanatory notes to this Category) Fee: \$119.90 Benefit: 75% = \$89.95 85% = \$101.95 Extended Medicare Safety Net Cap: \$18.00
	HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture (Anaes.)
14203	(See para TN.1.4, TN.1.17 of explanatory notes to this Category) Fee: \$51.15 Benefit: 75% = \$38.40 85% = \$43.50
	HORMONE OR LIVING TISSUE IMPLANTATION by cannula
14206	(See para TN.1.4, TN.1.17 of explanatory notes to this Category) Fee: \$35.60 Benefit: 75% = \$26.70 85% = \$30.30
	INTRAARTERIAL INFUSION or retrograde intravenous perfusion of a sympatholytic agent
14209	Fee: \$88.70 Benefit: 75% = \$66.55 85% = \$75.40
	INTUSSUSCEPTION, management of fluid or gas reduction for (Anaes.)
14212	Fee: \$185.30 Benefit: 75% = \$139.00 85% = \$157.55
	IMPLANTED INFUSION PUMP REFILLING OF reservoir, with a therapeutic agent or agents, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of chronic intractable pain
14218	Fee: \$97.95 Benefit: 75% = \$73.50 85% = \$83.30
	LONG-TERM IMPLANTED DEVICE FOR DELIVERY OF THERAPEUTIC AGENTS, accessing of, not being a service associated with a service to which item 13945 applies
14221	Fee: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65
	ELECTROCONVULSIVE THERAPY, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes.)
14224	Fee: \$70.35 Benefit: 75% = \$52.80 85% = \$59.80
	IMPLANTED INFUSION PUMP, REFILLING of reservoir, with baclofen, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of severe chronic spasticity
14227	(See para TN.1.18 of explanatory notes to this Category) Fee: \$97.95 Benefit: 75% = \$73.50 85% = \$83.30
	Intrathecal or epidural SPINAL CATHETER insertion or replacement of, for connection to a subcutaneous implanted infusion pump, for the management of severe chronic spasticity with baclofen (Anaes.) (Assist.)
14230	(See para TN.1.18 of explanatory notes to this Category) Fee: \$298.05 Benefit: 75% = \$223.55
	INFUSION PUMP, subcutaneous implantation or replacement of, and connection to intrathecal or epidural catheter, and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.) (Assist.)
14233	(See para TN.1.18 of explanatory notes to this Category) Fee: \$361.90 Benefit: 75% = \$271.45
14236	INFUSION PUMP, subcutaneous implantation of, AND intrathecal or epidural SPINAL CATHETER

PROCE	CELLANEOUS THERAPEUTIC DURES 13. OTHER THERAPEUTIC PROCEDURES	
	insertion, and connection of pump to catheter and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.) (Assist.)	
	(See para TN.1.18 of explanatory notes to this Category) Fee: \$659.95 Benefit: 75% = \$495.00	
İ	Removal of subcutaneously IMPLANTED INFUSION PUMP, OR removal or repositioning of intrathecal or epidural SPINAL CATHETER, for the management of severe chronic spasticity (Anaes.)	
14239	(See para TN.1.18 of explanatory notes to this Category) Fee: \$159.40 Benefit: 75% = \$119.55	
İ	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the management of severe chronic spasticity (Anaes.)	
14242	(See para TN.1.18 of explanatory notes to this Category) Fee: \$473.65 Benefit: 75% = \$355.25	
	IMMUNOMODULATING AGENT, administration of, by intravenous infusion for at least 2 hours duration - payable once only on the same day and where the agent is provided under section 100 of the Pharmaceutical Benefits Scheme	
14245	(See para TN.1.19 of explanatory notes to this Category) Fee: \$97.95 Benefit: 75% = \$73.50 85% = \$83.30	
T2. RAI	DIATION ONCOLOGY 1. SUPERFICIAL	
	Group T2. Radiation Oncology	
	Subgroup 1. Superficial	
	(Benefits for administration of general anaesthetic for radiotherapy are payable under Group T10)	
	RADIOTHERAPY, SUPERFICIAL (including treatment with xrays, radium rays or other radioactive substances), not being a service to which another item in this Group applies each attendance at which	
I	fractionated treatment is given	
15000	fractionated treatment is given	
15000	fractionated treatment is given - 1 field	
15000 15003	fractionated treatment is given - 1 field Fee: \$42.55 Benefit: 75% = \$31.95 85% = \$36.20	
	fractionated treatment is given - 1 field Fee: \$42.55 Benefit: 75% = \$31.95 85% = \$36.20 - 2 or more fields up to a maximum of 5 additional fields	
	fractionated treatment is given - 1 field Fee: \$42.55 Benefit: 75% = \$31.95 85% = \$36.20 - 2 or more fields up to a maximum of 5 additional fields Derived Fee: The fee for item 15000 plus for each field in excess of 1, an amount of \$17.10	
	fractionated treatment is given - 1 field Fee: \$42.55 Benefit: 75% = \$31.95 85% = \$36.20 - 2 or more fields up to a maximum of 5 additional fields Derived Fee: The fee for item 15000 plus for each field in excess of 1, an amount of \$17.10 RADIOTHERAPY, SUPERFICIAL, attendance at which single dose technique is applied	
15003	fractionated treatment is given - 1 field Fee: \$42.55 Benefit: 75% = \$31.95 85% = \$36.20 - 2 or more fields up to a maximum of 5 additional fields Derived Fee: The fee for item 15000 plus for each field in excess of 1, an amount of \$17.10 RADIOTHERAPY, SUPERFICIAL, attendance at which single dose technique is applied - 1 field	
15003	fractionated treatment is given - 1 field Fee: \$42.55 Benefit: 75% = \$31.95 85% = \$36.20 - 2 or more fields up to a maximum of 5 additional fields Derived Fee: The fee for item 15000 plus for each field in excess of 1, an amount of \$17.10 RADIOTHERAPY, SUPERFICIAL, attendance at which single dose technique is applied - 1 field Fee: \$94.35 Benefit: 75% = \$70.80 85% = \$80.20	
15003	fractionated treatment is given - 1 field Fee: \$42.55 Benefit: 75% = \$31.95 85% = \$36.20 - 2 or more fields up to a maximum of 5 additional fields Derived Fee: The fee for item 15000 plus for each field in excess of 1, an amount of \$17.10 RADIOTHERAPY, SUPERFICIAL, attendance at which single dose technique is applied - 1 field Fee: \$94.35 Benefit: 75% = \$70.80 85% = \$80.20 - 2 or more fields up to a maximum of 5 additional fields	

T2. RAI	DIATION ONCOLOGY 2. ORTHOVOLTAGE
	Group T2. Radiation Oncology
	Subgroup 2. Orthovoltage
	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 3 or more treatments per week
	- 1 field
15100	(See para TN.2.1 of explanatory notes to this Category) Fee: \$47.70 Benefit: 75% = \$35.80 85% = \$40.55
	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)
15103	(See para TN.2.1 of explanatory notes to this Category) Derived Fee: The fee for item 15100 plus for each field in excess of 1, an amount of \$18.80
	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 2 treatments per week or less frequently
	- 1 field
15106	Fee: \$56.30 Benefit: 75% = \$42.25 85% = \$47.90
	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)
15109	Derived Fee: The fee for item 15106 plus for each field in excess of 1, an amount of \$22.70
	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field
15112	Fee: \$120.25 Benefit: 75% = \$90.20 85% = \$102.25
	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)
15115	Derived Fee: The fee for item 15112 plus for each field in excess of 1, an amount of \$47.30
T2. RAI	DIATION ONCOLOGY 3. MEGAVOLTAGE
	Group T2. Radiation Oncology
	Subgroup 3. Megavoltage
	RADIATION ONCOLOGY TREATMENT, using cobalt unit or caesium teletherapy unit each attendance at which treatment is given
	- 1 field
15211	Fee: \$54.70 Benefit: 75% = \$41.05 85% = \$46.50
	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)
15214	Derived Fee: The fee for item 15211 plus for each field in excess of 1, an amount of \$31.90
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (lung)
15215	Fee: \$59.65 Benefit: 75% = \$44.75 85% = \$50.75
15218	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or

T2. RAI	. RADIATION ONCOLOGY 3. MEGAVO			
	without electron f primary site (pros		at which treatment is given - 1 field - treatment delivered to	
	Fee: \$59.65	Benefit: 75% = \$44.73	5 85% = \$50.75	
	RADIATION ON without electron f primary site (brea	facilities - each attendanc	T, using a single photon energy linear accelerator with or e at which treatment is given - 1 field - treatment delivered to	
15221	Fee: \$59.65	Benefit: 75% = \$44.73	5 85% = \$50.75	
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site for diseases and conditions not covered by items 15215, 15218 and 15221			
15224	Fee: \$59.65	Benefit: 75% = \$44.73	5 85% = \$50.75	
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to secondary site			
15227	Fee: \$59.65	Benefit: 75% = \$44.75	5 85% = \$50.75	
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (lung)			
15230	Derived Fee: The	e fee for item 15215 plus for	each field in excess of 1, an amount of \$37.95	
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate)			
15233	Derived Fee: The	e fee for item 15218 plus for	each field in excess of 1, an amount of \$37.95	
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast)			
15236	Derived Fee: The	e fee for item 15221 plus for	each field in excess of 1, an amount of \$37.95	
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary si for diseases and conditions not covered by items 15230, 15233 or 15236		e at which treatment is given - 2 or more fields up to a therapy being 3 fields) - treatment delivered to primary site	
15239	Derived Fee: The	e fee for item 15224 plus for	each field in excess of 1, an amount of \$37.95	
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to secondary site			
15242	Derived Fee: The	e fee for item 15227 plus for	each field in excess of 1, an amount of \$37.95	
15245	minimum higher	energy of at least 10MV	T, using a dual photon energy linear accelerator with a photons, with electron facilities - each attendance at which vered to primary site (lung)	

T2. RAI	DIATION ONCOL	OGY	3. MEGAVOLTAGE		
	Fee: \$59.65	Benefit: 75% = \$44.75	85% = \$50.75		
	minimum highe	r energy of at least 10MV pl	r, using a dual photon energy linear accelerator with a notons, with electron facilities - each attendance at which ered to primary site (prostate)		
15248	Fee: \$59.65	Benefit: 75% = \$44.75	85% = \$50.75		
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (breast)				
15251	Fee: \$59.65	Benefit: 75% = \$44.75	85% = \$50.75		
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site for diseases and conditions not covered by items 15245, 15248 or 15251				
15254	Fee: \$59.65	Benefit: 75% = \$44.75	85% = \$50.75		
	minimum highe		r, using a dual photon energy linear accelerator with a notons, with electron facilities - each attendance at which ered to secondary site		
15257	Fee: \$59.65	Benefit: 75% = \$44.75	85% = \$50.75		
	minimum highe treatment is give	r energy of at least 10MV pl	r, using a dual photon energy linear accelerator with a notons, with electron facilities - each attendance at which maximum of 5 additional fields (rotational therapy being 3 (lung)		
15260	Derived Fee: T	he fee for item 15245 plus for e	ach field in excess of 1, an amount of \$37.95		
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being fields) - treatment delivered to primary site (prostate)		notons, with electron facilities - each attendance at which maximum of 5 additional fields (rotational therapy being 3		
15263			ach field in excess of 1, an amount of \$37.95		
	minimum highe treatment is give	r energy of at least 10MV pl	r, using a dual photon energy linear accelerator with a notons, with electron facilities - each attendance at which maximum of 5 additional fields (rotational therapy being 3 (breast)		
15266	Derived Fee: T	he fee for item 15251 plus for e	ach field in excess of 1, an amount of \$37.95		
	minimum highe treatment is give	r energy of at least 10MV pl en - 2 or more fields up to a nt delivered to primary site	r, using a dual photon energy linear accelerator with a motons, with electron facilities - each attendance at which maximum of 5 additional fields (rotational therapy being 3 for diseases and conditions not covered by items 15260,		
15269	Derived Fee: T	he fee for item 15254 plus for e	ach field in excess of 1, an amount of \$37.95		
15272	RADIATION C minimum highe	NCOLOGY TREATMENT r energy of at least 10MV pl	r, using a dual photon energy linear accelerator with a notons, with electron facilities - each attendance at which maximum of 5 additional fields (rotational therapy being 3		

T2. RAI	DIATION ONCOLOGY	3. MEGAVOLTAGE			
	fields) - treatment delivered to secondary site				
	Derived Fee: The fee for item 15257 plus for each field in excess of 1, an amount	of \$37.05			
	RADIATION ONCOLOGY TREATMENT with IGRT imaging facilities undertaken:				
	(a) to implement an IMRT dosimetry plan prepared in accordance with item 15565; and				
	(b) utilising an intensity modulated treatment delivery mode (delivered by a fixed or dynamic gantry linear accelerator or by a helical non C-arm based linear accelerator), once only at each attendance at which treatment is given.				
15275	Fee: \$182.90 Benefit: 75% = \$137.20 85% = \$155.50				
T2. RAI	DIATION ONCOLOGY	4. BRACHYTHERAPY			
	Group T2. Radiation Oncology				
	Subgroup 4. Brachytherapy				
	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources than 115 days using manual afterloading techniques (Anaes.)	having a half-life greater			
15303	Fee: \$357.00 Benefit: 75% = \$267.75 85% = \$303.45				
	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)				
15304	Fee: \$357.00 Benefit: 75% = \$267.75 85% = \$303.45				
	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anae				
15307	Fee: \$676.80 Benefit: 75% = \$507.60 85% = \$593.40				
	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources than 115 days including iodine, gold, iridium or tantalum using automatic at (Anaes.)				
15308	Fee: \$676.80 Benefit: 75% = \$507.60 85% = \$593.40				
	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources than 115 days using manual afterloading techniques (Anaes.)	s having a half-life greater			
15311	Fee: \$333.20 Benefit: 75% = \$249.90 85% = \$283.25				
	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)				
15312	Fee: \$330.80 Benefit: 75% = \$248.10 85% = \$281.20				
	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources than 115 days including iodine, gold, iridium or tantalum using manual after				
15315	Fee: \$654.25 Benefit: 75% = \$490.70 85% = \$570.85				
	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources than 115 days including iodine, gold, iridium or tantalum using automatic at (Anaes.)				
15316	Fee: \$654.25 Benefit: 75% = \$490.70 85% = \$570.85				

T2. RAI	DIATION ONCOLO	OGY	4. BRACHYTHERAPY
			AVAGINAL TREATMENT using radioactive sealed ays using manual afterloading techniques (Anaes.)
15319	Fee: \$406.05	Benefit: 75% = \$304.55	85% = \$345.15
			AVAGINAL TREATMENT using radioactive sealed ays using automatic afterloading techniques (Anaes.)
15320	Fee: \$406.05	Benefit: 75% = \$304.55	85% = \$345.15
		half-life of less than 115 da	AVAGINAL TREATMENT using radioactive sealed ays including iodine, gold, iridium or tantalum using manual
15323	Fee: \$722.00	Benefit: 75% = \$541.50	85% = \$638.60
	sources having a		AVAGINAL TREATMENT using radioactive sealed ays including iodine, gold, iridium or tantalum using
15324	Fee: \$722.00	Benefit: 75% = \$541.50	85% = \$638.60
	including iodine,	, gold, iridium or tantalum)	ACTIVE SOURCE (having a half-life of less than 115 days to a region, under general anaesthesia, or epidural or spinal exposure and using manual afterloading techniques (Anaes.)
15327	Fee: \$785.45	Benefit: 75% = \$589.10	85% = \$702.05
	including iodine,	, gold, iridium or tantalum)	ACTIVE SOURCE (having a half-life of less than 115 days to a region, under general anaesthesia, or epidural or spinal exposure and using automatic afterloading techniques
15328	Fee: \$785.45	Benefit: 75% = \$589.10	85% = \$702.05
	including iodine, subcutaneous sit	, gold, iridium or tantalum)	ACTIVE SOURCE (having a half-life of less than 115 days to a site (including the tongue, mouth, salivary gland, axilla, ed involves multiple planes but does not require surgical iniques (Anaes.)
15331	Fee: \$745.80	Benefit: 75% = \$559.35	85% = \$662.40
	including iodine, subcutaneous sit	, gold, iridium or tantalum)	ACTIVE SOURCE (having a half-life of less than 115 days to a site (including the tongue, mouth, salivary gland, axilla, ed involves multiple planes but does not require surgical echniques (Anaes.)
15332	Fee: \$745.80	Benefit: 75% = \$559.35	85% = \$662.40
	including iodine,	, gold, iridium or tantalum)	ACTIVE SOURCE (having a half-life of less than 115 days to a site where the volume treated involves only a single and using manual afterloading techniques (Anaes.)
15335	Fee: \$676.80	Benefit: 75% = \$507.60	85% = \$593.40
	including iodine,	, gold, iridium or tantalum)	ACTIVE SOURCE (having a half-life of less than 115 days to a site where the volume treated involves only a single and using automatic afterloading techniques (Anaes.)
	plane out does in	ot require surgical exposure	and using automatic afterioading techniques (Anaes.)

T2. RAI	DIATION ONCOL	OGY	4. BRACHYTHERAPY
	ultrasound guida tumour not palpa score of less than	nce, for localised prostatic malignancy able or visible by imaging) or T2 (tume to or equal to 7 and a prostate specific a	on oncology component, using transrectal y at clinical stages T1 (clinically inapparent our confined within prostate), with a Gleason untigen (PSA) of less than or equal to 10ng/ml at ed at an approved site in association with a
15338	(See para TN.2.2 o Fee: \$935.60	of explanatory notes to this Category) Benefit: $75\% = \$701.70 85\% = \8	352.20
	REMOVAL OF spinal nerve bloc		CE under general anaesthesia, or under epidural or
15339	Fee: \$76.20	Benefit: 75% = \$57.15 85% = \$64	1.80
		ON AND APPLICATION OF A RAD e of greater than 115 days, to treat intra	IOACTIVE MOULD using a sealed source acavity, intraoral or intranasal site
15342	Fee: \$190.30	Benefit: 75% = \$142.75 85% = \$1	61.80
		e of less than 115 days including iodin	IOACTIVE MOULD using a sealed source e, gold, iridium or tantalum to treat intracavity,
15345	Fee: \$507.80	Benefit: 75% = \$380.85 85% = \$4	131.65
	SUBSEQUENT 15345 each atte		E MOULD referred to in item 15342 or
15348	Fee: \$58.40	Benefit: 75% = \$43.80 85% = \$49.	0.65
		ON WITH OR WITHOUT INITIAL A diameter to an external surface	PPLICATION OF RADIOACTIVE MOULD not
15351	Fee: \$116.60	Benefit: 75% = \$87.45 85% = \$99	0.15
	CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD 5 cm. or more in diameter to an external surface		F RADIOACTIVE MOULD 5 cm. or more in
15354	Fee: \$141.50	Benefit: 75% = \$106.15 85% = \$1	20.30
	SUBSEQUENT 15354 each atte		E MOULD referred to in item 15351 or
15357	Fee: \$40.05	Benefit: 75% = \$30.05 85% = \$34	1.05
T2. RAI	DIATION ONCOL	OGY	5. COMPUTERISED PLANNING
	Group T2. Radia	ation Oncology	
Subgroup 5. Computerised Planning		uterised Planning	
		RADIOTHERAPY	/ PLANNING
	single area for tr		socentric xray or megavoltage machine or CT of a posed fields (not being a service associated with a
15500	(See para TN.2.3 o Fee: \$242.65	of explanatory notes to this Category) Benefit: 75% = \$182.00 85% = \$2	206.30

T2. RADIATION ONCOLOGY 5. COMPUTERISED PLAN		5. COMPUTERISED PLANNING
	RADIATION FIELD SETTING using a simulator or isocentric single area, where views in more than 1 plane are required for (not being a service associated with a service to which item 1	r treatment by multiple fields, or of 2 areas
15503	(See para TN.2.3 of explanatory notes to this Category) Fee: \$311.55 Benefit: 75% = \$233.70 85% = \$264.85	
	RADIATION FIELD SETTING using a simulator or isocentror more areas, or of total body or half body irradiation, or of a irregularly shaped fields using multiple blocks, or of offaxis a service associated with a service to which item 15515 applies	mantle therapy or inverted Y fields, or of fields or several joined fields (not being a
15506	(See para TN.2.3 of explanatory notes to this Category) Fee: \$465.30 Benefit: 75% = \$349.00 85% = \$395.55	
	RADIATION FIELD SETTING using a diagnostic xray unit field or parallel opposed fields (not being a service associated applies)	
15509	(See para TN.2.3 of explanatory notes to this Category) Fee: \$210.30 Benefit: 75% = \$157.75 85% = \$178.80	
	RADIATION FIELD SETTING using a diagnostic xray unit 1 plane are required for treatment by multiple fields, or of 2 a service to which item 15503 applies)	
15512	(See para TN.2.3 of explanatory notes to this Category) Fee: \$271.10 Benefit: 75% = \$203.35 85% = \$230.45	
	RADIATION SOURCE LOCALISATION using a simulator where views in more than 1 plane are required, for brachyther implantation of localised prostate cancer, in association with	rapy treatment planning for I125 seed
15513	(See para TN.2.3 of explanatory notes to this Category) Fee: \$306.55 Benefit: 75% = \$229.95 85% = \$260.60	
	RADIATION FIELD SETTING using a diagnostic xray unit body irradiation, or of mantle therapy or inverted Y fields, or blocks, or of offaxis fields or several joined fields (not being item 15506 applies)	of irregularly shaped fields using multiple
15515	(See para TN.2.3 of explanatory notes to this Category) Fee: \$392.50 Benefit: 75% = \$294.40 85% = \$333.65	
	RADIATION DOSIMETRY by a CT interfacing planning coradiotherapy by a single field or parallel opposed fields to 1 a	
15518	(See para TN.2.3 of explanatory notes to this Category) Fee: \$77.00 Benefit: 75% = \$57.75 85% = \$65.45	
	RADIATION DOSIMETRY by a CT interfacing planning coradiotherapy to a single area by 3 or more fields, or by a single or where wedges are used	
15521	(See para TN.2.3 of explanatory notes to this Category) Fee: \$339.90 Benefit: 75% = \$254.95 85% = \$288.95	
	RADIATION DOSIMETRY by a CT interfacing planning coradiotherapy to 3 or more areas, or by mantle fields or invertes shaped fields using multiple blocks, or offaxis fields, or sever	ed Y fields or tangential fields or irregularly
15524	one of here doing multiple clocks, of offices, of sever	an joined notes

T2. RADIATION ONCOLOGY 5		5. COMPUTERISED PLANNING
	(See para TN.2.3 of explanatory notes to this Category) Fee: \$637.35 Benefit: 75% = \$478.05 85% = \$553.95	
	RADIATION DOSIMETRY by a non CT interfacing planning radiotherapy by a single field or parallel opposed fields to 1 ar	
15527	(See para TN.2.3 of explanatory notes to this Category) Fee: \$78.95 Benefit: 75% = \$59.25 85% = \$67.15	
	RADIATION DOSIMETRY by a non CT interfacing planning radiotherapy to a single area by 3 or more fields, or by a single or where wedges are used	
15530	(See para TN.2.3 of explanatory notes to this Category) Fee: \$352.15 Benefit: 75% = \$264.15 85% = \$299.35	
	RADIATION DOSIMETRY by a non CT interfacing planning radiotherapy to 3 or more areas, or by mantle fields or inverted irregularly shaped fields using multiple blocks, or offaxis field	d Y fields, or tangential fields or
15533	(See para TN.2.3 of explanatory notes to this Category) Fee: \$667.70 Benefit: 75% = \$500.80 85% = \$584.30	
	BRACHYTHERAPY PLANNING, computerised radiation do	osimetry
15536	(See para TN.2.3 of explanatory notes to this Category) Fee: \$266.90 Benefit: 75% = \$200.20 85% = \$226.90	
	BRACHYTHERAPY PLANNING, computerised radiation do localised prostate cancer, in association with item 15338	osimetry for I125 seed implantation of
15539	(See para TN.2.3 of explanatory notes to this Category) Fee: \$627.30 Benefit: 75% = \$470.50 85% = \$543.90	
	SIMULATION FOR THREE DIMENSIONAL CONFORMA contrast medium, where:	L RADIOTHERAPY without intravenous
	(a) treatment set up and technique specifications are in preparadiotherapy dose planning; and	arations for three dimensional conformal
	(b) patient set up and immobilisation techniques are suitable acquisition and three dimensional conformal radiotherapy trea	
	(c) a high-quality CT-image volume dataset must be acquire planned and treated; and	d for the relevant region of interest to be
	(d) the image set must be suitable for the generation of qualitimages	ty digitally reconstructed radiographic
15550	(See para TN.2.3 of explanatory notes to this Category) Fee: \$658.60 Benefit: 75% = \$493.95 85% = \$575.20	
	SIMULATION FOR THREE DIMENSIONAL CONFORMA intravenous contrast medium, where:	L RADIOTHERAPY pre and post
	(a) treatment set up and technique specifications are in preparadiotherapy dose planning; and	arations for three dimensional conformal
15553	(b) patient set up and immobilisation techniques are suitable	for reliable CT image volume data

T2. RADIATION ONCOLOGY		5. COMPUTERISED PLANNING
acquisition and thre	e dimensional conformal radio	otherapy treatment; and
(c) a high-quality planned and treated:		st be acquired for the relevant region of interest to be
(d) the image set r images	nust be suitable for the genera	tion of quality digitally reconstructed radiographic
(See para TN.2.3 of ex Fee: \$710.55	explanatory notes to this Category) Benefit: 75% = \$532.95 85%	
SIMULATION FOI intravenous contrast		D RADIATION THERAPY (IMRT), with or without
treatment set-up radiotherapy dose p		are in preparations for three-dimensional conformal
	nd immobilisation techniques e-dimensional conformal radio	are suitable for reliable CT-image volume data otherapy; and
3. a high-quality (and treated; and	CT-image volume dataset is ac	quired for the relevant region of interest to be planned
4. the image set is	suitable for the generation of	quality digitally-reconstructed radiographic images.
(See para TN.2.3 of ex 15555 Fee: \$710.55	explanatory notes to this Category) Benefit: 75% = \$532.95 85%	
DOSIMETRY FOR COMPLEXITY wh		ONFORMAL RADIOTHERAPY OF LEVEL 1
	a single phase three dimension a single treatment target volum	al conformal treatment plan using CT image volume are and organ at risk; and
		olume, plus one planning target volume plus at least ption must be rendered as volumes; and
	sk must be nominated as a plar risk dose goal or constraint; a	nning dose goal or constraint and the prescription must
(d) dose volume h	istograms must be generated,	approved and recorded with the plan; and
(e) a CT image vo	lume dataset must be used for	the relevant region to be planned and treated; and
(f) the CT images images	must be suitable for the gener	ation of quality digitally reconstructed radiographic
(See para TN.2.3 of ex 15556 Fee: \$664.40	explanatory notes to this Category) Benefit: 75% = \$498.30 85%	
DOSIMETRY FOR COMPLEXITY wh		ONFORMAL RADIOTHERAPY OF LEVEL 2
	ast one gross tumour volume, t	conformal treatment plan using CT image volume two planning target volumes and one organ at risk
(b) dosimetry for a	a one phase three dimensional	conformal treatment plan using CT image volume

T2. RADIATION ONCOLOGY

5. COMPUTERISED PLANNING

datasets with at least one gross tumour volume, one planning target volume and two organ at risk dose goals or constraints defined in the prescription; or

(c) image fusion with a secondary image (CT, MRI or PET) volume dataset used to define target and organ at risk volumes in conjunction with and as specified in dosimetry for three dimensional conformal radiotherapy of level 1 complexity.

All gross tumour targets, clinical targets, planning targets and organs at risk as defined in the prescription must be rendered as volumes. The organ at risk must be nominated as planning dose goals or constraints and the prescription must specify the organs at risk as dose goals or constraints. Dose volume histograms must be generated, approved and recorded with the plan. A CT image volume dataset must be used for the relevant region to be planned and treated. The CT images must be suitable for the generation of quality digitally reconstructed radiographic images

(See para TN.2.3 of explanatory notes to this Category)

Fee: \$866.55 **Benefit:** 75% = \$649.95 85% = \$783.15

DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 3 COMPLEXITY - where:

- (a) dosimetry for a three or more phase three dimensional conformal treatment plan using CT image volume dataset(s) with at least one gross tumour volume, three planning target volumes and one organ at risk defined in the prescription; or
- (b) dosimetry for a two phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, and
 - (i) two planning target volumes; or
 - (ii) two organ at risk dose goals or constraints defined in the prescription.

or

(c) dosimetry for a one phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, one planning target volume and three organ at risk dose goals or constraints defined in the prescription;

or

(d) image fusion with a secondary image (CT, MRI or PET) volume dataset used to define target and organ at risk volumes in conjunction with and as specified in dosimetry for three dimensional conformal radiotherapy of level 2 complexity.

All gross tumour targets, clinical targets, planning targets and organs at risk as defined in the prescription must be rendered as volumes. The organ at risk must be nominated as planning dose goals or constraints and the prescription must specify the organs at risk as dose goals or constraints. Dose volume histograms must be generated, approved and recorded with the plan. A CT image volume dataset must be used for the relevant region to be planned and treated. The CT images must be suitable for the generation of quality digitally reconstructed radiographic images

(See para TN.2.3 of explanatory notes to this Category)

Fee: \$1,120.75 **Benefit:** 75% = \$840.60 85% = \$1037.35

T2. RADIATION ONCOLOGY 5. COMPUTERISED PLANNING Preparation of an IMRT DOSIMETRY PLAN, which uses one or more CT image volume datasets, if: (a) in preparing the IMRT dosimetry plan: (i) the differential between target dose and normal tissue dose is maximised, based on a review and assessment by a radiation oncologist; and (ii) all gross tumour targets, clinical targets, planning targets and organs at risk are rendered as volumes as defined in the prescription; and (iii) organs at risk are nominated as planning dose goals or constraints and the prescription specifies the organs at risk as dose goals or constraints; and (iv) dose calculations and dose volume histograms are generated in an inverse planned process, using a specialised calculation algorithm, with prescription and plan details approved and recorded in the plan; and (v) a CT image volume dataset is used for the relevant region to be planned and treated; and (vi) the CT images are suitable for the generation of quality digitally reconstructed radiographic images; and (b) the final IMRT dosimetry plan is validated by the radiation therapist and the medical physicist, using robust quality assurance processes that include: (i) determination of the accuracy of the dose fluence delivered by the multi-leaf collimator and gantryposition (static or dynamic); and (ii) ensuring that the plan is deliverable, data transfer is acceptable and validation checks are completed on a linear accelerator; and (iii) validating the accuracy of the derived IMRT dosimetry plan; and (c) the final IMRT dosimetry plan is approved by the radiation oncologist prior to delivery. (See para TN.2.3 of explanatory notes to this Category) 15565 Fee: \$3.313.85 **Benefit:** 75% = \$2485.40 85% = \$3230.45 **T2. RADIATION ONCOLOGY** 6. STEREOTACTIC RADIOSURGERY **Group T2. Radiation Oncology** Subgroup 6. Stereotactic Radiosurgery STEREOTACTIC RADIOSURGERY, including all radiation oncology consultations, planning, simulation, dosimetry and treatment 15600 Fee: \$1,702.30 **Benefit:** 75% = \$1276.75 85% = \$1618.90 7. RADIATION ONCOLOGY TREATMENT T2. RADIATION ONCOLOGY **VERIFICATION Group T2. Radiation Oncology** Subgroup 7. Radiation Oncology Treatment Verification 15700 RADIATION ONCOLOGY TREATMENT VERIFICATION - single projection (with single or double

T2. RAI	7. RADIATION ONCOLOGY TREATMENT DIATION ONCOLOGY VERIFICATION
	exposures) - when prescribed and reviewed by a radiation oncologist and not associated with item 15705 or 15710 - each attendance at which treatment is verified (ie maximum one per attendance).
	(See para TN.2.4 of explanatory notes to this Category) Fee: \$45.95 Benefit: 75% = \$34.50 85% = \$39.10
	RADIATION ONCOLOGY TREATMENT VERIFICATION - multiple projection acquisition when prescribed and reviewed by a radiation oncologist and not associated with item 15700 or 15710 - each attendance at which treatment involving three or more fields is verified (ie maximum one per attendance).
15705	(See para TN.2.4 of explanatory notes to this Category) Fee: \$76.60 Benefit: 75% = \$57.45 85% = \$65.15
	RADIATION ONCOLOGY TREATMENT VERIFICATION - volumetric acquisition, when prescribed and reviewed by a radiation oncologist and not associated with item 15700 or 15705 - each attendance at which treatment involving three fields or more is verified (ie maximum one per attendance).
	(see para T2.5 of explanatory notes to this Category)
15710	(See para TN.2.4 of explanatory notes to this Category) Fee: \$76.60 Benefit: 75% = \$57.45 85% = \$65.15
	RADIATION ONCOLOGY TREATMENT VERIFICATION of planar or volumetric IGRT for IMRT, involving the use of at least 2 planar image views or projections or 1 volumetric image set to facilitate a 3-dimensional adjustment to radiation treatment field positioning, if:
	(a) the treatment technique is classified as IMRT; and
	(b) the margins applied to volumes (clinical target volume or planning target volume) are tailored or reduced to minimise treatment related exposure of healthy or normal tissues; and
	(c) the decisions made using acquired images are based on action algorithms and are given effect immediately prior to or during treatment delivery by qualified and trained staff considering complex competing factors and using software driven modelling programs; and
	(d) the radiation treatment field positioning requires accuracy levels of less than 5mm (curative cases) or up to 10mm (palliative cases) to ensure accurate dose delivery to the target; and
	(e) the image decisions and actions are documented in the patient's record; and
	(f) the radiation oncologist is responsible for supervising the process, including specifying the type and frequency of imaging, tolerance and action levels to be incorporated in the process, reviewing the trend analysis and any reports and relevant images during the treatment course and specifying action protocols as required; and
	(g) when treatment adjustments are inadequate to satisfy treatment protocol requirements, replanning is required; and
	(h) the imaging infrastructure (hardware and software) is linked to the treatment unit and networked to an image database, enabling both on line and off line reviews.
15715	(See para TN.2.4 of explanatory notes to this Category) Fee: \$76.60 Benefit: 75% = \$57.45 85% = \$65.15

T2. RADIATION ONCOLOGY

8. BRACHYTHERAPY PLANNING AND VERIFICATION

T2. RAI	8. BRACHYTHERAPY PLANNING AND VERIFICATION
	Group T2. Radiation Oncology
	Subgroup 8. Brachytherapy Planning And Verification
	BRACHYTHERAPY TREATMENT VERIFICATION - maximum of one only for each attendance.
15800	(See para TN.2.4 of explanatory notes to this Category) Fee: \$96.30 Benefit: 75% = \$72.25 85% = \$81.90
	RADIATION SOURCE LOCALISATION using a simulator, x-ray machine, CT or ultrasound of a single area, where views in more than one plane are required, for brachytherapy treatment planning, not being a service to which Item 15513 applies.
15850	Fee: \$199.50 Benefit: 75% = \$149.65 85% = \$169.60
T2. RAI	10. TARGETTED INTRAOPERATIVE RADIOTHERAPY
	Group T2. Radiation Oncology
	Subgroup 10. Targetted Intraoperative Radiotherapy
	INTRAOPERATIVE RADIOTHERAPY
	BREAST, MALIGNANT TUMOUR, targeted intraoperative radiotherapy, using an Intrabeam® device, delivered at the time of breast-conserving surgery (partial mastectomy or lumpectomy) for a patient who:
	a) is 45 years of age or more; and
	b) has a T1 or small T2 (less than or equal to 3cm in diameter) primary tumour; and
	c) has an histologic Grade 1 or 2 tumour; and
	d) has an oestrogen-receptor positive tumour; and
	e) has a node negative malignancy; and
	f) is suitable for wide local excision of a primary invasive ductal carcinoma that was diagnosed as unifocal on conventional examination and imaging; and
	g) has no contra-indications to breast irradiation
15900	Fee: \$250.00 Benefit: 75% = \$187.50
T3. THE	RAPEUTIC NUCLEAR MEDICINE
	Group T3. Therapeutic Nuclear Medicine
	INTRACAVITY ADMINISTRATION OF A THERAPEUTIC DOSE OF YTTRIUM 90 not including preliminary paracentesis, not being a service associated with selective internal radiation therapy or to which item 35404, 35406 or 35408 applies (Anaes.)
16003	(See para TN.3.1 of explanatory notes to this Category) Fee: \$650.50 Benefit: 75% = \$487.90 85% = \$567.10
16006	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose

T3. THE	RAPEUTIC NUCLEAR MEDICINE		
	technique		
	Fee: \$499.85 Benefit: 75% = \$374.90 85% = \$424.90		
	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique		
16009	Fee: \$341.15 Benefit: 75% = \$255.90 85% = \$290.00		
	INTRAVENOUS ADMINISTRATION OF A THERAPEUTIC DOSE OF PHOSPHOROUS 32		
16012	Fee: \$295.15 Benefit: 75% = \$221.40 85% = \$250.90		
	ADMINISTRATION OF STRONTIUM 89 for painful bony metastases from carcinoma of the prostate where hormone therapy has failed and either:		
	(i) the disease is poorly controlled by conventional radiotherapy; or		
	(ii) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain		
16015	Fee: \$4,085.70 Benefit: 75% = \$3064.30 85% = \$4002.30		
	ADMINISTRATION OF ¹⁵³ SM-LEXIDRONAM for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan) where hormonal therapy and/or chemotherapy have failed and either the disease is poorly controlled by conventional radiotherapy or conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain.		
16018	Fee: \$2,442.45 Benefit: 75% = \$1831.85 85% = \$2359.05		
T4. OB	STETRICS		
	Group T4. Obstetrics		
	Professional attendance on a patient by a specialist practising in his or her specialty of obstetrics if:		
	(a) the attendance is by video conference; and		
	(b) item 16401, 16404, 16406, 16500, 16590 or 16591 applies to the attendance; and		
	(c) the patient is not an admitted patient; and		
	(d) the patient:		
	(i) is located both:		
	(A) within a telehealth eligible area; and		
	(B) at the time of the attendance-at least 15 kms by road from the specialist; or		
	(ii) is a care recipient in a residential care service; or		
	(iii) is a patient of:		
	(A) an Aboriginal Medical Service; or		
	(B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies		

T4. OB	STETRICS
	Derived Fee: 50% of the fee for item 16401,16404,16406,16500,16590 or 16591. Benefit: 85% of the derived fee Extended Medicare Safety Net Cap: \$24.10
	ANTENATAL CARE
	Antenatal service provided by a midwife, nurse or an Aboriginal and Torres Strait Islander health practitioner if:
	(a) the service is provided on behalf of, and under the supervision of, a medical practitioner;
	(b) the service is provided at, or from, a practice location in a regional, rural or remote area RRMA 3-7;
	(c) the service is not performed in conjunction with another antenatal attendance item (same patient, same practitioner on the same day);
	(d) the service is not provided for an admitted patient of a hospital; and
	to a maximum of 10 service per pregnancy
16400	(See para TN.4.1 of explanatory notes to this Category) Fee: \$27.25 Benefit: 85% = \$23.20 Extended Medicare Safety Net Cap: \$11.05
	Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics, after referral of the patient to him or her - each attendance, other than a second or subsequent attendance in a single course of treatment
16401	(See para TN.4.2 of explanatory notes to this Category) Fee: \$85.55 Benefit: 75% = \$64.20 85% = \$72.75 Extended Medicare Safety Net Cap: \$54.90
	Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics after referral of the patient to him or her - each attendance SUBSEQUENT to the first attendance in a single course of treatment.
16404	(See para AN.0.70, TN.4.2 of explanatory notes to this Category) Fee: \$43.00 Benefit: 75% = \$32.25 Extended Medicare Safety Net Cap: \$32.95
	Antenatal professional attendance, by an obstetrician or general practitioner, as part of a single course of treatment when the patient is referred by a participating midwife. Payable only once for a pregnancy
16406	Fee: \$133.95 Benefit: 75% = \$100.50 85% = \$113.90 Extended Medicare Safety Net Cap: \$108.15
	Postnatal professional attendance (other than a service to which any other item applies) if the attendance:
	(a) is by an obstetrician or general practitioner; and
	(b) is in hospital or at consulting rooms; and
	(c) is between 4 and 8 weeks after the birth; and
	(d) lasts at least 20 minutes; and
16407	(e) includes a mental health assessment (including screening for drug and alcohol use and domestic

violence) of the patient; and
(f) is for a pregnancy in relation to which a service to which item 82140 applies is not provided Payable once only for a pregnancy
(See para TN.4.13 of explanatory notes to this Category) Fee: \$71.70 Benefit: 75% = \$53.80 85% = \$60.95 Extended Medicare Safety Net Cap: \$46.65
Postnatal attendance (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which any other item applies) if the attendance:
(a) is by:
(i) a midwife (on behalf of and under the supervision of the medical practitioner who attended the birth); or
(ii) an obstetrician; or
(iii) a general practitioner; and
(b) is between 1 week and 4 weeks after the birth; and
(c) lasts at least 20 minutes; and
(d) is for a patient who was privately admitted for the birth; and
(e) is for a pregnancy in relation to which a service to which item 82130, 82135 or 82140 applies is not provided Payable once only for a pregnancy
Fee: \$53.40 Benefit: 85% = \$45.40 Extended Medicare Safety Net Cap: \$34.75
ANTENATAL ATTENDANCE
(See para TN.4.3 of explanatory notes to this Category) Fee: \$47.15 Benefit: 75% = \$35.40 85% = \$40.10 Extended Medicare Safety Net Cap: \$32.95
EXTERNAL CEPHALIC VERSION for breech presentation, after 36 weeks where no contraindication exists, in a Unit with facilities for Caesarean Section, including pre- and post version CTG, with or without tocolysis, not being a service to which items 55718 to 55728 and 55768 to 55774 apply - chargeable whether or not the version is successful and limited to a maximum of 2 ECV's per pregnancy (See para TN.4.3, TN.4.4 of explanatory notes to this Category)
Fee: \$140.55 Benefit: 75% = \$105.45 85% = \$119.50 Extended Medicare Safety Net Cap: \$65.90
POLYHYDRAMNIOS, UNSTABLE LIE, MULTIPLE PREGNANCY, PREGNANCY COMPLICATED BY DIABETES OR ANAEMIA, THREATENED PREMATURE LABOUR treated by bed rest only or oral medication, requiring admission to hospital each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day
(See para TN.4.3 of explanatory notes to this Category) Fee: \$47.15 Benefit: 75% = \$35.40 85% = \$40.10 Extended Medicara Sefety Net Cap: \$22.00
Extended Medicare Safety Net Cap: \$22.00 THREATENED ABORTION, THREATENED MISCARRIAGE OR HYPEREMESIS

T4. OBS	STETRICS
	GRAVIDARUM, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance
	(See para TN.4.3 of explanatory notes to this Category) Fee: \$47.15 Benefit: 75% = \$35.40 Extended Medicare Safety Net Cap: \$22.00
	Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital - each professional attendance (other than a service to which item 16533 applies) that is not a routine antenatal attendance, to a maximum of one visit per day
16508	(See para TN.4.3 of explanatory notes to this Category) Fee: \$47.15 Benefit: 75% = \$35.40 85% = \$40.10 Extended Medicare Safety Net Cap: \$22.00
	Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of - each professional attendance (other than a service to which item 16534 applies) that is not a routine antenatal attendance
16509	(See para TN.4.3 of explanatory notes to this Category) Fee: \$47.15 Benefit: 75% = \$35.40 85% = \$40.10 Extended Medicare Safety Net Cap: \$22.00
	CERVIX, purse string ligation of (Anaes.)
16511	(See para TN.4.3 of explanatory notes to this Category) Fee: \$219.95 Benefit: 75% = \$165.00 85% = \$187.00 Extended Medicare Safety Net Cap: \$109.75
	CERVIX, removal of purse string ligature of (Anaes.)
16512	(See para TN.4.3 of explanatory notes to this Category) Fee: \$63.50 Benefit: 75% = \$47.65 Extended Medicare Safety Net Cap: \$32.95
	ANTENATAL CARDIOTOCOGRAPHY in the management of high risk pregnancy (not during the course of the confinement)
16514	(See para TN.4.3 of explanatory notes to this Category) Fee: \$36.65 Benefit: 75% = \$27.50 Extended Medicare Safety Net Cap: \$16.55
	Management of vaginal birth as an independent procedure, if the patient's care has been transferred by another medical practitioner for management of the birth and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the birth (Anaes.)
16515	(See para TN.4.5, TN.4.10 of explanatory notes to this Category) Fee: \$630.85 Benefit: 75% = \$473.15 85% = \$547.45 Extended Medicare Safety Net Cap: \$175.60
	Management of labour, incomplete, if the patient's care has been transferred to another medical practitioner for completion of the birth (Anaes.)
16518	(See para TN.4.5, TN.4.10 of explanatory notes to this Category) Fee: \$450.65 Benefit: 75% = \$338.00 85% = \$383.10 Extended Medicare Safety Net Cap: \$175.60
	Management of labour and birth by any means (including Caesarean section) including post-partum care for 5 days (Anaes.)
16519	(See para TN.4.5, TN.4.6, TN.4.10 of explanatory notes to this Category)

	Fee: \$693.95 Benefit: 75% = \$520.50 85% = \$610.55
	Extended Medicare Safety Net Cap: \$329.15
	Caesarean section and post-operative care for 7 days, if the patient's care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care (Anaes.)
16520	(See para TN.4.6, TN.4.10 of explanatory notes to this Category) Fee: \$630.85 Benefit: 75% = \$473.15 85% = \$547.45 Extended Medicare Safety Net Cap: \$329.15
	Management of labour and birth, or birth alone, (including caesarean section), on or after 23 weeks gestation, if in the course of antenatal supervision or intrapartum management one or more of the following conditions is present, including postnatal care for 7 days:
	(a) fetal loss;
	(b) multiple pregnancy;
	(c) antepartum haemorrhage that is:
	(i) of greater than 200 ml; or
	(ii) associated with disseminated intravascular coagulation;
	(d) placenta praevia on ultrasound in the third trimester with the placenta within 2 cm of the internal cervical os;
	(e) baby with a birth weight less than or equal to 2,500 g;
	(f) trial of vaginal birth in a patient with uterine scar where there has been a planned vaginal birth after caesarean section;
	(g) trial of vaginal breech birth where there has been a planned vaginal breech birth;
	(h) prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress as evidenced by cervical dilatation at less than 1 cm/hr in the active phase of labour (after 3 cm cervical dilatation and effacement until full dilatation of the cervix);
	(i) acute fetal compromise evidenced by:
	(i) scalp pH less than 7.15; or
	(ii) scalp lactate greater than 4.0;
	(j) acute fetal compromise evidenced by at least one of the following significant cardiotocograph abnormalities:
	(i) prolonged bradycardia (less than 100 bpm for more than 2 minutes);
	(ii) absent baseline variability (less than 3 bpm);
	(iii) sinusoidal pattern;
	(iv) complicated variable decelerations with reduced (3 to 5 bpm) or absent baseline variability;
16522	(v) late decelerations;
10322	

T4. OBSTETRICS

- (k) pregnancy induced hypertension of at least 140/90 mm Hg associated with:
 - (i) at least 2+ proteinuria on urinalysis; or
 - (ii) protein-creatinine ratio greater than 30 mg/mmol; or
 - (iii) platelet count less than 150×10^9 /L; or
 - (iv) uric acid greater than 0.36 mmol/L;
- (1) gestational diabetes mellitus requiring at least daily blood glucose monitoring;
- (m) mental health disorder (whether arising prior to pregnancy, during pregnancy or postpartum) that is demonstrated by:
 - (i) the patient requiring hospitalisation; or
 - (ii) the patient receiving ongoing care by a psychologist or psychiatrist to treat the symptoms of a mental health disorder; or
 - (iii) the patient having a GP mental health treatment plan; or
 - (iv) the patient having a management plan prepared in accordance with item 291;
- (n) disclosure or evidence of domestic violence;
- (o) any of the following conditions either diagnosed pre-pregnancy or evident at the first antenatal visit before 20 weeks gestation:
 - (i) pre-existing hypertension requiring antihypertensive medication prior to pregnancy;
 - (ii) cardiac disease (co-managed with a specialist physician and with echocardiographic evidence of myocardial dysfunction);
 - (iii) previous renal or liver transplant;
 - (iv) renal dialysis;
 - (v) chronic liver disease with documented oesophageal varices;
 - (vi) renal insufficiency in early pregnancy (serum creatinine greater than 110 mmol/L);
 - (vii) neurological disorder that confines the patient to a wheelchair throughout pregnancy;
 - (viii) maternal height of less than 148 cm;
 - (ix) a body mass index greater than or equal to 40;
 - (x) pre-existing diabetes mellitus on medication prior to pregnancy;
 - (xi) thyrotoxicosis requiring medication;
 - (xii) previous thrombosis or thromboembolism requiring anticoagulant therapy through pregnancy and the early puerperium;
 - (xiii) thrombocytopenia with platelet count of less than 100,000 prior to 20 weeks gestation;

TA ORG	OBSTETRICS	
14. 060	(xiv) HIV, hepatitis B or hepatitis C carrier status positive;	
	(XIV) HIV, hepatitis B of hepatitis C carrier status positive,	
	(xv) red cell or platelet iso-immunisation;	
	(xvi) cancer with metastatic disease;	
	(xvii) illicit drug misuse during pregnancy (Anaes.)	
	(See para TN.4.7 of explanatory notes to this Category) Fee: \$1,629.35 Benefit: 75% = \$1222.05 Extended Medicare Safety Net Cap: \$438.90	
	Management of vaginal birth, if the patient's care has been transferred by a participating midwife for management of the birth, including all attendances related to the birth. Payable once only for a pregnancy.	
	(Anaes.)	
16527	(See para TN.4.8 of explanatory notes to this Category) Fee: \$630.85 Benefit: 75% = \$473.15 Extended Medicare Safety Net Cap: \$175.60	
	Caesarean section and post-operative care for 7 days, if the patient's care has been transferred by a participating midwife for management of the birth. Payable once only for a pregnancy. (Anaes.)	
16528	(See para TN.4.8 of explanatory notes to this Category) Fee: \$630.85 Benefit: 75% = \$473.15 Extended Medicare Safety Net Cap: \$329.15	
	Management of pregnancy loss, from 14 weeks to 15 weeks and 6 days gestation, other than a service to which item 16531, 35640 or 35643 applies (Anaes.)	
16530	(See para TN.4.5 of explanatory notes to this Category) Fee: \$384.35 Benefit: 75% = \$288.30 85% = \$326.70 Extended Medicare Safety Net Cap: \$249.85	
	Management of pregnancy loss, from 16 weeks to 22 weeks and 6 days gestation, other than a service to which item 16530, 35640 or 35643 applies (Anaes.)	
16531	(See para TN.4.5, TN.4.14 of explanatory notes to this Category) Fee: \$768.70 Benefit: 75% = \$576.55 Extended Medicare Safety Net Cap: \$499.70	
	Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital—each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, to a maximum of 3 services per pregnancy	
16533	(See para TN.4.3, TN.4.14 of explanatory notes to this Category) Fee: \$105.55 Benefit: 75% = \$79.20 Extended Medicare Safety Net Cap: \$68.65	
10333	Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of—each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, to a maximum of 3 services per pregnancy	
16534	(See para TN.4.3, TN.4.14 of explanatory notes to this Category) Fee: \$105.55 Benefit: 75% = \$79.20 Extended Medicare Safety Net Cap: \$68.65	

T4. OB	DBSTETRICS	
	POST-PARTUM CARE	
	EVACUATION OF RETAINED PRODUCTS OF CONCEPTION (placenta, membranes or mole) as a complication of confinement, with or without curettage of the uterus, as an independent procedure (Anaes.)	
16564	(See para TN.4.10 of explanatory notes to this Category) Fee: \$218.00 Benefit: 75% = \$163.50 85% = \$185.30 Extended Medicare Safety Net Cap: \$219.45	
	MANAGEMENT OF POSTPARTUM HAEMORRHAGE by special measures such as packing of uterus, as an independent procedure (Anaes.)	
16567	(See para TN.4.10 of explanatory notes to this Category) Fee: \$318.80 Benefit: 75% = \$239.10 85% = \$271.00 Extended Medicare Safety Net Cap: \$219.45	
	ACUTE INVERSION OF THE UTERUS, vaginal correction of, as an independent procedure (Anaes.)	
16570	(See para TN.4.10 of explanatory notes to this Category) Fee: \$416.05 Benefit: 75% = \$312.05 85% = \$353.65 Extended Medicare Safety Net Cap: \$219.45	
	CERVIX, repair of extensive laceration or lacerations (Anaes.)	
16571	(See para TN.4.10 of explanatory notes to this Category) Fee: \$318.80 Benefit: 75% = \$239.10 85% = \$271.00 Extended Medicare Safety Net Cap: \$219.45	
	THIRD DEGREE TEAR, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.)	
16573	(See para TN.4.10 of explanatory notes to this Category) Fee: \$259.80 Benefit: 75% = \$194.85 85% = \$220.85 Extended Medicare Safety Net Cap: \$219.45	
	Planning and management, by a practitioner, of a pregnancy if:	
	(a) the practitioner intends to take primary responsibility for management of the pregnancy and any complications, and to be available for the birth; and	
	(b) the patient intends to be privately admitted for the birth; and	
	(c) the pregnancy has progressed beyond 28 weeks gestation; and	
	(d) the practitioner has maternity privileges at a hospital or birth centre; and	
	(e) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and	
	(f) a service to which item 16591 applies is not provided in relation to the same pregnancy	
	Payable once only for a pregnancy	
16590	(See para TN.4.13, TN.4.9 of explanatory notes to this Category) Fee: \$372.75 Benefit: 75% = \$279.60 85% = \$316.85	

STETRICS
Extended Medicare Safety Net Cap: \$219.45
Planning and management, by a practitioner, of a pregnancy if:
(a) the pregnancy has progressed beyond 28 weeks gestation; and
(b) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and
(c) a service to which item 16590 applies is not provided in relation to the same pregnancy
Payable once only for a pregnancy
(See para TN.4.13, TN.4.9 of explanatory notes to this Category) Fee: \$142.65 Benefit: 75% = \$107.00 85% = \$121.30 Extended Medicare Safety Net Cap: \$109.75
INTERVENTIONAL TECHNIQUES
AMNIOCENTESIS, diagnostic
(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$63.50 Benefit: 75% = \$47.65 85% = \$54.00
Extended Medicare Safety Net Cap: \$32.95
CHORIONIC VILLUS SAMPLING, by any route
(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$121.85 Benefit: 75% = \$91.40 85% = \$103.60 Extended Medicare Safety Net Cap: \$65.90
Fetal blood sampling, using interventional techniques from umbilical cord or fetus, including fetal neuromuscular blockade and amniocentesis (Anaes.)
(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$243.25 Benefit: 75% = \$182.45 85% = \$206.80
Extended Medicare Safety Net Cap: \$131.75 FOETAL INTRAVASCULAR BLOOD TRANSFUSION, using blood already collected, including
neuromuscular blockade, amniocentesis and foetal blood sampling (Anaes.)
(See para TN.4.11, TN.4.3 of explanatory notes to this Category)
Fee: \$496.00 Benefit: 75% = \$372.00 85% = \$421.60 Extended Medicare Safety Net Cap: \$252.40
FOETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including
neuromuscular blockade, amniocentesis and foetal blood sampling - not performed in conjunction with a service described in item 16609 (Anaes.)
(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$390.25 Benefit: 75% = \$292.70 85% = \$331.75
FOETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling - performed in conjunction with a service described in item 16609 (Anaes.)
(See para TN.4.11, TN.4.3 of explanatory notes to this Category)

T4. OB	4. OBSTETRICS		
	Fee: \$207.85 Benefit: 75% = \$155.90 85% = \$176.70		
	AMNIOCENTESIS, THERAPEUTIC, when indicated because of polyhydramnios with at least 500ml being aspirated		
	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$207.85 Benefit: 75% = \$155.90 85% = \$176.70		
16618	Extended Medicare Safety Net Cap: \$104.30		
	AMNIOINFUSION, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios		
16621	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$207.85 Benefit: 75% = \$155.90 85% = \$176.70		
	FOETAL FLUID FILLED CAVITY, drainage of		
16624	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$299.10 Benefit: 75% = \$224.35 85% = \$254.25 Extended Medicare Safety Net Cap: \$142.65		
	FETO-AMNIOTIC SHUNT, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis		
	(See para TN.4.11, TN.4.3 of explanatory notes to this Category)		
16627	Fee: \$608.95 Benefit: 75% = \$456.75 85% = \$525.55 Extended Medicare Safety Net Cap: \$307.25		
T6. AN	AESTHETICS 1. ANAESTHESIA CONSULTATION		
	Group T6. Anaesthetics		
	Subgroup 1. Anaesthesia Consultations		
	Professional attendance on a patient by a specialist practising in his or her specialty of anaesthesia if:		
	(a) the attendance is by video conference; and		
	(b) item 17610, 17615, 17620, 17625, 17640, 17645, 17650, or 17655 applies to the attendance; and		
	(c) the patient is not an admitted patient; and		
	(d) the patient:		
	(i) is located both:		
	(A) within a telehealth eligible area; and		
	(B) at the time of the attendance-at least 15 kms by road from the specialist; or		
	(ii) is a care recipient in a residential care service; or		
	(iii) is a patient of:		
	(A) an Aboriginal Medical Service; or		
	(B) an Aboriginal Community Controlled Health Service;		
	for which a direction made under subsection 19 (2) of the Act applies		
17609	(See para TN.6.4 of explanatory notes to this Category)		

T6. ANA	AESTHETICS 1. ANAESTHESIA CONSULTATIONS
	Derived Fee: 50% of the fee for item 17610, 17615, 17620, 17625, 17640, 17645, 17650, or 17655. Benefit: 85% of the derived fee
	Extended Medicare Safety Net Cap: 300% of the Derived fee for this item, or \$500.00, whichever is the lesser amount
	ANAESTHETIST, PRE-ANAESTHESIA CONSULTATION
	(Professional attendance by a medical practitioner in the practice of ANAESTHESIA)
	- a BRIEF consultation involving a targeted history and limited examination (including the cardio-respiratory system)
	 AND of not more than 15 minutes s duration, not being a service associated with a service to which items 2801 - 3000 apply
17610	(See para TN.6.1 of explanatory notes to this Category) Fee: \$43.65 Benefit: 75% = \$32.75 85% = \$37.15 Extended Medicare Safety Net Cap: \$130.95
	- a consultation on a patient undergoing advanced surgery or who has complex medical problems, involving a selective history and an extensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes
	- AND of more than 15 minutes but not more than 30 minutes duration, not being a service associated with a service to which items 2801 - 3000 applies
17615	(See para TN.6.1 of explanatory notes to this Category) Fee: \$86.85 Benefit: 75% = \$65.15 Extended Medicare Safety Net Cap: \$260.55
	- a consultation on a patient undergoing advanced surgery or who has complex medical problems involving a detailed history and comprehensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes
	- AND of more than 30 minutes but not more than 45 minutes duration, not being a service associated with a service to which items 2801 - 3000 apply
17620	(See para TN.6.1 of explanatory notes to this Category) Fee: \$120.30 Benefit: 75% = \$90.25 85% = \$102.30 Extended Medicare Safety Net Cap: \$360.90
17625	- a consultation on a patient undergoing advanced surgery or who has complex medical problems involving an exhaustive history and comprehensive examination of multiple systems, the formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of high complexity documented in the patient notes

T6. ANAESTHETICS 1. ANAESTHESIA CONSULTAT	
	- <i>AND of more than 45 minutes duration</i> , not being a service associated with a service to which items 2801 - 3000 apply
	(See para TN.6.1 of explanatory notes to this Category) Fee: \$153.15 Benefit: 75% = \$114.90 85% = \$130.20 Extended Medicare Safety Net Cap: \$459.45
	ANAESTHETIST, REFERRED CONSULTATION (other than prior to anaesthesia)
	(Professional attendance by a specialist anaesthetist in the practice of ANAESTHESIA where the patient is referred to him or her)
	- a BRIEF consultation involving a short history and limited examination
	- AND of not more than 15 minutes duration, not being a service associated with a service to which items 2801 - 3000 apply
17640	(See para TN.6.2 of explanatory notes to this Category) Fee: \$43.65 Benefit: 75% = \$32.75 Extended Medicare Safety Net Cap: \$130.95
	- a consultation involving a selective history and examination of multiple systems and the formulation of a written patient management plan
	- <i>AND of more than 15 minutes but not more than 30 minutes duration</i> , not being a service associated with a service to which items 2801 - 3000 apply.
17645	(See para TN.6.2 of explanatory notes to this Category) Fee: \$86.85 Benefit: 75% = \$65.15 Extended Medicare Safety Net Cap: \$260.55
	- a consultation involving a detailed history and comprehensive examination of multiple systems and the formulation of a written patient management plan
	- <i>AND of more than 30 minutes but not more than 45 minutes duration</i> , not being a service associated with a service to which items 2801 - 3000 apply
17650	(See para TN.6.2 of explanatory notes to this Category) Fee: \$120.30 Benefit: 75% = \$90.25 85% = \$102.30 Extended Medicare Safety Net Cap: \$360.90
17655	- a consultation involving an exhaustive history and comprehensive examination of multiple systems and the formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of high complexity,

T6. ANAESTHETICS 1. ANAESTHESIA CO	
	- <i>AND of more than 45 minutes duration</i> , not being a service associated with a service to which items 2801 - 3000 apply. (See para TN.6.2 of explanatory notes to this Category) Fee: \$153.15 Benefit: 75% = \$114.90 85% = \$130.20 Extended Medicare Safety Net Cap: \$459.45
	ANAESTHETIST, CONSULTATION, OTHER
	(Professional attendance by an anaesthetist in the practice of ANAESTHESIA)
	- a consultation immediately prior to the institution of a major regional blockade in a patient in labour, where no previous anaesthesia consultation has occurred, not being a service associated with a service to which items 2801 - 3000 apply.
17680	(See para TN.6.3 of explanatory notes to this Category) Fee: \$86.85 Benefit: 75% = \$65.15 85% = \$73.85 Extended Medicare Safety Net Cap: \$260.55
	- Where a pre-anaesthesia consultation covered by an item in the range 17615-17625 is performed in- rooms if:
	(a) the service is provided to a patient prior to an admitted patient episode of care involving anaesthesia; and
	(b) the service is not provided to an admitted patient of a hospital; and
	(c) the service is not provided on the day of admission to hospital for the subsequent episode of care involving anaesthesia services; and
	(d) the service is of more than 15 minutes duration
	not being a service associated with a service to which items 2801 - 3000 apply.
17690	(See para TN.6.3 of explanatory notes to this Category) Fee: \$40.15 Benefit: 75% = \$30.15 85% = \$34.15 Extended Medicare Safety Net Cap: \$120.45
T7. REG	GIONAL OR FIELD NERVE BLOCKS

T7. REC	EGIONAL OR FIELD NERVE BLOCKS	
	Group T7. Regional Or Field Nerve Blocks	
	INTRAVENOUS REGIONAL ANAESTHESIA of limb by retrograde perfusion	
18213	Fee: \$88.65 Benefit: 75% = \$66.50 85% = \$75.40	
	INTRATHECAL OR EPIDURAL INFUSION of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner (Anaes.)	
18216	Fee: \$189.90 Benefit: 75% = \$142.45 85% = \$161.45	
	INTRATHECAL or EPIDURAL INFUSION of a therapeutic substance, initial injection or commencement of, where continuous attendance by the medical practitioner extends beyond the first hour (Anaes.)	
18219	Derived Fee: The fee for item 18216 plus \$19.00 for each additional 15 minutes or part thereof beyond the first hour of attendance by the medical practitioner.	
	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is 15 minutes or less	
18222	(See para TN.7.2 of explanatory notes to this Category) Fee: \$37.65 Benefit: 75% = \$28.25 85% = \$32.05	
	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is more than 15 minutes	
18225	(See para TN.7.2 of explanatory notes to this Category) Fee: $$50.05$ Benefit: $75\% = 37.55 $85\% = 42.55	
	INTRATHECAL OR EPIDURAL INFUSION of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner, for a patient in labour, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday.	
18226	(See para TN.7.4 of explanatory notes to this Category) Fee: \$284.80 Benefit: 75% = \$213.60 85% = \$242.10	
	INTRATHECAL OR EPIDURAL INFUSION of a therapeutic substance, initial injection or commencement of, where continuous attendance by a medical practitioner extends beyond the first hour, for a patient in labour, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday.	
18227	(See para TN.7.4 of explanatory notes to this Category) Derived Fee: The fee for item 18226 plus \$28.60 for each additional 15 minutes or part there of beyond the first hour of attendance by the medical practitioner.	
	INTERPLEURAL BLOCK, initial injection or commencement of infusion of a therapeutic substance	
18228	Fee: \$62.50 Benefit: 75% = \$46.90 85% = \$53.15	
	INTRATHECAL or EPIDURAL INJECTION of neurolytic substance (Anaes.)	
18230	Fee: \$238.45 Benefit: 75% = \$178.85 85% = \$202.70	
	INTRATHECAL or EPIDURAL INJECTION of substance other than anaesthetic, contrast or neurolytic solutions, not being a service to which another item in this Group applies (Anaes.)	
18232	(See para TN.7.3 of explanatory notes to this Category)	

T7. REG	GIONAL OR FIELD NERVE BLOCKS		
	Fee: \$189.90	Benefit: 75% = \$142.45 85% = \$161.45	
	EPIDURAL INJE	CCTION of blood for blood patch (Anaes.)	
18233	Fee: \$189.90	Benefit: 75% = \$142.45 85% = \$161.45	
	TRIGEMINAL N	ERVE, primary division of, injection of an anaesthetic agent (Anaes.)	
18234	(See para TN.7.5 of Fee: \$124.85	Explanatory notes to this Category) Benefit: 75% = \$93.65 85% = \$106.15	
	TRIGEMINAL N	ERVE, peripheral branch of, injection of an anaesthetic agent (Anaes.)	
18236	(See para TN.7.5 of Fee: \$62.50	Sexplanatory notes to this Category) Benefit: 75% = \$46.90 85% = \$53.15	
	FACIAL NERVE which item 18240	, injection of an anaesthetic agent, not being a service associated with a service to applies	
18238	(See para TN.7.5 of Fee: \$37.65	Perplanatory notes to this Category) Benefit: 75% = \$28.25	
	RETROBULBAR	OR PERIBULBAR INJECTION of an anaesthetic agent	
(See para TN.7.5 Fee: \$93.60		explanatory notes to this Category) Benefit: 75% = \$70.20 85% = \$79.60	
	GREATER OCC	PITAL NERVE, injection of an anaesthetic agent (Anaes.)	
18242	(See para TN.7.5 of Fee: \$37.65	Sexplanatory notes to this Category) Benefit: 75% = \$28.25 85% = \$32.05	
	VAGUS NERVE	, injection of an anaesthetic agent	
18244	(See para TN.7.5 of Fee: \$100.80	Pexplanatory notes to this Category) Benefit: 75% = \$75.60 85% = \$85.70	
	PHRENIC NERV	E, injection of an anaesthetic agent	
18248	(See para TN.7.5 of Fee: \$88.65	Pexplanatory notes to this Category) Benefit: 75% = \$66.50 85% = \$75.40	
	SPINAL ACCES	SORY NERVE, injection of an anaesthetic agent	
18250	(See para TN.7.5 of Fee: \$62.50	Sexplanatory notes to this Category) Benefit: 75% = \$46.90 85% = \$53.15	
	CERVICAL PLE	XUS, injection of an anaesthetic agent	
18252	(See para TN.7.5 of Fee: \$100.80	Pexplanatory notes to this Category) Benefit: 75% = \$75.60 85% = \$85.70	
	BRACHIAL PLE	XUS, injection of an anaesthetic agent	
18254	(See para TN.7.5 of Fee: \$100.80	Sexplanatory notes to this Category) Benefit: 75% = \$75.60 85% = \$85.70	
_	SUPRASCAPUL	AR NERVE, injection of an anaesthetic agent	
18256	(See para TN.7.5 of Fee: \$62.50	explanatory notes to this Category) Benefit: 75% = \$46.90 85% = \$53.15	
		NERVE (single), injection of an anaesthetic agent	
		explanatory notes to this Category)	

	Fee: \$62.50 Benefit: 75% = \$46.90 85% = \$53.15	
	INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent	
	(See para TN.7.5 of explanatory notes to this Category)	
18260	Fee: \$88.65 Benefit: 75% = \$66.50 85% = \$75.40	
	ILIO-INGUINAL, ILIOHYPOGASTRIC OR GENITOFEMORAL NERVES, 1 or more of, injection of an anaesthetic agent (Anaes.)	
18262	(See para TN.7.5 of explanatory notes to this Category) Fee: \$62.50 Benefit: 75% = \$46.90 85% = \$53.15	
	PUDENDAL NERVE and or dorsal nerve, injection of anaesthetic agent	
	(See para TN.7.5 of explanatory notes to this Category)	
18264	Fee: \$100.80 Benefit: 75% = \$75.60 85% = \$85.70	
	ULNAR, RADIAL OR MEDIAN NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic	
	agent, not being associated with a brachial plexus block	
	(See para TN.7.5 of explanatory notes to this Category)	
18266	Fee: \$62.50 Benefit: 75% = \$46.90 85% = \$53.15	
	OBTURATOR NERVE, injection of an anaesthetic agent	
	(See para TN.7.5 of explanatory notes to this Category)	
18268	Fee: \$88.65 Benefit: 75% = \$66.50 85% = \$75.40	
	FEMORAL NERVE, injection of an anaesthetic agent	
	(See para TN.7.5 of explanatory notes to this Category)	
18270	Fee: \$88.65 Benefit: 75% = \$66.50 85% = \$75.40	
	SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent	
	(See para TN.7.5 of explanatory notes to this Category)	
18272	Fee: \$62.50 Benefit: 75% = \$46.90 85% = \$53.15	
	PARAVERTEBRAL, CERVICAL, THORACIC, LUMBAR, SACRAL OR COCCYGEAL NERVES, injection of an anaesthetic agent, (single vertebral level)	
	(See para TN.7.5 of explanatory notes to this Category)	
18274	Fee: \$88.65 Benefit: 75% = \$66.50 85% = \$75.40	
	PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels)	
	(See para TN.7.5 of explanatory notes to this Category)	
18276	Fee: \$124.85 Benefit: 75% = \$93.65 85% = \$106.15	
	SCIATIC NERVE, injection of an anaesthetic agent	
	(See para TN.7.5 of explanatory notes to this Category)	
18278	Fee: \$88.65 Benefit: 75% = \$66.50 85% = \$75.40	
	SPHENOPALATINE GANGLION, injection of an anaesthetic agent (Anaes.)	
18280	(See para TN.7.5 of explanatory notes to this Category) Fee: \$124.85 Benefit: 75% = \$93.65 85% = \$106.15	
10200	CAROTID SINUS, injection of an anaesthetic agent, as an independent percutaneous procedure	
18282	(See para TN.7.5 of explanatory notes to this Category)	

I /. KEG	IONAL OR FIELD NERVE BLOCKS	
	Fee: \$100.80 Benefit: 75% = \$75.60 85% = \$85.70	
	STELLATE GANGLION, injection of an anaesthetic agent, (cervical sympathetic block) (Anaes.)	
18284	(See para TN.7.5 of explanatory notes to this Category) Fee: \$147.65 Benefit: 75% = \$110.75 85% = \$125.55	
	LUMBAR OR THORACIC NERVES, injection of an anaesthetic agent, (paravertebral sympathetic block) (Anaes.)	
18286	(See para TN.7.5 of explanatory notes to this Category) Fee: \$147.65 Benefit: 75% = \$110.75 85% = \$125.55	
	COELIAC PLEXUS OR SPLANCHNIC NERVES, injection of an anaesthetic agent (Anaes.)	
18288	(See para TN.7.5 of explanatory notes to this Category) Fee: \$147.65 Benefit: 75% = \$110.75 85% = \$125.55	
	CRANIAL NERVE OTHER THAN TRIGEMINAL, destruction by a neurolytic agent, not being a service associated with the injection of botulinum toxin (Anaes.)	
18290	Fee: \$249.75 Benefit: 75% = \$187.35 85% = \$212.30	
	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies or a service associated with the injection of botulinum toxin except those services to which item 18354 applies (Anaes.)	
18292	(See para TN.7.5 of explanatory notes to this Category) Fee: \$124.85 Benefit: 75% = \$93.65 85% = \$106.15	
	COELIAC PLEXUS OR SPLANCHNIC NERVES, destruction by a neurolytic agent (Anaes.)	
18294	Fee: \$176.00 Benefit: 75% = \$132.00 85% = \$149.60	
	LUMBAR SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)	
18296	Fee: \$150.55 Benefit: 75% = \$112.95 85% = \$128.00	
	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)	
18298	Fee: \$176.00 Benefit: 75% = \$132.00 85% = \$149.60	
T8. SUR	GICAL OPERATIONS 1. GENERAL	
	Group T8. Surgical Operations	
	Subgroup 1. General	
	OPERATIVE PROCEDURE, not being a service to which any other item in this Group applies, bein service to which an item in this Group would have applied had the procedure not been discontinued of medical grounds	
30001	(See para TN.8.5 of explanatory notes to this Category) Derived Fee: 50% of the fee which would have applied had the procedure not been discontinued	
	LOCALISED BURNS, dressing of, (not involving grafting) each attendance at which the procedure is performed, including any associated consultation	
30003	Fee: \$36.30 Benefit: 75% = \$27.25 85% = \$30.90	
	EXTENSIVE BURNS, dressing of, without anaesthesia (not involving grafting) each attendance at which the procedure is performed, including any associated consultation	
30006	which the procedure is performed, including any associated consultation	

T8. SUF	RGICAL OPERAT	TIONS 1. GENE	ERAL
	Fee: \$46.50	Benefit: 75% = \$34.90 85% = \$39.55	
	LOCALISED B	URNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.)	
30010	Fee: \$73.90	Benefit: 75% = \$55.45	
	EXTENSIVE B	URNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.)	
30014	Fee: \$155.40	Benefit: 75% = \$116.55	
		on of, under general anaesthesia, involving not more than 10 per cent of body surfacts not carried out during the same operation (Anaes.) (Assist.)	e,
30017	Fee: \$326.05	Benefit: 75% = \$244.55 85% = \$277.15	
		on of, under general anaesthesia, involving more than 10 per cent of body surface, warried out during the same operation (Anaes.) (Assist.)	vhere
30020	Fee: \$635.00	Benefit: 75% = \$476.25	
		OFT TISSUE, traumatic, deep or extensively contaminated, debridement of, under esia or regional or field nerve block, including suturing of that wound when perform.)	ned
30023	(See para TN.8.6 Fee: \$326.05	of explanatory notes to this Category) Benefit: $75\% = 244.55 $85\% = 277.15	
	WOUND OF SOFT TISSUE, debridement of extensively infected post-surgical incision or Fournier's Gangrene, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.)		
30024	Fee: \$326.05	Benefit: 75% = \$244.55 85% = \$277.15	
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.)		
30026	(See para TN.8.6 Fee: \$52.20	of explanatory notes to this Category) Benefit: 75% = \$39.15 85% = \$44.40	
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.)		
30029	(See para TN.8.6 Fee: \$90.00	of explanatory notes to this Category) Benefit: 75% = \$67.50 85% = \$76.50	
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG) superficial (Anaes.)		
30032	(See para TN.8.6 Fee: \$82.50	of explanatory notes to this Category) Benefit: 75% = \$61.90 85% = \$70.15	
	other than woun	BCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND O d closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LOT r tissue (Anaes.)	
30035	(See para TN.8.6 Fee: \$117.55	of explanatory notes to this Category) Benefit: 75% = \$88.20 85% = \$99.95	
30038	SKIN AND SUI	BCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF	F,

T8. SUF	RGICAL OPERATION	DNS	1. GENERAL
		closure at time of surgery, not on face or neck, large (MORE THAT ng a service to which another item in Group T4 applies (Anaes.)	N 7 CM LONG),
	(See para TN.8.6 of Fee: \$90.00	explanatory notes to this Category) Benefit: $75\% = \$67.50$ $85\% = \$76.50$	
	other than wound	CUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF closure at time of surgery, other than on face or neck, large (MORE deeper tissue, other than a service to which another item in Group	E THAN 7 CM
30042	(See para TN.8.6 of Fee: \$185.60	explanatory notes to this Category) Benefit: $75\% = \$139.20 85\% = \157.80	
		CUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF closure at time of surgery, on face or neck, large (MORE THAN 7)	
30045	(See para TN.8.6 of Fee: \$117.55	explanatory notes to this Category) Benefit: 75% = \$88.20 85% = \$99.95	
		CUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF closure at time of surgery, on face or neck, large (MORE THAN 7 issue (Anaes.)	
30049	(See para TN.8.6 of Fee: \$185.60	explanatory notes to this Category) Benefit: 75% = \$139.20 85% = \$157.80	
		SS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, v layer of tissue (Anaes.) (Assist.)	vith accurate
30052	Fee: \$254.00	Benefit: 75% = \$190.50 85% = \$215.90	
		SING OF, under general anaesthesia, with or without removal of swith a service to which another item in this Group applies (Anaes.)	
30055	Fee: \$73.90	Benefit: 75% = \$55.45 85% = \$62.85	
	POSTOPERATIVE HAEMORRHAGE, control of, under general anaesthesia, as an independent procedure (Anaes.)		independent
30058	Fee: \$144.35	Benefit: 75% = \$108.30 85% = \$122.70	
	SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from cornea or sclera), as an independent procedure (Anaes.)		a), as an
30061	Fee: \$23.50	Benefit: 75% = \$17.65 85% = \$20.00	
	Etonogestrel subcutaneous implant, removal of, as an independent procedure (Anaes.))
30062	Fee: \$60.75	Benefit: 75% = \$45.60 85% = \$51.65	
	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and exploration, including clo of wound if performed, as an independent procedure (Anaes.)		n, including closure
30064	Fee: \$109.90	Benefit: 75% = \$82.45 85% = \$93.45	
	FOREIGN BODY procedure (Anaes.	IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of (Assist.)	, as an independent
30068	Fee: \$276.80	Benefit: 75% = \$207.60 85% = \$235.30	

T8. SUF	RGICAL OPERATIONS 1. GENERAL
	Diagnostic biopsy of skin, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.)
30071	(See para TN.8.7 of explanatory notes to this Category) Fee: \$52.20 Benefit: 75% = \$39.15 85% = \$44.40 Extended Medicare Safety Net Cap: \$41.80
30071	Diagnostic biopsy of mucous membrane, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.)
30072	(See para TN.8.7 of explanatory notes to this Category) Fee: \$52.20 Benefit: 75% = \$39.15 85% = \$44.40
	DIAGNOSTIC BIOPSY OF LYMPH GLAND, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.)
30075	Fee: \$149.75 Benefit: 75% = \$112.35 85% = \$127.30
	DIAGNOSTIC DRILL BIOPSY OF LYMPH GLAND, DEEP TISSUE OR ORGAN, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.)
30078	(See para TN.8.7 of explanatory notes to this Category) Fee: \$48.45 Benefit: 75% = \$36.35 85% = \$41.20
	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using open approach, where the biopsy specimen is sent for pathological examination (Anaes.)
30081	(See para TN.8.7 of explanatory notes to this Category) Fee: \$109.90 Benefit: 75% = \$82.45 85% = \$93.45
	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using percutaneous approach where the biopsy is sent for pathological examination (Anaes.)
30084	(See para TN.8.7 of explanatory notes to this Category) Fee: \$58.80 Benefit: 75% = \$44.10 85% = \$50.00
	DIAGNOSTIC BIOPSY OF BONE MARROW by aspiration or PUNCH BIOPSY OF SYNOVIAL MEMBRANE, where the biopsy is sent for pathological examination (Anaes.)
30087	(See para TN.8.7 of explanatory notes to this Category) Fee: \$29.45 Benefit: 75% = \$22.10 85% = \$25.05
	DIAGNOSTIC BIOPSY OF PLEURA, PERCUTANEOUS 1 or more biopsies on any 1 occasion, where the biopsy is sent for pathological examination (Anaes.)
30090	(See para TN.8.7 of explanatory notes to this Category) Fee: $$128.55$ Benefit: $75\% = 96.45 $85\% = 109.30
	DIAGNOSTIC NEEDLE BIOPSY OF VERTEBRA, where the biopsy is sent for pathological examination (Anaes.)
30093	(See para TN.8.7 of explanatory notes to this Category) Fee: \$171.55 Benefit: 75% = \$128.70 85% = \$145.85
	DIAGNOSTIC PERCUTANEOUS ASPIRATION BIOPSY of deep organ using interventional imaging techniques - but not including imaging, where the biopsy is sent for pathological examination (Anaes.)
30094	(See para TN.8.7 of explanatory notes to this Category) Fee: \$189.40 Benefit: 75% = \$142.05 85% = \$161.00
30096	DIAGNOSTIC SCALENE NODE BIOPSY, by open procedure, where the specimen excised is sent for

T8. SUI	IRGICAL OPERATIONS 1. G	ENERAL
	pathological examination (Anaes.)	-
	(See para TN.8.7 of explanatory notes to this Category) Fee: \$183.90 Benefit: 75% = \$137.95 85% = \$156.35	
	Personal performance of a Synacthen Stimulation Test, including associated consultation; by a practitioner with resuscitation training and access to facilities where life support procedures car implemented, if:	
	 a. serum cortisol at 0830-0930 hours on any day in the preceding month has been measu greater than 100 nmol/L but less than 400 nmol/L; or b. in a patient who is acutely unwell and adrenal insufficiency is suspected. 	red at
30097	(See para TN.8.139 of explanatory notes to this Category) Fee: \$97.15 Benefit: 75% = \$72.90 85% = \$82.60	
30077	SINUS, excision of, involving superficial tissue only (Anaes.)	
30099	Fee: \$90.00 Benefit: 75% = \$67.50 85% = \$76.50	
30099	SINUS, excision of, involving muscle and deep tissue (Anaes.)	
20102		
30103	Fee: \$183.90 Benefit: 75% = \$137.95 85% = \$156.35 PRE-AURICULAR SINUS, on a person 10 years of age or over. Excision of, (Anaes.)	
20101		
30104	Fee: \$126.90 Benefit: 75% = \$95.20 85% = \$107.90	
	PRE-AURICULAR SINUS, on a person under 10 years of age. Excision of, (Anaes.)	
30105	Fee: \$164.95 Benefit: 75% = \$123.75 85% = \$140.25	
	GANGLION OR SMALL BURSA, excision of, other than a service associated with a service another item in this Group applies (Anaes.)	to which
30107	Fee: \$219.95 Benefit: 75% = \$165.00 85% = \$187.00	
	BURSA (LARGE), INCLUDING OLECRANON, CALCANEUM OR PATELLA, excision of (Assist.)	f (Anaes.)
30111	Fee: \$371.50 Benefit: 75% = \$278.65 85% = \$315.80	
	BURSA, SEMIMEMBRANOSUS (Baker's cyst), excision of (Anaes.) (Assist.)	
30114	Fee: \$371.50 Benefit: 75% = \$278.65	
	Lipectomy, wedge excision of abdominal apron that is a direct consequence of significant weight not being a service associated with a service to which item 30168, 30171, 30172, 30176, 30177, 45530, 45564 or 45565 applies, if:	
	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and	
	(b) the abdominal apron interferes with the activities of daily living; and	
	(c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy	e
	(H) (Anaes.) (Assist.)	
30165	(See para TN.8.8 of explanatory notes to this Category) Fee: \$454.85 Benefit: 75% = \$341.15	

T8. SUR	RGICAL OPERATIONS	1. GENERAL
	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct conse significant weight loss, not being a service associated with a service to which item 30165 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if:	
	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has faile conventional (or non surgical) treatment; and	ed 3 months of
	(b) the redundant skin and fat interferes with the activities of daily living; and	
	(c) the weight has been stable for at least 6 months following significant weight loss prior lipectomy; and	to the
	(d) the procedure involves 1 excision only	
	(H) (Anaes.) (Assist.)	
30168	(See para TN.8.8 of explanatory notes to this Category) Fee: \$454.85 Benefit: 75% = \$341.15	
	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct conse significant weight loss, not being a service associated with a service to which item 30165, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if:	
	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has faile conventional (or non surgical) treatment; and	ed 3 months of
	(b) the redundant skin and fat interferes with the activities of daily living; and	
	(c) the weight has been stable for at least 6 months following significant weight loss prior lipectomy; and	to the
	(d) the procedure involves 2 excisions only	
	(H) (Anaes.) (Assist.)	
30171	(See para TN.8.8 of explanatory notes to this Category) Fee: \$691.75 Benefit: 75% = \$518.85	
	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct conse significant weight loss, not being a service associated with a service to which item 30165, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if:	
	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has faile conventional (or non surgical) treatment; and	ed 3 months of
	(b) the redundant skin and fat interferes with the activities of daily living; and	
	(c) the weight has been stable for at least 6 months following significant weight loss prior lipectomy; and	to the
	(d) the procedure involves 3 or more excisions	
	(H) (Anaes.) (Assist.)	
30172	(See para TN.8.8 of explanatory notes to this Category) Fee: \$691.75 Benefit: 75% = \$518.85	
30176	Lipectomy, radical abdominoplasty (Pitanguy type or similar), with excision of skin and s	ubcutaneous

T8. SUF	RGICAL OPERATIONS 1. GENERAL
	tissue, repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30177, 30179, 45530, 45564 or 45565 applies, if the patient has previously had a massive intra-abdominal or pelvic tumour surgically removed (Anaes.) (Assist.)
	(See para TN.8.8 of explanatory notes to this Category) Fee: \$985.70 Benefit: 75% = \$739.30
	Lipectomy, excision of skin and subcutaneous tissue associated with redundant abdominal skin and fat that is a direct consequence of significant weight loss, in conjunction with a radical abdominoplasty (Pitanguy type or similar), with or without repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30179, 45530, 45564 or 45565 applies, if:
	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and
	(b) the redundant skin and fat interferes with the activities of daily living; and
	(c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy
	(H) (Anaes.) (Assist.)
30177	(See para TN.8.8 of explanatory notes to this Category) Fee: \$985.70 Benefit: 75% = \$739.30
	Circumferential lipectomy, as an independent procedure, to correct circumferential excess of redundant skin and fat that is a direct consequence of significant weight loss, with or without a radical abdominoplasty (Pitanguy type or similar), not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 45530, 45564 or 45565 applies, if:
	(a) the circumferential excess of redundant skin and fat is complicated by intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and
	(b) the circumferential excess of redundant skin and fat interferes with the activities of daily living; and
	(c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy
	(H) (Anaes.) (Assist.)
30179	(See para TN.8.8 of explanatory notes to this Category) Fee: \$1,213.15 Benefit: 75% = \$909.90
	AXILLARY HYPERHIDROSIS, partial excision for (Anaes.)
30180	Fee: \$136.50 Benefit: 75% = \$102.40 85% = \$116.05
	AXILLARY HYPERHIDROSIS, total excision of sweat gland bearing area (Anaes.)
30183	Fee: \$246.50 Benefit: 75% = \$184.90 85% = \$209.55
	PALMAR OR PLANTAR WARTS, removal of, by carbon dioxide laser or erbium laser, requiring admission to a hospital, or when performed by a specialist in the practice of his/her specialty, (5 or more warts) (Anaes.)
30187	(See para TN.8.9 of explanatory notes to this Category)

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	Fee: \$256.95 Benefit: 75% = \$192.75 85% = \$218.45	
	WARTS or MOLLUSCUM CONTAGIOSUM (one or more), remo chemical means), where undertaken in the operating theatre of a hos with a service to which another item in this Group applies (H) (Anacomplete Control of the Contro	spital, not being a service associated
30189	(See para TN.8.9 of explanatory notes to this Category) Fee: \$147.30 Benefit: 75% = \$110.50	
	Angiofibromas, trichoepitheliomas or other severely disfiguring tun melanocytic naevi, sebaceous hyperplasia, dermatosis papulosa nigrand seborrheic or viral warts), suitable for laser ablation as confirme the specialty of dermatology—removal of, by carbon dioxide laser cassociated resurfacing (10 or more tumours) (Anaes.)	ra, Campbell De Morgan angiomas ed by the opinion of a specialist in
30190	Fee: \$397.75 Benefit: 75% = \$298.35 85% = \$338.10	
	Angiofibromas, trichoepithelioma, epidermal naevi, xanthelasma, prangiokeratomas, hereditary haemorrhagic telangiectasia and other sobleeding tumours (excluding melanocytic naevi, sebaceous hyperpla Campbell De Morgan angiomas and seborrheic or viral warts), treat or other appropriate laser (or curettage and fine point diathermy for confirmed by the opinion of a specialist in the specialty of dermatol	everely disfiguring or recurrently asia, dermatosis papulosa nigra, ment of, with carbon dioxide/erbium pyogenic granuloma only), if
30191	Fee: \$63.50 Benefit: 75% = \$47.65 85% = \$54.00	
	PREMALIGNANT SKIN LESIONS (including solar keratoses), tre or more lesions) (Anaes.)	eatment of, by ablative technique (10
30192	(See para TN.8.9 of explanatory notes to this Category) Fee: \$39.55 Benefit: 75% = \$29.70 85% = \$33.65	
	Malignant neoplasm of skin or mucous membrane that has been:	
	(a) proven by histopathology; or	
	(b) confirmed by the opinion of a specialist in the specialty of derma submitted for histologic confirmation;	atology where a specimen has been
	removal of, by serial curettage, or carbon dioxide laser or erbium lassociated cryotherapy or diathermy (Anaes.)	ser excision-ablation, including any
30196	(See para TN.8.10 of explanatory notes to this Category) Fee: \$126.30 Benefit: 75% = \$94.75 85% = \$107.40	
	Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by the opinio of a specialist in the specialty of dermatology—removal of, by liquid nitrogen cryotherapy using repeat freeze thaw cycles	
30202	(See para TN.8.10 of explanatory notes to this Category) Fee: \$48.35 Benefit: 75% = \$36.30 85% = \$41.10	
	Skin lesions, multiple injections with glucocorticoid preparations (A	Anaes.)
30207	Fee: \$44.60 Benefit: 75% = \$33.45 85% = \$37.95	
	Keloid and other skin lesions, extensive, multiple injections of glucocorticoid preparations, if undertake in the operating theatre of a hospital on a patient less than 16 years of age (Anaes.)	
	in the operating theatre of a hospital on a patient less than 16 years of	

T8. SUF	RGICAL OPERAT	IONS 1. GENERAL
	НАЕМАТОМА	, aspiration of (Anaes.)
30216	Fee: \$27.35	Benefit: 75% = \$20.55 85% = \$23.25
		, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to SION WITH DRAINAGE OF (excluding aftercare)
30219	(See para TN.8.4 c Fee: \$27.35	of explanatory notes to this Category) Benefit: 75% = \$20.55 85% = \$23.25
		ATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, ion to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.)
30223	(See para TN.8.4 o Fee: \$162.95	of explanatory notes to this Category) Benefit: 75% = \$122.25
	PERCUTANEO not including im-	US DRAINAGE OF DEEP ABSCESS using interventional imaging techniques - but aging (Anaes.)
30224	Fee: \$237.60	Benefit: 75% = \$178.20 85% = \$202.00
	ABSCESS DRA imaging (Anaes.	INAGE TUBE, exchange of using interventional imaging techniques - but not including)
30225	Fee: \$267.65	Benefit: 75% = \$200.75 85% = \$227.55
	MUSCLE, excis	ion of (LIMITED), or fasciotomy (Anaes.)
30226	Fee: \$149.75	Benefit: 75% = \$112.35 85% = \$127.30
	MUSCLE, excis	ion of (EXTENSIVE) (Anaes.) (Assist.)
30229	Fee: \$272.95	Benefit: 75% = \$204.75 85% = \$232.05
	MUSCLE, RUP	TURED, repair of (limited), not associated with external wound (Anaes.)
30232	Fee: \$223.60	Benefit: 75% = \$167.70 85% = \$190.10
	MUSCLE, RUP	TURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.)
30235	Fee: \$295.70	Benefit: 75% = \$221.80 85% = \$251.35
	FASCIA, DEEP	repair of, FOR HERNIATED MUSCLE (Anaes.)
30238	Fee: \$149.75	Benefit: 75% = \$112.35 85% = \$127.30
	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in this Group applies (Anaes.) (Assist.)	
30241	Fee: \$356.35	Benefit: 75% = \$267.30 85% = \$302.90
	STYLOID PROCESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.)	
30244	Fee: \$356.35	Benefit: 75% = \$267.30
	PAROTID DUC	T, repair of, using micro-surgical techniques (Anaes.) (Assist.)
30246	Fee: \$689.80	Benefit: 75% = \$517.35
	PAROTID GLA	ND, total extirpation of (Anaes.) (Assist.)
30247	Fee: \$739.35	Benefit: 75% = \$554.55
30250		ND, total extirpation of, with preservation of facial nerve (Anaes.) (Assist.)

T8. SUF	RGICAL OPERATI	ONS 1. GENERAL
	Fee: \$1,251.10	Benefit: 75% = \$938.35
	RECURRENT P.	AROTID TUMOUR, excision of, with preservation of facial nerve (Anaes.) (Assist.)
30251	Fee: \$1,921.75	Benefit: 75% = \$1441.35 85% = \$1838.35
	PAROTID GLAN (Assist.)	ND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (Anaes.)
30253	Fee: \$834.05	Benefit: 75% = \$625.55
	SUBMANDIBU	LAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.)
30255	Fee: \$1,110.65	Benefit: 75% = \$833.00
20200	-	LAR GLAND, extirpation of (Anaes.) (Assist.)
30256	Fee: \$445.40	Benefit: 75% = \$334.05
30230	<u> </u>	GLAND, extirpation of (Anaes.)
20250		
30259	Fee: \$198.50	Benefit: 75% = \$148.90 85% = \$168.75
		AND, DILATATION OR DIATHERMY of duct (Anaes.)
30262	Fee: \$58.80	Benefit: 75% = \$44.10 85% = \$50.00
	Salivary gland, re procedures. (Ana	emoval of calculus from duct or meatotomy or marsupialisation, 1 or more such es.)
30266	Fee: \$149.75	Benefit: 75% = \$112.35 85% = \$127.30
	SALIVARY GLA	AND, repair of CUTANEOUS FISTULA OF (Anaes.)
30269	Fee: \$149.75	Benefit: 75% = \$112.35 85% = \$127.30
	TONGUE, partia	l excision of (Anaes.) (Assist.)
30272	Fee: \$295.70	Benefit: 75% = \$221.80 85% = \$251.35
	RADICAL EXCI	SION OF INTRAORAL TUMOUR INVOLVING RESECTION OF MANDIBLE
	AND LYMPH G	LANDS OF NECK (commandotype operation) (Anaes.) (Assist.)
30275	Fee: \$1,762.75	Benefit: 75% = \$1322.10
	TONGUE TIE, re	epair of, not being a service to which another item in this Group applies (Anaes.)
30278	Fee: \$46.50	Benefit: 75% = \$34.90 85% = \$39.55
		MANDIBULAR FRENULUM or MAXILLARY FRENULUM, repair of, in a person over, under general anaesthesia (Anaes.)
30281	Fee: \$119.50	Benefit: 75% = \$89.65 85% = \$101.60
		UCOUS CYST OF MOUTH, removal of (Anaes.)
30283	Fee: \$204.70	Benefit: 75% = \$153.55 85% = \$174.00
.50205		YST, on a person 10 years of age or over. Removal of, (Anaes.) (Assist.)
20207		
30286	Fee: \$397.85	Benefit: 75% = \$298.40 85% = \$338.20 YST, on a person under 10 years of age. Removal of, (Anaes.) (Assist.)
30287	Fee: \$517.20	Benefit: 75% = \$387.90 85% = \$439.65

T8. SUF	RGICAL OPERAT	IONS	1. GENERAL
	BRANCHIAL F	ISTULA, on a person 10 years of age or over.	Removal of, (Anaes.) (Assist.)
30289	Fee: \$502.25	Benefit: 75% = \$376.70	
	CERVICAL OESOPHAGOSTOMY or CLOSURE OF CERVICAL OESOPHAGOSTOMY with or without plastic repair (Anaes.) (Assist.)		
30293	Fee: \$445.40	Benefit: 75% = \$334.05 85% = \$378.60	
		SOPHAGECTOMY with tracheostomy and or LARYNGOPHARYNGECTOMY with tract)	
30294	Fee: \$1,762.75	Benefit: 75% = \$1322.10	
	THYROIDECTO	DMY, total (Anaes.) (Assist.)	
30296	(See para TN.8.13' Fee: \$1,023.70	7 of explanatory notes to this Category) Benefit: 75% = \$767.80	
	THYROIDECTO	OMY following previous thyroid surgery (Ana	nes.) (Assist.)
30297	(See para TN.8.138 Fee: \$1,023.70	8 of explanatory notes to this Category) Benefit: 75% = \$767.80	
30299	axilla, using pred associated with a	MPH NODE BIOPSY OR BIOPSIES for brea operative lymphoscintigraphy and lymphotrop service to which item 30300, 30302 or 30303 of explanatory notes to this Category) Benefit: 75% = \$478.10	ic dye injection, not being a service
30277	SENTINEL LYN II/III axilla, using	MPH NODE BIOPSY OR BIOPSIES for brea g preoperative lymphoscintigraphy and lymph a service to which item 30299, 30302 or 30303	otropic dye injection, not being a service
30300	(See para TN.8.12 Fee: \$764.90	of explanatory notes to this Category) Benefit: 75% = \$573.70	
	axilla, using lym	MPH NODE BIOPSY OR BIOPSIES for brea photropic dye injection, not being a service as 30303 applies (Anaes.) (Assist.)	
30302	(See para TN.8.12 Fee: \$509.95	of explanatory notes to this Category) Benefit: 75% = \$382.50	
	II/III axilla, using	MPH NODE BIOPSY OR BIOPSIES for brea g lymphotropic dye injection, not being a serv 00 or 30302 applies (Anaes.) (Assist.)	
30303	(See para TN.8.12 Fee: \$611.85	of explanatory notes to this Category) Benefit: 75% = \$458.90	
	TOTAL HEMIT	HYROIDECTOMY (Anaes.) (Assist.)	
30306	(See para TN.8.13 Fee: \$798.65	7, TN.8.138 of explanatory notes to this Category) Benefit: 75% = \$599.00	
	Partial or subtota	ll thyroidectomy (Anaes.) (Assist.)	
30310	(See para TN.8.13' Fee: \$798.65	7 of explanatory notes to this Category) Benefit: 75% = \$599.00	

T8. SUF	RGICAL OPERATIO	NS	1. GENERAL
		CYST or FISTULA or both, on a person 10 years of age or over. glossal duct and portion of hyoid bone (Anaes.) (Assist.)	Radical removal
30314	Fee: \$457.40	Benefit: 75% = \$343.05	
		parathyroidectomy. Removal of 1 or more parathyroid adenoma r an image localised adenoma, including thymectomy.	through a small
	For any particular p	patient - applicable only once per occasion on which the service is	provided.
	Not in association v	with a service to which item 30318, 30317 or 30320 applies. (Anac	es.) (Assist.)
30315	Fee: \$1,139.90	Benefit: 75% = \$854.95	
		tomy. Cervical re-exploration for persistent or recurrent hyperparmy and cervical exploration of the mediastinum.	athyroidism,
	For any particular p	natient - applicable only once per occasion on which the service is	provided.
	Not in association v	with a service to which item 30315, 30318 or 30320 applies. (Anac	es.) (Assist.)
30317	Fee: \$1,364.90	Benefit: 75% = \$1023.70	
		ctomy, exploration and removal of 1 or more adenoma or hyperplached the hymectomy and cervical exploration of the mediastinum	
	For any particular p	natient - applicable only once per occasion on which the service is	provided.
	Not in association v	with a service to which item 30315, 30317 or 30320 applies. (Anac	es.) (Assist.)
30318	Fee: \$1,139.90	Benefit: 75% = \$854.95	
	Removal of a media	astinal parathyroid adenoma via sternotomy or mediastinal thorasc	copic approach.
	For any particular p	natient - applicable only once per occasion on which the service is	provided.
	Not in association v	with a service to which item 30315, 30317 or 30318 applies. (Anac	es.) (Assist.)
30320	Fee: \$1,364.90	Benefit: 75% = \$1023.70	
	Excision of phaeoc (Anaes.) (Assist.)	hromocytoma or extraadrenal paraganglioma via endoscopic or op	pen approach.
30323	Fee: \$1,364.90	Benefit: 75% = \$1023.70	
	Excision of an adre	nocortical tumour or hyperplasia via endoscopic or open approach	n. (Anaes.) (Assist.)
30324	Fee: \$1,364.90	Benefit: 75% = \$1023.70	
		CYST or FISTULA or both, radical removal of, including thyrogne, on a person under 10 years of age (Anaes.) (Assist.)	glossal duct and
30326	Fee: \$594.60	Benefit: 75% = \$445.95	
	LYMPH GLANDS	of GROIN, limited excision of (Anaes.)	
30329	Fee: \$246.95	Benefit: 75% = \$185.25 85% = \$209.95	
	LYMPH GLANDS	of GROIN, radical excision of (Anaes.) (Assist.)	
30330	Fee: \$718.75	Benefit: 75% = \$539.10	

T8. SUF	RGICAL OPERATIONS 1. GENERAL
	LYMPH NODES of AXILLA, limited excision of (sampling) (Anaes.) (Assist.)
30332	Fee: \$346.75 Benefit: 75% = \$260.10
30332	LYMPH NODES of AXILLA, complete excision of, to level I (Anaes.) (Assist.)
30335	(See para TN.8.13 of explanatory notes to this Category) Fee: \$866.85 Benefit: 75% = \$650.15
	LYMPH NODES of AXILLA, complete excision of, to level II or level III (Anaes.) (Assist.)
	(See para TN.8.13 of explanatory notes to this Category)
30336	Fee: \$1,040.25 Benefit: 75% = \$780.20
	LAPAROTOMY (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.)
30373	Fee: \$483.25 Benefit: 75% = \$362.45
	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, Gastrostomy, Gastrotomy, on a person 10 years of age or over. Reduction of intussusception, Removal of Meckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty (adult) or Drainage of pancreas (Anaes.) (Assist.)
30375	(See para TN.8.14 of explanatory notes to this Category) Fee: \$521.25 Benefit: 75% = \$390.95
	LAPAROTOMY INVOLVING DIVISION OF PERITONEAL ADHESIONS (where no other intraabdominal procedure is performed) on a person 10 years of age or over (Anaes.) (Assist.)
30376	Fee: \$521.25 Benefit: 75% = \$390.95
	LAPAROTOMY involving division of adhesions in conjunction with another intraabdominal procedure where the time taken to divide the adhesions is between 45 minutes and 2 hours, on a person 10 years of age or over (Anaes.) (Assist.)
30378	Fee: \$523.70 Benefit: 75% = \$392.80
	LAPAROTOMY WITH DIVISION OF EXTENSIVE ADHESIONS (duration greater than 2 hours) with or without insertion of long intestinal tube (Anaes.) (Assist.)
30379	Fee: \$928.15 Benefit: 75% = \$696.15
	ENTEROCUTANEOUS FISTULA, radical repair of, involving extensive dissection and resection of bowel (Anaes.) (Assist.)
30382	Fee: \$1,306.90 Benefit: 75% = \$980.20
	LAPAROTOMY FOR GRADING OF LYMPHOMA, including splenectomy, liver biopsies, lymph node biopsies and oophoropexy (Anaes.) (Assist.)
	Fee: \$1,099.40 Benefit: 75% = \$824.55
30384	
30384	LAPAROTOMY FOR CONTROL OF POSTOPERATIVE HAEMORRHAGE, where no other procedure is performed (Anaes.) (Assist.)
30384	LAPAROTOMY FOR CONTROL OF POSTOPERATIVE HAEMORRHAGE, where no other
	LAPAROTOMY FOR CONTROL OF POSTOPERATIVE HAEMORRHAGE, where no other procedure is performed (Anaes.) (Assist.)

T8. SUF	IRGICAL OPERATIONS	1. GENERAL		
	LAPAROTOMY for trauma involving 3 or more organs (Anaes.) (Assist.)			
30388	Fee: \$1,597.55 Benefit: 75% = \$1198.20			
	LAPAROSCOPY, diagnostic, not being a service associated with any other laparoscopic person 10 years of age or over (Anaes.)	procedure, on a		
30390	(See para TN.8.15 of explanatory notes to this Category) Fee: \$219.95 Benefit: 75% = \$165.00			
	LAPAROSCOPY with biopsy (Anaes.) (Assist.)			
30391	Fee: \$284.35 Benefit: 75% = \$213.30			
	RADICAL OR DEBULKING OPERATION for advanced intra-abdominal malignancy, omentectomy, as an independent procedure (Anaes.) (Assist.)	with or without		
30392	Fee: \$674.50 Benefit: 75% = \$505.90			
	LAPAROSCOPIC DIVISION OF ADHESIONS in association with another intra-abdom where the time taken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.)	ninal procedure		
30393	Fee: \$523.70 Benefit: 75% = \$392.80			
	LAPAROTOMY for drainage of subphrenic abscess, pelvic abscess, appendiceal abscess appendix or for peritonitis from any cause, with or without appendicectomy (Anaes.) (As			
30394	Fee: \$492.85 Benefit: 75% = \$369.65			
	LAPAROTOMY for gross intra peritoneal sepsis requiring debridement of fibrin, with or without removal of foreign material or enteric contents, with lavage of the entire peritoneal cavity via a major abdominal incision, with or without closure of abdomen and with or without mesh or zipper insertion (Anaes.) (Assist.)			
30396	(See para TN.8.16 of explanatory notes to this Category) Fee: \$1,016.55 Benefit: 75% = \$762.45			
	LAPAROSTOMY, via wound previously made and left open or closed with zipper, invo dressings or packs, and with or without drainage of loculated collections (Anaes.)	lving change of		
30397	Fee: \$232.35 Benefit: 75% = \$174.30			
	LAPAROSTOMY, final closure of wound made at previous operation, after removal of opacks and removal of mesh or zipper if previously inserted (Anaes.) (Assist.)	dressings or		
30399	Fee: \$319.60 Benefit: 75% = \$239.70			
	LAPAROTOMY WITH INSERTION OF PORTACATH for administration of cytotoxic including placement of reservoir (Anaes.) (Assist.)	therapy		
30400	Fee: \$632.50 Benefit: 75% = \$474.40			
	RETROPERITONEAL ABSCESS, drainage of, not involving laparotomy (Anaes.) (Ass.	ist.)		
30402	Fee: \$464.60 Benefit: 75% = \$348.45			
	VENTRAL, INCISIONAL, OR RECURRENT HERNIA OR BURST ABDOMEN, repa without mesh (Anaes.) (Assist.)	ir of with or		
30403	Fee: \$521.25 Benefit: 75% = \$390.95			
30405	VENTRAL OR INCISIONAL HERNIA, (excluding recurrent inguinal or femoral hernia) repair of		

T8. SUF	RGICAL OPERATIO	NS 1. GENERA
	requiring muscle tra	nsposition, mesh hernioplasty or resection of strangulated bowel (Anaes.) (Assist.)
	Fee: \$914.95	Benefit: 75% = \$686.25
	PARACENTESIS A	ABDOMINIS (Anaes.)
30406	Fee: \$52.20	Benefit: 75% = \$39.15 85% = \$44.40
	PERITONEOVENO	OUS shunt, insertion of (Anaes.) (Assist.)
30408	Fee: \$392.10	Benefit: 75% = \$294.10
	LIVER BIOPSY, pe	ercutaneous (Anaes.)
30409	Fee: \$174.45	Benefit: 75% = \$130.85 85% = \$148.30
	LIVER BIOPSY by procedure (Anaes.)	wedge excision when performed in conjunction with another intraabdominal
30411	Fee: \$88.80	Benefit: 75% = \$66.60
	LIVER BIOPSY by (Anaes.)	core needle, when performed in conjunction with another intra-abdominal procedu
30412	Fee: \$52.35	Benefit: 75% = \$39.30 85% = \$44.50
	LIVER, subsegmen	tal resection of, (local excision), other than for trauma (Anaes.) (Assist.)
30414	Fee: \$689.80	Benefit: 75% = \$517.35
	LIVER, segmental i	resection of, other than for trauma (Anaes.) (Assist.)
30415	Fee: \$1,379.50	Benefit: 75% = \$1034.65
	LIVER CYST, lapa diameter (Anaes.) (A	roscopic marsupialisation of, where the size of the cyst is greater than 5cm in Assist.)
30416	Fee: \$748.95	Benefit: 75% = \$561.75
	LIVER CYSTS, lap diameter (Anaes.) (A	aroscopic marsupialisation of 5 or more, including any cyst greater than 5cm in Assist.)
30417	Fee: \$1,123.40	Benefit: 75% = \$842.55
	LIVER, lobectomy	of, other than for trauma (Anaes.) (Assist.)
30418	Fee: \$1,597.55	Benefit: 75% = \$1198.20
		, destruction of, by hepatic cryotherapy, not being a service associated with a service or 50952 applies (Anaes.) (Assist.)
30419	Fee: \$817.10	Benefit: 75% = \$612.85 85% = \$733.70
	LIVER, TRI-SEGM (Assist.)	IENTAL RESECTION (extended lobectomy) of, other than for trauma (Anaes.)
30421	Fee: \$1,996.55	Benefit: 75% = \$1497.45
	LIVER, repair of su	perficial laceration of, for trauma (Anaes.) (Assist.)
30422	Fee: \$675.35	Benefit: 75% = \$506.55
30425	LIVER, repair of de	ep multiple lacerations of, or debridement of, for trauma (Anaes.) (Assist.)

RGICAL OPERATION	ONS 1. GENERAL
Fee: \$1,306.90	Benefit: 75% = \$980.20
LIVER, segmenta	ll resection of, for trauma (Anaes.) (Assist.)
Fee: \$1,560.95	Benefit: 75% = \$1170.75
LIVER, lobectom	y of, for trauma (Anaes.) (Assist.)
Fee: \$1,670.00	Benefit: 75% = \$1252.50 85% = \$1586.60
LIVER, extended	lobectomy (tri-segmental resection) of, for trauma (Anaes.) (Assist.)
Fee: \$2,323.30	Benefit: 75% = \$1742.50 85% = \$2239.90
LIVER ABSCES	S, open abdominal drainage of (Anaes.) (Assist.)
Fee: \$521.25	Benefit: 75% = \$390.95 85% = \$443.10
LIVER ABSCES	S (multiple), open abdominal drainage of (Anaes.) (Assist.)
Fee: \$726.05	Benefit: 75% = \$544.55
	OF LIVER, peritoneum or viscus, complete removal of contents of, with or without adicles (Anaes.) (Assist.)
Fee: \$588.15	Benefit: 75% = \$441.15
	OF LIVER, peritoneum or viscus, complete removal of contents of, with or without adicles, with omentoplasty or myeloplasty (Anaes.) (Assist.)
Fee: \$653.45	Benefit: 75% = \$490.10
	OF LIVER, total excision of, by cysto-pericystectomy (membrane plus fibrous wall)
Fee: \$813.30	Benefit: 75% = \$610.00
HYDATID CYST	OF LIVER, excision of, with drainage and excision of liver tissue (Anaes.) (Assist.)
Fee: \$1,150.85	Benefit: 75% = \$863.15 85% = \$1067.45
OPERATIVE UL	OLANGIOGRAPHY OR OPERATIVE PANCREATOGRAPHY OR INTRA TRASOUND of the biliary tract (including 1 or more examinations performed during Anaes.) (Assist.)
Fee: \$185.60	Benefit: 75% = \$139.20
interventional ima	AAM, percutaneous transhepatic, and insertion of biliary drainage tube, using aging techniques - but not including imaging, not being a service associated with a tem 30451 applies (Anaes.) (Assist.)
Fee: \$526.40	Benefit: 75% = \$394.80 85% = \$447.45
INTRA OPERAT	TVE ULTRASOUND for staging of intra abdominal tumours (Anaes.)
Fee: \$136.25	Benefit: 75% = \$102.20
CHOLEDOCHOS	SCOPY in conjunction with another procedure (Anaes.)
Fee: \$185.60	Benefit: 75% = \$139.20
	TOMY (Anaes.) (Assist.)
Fee: \$739.35	Benefit: 75% = \$554.55
	LIVER, segmenta Fee: \$1,560.95 LIVER, lobectom Fee: \$1,670.00 LIVER, extended Fee: \$2,323.30 LIVER ABSCESS Fee: \$521.25 LIVER ABSCESS Fee: \$726.05 HYDATID CYST suture of biliary ra Fee: \$588.15 HYDATID CYST suture of biliary ra Fee: \$653.45 HYDATID CYST (Anaes.) (Assist.) Fee: \$813.30 HYDATID CYST (Anaes.) (Assist.) Fee: \$1,150.85 OPERATIVE CH OPERATIVE CH OPERATIVE UL the 1 operation) (A Fee: \$185.60 CHOLANGIOGR interventional ima service to which i Fee: \$526.40 INTRA OPERATI Fee: \$136.25 CHOLEDOCHOS Fee: \$185.60

T8. SUF	RGICAL OPERATI	ONS 1. GENERAL	
	LAPAROSCOPI	C CHOLECYSTECTOMY (Anaes.) (Assist.)	
30445	Fee: \$739.35	Benefit: 75% = \$554.55	
		C CHOLECYSTECTOMY when procedure is completed by laparotomy (Anaes.)	
30446	Fee: \$739.35	Benefit: 75% = \$554.55	
	LAPAROSCOPI duct (Anaes.) (As	C CHOLECYSTECTOMY, involving removal of common duct calculi via the cystic ssist.)	
30448	Fee: \$972.90	Benefit: 75% = \$729.70	
	LAPAROSCOPIC CHOLECYSTECTOMY with removal of common duct calculi via laparoscopic choledochotomy (Anaes.) (Assist.)		
30449	Fee: \$1,081.85	Benefit: 75% = \$811.40	
		BILIARY OR RENAL TRACT, extraction of, using interventional imaging techniques ice associated with a service to which items 36627, 36630, 36645 or 36648 applies	
30450	Fee: \$524.40	Benefit: 75% = \$393.30 85% = \$445.75	
		NAGE TUBE, exchange of, using interventional imaging techniques - but not including a service associated with a service to which item 30440 applies (Anaes.) (Assist.)	
30451	Fee: \$267.65	Benefit: 75% = \$200.75 85% = \$227.55	
	CHOLEDOCHO (Anaes.) (Assist.)	SCOPY with balloon dilation of a stricture or passage of stent or extraction of calculi	
30452	Fee: \$377.50	Benefit: 75% = \$283.15	
	CHOLEDOCHO (Assist.)	TOMY (with or without cholecystectomy), with or without removal of calculi (Anaes.)	
30454	Fee: \$862.50	Benefit: 75% = \$646.90	
		TOMY (with or without cholecystectomy), with removal of calculi including biliary nosis (Anaes.) (Assist.)	
30455	Fee: \$1,014.05	Benefit: 75% = \$760.55	
	CHOLEDOCHO (Assist.)	TOMY, intrahepatic, involving removal of intrahepatic bile duct calculi (Anaes.)	
30457	Fee: \$1,379.50	Benefit: 75% = \$1034.65 85% = \$1296.10	
	TRANSDUODENAL OPERATION ON SPHINCTER OF ODDI, involving 1 or more of, removal of calculi, sphincterotomy, sphincteroplasty, biopsy, local excision of peri-ampullary or duodenal tumour, sphincteroplasty of the pancreatic duct, pancreatic duct septoplasty, with or without choledochotomy (Anaes.) (Assist.)		
30458	Fee: \$1,014.05	Benefit: 75% = \$760.55	
		DUODENOSTOMY, CHOLECYSTOENTEROSTOMY, JEJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior biliary surgery s.) (Assist.)	
30460	Fee: \$862.50	Benefit: 75% = \$646.90	

T8. SUF	RGICAL OPERATIONS 1. (GENERAL	
	RADICAL RESECTION of porta hepatis with biliary-enteric anastomoses, not being a servic associated with a service to which item 30443, 30454, 30455, 30458 or 30460 applies (Anaes.		
30461	Fee: \$1,478.40 Benefit: 75% = \$1108.80		
	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, with 2 duc anastomoses (Anaes.) (Assist.)	t	
30463	Fee: \$1,815.20 Benefit: 75% = \$1361.40		
	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, involving 2 anastomoses or resection of segment or major portion of segment of liver (Anaes.) (Assist.)	more than	
30464	Fee: \$2,178.25 Benefit: 75% = \$1633.70		
	INTRAHEPATIC biliary bypass of left hepatic ductal system by Roux-en-Y loop to periphera system (Anaes.) (Assist.)	al ductal	
30466	Fee: \$1,256.05 Benefit: 75% = \$942.05		
	INTRAHEPATIC BYPASS of right hepatic ductal system by Roux-en-Y loop to peripheral d system (Anaes.) (Assist.)	uctal	
30467	Fee: \$1,553.70 Benefit: 75% = \$1165.30		
	BILIARY STRICTURE, repair of, after 1 or more operations on the biliary tree (Anaes.) (Ass	sist.)	
30469	Fee: \$1,720.90 Benefit: 75% = \$1290.70 85% = \$1637.50		
	HEPATIC OR COMMON BILE DUCT, repair of, as the primary procedure subsequent to patotal transection of bile duct or ducts (Anaes.) (Assist.)	rtial or	
30472	Fee: \$929.35 Benefit: 75% = \$697.05 85% = \$845.95		
	Oesophagoscopy (not being a service to which item 41816 or 41822 applies), gastroscopy, duodenoscopy or panendoscopy (1 or more such procedures), with or without bid being a service associated with a service to which item 30478 or 30479 applies. (Anaes.)	opsy, not	
30473	(See para TN.8.17 of explanatory notes to this Category) Fee: \$177.10 Benefit: 75% = \$132.85 85% = \$150.55		
	Endoscopic dilatation of stricture of upper gastrointestinal tract (including the use of imaging intensification where clinically indicated) (Anaes.)		
30475	(See para TN.8.17, TN.8.133 of explanatory notes to this Category) Fee: \$348.95 Benefit: 75% = \$261.75 85% = \$296.65		
	Oesophagoscopy (other than a service to which item 41816, 41822 or 41825 applies), gastrosoduodenoscopy, panendoscopy or push enteroscopy, one or more such procedures, if:	сору,	
	(a) the procedures are performed using one or more of the following endoscopic procedures:		
	(i) polypectomy;		
	(ii) sclerosing or adrenalin injections;		
	(iii) banding;		
	(iv) endoscopic clips;		
30478	(v) haemostatic powders;		

T8. SUI	RGICAL OPERATIONS	1. GENERAL
	(vi) diathermy;	
	(vii) argon plasma coagulation; and	
	(b) the procedures are for the treatment of one or more of the following:	
	(i) upper gastrointestinal tract bleeding;	
	(ii) polyps;	
	(iii) removal of foreign body;	
	(iv) oesophageal or gastric varices;	
	(v) peptic ulcers;	
	(vi) neoplasia;	
	(vii) benign vascular lesions;	
	(viii) strictures of the gastrointestinal tract;	
	(ix) tumorous overgrowth through or over oesophageal stents;	
	other than a service associated with a service to which item 30473 or 30479 applies (See para TN.8.17 of explanatory notes to this Category) Fee: \$245.55 Benefit: 75% = \$184.20 85% = \$208.75	(Anaes.)
	Endoscopy with laser therapy, for the treatment of one or more of the following:	
	(a) neoplasia;	
	(b) benign vascular lesions;	
	(c) strictures of the gastrointestinal tract;	
	(d) tumorous overgrowth through or over oesophageal stents;	
	(e) peptic ulcers;	
	(f) angiodysplasia;	
	(g) gastric antral vascular ectasia;	
	(h) post-polypectomy bleeding;	
	other than a service associated with a service to which item 30473 or 30478 applies ((Anaes.)
30479	(See para TN.8.17 of explanatory notes to this Category) Fee: \$476.10 Benefit: 75% = \$357.10 85% = \$404.70	

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	PERCUTANEOUS GASTROSTOMY (initial procedure):	
	(a) including any associated imaging services; and	
	(b) excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.)
30481	(See para TN.8.17 of explanatory notes to this Category) Fee: \$357.00 Benefit: 75% = \$267.75 85% = \$303.45	
	PERCUTANEOUS GASTROSTOMY (repeat procedure):	
	(a) including any associated imaging services; and	
	(b) excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.)
30482	Fee: \$253.85 Benefit: 75% = \$190.40 85% = \$215.80	
	GASTROSTOMY BUTTON, CAECOSTOMY ANTEGRADE ENEMA DEVICE (CH STOMAL INDWELLING DEVICE:	AIT etc.) or
	(a) non-endoscopic insertion of; or	
	(b) non-endoscopic replacement of;	
	on a person 10 years of age or over, excluding the insertion of a device for the purpose of weight loss (Anaes.)	of facilitating
30483	Fee: \$177.05 Benefit: 75% = \$132.80 85% = \$150.50	
	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (Anaes.)	
30484	(See para TN.8.17 of explanatory notes to this Category) Fee: \$364.90 Benefit: 75% = \$273.70 85% = \$310.20	
	ENDOSCOPIC SPHINCTEROTOMY with or without extraction of stones from commo (Anaes.)	on bile duct
30485	(See para TN.8.17 of explanatory notes to this Category) Fee: \$563.30 Benefit: 75% = \$422.50 85% = \$479.90	
	SMALL BOWEL INTUBATION as an independent procedure (Anaes.)	
30488	Fee: \$90.00 Benefit: 75% = \$67.50 85% = \$76.50	
	OESOPHAGEAL PROSTHESIS, insertion of, including endoscopy and dilatation (Ana	es.)
30490	(See para TN.8.17 of explanatory notes to this Category) Fee: \$526.40 Benefit: 75% = \$394.80 85% = \$447.45	
	BILE DUCT, ENDOSCOPIC STENTING OF (including endoscopy and dilatation) (Ar	aes.)
30491	(See para TN.8.17 of explanatory notes to this Category) Fee: \$555.35 Benefit: 75% = \$416.55 85% = \$472.05	
	BILE DUCT, PERCUTANEOUS STENTING OF (including dilatation when performed interventional imaging techniques - but not including imaging (Anaes.)	l), using
30492	Fee: \$787.30 Benefit: 75% = \$590.50	
	ENDOSCOPIC BILIARY DILATATION (Anaes.)	
30494	(See para TN.8.17 of explanatory notes to this Category)	

T8. SUF	RGICAL OPERAT	IONS 1. GENERAL
	Fee: \$420.50	Benefit: 75% = \$315.40
	PERCUTANEO	US BILIARY DILATATION for biliary stricture, using interventional imaging
	techniques - but	not including imaging (Anaes.)
30495	Fee: \$787.30	Benefit: 75% = \$590.50
	VAGOTOMY, t	runcal or selective, with or without pyloroplasty or gastroenterostomy (Anaes.) (Assist.)
30496	Fee: \$588.15	Benefit: 75% = \$441.15 85% = \$504.75
	VAGOTOMY at	nd ANTRECTOMY (Anaes.) (Assist.)
30497	Fee: \$701.30	Benefit: 75% = \$526.00
	VAGOTOMY, h	ighly selective (Anaes.) (Assist.)
30499	Fee: \$834.05	Benefit: 75% = \$625.55
	VAGOTOMY, h	nighly selective with duodenoplasty for peptic stricture (Anaes.) (Assist.)
30500	Fee: \$893.10	Benefit: 75% = \$669.85 85% = \$809.70
20200		highly selective, with dilatation of pylorus (Anaes.) (Assist.)
30502	Fee: \$985.70	Benefit: 75% = \$739.30
30302		ANTRECTOMY, or both, for peptic ulcer following previous operation for peptic
30503	Fee: \$1,103.80	Benefit: 75% = \$827.85 85% = \$1020.40
30303		PTIC ULCER, control of, involving suture of bleeding point or wedge excision (Anaes.)
	(Assist.)	
30505	Fee: \$551.85	Benefit: 75% = \$413.90
		PTIC ULCER, control of, involving suture of bleeding point or wedge excision, and ploroplasty or gastroenterostomy (Anaes.) (Assist.)
30506	Fee: \$965.75	Benefit: 75% = \$724.35
		PTIC ULCER, control of, involving suture of bleeding point or wedge excision, and wagotomy (Anaes.) (Assist.)
30508	Fee: \$1,016.55	Benefit: 75% = \$762.45
	BLEEDING PER (Anaes.) (Assist.	PTIC ULCER, control of, involving gastric resection (other than wedge resection)
30509	Fee: \$1,016.55	Benefit: 75% = \$762.45 85% = \$933.15
		ny (including gastroduodenostomy) or enterocolostomy or enteroenterostomy, not being h any of items 31569 to 31581 apply (Anaes.) (Assist.)
30515	Fee: \$704.35	Benefit: 75% = \$528.30
	GASTROENTE (Anaes.) (Assist.	ROSTOMY, PYLOROPLASTY or GASTRODUODENOSTOMY, reconstruction of)
30517	Fee: \$922.20	Benefit: 75% = \$691.65
30518	Partial gastrector	my, not being a service associated with a service to which any of items 31569 to 31581

T8. SUF	RGICAL OPERATION	IS 1. GENERAL
	apply (Anaes.) (Assi	st.)
	Fee: \$987.50	Benefit: 75% = \$740.65
	GASTRIC TUMOU (Anaes.) (Assist.)	R, removal of, by local excision, not being a service to which item 30518 applies
30520	Fee: \$675.35	Benefit: 75% = \$506.55
	GASTRECTOMY, 7	ΓΟΤΑL, for benign disease (Anaes.) (Assist.)
30521	Fee: \$1,444.90	Benefit: 75% = \$1083.70
	GASTRECTOMY, S (Anaes.) (Assist.)	SUBTOTAL RADICAL, for carcinoma, (including splenectomy when performed)
30523	(See para TN.8.18 of e Fee: \$1,510.10	xplanatory notes to this Category) Benefit: 75% = \$1132.60
		FOTAL RADICAL, for carcinoma (including extended node dissection and distal splenectomy when performed) (Anaes.) (Assist.)
30524	Fee: \$1,662.65	Benefit: 75% = \$1247.00
		FOTAL, and including lower oesophagus, performed by left thoraco-abdominal of diaphragmatic hiatus, (including splenectomy when performed) (Anaes.) (Assist.)
30526	Fee: \$2,156.35	Benefit: 75% = \$1617.30
		ERATION by fundoplasty, via abdominal or thoracic approach, with or without agmatic hiatus not being a service to which item 30601 applies (Anaes.) (Assist.)
30527	(See para TN.8.19 of e Fee: \$871.30	xplanatory notes to this Category) Benefit: 75% = \$653.50
	ANTIREFLUX oper (Anaes.) (Assist.)	ration by fundoplasty, with OESOPHAGOPLASTY for stricture or short oesophagus
30529	(See para TN.8.19 of e Fee: \$1,306.90	xplanatory notes to this Category) Benefit: 75% = \$980.20
	ANTIREFLUX oper	ration by cardiopexy, with or without fundoplasty (Anaes.) (Assist.)
30530	(See para TN.8.19 of e Fee: \$784.20	xplanatory notes to this Category) Benefit: 75% = \$588.15
		TRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, with or e diaphragmatic hiatus, by laparoscopy or open operation (Anaes.) (Assist.)
30532	(See para TN.8.19 of e Fee: \$900.45	xplanatory notes to this Category) Benefit: 75% = \$675.35
		TRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, WITH vith or without closure of the diaphragmatic hiatus, by laparoscopy or open operation
30533	(See para TN.8.19 of e Fee: \$1,071.00	xplanatory notes to this Category) Benefit: 75% = \$803.25
	OESOPHAGECTON (Anaes.) (Assist.)	MY with gastric reconstruction by abdominal mobilisation and thoracotomy
30535	Fee: \$1,696.65	Benefit: 75% = \$1272.50

T8. SUF	RGICAL OPERATION	ONS	1. GENERAL
		OMY involving gastric reconstruction by abdominal mobilisation, thorace neck or chest - 1 surgeon (Anaes.) (Assist.)	cotomy and
30536	Fee: \$1,720.90	Benefit: 75% = \$1290.70	
		OMY involving gastric reconstruction by abdominal mobilisation, thorace neck or chest- conjoint surgery, principal surgeon (including aftercare) (
30538	Fee: \$1,190.80	Benefit: 75% = \$893.10	
		OMY involving gastric reconstruction by abdominal mobilisation, thorace neck or chest - conjoint surgery, co-surgeon (Assist.)	cotomy and
30539	Fee: \$871.30	Benefit: 75% = \$653.50	
		OMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisal posterior or anterior mediastinal placement - 1 surgeon (Anaes.) (Assist.	
30541	Fee: \$1,517.50	Benefit: 75% = \$1138.15	
	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.)		
30542	Fee: \$1,031.10	Benefit: 75% = \$773.35	
		OMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisal posterior or anterior mediastinal placement - conjoint surgery, co-surged	
30544	Fee: \$755.20	Benefit: 75% = \$566.40	
		OMY with colon or jejunal anastomosis, (abdominal and thoracic mobiliosis) - 1 surgeon (Anaes.) (Assist.)	sation with
30545	Fee: \$1,837.10	Benefit: 75% = \$1377.85	
		OMY with colon or jejunal anastomosis, (abdominal and thoracic mobiliosis) - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Anaes.)	
30547	Fee: \$1,263.35	Benefit: 75% = \$947.55 85% = \$1179.95	
		OMY with colon or jejunal anastomosis, (abdominal and thoracic mobiliosis) - conjoint surgery, co-surgeon (Assist.)	sation with
30548	Fee: \$943.80	Benefit: 75% = \$707.85 85% = \$860.40	
30548	OESOPHAGECT	Benefit: 75% = \$707.85 85% = \$860.40 COMY with colon or jejunal replacement (abdominal and thoracic mobilis dicle in the neck) - 1 surgeon (Anaes.) (Assist.)	sation with
30548	OESOPHAGECT	OMY with colon or jejunal replacement (abdominal and thoracic mobilis	sation with
	OESOPHAGECTO anastomosis of peo Fee: \$2,062.20 OESOPHAGECTO	OMY with colon or jejunal replacement (abdominal and thoracic mobilis dicle in the neck) - 1 surgeon (Anaes.) (Assist.)	sation with
	OESOPHAGECTO anastomosis of peo Fee: \$2,062.20 OESOPHAGECTO anastomosis of peo	OMY with colon or jejunal replacement (abdominal and thoracic mobilis dicle in the neck) - 1 surgeon (Anaes.) (Assist.) Benefit: 75% = \$1546.65 OMY with colon or jejunal replacement (abdominal and thoracic mobilis	sation with
30550	OESOPHAGECTO anastomosis of peo Fee: \$2,062.20 OESOPHAGECTO anastomosis of peo (Assist.) Fee: \$1,423.15 OESOPHAGECTO	OMY with colon or jejunal replacement (abdominal and thoracic mobilis dicle in the neck) - 1 surgeon (Anaes.) (Assist.) Benefit: 75% = \$1546.65 OMY with colon or jejunal replacement (abdominal and thoracic mobilis dicle in the neck) - conjoint surgery, principal surgeon (including aftercare)	sation with re) (Anaes.)

T8. SUF	RGICAL OPERATI	ONS 1. GENERAL
	OESOPHAGECT	TOMY with reconstruction by free jejunal graft - 1 surgeon (Anaes.) (Assist.)
30554	Fee: \$2,294.45	Benefit: 75% = \$1720.85
		TOMY with reconstruction by free jejunal graft - conjoint surgery, principal surgeon are) (Anaes.) (Assist.)
30556	Fee: \$1,582.80	Benefit: 75% = \$1187.10
	OESOPHAGECT	TOMY with reconstruction by free jejunal graft - conjoint surgery, co-surgeon (Assist.)
30557	Fee: \$1,169.00	Benefit: 75% = \$876.75
	OESOPHAGUS,	local excision for tumour of (Anaes.) (Assist.)
30559	Fee: \$849.55	Benefit: 75% = \$637.20 85% = \$766.15
	OESOPHAGEAI	PERFORATION, repair of, by thoracotomy (Anaes.) (Assist.)
30560	Fee: \$943.80	Benefit: 75% = \$707.85
		Y or COLOSTOMY, closure of (not involving resection of bowel), on a person 10 ver (Anaes.) (Assist.)
30562	Fee: \$595.00	Benefit: 75% = \$446.25
	COLOSTOMY C (Assist.)	OR ILEOSTOMY, refashioning of, on a person 10 years of age or over (Anaes.)
30563	Fee: \$595.00	Benefit: 75% = \$446.25 85% = \$511.60
	SMALL BOWEL	STRICTUREPLASTY for chronic inflammatory bowel disease (Anaes.) (Assist.)
30564	Fee: \$772.30	Benefit: 75% = \$579.25
	SMALL INTEST (Assist.)	TNE, resection of, without anastomosis (including formation of stoma) (Anaes.)
30565	Fee: \$871.30	Benefit: 75% = \$653.50
	SMALL INTESTINE, resection of, with anastomosis, on a person 10 years of age or over (Anaes.) (Assist.)	
30566	Fee: \$967.85	Benefit: 75% = \$725.90
	INTRAOPERAT (Assist.)	IVE ENTEROTOMY for visualisation of the small intestine by endoscopy (Anaes.)
30568	Fee: \$726.05	Benefit: 75% = \$544.55
		EXAMINATION of SMALL BOWEL with flexible endoscope passed at laparotomy, iopsies (Anaes.) (Assist.)
30569	Fee: \$370.20	Benefit: 75% = \$277.65
	APPENDICECTO over (Anaes.) (As	OMY, not being a service to which item 30574 applies on a person 10 years of age or ssist.)
30571	Fee: \$445.40	Benefit: 75% = \$334.05
	LAPAROSCOPIO	C APPENDICECTOMY, on a person 10 years of age or over (Anaes.) (Assist.)
30572	Fee: \$445.40	Benefit: 75% = \$334.05

T8. SUF	RGICAL OPERATION	DNS 1. GENERAL
	NOTE: Multiple C	Pperation and Multiple Anaesthetic rules apply to this item
	APPENDICECTO through the same is	MY, when performed in conjunction with any other intraabdominal procedure ncision (Anaes.)
30574	Fee: \$123.25	Benefit: 75% = \$92.45
	PANCREATIC Adissection (Anaes.	BSCESS, laparotomy and external drainage of, not requiring retro-pancreatic (Assist.)
30575	Fee: \$512.70	Benefit: 75% = \$384.55
		ECROSECTOMY for PANCREATIC NECROSIS or ABSCESS FORMATION uncreatic or retro-pancreatic dissection, excluding aftercare (Anaes.) (Assist.)
30577	Fee: \$1,089.15	Benefit: 75% = \$816.90
	ENDOCRINE TU pancreatic tumour	MOUR, exploration of pancreas or duodenum, followed by local excision of (Anaes.) (Assist.)
30578	Fee: \$1,147.20	Benefit: 75% = \$860.40
	ENDOCRINE TU tumour (Anaes.) (A	MOUR, exploration of pancreas or duodenum, followed by local excision of duodenal Assist.)
30580	Fee: \$1,045.40	Benefit: 75% = \$784.05
	ENDOCRINE TU (Assist.)	MOUR, exploration of pancreas or duodenum for, but no tumour found (Anaes.)
30581	Fee: \$762.35	Benefit: 75% = \$571.80
	DISTAL PANCRI	EATECTOMY (Anaes.) (Assist.)
30583	Fee: \$1,194.25	Benefit: 75% = \$895.70
	PANCREATICO- pylorus (Anaes.) (DUODENECTOMY, WHIPPLE'S OPERATION, with or without preservation of Assist.)
30584	Fee: \$1,762.75	Benefit: 75% = \$1322.10
	PANCREATIC C means (Anaes.) (A	YST ANASTOMOSIS TO STOMACH OR DUODENUM - by open or endoscopic assist.)
30586	Fee: \$701.30	Benefit: 75% = \$526.00
	PANCREATIC C	YST, anastomosis to Roux loop of jejunum (Anaes.) (Assist.)
30587	Fee: \$726.05	Benefit: 75% = \$544.55
		JEJUNOSTOMY for pancreatitis or trauma (Anaes.) (Assist.)
30589	Fee: \$1,251.10	Benefit: 75% = \$938.35
		JEJUNOSTOMY following previous pancreatic surgery (Anaes.) (Assist.)
30590	Fee: \$1,379.50	Benefit: 75% = \$1034.65
20270		OMY, near total or total (including duodenum), with or without splenectomy (Anaes.)
	(Assist.)	2.1.1., near total of total (meridaing adodentially, with of without spicificationly (Allacs.)
30593	Fee: \$1,887.75	Benefit: 75% = \$1415.85 85% = \$1804.35
30594	PANCREATECT	OMY for pancreatitis following previously attempted drainage procedure or partial

T8. SUF	RGICAL OPERATIO	NS 1. GENERAL
	resection (Anaes.)	(Assist.)
	Fee: \$2,178.25	Benefit: 75% = \$1633.70
	SPLENORRHAPH	Y OR PARTIAL SPLENECTOMY (Anaes.) (Assist.)
30596	Fee: \$897.30	Benefit: 75% = \$673.00
	SPLENECTOMY ((Anaes.) (Assist.)
30597	Fee: \$720.20	Benefit: 75% = \$540.15
	SPLENECTOMY, incision (Anaes.) (A	for massive spleen (weighing more than 1500 grams) or involving thoraco-abdominal Assist.)
30599	Fee: \$1,306.90	Benefit: 75% = \$980.20
	DIAPHRAGMATI	C HERNIA, TRAUMATIC, repair of (Anaes.) (Assist.)
30600	Fee: \$777.10	Benefit: 75% = \$582.85
		nia, congential repair of, by thoracic or abdominal approach, not being a service to 31569 to 31581 apply, on a person 10 years of age or over (Anaes.) (Assist.)
30601	Fee: \$957.30	Benefit: 75% = \$718.00
	PORTAL HYPER	TENSION, porto-caval shunt for (Anaes.) (Assist.)
30602	Fee: \$1,553.70	Benefit: 75% = \$1165.30
	PORTAL HYPER	TENSION, meso-caval shunt for (Anaes.) (Assist.)
30603	Fee: \$1,640.90 Benefit: 75% = \$1230.70 85% = \$1557.50	
	PORTAL HYPER	TENSION, selective spleno-renal shunt for (Anaes.) (Assist.)
30605	Fee: \$1,865.95	Benefit: 75% = \$1399.50
		TENSION, oesophageal transection via stapler or oversew of gastric varices with or isation (Anaes.) (Assist.)
30606	Fee: \$1,110.80	Benefit: 75% = \$833.10
	SMALL INTESTIN (Assist.)	NE, resection of, with anastomosis, on a person under 10 years of age (Anaes.)
30608	Fee: \$1,258.20	Benefit: 75% = \$943.65
		GUINAL HERNIA, laparoscopic repair of, not being a service associated with a sm 30614 applies (Anaes.) (Assist.)
30609	Fee: \$464.50	Benefit: 75% = \$348.40
	BENIGN TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage, and bone, simple lipomas covered by item 31345 and lipomata - removal of by surgical excision, where the specimen excised is sent for histological confirmation of diagnosis, on a person under 10 years of age, not being a service to which another item in this Group applies (Anaes.) (Assist.)	
30611	Fee: \$563.35	Benefit: 75% = \$422.55 85% = \$479.95
		GUINAL HERNIA OR INFANTILE HYDROCELE, repair of, not being a service to or 30615 applies, on a person 10 years of age or over (Anaes.) (Assist.)
30614	Fee: \$464.50	Benefit: 75% = \$348.40
	1	

T8. SUF	RGICAL OPERATIO	DNS	1. GENERAL
		D, INCARCERATED OR OBSTRUCTED HERNIA, repair of,	without bowel
	resection, on a per	son 10 years of age or over (Anaes.) (Assist.)	
30615	Fee: \$521.25	Benefit: 75% = \$390.95	
		OF NECK, selective dissection of 1 or 2 lymph node levels invoodes from one side of the neck, on a person under 10 years of a	
30618	(See para TN.8.24 of Fee: \$522.25	f explanatory notes to this Category) Benefit: 75% = \$391.70 85% = \$443.95	
	LAPAROSCOPIC	SPLENECTOMY, on a person under 10 years of age (Anaes.) ((Assist.)
30619	Fee: \$936.25	Benefit: 75% = \$702.20	
		natic umbilical, epigastric or linea alba hernia requiring mesh or rs of age or over, other than a service to which item 30403 or 30403.	
30621	Fee: \$407.50	Benefit: 75% = \$305.65	
	Gastrotomy, Redu peptic ulcer, Simple	rostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, ction of intussusception, Removal of Meckel's diverticulum, Sut le repair of ruptured viscus, Reduction of volvulus, Pyloroplasty on under 10 years of age (Anaes.) (Assist.)	ure of perforated
30622	(See para TN.8.14 of Fee: \$677.65	f explanatory notes to this Category) Benefit: 75% = \$508.25	
		NVOLVING DIVISION OF PERITONEAL ADHESIONS (who because is performed) on a person under 10 years of age (Anaes.)	
30623	Fee: \$677.65	Benefit: 75% = \$508.25	
		nvolving division of adhesions in conjunction with another intra en to divide the adhesions is between 45 minutes and 2 hours, or s.) (Assist.)	
30626	Fee: \$680.80	Benefit: 75% = \$510.60	
	-	diagnostic, not being a service associated with any other laparotears of age (Anaes.)	scopic procedure, on a
	-	f explanatory notes to this Category)	
30627	Fee: \$285.95	Benefit: 75% = \$214.50	
	HYDROCELE, taj	oping of	
30628	Fee: \$35.60	Benefit: 75% = \$26.70 85% = \$30.30	
	Hydrocele, removal of, other than a service associated with a service to which item 30641, 30642 or 30644 applies (Anaes.)		1 30641, 30642 or
30631	Fee: \$236.65	Benefit: 75% = \$177.50 85% = \$201.20	
		al correction of, other than a service associated with a service to plies—one procedure (Anaes.) (Assist.)	which item 30641,
30635	Fee: \$291.80	Benefit: 75% = \$218.85	
30636		BUTTON, caecostomy antegrade enema device (chait etc) and/copic insertion of, or non-endoscopic replacement of, on a perso	

T8. SUF	RGICAL OPERAT	ONS 1. GENERAL
	age (Anaes.)	
	Fee: \$233.15	Benefit: 75% = \$174.90 85% = \$198.20
	ENTEROSTOM years of age (Ana	Y or COLOSTOMY, closure of not involving resection of bowel, on a person under 10 aes.) (Assist.)
30637	Fee: \$773.50	Benefit: 75% = \$580.15
	COLOSTOMY (OR ILEOSTOMY, refashioning of, on a person under 10 years of age (Anaes.) (Assist.)
30639	Fee: \$773.50	Benefit: 75% = \$580.15 85% = \$690.10
		nd irreducible scrotal hernia, where duration of surgery exceeds 2 hours, in a person 10 ver, other than a service to which item 30403, 30405, 30614, 30615 or 30621 applies
30640	Fee: \$914.95	Benefit: 75% = \$686.25
	ORCHIDECTON (Anaes.) (Assist.)	MY, simple or subscapsular, unilateral with or without insertion of testicular prosthesis
30641	Fee: \$407.50	Benefit: 75% = \$305.65
		idical, unilateral, with or without insertion of testicular prosthesis, other than a service service to which item 30631, 30635, 30641, 30643 or 30644 applies (Anaes.) (Assist.)
30642	Fee: \$521.25	Benefit: 75% = \$390.95
		OF SPERMATIC CORD, inguinal approach, with or without testicular biopsy and xcision of spermatic cord and testis on a person under 10 years of age (Anaes.) (Assist.)
30643	Fee: \$677.65	Benefit: 75% = \$508.25
	EXPLORATION OF SPERMATIC CORD, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis on a person 10 years of age or over (Anaes.) (Assist.)	
30644	Fee: \$521.25	Benefit: 75% = \$390.95
	APPENDICECT age (Anaes.) (As	OMY, not being a service to which item 30574 applies, on a person under 10 years of sist.)
30645	Fee: \$579.00	Benefit: 75% = \$434.25
	LAPAROSCOPI	C APPENDICECTOMY, on a person under 10 years of age (Anaes.) (Assist.)
30646	Fee: \$579.00	Benefit: 75% = \$434.25
	HAEMORRHAGE, arrest of, following circumcision requiring general anaesthesia on a person under 10 years of age (Anaes.)	
30649	Fee: \$187.65	Benefit: 75% = \$140.75 85% = \$159.55
	Circumcision of	the penis (other than a service to which item 30658 applies)
30654	Fee: \$46.50	Benefit: 75% = \$34.90 85% = \$39.55
	Circumcision of or Group T10 ap	the penis, when performed in conjunction with a service to which an item in Group T7
30658	Fee: \$142.00	Benefit: 75% = \$106.50 85% = \$120.70
30663		GE, arrest of, following circumcision requiring general anaesthesia on a person 10 years

T8. SUF	RGICAL OPERATI	ons	1. GENERAL	
	of age or over (Ar	naes.)		
	Fee: \$144.35	Benefit: 75% = \$108.30 85% = \$122.70		
		S or PHIMOSIS, reduction of, under general anaesthesia, with or with g a service associated with a service to which another item in this Gro		
30666	Fee: \$47.45	Benefit: 75% = \$35.60 85% = \$40.35		
	COCCYX, excisi	on of (Anaes.) (Assist.)		
30672	Fee: \$445.40	Benefit: 75% = \$334.05		
	PILONIDAL SIN	IUS OR CYST, OR SACRAL SINUS OR CYST, excision of (Anaes.)	
30676	Fee: \$379.05	Benefit: 75% = \$284.30 85% = \$322.20		
	PILONIDAL SIN	IUS, injection of sclerosant fluid under anaesthesia (Anaes.)		
30679	Fee: \$96.30	Benefit: 75% = \$72.25 85% = \$81.90		
	WITHOUT intrap in association wit	opy, examination of the small bowel (oral approach), with or without brocedural therapy, for diagnosis of patients with obscure gastrointestic hanother item in this subgroup (with the exception of item 30682 or	inal bleeding, not	
	The patient to wh	The patient to whom the service is provided must:		
	(i) have recurrent or persistent bleeding; and			
	(ii) be anaemic	or have active bleeding; and		
	(iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not ide the cause of the bleeding. (Anaes.)		ch did not identify	
30680	(See para TN.8.17 o Fee: \$1,170.00	of explanatory notes to this Category) Benefit: 75% = \$877.50 85% = \$1086.60		
	WITHOUT intrap	opy, examination of the small bowel (anal approach), with or without procedural therapy, for diagnosis of patients with obscure gastrointests h another item in this subgroup (with the exception of item 30680 or 3	inal bleeding, not	
	The patient to wh	om the service is provided must:		
	(i) have recurren	nt or persistent bleeding; and		
	(ii) be anaemic	or have active bleeding; and		
		n upper gastrointestinal endoscopy and a colonoscopy performed whice bleeding.	ch did not identify	
	(Anaes.)			
30682	(See para TN.8.17 o Fee: \$1,170.00	of explanatory notes to this Category) Benefit: 75% = \$877.50 85% = \$1086.60		

T8. SURC	GICAL OPERATIONS	1. GENERAL
	Balloon enteroscopy, examination of the small bowel (oral approach), with or without to or more of the following procedures (snare polypectomy, removal of foreign body, diat probe, laser coagulation or argon plasma coagulation), for diagnosis and management of obscure gastrointestinal bleeding, not in association with another item in this subgroup exception of item 30682 or 30686)	hermy, heater of patients with
	The patient to whom the service is provided must:	
	(i) have recurrent or persistent bleeding; and	
	(ii) be anaemic or have active bleeding; and	
	(iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which the cause of the bleeding.	ch did not identify
	(Anaes.)	
30684	(See para TN.8.17 of explanatory notes to this Category) Fee: \$1,439.85 Benefit: 75% = \$1079.90 85% = \$1356.45	
	Balloon enteroscopy, examination of the small bowel (anal approach), with or without lor more of the following procedures (snare polypectomy, removal of foreign body, diatiprobe, laser coagulation or argon plasma coagulation), for diagnosis and management obscure gastrointestinal bleeding, not in association with another item in this subgroup exception of item 30680 or 30684)	hermy, heater of patients with
	The patient to whom the service is provided must:	
	(i) have recurrent or persistent bleeding; and	
	(ii) be anaemic or have active bleeding; and	
	(iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which the cause of the bleeding. (Anaes.)	h did not identify
30686	(See para TN.8.17 of explanatory notes to this Category) Fee: \$1,439.85 Benefit: 75% = \$1079.90 85% = \$1356.45	
	ENDOSCOPY with RADIOFREQUENCY ABLATION of mucosal metaplasia for the Barrett's Oesophagus in a single course of treatment, following diagnosis of high grade confirmed by histological examination (Anaes.)	
30687	(See para TN.8.17, TN.8.20 of explanatory notes to this Category) Fee: \$476.10 Benefit: 75% = \$357.10 85% = \$404.70	
	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for more of oesophageal, gastric or pancreatic cancer, not in association with another ite Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service assoroutine monitoring of chronic pancreatitis. (Anaes.)	m in this
30688	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) Fee: \$364.90 Benefit: 75% = \$273.70 85% = \$310.20	
30690	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy,	with fine needle

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	aspiration, including aspiration of the locoregional lymph nodes if performed, for the stagin more of oesophageal, gastric or pancreatic cancer, not in association with another item in the (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the monitoring of chronic pancreatitis. (Anaes.)	nis Subgroup
	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) Fee: \$563.30 Benefit: 75% = \$422.50 85% = \$479.90	
	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with at this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service asset the routine monitoring of chronic pancreatitis. (Anaes.)	nother item in
30692	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) Fee: \$364.90 Benefit: 75% = \$273.70 85% = \$310.20	
	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, with aspiration, for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumou association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30 other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)	ars, not in 494) and
30694	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) Fee: \$563.30 Benefit: 75% = \$422.50 85% = \$479.90	
	ENDOSCOPIC ULTRASOUND GUIDED FINE NEEDLE ASPIRATION BIOPSY(S) (ewith ultrasound imaging) to obtain one or more specimens from either:	ndoscopy
	(a) mediastinal mass(es) or	
	(b) locoregional nodes to stage non-small cell lung carcinoma	
	not being a service associated with another item in this subgroup or to which items 30710 apply (Anaes.)	and 55054
30696	(See para TN.8.21 of explanatory notes to this Category) Fee: \$563.30 Benefit: 75% = \$422.50 85% = \$479.90	
	ENDOBRONCHIAL ULTRASOUND GUIDED BIOPSY(S) (bronchoscopy with ultrasou with or without associated fluoroscopic imaging) to obtain one or more specimens by eithe	
	(a) transbronchial biopsy(s) of peripheral lung lesions; or	
	(b) fine needle aspiration(s) of a mediastinal mass(es); or	
	(c) fine needle aspiration(s) of locoregional nodes to stage non-small cell lung carcinoma	
	not being a service associated with another item in this subgroup or to which items 30696, 41898, and 60500 to 60509 applies (Anaes.)	41892,
30710	(See para TN.8.21 of explanatory notes to this Category) Fee: \$563.30 Benefit: 75% = \$422.50 85% = \$479.90	
31000	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (below l	knee) or foot,

T8. SUF	RGICAL OPERATIONS 1. GE	ENERAL
	utilising horizontal frozen sections with mapping of all excised tissue, and histological examinat all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—6 or fewer sections (An	e
	(See para TN.8.151 of explanatory notes to this Category) Fee: \$580.90 Benefit: 75% = \$435.70 85% = \$497.50	
	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (below knee) utilising horizontal frozen sections with mapping of all excised tissue, and histological examinat all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—7 to 12 sections (inclusi (Anaes.)	tion of e
31001	(See para TN.8.151 of explanatory notes to this Category) Fee: \$726.05 Benefit: 75% = \$544.55 85% = \$642.65	
	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (below knee) utilising horizontal frozen sections with mapping of all excised tissue, and histological examinat all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—13 or more sections (Ar	tion of e
31002	(See para TN.8.151 of explanatory notes to this Category) Fee: \$871.30 Benefit: 75% = \$653.50 85% = \$787.90	
	Mohs surgery of skin tumour utilising horizontal frozen sections with mapping of all excised tiss histological examination of all excised tissue by the specialist performing the procedure, if the sis recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—6 of sections	pecialist
	Not applicable to a service performed in association with a service to which item 31000 applies	(Anaes.)
31003	(See para TN.8.151 of explanatory notes to this Category) Fee: \$580.90 Benefit: 75% = \$435.70 85% = \$497.50	
	Mohs surgery of skin tumour utilising horizontal frozen sections with mapping of all excised tiss histological examination of all excised tissue by the specialist performing the procedure, if the sis recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—7 to sections (inclusive)	pecialist
	Not applicable to a service performed in association with a service to which item 31001 applies	(Anaes.)
31004	(See para TN.8.151 of explanatory notes to this Category) Fee: \$726.05 Benefit: 75% = \$544.55 85% = \$642.65	
	Mohs surgery of skin tumour utilising horizontal frozen sections with mapping of all excised tis histological examination of all excised tissue by the specialist performing the procedure, if the sis recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—13 sections	pecialist
	Not applicable to a service performed in association with a service to which item 31002 applies	(Anaes.)
31005	(See para TN.8.151 of explanatory notes to this Category) Fee: \$871.30 Benefit: 75% = \$653.50 85% = \$787.90	
	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operative removal of and suture, if:	ion),
31206	(a) the lesion size is not more than 10 mm in diameter; and	

T8. SUF	GICAL OPERATIONS 1. GENERA
	(b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and
	(c) the specimen excised is sent for histological examination (Anaes.)
	Fee: \$95.45 Benefit: 75% = \$71.60 85% = \$81.15
	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if:
	(a) the lesion size is more than 10 mm, but not more than 20 mm, in diameter; and
	(b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and
	(c) the specimen excised is sent for histological examination (Anaes.)
31211	Fee: \$123.10 Benefit: 75% = \$92.35 85% = \$104.65
	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if:
	(a) the lesion size is more than 20 mm in diameter; and
	(b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and
	(c) the specimen excised is sent for histological examination (Anaes.)
31216	Fee: \$143.55 Benefit: 75% = \$107.70 85% = \$122.05
	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of 4 to 10 lesions and suture, if:
	(a) the size of each lesion is not more than 10 mm in diameter; and
	(b) each removal is from cutaneous or subcutaneous tissue by surgical excision (other than by shave excision); and
	(c) all of the specimens excised are sent for histological examination (Anaes.)
31220	Fee: \$214.55 Benefit: 75% = \$160.95 85% = \$182.40
	Tumours, cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of 4 to 10 lesions, if:
	(a) the size of each lesion is not more than 10 mm in diameter; and
	(b) each removal is from a mucous membrane by surgical excision (other than by shave excision); an
	(c) each site of excision is closed by suture; and
	(d) all of the specimens excised are sent for histological examination (Anaes.)
31221	Fee: \$214.55 Benefit: 75% = \$160.95 85% = \$182.40
	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of more than 10 lesions, if:
31225	(a) the size of each lesion is not more than 10 mm in diameter; and

T8. SUF	RGICAL OPERATIONS 1. GENERAL
	(b) each removal is from cutaneous or subcutaneous tissue or mucous membrane by surgical excision (other than by
	shave excision); and
	(c) each site of excision is closed by suture; and
	(d) all of the specimens excised are sent for histological examination (Anaes.)
	Fee: \$381.30 Benefit: 75% = \$286.00 85% = \$324.15
	SKIN AND SUBCUTANEOUS TISSUE, extensive excision of, in the treatment of SUPPURATIVE HIDRADENITIS (excision from axilla, groin or natal cleft) or SYCOSIS BARBAE or NUCHAE (excision from face or neck) (Anaes.)
31245	(See para TN.8.23 of explanatory notes to this Category) Fee: \$369.00 Benefit: 75% = \$276.75 85% = \$313.65
	GIANT HAIRY or COMPOUND NAEVUS, excision of an area at least 1 percent of body surface where the specimen excised is sent for histological confirmation of diagnosis (Anaes.)
31250	Fee: \$369.00 Benefit: 75% = \$276.75 85% = \$313.65
	Muscle, bone or cartilage, excision of one or more of, if clinically indicated, and if:
	(a) the specimen excised is sent for histological confirmation; and
	(b) a malignant tumour of skin covered by item 31000, 31001, 31002, 31003, 31004, 31005, 31356, 31358, 31359, 31361, 31363, 31365, 31367, 31369, 31371, 31372, 31373, 31374, 31375 or 31376 is excised (Anaes.)
31340	Derived Fee: 75% of the fee for excision of malignant tumour
	LIPOMA, removal of by surgical excision or liposuction, where lesion is subcutaneous and 50mm or more in diameter, or is sub-fascial, where the specimen is sent for histological confirmation of diagnosis (Anaes.)
31345	Fee: \$210.95 Benefit: 75% = \$158.25 85% = \$179.35
	Liposuction (suction assisted lipolysis) to one regional area for contour problems of abdominal, upper arm or thigh fat because of repeated insulin injections, if:
	(a) the lesion is subcutaneous; and
	(b) the lesion is 50 mm or more in diameter; and
	(c) photographic and/or diagnostic imaging evidence demonstrating the need for this service is documented in the patient notes (Anaes.)
31346	(See para TN.8.101 of explanatory notes to this Category) Fee: \$210.95 Benefit: 75% = \$158.25 85% = \$179.35
	BENIGN TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage, and bone, simple lipomas covered by item 31345 and lipomata, removal of by surgical excision, where the specimen excised is sent for histological confirmation of diagnosis, on a person 10 years of age or over, not being a service to which another item in this Group applies (Anaes.) (Assist.)
31350	Fee: \$433.35 Benefit: 75% = \$325.05 85% = \$368.35
31355	MALIGNANT TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage and bone, removal of

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	by surgical excision, where <i>histological proof of malignancy</i> which another item in this Group applies (Anaes.) (Assist.)	has been obtained, not being a service to
	Fee: \$714.45 Benefit: 75% = \$535.85 85% = \$631.05	
	Malignant skin lesion (other than a malignant skin lesion covers) 31375 or 31376), surgical excision (other than by shave excision)	
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear area; and	, digit or genitalia, or from a contiguous
	(b) the necessary excision diameter is less than 6 mm; and	
	(c) the excised specimen is sent for histological examination	n; and
	(d) malignancy is confirmed from the excised specimen or	previous biopsy;
	not in association with item 45201 (Anaes.)	
31356	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$221.35 Benefit: 75% = \$166.05 85% = \$188.15	
	Non-malignant skin lesion (other than viral verrucae (commoi including a cyst, ulcer or scar (other than a scar removed durin surgical excision (other than by shave excision) and repair of,	ng the surgical approach at an operation),
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear area; and	, digit or genitalia, or from a contiguous
	(b) the necessary excision diameter is less than 6 mm; and	
	(c) the excised specimen is sent for histological examination	n;
	not in association with item 45201 (Anaes.)	
31357	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$109.70 Benefit: 75% = \$82.30 85% = \$93.25	
	Malignant skin lesion (other than a malignant skin lesion covers) 31375 or 31376), surgical excision (other than by shave excision)	
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear area; and	r, digit or genitalia, or from a contiguous
	(b) the necessary excision diameter is 6 mm or more; and	
	(c) the excised specimen is sent for histological examination	n; and
	(d) malignancy is confirmed from the excised specimen or	previous biopsy (Anaes.)
31358	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$270.85 Benefit: 75% = \$203.15 85% = \$230.25	
	Malignant skin lesion (other than a malignant skin lesion covers) 31375 or 31376), surgical excision (other than by shave excision)	
31359	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear	, digit or genitalia (the applicable site); and

T8. SURG	GICAL OPERATIONS 1. GEI	NERAL		
	(b) the necessary excision area is at least one third of the surface area of the applicable site; and	d		
	(c) the excised specimen is sent for histological examination; and			
	(d) malignancy is confirmed from the excised specimen or previous biopsy			
	(H) (Anaes.)			
	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$330.15 Benefit: 75% = \$247.65			
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an opera surgical excision (other than by shave excision) and repair of, if:	ntion),		
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contig area; and	uous		
	(b) the necessary excision diameter is 6 mm or more; and			
	(c) the excised specimen is sent for histological examination (Anaes.)			
31360	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$168.05 Benefit: 75% = \$126.05 85% = \$142.85			
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:	31374,		
	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal including, the	to, and		
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and			
	(b) the necessary excision diameter is less than 14 mm; and			
	(c) the excised specimen is sent for histological examination; and			
	(d) malignancy is confirmed from the excised specimen or previous biopsy;			
	not in association with item 45201 (Anaes.)			
31361	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$186.70 Benefit: 75% = \$140.05 85% = \$158.70			
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an opera surgical excision (other than by shave excision) and repair of, if:	ntion),		
	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to including, the			
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and			
	(b) the necessary excision diameter is less than 14 mm; and			
	(c) the excised specimen is sent for histological examination;			
31362	not in association with item 45201 (Anaes.)			

T8. SUR	GICAL OPERATIONS	1. GENERAL
	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$133.90 Benefit: 75% = \$100.45 85% = \$113.85	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:	
	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distinctuding, the	
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and	
	(b) the necessary excision diameter is 14 mm or more; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	
31363	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$244.30 Benefit: 75% = \$183.25 85% = \$207.70	
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic ke including a cyst, ulcer or scar (other than a scar removed during the surgical approach a surgical excision (other than by shave excision) and repair of, if:	
	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower lincluding, the	mb (distal to, and
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and	
	(b) the necessary excision diameter is 14 mm or more; and	
	(c) the excised specimen is sent for histological examination (Anaes.)	
31364	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$168.05 Benefit: 75% = \$126.05 85% = \$142.85	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31369, 31370 or 31373), surgical excision (other than by shave excision) and repair of, if:	0, 31371, 31372
	(a) the lesion is excised from any part of the body not covered by item 31356, 31358 31363; and	, 31359, 31361 or
	(b) the necessary excision diameter is less than 15 mm; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy;	
	not in association with item 45201 (Anaes.)	
31365	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$158.30 Benefit: 75% = \$118.75 85% = \$134.60	
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keincluding a cyst, ulcer or scar (other than a scar removed during the surgical approach a surgical excision (other than by shave excision) and repair of, if:	
31366	(a) the lesion is excised from any part of the body not covered by item 31357, 31360	, 31362 or 31364;

T8. SUR	GICAL OPERATIONS 1. GENERAL
	and
	(b) the necessary excision diameter is less than 15 mm; and
	(c) the excised specimen is sent for histological examination;
	not in association with item 45201 (Anaes.)
	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$95.45 Benefit: 75% = \$71.60 85% = \$81.15
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:
	(a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and
	(b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and
	(c) the excised specimen is sent for histological examination; and
	(d) malignancy is confirmed from the excised specimen or previous biopsy;
	not in association with item 45201 (Anaes.)
31367	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$213.60 Benefit: 75% = \$160.20 85% = \$181.60
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if:
	(a) the lesion is excised from any part of the body not covered by item 31357, 31360, 31362 or 31364; and
	(b) the necessary excision diameter is at least 15 mm but not more than 30mm; and
	(c) the excised specimen is sent for histological examination;
	not in association with item 45201 (Anaes.)
31368	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$125.55 Benefit: 75% = \$94.20 85% = \$106.75
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:
	(a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and
	(b) the necessary excision diameter is more than 30 mm; and
	(c) the excised specimen is sent for histological examination; and
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)
31369	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$245.90 Benefit: 75% = \$184.45 85% = \$209.05

T8. SUR	GICAL OPERATIONS	1. GENERAL
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keincluding a cyst, ulcer or scar (other than a scar removed during the surgical approach a surgical excision (other than by shave excision) and repair of, if:	/ /
	(a) the lesion is excised from any part of the body not covered by item 31357, 31360 and	, 31362 or 31364;
	(b) the necessary excision diameter is more than 30 mm; and	
	(c) the excised specimen is sent for histological examination (Anaes.)	
31370	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$143.55 Benefit: 75% = \$107.70 85% = \$122.05	
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of s carcinoma of skin, definitive surgical excision (other than by shave excision) and repair	
	(a) the tumour is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from area; and	om a contiguous
	(b) the necessary excision diameter is 6 mm or more; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	
31371	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$357.00 Benefit: 75% = \$267.75 85% = \$303.45	
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of s carcinoma of skin, definitive surgical excision (other than by shave excision) and repair	
	(a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower and including,	limb (distal to,
	the knee) or distal upper limb (distal to, and including, the ulnar styloid); and	
	(b) the necessary excision diameter is less than 14 mm; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy;	
	not in association with item 45201 (Anaes.)	
31372	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$308.70 Benefit: 75% = \$231.55 85% = \$262.40	
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if:	
	(a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to and including,	
	the knee) or distal upper limb (distal to, and including, the ulnar styloid); and	
31373	(b) the necessary excision diameter is 14 mm or more; and	

T8. SUF	RGICAL OPERATIONS 1. GENERAL
	(c) the excised specimen is sent for histological examination; and
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)
	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$356.80 Benefit: 75% = \$267.60 85% = \$303.30
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cel carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if:
	(a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and
	(b) the necessary excision diameter is less than 15 mm; and
	(c) the excised specimen is sent for histological examination; and
	(d) malignancy is confirmed from the excised specimen or previous biopsy;
	not in association with item 45201 (Anaes.)
31374	(See para TN.8.125, TN.1.21 of explanatory notes to this Category) Fee: \$281.90 Benefit: 75% = \$211.45 85% = \$239.65
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cel carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if:
	(a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and
	(b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and
	(c) the excised specimen is sent for histological examination; and
	(d) malignancy is confirmed from the excised specimen or previous biopsy;
	not in association with item 45201 (Anaes.)
31375	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$303.40 Benefit: 75% = \$227.55 85% = \$257.90
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel cel carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if:
	(a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and
	(b) the necessary excision diameter is more than 30 mm; and
	(c) the excised specimen is sent for histological examination; and
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)
31376	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$351.60 Benefit: 75% = \$263.70 85% = \$298.90
	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR up to and including 20mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.)
31400	Fee: \$261.05 Benefit: 75% = \$195.80 85% = \$221.90
31403	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 20mm and up to and

T8. SUF	SURGICAL OPERATIONS 1. GENE		
	including 40mm in diameter (excluding tumour of the lip), excision of, where histolog of malignancy has been obtained (Anaes.) (Assist.)	gical confirmation	
	Fee: \$301.35 Benefit: 75% = \$226.05		
	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 40mm in a (excluding tumour of the lip), excision of, where histological confirmation of maligna obtained (Anaes.) (Assist.)		
31406	Fee: \$502.15 Benefit: 75% = \$376.65 85% = \$426.85		
	PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist	t.)	
31409	Fee: \$1,560.15 Benefit: 75% = \$1170.15		
	RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by (Anaes.) (Assist.)	cervical approach	
31412	Fee: \$1,921.75 Benefit: 75% = \$1441.35		
	LYMPH NODE OF NECK, biopsy of (Anaes.)		
31420	Fee: \$183.90 Benefit: 75% = \$137.95 85% = \$156.35		
	LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels involving tissue and lymph nodes from one side of the neck, on a person 10 years of age or over		
31423	(See para TN.8.24 of explanatory notes to this Category) Fee: \$401.75 Benefit: 75% = \$301.35 85% = \$341.50		
	LYMPH NODES OF NECK, selective dissection of 3 lymph node levels involving retissue and lymph nodes from one side of the neck (Anaes.) (Assist.)	moval of soft	
31426	(See para TN.8.24 of explanatory notes to this Category) Fee: \$803.45 Benefit: 75% = \$602.60		
	LYMPH NODES OF NECK, selective dissection of 4 lymph node levels on one side preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or nerve (Anaes.) (Assist.)		
31429	(See para TN.8.24 of explanatory notes to this Category) Fee: \$1,252.10 Benefit: 75% = \$939.10		
51.25	LYMPH NODES OF NECK, bilateral selective dissection of levels I, II and III (bilate dissections) (Anaes.) (Assist.)	eral supraomohyoid	
31432	(See para TN.8.24 of explanatory notes to this Category) Fee: \$1,339.15 Benefit: 75% = \$1004.40		
	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on neck (Anaes.) (Assist.)	one side of the	
31435	(See para TN.8.24 of explanatory notes to this Category) Fee: \$984.30 Benefit: 75% = \$738.25		
	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid accessory nerve (Anaes.) (Assist.)		
31438	(See para TN.8.24 of explanatory notes to this Category) Fee: \$1,560.15 Benefit: 75% = \$1170.15		
31450	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where	the time taken is 1	

T8. SUF	RGICAL OPERATIONS 1. GENERA		
	hour or less (Anaes.) (Assist.)		
	Fee: \$406.65 Benefit: 75% = \$305.00		
	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken in more than 1 hour (Anaes.) (Assist.)		
31452	Fee: \$711.50 Benefit: 75% = \$533.65		
	LAPAROSCOPY with drainage of pus, bile or blood, as an independent procedure (Anaes.) (Assist.)		
31454	Fee: \$563.30 Benefit: 75% = \$422.50		
	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition (Anaes.)		
31456	Fee: \$245.55 Benefit: 75% = \$184.20		
	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition, and where the use of imaging intensification is clinically indicated (Anaes.)		
31458	Fee: \$294.65 Benefit: 75% = \$221.00		
	PERCUTANEOUS GASTROSTOMY TUBE, jejunal extension to, including any associated imaging services (Anaes.) (Assist.)		
31460	Fee: \$357.00 Benefit: 75% = \$267.75		
	OPERATIVE FEEDING JEJUNOSTOMY performed in conjunction with major upper gastro-intestina resection (Anaes.) (Assist.)		
31462	Fee: \$521.25 Benefit: 75% = \$390.95		
	ANTIREFLUX OPERATION BY FUNDOPLASTY, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopic technique - not being a service to which item 30601 applies (Anaes.) (Assist.)		
31464	(See para TN.8.19 of explanatory notes to this Category) Fee: \$871.30 Benefit: 75% = \$653.50		
	ANTIREFLUX OPERATION BY FUNDOPLASTY, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, revision procedure, by laparoscopy or open operation (Anaes.) (Assist.)		
31466	(See para TN.8.19 of explanatory notes to this Category) Fee: \$1,306.95 Benefit: 75% = \$980.25		
	PARA-OESOPHAGEAL HIATUS HERNIA, repair of, with complete reduction of hernia, resection of sac and repair of hiatus, with or without fundoplication (Anaes.) (Assist.)		
31468	Fee: \$1,435.85 Benefit: 75% = \$1076.90		
	LAPAROSCOPIC SPLENECTOMY, on a person 10 years of age or over (Anaes.) (Assist.)		
31470	Fee: \$720.20 Benefit: 75% = \$540.15		
	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY OR ROUX-EN-Y as a bypass procedure where prior biliary surgery has been performed (Anaes.) (Assist.)		
31472	Fee: \$1,169.80 Benefit: 75% = \$877.35		

T8. SUF	3. SURGICAL OPERATIONS 1. GENERA			
	BREAST, BENIGN LESION up to and including 50mm in diameter, including simple fibroadenoma or fibrocystic disease, open surgical biopsy or excision of, with or withous histology (Anaes.)			
31500	(See para TN.8.25 of explanatory notes to this Category) Fee: \$260.05 Benefit: 75% = \$195.05 85% = \$221.05			
	BREAST, BENIGN LESION more than 50mm in diameter, excision of (Anaes.) (Assist.)			
31503	(See para TN.8.25 of explanatory notes to this Category) Fee: \$346.75 Benefit: 75% = \$260.10 85% = \$294.75			
	BREAST, ABNORMALITY detected by mammography or ultrasound where guidewill localisation procedure is performed, excision biopsy of (Anaes.) (Assist.)	re or other		
31506	(See para TN.8.25 of explanatory notes to this Category) Fee: \$390.10 Benefit: 75% = \$292.60			
	BREAST, MALIGNANT TUMOUR, open surgical biopsy of, with or without frozen (Anaes.)	section histology		
31509	(See para TN.8.25 of explanatory notes to this Category) Fee: \$346.75 Benefit: 75% = \$260.10 85% = \$294.75			
	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen histology (Anaes.) (Assist.)	en section		
31512	Fee: \$650.15 Benefit: 75% = \$487.65			
	BREAST, TUMOUR SITE, re-excision of following open biopsy or incomplete excisi tumour (Anaes.) (Assist.)	on of malignant		
31515	(See para TN.8.25 of explanatory notes to this Category) Fee: \$436.15 Benefit: 75% = \$327.15			
	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen histology when targeted intraoperative radiotherapy (using an Intrabeam® device) is proncurrently, if the requirements of item 15900 are met for the patient (Anaes.) (Assist)	erformed		
31516	Fee: \$867.00 Benefit: 75% = \$650.25			
	BREAST, total mastectomy (H) (Anaes.) (Assist.)			
31519	Fee: \$736.05 Benefit: 75% = \$552.05			
	BREAST, subcutaneous mastectomy (H) (Anaes.) (Assist.)			
31524	Fee: \$1,040.25 Benefit: 75% = \$780.20			
	BREAST, mastectomy for gynecomastia, with or without liposuction (suction assisted being a service associated with a service to which item 45585 applies (H) (Anaes.) (As			
31525	Fee: \$520.00 Benefit: 75% = \$390.00			
	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a vacuum-assisted device under imaging guidance, for histological examination, where imaging has demo			
	(a) microcalcification of lesion; or			
	(b) impalpable lesion less than 1cm in diameter			
31530	- including pre-operative localisation of lesion where performed, not being a service	to which items		

T8. SUF	RGICAL OPERAT	IONS 1. GENERAL		
	31539, 31545 or	31548 apply		
	Fee: \$595.65	Benefit: 75% = \$446.75 85% = \$512.25		
		ASPIRATION of an impalpable breast lesion detected by mammography or ultrasound, but not including imaging (Anaes.)		
31533	(See para TN.8.26 Fee: \$137.90	of explanatory notes to this Category) Benefit: 75% = \$103.45 85% = \$117.25		
	imaging techniqu	BREAST, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques - but not including imaging, not being a service to which item 31539, 31542 or 31545 applies (Anaes.)		
31536	Fee: \$189.40	Benefit: 75% = \$142.05 85% = \$161.00		
	histological exan of Surgeons, and	SY OF SOLID TUMOUR OR TISSUE OF, using a bore-enbloc stereotactic biopsy, for nination, when conducted by a surgeon as determined by the Royal Australasian College where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, ce to which item 31530, 31536 or 31548 applies (Anaes.)		
31539	(See para TN.8.27 Fee: \$398.80	of explanatory notes to this Category) Benefit: 75% = \$299.10		
	BREAST, initial guidewire localisation of lesion, by hookwire or similar device, when conductation radiologist as determined by the Royal Australian and New Zealand College of Radiologists, interventional imaging techniques prior to using a bore-enbloc stereotactic biopsy - including not being a service associated with a service to which item 31536 applies (Anaes.)			
31542	(See para TN.8.28 Fee: \$196.95	of explanatory notes to this Category) Benefit: 75% = \$147.75 85% = \$167.45		
	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a bore-enbloc stereotactic biopsy, for histological examination, when conducted by a surgeon as determined by the Royal Australasian College of Surgeons; where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, including initial guidewire localisation of lesion, by hookwire or similar device, using interventional imaging techniques and including imaging not being a service associated with a service to which item 31530, 31536 or 31548 applies (Anaes.)			
31545	(See para TN.8.27 Fee: \$595.65	of explanatory notes to this Category) Benefit: 75% = \$446.75 85% = \$512.25		
	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using mechanical biopsy device, for histological examination, not being a service to which items 31530, 31539 or 31545 apply (Anaes.)			
31548	Fee: \$137.90	Benefit: 75% = \$103.45 85% = \$117.25		
	BREAST, HAEMATOMA, SEROMA OR INFLAMMATORY CONDITION including abscess, granulomatous mastitis or similar, exploration and drainage of when undertaken in the operating thea of a hospital, excluding aftercare (Anaes.)			
31551	Fee: \$216.75	Benefit: 75% = \$162.60		
	BREAST, micro	dochotomy of, for benign or malignant condition (Anaes.) (Assist.)		
31554	Fee: \$433.50	Benefit: 75% = \$325.15		
	BREAST CENTRAL DUCTS, excision of, for benign condition (Anaes.) (Assist.)			

	RGICAL OPERAT		1. GENERAI
	ACCESSORY B	BREAST TISSUE, excision of (Anaes.) (Assist.)	
31560	Fee: \$346.75 Extended Medic	Benefit: 75% = \$260.10 85% = \$294.75 care Safety Net Cap: \$277.40	
	INVERTED NIPPLE, surgical eversion of (Anaes.)		
31563	Fee: \$259.75	Benefit: 75% = \$194.85 85% = \$220.80	
	ACCESSORY N	IIPPLE, excision of (Anaes.)	
31566	Fee: \$129.95	Benefit: 75% = \$97.50 85% = \$110.50	
		BARIATRIC	
		ic band, placement of, with or without crural repair taking ically severe obesity (Anaes.) (Assist.)	45 minutes or less, for a
31569	(See para TN.8.29 Fee: \$849.55	of explanatory notes to this Category) Benefit: 75% = \$637.20	
	minutes or less,	y Roux-en-Y including associated anastomoses, with or w for a patient with clinically severe obesity not being associ ies (Anaes.) (Assist.)	
31572	(See para TN.8.29 Fee: \$1,045.40	of explanatory notes to this Category) Benefit: 75% = \$784.05	
	Sleeve gastrector severe obesity (A	my, with or without crural repair taking 45 minutes or less. Anaes.) (Assist.)	, for a patient with clinically
31575	(See para TN.8.29 Fee: \$849.55	of explanatory notes to this Category) Benefit: 75% = \$637.20	
		cluding by gastric plication), with or without crural repair nically severe obesity (Anaes.) (Assist.)	taking 45 minutes or less, for
31578	(See para TN.8.29 Fee: \$849.55	of explanatory notes to this Category) Benefit: 75% = \$637.20	
		y biliopancreatic diversion with or without duodenal swite, with or without crural repair taking 45 minutes or less, for Anaes.) (Assist.)	
31581	(See para TN.8.29 Fee: \$1,045.40	of explanatory notes to this Category) Benefit: 75% = \$784.05	
	Surgical reversal of adjustable gastric banding (removal or replacement of gastric band), gastric bypa gastroplasty (excluding by gastric plication) or biliopancreatic diversion being services to which item 31569 to 31581 apply (Anaes.) (Assist.)		
31584	(See para TN.8.30 of explanatory notes to this Category) Fee: \$1,539.10 Benefit: 75% = \$1154.35		
	Adjustment of gastric band as an independent procedure including any associated consultation		ociated consultation
31587	Fee: \$97.95	Benefit: 75% = \$73.50 85% = \$83.30	
	Adjustment of ga	astric band reservoir, repair, revision or replacement of (An	naes.) (Assist.)
31590	Fee: \$251.70	Benefit: 75% = \$188.80 85% = \$213.95	
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T8. SUF	RGICAL OPERATIONS 2. COLORECTAL	
	Group T8. Surgical Operations	
	Subgroup 2. Colorectal	
	LARGE INTESTINE, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Anaes.) (Assist.)	
32000	Fee: \$1,031.35 Benefit: 75% = \$773.55	
	LARGE INTESTINE, resection of, with anastomosis, including right hemicolectomy (Anaes.) (Assist.)	
32003	Fee: \$1,078.80 Benefit: 75% = \$809.10	
	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) without anastomosis, not being a service associated with a service to which item 32000, 32003, 32005 or 32006 applies (Anaes.) (Assist.)	
32004	Fee: \$1,150.35 Benefit: 75% = \$862.80	
	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) with anastomosis, not being a service associated with a service to which item 32000, 32003, 32004 or 32006 applies (Anaes.) (Assist.)	
32005	Fee: \$1,299.55 Benefit: 75% = \$974.70	
	LEFT HEMICOLECTOMY, including the descending and sigmoid colon (including formation of stoma) (Anaes.) (Assist.)	
32006	Fee: \$1,150.35 Benefit: 75% = \$862.80	
	TOTAL COLECTOMY AND ILEOSTOMY (Anaes.) (Assist.)	
32009	Fee: \$1,364.60 Benefit: 75% = \$1023.45	
	TOTAL COLECTOMY AND ILEORECTAL ANASTOMOSIS (Anaes.) (Assist.)	
32012	Fee: \$1,507.40 Benefit: 75% = \$1130.55	
	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY 1 surgeon (Anaes.) (Assist.)	
32015	Fee: \$1,852.50 Benefit: 75% = \$1389.40	
	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; ABDOMINAL RESECTION (including aftercare) (Anaes.) (Assist.)	
32018	Fee: \$1,570.85 Benefit: 75% = \$1178.15	
	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; PERINEAL RESECTION (Assist.)	
32021	Fee: \$563.30 Benefit: 75% = \$422.50	
	Endoscopic insertion of stent or stents for large bowel obstruction, stricture or stenosis, including colonoscopy and any image intensification, where the obstruction is due to:	
	a) a pre-diagnosed colorectal cancer, or cancer of an organ adjacent to the bowel; or	
	b) an unknown diagnosis (Anaes.)	
32023	(See para TN.8.17 of explanatory notes to this Category) Fee: \$555.35 Benefit: 75% = \$416.55	

T8. SUF	RGICAL OPERAT	ONS	2. COLORECTAL
	ANASTOMOSIS	H RESTORATIVE ANTERIOR RESECTION W S (of the rectum) greater than 10 centimetres from one not being a service associated with a service t (Assist.)	the anal verge excluding resection of
32024	Fee: \$1,364.60	Benefit: 75% = \$1023.45	
	ANASTOMOSIS	RESTORATIVE ANTERIOR RESECTION WIS (of the rectum) less than 10 centimetres from the a service associated with a service to which item 3	e anal verge, with or without covering
32025	Fee: \$1,825.30	Benefit: 75% = \$1369.00	
		RA LOW RESTORATIVE RESECTION, with or ted in the anorectal region and is 6cm or less from	
32026	Fee: \$1,965.65	Benefit: 75% = \$1474.25	
		OR ULTRA LOW RESTORATIVE RESECTION or without covering stoma (Anaes.) (Assist.)	DN, with peranal sutured coloanal
32028	Fee: \$2,106.20	Benefit: 75% = \$1579.65	
		ERVOIR, construction of, being a service associate roup applies (Anaes.) (Assist.)	ted with a service to which any other
32029	Fee: \$421.20	Benefit: 75% = \$315.90	
	RECTOSIGMOI	DECTOMY (Hartmann's operation) (Anaes.) (A	ssist.)
32030	Fee: \$1,031.35	Benefit: 75% = \$773.55	
	RESTORATION stoma (Anaes.) (A	OF BOWEL following Hartmann's or similar op Assist.)	eration, including dismantling of the
32033	Fee: \$1,507.40	Benefit: 75% = \$1130.55	
	SACROCOCCY	GEAL AND PRESACRAL TUMOUR excision	of (Anaes.) (Assist.)
32036	Fee: \$1,911.80	Benefit: 75% = \$1433.85	
	RECTUM AND	ANUS, ABDOMINOPERINEAL RESECTION	OF 1 surgeon (Anaes.) (Assist.)
32039	Fee: \$1,535.05	Benefit: 75% = \$1151.30	
	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION abdominal resection (Anaes.) (Assist.)		OF, COMBINED SYNCHRONOUS
32042	Fee: \$1,293.15	Benefit: 75% = \$969.90	
	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION perineal resection (Assist.)		
32045	Fee: \$483.95	Benefit: 75% = \$363.00	
		NUS, abdomino-perineal resection of, combined he perineal surgeon also provides assistance to the	
32046	Fee: \$747.90	Benefit: 75% = \$560.95	
32047	PERINEAL PRO	OCTECTOMY (Anaes.) (Assist.)	

T8. SUF	RGICAL OPERATI	ONS 2. COLORECTA
	Fee: \$871.30	Benefit: 75% = \$653.50
		TOMY with excision of rectum and ileoanal anastomosis with formation of ileal without creation of temporary ileostomy 1 surgeon (Anaes.) (Assist.)
32051	Fee: \$2,316.60	Benefit: 75% = \$1737.45
	reservoir, with or	TOMY with excision of rectum and ileoanal anastomosis with formation of ileal without creation of temporary ileostomy conjoint surgery, abdominal surgeon are) (Anaes.) (Assist.)
32054	Fee: \$2,126.20	Benefit: 75% = \$1594.65
		TOMY with excision of rectum and ileoanal anastomosis with formation of ileal at surgery, perineal surgeon (Assist.)
32057	Fee: \$563.30	Benefit: 75% = \$422.50
		LOSURE with rectal resection and mucosectomy and ileoanal anastomosis with reservoir, with or without temporary loop ileostomy 1 surgeon (Anaes.) (Assist.)
32060	Fee: \$2,316.60	Benefit: 75% = \$1737.45
	formation of ileal	LOSURE with rectal resection and mucosectomy and ileoanal anastomosis with reservoir, with or without temporary loop ileostomy conjoint surgery, abdominal ag aftercare) (Anaes.) (Assist.)
32063	Fee: \$2,126.20	Benefit: 75% = \$1594.65
		LOSURE with rectal resection and mucosectomy and ileoanal anastomosis with reservoir, with or without temporary loop ileostomy conjoint surgery, perineal
32066	Fee: \$563.30	Benefit: 75% = \$422.50
	ILEOSTOMY RI where appropriat	ESERVOIR, continent type, creation of, including conversion of existing ileostomy e (Anaes.)
32069	Fee: \$1,713.65	Benefit: 75% = \$1285.25
	SIGMOIDOSCO	PIC EXAMINATION (with rigid sigmoidoscope), with or without biopsy
32072	Fee: \$47.85	Benefit: 75% = \$35.90 85% = \$40.70
	SIGMOIDOSCO ANAESTHESIA	PIC EXAMINATION (with rigid sigmoidoscope), UNDER GENERAL, with or without biopsy, not being a service associated with a service to which another p applies (Anaes.)
32075	Fee: \$75.05	Benefit: 75% = \$56.30 85% = \$63.80
		c sigmoidoscopy or fibreoptic colonoscopy up to the hepatic flexure, with or without a service associated with a service to which item 32090 or 32093 applies.
	(Anaes.)	
32084	(See para TN.8.17, Fee: \$111.35	TN.8.134 of explanatory notes to this Category) Benefit: $75\% = \$83.55$ $85\% = \$94.65$
32087		nination of the colon up to the hepatic flexure by flexible fibreoptic sigmoidoscopy or scopy for the removal of 1 or more polyps or the treatment of radiation proctitis,

T8. SUF	RGICAL OPERATIONS	2. COLORECTAL
	angiodysplasia or post-polypectomy bleeding by argon plasma coagulation, of service associated with a service to which item 32090 or 32093 applies	ne or more of, other than a
	(Anaes.)	
	(See para TN.8.17, TN.8.134 of explanatory notes to this Category) Fee: \$204.70 Benefit: 75% = \$153.55 85% = \$174.00	
	FIBREOPTIC COLONOSCOPY examination of the colon beyond the hepati WITHOUT BIOPSY, following a positive faecal occult blood test for a partic National Bowel Cancer Screening Program. (Anaes.)	
32088	(See para TN.8.17 of explanatory notes to this Category) Fee: \$334.35 Benefit: 75% = \$250.80 85% = \$284.20	
	Endoscopic examination of the colon beyond the hepatic flexure by FIBREO the REMOVAL OF 1 OR MORE POLYPS, following a positive faecal occurregistered on the National Bowel Cancer Screening Program. (Anaes.)	
32089	(See para TN.8.17 of explanatory notes to this Category) Fee: \$469.20 Benefit: 75% = \$351.90 85% = \$398.85	
	FIBREOPTIC COLONOSCOPY examination of colon beyond the hepatic f WITHOUT BIOPSY (Anaes.)	lexure WITH or
32090	(See para TN.8.17, TN.8.134 of explanatory notes to this Category) Fee: \$334.35 Benefit: 75% = \$250.80 85% = \$284.20	
	Endoscopic examination of the colon beyond the hepatic flexure by FIBREO the REMOVAL OF 1 OR MORE POLYPS, or the treatment of radiation pro post-polypectomy bleeding by ARGON PLASMA COAGULATION, 1 or m	ctitis, angiodysplasia or
32093	(See para TN.8.17, TN.8.134 of explanatory notes to this Category) Fee: \$469.20 Benefit: 75% = \$351.90 85% = \$398.85	
	ENDOSCOPIC DILATATION OF COLORECTAL STRICTURES includin	g colonoscopy (Anaes.)
32094	(See para TN.8.17 of explanatory notes to this Category) Fee: \$551.85 Benefit: 75% = \$413.90	
	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endosco or without biopsies (Anaes.)	ppe passed by stoma, with
32095	(See para TN.8.17 of explanatory notes to this Category) Fee: \$127.80 Benefit: 75% = \$95.85 85% = \$108.65	
	RECTAL BIOPSY, full thickness, under general anaesthesia, or under epidur nerve block where undertaken in a hospital (Anaes.) (Assist.)	ral or spinal (intrathecal)
32096	Fee: \$256.95 Benefit: 75% = \$192.75	
	RECTAL TUMOUR of 5 centimetres or less in diameter, per anal submucos (Assist.)	al excision of (Anaes.)
32099	Fee: \$333.20 Benefit: 75% = \$249.90	
32102	RECTAL TUMOUR of greater than 5 centimetres in diameter, indicated by p	oathological examination,

T8. SUF	RGICAL OPERAT	IONS	2. COLORECTAL
	per anal submuce	osal excision of (Anaes.) (Assist.)	
	Fee: \$634.70	Benefit: 75% = \$476.05	
	either 3 dimension during colonosco	DUR, of less than 4 cm in diameter, per anal excision of, onal or 2 dimensional optic viewing systems, if removal is opy or by local excision, other than a service associated version of 2104 or 32106 applies (Anaes.) (Assist.)	s unable to be performed
32103	(See para TN.8.31, Fee: \$772.30	TN.8.17 of explanatory notes to this Category) Benefit: 75% = \$579.25	
	incorporating eit performed during	OUR, of 4 cm or greater in diameter, per anal excision of her 3 dimensional or 2 dimensional optic viewing system g colonoscopy or by local excision, other than a service a 4, 32025, 32103 or 32106 applies (Anaes.) (Assist.)	ns, if removal is unable to be
32104	(See para TN.8.31, Fee: \$999.65	TN.8.17 of explanatory notes to this Category) Benefit: 75% = \$749.75	
	ANORECTAL O	CARCINOMA per anal full thickness excision of (Anaes	s.) (Assist.)
32105	Fee: \$483.95	Benefit: 75% = \$363.00 85% = \$411.40	
	rectoscopy incor unable to be perf	RAL INTRAPERITONEAL RECTAL TUMOUR, per a porating either 3 dimensional or 2 dimensional optic view ormed during colonoscopy and if removal requires dissent a service associated with a service to which item 32024 (Assist.)	wing systems, if removal is ction within the peritoneal
32106	(See para TN.8.31, Fee: \$1,364.60	TN.8.17 of explanatory notes to this Category) Benefit: 75% = \$1023.45 85% = \$1281.20	
	RECTAL TUMO	OUR, transsphincteric excision of (Kraske or similar open	ration) (Anaes.) (Assist.)
32108	Fee: \$999.65	Benefit: 75% = \$749.75	
	RECTAL PROL	APSE Delorme procedure for (Anaes.) (Assist.)	
32111	Fee: \$634.70	Benefit: 75% = \$476.05	
	RECTAL PROL	APSE, perineal recto-sigmoidectomy for (Anaes.) (Assis	st.)
32112	Fee: \$772.30	Benefit: 75% = \$579.25	
		CTURE, per anal release of (Anaes.)	
32114	Fee: \$174.45	Benefit: 75% = \$130.85 85% = \$148.30	
		CTURE, dilatation of (Anaes.)	
32115	Fee: \$126.85	Benefit: 75% = \$95.15	
		APSE, abdominal rectopexy of (Anaes.) (Assist.)	
32117	Fee: \$999.65	Benefit: 75% = \$749.75	
		APSE, perineal repair of (Anaes.) (Assist.)	
32120	Fee: \$256.95	Benefit: 75% = \$192.75	
		URE, anoplasty for (Anaes.) (Assist.)	
32123			

T8. SUF	IRGICAL OPERATIONS 2. COLORE	
	Fee: \$333.20	Benefit: 75% = \$249.90 85% = \$283.25
	ANAL INCONT	TINENCE, Parks' intersphincteric procedure for (Anaes.) (Assist.)
32126	Fee: \$483.95	Benefit: 75% = \$363.00
	ANAL SPHINC	TER, direct repair of (Anaes.) (Assist.)
32129	Fee: \$634.70	Benefit: 75% = \$476.05
32129		ransanal repair of rectocele (Anaes.) (Assist.)
32131	Fee: \$533.60	Benefit: 75% = \$400.20
32131		IDS OR RECTAL PROLAPSE sclerotherapy for (Anaes.)
22122		•• • • • • • • • • • • • • • • • • • • •
32132	Fee: \$45.10	Benefit: 75% = \$33.85 85% = \$38.35
		IDS OR RECTAL PROLAPSE rubber band ligation of, with or without sclerotherapy, nfra red therapy for (Anaes.)
32135	Fee: \$67.50	Benefit: 75% = \$50.65 85% = \$57.40
	HAEMORRHO	IDECTOMY including excision of anal skin tags when performed (Anaes.)
32138	Fee: \$367.75	Benefit: 75% = \$275.85 85% = \$312.60
		IDECTOMY involving third or fourth degree haemorrhoids, including excision of anal
	skin tags when p	erformed (Anaes.) (Assist.)
32139	Fee: \$367.75	Benefit: 75% = \$275.85
	ANAL SKIN TA	AGS or ANAL POLYPS, excision of 1 or more of (Anaes.)
32142	Fee: \$67.50	Benefit: 75% = \$50.65 85% = \$57.40
	ANAL SKIN TA a hospital (Anae	AGS or ANAL POLYPS, excision of 1 or more of, undertaken in the operating theatre of s.)
32145	Fee: \$135.05	Benefit: 75% = \$101.30
	PERIANAL TH	ROMBOSIS, incision of (Anaes.)
32147	Fee: \$45.10	Benefit: 75% = \$33.85 85% = \$38.35
32147		OR FISSUREINANO, including excision or sphincterotomy, but excluding dilatation
	only (Anaes.) (A	
32150	Fee: \$256.95	Benefit: 75% = \$192.75 85% = \$218.45
		ATION OF, under general anaesthesia, with or without disimpaction of faeces, not being ted with a service to which another item in this Group applies (Anaes.)
32153	Fee: \$70.10	Benefit: 75% = \$52.60
	FISTULA-IN-A	NO, SUBCUTANEOUS, excision of (Anaes.)
32156	Fee: \$131.75	Benefit: 75% = \$98.85 85% = \$112.00
	ANAL FISTUL	A, treatment of, by excision or by insertion of a Seton, or by a combination of both living the lower half of the anal sphincter mechanism (Anaes.) (Assist.)
32159	Fee: \$333.20	Benefit: 75% = \$249.90
32162		A, treatment of, by excision or by insertion of a Seton, or by a combination of both

T8. SUF	RGICAL OPERAT	ONS 2. COLORECTAL
	procedures, invo	ving the upper half of the anal sphincter mechanism (Anaes.) (Assist.)
	Fee: \$483.95	Benefit: 75% = \$363.00
	ANAL FISTUL	, repair of, by mucosal flap advancement (Anaes.) (Assist.)
32165	Fee: \$634.70	Benefit: 75% = \$476.05 85% = \$551.30
	ANAL FISTUL	- readjustment of Seton (Anaes.)
32166	Fee: \$206.20	Benefit: 75% = \$154.65 85% = \$175.30
	FISTULA WOU (Anaes.)	ND, review of, under general or regional anaesthetic, as an independent procedure
32168	Fee: \$131.75	Benefit: 75% = \$98.85
		XAMINATION, with or without biopsy, under general anaesthetic, not being a service service to which another item in this Group applies (Anaes.)
32171	Fee: \$88.80	Benefit: 75% = \$66.60
	INTR-AANAL,	perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.)
32174	Fee: \$88.80	Benefit: 75% = \$66.60 85% = \$75.50
INTRA-ANAL, PERIANAL or ISCHIO-RECTAL ABSCESS, draining of, undertaken in t theatre of a hospital (excluding aftercare) (Anaes.)		
32175	Fee: \$162.65	Benefit: 75% = \$122.00
	(excluding pude	removal of, under general anaesthesia, or under regional or field nerve block dal block) requiring admission to a hospital, where the time taken is less than or equal of being a service associated with a service to which item 35507 or 35508 applies
32177	Fee: \$174.25	Benefit: 75% = \$130.70
	(excluding pude	removal of, under general anaesthesia, or under regional or field nerve block dal block) requiring admission to a hospital, where the time taken is greater than 45 ng a service associated with a service to which item 35507 or 35508 applies (Anaes.)
32180	Fee: \$256.95	Benefit: 75% = \$192.75
	INTESTINAL S	LING PROCEDURE prior to radiotherapy (Anaes.) (Assist.)
32183	Fee: \$561.65	Benefit: 75% = \$421.25
	COLONIC LAV	AGE, total, intra operative (Anaes.) (Assist.)
32186	Fee: \$561.65	Benefit: 75% = \$421.25
	DISTAL MUSC	LE, devascularisation of (Anaes.) (Assist.)
32200	Fee: \$295.70	Benefit: 75% = \$221.80 85% = \$251.35
	ANAL OR PER	NEAL GRACILOPLASTY (Anaes.) (Assist.)
32203	Fee: \$635.00	Benefit: 75% = \$476.25
	STIMULATOR	AND ELECTRODES, insertion of, following previous graciloplasty (Anaes.) (Assist.)
32206	Fee: \$573.70	Benefit: 75% = \$430.30

T8. SUF	SURGICAL OPERATIONS 2. COLORECTA		
	ANAL OR PERINEAL GRACILOPLASTY with insertion of stimulator and electro (Assist.)	des (Anaes.)	
32209	Fee: \$921.95 Benefit: 75% = \$691.50		
	GRACILIS NEOSPHINCTER PACEMAKER, replacement of (Anaes.)		
32210	Fee: \$255.45 Benefit: 75% = \$191.60 85% = \$217.15		
	ANO-RECTAL APPLICATION OF FORMALIN in the treatment of radiation procuperformed in the operating theatre of a hospital, excluding aftercare (Anaes.)	titis, where	
32212	Fee: \$136.25 Benefit: 75% = \$102.20		
	Sacral nerve lead or leads, percutaneous placement using fluoroscopic guidance (or intraoperative test stimulation, to manage faecal incontinence in a patient who:	open placement) and	
	a) has an anatomically intact but functionally deficient anal sphincter; and		
	b) has faecal incontinence that has been refractory to conservative non-surgical treat months;	ment for at least 12	
	other than a patient who:		
	c) is medically unfit for surgery; or		
	d) is pregnant or planning pregnancy; or		
	e) has irritable bowel syndrome; or		
	f) has congenital anorectal malformations; or		
	g) has active anal abscesses or fistulas; or		
	h) has anorectal organic bowel disease, including cancer; or		
	i) has functional effects of previous pelvic irradiation; or		
	j) has congenital or acquired malformations of the sacrum; or		
	k) has had rectal or anal surgery within the previous 12 months (Anaes.)		
32213	Fee: \$660.95 Benefit: 75% = \$495.75		
	Neurostimulator or receiver, subcutaneous placement of, involving placement and context extension wire to a sacral nerve electrode using fluoroscopic guidance, to manage far a patient who:		
	a) has an anatomically intact but functionally deficient anal sphincter; and		
	b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months;		
	other than a patient who:		
	c) is medically unfit for surgery; or		
32214	d) is pregnant or planning pregnancy; or		

T8. SUR	GICAL OPERATIONS 2. COLORECTAI
	e) has irritable bowel syndrome; or
	f) has congenital anorectal malformations; or
	g) has active anal abscesses or fistulas; or
	h) has anorectal organic bowel disease, including cancer; or
	i) has functional effects of previous pelvic irradiation; or
	j) has congenital or acquired malformations of the sacrum; or
	k) has had rectal or anal surgery within the previous 12 months
	(Anaes.) (Assist.)
	Fee: \$334.00 Benefit: 75% = \$250.50
	Sacral nerve electrode or electrodes, management, adjustment and electronic programming of the neurostimulator by a medical practitioner, to manage faecal incontinence, other than in a patient who:
	a) is medically unfit for surgery; or
	b) is pregnant or planning pregnancy; or
	c) has irritable bowel syndrome; or
	d) has congenital anorectal malformations; or
	e) has active anal abscesses or fistulas; or
	f) has anorectal organic bowel disease, including cancer; or
	g) has functional effects of previous pelvic irradiation; or
	h) has congenital or acquired malformations of the sacrum; or
	i) has had rectal or anal surgery within the previous 12 months
	–each day
32215	Fee: \$125.40 Benefit: 75% = \$94.05 85% = \$106.60
	Sacral nerve lead or leads, percutaneous surgical repositioning of, using fluoroscopic guidance (or open surgical repositioning of) and interoperative test stimulation, to correct displacement or unsatisfactory positioning, if the lead was inserted to manage faecal incontinence in a patient who:
	a) has an anatomically intact but functionally deficient anal sphincter; and
	b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months;
	other than a patient who:
	c) is medically unfit for surgery; or
32216	d) is pregnant or planning pregnancy; or

T8. SUF	RGICAL OPERATIONS	2. COLORECTAL
	e) has irritable bowel syndrome; or	
	f) has congenital anorectal malformations; or	
	g) has active anal abscesses or fistulas; or	
	h) has anorectal organic bowel disease, including cancer; or	
	i) has functional effects of previous pelvic irradiation; or	
	j) has congenital or acquired malformations of the sacrum; or	
	k) has had rectal or anal surgery within the previous 12 months	
	other than a service to which item 32213 applies	
	(Anaes.)	
	Fee: \$593.55 Benefit: 75% = \$445.20	
	Neurostimulator or receiver, removal of, if the neurostimulator or receiver was insincontinence in a patient who:	erted to manage faecal
	a) has an anatomically intact but functionally deficient anal sphincter; and	
	b) has faecal incontinence that has been refractory to conservative non-surgical tremonths;	eatment for at least 12
	other than a patient who:	
	c) is medically unfit for surgery; or	
	d) is pregnant or planning pregnancy; or	
	e) has irritable bowel syndrome; or	
	f) has congenital anorectal malformations; or	
	g) has active anal abscesses or fistulas; or	
	h) has anorectal organic bowel disease, including cancer; or	
	i) has functional effects of previous pelvic irradiation; or	
	j) has congenital or acquired malformations of the sacrum; or	
	k) has had rectal or anal surgery within the previous 12 months	
	(Anaes.)	
32217	Fee: \$156.30 Benefit: 75% = \$117.25	
	Sacral nerve lead or leads, removal of, if the lead was inserted to manage faecal in who:	acontinence in a patient
	a) has an anatomically intact but functionally deficient anal sphincter; and	
32218	b) has faecal incontinence that has been refractory to conservative non-surgical tre	eatment for at least 12

T8. SUF	RGICAL OPERATIONS 2.	COLORECTAL
	months;	
	other than a patient who:	
	c) is medically unfit for surgery; or	
	d) is pregnant or planning pregnancy; or	
	e) has irritable bowel syndrome; or	
	f) has congenital anorectal malformations; or	
	g) has active anal abscesses or fistulas; or	
	h) has anorectal organic bowel disease, including cancer; or	
	i) has functional effects of previous pelvic irradiation; or	
	j) has congenital or acquired malformations of the sacrum; or	
	k) has had rectal or anal surgery within the previous 12 months	
	(Anaes.)	
	Fee: \$156.30 Benefit: 75% = \$117.25	
	Insertion of an artificial bowel sphincter for severe faecal incontinence in the treatment whom conservative and other less invasive forms of treatment are contraindicated or have failed. Contraindicated in:	
	(a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive de diseases or a scarred or fragile perineum; and	egenerative
	(b) patients who have had an adverse reaction or radiopaque solution; and	
	(c) patients who enage in receptive anal intercourse (Anaes.) (Assist.)	
32220	Fee: \$903.90 Benefit: 75% = \$677.95 85% = \$820.50	
	Removal or revision of an artificial bowel sphincter (with or without replacement) for so incontinence in the treatment of a patient for whom conservative and other less invasive treatment are contraindicated or have failed. Contraindicated in:	
	(a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive de diseases or a scarred or fragile perineum; and	egenerative
	(b) patients who have had an adverse reaction to radiopaque solution; and	
	(c) patients who engage in receptive anal intercourse (Anaes.) (Assist.)	
32221	Fee: \$903.90 Benefit: 75% = \$677.95 85% = \$820.50	
T8. SUI	RGICAL OPERATIONS	3. VASCULAR
	Group T8. Surgical Operations	
	Subgroup 3. Vascular	
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T8. SUF	JRGICAL OPERATIONS 3. VASCULA	
	VARICOSE VEINS	
	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple injections of sclerosant using continuous compression techniques, including associated consultation - 1 or both legs - not being a service associated with any other varicose vein operation on the same leg (excluding aftercare) - to a maximum of 6 treatments in a 12 month period (Anaes.) (See para TN.8.4, TN.8.32 of explanatory notes to this Category) Fee: \$109.80 Benefit: 75% = \$82.35 85% = \$93.35	
32500	Extended Medicare Safety Net Cap: \$120.80	
	VARICOSE VEINS, multiple excision of tributaries, with or without division of 1 or more perforating veins - 1 leg - not being a service associated with a service to which item 32507, 32508, 32511, 32514 or 32517 applies on the same leg (Anaes.)	
32504	(See para TN.8.32 of explanatory notes to this Category) Fee: \$267.65 Benefit: 75% = \$200.75 85% = \$227.55 Extended Medicare Safety Net Cap: \$214.15	
	VARICOSE VEINS, sub-fascial surgical exploration of one or more incompetent perforating veins - 1 leg - not being a service associated with a service to which item 32508, 32511, 32514 or 32517 applies on the same leg (Anaes.) (Assist.)	
32507	(See para TN.8.32 of explanatory notes to this Category) Fee: \$533.60	
	VARICOSE VEINS, complete dissection at the sapheno-femoral OR sapheno-popliteal junction - 1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.)	
32508	(See para TN.8.32 of explanatory notes to this Category) Fee: \$533.60 Benefit: 75% = \$400.20	
	VARICOSE VEINS, complete dissection at the sapheno-femoral AND sapheno-popliteal junction - 1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.)	
32511	(See para TN.8.32 of explanatory notes to this Category) Fee: \$793.30 Benefit: 75% = \$595.00	
	VARICOSE VEINS, ligation of the long or short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in the same territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.)	
32514	(See para TN.8.32 of explanatory notes to this Category) Fee: \$926.80 Benefit: 75% = \$695.10	
	VARICOSE VEINS, ligation of the long and short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in either territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.)	
32517	(See para TN.8.32 of explanatory notes to this Category) Fee: \$1,193.40 Benefit: 75% = \$895.05	
32520	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) or small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a laser probe introduced by an endovenous catheter, if it is documented by duplex ultrasound that the great or	

T8. SURG	GICAL OPERATIONS	3. VASCULAR
	small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds o	r longer:
	(a) including all preparation and immediate clinical aftercare (including excision or injutributaries or incompetent perforating veins, or both); and	ection of either
	(b) not including radiofrequency diathermy, radiofrequency ablation or cyanoacrylate	embolisation; and
	(c) not provided on the same occasion as a service described in any of items 32500, 32 (Anaes.)	504 and 32507
	(See para TN.8.33 of explanatory notes to this Category) Fee: \$533.60 Benefit: 75% = \$400.20 85% = \$453.60 Extended Medicare Safety Net Cap: \$80.05	
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessar probe introduced by an endovenous catheter, if it is documented by duplex ultrasound small saphenous veins demonstrate reflux of 0.5 seconds or longer:	y), using a laser
	(a) including all preparation and immediate clinical aftercare (including excision or injuributaries or incompetent perforating veins, or both); and	ection of either
	(b) not including radiofrequency diathermy, radiofrequency ablation or cyanoacrylate on not provided on the same occasion as a service described in any of items 32500, 32504 (Anaes.)	
32522	(See para TN.8.33 of explanatory notes to this Category) Fee: \$793.30 Benefit: 75% = \$595.00 85% = \$709.90 Extended Medicare Safety Net Cap: \$79.35	
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessar radiofrequency catheter introduced by an endovenous catheter, if it is documented by that the great or small saphenous vein (whichever is to be treated) demonstrates reflux longer:	ry), using a luplex ultrasound
	(a) including all preparation and immediate clinical aftercare (including excision or injuributaries or incompetent perforating veins, or both); and	ection of either
	(b) not including endovenous laser therapy or cyanoacrylate embolisation; and	
	(c) not provided on the same occasion as a service described in any of items 32500, 32 (Anaes.)	504 and 32507
32523	(See para TN.8.33 of explanatory notes to this Category) Fee: \$533.60 Benefit: 75% = \$400.20 85% = \$453.60 Extended Medicare Safety Net Cap: \$80.05	
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessar radiofrequency catheter introduced by an endovenous catheter, if it is documented by that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer:	y), using a
	(a) including all preparation and immediate clinical aftercare (including excision or injuributaries or incompetent perforating veins, or both); and	ection of either
32526	(b) not including endovenous laser therapy or cyanoacrylate embolisation; and	

T8. SUF	RGICAL OPERATIONS 3. VASCULA
	(c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.)
	(See para TN.8.33 of explanatory notes to this Category) Fee: \$793.30 Benefit: 75% = \$595.00 Extended Medicare Safety Net Cap: \$79.35
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) or small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using cyanoacrylate adhesive, if it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer:
	(a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and
	(b) not including radiofrequency diathermy, radiofrequency ablation or endovenous laser therapy; and
	(c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507
	(Anaes.)
32528	(See para TN.8.33 of explanatory notes to this Category) Fee: \$533.60 Benefit: 75% = \$400.20 85% = \$453.60 Extended Medicare Safety Net Cap: \$80.05
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) and small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using cyanoacrylate adhesive, if it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer:
	(a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and
	(b) not including radiofrequency diathermy, radiofrequency ablation or endovenous laser therapy; and
	(c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507
	(Anaes.)
	(See para TN.8.33 of explanatory notes to this Category)
32529	Fee: \$793.30 Benefit: 75% = \$595.00 85% = \$709.90 Extended Medicare Safety Net Cap: \$79.35
	BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTERIAL DISEASE
	ARTERY OF NECK, bypass using vein or synthetic material (Anaes.) (Assist.)
32700	Fee: \$1,436.30 Benefit: 75% = \$1077.25
	INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy (Anaes.) (Assist.)
32703	Fee: \$1,188.20 Benefit: 75% = \$891.15
	AORTIC BYPASS for occlusive disease using a straight non-bifurcated graft (Anaes.) (Assist.)
32708	Fee: \$1,421.35 Benefit: 75% = \$1066.05
32710	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliae

T8. SUF	RGICAL OPERATIO	DNS 3. VASCULAR
	arteries (Anaes.) (A	Assist.)
	Fee: \$1,579.30	Benefit: 75% = \$1184.50
	AORTIC BYPASS	S for occlusive disease using a bifurcated graft with 1 or both anastomoses to the profunda femoris arteries (Anaes.) (Assist.)
32711	Fee: \$1,737.25	Benefit: 75% = \$1302.95
	ILIO-FEMORAL	BYPASS GRAFTING (Anaes.) (Assist.)
32712	Fee: \$1,255.80	Benefit: 75% = \$941.85
	AXILLARY or SU ARTERIES (Anae	UBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL s.) (Assist.)
32715	Fee: \$1,255.80	Benefit: 75% = \$941.85
	FEMORO-FEMO	RAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes.) (Assist.)
32718	Fee: \$1,188.20	Benefit: 75% = \$891.15
	RENAL ARTERY	, bypass grafting to (Anaes.) (Assist.)
32721	Fee: \$1,887.35	Benefit: 75% = \$1415.55
	-	ES (both), bypass grafting to (Anaes.) (Assist.)
32724	Fee: \$2,143.10	Benefit: 75% = \$1607.35
32124	-	ESSEL (single), bypass grafting to (Anaes.) (Assist.)
22720		Benefit: 75% = \$1218.25
32730	Fee: \$1,624.30	ESSELS (multiple), bypass grafting to (Anaes.) (Assist.)
32733	Fee: \$1,887.35	Benefit: 75% = \$1415.55
		NTERIC ARTERY, operation on, when performed in conjunction with another intraroperation (Anaes.) (Assist.)
32736	Fee: \$413.55	Benefit: 75% = \$310.20
		ERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the henous vein) with above knee anastomosis (Anaes.) (Assist.)
32739	Fee: \$1,293.40	Benefit: 75% = \$970.05
	FEMORAL ARTE ipsilateral long sap	ERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the shenous vein) with distal anastomosis to below knee popliteal artery (Anaes.) (Assist.)
32742	Fee: \$1,481.50	Benefit: 75% = \$1111.15
		ERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the thenous vein) with distal anastomosis to tibio peroneal trunk or tibial or peroneal ssist.)
32745	Fee: \$1,691.95	Benefit: 75% = \$1269.00
		ERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the henous vein) with distal anastomosis within 5cms of the ankle joint (Anaes.) (Assist.)
32748	Fee: \$1,834.80	Benefit: 75% = \$1376.10

T8. SUF	RGICAL OPERATIO	NS	3. VASCULAR
	FEMORAL ARTE below the knee (Ar	RY BYPASS GRAFTING using synthetic graft, with lownaes.) (Assist.)	wer anastomosis above or
32751	Fee: \$1,188.20	Benefit: 75% = \$891.15	
		RY BYPASS GRAFTING, using a composite graft (syntabove or below the knee, including use of a cuff or sleeves.) (Assist.)	
32754	Fee: \$1,481.50	Benefit: 75% = \$1111.15	
	an additional anast	RY SEQUENTIAL BYPASS GRAFTING, (using a veir pmosis is made to separately revascularise more than 1 around a femoral bypass (Anaes.) (Assist.)	
32757	Fee: \$413.55	Benefit: 75% = \$310.20	
		ING OF, FROM LEG OR ARM for bypass or replaceme is the subject of the bypass or graft - each vein (Anaes.) (
32760	Fee: \$406.05	Benefit: 75% = \$304.55	
		ASS GRAFTING, using vein or synthetic material, not be Sub-group applies (Anaes.) (Assist.)	ing a service to which
32763	Fee: \$1,188.20	Benefit: 75% = \$891.15	
		ENOUS ANASTOMOSIS, not being a service to which a independent procedure (Anaes.) (Assist.)	another item in this Sub-
32766	Fee: \$789.65	Benefit: 75% = \$592.25	
		ENOUS ANASTOMOSIS not being a service to which an performed in combination with another vascular operates.) (Assist.)	
32769	Fee: \$273.65	Benefit: 75% = \$205.25	
		BYPASS, REPLACEMENT, LIGATION OF ANEURY	/SMS
		NG to replace a popliteal aneurysm using vein, including saphenous vein) (Anaes.) (Assist.)	harvesting vein (when it is
33050	Fee: \$1,455.30	Benefit: 75% = \$1091.50	
	BYPASS GRAFTI	NG to replace a popliteal aneurysm using a synthetic gra	ft (Anaes.) (Assist.)
33055	Fee: \$1,167.05	Benefit: 75% = \$875.30	
	ANEURYSM IN T (Anaes.) (Assist.)	THE EXTREMITIES, ligation, suture closure or excision	of, without bypass grafting
33070	Fee: \$842.00	Benefit: 75% = \$631.50 85% = \$758.60	
	ANEURYSM IN T (Assist.)	THE NECK, ligation, suture closure or excision of, without	ut bypass grafting (Anaes.)
33075	Fee: \$1,071.05	Benefit: 75% = \$803.30	
	INTRA-ABDOMI bypass grafting (A	NAL OR PELVIC ANEURYSM, ligation, suture closure naes.) (Assist.)	or excision of, without
	Fee: \$1,307.45	Benefit: 75% = \$980.60	

T8. SUF	RGICAL OPERATIO	NS	3. VASCULAR
		COMMON OR INTERNAL CAROTID ARTERY, OR BOTH material (Anaes.) (Assist.)	H, replacement by graft
33100	Fee: \$1,436.30	Benefit: 75% = \$1077.25 85% = \$1352.90	
	THORACIC ANEU	JRYSM, replacement by graft (Anaes.) (Assist.)	
33103	Fee: \$2,015.30	Benefit: 75% = \$1511.50	
		OMINAL ANEURYSM, replacement by graft including re-im	plantation of arteries
33109	Fee: \$2,436.50	Benefit: 75% = \$1827.40 85% = \$2353.10	
	SUPRARENAL Al of arteries (Anaes.)	BDOMINAL AORTIC ANEURYSM, replacement by graft in (Assist.)	ncluding re-implantation
33112	Fee: \$2,113.10	Benefit: 75% = \$1584.85	
		BDOMINAL AORTIC ANEURYSM, replacement by tube graphics to which item 33116 applies (Anaes.) (Assist.)	aft, not being a service
33115	Fee: \$1,421.35	Benefit: 75% = \$1066.05	
		BDOMINAL AORTIC ANEURYSM, replacement by tube graceluding associated radiological services (Anaes.) (Assist.)	aft using endovascular
33116	Fee: \$1,399.00	Benefit: 75% = \$1049.25 85% = \$1315.60	
	arteries (with or wi	BDOMINAL AORTIC ANEURYSM, replacement by bifurcathout excision of common iliac aneurysms) not being a servicism 33119 applies (Anaes.) (Assist.)	
33118	Fee: \$1,579.30	Benefit: 75% = \$1184.50	
		BDOMINAL AORTIC ANEURYSM, replacement by bifurcatendovascular repair procedure, excluding associated radiological	
33119	Fee: \$1,554.55	Benefit: 75% = \$1165.95 85% = \$1471.15	
		BDOMINAL AORTIC ANEURYSM, replacement by bifurcatith or without excision or bypass of common iliac aneurysms)	
33121	Fee: \$1,737.25	Benefit: 75% = \$1302.95	
	ANEURYSM OF I (Anaes.) (Assist.)	LIAC ARTERY (common, external or internal), replacement	by graft - unilateral
33124	Fee: \$1,210.80	Benefit: 75% = \$908.10	
	ANEURYSMS OF (Anaes.) (Assist.)	ILIAC ARTERIES (common, external or internal), replacem	ent by graft - bilateral
33127	Fee: \$1,586.75	Benefit: 75% = \$1190.10 85% = \$1503.35	
	ANEURYSM OF V graft (Anaes.) (Ass	VISCERAL ARTERY, excision and repair by direct anastomoist.)	osis or replacement by
33130	Fee: \$1,383.65	Benefit: 75% = \$1037.75	
55150			

T8. SUF	RGICAL OPERATION	ONS 3. VASCULAR
	continuity (Anaes	.) (Assist.)
	Fee: \$1,037.65	Benefit: 75% = \$778.25
	FALSE ANEURY (Assist.)	YSM, repair of, at aortic anastomosis following previous aortic surgery (Anaes.)
33136	Fee: \$2,616.75	Benefit: 75% = \$1962.60
	FALSE ANEURY	YSM, repair of, in iliac artery and restoration of arterial continuity (Anaes.) (Assist.)
33139	Fee: \$1,586.75	Benefit: 75% = \$1190.10
	FALSE ANEURY	YSM, repair of, in femoral artery and restoration of arterial continuity (Anaes.) (Assist.)
33142	Fee: \$1,481.50	Benefit: 75% = \$1111.15 85% = \$1398.10
	RUPTURED THO	ORACIC AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.)
33145	Fee: \$2,549.20	Benefit: 75% = \$1911.90
		ORACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.)
33148	Fee: \$3,165.80	Benefit: 75% = \$2374.35
	RUPTURED SUI (Assist.)	PRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.)
33151	Fee: \$3,007.90	Benefit: 75% = \$2255.95
	RUPTURED INF (Anaes.) (Assist.)	RARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft
33154	Fee: \$2,225.90	Benefit: 75% = \$1669.45
		RARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft vith or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.)
33157	Fee: \$2,481.50	Benefit: 75% = \$1861.15
		RARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft ral arteries (Anaes.) (Assist.)
33160	Fee: \$2,481.50	Benefit: 75% = \$1861.15
	RUPTURED ILIA	AC ARTERY ANEURYSM, replacement by graft (Anaes.) (Assist.)
33163	Fee: \$2,105.70	Benefit: 75% = \$1579.30
	RUPTURED AND (Assist.)	EURYSM OF VISCERAL ARTERY, replacement by anastomosis or graft (Anaes.)
33166	Fee: \$2,105.70	Benefit: 75% = \$1579.30 85% = \$2022.30
	RUPTURED AN	EURYSM OF VISCERAL ARTERY, simple ligation of (Anaes.) (Assist.)
33169	Fee: \$1,639.35	Benefit: 75% = \$1229.55
		MAJOR ARTERY, replacement by graft, not being a service to which another item in plies (Anaes.) (Assist.)
33172	Fee: \$1,278.35	Benefit: 75% = \$958.80

T8. SUF	RGICAL OPERATION	ONS 3. VASCULAR
	RUPTURED AND bypass grafting (A	EURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without
	bypass granting (F	macs.) (Assist.)
33175	Fee: \$1,178.10	Benefit: 75% = \$883.60
	RUPTURED AND grafting (Anaes.)	EURYSM IN THE NECK, ligation, suture closure or excision of, without bypass (Assist.)
33178	Fee: \$1,498.20	Benefit: 75% = \$1123.65
		RA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, afting (Anaes.) (Assist.)
33181	Fee: \$1,831.70	Benefit: 75% = \$1373.80
		ENDARTERECTOMY AND ARTERIAL PATCH
		TERIES OF NECK, endarterectomy of, including closure by suture (where f 1 or more arteries is undertaken through 1 arteriotomy incision) (Anaes.) (Assist.)
33500	Fee: \$1,135.40	Benefit: 75% = \$851.55
	INNOMINATE ((Assist.)	DR SUBCLAVIAN ARTERY, endarterectomy of, including closure by suture (Anaes.)
33506	Fee: \$1,270.90	Benefit: 75% = \$953.20
		RTERECTOMY, including closure by suture, not being a service associated with e on the aorta (Anaes.) (Assist.)
33509	Fee: \$1,421.35	Benefit: 75% = \$1066.05
		ENDARTERECTOMY (1 or both iliac arteries), including closure by suture not being a with a service to which item 33515 applies (Anaes.) (Assist.)
33512	Fee: \$1,579.30	Benefit: 75% = \$1184.50
	FEMORAL END	AL ENDARTERECTOMY (1 or both femoral arteries) or BILATERAL ILIO-ARTERECTOMY, including closure by suture, not being a service associated with a tem 33512 applies (Anaes.) (Assist.)
33515	Fee: \$1,737.25	Benefit: 75% = \$1302.95
	ILIAC ENDART	ERECTOMY, including closure by suture, not being a service associated with another iliac artery (Anaes.) (Assist.)
33518	Fee: \$1,270.90	Benefit: 75% = \$953.20 85% = \$1187.50
		ENDARTERECTOMY (1 side), including closure by suture (Anaes.) (Assist.)
33521	Fee: \$1,376.10	Benefit: 75% = \$1032.10
	-	Y, endarterectomy of (Anaes.) (Assist.)
33524	Fee: \$1,624.30	Benefit: 75% = \$1218.25
JJJ4 1	-	ES (both), endarterectomy of (Anaes.) (Assist.)
22.52-		
33527	Fee: \$1,887.35	Benefit: 75% = \$1415.55
	COELIAC OR SU	JPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.)
33530	Fee: \$1,624.30	Benefit: 75% = \$1218.25

T8. SUF	RGICAL OPERATIO	NS	3. VASCULAR
	COELIAC AND SI	JPERIOR MESENTERIC ARTERY, endarterectom	y of (Anaes.) (Assist.)
33533	Fee: \$1,887.35	Benefit: 75% = \$1415.55	
		NTERIC ARTERY, endarterectomy of, not being a seem in this Sub-group applies (Anaes.) (Assist.)	ervice associated with a service
33536	Fee: \$1,346.10	Benefit: 75% = \$1009.60	
	ARTERY OF EXT	REMITIES, endarterectomy of, including closure by	suture (Anaes.) (Assist.)
33539	Fee: \$970.05	Benefit: 75% = \$727.55	
	EXTENDED DEEL (Anaes.) (Assist.)	P FEMORAL ENDARTERECTOMY where the enda	arterectomy is at least 7cms long
33542	Fee: \$1,383.65	Benefit: 75% = \$1037.75	
	ARTERY, VEIN O less than 3cm long	R BYPASS GRAFT, patch grafting to by vein or syr (Anaes.) (Assist.)	athetic material where patch is
33545	(See para TN.8.36 of Fee: \$273.65	explanatory notes to this Category) Benefit: 75% = \$205.25	
	ARTERY, VEIN O 3cm long or greater	R BYPASS GRAFT, patch grafting to by vein or syr (Anaes.) (Assist.)	athetic material where patch is
33548	(See para TN.8.36 of Fee: \$556.60	explanatory notes to this Category) Benefit: 75% = \$417.45	
	VEIN, harvesting o (Anaes.) (Assist.)	f from leg or arm for patch when not performed throu	ugh same incision as operation
33551	(See para TN.8.36 of Fee: \$273.65	explanatory notes to this Category) Benefit: 75% = \$205.25	
		MY, in conjunction with an arterial bypass operation site (Anaes.) (Assist.)	to prepare the site for
33554	Fee: \$272.40	Benefit: 75% = \$204.30	
		EMBOLECTOMY, THROMBECTOMY AND VASCUL	AR TRAUMA
	EMBOLUS, remov	al of, from artery of neck (Anaes.) (Assist.)	
33800	Fee: \$1,180.60	Benefit: 75% = \$885.45 85% = \$1097.20	
	EMBOLECTOMY trunk (Anaes.) (Ass	or THROMBECTOMY, by abdominal approach, of ist.)	an artery or bypass graft of
33803	Fee: \$1,128.05	Benefit: 75% = \$846.05	
	Embolectomy or thrombectomy (including the infusion of thrombolytic or other agents) from or bypass graft of extremities, or embolectomy of abdominal artery via the femoral artery, it claimed once per extremity, regardless of the number of incisions required to access the artegraft (Anaes.) (Assist.)		he femoral artery, item to be
33806	Fee: \$812.15	Benefit: 75% = \$609.15 85% = \$728.75	
	INFERIOR VENA (Anaes.) (Assist.)	CAVA OR ILIAC VEIN, closed thrombectomy by c	atheter via the femoral vein
33810	Fee: \$592.45	Benefit: 75% = \$444.35 85% = \$509.05	

T8. SUF	RGICAL OPERATIONS 3. VASCULAR
	INFERIOR VENA CAVA OR ILIAC VEIN, open removal of thrombus or tumour (Anaes.) (Assist.)
33811	Fee: \$1,763.80 Benefit: 75% = \$1322.85
	THROMBUS, removal of, from femoral or other similar large vein (Anaes.) (Assist.)
33812	Fee: \$932.45 Benefit: 75% = \$699.35 85% = \$849.05
	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.)
33815	Fee: \$857.30 Benefit: 75% = \$643.00
	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.)
33818	Fee: \$1,000.15 Benefit: 75% = \$750.15
	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.)
33821	Fee: \$1,143.00 Benefit: 75% = \$857.25
	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.)
33824	Fee: \$1,090.35 Benefit: 75% = \$817.80
	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.)
33827	Fee: \$1,278.35 Benefit: 75% = \$958.80
	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.)
33830	Fee: \$1,466.30 Benefit: 75% = \$1099.75
	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by lateral suture (Anaes.) (Assist.)
33833	Fee: \$1,331.15 Benefit: 75% = \$998.40
	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by direct anastomosis (Anaes.) (Assist.)
33836	Fee: \$1,586.75 Benefit: 75% = \$1190.10
	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by means of interposition graft (Anaes.) (Assist.)
33839	Fee: \$1,857.40 Benefit: 75% = \$1393.05
	ARTERY OF NECK, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (Anaes.) (Assist.)
33842	Fee: \$917.40 Benefit: 75% = \$688.05
	LAPAROTOMY for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (Anaes.) (Assist.)
33845	Fee: \$639.20 Benefit: 75% = \$479.40
33848	EXTREMITY, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no

T8. SUF	RGICAL OPERATION	ONS 3. VA	SCULAR
	other procedure is	performed (Anaes.) (Assist.)	
	Fee: \$639.20	Benefit: 75% = \$479.40	
		TION, EXCISION, ELECTIVE REPAIR, DECOMPRESSION OF VESSELS	
		OF NECK, elective ligation or exploration of, not being a service associate procedure (Anaes.) (Assist.)	d with
34100	Fee: \$707.00	Benefit: 75% = \$530.25	
	exploration of immiliac, femoral or po 32520, 32522, 325	or pulmonary artery) or great vein (superior or inferior vena cava), ligation of nediate branches or tributaries, or ligation or exploration of the subclavian, as opliteal arteries or veins, if the service is not associated with item 32508, 32523, 32526, 32528 or 32529 - for a maximum of 2 services provided to the safe occasion (H) (Anaes.) (Assist.)	xillary, 11,
34103	Fee: \$413.55	Benefit: 75% = \$310.20	
	exploration of, not	N (including brachial, radial, ulnar or tibial), ligation of, by elective operation being a service associated with any other vascular procedure except those sets, 32511, 32514 or 32517 apply (Anaes.) (Assist.)	
	Fee: \$291.70	Benefit: 75% = \$218.80 85% = \$247.95	
34106		re Safety Net Cap: \$233.40	
	TEMPORAL ART	ERY, biopsy of (Anaes.) (Assist.)	
34109	Fee: \$338.35	Benefit: 75% = \$253.80 85% = \$287.60	
	ARTERIO-VENO	US FISTULA OF AN EXTREMITY, dissection and ligation (Anaes.) (Assis	st.)
34112	Fee: \$857.30	Benefit: 75% = \$643.00	
	ARTERIO-VENO	US FISTULA OF THE NECK, dissection and ligation (Anaes.) (Assist.)	
34115	Fee: \$970.05	Benefit: 75% = \$727.55	
	ARTERIO-VENO	US FISTULA OF THE ABDOMEN, dissection and ligation (Anaes.) (Assis	t.)
34118	Fee: \$1,383.65	Benefit: 75% = \$1037.75 85% = \$1300.25	
		US FISTULA OF AN EXTREMITY, dissection and repair of, with restorati	on of
34121	Fee: \$1,105.35	Benefit: 75% = \$829.05	
	ARTERIO-VENO (Anaes.) (Assist.)	US FISTULA OF THE NECK, dissection and repair of, with restoration of o	continuity
34124	Fee: \$1,210.80	Benefit: 75% = \$908.10	
	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and repair of, with restoration of continuity (Anaes.) (Assist.)		on of
34127	Fee: \$1,586.75	Benefit: 75% = \$1190.10	
	SURGICALLY CI (Assist.)	REATED ARTERIO-VENOUS FISTULA OF AN EXTREMITY, closure o	f (Anaes.)
34130	Fee: \$496.30	Benefit: 75% = \$372.25 85% = \$421.90	
34133	SCALENOTOMY	(Anaes.) (Assist.)	

T8. SUF	RGICAL OPERAT	ONS 3. VASCULAR
	Fee: \$556.60	Benefit: 75% = \$417.45
	FIRST RIB, rese	ction of portion of (Anaes.) (Assist.)
34136	Fee: \$894.75	Benefit: 75% = \$671.10
		r, removal of, or other operation for removal of thoracic outlet compression, not being a another item in this Sub-group applies (Anaes.) (Assist.)
34139	Fee: \$894.75	Benefit: 75% = \$671.10
	COELIAC ART	ERY, decompression of, for coeliac artery compression syndrome, as an independent s.) (Assist.)
34142	Fee: \$1,105.35	Benefit: 75% = \$829.05
		TERY, exploration of, for popliteal entrapment, with or without division of fibrous e (Anaes.) (Assist.)
34145	Fee: \$804.65	Benefit: 75% = \$603.50
		OCIATED TUMOUR, resection of, with or without repair or reconstruction of internal id arteries, when tumour is 4cm or less in maximum diameter (Anaes.) (Assist.)
34148	Fee: \$1,436.30	Benefit: 75% = \$1077.25
		OCIATED TUMOUR, resection of, with or without repair or reconstruction of internal id arteries, when tumour is greater than 4cm in maximum diameter (Anaes.) (Assist.)
34151	Fee: \$1,962.65	Benefit: 75% = \$1472.00
		AROTID ASSOCIATED TUMOUR, resection of, with or without repair or ortion of internal or common carotid arteries (Anaes.) (Assist.)
34154	Fee: \$2,338.75	Benefit: 75% = \$1754.10 85% = \$2255.35
	NECK, excision	of infected bypass graft, including closure of vessel or vessels (Anaes.) (Assist.)
34157	Fee: \$1,188.20	Benefit: 75% = \$891.15
	AORTO-DUOD (Assist.)	ENAL FISTULA, repair of, by suture of aorta and repair of duodenum (Anaes.)
34160	Fee: \$2,225.90	Benefit: 75% = \$1669.45
	AORTO-DUOD (Anaes.) (Assist.	ENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum
34163	Fee: \$2,857.55	Benefit: 75% = \$2143.20
	AORTO-DUODENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum a axillo-bifemoral grafting (Anaes.) (Assist.)	
34166	Fee: \$2,857.55	Benefit: 75% = \$2143.20
	INFECTED BYI (Assist.)	PASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes.)
34169	Fee: \$1,586.75	Benefit: 75% = \$1190.10
	INFECTED AX arteries (Anaes.)	LLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of (Assist.)
34172	Fee: \$1,293.40	Benefit: 75% = \$970.05

T8. SUF	RGICAL OPERATION	ONS	3. VASCULAF
	INFECTED BYP (Anaes.) (Assist.)	ASS GRAFT FROM EXTREMITIES, ex	cision of including closure of arteries
34175	Fee: \$1,188.20	Benefit: 75% = \$891.15	
		OPERATIONS FOR VASCU	JLAR ACCESS
	ARTERIOVENO	US SHUNT, EXTERNAL, insertion of (A	Anaes.) (Assist.)
34500	Fee: \$308.40	Benefit: 75% = \$231.30 85% = \$262.1	5
		US ANASTOMOSIS OF UPPER OR LC operation (Anaes.) (Assist.)	OWER LIMB, in conjunction with another
34503	Fee: \$413.55	Benefit: 75% = \$310.20	
	ARTERIOVENO	US SHUNT, EXTERNAL, removal of (A	anaes.) (Assist.)
34506	Fee: \$210.45	Benefit: 75% = \$157.85	
		US ANASTOMOSIS OF UPPER OR LC arterial operation (Anaes.) (Assist.)	OWER LIMB, not in conjunction with
34509	Fee: \$977.55	Benefit: 75% = \$733.20	
	ARTERIOVENO	US ACCESS DEVICE, insertion of (Ana	es.) (Assist.)
34512	Fee: \$1,075.40	Benefit: 75% = \$806.55	
	ARTERIOVENO	US ACCESS DEVICE, thrombectomy of	f (Anaes.) (Assist.)
34515	Fee: \$767.00	Benefit: 75% = \$575.25	
		RTERIOVENOUS FISTULA OR PROS' on of (Anaes.) (Assist.)	THETIC ARTERIOVENOUS ACCESS
34518	Fee: \$1,285.75	Benefit: 75% = \$964.35	
		INAL ARTERY OR VEIN, cannulation of ing aftercare) (Anaes.) (Assist.)	of, for infusion chemotherapy, by open
34521	(See para TN.8.4 of Fee: \$789.95	explanatory notes to this Category) Benefit: 75% = \$592.50	
	ARTERIAL CAN which item 34521	NULATION for infusion chemotherapy applies (excluding after-care) (Anaes.) (A	by open operation, not being a service to Assist.)
34524	(See para TN.8.4 of Fee: \$413.55	explanatory notes to this Category) Benefit: 75% = \$310.20	
	access port as with		ne, using subcutaneous tunnel with pump or emotherapy delivery device, including any erson 10 years of age or over (Anaes.)
34527	Fee: \$551.60	Benefit: 75% = \$413.70 85% = \$468.9	0
	pump or access po		technique, using subcutaneous tunnel with other chemotherapy delivery device, on a
34528	Fee: \$272.40	Benefit: 75% = \$204.30 85% = \$231.5	5
34529			ne, using subcutaneous tunnel with pump or emotherapy delivery device, including any

RGICAL OPERATION	ONS	3. VASCULAR
associated percuta	neous central vein catheteriz	ration, on a person under 10 years of age (Anaes.)
Fee: \$717.10	Benefit: 75% = \$537.85	85% = \$633.70
		EMOTHERAPY DEVICE, removal of, by open surgical on a person 10 years of age or over (Anaes.)
Fee: \$204.25	Benefit: 75% = \$153.20	85% = \$173.65
procedure, regiona	al perfusion for chemotherap	innulation of artery and vein at commencement of y, or other therapy, repair of arteriotomy and venotomy at (Anaes.) (Assist.)
Fee: \$1,240.65	Benefit: 75% = \$930.50	85% = \$1157.25
pump or access po	ort as with central venous line	percutaneous technique, using subcutaneous tunnel with e catheter or other chemotherapy delivery device, on a
Fee: \$354.10	Benefit: 75% = \$265.60	85% = \$301.00
		percutaneous technique, using subcutaneous tunnelled nistration of haemodialysis or parenteral nutrition (Anaes.)
Fee: \$272.40	Benefit: 75% = \$204.30	85% = \$231.55
TUNNELLED CU (Anaes.)	JFFED CATHETER, OR SI	MILAR DEVICE, removal of, by open surgical procedure
Fee: \$204.25	Benefit: 75% = \$153.20	85% = \$173.65
		EMOTHERAPY DEVICE, removal of, by open surgical , on a person under 10 years of age (Anaes.)
Fee: \$265.50	Benefit: 75% = \$199.15	85% = \$225.70
	COMPLEX	VENOUS OPERATIONS
INFERIOR VENA	A CAVA, plication, ligation,	or application of caval clip (Anaes.) (Assist.)
Fee: \$812.15	Benefit: 75% = \$609.15	85% = \$728.75
INFERIOR VENA	A CAVA, reconstruction of o	or bypass by vein or synthetic material (Anaes.) (Assist.)
Fee: \$1,789.85	Benefit: 75% = \$1342.40	
CROSS LEG BYI	PASS GRAFTING, saphenor	us to iliac or femoral vein (Anaes.) (Assist.)
Fee: \$970.05	Benefit: 75% = \$727.55	
		noral or popliteal vein for femoral vein bypass (Anaes.)
Fee: \$970.05	Benefit: 75% = \$727.55	
		a bypass for, using vein or synthetic material, not being a 34806 or 34809 applies (Anaes.) (Assist.)
Fee: \$1,173.05	Benefit: 75% = \$879.80	
VEIN STENOSIS (Anaes.) (Assist.)	, patch angioplasty for, (excl	luding vein graft stenosis)-using vein or synthetic material
(See para TN.8.36 o	f explanatory notes to this Cates	gory)
	associated percuta Fee: \$717.10 CENTRAL VENO procedure in the o Fee: \$204.25 ISOLATED LIME procedure, regiona conclusion of proc Fee: \$1,240.65 CENTRAL VEIN pump or access po person under 10 you Fee: \$354.10 CENTRAL VEIN cuffed catheter or Fee: \$272.40 TUNNELLED CU (Anaes.) Fee: \$204.25 CENTRAL VENO procedure in the o Fee: \$204.25 CENTRAL VENO procedure in the o Fee: \$265.50 INFERIOR VENA Fee: \$1,789.85 CROSS LEG BYE Fee: \$970.05 VENOUS STENO service associated Fee: \$1,173.05 VEIN STENOSIS (Anaes.) (Assist.)	Fee: \$717.10 Benefit: 75% = \$537.85 CENTRAL VENOUS LINE, OR OTHER CH procedure in the operating theatre of a hospital Fee: \$204.25 Benefit: 75% = \$153.20 ISOLATED LIMB PERFUSION, including ca procedure, regional perfusion for chemotherap conclusion of procedure (excluding aftercare) of the see: \$1,240.65 Benefit: 75% = \$930.50 CENTRAL VEIN CATHETERISATION by pump or access port as with central venous line person under 10 years of age (Anaes.) Fee: \$354.10 Benefit: 75% = \$265.60 CENTRAL VEIN CATHERTERISATION by cuffed catheter or similar device, for the admir fee: \$272.40 Benefit: 75% = \$204.30 TUNNELLED CUFFED CATHETER, OR SI (Anaes.) Fee: \$204.25 Benefit: 75% = \$153.20 CENTRAL VENOUS LINE, OR OTHER CH procedure in the operating theatre of a hospital fee: \$265.50 Benefit: 75% = \$199.15 COMPLEX ON THE COM

T8. SUF	RGICAL OPERAT	ONS 3. VASCULAR
	Fee: \$970.05	Benefit: 75% = \$727.55
	VENOUS VALV	YE, plication or repair to restore valve competency (Anaes.) (Assist.)
34818	Fee: \$1,067.80	Benefit: 75% = \$800.85
	-	ANT to restore valvular function (Anaes.) (Assist.)
34821	Fee: \$1,451.45	Benefit: 75% = \$1088.60
34621		ENT, application of, to restore venous valve competency to superficial vein - 1 stent
	(Anaes.) (Assist.)	
34824	Fee: \$496.30	Benefit: 75% = \$372.25
	EXTERNAL ST	ENTS, application of, to restore venous valve competency to superficial vein or veins -
	more than 1 stent	(Anaes.) (Assist.)
34827	Fee: \$601.65	Benefit: 75% = \$451.25
		ENT, application of, to restore venous valve competency to deep vein (1 stent) (Anaes.)
	(Assist.)	
34830	Fee: \$707.00	Benefit: 75% = \$530.25 85% = \$623.60
		ENTS, application of, to restore venous valve competency to deep vein or veins (more
	than 1 stent) (An	aes.) (Assist.)
34833	Fee: \$917.40	Benefit: 75% = \$688.05
		SYMPATHECTOMY
	LUMBAR SYM	PATHECTOMY (Anaes.) (Assist.)
35000	Fee: \$707.00	Benefit: 75% = \$530.25 85% = \$623.60
		UPPER THORACIC SYMPATHECTOMY by any surgical approach (Anaes.)
	(Assist.)	
35003	Fee: \$917.40	Benefit: 75% = \$688.05
		UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for
	previous incomp	lete sympathectomy by any surgical approach (Anaes.) (Assist.)
35006	Fee: \$1,150.55	Benefit: 75% = \$862.95
		PATHECTOMY, where operation is following chemical sympathectomy or for
	previous incomp	lete surgical sympathectomy (Anaes.) (Assist.)
35009	Fee: \$894.75	Benefit: 75% = \$671.10
	SACRAL or PRI	E-SACRAL SYMPATHECTOMY (Anaes.) (Assist.)
35012	Fee: \$707.00	Benefit: 75% = \$530.25
		DEBRIDEMENT AND AMPUTATIONS FOR VASCULAR DISEASE
		MB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating tal, when debridement includes muscle, tendon or bone (Anaes.) (Assist.)
35100	Fee: \$368.55	Benefit: 75% = \$276.45
		MB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating
35103	theatre of a hospi	tal, superficial tissue only (Anaes.)
22103		

T8. SUF	RGICAL OPERAT	IONS	3. VASCULAR
	Fee: \$234.55	Benefit: 75% = \$175.95	
		MISCELLANEOUS VASCULAR PROCED	URES
		RTERIOGRAPHY OR VENOGRAPHY, 1 or more of cedure on an artery or vein, 1 site (Anaes.)	f, performed during the course of
35200	Fee: \$171.50	Benefit: 75% = \$128.65	
		RIES OR VEINS IN THE NECK, ABDOMEN OR EXN after prior surgery on these vessels (Anaes.) (Assist.	
35202	Fee: \$817.10	Benefit: 75% = \$612.85	
		ENDOVASCULAR INTERVENTIONAL PROC	EDURES
		AL BALLOON ANGIOPLASTY of 1 peripheral arter sure, excluding associated radiological services or preparations.	
35300	Fee: \$515.35	Benefit: 75% = \$386.55 85% = \$438.05	
	more than 1 peri	AL BALLOON ANGIOPLASTY of aortic arch branch pheral artery or vein of 1 limb, percutaneous or by ope ices or preparation, and excluding aftercare (Anaes.) (n exposure, excluding associated
35303	Fee: \$660.80	Benefit: 75% = \$495.60 85% = \$577.40	
	peripheral artery	AL STENT INSERTION, 1 or more stents, including a or vein of 1 limb, percutaneous or by open exposure, aration, and excluding aftercare. (Anaes.) (Assist.)	
35306	Fee: \$609.90	Benefit: 75% = \$457.45 85% = \$526.50	
	associated balloc	AL STENT INSERTION, 1 or more stents (not drug-endilatation, for 1 carotid artery, percutaneous (not directly on device, in patients who:	
	- meet the indi	cations for carotid endarterectomy; and	
		or surgical comorbidities that would make them at hig om carotid endarterectomy,	gh risk of perioperative
	excluding associ	ated radiological services or preparation, and excluding	g aftercare (Anaes.) (Assist.)
35307	(See para TN.8.37 Fee: \$1,121.15	of explanatory notes to this Category) Benefit: 75% = \$840.90	
	visceral arteries	AL STENT INSERTION, 1 or more stents, including a per veins, or more than 1 peripheral artery or vein of 1 ling associated radiological services or preparation, and	imb, percutaneous or by open
35309	Fee: \$762.35	Benefit: 75% = \$571.80 85% = \$678.95	
	percutaneous or	ARTERIAL ATHERECTOMY including associated baby open exposure, excluding associated radiological seare (Anaes.) (Assist.)	
35312	Fee: \$864.05	Benefit: 75% = \$648.05	
33312	2 CC C GOO		

T8. SUF	RGICAL OPERATIONS 3. VASCULAR
	or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)
	Fee: \$864.05 Benefit: 75% = \$648.05
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY CONTINUOUS INFUSION, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35319 or 35320 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.)
35317	(See para TN.8.38 of explanatory notes to this Category) Fee: \$355.80 Benefit: 75% = \$266.85 85% = \$302.45
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY PULSE SPRAY TECHNIQUE, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35320 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.)
35319	Fee: \$637.80 Benefit: 75% = \$478.35 85% = \$554.40
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY OPEN EXPOSURE, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35319 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.)
35320	Fee: \$856.70 Benefit: 75% = \$642.55 85% = \$773.30
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION to administer agents to occlude arteries, veins or arterio-venous fistulae or to arrest haemorrhage, (but not for the treatment of uterine fibroids or varicose veins) percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.)
35321	(See para TN.8.39 of explanatory notes to this Category) Fee: \$813.30 Benefit: 75% = \$610.00 85% = \$729.90
	ANGIOSCOPY not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)
35324	Fee: \$304.95 Benefit: 75% = \$228.75
	ANGIOSCOPY combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)
35327	Fee: \$408.70 Benefit: 75% = \$306.55
	INSERTION of INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)
35330	Fee: \$515.35 Benefit: 75% = \$386.55 85% = \$438.05
	RETRIEVAL OF INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (Anaes.)
	increasing associated radiological services of preparation, and not increasing afterence (Finales.)
35331	Fee: \$592.45 Benefit: 75% = \$444.35

T8. SUF	RGICAL OPERATIONS	3. VASCULAR
	associated radiological services or preparation, and not including aftercare	
	(foreign body does not include an instrument inserted for the purpose of a service (Anaes.) (Assist.)	being rendered)
	Fee: \$828.20 Benefit: 75% = \$621.15	
	Retrieval of foreign body in RIGHT ATRIUM, percutaneous or by open exposure associated radiological services or preparation, and not including aftercare	, not including
	(foreign body does not include an instrument inserted for the purpose of a service (Anaes.) (Assist.)	being rendered)
35361	Fee: \$710.30 Benefit: 75% = \$532.75	
	Retrieval of foreign body in INFERIOR VENA CAVA or AORTA, percutaneous not including associated radiological services or preparation, and not including aft	
	(foreign body does not include an instrument inserted for the purpose of a service (Anaes.) (Assist.)	being rendered)
35362	Fee: \$592.45 Benefit: 75% = \$444.35	
	Retrieval of foreign body in PERIPHERAL VEIN or PERIPHERAL ARTERY, polynomer, not including associated radiological services or preparation, and not including associated radiological services or preparation.	
	(foreign body does not include an instrument inserted for the purpose of a service (Anaes.) (Assist.)	being rendered)
35363	Fee: \$474.65 Benefit: 75% = \$356.00	
	INTERVENTIONAL RADIOLOGY PROCEDURES	
	DOSIMETRY, HANDLING AND INJECTION OF SIR-SPHERES for selective therapy of hepatic metastases which are secondary to colorectal cancer and are not or ablation, used in combination with systemic chemotherapy using 5-fluorouracil not being a service to which item 35317, 35319, 35320 or 35321 applies	suitable for resection
	The procedure must be performed by a specialist or consultant physician recognise nuclear medicine or radiation oncology on an admitted patient in a hospital. To be patient's lifetime only.	
35404	(See para TN.3.1, TN.8.40 of explanatory notes to this Category) Fee: \$346.60 Benefit: 75% = \$259.95	
2546	Trans-femoral catheterisation of the hepatic artery to administer SIR-Spheres to en microvasculature of hepatic metastases which are secondary to colorectal cancer a resection or ablation, for selective internal radiation therapy used in combination vechemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to wi 35319, 35320 or 35321 applies	nd are not suitable for vith systemic
35406		

T8. SUF	RGICAL OPERATIONS	3. VASCULAR
	excluding associated radiological services or preparation, and excluding	g aftercare (Anaes.) (Assist.)
	(See para TN.3.1, TN.8.40 of explanatory notes to this Category) Fee: \$813.30 Benefit: 75% = \$610.00	
	Catheterisation of the hepatic artery via a permanently implanted hepat Spheres to embolise the microvasculature of hepatic metastases which and are not suitable for resection or ablation, for selective internal radia with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin item 35317, 35319, 35320 or 35321 applies	are secondary to colorectal cancer ation therapy used in combination
	excluding associated radiological services or preparation, and excluding	g aftercare (Anaes.) (Assist.)
35408	(See para TN.3.1, TN.8.40 of explanatory notes to this Category) Fee: \$610.10 Benefit: 75% = \$457.60	
	UTERINE ARTERY CATHETERISATION with percutaneous adminithe treatment of symptomatic uterine fibroids in a patient who has been embolisation by a specialist gynaecologist, excluding associated radiologist excluding aftercare (Anaes.) (Assist.)	referred for uterine artery
35410	(See para TN.8.34 of explanatory notes to this Category) Fee: \$813.30 Benefit: 75% = \$610.00 85% = \$729.90	
	Intracranial aneurysm, ruptured or unruptured, endovascular occlusion assisted coiling if performed, with parent artery preservation, not for us including aftercare, including intra-operative imaging, but in associatio operative diagnostic imaging items:	se with liquid embolics only,
	- either 60009 or 60010; and	
	- either 60072, 60073, 60075, 60076, 60078 or 60079 (Anaes.) (Assi	ist.)
35412	(See para TN.8.35 of explanatory notes to this Category) Fee: \$2,857.55 Benefit: 75% = \$2143.20 85% = \$2774.15	
	Mechanical thrombectomy, in a patient with a diagnosis of acute ischae of a large vessel of the anterior cerebral circulation, including intra-ope	
	(a) the diagnosis is confirmed by an appropriate imaging modality such magnetic resonance imaging or angiography; and	as computed tomography,
	(b) the service is performed by a specialist or consultant physician with recognised by the Conjoint Committee for Recognition of Training in I and	
	(c) the service is provided in an eligible stroke centre.	
	For any particular patient - applicable once per presentation by the patier regardless of the number of times mechanical thrombectomy is attempt (Anaes.) (Assist.)	
35414	(See para TR.8.1 of explanatory notes to this Category) Fee: \$3,500.00 Benefit: 75% = \$2625.00	
TO CLIE	RGICAL OPERATIONS	4. GYNAECOLOGICAL

T8. SUF	GICAL OPERAT	TIONS	4. GYNAECOLOGICAL
		Sub	ogroup 4. Gynaecological
		GICAL EXAMINATION U	JNDER ANAESTHESIA, not being a service associated with up applies (Anaes.)
35500	Fee: \$81.30	Benefit: 75% = \$61.00	85% = \$69.15
	ENDOMETRI <i>A</i>		TION OF, for the control of idiopathic menorrhagia, AND ometrial pathology, not being a service associated with a applies (Anaes.)
35502	Fee: \$80.15	Benefit: 75% = \$60.15	85% = \$68.15
			tion of, if the service is not associated with a service to which an a service mentioned in item 30062) (Anaes.)
35503	Fee: \$53.55	Benefit: 75% = \$40.20	85% = \$45.55
		A, not being a service assoc	VICE, REMOVAL OF UNDER GENERAL iated with a service to which another item in this Group
35506	Fee: \$53.70	Benefit: 75% = \$40.30	85% = \$45.65
	nerve block (ex	cluding pudendal block) req 45 minutes - not being a se	ral of under general anaesthesia, or under regional or field quiring admission to a hospital, where the time taken is less rvice associated with a service to which item 32177 or 32180
35507	Fee: \$174.45	Benefit: 75% = \$130.85	5 85% = \$148.30
	nerve block (ex	cluding pudendal block) req minutes - not being a servic	ral of under general anaesthesia, or under regional or field quiring admission to a hospital, where the time taken is e associated with a service to which item 32177 or 32180
35508	Fee: \$256.95	Benefit: 75% = \$192.73	5 85% = \$218.45
	HYMENECTO	MY (Anaes.)	
35509	Fee: \$89.45	Benefit: 75% = \$67.10	85% = \$76.05
	BARTHOLIN'S	CYST, excision of (Anaes	.)
35513	Fee: \$221.70	Benefit: 75% = \$166.30	0 85% = \$188.45
	BARTHOLIN'S	CYST OR GLAND, marsu	upialisation of (Anaes.)
35517	Fee: \$146.00	Benefit: 75% = \$109.56	0 85% = \$124.10
	OVARIAN CY least 2cm in dia	ST ASPIRATION, for cysts meter in a postmenopausal J	s of at least 4cm in diameter in a premenopausal person and at person, by abdominal or vaginal route, using interventional services provided for assisted reproductive techniques
35518	(See para TN.4.11) Fee: \$207.85	of explanatory notes to this C Benefit: 75% = \$155.96	
	BARTHOLIN'S	S ABSCESS, incision of (Ar	naes.)
	Fee: \$58.30	Benefit: 75% = \$43.75	050/ 040.60

T8. SUF	RGICAL OPERAT	TIONS	4. GYNAECOLOGICAL
	URETHRA OR	URETHRAL CARUNCLE, cauterisation of (Anaes.)	
35523	Fee: \$58.30	Benefit: 75% = \$43.75 85% = \$49.60	
		ARUNCLE, excision of (Anaes.)	
35527	Fee: \$146.00	Benefit: 75% = \$109.50 85% = \$124.10	
50027		outation of, where medically indicated (Anaes.) (Assist.)	
35530	Fee: \$269.85	Benefit: 75% = \$202.40	
33330		abioplasty, for repair of:	
	(a) female genit	al mutilation; or	
			1 1 1 1
	(b) an anomaly	associated with a major congenital anomaly of the uro-g	ynaecological tract
	other than a serv 43882 applies (A	vice associated with a service to which item 35536, 3783 Anaes.)	6, 37050, 37842, 37851 or
		23 of explanatory notes to this Category)	
35533	Fee: \$349.85	Benefit: 75% = \$262.40 abioplasty, in a patient aged 18 years or more, performed	d by a specialist in the practice
	of the specialist if the patient's la	s specialty, for a structural abnormality that is causing sibium extends more than 8 cm below the vaginal introitu position (Anaes.)	ignificant functional impairment,
35534	(See para TN.8.12 Fee: \$349.85	23 of explanatory notes to this Category) Benefit: 75% = \$262.40	
	VULVA, wide l (Anaes.) (Assist	ocal excision of suspected malignancy or hemivulvector .)	ny, 1 or both procedures
35536	Fee: \$348.45	Benefit: 75% = \$261.35 85% = \$296.20	
	COLPOSCOPICALLY DIRECTED CO ² LASER THERAPY for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 1 anatomical site (Anaes.)		
35539	Fee: \$272.95	Benefit: 75% = \$204.75 85% = \$232.05	
	COLPOSCOPICALLY DIRECTED CO ² LASER THERAPY for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 2 or more anatomical sites (Anaes.) (Assist.)		
35542	Fee: \$319.60	Benefit: 75% = \$239.70 85% = \$271.70	
	COLPOSCOPIO by other method	CALLY DIRECTED CO ² LASER THERAPY for condy is (Anaes.)	lomata, unsuccessfully treated
35545	Fee: \$183.60	Benefit: 75% = \$137.70 85% = \$156.10	
	VULVECTOMY, radical, for malignancy (Anaes.) (Assist.)		
35548	Fee: \$834.05	Benefit: 75% = \$625.55	
		H GLANDS, excision of (radical) (Anaes.) (Assist.)	
35551	Fee: \$683.90	Benefit: 75% = \$512.95	
35554		ATATION OF, as an independent procedure including an	ny associated consultation

T8. SUF	RGICAL OPERATI	ONS	4. GYNAECOLOGICAL	
	(Anaes.)			
	Fee: \$43.50	Benefit: 75% = \$32.65 85% = \$37.00		
		ral of simple tumour (including Gartner duct cyst) (A	naes.)	
35557	Fee: \$214.50	Benefit: 75% = \$160.90 85% = \$182.35		
30007		or complete removal of (Anaes.) (Assist.)		
35560	Fee: \$683.90	Benefit: 75% = \$512.95		
		Y, radical, for proven invasive malignancy - 1 surgeo	on (Anaes.) (Assist.)	
35561	Fee: \$1,379.50	Benefit: 75% = \$1034.65		
33301	VAGINECTOM	Y, radical, for proven invasive malignancy, conjoint sure) (Anaes.) (Assist.)	surgery - abdominal surgeon	
35562	Fee: \$1,132.60	Benefit: 75% = \$849.45		
		Y, radical, for proven invasive malignancy, conjoints	surgery - perineal surgeon (Assist.)	
35564	Fee: \$522.85	Benefit: 75% = \$392.15		
		ONSTRUCTION for congenital absence, gynatresia	or urogenital sinus (Anaes.)	
35565	Fee: \$683.90	Benefit: 75% = \$512.95		
	VAGINAL SEPT	TUM, excision of, for correction of double vagina (An	naes.) (Assist.)	
35566	Fee: \$397.25	Benefit: 75% = \$297.95		
	SACROSPINOU (Assist.)	S COLPOPEXY FOR MANAGEMENT OF UPPER	2 VAGINAL PROLAPSE (Anaes.)	
35568	Fee: \$624.60	Benefit: 75% = \$468.45		
	PLASTIC REPA	IR TO ENLARGE VAGINAL ORIFICE (Anaes.)		
35569	Fee: \$160.85	Benefit: 75% = \$120.65 85% = \$136.75		
	Anterior vaginal compartment repair by vaginal approach for pelvic organ prolapse (involving repair of urethrocele and cystocele), using native tissue without graft, other than a service associated with a service to which item 35573, 35577 or 35578 applies.			
	(Anaes.) (Assist	<i>i.</i>)		
35570	Fee: \$553.85	Benefit: 75% = \$415.40		
	Posterior vaginal compartment repair by vaginal approach for pelvic organ prolapse involving repair of one or more of the following:			
	(a) perineum;			
	(b) rectocoele;			
	(c) enterocoele;			
		e without graft, other than a service associated with a	a service to which item 35573,	
35571	33311 01 33318 a	ppnes.		

T8. SUF	RGICAL OPERATIONS 4. GYNAECOLOGICAL
	(Anaes.) (Assist.)
	Fee: \$553.85 Benefit: 75% = \$415.40
	COLPOTOMY not being a service to which another item in this Group applies (Anaes.)
35572	Fee: \$123.80 Benefit: 75% = \$92.85
	Anterior and posterior vaginal compartment repair by vaginal approach for pelvic organ prolapse (involving anterior and posterior compartment defects), using native tissue without graft, other than a service associated with a service to which item 35577 or 35578 applies.
	(Anaes.) (Assist.)
35573	Fee: \$830.90 Benefit: 75% = \$623.20
	Manchester (Donald Fothergill) operation for pelvic organ prolapse (includes cervical amputation, anterior and posterior native tissue vaginal wall repairs without graft).
	(Anaes.) (Assist.)
35577	Fee: \$674.50 Benefit: 75% = \$505.90
	LE FORT OPERATION for genital prolapse, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) (Assist.)
35578	Fee: \$674.50 Benefit: 75% = \$505.90
	Vaginal procedure for excision of graft material in symptomatic patients with graft related complications, including graft related pain or discharge and bleeding related to graft exposure, less than 2cm ² in its maximum area, either singly or in multiple pieces, other than a service associated with a service to which item 35582 or 35585 applies.
	(Anaes.) (Assist.)
35581	(See para TN.8.140 of explanatory notes to this Category) Fee: \$553.85 Benefit: 75% = \$415.40
	Vaginal procedure for excision of graft material in symptomatic patients with graft related complications, including graft related pain or discharge and bleeding related to graft exposure, more than
	2cm² in its maximum area, either singly or in multiple pieces, other than a service associated with a service to which item 35581 or 35585 applies.
	(Anaes.) (Assist.)
35582	(See para TN.8.140 of explanatory notes to this Category) Fee: \$830.90 Benefit: 75% = \$623.20
	Abdominal procedure either open, laparoscopic or robotic, for removal of graft material in patients symptomatic with graft related complications, including graft related pain or discharge and bleeding related to graft exposure or where the graft has penetrated adjacent organs such as the bladder (including urethra) or bowel, including retroperitoneal dissection and mobilisation of bladder and/or bowel, other than a service associated with a service to which item 35581 or 35582 applies.
35585	(Anaes.) (Assist.)

T8. SUF	RGICAL OPERATI	ONS	4. GYNAECOLOGICAL	
	Fee: \$1,473.20	Benefit: 75% = \$1104.90		
	FIXATION OF T	C OR ABDOMINAL PELVIC FLOOR REPAIL THE UTEROSACRAL AND CARDINAL LIGA L FASCIA for symptomatic upper vaginal vault	AMENTS TO RECTOVAGINAL AND	
35595	Fee: \$1,155.00	Benefit: 75% = \$866.25		
		VEEN GENITAL AND URINARY OR ALIME th item 37029, 37333 or 37336 applies (Anaes.) (
35596	Fee: \$683.90	Benefit: 75% = \$512.95		
		OPEXY, laparoscopic or open procedure where npartment and to sacrum for correction of sympt		
35597	Fee: \$1,473.20	Benefit: 75% = \$1104.90		
		TINENCE, sling operation for, with or without service to which item 30405 applies (Anaes.) (A		
35599	Fee: \$674.50	Benefit: 75% = \$505.90		
	procedure, with o	TINENCE, combined synchronous ABDOMING or without mesh, (including aftercare), not being 5 applies (Anaes.) (Assist.)		
35602	Fee: \$674.50	Benefit: 75% = \$505.90		
	procedure, with o	TINENCE, combined synchronous ABDOMING or without mesh, (including aftercare), not being 5 applies (Assist.)		
35605	Fee: \$365.95	Benefit: 75% = \$274.50 85% = \$311.10		
	CERVIX, cauterisation (other than by chemical means), ionisation, diathermy or biopsy of, with or without dilatation of cervix (Anaes.)			
35608	Fee: \$64.00	Benefit: 75% = \$48.00 85% = \$54.40		
	· ·	al of polyp or polypi, with or without dilatation of which item 35608 applies (Anaes.)	of cervix, not being a service associated	
35611	Fee: \$64.00	Benefit: 75% = \$48.00 85% = \$54.40		
	CERVIX, RESIDUAL STUMP, removal of, by abdominal approach (Anaes.) (Assist.)			
35612	Fee: \$506.00	Benefit: 75% = \$379.50 85% = \$430.10		
	CERVIX, RESID	DUAL STUMP, removal of, by vaginal approach	(Anaes.) (Assist.)	
35613	Fee: \$404.80	Benefit: 75% = \$303.60		
	EXAMINATION OF LOWER TRACT by a Hinselmanntype colposcope in a patient with a previous abnormal cervical smear screen result or a history of maternal ingestion of oestrogen or where a patient, because of suspicious signs of cancer, has been referred by another medical practitioner (Anaes.)			
35614	(See para TN.8.42 Fee: \$63.90	of explanatory notes to this Category) Benefit: 75% = \$47.95 85% = \$54.35		
35615	VULVA, biopsy	of, when performed in conjunction with a service	ee to which item 35614 applies	

T8. SUF	RGICAL OPERATIO	NS	4. GYNAECOLOGICAL
	Fee: \$53.70	Benefit: 75% = \$40.30 85% =	= \$45.65
	radiofrequency elec		l ablation of, by microwave or thermal balloon or ry menorrhagia including any hysteroscopy e curettage (Anaes.)
35616	Fee: \$449.60	Benefit: 75% = \$337.20	
	CERVIX, cone biopsy, amputation or repair of, other than a service to which item 35577 or 35578 applies (Anaes.)		
35618	Fee: \$218.00	Benefit: 75% = \$163.50 85%	= \$185.30
	ENDOMETRIAL I post menopausal bl		uspected in patients with abnormal uterine bleeding or
35620	Fee: \$53.35	Benefit: 75% = \$40.05 85% =	= \$45.35
	including any hyste		or or diathermy, for chronic refractory menorrhagia e day, with or without uterine curettage, not being a 190 applies (Anaes.)
35622	Fee: \$602.45	Benefit: 75% = \$451.85	
		C RESECTION of myoma, or need by endometrial ablation by la	nyoma and uterine septum resection (where both are aser or diathermy (Anaes.)
35623	Fee: \$819.25	Benefit: 75% = \$614.45	
	where the patient is	referred to him or her for the in	by a specialist in the practice of his or her specialty investigation of suspected intrauterine pathology (with a sociated with a service to which item 35627 or 35630
35626	(See para TN.8.43 of Fee: \$82.80	explanatory notes to this Category Benefit: 75% = \$62.10 85% =	
	HYSTEROSCOPY with dilatation of the cervix performed in the operating theatre of a hospital - not being a service associated with a service to which item 35626 or 35630 applies (Anaes.)		
35627	Fee: \$107.15	Benefit: 75% = \$80.40	
			ormed in the operating theatre of a hospital - not being 5626 or 35627 applies (Anaes.)
35630	Fee: \$183.00	Benefit: 75% = \$137.25	
			lypectomy or tubal catheterisation (including for UD which cannot be removed by other means, 1 or
35633	Fee: \$218.00	Benefit: 75% = \$163.50 85%	= \$185.30
	HYSTEROSCOPIC diathermy (Anaes.)		m followed by endometrial ablation by laser or
35634	Fee: \$685.70	Benefit: 75% = \$514.30 85%	= \$602.30
	HYSTEROSCOPY	involving resection of the uter	ne septum (Anaes.)
35635	Fee: \$299.45	Benefit: 75% = \$224.60	
35636			, or resection of myoma and uterine septum (where

T8. SUF	RGICAL OPERATIONS		4. GYNAECOLOGICAL
	both are performed) (Ar	naes.)	
	Fee: \$433.00 Be	enefit: 75% = \$324.75	
	of adhesions or similar	lving puncture of cysts, diathermy of endomet procedure - 1 or more procedures with or with er laparoscopic procedure or hysterectomy (Ar	out biopsy - not being a service
35637		natory notes to this Category) enefit: 75% = \$305.00	
	of the following proced salpingostomy, ablation or division of utero-sact	RATIVE LAPAROSCOPY, including use of laures; oophorectomy, ovarian cystectomy, myo of moderate or severe endometriosis requiring ral ligaments for significant dysmenorrhoea - rul or retroperitoneal procedure except item 303	mectomy, salpingectomy or g more than 1 hours operating time, not being a service associated with
35638	Fee: \$711.50 Be	enefit: 75% = \$533.65	
	miscarriage) under gene	GE OF, with or without dilatation (including exeral anaesthesia, or under epidural or spinal (in m 35626, 35627 or 35630 applies, if performed	trathecal) nerve block, including
35640		anatory notes to this Category) enefit: 75% = \$137.25	
	following procedures, retissue from the ureter, rethan 2 cms in diameter,	EVEL 4 OR 5, LAPAROSCOPIC RESECTION esection of the pelvic side wall including disse esection of the Pouch of Douglas, resection of dissection of bowel from uterus from the level ting time exceeds 90 minutes (Anaes.) (Assist.	ection of endometriosis or scar an ovarian endometrioma greater I of the endocervical junction or
35641	Fee: \$1,242.65 Be	enefit: 75% = \$932.00	
	CURETTAGE other tha	IE CONTENTS OF THE GRAVID UTERUS an a service to which item 35640 applies, incluapplies, if performed (Anaes.)	
35643	Fee: \$218.00 Be	enefit: 75% = \$163.50 85% = \$185.30	
	neoplastic changes of th	lation diathermy with colposcopy, for previous ne cervix, including any local anaesthesia and be to which item 35640 or 35647 applies (Anae	piopsies, other than a service
35644		anatory notes to this Category) enefit: 75% = \$152.75 85% = \$173.15	
	neoplastic changes of the ablative therapy of addi	lation diathermy with colposcopy, for previous ne cervix, including any local anaesthesia and be tional areas of intraepithelial change in 1 or me vice associated with a service to which item 35	piopsies, in conjunction with ore sites of vagina, vulva, urethra
35645		anatory notes to this Category) enefit: 75% = \$239.05	
		with radical diathermy of, with or without cervial neoplastic changes of the cervix (Anaes.)	ical biopsy, for previously
35646		anatory notes to this Category) enefit: 75% = \$152.75 85% = \$173.15	

T8. SUF	RGICAL OPERATIONS	4. GYNAECOLOGICAL
	CERVIX, large loop excision of transformation zone together wintraepithelial neoplastic changes of the cervix, including any loservice associated with a service to which item 35644 applies (A	ocal anaesthesia and biopsies, not being a
35647	(See para TN.8.45 of explanatory notes to this Category) Fee: \$203.65 Benefit: 75% = \$152.75 85% = \$173.15	
	CERVIX, large loop excision diathermy for previously confirme the cervix, including any local anaesthesia and biopsies, in conju- additional areas of intraepithelial change of 1 or more sites of va- service associated with a service to which item 35645 applies (A	unction with ablative treatment of agina, vulva, urethra or anus, not being a
35648	(See para TN.8.45 of explanatory notes to this Category) Fee: \$318.70 Benefit: 75% = \$239.05 85% = \$270.90	
	HYSTEROTOMY or UTERINE MYOMECTOMY, abdominal	(Anaes.) (Assist.)
35649	Fee: \$536.00 Benefit: 75% = \$402.00	
	HYSTERECTOMY, ABDOMINAL, SUBTOTAL or TOTAL, adnexae (Anaes.) (Assist.)	with or without removal of uterine
35653	Fee: \$674.70 Benefit: 75% = \$506.05	
	HYSTERECTOMY, VAGINAL, with or without uterine curetta 35673 applies NOTE: Strict legal requirements apply in relation to sterilisation benefits are not payable for services not rendered in accordance and Territory law. Observe the explanatory note before submitted.	on procedures on minors. Medicare e with relevant Commonwealth and State
35657	(See para TN.8.46 of explanatory notes to this Category) Fee: \$674.70 Benefit: 75% = \$506.05	
	UTERUS (at least equivalent in size to a 10 week gravid uterus) at hysterectomy (Anaes.) (Assist.)), debulking of, prior to vaginal removal
35658	(See para TN.8.47 of explanatory notes to this Category) Fee: \$416.05 Benefit: 75% = \$312.05	
	HYSTERECTOMY, ABDOMINAL, requiring extensive retrop exposure of 1 or both ureters, for the management of severe end or benign pelvic tumours, with or without conservation of the over the content of the order of the content of the c	lometriosis, pelvic inflammatory disease
35661	Fee: \$871.30 Benefit: 75% = \$653.50	
	RADICAL HYSTERECTOMY with radical excision of pelvic of uterine adnexae) for proven malignancy including excision of paracolpos, upper vagina or contiguous pelvic peritoneum and in (Anaes.) (Assist.)	f any 1 or more of parametrium,
35664	Fee: \$1,452.20 Benefit: 75% = \$1089.15	
	RADICAL HYSTERECTOMY without gland dissection (with of for proven malignancy including excision of any 1 or more of page 1.2).	
	contiguous pelvic peritoneum and involving ureterolysis where	

T8. SUF	RGICAL OPERATI	ONS	4. GYNAECOLOGICAL
		MY, abdominal, with radical excision of pelvic le (Anaes.) (Assist.)	ymph glands, with or without removal
35670	Fee: \$1,016.30	Benefit: 75% = \$762.25	
		MY, VAGINAL (with or without uterine curettagarian cyst, 1 or more, 1 or both sides (Anaes.) (A	
35673	Fee: \$757.80	Benefit: 75% = \$568.35	
	ULTRASOUND	GUIDED NEEDLING and injection of ectopic	pregnancy
35674	(See para TN.4.11 Fee: \$207.85	of explanatory notes to this Category) Benefit: 75% = \$155.90 85% = \$176.70	
	ECTOPIC PREG	NANCY, removal of (Anaes.) (Assist.)	
35677	Fee: \$536.00	Benefit: 75% = \$402.00	
	ECTOPIC PREG	NANCY, laparoscopic removal of (Anaes.) (As	sist.)
35678	Fee: \$646.25	Benefit: 75% = \$484.70	
	BICORNUATE	UTERUS, plastic reconstruction for (Anaes.) (A	ssist.)
35680	Fee: \$582.05	Benefit: 75% = \$436.55 85% = \$498.65	
	UTERUS, SUSP	ENSION OR FIXATION OF, as an independent	t procedure (Anaes.) (Assist.)
35684	Fee: \$471.15	Benefit: 75% = \$353.40	
		N BY TRANSECTION OR RESECTION OF Facility or any other m	
	benefits are not p	gal requirements apply in relation to sterilisation ayable for services not rendered in accordance v. Observe the explanatory note before submitti	with relevant Commonwealth and State
35688	(See para TN.8.46 Fee: \$397.25	of explanatory notes to this Category) Benefit: 75% = \$297.95	
	STERILISATION with Caesarean se	N BY INTERRUPTION OF FALLOPIAN TUB ection	BES, when performed in conjunction
	benefits are not p	gal requirements apply in relation to sterilisation ayable for services not rendered in accordance on. Observe the explantory note before submitting	with relevant Commonwealth and State
35691	(See para TN.8.46 Fee: \$158.70	of explanatory notes to this Category) Benefit: 75% = \$119.05	
		(salpingostomy, salpingolysis or tubal implantator more procedures (Anaes.) (Assist.)	ion into uterus), UNILATERAL or
35694	Fee: \$637.70	Benefit: 75% = \$478.30	
35697		AL TUBOPLASTY (salpingostomy, salpingoly	rsis or tubal implantation into uterus),

T8. SUF	RGICAL OPERAT	IONS	4. GYNAECOLOGICA
	UNILATERAL	or BILATERAL, 1 or more proceed	edures (Anaes.) (Assist.)
	Fee: \$946.20	Benefit: 75% = \$709.65	
	FALLOPIAN T (Assist.)	JBES, unilateral microsurgical and	nastomosis of, using operating microscope (Anaes.)
35700	Fee: \$730.05	Benefit: 75% = \$547.55	
		TION OF FALLOPIAN TUBES as a service to which another item in	as a nonrepetitive procedure not being a service this Sub-group applies (Anaes.)
35703	Fee: \$67.50	Benefit: 75% = \$50.65 85% =	= \$57.40
	RUBIN TEST F	OR PATENCY OF FALLOPIAN	N TUBES (Anaes.)
35706	Fee: \$67.50	Benefit: 75% = \$50.65 85% =	= \$57.40
	FALLOPIAN T	JBES, hydrotubation of, as a repet	etitive postoperative procedure (Anaes.)
35709	Fee: \$43.50	Benefit: 75% = \$32.65 85% =	= \$37.00
	FALLOPOSCO (Assist.)	PY, unilateral or bilateral, including	ng hysteroscopy and tubal catheterization (Anaes.)
35710	Fee: \$463.30	Benefit: 75% = \$347.50	
	OOPHORECTO	MY, removal of OVARIAN, PAR	, SALPINGECTOMY, SALPINGO- RAOVARIAN, FIMBRIAL or BROAD LIGAMENT associated with hysterectomy (Anaes.) (Assist.)
35713	Fee: \$452.85	Benefit: 75% = \$339.65	
	OOPHORECTO	MY, removal of OVARIAN, PAR re such procedures, unilateral or bi	, SALPINGECTOMY, SALPINGO- RAOVARIAN, FIMBRIAL or BROAD LIGAMENT bilateral, other than a service associated with
35717	Fee: \$545.30	Benefit: 75% = \$409.00	
	RADICAL OR I omentectomy (A		advanced gynaecological malignancy, with or without
35720	(See para TN.8.57 Fee: \$674.50	of explanatory notes to this Category Benefit: 75% = \$505.90	y)
		NEAL LYMPH NODE BIOPSIE ing of gynaecological malignancy	ES from above the level of the aortic bifurcation, for y (Anaes.) (Assist.)
35723	Fee: \$483.10	Benefit: 75% = \$362.35	
		OMENTECTOMY with multiple pnalignancy (Anaes.) (Assist.)	peritoneal biopsies for staging or restaging of
35726	Fee: \$483.10	Benefit: 75% = \$362.35	
	OVARIAN TRA	· ·	in conjunction with radical hysterectomy for invasive
35729	Fee: \$217.80	Benefit: 75% = \$163.35	
35730			reserve ovarian function, prior to gonadotoxic of radiation have a high probability of causing

T8. SUF	RGICAL OPERATIONS 4. GYNAECOLOGICA
	infertility (Anaes.)
	Fee: \$217.80 Benefit: 75% = \$163.35
	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, including any associated laparoscopy (Anaes.) (Assist.)
35750	Fee: \$784.60 Benefit: 75% = \$588.45
	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY with one or more of the following procedures: salpingectomy, oophorectomy, excision of ovarian cyst or treatment of moderate endometriosis, one or both sides, including any associated laparoscopy (Anaes.) (Assist.)
35753	Fee: \$867.60 Benefit: 75% = \$650.70
	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY which requires dissection of endometriosis, or other pathology, from the ureter, one or both sides, including any associated laparoscopy, including when performed with one or more of the following procedures: salpingectomy, oophorectomy, excisio of ovarian cyst, or treatment of endometriosis, not being a service to which item 35641 applies (Anaes. (Assist.)
35754	Fee: \$1,091.90 Benefit: 75% = \$818.95
	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, when procedure is completed by open hysterectomy, including any associated laparoscopy (Anaes.) (Assist.)
35756	Fee: \$784.60 Benefit: 75% = \$588.45
	Procedure for the control of POST OPERATIVE HAEMORRHAGE following gynaecological surgery under general anaesthesia, utilising a vaginal or abdominal and vaginal approach where no other procedure is performed (Anaes.) (Assist.)
35759	Fee: \$563.30 Benefit: 75% = \$422.50
T8. SUF	RGICAL OPERATIONS 5. UROLOGICA
	Group T8. Surgical Operations
	Subgroup 5. Urological
	GENERAL
	PELVIC LYMPHADENECTOMY, open or laparoscopic, or both, unilateral or bilateral (Anaes.) (Assist.)
36502	Fee: \$683.90 Benefit: 75% = \$512.95
	RENAL TRANSPLANT (not being a service to which item 36506 or 36509 applies) (Anaes.) (Assist.)
36503	Fee: \$1,391.15 Benefit: 75% = \$1043.40
	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together vascular anastomosis including aftercare (Anaes.) (Assist.)
36506	Fee: \$924.70 Benefit: 75% = \$693.55
36506	Fee: \$924.70 Benefit: 75% = \$693.55 RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together ureterovesical anastomosis including aftercare (Assist.)

T8. SUF	RGICAL OPERATION	ONS 5. UROLOGICAL
	NEPHRECTOMY	, complete (Anaes.) (Assist.)
36516	Fee: \$924.70	Benefit: 75% = \$693.55
30310	_	, complete, complicated by previous surgery on the same kidney (Anaes.) (Assist.)
36519	Fee: \$1,291.10	Benefit: 75% = \$968.35
	NEPHRECIONY	, partial (Anaes.) (Assist.)
36522	Fee: \$1,107.95	Benefit: 75% = \$831.00
	NEPHRECTOMY	, partial, complicated by previous surgery on the same kidney (Anaes.) (Assist.)
36525	Fee: \$1,574.45	Benefit: 75% = \$1180.85
	tumour less than 1	r, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a 0cms in diameter, where performed if malignancy is clinically suspected but not epathological examination (Anaes.) (Assist.)
36526	(See para TN.8.48 o Fee: \$1,291.10	f explanatory notes to this Category) Benefit: $75\% = \$968.35$ $85\% = \$1207.70$
	tumour 10cms or same kidney, whe	r, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a more in diameter, or complicated by previous open or laparoscopic surgery on the re performed if malignancy is clinically suspected but not confirmed by examination (Anaes.) (Assist.)
36527	(See para TN.8.48 o Fee: \$1,593.40	f explanatory notes to this Category) Benefit: $75\% = 1195.05 $85\% = 1510.00
		, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a 0 cms in diameter (Anaes.) (Assist.)
36528	Fee: \$1,291.10	Benefit: 75% = \$968.35
		r, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a more in diameter, or complicated by previous open or laparoscopic surgery on the es.) (Assist.)
36529	Fee: \$1,593.40	Benefit: 75% = \$1195.05
		RECTOMY, complete, including associated bladder repair and any associated ures (Anaes.) (Assist.)
36531	Fee: \$1,157.85	Benefit: 75% = \$868.40
		RECTOMY, for tumour, with or without en bloc dissection of lymph nodes, including repair and any associated endoscopic procedures (Anaes.) (Assist.)
36532	Fee: \$1,661.85	Benefit: 75% = \$1246.40
	associated bladder	RECTOMY, for tumour, with or without en bloc dissection of lymph nodes, including repair and any associated endoscopic procedures, complicated by previous open or ry on the same kidney or ureter (Anaes.) (Assist.)
36533	Fee: \$1,964.15	Benefit: 75% = \$1473.15
	KIDNEY OR PER	INEPHRIC AREA, EXPLORATION OF, with or without drainage of, by open
		g a service to which another item in this Sub-group applies (Anaes.) (Assist.)

RGICAL OPERATI	ONS 5. UROLOGICAL
	TOMY OR PYELOLITHOTOMY, or both, through the same skin incision, for 1 or 2 Assist.)
Fee: \$1,107.95	Benefit: 75% = \$831.00 85% = \$1024.55
stones, including	TOMY OR PYELOLITHOTOMY, or both, extended, for staghorn stone or 3 or more 1 or more of the following: nephrostomy, pyelostomy, pedicle control with or without aphy or pyeloplasty (Anaes.) (Assist.)
Fee: \$1,291.10	Benefit: 75% = \$968.35 85% = \$1207.70
	REAL SHOCK WAVE LITHOTRIPSY (ESWL) to urinary tract and posttreatment care ing pretreatment consultation, unilateral (Anaes.)
Fee: \$691.40	Benefit: 75% = \$518.55 85% = \$608.00
URETEROLITH	OTOMY (Anaes.) (Assist.)
Fee: \$833.10	Benefit: 75% = \$624.85
NEPHROSTOM	Y or pyelostomy, open, as an independent procedure (Anaes.) (Assist.)
Fee: \$741.50	Benefit: 75% = \$556.15
RENAL CYST C	R CYSTS, excision or unroofing of (Anaes.) (Assist.)
Fee: \$649.80	Benefit: 75% = \$487.35 85% = \$566.40
-	(closed) (Anaes.)
Fee: \$172.50	Benefit: 75% = \$129.40 85% = \$146.65
PYELOPLASTY	(plastic reconstruction of the pelvi-ureteric junction) by open exposure, laparoscopy ssisted techniques (Anaes.) (Assist.)
Fee: \$924.70	Benefit: 75% = \$693.55
	in a kidney that is congenitally abnormal in addition to the presence of PUJ a solitary kidney, by open exposure (Anaes.) (Assist.)
Fee: \$1,016.30	Benefit: 75% = \$762.25
PYELOPLASTY (Assist.)	, complicated by previous surgery on the same kidney, by open exposure (Anaes.)
Fee: \$1,291.10	Benefit: 75% = \$968.35
DIVIDED URET	ER, repair of (Anaes.) (Assist.)
Fee: \$924.70	Benefit: 75% = \$693.55
	re and exploration of, including repair or nephrectomy, for trauma, not being a service by other procedure performed on the kidney, renal pelvis or renal pedicle (Anaes.)
Fee: \$1,157.85	Benefit: 75% = \$868.40
	MY, COMPLETE OR PARTIAL, with or without associated bladder repair, not being a with a service to which item 37000 applies (Anaes.) (Assist.)
Fee: \$741.50	Benefit: 75% = \$556.15
URETER, transpl	antation of, into skin (Anaes.) (Assist.)
	NEPHROLITHO's tones (Anaes.) (

T8. SUF	RGICAL OPERATI	ons	5. UROLOGICAL
	Fee: \$741.50	Benefit: 75% = \$556.15	
	URETER, reimp	antation into bladder (Anaes.) (Assist.)	
36588	Fee: \$924.70	Benefit: 75% = \$693.55	
	URETER, reimp	antation into bladder with psoas hitch or Boari flap or	r both (Anaes.) (Assist.)
36591	Fee: \$1,107.95	Benefit: 75% = \$831.00	
	URETER, transp	lantation of, into intestine (Anaes.) (Assist.)	
36594	Fee: \$924.70	Benefit: 75% = \$693.55	
	URETER, transp	lantation of, into another ureter (Anaes.) (Assist.)	
36597	Fee: \$924.70	Benefit: 75% = \$693.55	
	URETER, transp	lantation of, into isolated intestinal segment, unilatera	ıl (Anaes.) (Assist.)
36600	Fee: \$1,107.95	Benefit: 75% = \$831.00 85% = \$1024.55	
		plantation of, into isolated intestinal segment, bilatera	al (Anaes.) (Assist.)
36603	Fee: \$1,291.10	Benefit: 75% = \$968.35	
30003		NT, passage of through percutaneous nephrostomy tu	be, using interventional imaging
	techniques (Anae		, , ,
36604	Fee: \$267.65	Benefit: 75% = \$200.75 85% = \$227.55	
	URETERIC STE	NT, insertion of, with removal of calculus from:	
	(a) the pelvicalyceal system; or		
	(b) ureter; or		
	(c) the pelvicalyceal system and ureter;		
	through a nephrostomy tube using interventional imaging techniques (Anaes.)		
36605	Fee: \$690.70	Benefit: 75% = \$518.05	
		RINARY RESERVOIR, continent, formation of, includation of ureters (1 or both) into reservoir (Anaes.) (A	
36606	Fee: \$2,315.80	Benefit: 75% = \$1736.85	
	URETERIC STENT insertion of, with baloon dilatation of:		
	(a) the pelvicalyceal system; or		
	(b) ureter; or		
	(c) the pelvicalyceal system and ureter;		
	through a nephrostomy tube using interventional imaging techniques (Anaes.)		
36607	Fee: \$690.70	Benefit: 75% = \$518.05	
36608		NT, exchange of, percutaneously through either the il aging techniques, not being a service associated with	

T8. SUF	RGICAL OPERAT	IONS 5. UROLOGICAL
	36854 apply (An	aes.)
	Fee: \$267.65	Benefit: 75% = \$200.75
	INTESTINAL U	RINARY CONDUIT OR URETEROSTOMY, revision of (Anaes.) (Assist.)
36609	Fee: \$741.50	Benefit: 75% = \$556.15
	URETER, explo	ration of, with or without drainage of, as an independent procedure (Anaes.) (Assist.)
36612	Fee: \$649.80	Benefit: 75% = \$487.35
	either radiologic	(S, with or without repositioning of the ureter, for obstruction of the ureter, evident ally or by proximal ureteric dilatation at operation, secondary to retroperitoneal fibrosis, ion (Anaes.) (Assist.)
36615	Fee: \$741.50	Benefit: 75% = \$556.15
	REDUCTION U	RETEROPLASTY (Anaes.) (Assist.)
36618	Fee: \$649.80	Benefit: 75% = \$487.35
	CLOSURE OF O	CUTANEOUS URETEROSTOMY (Anaes.) (Assist.)
36621	Fee: \$464.50	Benefit: 75% = \$348.40
	NEPHROSTOM	Y, percutaneous, using interventional imaging techniques (Anaes.) (Assist.)
36624	Fee: \$558.10	Benefit: 75% = \$418.60 85% = \$474.70
		Y, percutaneous, with or without any 1 or more of; stone extraction, biopsy or eing a service to which item 36639, 36642, 36645 or 36648 applies (Anaes.)
36627	Fee: \$691.40	Benefit: 75% = \$518.55
	substantial portion	Y, BEING A SERVICE TO WHICH ITEM 36627 APPLIES, WHERE, after a on of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE UE TO BLEEDING (Anaes.) (Assist.)
36630	Fee: \$341.50	Benefit: 75% = \$256.15
	ureter and includ	Y, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ing antegrade insertion of ureteric stent, not being a service associated with a service to 7, 36639, 36642, 36645 or 36648 applies (Anaes.) (Assist.)
36633	Fee: \$741.50	Benefit: 75% = \$556.15 85% = \$658.10
	ureter and includ	Y, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ing antegrade insertion of ureteric stent, being a service associated with a service to 7, 36639, 36642, 36645 or 36648 applies (Anaes.) (Assist.)
36636	Fee: \$399.90	Benefit: 75% = \$299.95
		Y, percutaneous, with destruction and extraction of 1 or 2 stones using ultrasound or shock waves or lasers (not being a service to which item 36645 or 36648 applies)
36639	Fee: \$833.10	Benefit: 75% = \$624.85
36642	substantial portion	Y, BEING A SERVICE TO WHICH ITEM 36639 APPLIES, WHERE, after a on of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE UE TO BLEEDING (Anaes.) (Assist.)

T8. SUF	RGICAL OPERATI	ONS	5. UROLOGICAL
	Fee: \$416.45	Benefit: 75% = \$312.35	
		7, percutaneous, with removal or destruction of 3 or more stones (Anaes.) (Assist.)	of a stone greater than 3 cm in any
36645	Fee: \$1,066.30	Benefit: 75% = \$799.75	
		7, being a service to which item 36645 applies been performed, IT IS NECESSARY TO DI	
36648	Fee: \$949.60	Benefit: 75% = \$712.20	
	NEPHROSTOM	Y DRAINAGE TUBE, exchange of - but not	including imaging (Anaes.) (Assist.)
36649	Fee: \$267.65	Benefit: 75% = \$200.75 85% = \$227.55	
		Y TUBE, removal of, if the ureter has been st in place, using interventional imaging technique	
36650	Fee: \$149.70	Benefit: 75% = \$112.30	
	ureteric meatoton	retrograde, of one collecting system, with or my, ureteric dilatation, not being a service associated applies (Anaes.) (Assist.)	
36652	Fee: \$649.80	Benefit: 75% = \$487.35	
	1 or more of extra pelvis or calyces,	retrograde, of one collecting system, being a action of stone from the renal pelvis or calyce not being a service associated with a service med in the same collecting system (Anaes.) (A	es, or biopsy or diathermy of the renal to which item 36656 applies to a
36654	Fee: \$833.10	Benefit: 75% = \$624.85	
	extraction of 2 or electrohydraulic fragments, not be	retrograde, of one collecting system, being a more stones in the renal pelvis or calyces or kinetic lithotripsy, or laser in the renal pelving a service associated with a service to whi same collecting system (Anaes.) (Assist.)	destruction of stone with ultrasound, vis or calyces, with or without extraction of
36656	Fee: \$1,066.30	Benefit: 75% = \$799.75	
		OPERATIONS ON BLAD	DDER
	Both:		
	(a) percutaneous of sacral nerve le	placement of sacral nerve lead or leads using ad or leads; and	fluoroscopic guidance, or open placement
	(b) intra-operative test stimulation, to manage:		
	(i) detrusor treatment; o	over-activity that has been refractory to at least	ast 12 months conservative non-surgical
	(ii) non-obs non-surgica	structive urinary retention that has been refractly treatment	tory to at least 12 months conservative
	(Anaes.)		
36663	Fee: \$660.95	Benefit: 75% = \$495.75 85% = \$577.55	

T8. SUF	RGICAL OPERATIONS	5. UROLOGICAL	
	Both:		
	(a) percutaneous repositioning of sacral nerve lead or leads u repositioning of sacral nerve lead or leads; and	using fluoroscopic guidance, or open	
	(b) intra-operative test stimulation, to correct displacement of the management of:	or unsatisfactory positioning, if inserted for	
	(i) detrusor over-activity that has been refractory to at treatment; or	least 12 months conservative non-surgical	
	(ii) non-obstructive urinary retention that has been refr non-surgical treatment	actory to at least 12 months conservative	
	—other than a service to which item 36663 applies (An	naes.)	
36664	Fee: \$593.55 Benefit: 75% = \$445.20 85% = \$510.15		
	Sacral nerve electrode or electrodes, management and adjust practitioner, to manage detrusor overactivity or non obstruct		
36665	Fee: \$125.40 Benefit: 75% = \$94.05 85% = \$106.60		
	Pulse generator, subcutaneous placement of, and placement sacral nerve electrode or electrodes, for the management of:	and connection of extension wire or wires to	
	(a) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or		
	(b) non-obstructive urinary retention that has been refractory non-surgical treatment (Anaes.)	to at least 12 months conservative	
36666	Fee: \$334.00 Benefit: 75% = \$250.50 85% = \$283.90		
	Sacral nerve lead or leads, removal of, if the lead was inserted	ed to manage:	
	(a) detrusor over-activity that has been refractory to at least treatment; or	12 months conservative non-surgical	
	(b) non-obstructive urinary retention that has been refractory non-surgical treatment	to at least 12 months conservative	
	(Anaes.)		
36667	Fee: \$156.30 Benefit: 75% = \$117.25 85% = \$132.90		
	Pulse generator, removal of, if the pulse generator was inser-		
	(a) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or		
	(b) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment		
	(Amaga)		
	(Anaes.)		
36668	Fee: \$156.30 Benefit: 75% = \$117.25 85% = \$132.90		

T8. SURGICAL OPERATIONS

5. UROLOGICAL

Percutaneous tibial nerve stimulation, initial treatment protocol, for the treatment of overactive bladder, by a specialist urologist, gynaecologist or urogynaecologist, if:

- (a) the patient has been diagnosed with idiopathic overactive bladder; and
- (b) the patient has been refractory to, is contraindicated or otherwise not suitable for conservative treatments (including anti-cholinergic agents); and
- (c) the patient is contraindicated or otherwise not a suitable candidate for botulinum toxin type A therapy; and
- (d) the patient is contraindicated or otherwise not a suitable candidate for sacral nerve stimulation; and
- (e) the patient is willing and able to comply with the treatment protocol; and
- (f) the initial treatment protocol comprises 12 sessions, delivered over a 3 month period; and
- (g) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts for 30 minutes.

For each patient—applicable only once, unless the patient achieves at least a 50% reduction in overactive bladder symptoms from baseline at any time during the 3 month treatment period.

Not applicable for a service associated with a service to which item 36672 or 36673 applies

36671 S

Fee: \$200.00

Benefit: 75% = \$150.00 85% = \$170.00

Percutaneous tibial nerve stimulation, tapering treatment protocol, for the treatment of overactive bladder, including any associated consultation at the time the percutaneous tibial nerve stimulation treatment is administered, if:

- (a) the patient responded to the percutaneous tibial nerve stimulation initial treatment protocol and has achieved at least a 50% reduction in overactive bladder symptoms from baseline at any time during the treatment period for the initial treatment protocol; and
- (b) the tapering treatment protocol comprises no more than 5 sessions, delivered over a 3 month period, and the interval between sessions is adjusted with the aim of sustaining therapeutic benefit of the treatment; and
- (c) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts for 30 minutes.

Not applicable for a service associated with a service to which item 36671 or 36673 applies

36672 G

Fee: \$200.00

Benefit: 75% = \$150.00 85% = \$170.00

Percutaneous tibial nerve stimulation, maintenance treatment protocol, for the treatment of overactive bladder, including any associated consultation at the time the percutaneous tibial nerve stimulation treatment is administered, if:

(a) the patient responded to the percutaneous tibial nerve stimulation initial treatment protocol and to the tapering treatment protocol, and has achieved at least a 50% reduction in overactive bladder symptoms from baseline at any time during the treatment period for the initial treatment protocol; and

36673 G

(b) the maintenance treatment protocol comprises no more than 12 sessions, delivered over a 12 month

T8. SUF	RGICAL OPERATION	DNS	5. UROLOGICAL
	period, and the inte	erval between sessions is adjusted with the aim of	of sustaining therapeutic benefit of the
	(c) each session las	sts for a minimum of 45 minutes, of which neuro	ostimulation lasts for 30 minutes.
	Not applicable for	service associated with a service to which item	36671 or 36672 applies
	Fee: \$200.00	Benefit: 75% = \$150.00 85% = \$170.00	
	BLADDER, cather	terisation of, where no other procedure is perfor	med (Anaes.)
36800	Fee: \$27.60	Benefit: 75% = \$20.70 85% = \$23.50	
	or ureteric dilatation	7, of one ureter, with or without any one or more on, not being a service associated with a service 809, 36812, 36824, 36848 or 36857 applies (Analysis)	to which item 36652, 36654,
36803	(See para TN.8.51 of Fee: \$466.35	f explanatory notes to this Category) Benefit: 75% = \$349.80 85% = \$396.40	
	or ureteric dilatation the ureter, not being service associated	A, of one ureter, with or without any one or more on, plus one or more of extraction of stone from 1g a service associated with a service to which it with a service to which item 36809, 36824, 368 ame ureter (Anaes.) (Assist.)	the ureter, or biopsy or diathermy of em 36803 or 36812 applies, or a
36806	Fee: \$649.80	Benefit: 75% = \$487.35	
	or ureteric dilatatic lithotripsy, or laser to which item 3680	7, of one ureter, with or without any one or more on, PLUS destruction of stone in the ureter with r, with or without extraction of fragments, not be 33 or 36812 applies, or a service associated with 6857 applies to a procedure performed on the sa	ultrasound, electrohydraulic or kinetic eing a service associated with a service a service to which item 36806,
36809	Fee: \$833.10	Benefit: 75% = \$624.85	
	CYSTOSCOPY w	ith insertion of urethral prosthesis (Anaes.)	
36811	Fee: \$323.40	Benefit: 75% = \$242.55 85% = \$274.90	
		ith urethroscopy with or without urethral dilatat logical endoscopic procedure on the lower urina aes.)	
36812	Fee: \$166.70	Benefit: 75% = \$125.05 85% = \$141.70	
		with or without urethroscopy, for the treatment of ociated with a service to which item 30189 apple	
36815	(See para TN.8.9 of Fee: \$237.90	explanatory notes to this Category) Benefit: 75% = \$178.45 85% = \$202.25	
		ith ureteric catheterisation including fluoroscopral, not being a service associated with a service	
36818	Fee: \$276.60	Benefit: 75% = \$207.45 85% = \$235.15	

T8. SUF	RGICAL OPERAT	TIONS	5. UROLOGICAL
		elvis, unilateral, not being a service asso	nsertion of ureteric stent, or brush biopsy of ociated with a service to which item 36824 or
36821	Fee: \$323.20	Benefit: 75% = \$242.40 85% = \$27	4.75
		, with ureteric catheterisation, unilateral ch item 36818 or 36821 applies (Anaes.)	or bilateral, not being a service associated with
36824	Fee: \$213.15	Benefit: 75% = \$159.90 85% = \$18	31.20
	removal or repla		ric junction or ureteric stricture, including vice associated with a service to which item (Assist.)
36825	Fee: \$581.30	Benefit: 75% = \$436.00	
	CYSTOSCOPY	, with controlled hydrodilatation of the	bladder (Anaes.)
36827	Fee: \$229.85	Benefit: 75% = \$172.40 85% = \$19	95.40
	CYSTOSCOPY	, with ureteric meatotomy (Anaes.)	
36830	Fee: \$203.25	Benefit: 75% = \$152.45	
30030		, with removal of ureteric stent or other	foreign body (Anaes.) (Assist.)
36833	Fee: \$276.60	Benefit: 75% = \$207.45 85% = \$23	, , , , ,
30833	CYSTOSCOPY		vice associated with a service to which item
36836	Fee: \$229.85	Benefit: 75% = \$172.40 85% = \$19	95.40
		, with resection, diathermy or visual last to being a service to which item 36845	er destruction of bladder tumour or other lesion applies (Anaes.)
36840	Fee: \$323.20	Benefit: 75% = \$242.40 85% = \$27	4.75
	or bladder and n		er including any associated diathermy of prostate rice to which item 36812, 36827 to 36863, 37203
36842	Fee: \$325.20	Benefit: 75% = \$243.90	
		, with diathermy, resection or visual last bladder or solitary tumour greater than	er destruction of multiple tumours in more than 2 2cm in diameter (Anaes.)
36845	Fee: \$691.40	Benefit: 75% = \$518.55 85% = \$60	8.00
	CYSTOSCOPY	, with resection of ureterocele (Anaes.)	
36848	Fee: \$229.85	Benefit: 75% = \$172.40	
	Cystoscopy, with injection into bladder wall, other than a service associated with a service to which ite 18375 or 18379 applies (H) (Anaes.)		a service associated with a service to which item
36851	Fee: \$229.85	Benefit: 75% = \$172.40	
		, with endoscopic incision or resection of	of external sphincter, bladder neck or both
	(Anaes.)		

T8. SUF	RGICAL OPERATION	DNS	5. UROLOGICAL
	ENDOSCOPIC M	ANIPULATION OR EXTRACTI	ON of ureteric calculus (Anaes.)
36857	Fee: \$366.45	Benefit: 75% = \$274.85	
	ENDOSCOPIC E	XAMINATION of intestinal condu	uit or reservoir (Anaes.)
36860	Fee: \$166.70	Benefit: 75% = \$125.05 85% =	\$141.70
	LITHOLAPAXY	with or without cystoscopy (Anae	s.) (Assist.)
36863	Fee: \$466.35	Benefit: 75% = \$349.80	
	BLADDER, partia	al excision of (Anaes.) (Assist.)	
37000	Fee: \$741.50	Benefit: 75% = \$556.15	
	BLADDER, repai	r of rupture (Anaes.) (Assist.)	
37004	Fee: \$649.80	Benefit: 75% = \$487.35	
		OR CYSTOTOMY, suprapubic, no associated with other open bladde	ot being a service to which item 37011 applies and er procedure (Anaes.)
37008	Fee: \$416.45	Benefit: 75% = \$312.35 85% =	\$354.00
	SUPRAPUBIC ST 37200 to 37221 ap		ervice associated with a service to which items
37011	Fee: \$93.35	Benefit: 75% = \$70.05 85% = \$	79.35
	BLADDER, total	excision of (Anaes.) (Assist.)	
37014	Fee: \$1,066.30	Benefit: 75% = \$799.75	
	BLADDER DIVE	RTICULUM, excision or obliterat	ion of (Anaes.) (Assist.)
37020	Fee: \$741.50	Benefit: 75% = \$556.15	
	VESICAL FISTU	LA, cutaneous, operation for (Ana	es.)
37023	Fee: \$416.45	Benefit: 75% = \$312.35	
	CUTANEOUS VI	ESICOSTOMY, establishment of (Anaes.) (Assist.)
37026	Fee: \$416.45	Benefit: 75% = \$312.35	
	VESICOVAGINA	AL FISTULA, closure of, by abdor	ninal approach (Anaes.) (Assist.)
37029	Fee: \$924.70	Benefit: 75% = \$693.55	
	VESICOINTEST	NAL FISTULA, closure of, exclu-	ding bowel resection (Anaes.) (Assist.)
37038	Fee: \$691.75	Benefit: 75% = \$518.85	
	Bladder stress inc	esh, other than a service associated	ng a non-adjustable synthetic male sling system, with a service to which item 30405, 35599 or
37040	Fee: \$911.30	Benefit: 75% = \$683.50	
	BLADDER ASPI	RATION by needle	
37041	Fee: \$46.60	Benefit: 75% = \$34.95 85% = \$	39.65
37042		SS INCONTINENCE, sling proce	dure for, using autologous fascial sling, including

T8. SUF	RGICAL OPERAT	IONS	5. UROLOGICAL
	_	ng, with or without mesh, not being applies (Anaes.) (Assist.)	a service associated with a service to which item
	Fee: \$911.30	Benefit: 75% = \$683.50	
		ot being a service associated with a s	similar type needle colposuspension, with or service to which item 30405 or 35599 applies
37043	Fee: \$674.50	Benefit: 75% = \$505.90	
		ot being a service associated with a s	procedure for, eg Burch colposuspension, with or service to which item 30405 or 35599 applies
37044	Fee: \$691.75	Benefit: 75% = \$518.85	
	CONTINENT C (Assist.)	ATHETERISATION BLADDER S	TOMAS (eg. Mitrofanoff), formation of (Anaes.)
37045	Fee: \$1,428.75	Benefit: 75% = \$1071.60	
	BLADDER ENI	ARGEMENT using intestine (Anae	es.) (Assist.)
37047	Fee: \$1,666.05	Benefit: 75% = \$1249.55	
	BLADDER EXS	TROPHY CLOSURE, not involvin	g sphincter reconstruction (Anaes.) (Assist.)
37050	Fee: \$741.50	Benefit: 75% = \$556.15	
	BLADDER TRA	NSECTION AND RE-ANASTOM	OSIS TO TRIGONE (Anaes.) (Assist.)
37053	Fee: \$856.70	Benefit: 75% = \$642.55	
		OPERATIONS (ON PROSTATE
	PROSTATECTO	OMY, open (Anaes.) (Assist.)	
37200	Fee: \$1,016.30	Benefit: 75% = \$762.25	
	PROSTATE, transurethral radio-frequency needle ablation of, with or without cystoscopy and with without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who are not medically fit for transurethral resection of the prostate (that is, prostatectomy using diathermy or col punch) and including services to which item 36854, 37203, 37206, 37207, 37208, 37245, 37303, 37 or 37324 applies (Anaes.)		evere lower urinary tract symptoms who are not the (that is, prostatectomy using diathermy or cold
37201	(See para TN.8.53 Fee: \$828.85	of explanatory notes to this Category) Benefit: 75% = \$621.65	
	PROSTATE, transurethral radio-frequency needle ablation of, with or without cystoscopy and without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who medically fit for transurethral resection of the prostate (that is prostatectomy using diathermy punch) and including services to which item 36854, 37245, 37303, 37321 or 37324 applies, c of, within 10 days of the procedure described by item 37201, 37203 or 37207 which had to be discontinued for medical reasons (Anaes.)		evere lower urinary tract symptoms who are not the (that is prostatectomy using diathermy or cold 37245, 37303, 37321 or 37324 applies, continuation
37202	(See para TN.8.53 Fee: \$416.05	of explanatory notes to this Category) Benefit: 75% = \$312.05 85% =	\$353.65
37203			or cold punch), with or without cystoscopy and with hich item 36854, 37201, 37202, 37207, 37208,

T8. SUF	RGICAL OPERAT	ONS 5. UROLOGICA
	37245, 37303, 37	321 or 37324 applies (Anaes.)
	Fee: \$1,042.15	Benefit: 75% = \$781.65
	or without urethr	MY (endoscopic, using diathermy or cold punch), with or without cystoscopy and with oscopy, and including services to which item 36854, 37303, 37321 or 37324 applies, within 10 days of the procedure described by item 37201, 37203, 37207 or 37245 which nued for medical reasons (Anaes.)
37206	Fee: \$558.10	Benefit: 75% = \$418.60
	with or without u	oscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and rethroscopy, and including services to which items 36854, 37201, 37202, 37203, 321 or 37324 applies (Anaes.)
37207	Fee: \$866.45	Benefit: 75% = \$649.85
	with or without uapplies, continua	oscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and rethroscopy, and including services to which item 36854, 37303, 37321 or 37324 ion of, within 10 days of the procedure described by items 37201, 37203, 37207 or to be discontinued for medical reasons (Anaes.)
37208	Fee: \$416.05	Benefit: 75% = \$312.05
		/or SEMINAL VESICLE/AMPULLA OF VAS, unilateral or bilateral, total excision rvice associated with a service to which item number 37210 or 37211 applies (Anaes.)
37209	Fee: \$1,291.10	Benefit: 75% = \$968.35
	bladder and blad	MY, radical, involving total excision of the prostate, sparing of nerves around the ler neck reconstruction, not being a service associated with a service to which item 37375 applies (Anaes.) (Assist.)
37210	Fee: \$1,593.40	Benefit: 75% = \$1195.05
	bladder and blad	MY, radical, involving total excision of the prostate, sparing of nerves around the ler neck reconstruction, <i>with pelvic lymphadenectomy</i> , not being a service associated which item 35551, 36502 or 37375 applies (Anaes.) (Assist.)
37211	Fee: \$1,935.20	Benefit: 75% = \$1451.40
	PROSTATE, ope	n perineal biopsy or open drainage of abscess (Anaes.) (Assist.)
37212	Fee: \$276.60	Benefit: 75% = \$207.45
	PROSTATE, bio	psy of, endoscopic, with or without cystoscopy (Anaes.) (Assist.)
37215	Fee: \$416.45	Benefit: 75% = \$312.35 85% = \$354.00
	Prostate, implant (Anaes.)	ntion of radio-opaque fiducial markers into the prostate gland or prostate surgical bed
37217	(See para TN.8.54 Fee: \$138.30	of explanatory notes to this Category) Benefit: 75% = \$103.75 85% = \$117.60
	PROSTATE, nee	dle biopsy of, or injection into, excluding for insertion of radiopaque markers (Anaes.)
37218	Fee: \$138.30	Benefit: 75% = \$103.75 85% = \$117.60
37219		dle biopsy of, using prostatic ultrasound techniques and obtaining 1 or more prostatic a service associated with a service to which item 55600 or 55603 applies (Anaes.)

T8. SUF	RGICAL OPERAT	IONS	5. UROLOGICAL
	(Assist.)		
	Fee: \$280.85	Benefit: 75% = \$210.65	5 85% = \$238.75
	guidance, for loc palpable or visib than or equal to diagnosis. The p	alised prostatic malignancy le by imaging) or T2 (tumo and a prostate specific ant rocedure must be performe	of, urological component, using transrectal ultrasound at clinical stages T1 (clinically inapparent tumour not ur confined within prostate), with a Gleason score of less tigen (PSA) of less than or equal to 10ng/ml at the time of ed by a urologist at an approved site in association with a a service to which item 55603 applies. (Anaes.)
37220	(See para TN.8.55 Fee: \$1,044.20	of explanatory notes to this Ca Benefit: 75% = \$783.15	
	PROSTATIC AI	SCESS, endoscopic draina	age of (Anaes.) (Assist.)
37221	Fee: \$466.35	Benefit: 75% = \$349.80	
	PROSTATIC CO	OIL, insertion of, under ultra	asound control (Anaes.)
37223	Fee: \$206.25	Benefit: 75% = \$154.70	
	PROSTATE, dia	thermy or visual laser destr	ruction of lesion of, not being a service associated with a 37206, 37207, 37208 or 37215 applies (Anaes.)
37224	Fee: \$323.20	Benefit: 75% = \$242.40	85% = \$274.75
	guidance includi	ng any associated cystoscop a radiation oncologist, and	eters into, for high dose rate brachytherapy using ultrasound py. The procedure must be performed at an approved site in be associated with a service to which item 15331 or 15332
37227	(See para TN.8.56 Fee: \$565.85	of explanatory notes to this Ca Benefit: 75% = \$424.40	
	with or without i		rowave thermotherapy of, with or without cystoscopy and services to which item 36854, 37203, 37206, 37207, 37208,
37230	Fee: \$1,042.15	Benefit: 75% = \$781.65	5 85% = \$958.75
	PROSTATE, high-energy transurethral microwave thermotherapy of, with or without cystoscopy and with or without urethroscopy and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203, 37207, 372 which had to be discontinued for medical reasons (Anaes.)		services to which item 36854, 37303, 37321 or 37324 he procedure described by item 37201, 37203, 37207, 37230
37233	Fee: \$558.10	Benefit: 75% = \$418.60	85% = \$474.70
	Prostate, endoscopic enucleation of, using high powered Holmium:YAG laser and an end-firing, non-contact fibre, with or without tissue morcellation, cystoscopy or urethroscopy, for the treatment of benign prostatic hyperplasia, and other than a service associated with a service to which item 36854, 37201, 37202, 37203, 37206, 37207, 37208, 37303, 37321, or 37324 applies. (Anaes.)		
37245	Fee: \$1,262.15	Benefit: 75% = \$946.65	;
	,		I URETHRA, PENIS OR SCROTUM
	URETHRAL SC	UNDS, passage of, as an ir	ndependent procedure (Anaes.)
37300	Fee: \$46.60	Benefit: 75% = \$34.95	85% = \$39.65

T8. SUF	RGICAL OPERAT	IONS 5. UROLOGICAL	
	URETHRAL ST	FRICTURE, dilatation of (Anaes.)	
37303	Fee: \$74.05	Benefit: 75% = \$55.55 85% = \$62.95	
	URETHRA, rep	air of rupture of distal section (Anaes.) (Assist.)	
37306	Fee: \$649.80	Benefit: 75% = \$487.35	
	URETHRA, rep	air of rupture of prostatic or membranous segment (Anaes.) (Assist.)	
37309	Fee: \$924.70	Benefit: 75% = \$693.55	
	URETHROSCO	PY, as an independent procedure (Anaes.)	
37315	Fee: \$138.30	Benefit: 75% = \$103.75 85% = \$117.60	
		PY with any 1 or more of - biopsy, diathermy, visual laser destruction of stone or gn body or stone (Anaes.) (Assist.)	
37318	Fee: \$276.60	Benefit: 75% = \$207.45 85% = \$235.15	
	URETHRAL M	EATOTOMY, EXTERNAL (Anaes.)	
37321	Fee: \$93.35	Benefit: 75% = \$70.05 85% = \$79.35	
	URETHROTON	MY OR URETHROSTOMY, internal or external (Anaes.)	
37324	Fee: \$229.85	Benefit: 75% = \$172.40	
	URETHROTON	MY, optical, for urethral stricture (Anaes.) (Assist.)	
37327	Fee: \$323.20	Benefit: 75% = \$242.40	
	URETHRECTO	MY, partial or complete, for removal of tumour (Anaes.) (Assist.)	
37330	Fee: \$649.80	Benefit: 75% = \$487.35	
	URETHROVAC	GINAL FISTULA, closure of (Anaes.) (Assist.)	
37333	Fee: \$558.10	Benefit: 75% = \$418.60	
	URETHROREC	TAL FISTULA, closure of (Anaes.) (Assist.)	
37336	Fee: \$741.50	Benefit: 75% = \$556.15	
	Urethral synthetic male sling system, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, other than a service associated with a service to which item 37340 or 37341 applies (Anaes.) (Assist.)		
37338	Fee: \$911.30	Benefit: 75% = \$683.50	
	Periurethral or transurethral injection of materials for the treatment of urinary incontinence, including cystoscopy and urethroscopy, other than a service associated with a service to which item 18375 or 18379 applies (Anaes.)		
37339	Fee: \$239.85	Benefit: 75% = \$179.90 85% = \$203.90	
	surgery for urina	JING, division or removal of, for urethral obstruction or erosion, following previous ary incontinence, vaginal approach, not being a service associated with a service to ber 37341 applies (Anaes.) (Assist.)	
37340	Fee: \$425.00	Benefit: 75% = \$318.75	
37341	URETHRAL SI	ING, division or removal of, for urethral obstruction or erosion, following previous	

T8. SUF	RGICAL OPERATI	ONS	5. UROLOGICAL
		y incontinence, suprapubic or combine I with a service to which item number 3	d suprapubic/vaginal approach, not being a 37340 applies (Anaes.) (Assist.)
	Fee: \$911.30	Benefit: 75% = \$683.50	
	URETHROPLAS	TY single stage operation (Anaes.) (A	ssist.)
37342	Fee: \$833.10	Benefit: 75% = \$624.85	
	below the symphy		approach via separate incisions above and shysectomy and suprapubic cystotomy, with or s.) (Assist.)
37343	Fee: \$1,391.15	Benefit: 75% = \$1043.40	
	URETHROPLAS	STY 2 stage operation first stage (Ana	es.) (Assist.)
37345	Fee: \$691.40	Benefit: 75% = \$518.55	
	URETHROPLAS	TY 2 stage operation second stage (A	naes.) (Assist.)
37348	Fee: \$691.40	Benefit: 75% = \$518.55	
37310		·	her item in this Group applies (Anaes.) (Assist.)
37351	Fee: \$276.60	Benefit: 75% = \$207.45	2 2 2 7 7 7
37331		, meatotomy and hemicircumcision (Ar	naes.) (Assist.)
37354	Fee: \$323.20	Benefit: 75% = \$242.40	
		sion of prolapse of (Anaes.)	
37369	Fee: \$186.60	Benefit: 75% = \$139.95	
		/ERTICULUM, excision of (Anaes.) (A	Assist.)
37372	Fee: \$466.35	Benefit: 75% = \$349.80	
37372		HINCTER, reconstruction by bladder tu	abularisation technique or similar procedure
37375	Fee: \$1,157.85	Benefit: 75% = \$868.40	
		ZINARY SPHINCTER, insertion of cut	f, perineal approach (Anaes.) (Assist.)
37381	Fee: \$741.50	Benefit: 75% = \$556.15	
			f, abdominal approach (Anaes.) (Assist.)
37384	Fee: \$1,157.85	Benefit: 75% = \$868.40	
	- i		essure regulating balloon and pump (Anaes.)
37387	Fee: \$323.20	Benefit: 75% = \$242.40	
	ARTIFICIAL UF (Assist.)	NINARY SPHINCTER, revision or rem	oval of, with or without replacement (Anaes.)
37390	Fee: \$924.70	Benefit: 75% = \$693.55	
37393	PRIAPISM, deco	mpression by glanular stab cavernosos	pongiosum shunt or penile aspiration with or

T8. SUF	RGICAL OPERAT	IONS 5. UROLOGICAL			
	without lavage (Anaes.)			
	Fee: \$229.85	Benefit: 75% = \$172.40 85% = \$195.40			
	PRIAPISM, shu	nt operation for, not being a service to which item 37393 applies (Anaes.) (Assist.)			
37396	Fee: \$741.50	Benefit: 75% = \$556.15			
2,000		mputation of (Anaes.) (Assist.)			
37402	Fee: \$466.35	Benefit: 75% = \$349.80			
37102		e or radical amputation of (Anaes.) (Assist.)			
37405	Fee: \$924.70	Benefit: 75% = \$693.55			
37403		f laceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.) (Assist.)			
27400	Fee: \$466.35				
37408		Benefit: 75% = \$349.80 f avulsion (Anaes.) (Assist.)			
2=444					
37411	Fee: \$924.70	Benefit: 75% = \$693.55 85% = \$841.30			
	, ,	PENIS, injection of, for the investigation and treatment of impotence - 2 services only in a period of 36 consecutive months			
37415	Fee: \$46.60	Benefit: 75% = \$34.95 85% = \$39.65			
5,110		on of chordee, with or without excision of fibrous plaque or plaques and with or without			
	grafting (Anaes.	(Assist.)			
37417	Fee: \$558.10	Benefit: 75% = \$418.60			
		on of chordee, with or without excision of fibrous plaque or plaques and with or without ng mobilization of the urethra (Anaes.) (Assist.)			
37418	Fee: \$741.50	Benefit: 75% = \$556.15 85% = \$658.10			
	PENIS, surgery to inhibit rapid penile drainage causing impotence, by ligation of veins deep to Buck's fascia including 1 or more deep cavernosal veins with or without pharmacological erection test (Anaes.) (Assist.)				
37420	Fee: \$366.45	Benefit: 75% = \$274.85			
	PENIS, lengther	ning by translocation of corpora (Anaes.) (Assist.)			
37423	Fee: \$924.70	Benefit: 75% = \$693.55			
	PENIS, artificia	erection device, insertion of, into 1 or both corpora (Anaes.) (Assist.)			
37426	Fee: \$974.55	Benefit: 75% = \$730.95			
		erection device, insertion of pump and pressure regulating reservoir (Anaes.) (Assist.)			
37429	Fee: \$323.20	Benefit: 75% = \$242.40			
		erection device, complete or partial revision or removal of components, with or without			
37432	Fee: \$924.70	Benefit: 75% = \$693.55			
37435		plasty as an independent procedure (Anaes.)			

T8. SUF	RGICAL OPERAT	TIONS 5. UROLOGICAL
	Fee: \$93.35	Benefit: 75% = \$70.05 85% = \$79.35
	SCROTUM, par	rtial excision of (Anaes.) (Assist.)
37438	Fee: \$276.60	Benefit: 75% = \$207.45 85% = \$235.15
	URETEROLITI ureter (Anaes.)	HOTOMY COMPLICATED BY PREVIOUS SURGERY at the same site of the same (Assist.)
37444	Fee: \$999.65	Benefit: 75% = \$749.75 85% = \$916.25
		OPERATIONS ON TESTES, VASA OR SEMINAL VESICLES
	SPERMATOCE	ELE OR EPIDIDYMAL CYST, excision of, 1 or more of, on 1 side (Anaes.)
37601	Fee: \$276.60	Benefit: 75% = \$207.45 85% = \$235.15
		N OF SCROTAL CONTENTS, with or without fixation and with or without biopsy, eing a service associated with sperm harvesting for IVF (Anaes.)
37604	Fee: \$276.60	Benefit: 75% = \$207.45 85% = \$235.15
		sperm retrieval, unilateral, from either the testis or the epididymis, for the purposes mic sperm injection, for male factor infertility, excluding a service to which item 13218
37605	(See para TN.8.58 Fee: \$373.45	8, TN.1.5 of explanatory notes to this Category) Benefit: $75\% = 280.10 $85\% = 317.45
	biopsy, for the p	perm retrieval, unilateral, including the exploration of scrotal contents, with our without purposes of intracytoplasmic sperm injection, for male factor infertility, performed in a ing a service to which item 13218 or 37604 applies. (Anaes.)
37606	(See para TN.1.5, Fee: \$554.55	TN.8.59 of explanatory notes to this Category) Benefit: 75% = \$415.95 85% = \$471.40
		ONEAL LYMPH NODE DISSECTION, unilateral, not being a service associated with a item 36528 applies (Anaes.) (Assist.)
37607	Fee: \$924.70	Benefit: 75% = \$693.55
	service to which	ONEAL LYMPH NODE DISSECTION, unilateral, not being a service associated with a titem 36528 applies, following previous similar retroperitoneal dissection, rradiation or chemotherapy (Anaes.) (Assist.)
37610	Fee: \$1,391.15	Benefit: 75% = \$1043.40
	EPIDIDYMEC	TOMY (Anaes.)
37613	Fee: \$276.60	Benefit: 75% = \$207.45 85% = \$235.15
		OMY or VASOEPIDIDYMOSTOMY, unilateral, using operating microscope, not associated with sperm harvesting for IVF (Anaes.) (Assist.)
37616	Fee: \$691.40	Benefit: 75% = \$518.55
		OMY or VASOEPIDIDYMOSTOMY, unilateral, not being a service associated with g for IVF (Anaes.) (Assist.)
37619	Fee: \$276.60 Extended Medi	Benefit: 75% = \$207.45 85% = \$235.15 care Safety Net Cap: \$221.30
37623	+	DR VASECTOMY, unilateral or bilateral

T8. SUF	RGICAL OPERAT	TIONS	5. UROLOGICAL
	benefits are not	egal requirements apply in relation to sterilisation proce payable for services not rendered in accordance with re w. Observe the explanatory note before submitting a clo	levant Commonwealth and State
	(See para TN.8.46 Fee: \$229.85	6 of explanatory notes to this Category) Benefit: 75% = \$172.40 85% = \$195.40	
		PAEDIATRIC GENITURINARY SURGER	Υ
	PATENT URA	CHUS, excision of, on a person 10 years of age or over.	(Anaes.) (Assist.)
37800	Fee: \$521.25	Benefit: 75% = \$390.95	
	PATENT URA	CHUS, excision of, when performed on a person under 1	0 years of age (Anaes.) (Assist.)
37801	Fee: \$677.65	Benefit: 75% = \$508.25	
		ED TESTIS, orchidopexy for, not being a service to which of age or over. (Anaes.) (Assist.)	ch item 37806 applies, on a
37803	Fee: \$521.25	Benefit: 75% = \$390.95	
		ED TESTIS, orchidopexy for, not being a service to which years of age (Anaes.) (Assist.)	ch item 37807 applies, on a
37804	Fee: \$677.65	Benefit: 75% = \$508.25	
		ED TESTIS in inguinal canal close to deep inguinal ring , on a person 10 years of age or over (Anaes.) (Assist.)	or within abdominal cavity,
37806	Fee: \$602.25	Benefit: 75% = \$451.70 85% = \$518.85	
		ED TESTIS in inguinal canal close to deep inguinal ring , on a person under 10 years of age (Anaes.) (Assist.)	or within abdominal cavity,
37807	Fee: \$782.95	Benefit: 75% = \$587.25 85% = \$699.55	
	UNDESCENDE (Assist.)	ED TESTIS, revision orchidopexy for, on a person 10 years	ars of age or over. (Anaes.)
37809	Fee: \$602.25	Benefit: 75% = \$451.70	
	UNDESCENDE (Assist.)	ED TESTIS, revision orchidopexy for, on a person under	10 years of age (Anaes.)
37810	Fee: \$782.95	Benefit: 75% = \$587.25	
		TESTIS, exploration of groin for, not being a service as 806 and 37809 applies, on a person 10 years of age or or	
37812	Fee: \$556.00	Benefit: 75% = \$417.00	
		TESTIS, exploration of groin for, not being a service ass 807 and 37810 applies, on a person under 10 years of ag	
37813	Fee: \$722.80	Benefit: 75% = \$542.10	
	HYPOSPADIA (Anaes.)	S, examination under anaesthesia with erection test on a	person 10 years of age or over.

RGICAL OPERATI	ONS 5. UROLOGICA	
HYPOSPADIAS (Anaes.)	examination under anaesthesia with erection test, on a person under 10 years of age	
Fee: \$120.60	Benefit: 75% = \$90.45	
	glanuloplasty incorporating meatal advancement, on a person 10 years of age or over	
Fee: \$491.45	Benefit: 75% = \$368.60 85% = \$417.75	
	glanuloplasty incorporating meatal advancement, on a person under 10 years of age	
Fee: \$638.90	Benefit: 75% = \$479.20 85% = \$555.50	
HYPOSPADIAS	distal, 1 stage repair, on a person 10 years of age or over. (Anaes.) (Assist.)	
Fee: \$833.10	Benefit: 75% = \$624.85	
HYPOSPADIAS	distal, 1 stage repair, on a person under 10 years of age (Anaes.) (Assist.)	
Fee: \$1,083.05	Benefit: 75% = \$812.30	
HYPOSPADIAS	proximal, 1 stage repair on a person 10 years of age or over. (Anaes.) (Assist.)	
Fee: \$1,158.30	Benefit: 75% = \$868.75	
HYPOSPADIAS	proximal, 1 stage repair, on a person under 10 years of age (Anaes.) (Assist.)	
Fee: \$1,505.80	Benefit: 75% = \$1129.35	
HYPOSPADIAS	staged repair, first stage, on a person 10 years of age or over. (Anaes.) (Assist.)	
Fee: \$533.60	Benefit: 75% = \$400.20	
HYPOSPADIAS, staged repair, first stage, on a person under 10 years of age (Anaes.) (Assist.)		
Fee: \$693.70 Benefit: 75% = \$520.30		
HYPOSPADIAS, staged repair, second stage, on a person 10 years of age or over. (Anaes.) (Assist.)		
Fee: \$691.40	Benefit: 75% = \$518.55 85% = \$608.00	
HYPOSPADIAS	staged repair, second stage, on a person under 10 years of age. (Anaes.) (Assist.)	
Fee: \$898.90	Benefit: 75% = \$674.20 85% = \$815.50	
HYPOSPADIAS (Assist.)	repair of post-operative urethral fistula, on a person 10 years of age or over. (Anaes.)	
Fee: \$329.95	Benefit: 75% = \$247.50	
HYPOSPADIAS (Assist.)	repair of post-operative urethral fistula, on a person under 10 years of age (Anaes.)	
Fee: \$428.95	Benefit: 75% = \$321.75	
EPISPADIAS, sta	nged repair, first stage (Anaes.) (Assist.)	
Fee: \$695.00	Benefit: 75% = \$521.25	
EPISPADIAS, sta	aged repair, second stage (Anaes.) (Assist.)	
Fee: \$787.60	Benefit: 75% = \$590.70	
	HYPOSPADIAS, (Anaes.) Fee: \$120.60 HYPOSPADIAS, (Anaes.) (Assist.) Fee: \$491.45 HYPOSPADIAS, (Anaes.) (Assist.) Fee: \$638.90 HYPOSPADIAS, Fee: \$833.10 HYPOSPADIAS, Fee: \$1,083.05 HYPOSPADIAS, Fee: \$1,158.30 HYPOSPADIAS, Fee: \$1,505.80 HYPOSPADIAS, Fee: \$533.60 HYPOSPADIAS, Fee: \$693.70 HYPOSPADIAS, Fee: \$693.70 HYPOSPADIAS, Fee: \$691.40 HYPOSPADIAS, Fee: \$898.90 HYPOSPADIAS, Fee: \$329.95 HYPOSPADIAS, (Assist.) Fee: \$428.95 EPISPADIAS, starfee: \$695.00 EPISPADIAS, starfee: \$695.00 EPISPADIAS, starfee: \$695.00	

T8. SUF	RGICAL OPERATION	ONS	5. UROLOGICAL
		F BLADDER OR EPISPADIA c reimplantation (Anaes.) (Ass	AS, secondary repair with bladder neck tightening, with sist.)
37842	Fee: \$1,529.10	Benefit: 75% = \$1146.85	
	AMBIGUOUS Grendoscopy (Anaes		ITAL SINUS, reduction clitoroplasty, with or without
37845	Fee: \$695.00	Benefit: 75% = \$521.25	
	AMBIGUOUS Grand vaginoplasty		ITAL SINUS, reduction clitoroplasty with endoscopy
37848	Fee: \$1,251.05	Benefit: 75% = \$938.30	
		ADRENAL HYPERPLASIA, with or without endoscopy (A	mixed gonadal dysgenesis or similar condition, naes.) (Assist.)
37851	Fee: \$926.80	Benefit: 75% = \$695.10	
_	URETHRAL VA	LVE, destruction of, including	cystoscopy and urethroscopy (Anaes.) (Assist.)
37854	Fee: \$366.45	Benefit: 75% = \$274.85	
T8. SUF	RGICAL OPERATION	ONS	6. CARDIO-THORACIC
	Group T8. Surgio	al Operations	
		Subgrou	p 6. Cardio-Thoracic
		CARDIOLO	DGY PROCEDURES
	RIGHT HEART CATHETERISATION, with any one or more of the following: fluoroscopy, oximetr dye dilution curves, cardiac output measurement by any method, shunt detection or exercise stress tes (Anaes.)		
38200	Fee: \$445.40	Benefit: 75% = \$334.05 8	5% = \$378.60
	LEFT HEART CATHETERISATION by percutaneous arterial puncture, arteriotomy or percutaneous left ventricular puncture with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection or exercise stress test (Anaes.)		
38203	Fee: \$531.55	Benefit: 75% = \$398.70 8	5% = \$451.85
	or by any other pr	ocedure with any one or more	LEFT HEART CATHETERISATION via the right heart of the following: fluoroscopy, oximetry, dye dilution thod, shunt detection or exercise stress test (Anaes.)
38206	Fee: \$642.65	Benefit: 75% = \$482.00 8	5% = \$559.25
	CARDIAC ELECTROPHYSIOLOGICAL STUDY up to and including 3 catheter investigation of a 1 or more of syncope, atrioventricular conduction, sinus node function or simple ventricular tachycar studies, not being a service associated with a service to which item 38212 or 38213 applies (Anaes.)		on, sinus node function or simple ventricular tachycardia
38209	(See para TN.8.60 c Fee: \$825.15	of explanatory notes to this Categor Benefit: 75% = \$618.90 8	
38212	investigation; or cantiarrhythmic dru	omplex tachycardia induction ag testing with pre and post dr	JDY 4 or more catheter supraventricular tachycardia s, or multiple catheter mapping, or acute intravenous ug inductions; or catheter ablation to intentionally induce or electrophysiological services during defibrillator

T8. SUF	RGICAL OPERATIONS	6. CARDIO-THORACIC
	implantation not being a service associated with a service to wh (Anaes.)	nich item 38209 or 38213 applies
	(See para TN.8.60 of explanatory notes to this Category) Fee: \$1,372.45 Benefit: 75% = \$1029.35 85% = \$1289.05	
	CARDIAC ELECTROPHYSIOLOGICAL STUDY, for follow being a service associated with a service to which item 38209 or	
38213	Fee: \$408.70 Benefit: 75% = \$306.55 85% = \$347.40	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of ca into the native coronary arteries, not being a service associated 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 3	with a service to which item 38218,
38215	(See para TN.8.52 of explanatory notes to this Category) Fee: \$354.90 Benefit: 75% = \$266.20 85% = \$301.70	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of cawith right or left heart catheterisation or both, or aortography, n service to which item 38215, 38220, 38222, 38225, 38228, 3822 applies (Anaes.)	ot being a service associated with a
38218	(See para TN.8.52 of explanatory notes to this Category) Fee: \$532.25 Benefit: 75% = \$399.20 85% = \$452.45	
	SELECTIVE CORONARY GRAFT ANGIOGRAPHY placem material into free coronary graft(s) attached to the aorta (irrespe a service associated with a service to which item 38215, 38218, 38237, 38240 or 38246 applies (Anaes.)	ective of the number of grafts), not being
38220	(See para TN.8.52 of explanatory notes to this Category) Fee: \$177.40 Benefit: 75% = \$133.05 85% = \$150.80	
	SELECTIVE CORONARY GRAFT ANGIOGRAPHY, placen opaque material into direct internal mammary artery graft(s) to (irrespective of the number of grafts), not being a service associ 38218, 38220, 38225, 38228, 38231, 38234, 38237, 38240 or 38	one or more coronary arteries ated with a service to which item 38215,
38222	(See para TN.8.52 of explanatory notes to this Category) Fee: \$354.90 Benefit: 75% = \$266.20 85% = \$301.70	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of ca into the native coronary arteries and placement of catheter(s) an coronary graft(s) attached to the aorta (irrespective of the numb associated with a service to which item 38215, 38218, 38220, 3 38240 or 38246 applies (Anaes.)	d injection of opaque material into free er of grafts), not being a service
38225	(See para TN.8.52 of explanatory notes to this Category) Fee: \$532.35 Benefit: 75% = \$399.30 85% = \$452.50	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of ca into the native coronary arteries and placement of catheter(s) an internal mammary artery graft(s) to one or more coronary arteri- not being a service associated with a service to which item 3821 38234, 38237, 38240 or 38246 applies (Anaes.)	d injection of opaque material into direct es (irrespective of the number of grafts),
38228	(See para TN.8.52 of explanatory notes to this Category) Fee: \$709.90 Benefit: 75% = \$532.45 85% = \$626.50	

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THORACIO	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into the free coronary graft(s) attached to the aorta (irrespective of the number of grafts), and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38234, 38237, 38240 or 38246 applies (Anaes.)	
38231	(See para TN.8.52 of explanatory notes to this Category) Fee: \$887.25 Benefit: 75% = \$665.45 85% = \$803.85	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38237, 38240 or 38246 applies (Anaes.)	
38234	(See para TN.8.52 of explanatory notes to this Category) Fee: \$709.75 Benefit: 75% = \$532.35 85% = \$626.35	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38240 or 38246 applies (Anaes.)	
38237	(See para TN.8.52 of explanatory notes to this Category) Fee: \$887.20 Benefit: 75% = \$665.40 85% = \$803.80	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts) and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237 or 38246 applies (Anaes.)	
38240	(See para TN.8.52 of explanatory notes to this Category) Fee: \$1,064.60 Benefit: 75% = \$798.45 85% = \$981.20	
	USE OF A CORONARY PRESSURE WIRE during selective coronary angiography to measure fractional flow reserve (FFR) and coronary flow reserve (CFR) in one or more intermediate coronary artery or graft lesions (stenosis of 30-70%), to determine whether revascularisation should be performed where previous stress testing has either not been performed or the results are inconclusive (Anaes.)	
38241	Fee: \$469.70 Benefit: 75% = \$352.30 85% = \$399.25	
	PLACEMENT OF CATHETER(S) and injection of opaque material into any coronary vessel(s) or graft(s) prior to any coronary interventional procedure, not being a service associated with a service to which item 38246 applies (Anaes.)	
38243	(See para TN.8.52 of explanatory notes to this Category) Fee: \$443.60 Benefit: 75% = \$332.70 85% = \$377.10	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography followed by placement of catheters prior to any coronary interventional procedure, not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38243 applies (Anaes.)	
38246	(See para TN.8.52 of explanatory notes to this Category)	

T8. SUF	SURGICAL OPERATIONS		6. CARDIO-THORACIC	
	Fee: \$887.20	Benefit: 75% = \$665.40	85% = \$803.80	
	TEMPORARY	TRANSVENOUS PACEM	AKING ELECTRODE, insertion of (Anaes.)	
38256	Fee: \$267.25	Benefit: 75% = \$200.45	85% = \$227.20	
		LVULOPLASTY OR ISOI before and after balloon dila	ATED ATRIAL SEPTOSTOMY, including cardiac atation (Anaes.) (Assist.)	
38270	Fee: \$912.30	Benefit: 75% = \$684.25	85% = \$828.90	
	ATRIAL SEPTA approach (Anaes	· · · · · · · · · · · · · · · · · · ·	eptal occluder or other similar device, by transcatheter	
38272	Fee: \$912.30	Benefit: 75% = \$684.25	85% = \$828.90	
		teriosus, transcatheter closu the service (Anaes.) (Assist	re of, including cardiac catheterisation and any imaging)	
38273	Fee: \$912.30	Benefit: 75% = \$684.25		
	Ventricular septa (Assist.)	al defect, transcatheter closu	are of, with imaging and cardiac catheterisation (Anaes.)	
38274	Fee: \$912.30	Benefit: 75% = \$684.25		
	MYOCARDIAI	BIOPSY, by cardiac cathe	terisation (Anaes.)	
38275	Fee: \$298.20	Benefit: 75% = \$223.65	85% = \$253.50	
	Transcatheter occlusion of left atrial appendage, and cardiac catheterisation performed by the same practitioner, for stroke prevention in a patient who has non-valvular atrial fibrillation and a contraindication to life-long oral anticoagulation therapy, and is at increased risk of thromboembolism demonstrated by:			
		e (whether of an ischaemic of systemic embolism; or	or unknown type), transient ischaemic attack or non-central	
	(b) at least 2 of t	he following risk factors:		
	(i) an age of 65 years or more;			
	(ii) hypertension;			
	(iii) diabetes mellitus;			
	(iv) heart failure or left ventricular ejection fraction of 35% or less (or both);			
		J	etion, peripheral artery disease or aortic plaque)	
	(v) vasculai dise	ase (prior myocardiai imarc	enon, peripheral aftery disease of aortic plaque)	
	(Anaes.) (Assis	st.)		
38276	(See para TN.8.13 Fee: \$912.30	2 of explanatory notes to this Benefit: 75% = \$684.25		
38285		E ECG LOOP RECORDER nexplained syncope where:	, insertion of, for diagnosis of primary disorder in patients	

T8. SUR	GICAL OPERATIONS	6. CARDIO-THORACIC	
	- a diagnosis has not been achieved through all other available cardia	c investigations; and	
	- a neurogenic cause is not suspected; and		
	- it has been determined that the patient does not have structural hear risk of sudden cardiac death.	t disease associated with a high	
	including initial programming and testing, as an admitted patient in an ap	proved hospital (Anaes.)	
	(See para TN.8.61 of explanatory notes to this Category) Fee: \$192.90 Benefit: 75% = \$144.70 85% = \$164.00		
	IMPLANTABLE ECG LOOP RECORDER, removal of, as an admitted p (Anaes.)	patient in an approved hospital	
38286	Fee: \$173.75 Benefit: 75% = \$130.35 85% = \$147.70		
	Implantable loop recorder, insertion of, for diagnosis of atrial fibrillation,	if:	
	(a) the patient to whom the service is provided has been diagnosed as hav undetermined source; and	ing had an embolic stroke of	
	(b) the bases of the diagnosis included the following:		
	(i) the medical history of the patient;		
	(ii) physical examination;		
	(iii) brain and carotid imaging;		
	(iv) cardiac imaging;		
	(v) surface ECG testing including 24-hour Holter monitoring; and		
	(c) atrial fibrillation is suspected; and		
	(d) the patient:		
	(i) does not have a permanent indication for oral anticoagulants; or		
	(ii) does not have a permanent oral anticoagulants contraindication;		
	including initial programming and testing		
	(Anaes.)		
38288	Fee: \$192.90 Benefit: 75% = \$144.70 85% = \$164.00		
	CATHETER BASED ARRHYTHMIA ABLATIC	ON	
	ABLATION OF ARRHYTHMIA CIRCUIT OR FOCUS or isolation pro chamber (Anaes.) (Assist.)	cedure involving 1 atrial	
38287	Fee: \$2,098.45 Benefit: 75% = \$1573.85 85% = \$2015.05		
38290	ABLATION OF ARRHYTHMIA CIRCUITS OR FOCI, or isolation prochambers and including curative procedures for atrial fibrillation (Anaes.)		

T8. SUF	RGICAL OPERATION	ONS	6. CARDIO-THORACIC
	Fee: \$2,671.95	Benefit: 75% = \$2004.00	
	VENTRICULAR ARRHYTHMIA with mapping and ablation, including all associated electrophysiological studies performed on the same day (Anaes.) (Assist.)		
38293	Fee: \$2,868.05	Benefit: 75% = \$2151.05 85%	= \$2784.65
		ENDOVASCULAR INTER	/ENTIONAL PROCEDURES
	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)		
38300	Fee: \$515.35	Benefit: 75% = \$386.55 85%	= \$438.05
			of more than 1 coronary artery, percutaneous or by ervices or preparation and excluding aftercare
38303	Fee: \$660.80	Benefit: 75% = \$495.60 85%	= \$577.40
	of coronary artery		clusional site, including associated balloon dilatation re, excluding associated radiological services, ssist.)
38306	(See para TN.8.62 of Fee: \$762.35	of explanatory notes to this Category) Benefit: 75% = \$571.80 85% =	= \$678.95
		S TRANSLUMINAL ROTATIO angioplasty with no stent insertion	NAL ATHERECTOMY of 1 coronary artery, n, where:
	- no lesion of the coronary artery has been stented; and		
	- each lesion of the coronary artery is complex and heavily calcified; and		
	- balloon angior	lasty with or without stenting is n	ot suitable;
	excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)		
38309	(See para TN.8.41 of explanatory notes to this Category) Fee: \$885.45 Benefit: 75% = \$664.10 85% = \$802.05		
		S TRANSLUMINAL ROTATIO angioplasty with insertion of 1 or	NAL ATHERECTOMY of 1 coronary artery, more stents, where:
	- no lesion of th	e coronary artery has been stented	; and
	- each lesion of	the coronary artery is complex an	d heavily calcified; and
	- balloon angior	lasty with or without stenting is n	ot suitable;
	excluding associa	ted radiological services or prepar	ration, and excluding aftercare (Anaes.) (Assist.)
38312	(See para TN.8.41 c Fee: \$1,132.35	f explanatory notes to this Category) Benefit: 75% = \$849.30 85%	= \$1048.95
		S TRANSLUMINAL ROTATIO calloon angioplasty with no stent is	NAL ATHERECTOMY of more than 1 coronary nsertion, where:
38315	- no lesion of th	e coronary arteries has been stente	ed; and

RGICAL OPERATIONS	6. CARDIO-THORACIC
- each lesion of the coronary arteries is complex and heavily calcified; and	
- balloon angioplasty with or without stenting is not suitable;	
excluding associated radiological services or preparation, and excluding afte	rcare (Anaes.) (Assist.)
(See para TN.8.41 of explanatory notes to this Category) Fee: \$1,215.85 Benefit: 75% = \$911.90 85% = \$1132.45	
PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY artery, including balloon angioplasty, with insertion of 1 or more stents, whe	
- no lesion of the coronary arteries has been stented; and	
- each lesion of the coronary arteries is complex and heavily calcified; and	
- balloon angioplasty with or without stenting is not suitable,	
excluding associated radiological services or preparation, and excluding afte	ercare (Anaes.) (Assist.)
(See para TN.8.41 of explanatory notes to this Category) Fee: \$1,586.35 Benefit: 75% = \$1189.80 85% = \$1502.95	
MISCELLANEOUS CARDIAC PROCEDURES	
SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insereplacement of, including cardiac electrophysiological services where used f (Anaes.)	
(See para TN.8.60 of explanatory notes to this Category) Fee: \$638.65 Benefit: 75% = \$479.00	
PERMANENT CARDIAC PACEMAKER, insertion, removal or replacement resynchronisation therapy, including cardiac electrophysiological services with implantation (Anaes.)	
(See para TN.8.60 of explanatory notes to this Category) Fee: \$255.45 Benefit: 75% = \$191.60	
DUAL CHAMBER PERMANENT TRANSVENOUS ELECTRODES, insereplacement of, including cardiac electrophysiological services where used f (Anaes.)	
(See para TN.8.60 of explanatory notes to this Category) Fee: \$837.35 Benefit: 75% = \$628.05	
Extraction of chronically implanted transvenous pacing or defibrillator lead or leads, by percutaneous method where the leads have been in situ for greater than six months and require removal with locking stylets, snares and/or extraction sheaths in a facility where cardiac surgery is available, in association with item 61109 or 60509 (Anaes.) (Assist.)	
(See para TN.8.64 of explanatory notes to this Category) Fee: \$2,868.05 Benefit: 75% = \$2151.05	
PERICARDIUM, paracentesis of (excluding aftercare) (Anaes.)	
Fee: \$133.55 Benefit: 75% = \$100.20 85% = \$113.55	
•	
INTRA-AORTIC BALLOON PUMP, percutaneous insertion of (Anaes.)	
	- each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding afte (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,215.85 Benefit: 75% = \$911.90 85% = \$1132.45 PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY artery, including balloon angioplasty, with insertion of 1 or more stents, who - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding afte (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,586.35 Benefit: 75% = \$1189.80 85% = \$1502.95 MISCELLANEOUS CARDIAC PROCEDURES SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, ins replacement of, including cardiac electrophysiological services where used for (Anaes.) (See para TN.8.60 of explanatory notes to this Category) Fee: \$638.65 Benefit: 75% = \$479.00 PERMANENT CARDIAC PACEMAKER, insertion, removal or replaceme resynchronisation therapy, including cardiac electrophysiological services with implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) Fee: \$255.45 Benefit: 75% = \$191.60 DUAL CHAMBER PERMANENT TRANSVENOUS ELECTRODES, insereplacement of, including cardiac electrophysiological services where used for the company of the compan

T8. SURGICAL OPERATIONS 6. CARDIO-THORACIC Permanent cardiac synchronisation device (including a cardiac synchronisation device that is capable of defibrillation), insertion, removal or replacement of, for a patient who: (a) has: (i) moderate to severe chronic heart failure (New York Heart Association (NYHA) class III or IV) despite optimised medical therapy; and (ii) sinus rhythm; and (iii) a left ventricular ejection fraction of less than or equal to 35%; and a QRS duration greater than or equal to 120 ms; or (b) satisfied the requirements mentioned in paragraph (a) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode (Anaes.) (See para TN.8.63 of explanatory notes to this Category) 38365 Fee: \$255.45 **Benefit:** 75% = \$191.60Permanent transvenous left ventricular electrode, insertion, removal or replacement of through the coronary sinus, for the purpose of cardiac resynchronisation therapy, including right heart catheterisation and any associated venogram of left ventricular veins, other than a service associated with a service to which item 35200 or 38200 applies, for a patient who: (a) has: (i) moderate to severe chronic heart failure (New York Heart Association (NYHA) class III or IV) despite optimised medical therapy; and (ii) sinus rhythm; and a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 120 ms; or (b) has: (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and sinus rhythm; and a left ventricular ejection fraction of less than or equal to 35%; and (iv) a QRS duration greater than or equal to 150 ms; or (c) satisfied the requirements mentioned in paragraph (a) or (b) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode (Anaes.) (See para TN.8.63 of explanatory notes to this Category) Fee: \$1,224.60 **Benefit:** 75% = \$918.45 38368 Permanent cardiac synchronisation device capable of defibrillation, insertion, removal or replacement of, for a patient who: (a) has: 38371

T8. SURGICAL OPERATIONS 6. CARDIO-THORACIC moderate to severe chronic heart failure (New York Heart Association ((NYHA) class III or IV) despite optimised medical therapy; and sinus rhythm; and a left ventricular ejection fraction of less than or equal to 35%; and a QRS duration greater than or equal to 120 ms; or (b) has: (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and (ii) sinus rhythm; and a left ventricular ejection fraction of less than or equal to 35%; and a QRS duration greater than or equal to 150 ms (Anaes.) (See para TN.8.65 of explanatory notes to this Category) Fee: \$287.85 **Benefit:** 75% = \$215.90 AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for, primary prevention of sudden cardiac death in: - patients with a left ventricular ejection fraction of less than or equal to 30% at least one month after a myocardial infarct when the patient has received optimised medical therapy; or - patients with chronic heart failure associated with mild to moderate symptoms (NYHA II and III) and a left ventricular ejection fraction less than or equal to 35% when the patient has received optimised medical therapy. Not being a service associated with a service to which item 38213 applies (Anaes.) (Assist.) 38384 Fee: \$1.052.65 **Benefit:** 75% = \$789.50 85% = \$969.25 AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of for, primary prevention of sudden cardiac death in: - patients with a left ventricular ejection fraction of less than or equal to 30% at least one month after a myocardial infarct when the patient has received optimised medical therapy; or - patients with chronic heart failure associated with mild to moderate symptoms (NYHA II and III) and a left ventricular ejection fraction less than or equal to 35% when the patient has received optimised medical therapy. 38387

T8. SUF	RGICAL OPERATIONS		6. CARDIO-THORACI
	Not being a service ass of cardiac resynchronis		ce to which item 38213 applies, not for defibrillators capable s.) (Assist.)
	Fee: \$287.85 B	enefit: 75% = \$215.90	0 85% = \$244.70
	defibrillation electrode	s for - not for patients	on of patches for, or insertion of transvenous endocardial ts with heart failure or as primary prevention for tachycardial with a service to which item 38213 applies (Anaes.)
38390	Fee: \$1,052.65 B	enefit: 75% = \$789.50	0 85% = \$969.25
		ary prevention for ta	RATOR, insertion or replacement of for - not for patients wi achycardia arrhythmias. Not being a service associated with es.) (Assist.)
38393	Fee: \$287.85 B	enefit: 75% = \$215.90	0 85% = \$244.70
		TH	HORACIC SURGERY
	EMPYEMA, radical of	peration for, involving	ng resection of rib (Anaes.) (Assist.)
38415	Fee: \$399.35 B	enefit: 75% = \$299.55	5 85% = \$339.45
	THORACOTOMY, ex	ploratory, with or wi	ithout biopsy (Anaes.) (Assist.)
38418	Fee: \$958.40 B	enefit: 75% = \$718.80	0
			tication (Anaes.) (Assist.)
38421	Fee: \$1,532.00 B	enefit: 75% = \$1149.0	00
			leurodesis, OR ENUCLEATION OF HYDATID cysts
38424	Fee: \$958.40 B	enefit: 75% = \$718.80	0
	THORACOPLASTY (complete) - 3 or more	re ribs (Anaes.) (Assist.)
38427	Fee: \$1,183.40 B	enefit: 75% = \$887.55	5
	THORACOPLASTY (
38430	Fee: \$609.90 B	enefit: 75% = \$457.45	5
30 130		rith or without divisio	on of pleural adhesions, including insertion of intercostal
38436	Fee: \$249.75 B	enefit: 75% = \$187.35	5
	PNEUMONECTOMY service to which Item 3		or SEGMENTECTOMY not being a service associated with s.) (Assist.)
38438	Fee: \$1,532.00 B	enefit: 75% = \$1149.0	00
	LUNG, wedge resection	n of (Anaes.) (Assist	t.)
38440	Fee: \$1,147.20 B	enefit: 75% = \$860.40	0
38441	RADICAL LOBECTO	MY or PNEUMONE	ECTOMY including resection of chest wall, diaphragm, ssection (Anaes.) (Assist.)

T8. SUF	RGICAL OPERATI	ons	6. CARDIO-THORACIC	
	Fee: \$1,815.20	Benefit: 75% = \$1361.40		
	THORACOTOM	Y or STERNOTOMY, for removal of thymu-	s or mediastinal tumour (Anaes.) (Assist.)	
38446	Fee: \$1,183.40	Benefit: 75% = \$887.55		
	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (Anaes.) (Assist.)		otomy without cardiopulmonary bypass	
38447	Fee: \$1,532.00	Benefit: 75% = \$1149.00		
	MEDIASTINUM	, cervical exploration of, with or without biop	osy (Anaes.) (Assist.)	
38448	Fee: \$363.05	Benefit: 75% = \$272.30		
	PERICARDIECT (Anaes.) (Assist.)	OMY via sternotomy or anterolateral thoraco	otomy with cardiopulmonary bypass	
38449	Fee: \$2,143.20	Benefit: 75% = \$1607.40		
	PERICARDIUM	transthoracic open surgical drainage of (Ana	nes.) (Assist.)	
38450	Fee: \$856.65	Benefit: 75% = \$642.50		
	PERICARDIUM	subxiphoid open surgical drainage of (Anaes	s.) (Assist.)	
38452	Fee: \$573.70	Benefit: 75% = \$430.30		
	TRACHEAL exc	sion and repair without cardiopulmonary byp	pass (Anaes.) (Assist.)	
38453	Fee: \$1,720.90	Benefit: 75% = \$1290.70		
		EAL EXCISION AND REPAIR OF, with cardiopulmonary bypass (Anaes.) (Assist.)		
38455	Fee: \$2,327.70	Benefit: 75% = \$1745.80		
	INTRATHORAC	IC OPERATION on heart, lungs, great vesses on more than 1 of those organs, not being a se Assist.)		
38456	Fee: \$1,532.00	Benefit: 75% = \$1149.00		
	PECTUS EXCAVATUM or PECTUS CARINATUM, repair or radical correction of (Anaes.) (Assist.)		or radical correction of (Anaes.) (Assist.)	
38457	Fee: \$1,430.25	Benefit: 75% = \$1072.70		
		ATUM, repair of, with implantation of subc	utaneous prosthesis (Anaes.) (Assist.)	
38458	Fee: \$762.35	Benefit: 75% = \$571.80		
		OR WIRES, removal of (Anaes.)		
38460	Fee: \$275.40	Benefit: 75% = \$206.55		
20100		WOUND, debridement of, not involving reor	pening of the mediastinum (Anaes.)	
38462	Fee: \$326.45	Benefit: 75% = \$244.85		
30402	STERNOTOMY	WOUND, debridement of, involving curettage but not involving reopening of the mediastinu		
38464	Fee: \$354.80	Benefit: 75% = \$266.10		
38466		eration on, for dehiscence or infection involv	ing reopening of the mediastinum, with or	

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THORAC	
	without rewiring (Anaes.) (Assist.)	
	Fee: \$958.00 Benefit: 75% = \$718.50	
	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps or greater omentum (Anaes.) (Assist.)	
38468	Fee: \$1,476.15 Benefit: 75% = \$1107.15	
	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps and greater omentum (Anaes.) (Assist.)	
38469	Fee: \$1,720.90 Benefit: 75% = \$1290.70	
	CARDIAC SURGERY PROCEDURES	
	PERMANENT MYOCARDIAL ELECTRODE, insertion of, by thoracotomy or sternotomy (Anaes.) (Assist.)	
38470	(See para TN.8.67 of explanatory notes to this Category) Fee: \$958.40 Benefit: 75% = \$718.80	
	PERMANENT PACEMAKER ELECTRODE, insertion by open surgical approach (Anaes.) (Assist.)	
38473	(See para TN.8.67 of explanatory notes to this Category) Fee: \$573.70 Benefit: 75% = \$430.30	
	VALVULAR PROCEDURES	
	VALVE ANNULOPLASTY without insertion of ring, not being a service associated with a service to which item 38480 or 38481 applies (Anaes.) (Assist.)	
38475	(See para TN.8.67 of explanatory notes to this Category) Fee: \$831.75 Benefit: 75% = \$623.85	
	VALVE ANNULOPLASTY with insertion of ring not being a service to which item 38478 applies (Anaes.) (Assist.)	
38477	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,003.35 Benefit: 75% = \$1502.55	
	VALVE ANNULOPLASTY with insertion of ring performed in conjunction with item 38480 or 38481 (Anaes.) (Assist.)	
38478	(See para TN.8.67 of explanatory notes to this Category) Fee: \$970.40 Benefit: 75% = \$727.80	
	VALVE REPAIR, 1 leaflet (Anaes.) (Assist.)	
38480	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,003.35 Benefit: 75% = \$1502.55	
	VALVE REPAIR, 2 or more leaflets (Anaes.) (Assist.)	
38481	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,280.65 Benefit: 75% = \$1710.50	
	AORTIC VALVE LEAFLET OR LEAFLETS, decalcification of, not being a service to which item 38475, 38477, 38480, 38481, 38488 or 38489 applies (Anaes.) (Assist.)	
38483	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,720.90 Benefit: 75% = \$1290.70	
38485	MITRAL ANNULUS, reconstruction of, after decalcification, when performed in association with valv	

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THORACIC	
	surgery (Anaes.) (Assist.)	
	(See para TN.8.67 of explanatory notes to this Category) Fee: \$817.10 Benefit: 75% = \$612.85	
	MITRAL VALVE, open valvotomy of (Anaes.) (Assist.)	
38487	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,720.90 Benefit: 75% = \$1290.70	
	VALVE REPLACEMENT with BIOPROSTHESIS OR MECHANICAL PROSTHESIS (Anaes.) (Assist.)	
38488	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,909.60 Benefit: 75% = \$1432.20	
	VALVE REPLACEMENT with allograft (subcoronary or cylindrical implant), or unstented xenograft (Anaes.) (Assist.)	
38489	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,271.05 Benefit: 75% = \$1703.30	
	SUB-VALVULAR STRUCTURES, reconstruction and re-implantation of, associated with mitral and tricuspid valve replacement (Anaes.) (Assist.)	
38490	(See para TN.8.67 of explanatory notes to this Category) Fee: \$554.55 Benefit: 75% = \$415.95	
	OPERATIVE MANAGEMENT of acute infective endocarditis, in association with heart valve surgery (Anaes.) (Assist.)	
38493	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,957.60 Benefit: 75% = \$1468.20	
	TAVI, for the treatment of symptomatic severe aortic stenosis, performed via transfemoral delivery, unless transfemoral delivery is contraindicated or not feasible, in a TAVI Hospital on a TAVI Patient by a TAVI Practitioner – includes all intraoperative diagnostic imaging that the TAVI Practitioner performs upon the TAVI Patient.	
	(Not payable more than once per patient in a five year period.) (Anaes.) (Assist.)	
38495	(See para AN.33.1, TN.8.135 of explanatory notes to this Category) Fee: \$1,432.20 Benefit: 75% = \$1074.15 85% = \$1348.80	
	SURGERY FOR ISCHAEMIC HEART DISEASE	
	ARTERY HARVESTING (other than internal mammary), for coronary artery bypass (Anaes.) (Assist.)	
38496	(See para TN.8.67 of explanatory notes to this Category) Fee: \$623.95 Benefit: 75% = \$468.00	
	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, not being a service associated with service to which items 38498, 38500, 38501, 38503 or 38504 apply (Anaes.) (Assist.)	
38497	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,047.60 Benefit: 75% = \$1535.70	
38498	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38500,	

T8. SUF	RGICAL OPERATIONS	6. CARDIO-THORACIC
	38501, 38503, 38504 or 38600 apply (Anaes.) (Assist.)	
	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,047.60 Benefit: 75% = \$1535.70	
	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using without vein graft or grafts, including harvesting of internal mammary at where performed, not being a service associated with a service to which 38503 or 38504 apply (Anaes.) (Assist.)	rtery or vein graft material
38500	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,200.00 Benefit: 75% = \$1650.00	
	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, perfebypass, using single arterial graft, with or without vein graft or grafts, in mammary artery or vein graft material where performed, either via a me minimally invasive technique and where a stand-by perfusionist is prese with a service to which items 38497, 38498, 38500, 38503, 38504 or 38	cluding harvesting of internal dian sternotomy or other nt, not being a service associated
38501	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,200.00 Benefit: 75% = \$1650.00	
	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using without vein graft or grafts, including harvesting of internal mammary at where performed, not being a service associated with a service to which 38501 or 38504 apply (Anaes.) (Assist.)	rtery or vein graft material
38503	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,388.70 Benefit: 75% = \$1791.55	
	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, perfebypass, using 2 or more arterial grafts, with or without vein graft or graft internal mammary artery or vein graft material where performed, either minimally invasive technique and where a stand-by perfusionist is prese with a service to which items 38497, 38498, 38500, 38501, 38503 or 3860	ts, including harvesting of via a median sternotomy or other nt, not being a service associated
38504	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,388.70 Benefit: 75% = \$1791.55	
	CORONARY ENDARTERECTOMY, by open operation, including rep each vessel (Anaes.) (Assist.)	air with 1 or more patch grafts,
38505	(See para TN.8.67 of explanatory notes to this Category) Fee: \$277.25 Benefit: 75% = \$207.95	
	LEFT VENTRICULAR ANEURYSM, plication of (Anaes.) (Assist.)	
38506	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,626.25 Benefit: 75% = \$1219.70	
	LEFT VENTRICULAR ANEURYSM resection with primary repair (An	naes.) (Assist.)
38507	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,909.20 Benefit: 75% = \$1431.90	
	LEFT VENTRICULAR ANEURYSM resection with patch reconstruction (Assist.)	on of the left ventricle (Anaes.)
38508	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,388.70 Benefit: 75% = \$1791.55	

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THORAC
	ISCHAEMIC VENTRICULAR SEPTAL RUPTURE, repair of (Anaes.) (Assist.)
38509	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,388.70 Benefit: 75% = \$1791.55
	ARRHYTHMIA SURGERY
	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving 1 atrial chamber only (Anaes.) (Assist.)
38512	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,098.45 Benefit: 75% = \$1573.85
	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving both atrial chambers and including curative surgery for atrial fibrillation (Anaes.) (Assist.)
38515	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,671.95 Benefit: 75% = \$2004.00
	VENTRICULAR ARRHYTHMIA with mapping and muscle ablation, with or without aneurysmeotom (Anaes.) (Assist.)
38518	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,868.05 Benefit: 75% = \$2151.05
	PROCEDURES ON THORACIC AORTA
	ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.)
38550	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,146.15 Benefit: 75% = \$1609.65
	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.)
38553	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,719.75 Benefit: 75% = \$2039.85
	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.)
38556	(See para TN.8.67 of explanatory notes to this Category) Fee: \$3,104.70 Benefit: 75% = \$2328.55
	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, not involving value replacement or repair or coronary artery implantation (Anaes.) (Assist.)
38559	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,531.00 Benefit: 75% = \$1898.25
	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.)
38562	(See para TN.8.67 of explanatory notes to this Category) Fee: \$3,104.70 Benefit: 75% = \$2328.55
	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.)
38565	(See para TN.8.67 of explanatory notes to this Category) Fee: \$3,482.25 Benefit: 75% = \$2611.70

T8. SUF	8. SURGICAL OPERATIONS 6. CARDIO-THORA		
	DESCENDING THORACIC AORTA, repair or replacement of, wi bypass, by open exposure, percutaneous or endovascular means (An		
38568	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,862.95 Benefit: 75% = \$1397.25		
	DESCENDING THORACIC AORTA, repair or replacement of, us (Anaes.) (Assist.)	ing shunt or cardiopulmonary bypass	
38571	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,051.75 Benefit: 75% = \$1538.85		
	OPERATIVE MANAGEMENT OF ACUTE RUPTURE OR DISS procedures on the thoracic aorta (Anaes.) (Assist.)	ECTION, in conjunction with	
38572	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,987.05 Benefit: 75% = \$1490.30		
	CANNULATION FOR, and supervision and monitoring of, the adr perfusion during deep hypothermic arrest (Assist.)	ministration of retrograde cerebral	
38577	(See para TN.8.67 of explanatory notes to this Category) Fee: \$554.55 Benefit: 75% = \$415.95		
	TECHNIQUES FOR PRESERVATION OF ARI	RESTED HEART	
	CANNULATION of the coronary sinus for, and supervision of, the crystalloid for cardioplegia, including pressure monitoring (Assist.)		
38588	(See para TN.8.67 of explanatory notes to this Category) Fee: \$416.05 Benefit: 75% = \$312.05		
	CIRCULATORY SUPPORT PROCEI	DURES	
	CENTRAL CANNULATION for cardiopulmonary bypass excluding being a service associated with a service to which another item in the (Assist.)		
38600	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,532.00 Benefit: 75% = \$1149.00		
	PERIPHERAL CANNULATION for cardiopulmonary bypass excl (Anaes.) (Assist.)	uding post-operative management	
38603	(See para TN.8.67 of explanatory notes to this Category) Fee: \$958.40 Benefit: 75% = \$718.80		
	INTRA-AORTIC BALLOON PUMP, insertion of, by arteriotomy	(Anaes.) (Assist.)	
38609	(See para TN.8.67 of explanatory notes to this Category) Fee: \$479.15 Benefit: 75% = \$359.40		
	INTRA-AORTIC BALLOON PUMP, removal of, with closure of a (Assist.)	artery by direct suture (Anaes.)	
38612	(See para TN.8.67 of explanatory notes to this Category) Fee: \$537.10 Benefit: 75% = \$402.85 85% = \$456.55		
	INTRA-AORTIC BALLOON PUMP, removal of, with closure of a (Assist.)	artery by patch graft (Anaes.)	
38613	(See para TN.8.67 of explanatory notes to this Category) Fee: \$674.05 Benefit: 75% = \$505.55		

T8. SURG	SICAL OPERATIONS	6. CARDIO-THORACIC
	Insertion of a left or right ventricular assist device, for use as:	
	(a) a bridge to cardiac transplantation in patients with refractory heart failur	e who are:
	(i) currently on a heart transplant waiting list, or	
	(ii) expected to be suitable candidates for cardiac transplantation following the ventricular	ng a period of support on
	assist device; or	
	(b) acute post cardiotomy support for failure to wean from cardiopulmonary	y transplantation; or
	(c) cardio-respiratory support for acute cardiac failure which is likely to rec support of less than 6	over with short term
	weeks;	
	not being a service associated with the use of a ventricular assist device as demanagement of patients with heart failure who are not expected to be suitable transplantation (Anaes.) (Assist.)	
38615	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,532.00 Benefit: 75% = \$1149.00	
	Insertion of a left and right ventricular assist device, for use as:	
	(a) a bridge to cardiac transplantation in patients with refractory heart failur	re who are:
	(i) currently on a heart transplant waiting list, or	
	(ii) expected to be suitable candidates for cardiac transplantation following the ventricular	ng a period of support on
	assist device; or	
	(b) acute post cardiotomy support for failure to wean from cardiopulmonary	ransplantation; or
	(c) cardio-respiratory support for acute cardiac failure which is likely to rec support of less than 6	over with short term
	weeks;	
	not being a service associated with the use of a ventricular assist device as demanagement of patients with heart failure who are not expected to be suitable transplantation (Anaes.) (Assist.)	stination therapy in the candidates for cardiac
38618	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,909.60 Benefit: 75% = \$1432.20	
	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an ind (Anaes.) (Assist.)	lependent procedure
38621	(See para TN.8.67 of explanatory notes to this Category) Fee: \$762.35 Benefit: 75% = \$571.80	
38624	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an in	ndependent procedure

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THORACIO
	(Anaes.) (Assist.)
	(See para TN.8.67 of explanatory notes to this Category) Fee: \$856.65 Benefit: 75% = \$642.50
	EXTRA-CORPOREAL MEMBRANE OXYGENATION, BYPASS OR VENTRICULAR ASSIST DEVICE CANNULAE, adjustment and re-positioning of, by open operation, in patients supported by these devices (Anaes.) (Assist.)
38627	(See para TN.8.67 of explanatory notes to this Category) Fee: \$669.60 Benefit: 75% = \$502.20
	RE-OPERATION
	PATENT DISEASED coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of (Anaes.) (Assist.)
38637	(See para TN.8.67 of explanatory notes to this Category) Fee: \$554.55 Benefit: 75% = \$415.95
	RE-OPERATION via median sternotomy, for any procedure, including any divisions of adhesions where the time taken to divide the adhesions is 45 minutes or less (Anaes.) (Assist.)
38640	(See para TN.8.69, TN.8.67 of explanatory notes to this Category) Fee: \$958.40 Benefit: 75% = \$718.80
	MISCELLANEOUS CARDIOTHORACIC SURGICAL PROCEDURES
	THORACOTOMY OR STERNOTOMY involving division of adhesions where the time taken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.)
38643	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,067.40 Benefit: 75% = \$800.55
	THORACOTOMY OR STERNOTOMY involving division of extensive adhesions where the time taken to divide the adhesions exceeds 2 hours (Anaes.) (Assist.)
38647	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,134.50 Benefit: 75% = \$1600.90
	MYOMECTOMY or MYOTOMY for hypertrophic obstructive cardiomyopathy (Anaes.) (Assist.)
38650	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,909.60 Benefit: 75% = \$1432.20
	OPEN HEART SURGERY, not being a service to which another item in this Group applies (Anaes.) (Assist.)
38653	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,909.60 Benefit: 75% = \$1432.20
	Permanent left ventricular electrode, insertion, removal or replacement of via open thoracotomy, for the purpose of cardiac resynchronisation therapy, for a patient who:
	(a) has:
	(i) moderate to severe chronic heart failure (New York Heart Association (NYHA) class III or IV) despite optimised medical therapy; and
	(ii) sinus rhythm; and
38654	(iii) a left ventricular ejection fraction of less than or equal to 35%; and

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THORAC
	(iv) a QRS duration greater than or equal to 120 ms; or
	(b) has:
	(i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and
	(ii) sinus rhythm; and
	(iii) a left ventricular ejection fraction of less than or equal to 35%; and
	(iv) a QRS duration greater than or equal to 150 ms; or
	(c) satisfied the requirements mentioned in paragraph (a) or (b) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode
	(Anaes.) (Assist.)
	(See para TN.8.63, TN.8.67 of explanatory notes to this Category) Fee: \$1,224.60 Benefit: 75% = \$918.45
	THORACOTOMY or median sternotomy for post-operative bleeding (Anaes.) (Assist.)
38656	(See para TN.8.67 of explanatory notes to this Category) Fee: \$958.40 Benefit: 75% = \$718.80
	CARDIAC TUMOURS
	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, without pate or conduit reconstruction (Anaes.) (Assist.)
38670	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,909.20 Benefit: 75% = \$1431.90
	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit (Anaes.) (Assist.)
38673	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,148.85 Benefit: 75% = \$1611.65
	CARDIAC TUMOUR arising from ventricular myocardium, partial thickness excision of (Anaes.) (Assist.)
38677	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,010.35 Benefit: 75% = \$1507.80
	CARDIAC TUMOUR arising from ventricular myocardium, full thickness excision of including repair or reconstruction (Anaes.) (Assist.)
38680	(See para TN.8.70 of explanatory notes to this Category) Fee: \$2,384.55 Benefit: 75% = \$1788.45 85% = \$2301.15
	CONGENITAL CARDIAC SURGERY
	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation o without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)
38700	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,067.40 Benefit: 75% = \$800.55
	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation o

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THORAG	6. CARDIO-THORACIC	
	with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)		
	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,924.10 Benefit: 75% = \$1443.10		
	AORTA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)		
38706	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,822.40 Benefit: 75% = \$1366.80		
	AORTA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes. (Assist.))	
38709	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,134.50 Benefit: 75% = \$1600.90		
	AORTIC INTERRUPTION, repair of, for congenital heart disease (Anaes.) (Assist.)		
38712	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,563.15 Benefit: 75% = \$1922.40		
	MAIN PULMONARY ARTERY, banding, debanding or repair of, without cardiopulmonary bypass, congenital heart disease (Anaes.) (Assist.)	for	
38715	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,706.30 Benefit: 75% = \$1279.75		
	MAIN PULMONARY ARTERY, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)		
38718	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,134.50 Benefit: 75% = \$1600.90		
	VENA CAVA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)	e	
38721	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,495.80 Benefit: 75% = \$1121.85		
	VENA CAVA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)		
38724	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,134.50 Benefit: 75% = \$1600.90		
	INTRATHORACIC VESSELS, anastomosis or repair of, without cardiopulmonary bypass, not being service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Anaes.) (Assist.)		
38727	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,495.80 Benefit: 75% = \$1121.85		
	INTRATHORACIC VESSELS, anastomosis or repair of, with cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Anaes.) (Assist.)		
38730	Fee: \$2,134.50 Benefit: 75% = \$1600.90		
38733	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, without cardiopulmonar bypass, for congenital heart disease (Anaes.) (Assist.)	ry	

T8. SUF	RGICAL OPERATIONS	6. CARDIO-THORACIC
	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,495.80 Benefit: 75% = \$1121.85	
	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of bypass, for congenital heart disease (Anaes.) (Assist.)	of, with cardiopulmonary
38736	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,134.50 Benefit: 75% = \$1600.90	
	ATRIAL SEPTECTOMY, with or without cardiopulmonary bypass, for cor (Anaes.) (Assist.)	ngenital heart disease
38739	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,924.10 Benefit: 75% = \$1443.10	
	ATRIAL SEPTAL DEFECT, closure by open exposure direct suture or pate disease (Anaes.) (Assist.)	ch, for congenital heart
38742	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,924.10 Benefit: 75% = \$1443.10	
	INTRA-ATRIAL BAFFLE, insertion of, for congenital heart disease (Anae	s.) (Assist.)
38745	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,134.50 Benefit: 75% = \$1600.90	
	VENTRICULAR SEPTECTOMY, for congenital heart disease (Anaes.) (A	ssist.)
38748	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,134.50 Benefit: 75% = \$1600.90	
	Ventricular septal defect, closure by direct suture or patch (Anaes.) (Assist.)	
38751	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,134.50 Benefit: 75% = \$1600.90	
	INTRAVENTRICULAR BAFFLE OR CONDUIT, insertion of, for congen (Assist.)	ital heart disease (Anaes.)
38754	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,671.95 Benefit: 75% = \$2004.00	
	EXTRACARDIAC CONDUIT, insertion of, for congenital heart disease (A	anaes.) (Assist.)
38757	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,134.50 Benefit: 75% = \$1600.90	
	EXTRACARDIAC CONDUIT, replacement of, for congenital heart disease	e (Anaes.) (Assist.)
38760	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,134.50 Benefit: 75% = \$1600.90	
	VENTRICULAR MYECTOMY, for relief of ventricular obstruction, right disease (Anaes.) (Assist.)	or left, for congenital heart
38763	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,134.50 Benefit: 75% = \$1600.90	
	VENTRICULAR AUGMENTATION, right or left, for congenital heart disc	ease (Anaes.) (Assist.)
38766	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,134.50 Benefit: 75% = \$1600.90	
	MISCELLANEOUS PROCEDURES ON THE CHE	ST

T8. SUF	RGICAL OPERAT	TIONS	6. CARDIO-THORACIC		
		AVITY, aspiration of, for diagnostic purposes, no item 38803 applies	ot being a service associated with a		
38800	Fee: \$38.50	Benefit: 75% = \$28.90 85% = \$32.75			
	THORACIC CA	VITY, aspiration of, with therapeutic drainage le	(paracentesis), with or without		
38803	Fee: \$76.90	Benefit: 75% = \$57.70 85% = \$65.40			
	INTERCOSTA	DRAIN, insertion of, not involving resection of	of rib (excluding aftercare) (Anaes.)		
38806	Fee: \$133.55	Benefit: 75% = \$100.20 85% = \$113.55			
	INTERCOSTAL aftercare) (Anae	DRAIN, insertion of, with pleurodesis and not s.)	involving resection of rib (excluding		
38809	Fee: \$164.55	Benefit: 75% = \$123.45 85% = \$139.90			
	PERCUTANEO	US NEEDLE BIOPSY of lung (Anaes.)			
38812	Fee: \$209.15	Benefit: 75% = \$156.90 85% = \$177.80			
T8. SUF	RGICAL OPERAT	ions	7. NEUROSURGICAL		
	Group T8. Surgical Operations				
		Subgroup 7. Neurosurgical			
		GENERAL			
	LUMBAR PUN	CTURE (Anaes.)			
39000	Fee: \$75.30	Benefit: 75% = \$56.50 85% = \$64.05			
	CISTERNAL P	UNCTURE (Anaes.)			
39003	Fee: \$85.65	Benefit: 75% = \$64.25 85% = \$72.85			
	VENTRICULA	R PUNCTURE (not including burr-hole) (Anaes	s.)		
39006	Fee: \$159.40	Benefit: 75% = \$119.55 85% = \$135.50			
		AEMORRHAGE, tap for, each tap (Anaes.)			
39009	Fee: \$59.35	Benefit: 75% = \$44.55			
		ingle, preparatory to ventricular puncture or for item applies (Anaes.)	inspection purpose - not being a service		
39012	Fee: \$237.60	Benefit: 75% = \$178.20			
	or corticosteroic	NDER IMAGE INTENSIFICATION with 1 or n into 1 or more zygo-apophyseal or costo-transv f spinal nerves (Anaes.)			
39013	(See para TN.8.4 Fee: \$109.15	of explanatory notes to this Category) Benefit: 75% = \$81.90 85% = \$92.80			
39015		R RESERVOIR, EXTERNAL VENTRICULAR ONITORING DEVICE, insertion of - including l			

T8. SUR	GICAL OPERATIONS 7. NEUROSURGICA		
	(Assist.)		
ı	(See para TN.8.4 of explanatory notes to this Category) Fee: \$376.00 Benefit: 75% = \$282.00		
	CEREBROSPINAL FLUID reservoir, insertion of (Anaes.) (Assist.)		
39018	Fee: \$376.00 Benefit: 75% = \$282.00		
-	PAIN RELIEF		
	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.)		
39100	(See para TN.8.4 of explanatory notes to this Category) Fee: \$237.60 Benefit: 75% = \$178.20 85% = \$202.00		
	NEURECTOMY, INTRACRANIAL, for trigeminal neuralgia (Anaes.) (Assist.)		
39106	Fee: \$1,188.20 Benefit: 75% = \$891.15		
	TRIGEMINAL GANGLIOTOMY by radiofrequency, balloon or glycerol (Anaes.)		
39109	Fee: \$443.70 Benefit: 75% = \$332.80 85% = \$377.15		
	CRANIAL NERVE, intracranial decompression of, using microsurgical techniques (Anaes.) (Assist.)		
39112	Fee: \$1,541.50 Benefit: 75% = \$1156.15		
	PERCUTANEOUS NEUROTOMY of posterior divisions (or rami) of spinal nerves by any method, including any associated spinal, epidural or regional nerve block (payable once only in a 30 day period) (Anaes.)		
39115	(See para TN.8.4 of explanatory notes to this Category) Fee: \$75.30 Benefit: 75% = \$56.50 85% = \$64.05		
	PERCUTANEOUS NEUROTOMY for facet joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.) (Assist.)		
39118	(See para TN.8.4 of explanatory notes to this Category) Fee: \$297.85 Benefit: 75% = \$223.40 85% = \$253.20		
	PERCUTANEOUS CORDOTOMY (Anaes.) (Assist.)		
39121	(See para TN.8.4 of explanatory notes to this Category) Fee: \$631.75 Benefit: 75% = \$473.85 85% = \$548.35		
	CORDOTOMY OR MYELOTOMY, partial or total laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Anaes.) (Assist.)		
39124	Fee: \$1,616.80 Benefit: 75% = \$1212.60		
	Intrathecal or epidural SPINAL CATHETER insertion or replacement of, and connection to a subcutaneous implanted infusion pump, for the management of chronic intractable pain (Anaes.) (Assist.)		
39125	Fee: \$298.05 Benefit: 75% = \$223.55		
	INFUSION PUMP, subcutaneous implantation or replacement of, and connection of the pump to an intrathecal or epidural catheter, and filling of reservoir with a therapeutic agent or agents, with or without programming the pump, for the management of chronic intractable pain (Anaes.) (Assist.)		

T8. SUF	RGICAL OPERATIONS	7. NEUROSURGICAL	
	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, inser chronic intractable pain (Anaes.)	rtion of, for the management of	
39127	(See para TN.8.4 of explanatory notes to this Category) Fee: \$473.65 Benefit: 75% = \$355.25		
	INFUSION PUMP, subcutaneous implantation of, AND intrathecal of insertion of, and connection of pump to catheter, and filling of reserve agents, with or without programming the pump, for the management of (Assist.)	oir with a therapeutic agent or	
39128	Fee: \$659.95 Benefit: 75% = \$495.00		
	EPIDURAL LEAD, percutaneous placement of, including intraoperar management of chronic intractable neuropathic pain or pain from refr maximum of 4 leads (Anaes.)		
39130	(See para TN.8.4 of explanatory notes to this Category) Fee: \$674.15 Benefit: 75% = \$505.65		
	ELECTRODES, epidural or peripheral nerve, management of patient of neurostimulator by a medical practitioner, for the management of or pain from refractory angina pectoris - each day		
39131	Fee: \$127.80 Benefit: 75% = \$95.85 85% = \$108.65		
	Removal of subcutaneously IMPLANTED INFUSION PUMP OR reintrathecal or epidural SPINAL CATHETER, for the management of		
39133	(See para TN.8.4 of explanatory notes to this Category) Fee: \$159.40 Benefit: 75% = \$119.55		
	NEUROSTIMULATOR or RECEIVER, subcutaneous placement of, including placement and connection of extension wires to epidural or peripheral nerve electrodes, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris (Anaes.) (Assist.)		
39134	Fee: \$340.60 Benefit: 75% = \$255.45		
	NEUROSTIMULATOR or RECEIVER, that was inserted for the maneuropathic pain or pain from refractory angina pectoris, removal of, of a hospital (Anaes.)		
39135	Fee: \$159.40 Benefit: 75% = \$119.55		
	LEAD, epidural or peripheral nerve that was inserted for the manager neuropathic pain or pain from refractory angina pectoris, removal of, of a hospital (Anaes.)		
39136	(See para TN.8.4 of explanatory notes to this Category) Fee: \$159.40 Benefit: 75% = \$119.55		
	LEAD, epidural or peripheral nerve that was inserted for the manager neuropathic pain or pain from refractory angina pectoris, surgical report unsatisfactory positioning, including intraoperative test stimulation 39130, 39138 or 39139 applies (Anaes.)	ositioning to correct displacement	
39137	Fee: \$605.35 Benefit: 75% = \$454.05		
39138	PERIPHERAL NERVE LEAD, surgical placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to a		

T8. SUF	RGICAL OPERAT	ONS	7. NEUROSURGICAL	
	maximum of 4 le	ads (Anaes.) (Assist.)		
	Fee: \$674.15	Benefit: 75% = \$505.65		
	Epidural lead, su intraoperative tes	rgical placement of one or more by partial or tot t stimulation, for the management of chronic int pectoris—to a maximum of 4 leads (H) (Anaes	tractable neuropathic pain or pain from	
39139	Fee: \$905.10	Benefit: 75% = \$678.85		
		THETER, insertion of, under imaging control, with ion for lysis of adhesions (Anaes.)	rith epidurogram and epidural	
39140	Fee: \$292.85	Benefit: 75% = \$219.65 85% = \$248.95		
		PERIPHERAL NERVES		
	CUTANEOUS N (Anaes.) (Assist.	IERVE (including digital nerve), primary repair	of, using microsurgical techniques	
39300	Fee: \$353.35	Benefit: 75% = \$265.05		
	CUTANEOUS N (Anaes.) (Assist.	ERVE (including digital nerve), secondary repair	air of, using microsurgical techniques	
39303	Fee: \$466.10	Benefit: 75% = \$349.60		
	NERVE TRUNK	, primary repair of, using microsurgical techniq	ues (Anaes.) (Assist.)	
39306	Fee: \$676.80	Benefit: 75% = \$507.60		
	NERVE TRUNK	, secondary repair of, using microsurgical techn	iques (Anaes.) (Assist.)	
39309	Fee: \$714.35	Benefit: 75% = \$535.80		
	NERVE TRUNK	, (interfascicular), neurolysis of, using microsur	rgical techniques (Anaes.) (Assist.)	
39312	Fee: \$398.55	Benefit: 75% = \$298.95		
	NERVE TRUNK techniques (Anac	c, nerve graft to, (cable graft) including harvestings.) (Assist.)	ng of nerve graft using microsurgical	
39315	Fee: \$1,030.20	Benefit: 75% = \$772.65		
	CUTANEOUS N (Anaes.) (Assist.	IERVE (including digital nerve), nerve graft to,	using microsurgical techniques	
39318	Fee: \$639.20	Benefit: 75% = \$479.40		
	NERVE, transpo	sition of (Anaes.) (Assist.)		
39321	Fee: \$473.65	Benefit: 75% = \$355.25		
		US NEUROTOMY by cryotherapy or radiofrequanother item applies (Anaes.) (Assist.)	uency lesion generator, not being a	
39323	Fee: \$276.80	Benefit: 75% = \$207.60 85% = \$235.30		
	NEURECTOMY operation (Anaes	, NEUROTOMY or removal of tumour from su .) (Assist.)	perficial peripheral nerve, by open	
39324	(See para TN.8.4 c Fee: \$276.80	f explanatory notes to this Category) Benefit: 75% = \$207.60 85% = \$235.30		

T8. SUF	3. SURGICAL OPERATIONS 7. NEUROSUR			
			al of tumour from deep peripheral or cranial nerve, by open 41575, 41576, 41578 or 41579 applies (Anaes.) (Assist.)	
39327	(See para TN.8.4 or Fee: \$473.75	f explanatory notes to this Cate Benefit: 75% = \$355.35	egory)	
	NEUROLYSIS by open operation without transposition, not being a service associated with a service to which item 39312 applies (Anaes.) (Assist.)			
39330	Fee: \$276.80	Benefit: 75% = \$207.60		
	CARPAL TUNN	EL RELEASE (division of	transverse carpal ligament), by any method (Anaes.)	
39331	Fee: \$276.80	Benefit: 75% = \$207.60	85% = \$235.30	
	BRACHIAL PLE (Anaes.) (Assist.)		eing a service to which another item in this Group applies	
39333	Fee: \$398.55	Benefit: 75% = \$298.95	85% = \$338.80	
		C	RANIAL NERVES	
	VESTIBULAR N	IERVE, section of, via post	erior fossa (Anaes.) (Assist.)	
39500	Fee: \$1,270.90	Benefit: 75% = \$953.20		
	FACIO-HYPOG	LOSSAL nerve or FACIO-	ACCESSORY nerve, anastomosis of (Anaes.) (Assist.)	
39503	Fee: \$955.00	Benefit: 75% = \$716.25		
3,003	CRANIO-CEREBRAL INJURIES			
	INTRACRANIA (Assist.)	L HAEMORRHAGE, burr	-hole craniotomy for - including burr-holes (Anaes.)	
39600	Fee: \$473.65	Benefit: 75% = \$355.25		
	INTRACRANIA of haematoma (A		oplastic craniotomy or extensive craniectomy and removal	
39603	Fee: \$1,195.70	Benefit: 75% = \$896.80		
	FRACTURED SI	KULL, depressed or comm	inuted, operation for (Anaes.) (Assist.)	
39606	Fee: \$797.10	Benefit: 75% = \$597.85		
			dural penetration, operation for (Anaes.) (Assist.)	
39609	Fee: \$955.00	Benefit: 75% = \$716.25		
37007	FRACTURED SKULL, compound, depressed or complicated, with dural penetration and brain laceration, operation for (Anaes.) (Assist.)			
39612	Fee: \$1,120.45	Benefit: 75% = \$840.35		
	-	KULL with rhinorrhoea or	otorrhoea, repair of by cranioplasty or endoscopic approach	
39615	Fee: \$1,195.70	Benefit: 75% = \$896.80		
	·		LL BASE SURGERY	
39640		LVING ANTERIOR CRA ull base, and dural repair (A	NIAL FOSSA, removal of, involving craniotomy, radical Anaes.) (Assist.)	

T8. SUF	RGICAL OPERATIONS 7. NEUROSURGICA
	(See para TN.8.70 of explanatory notes to this Category) Fee: \$3,031.65 Benefit: 75% = \$2273.75
	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving frontal craniotomy with lateral rhinotomy for clearance of paranasal sinus extension (intracranial procedure) (Anaes.) (Assist.)
39642	(See para TN.8.70 of explanatory notes to this Category) Fee: \$3,187.25 Benefit: 75% = \$2390.45
	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving frontal craniotomy with lateral rhinotomy and radical clearance of paranasal sinus and orbital fossa extensions, with intracranial decompression of the optic nerve, (intracranial procedure) (Anaes.) (Assist.)
39646	(See para TN.8.70 of explanatory notes to this Category) Fee: \$3,653.60 Benefit: 75% = \$2740.20
	TUMOUR INVOLVING MIDDLE CRANIAL FOSSA AND INFRA-TEMPORAL FOSSA, removal of, craniotomy and radical or sub-total radical excision, with division and reconstruction of zygomatic arch, (intracranial procedure) (Anaes.) (Assist.)
39650	(See para TN.8.70 of explanatory notes to this Category) Fee: \$2,642.95 Benefit: 75% = \$1982.25
	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision (intracranial procedure), not being a service to which item 39654 or 39656 applies (Anaes.) (Assist.)
39653	(See para TN.8.70 of explanatory notes to this Category) Fee: \$4,703.15 Benefit: 75% = \$3527.40
	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision, (intracranial procedure), conjoint surgery, principal surgeon (Anaes.) (Assist.)
39654	(See para TN.8.70 of explanatory notes to this Category) Fee: \$3,420.50 Benefit: 75% = \$2565.40
	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision, (intracranial procedure) conjoint surgery, co-surgeon (Assist.)
39656	(See para TN.8.70 of explanatory notes to this Category) Fee: \$2,565.30 Benefit: 75% = \$1924.00
	TUMOUR INVOLVING THE CLIVUS, radical or sub-total radical excision of, involving transoral or transmaxillary approach (Anaes.) (Assist.)
39658	(See para TN.8.70 of explanatory notes to this Category) Fee: \$3,031.65 Benefit: 75% = \$2273.75
	TUMOUR OR VASCULAR LESION OF CAVERNOUS SINUS, radical excision of, involving craniotomy with or without intracranial carotid artery exposure (Anaes.) (Assist.)
39660	(See para TN.8.70 of explanatory notes to this Category) Fee: \$3,031.65 Benefit: 75% = \$2273.75
	TUMOUR OR VASCULAR LESION OF FORAMEN MAGNUM, radical excision of, via transcondylar or far lateral suboccipital approach (Anaes.) (Assist.)
39662	(See para TN.8.70 of explanatory notes to this Category) Fee: \$3,031.65 Benefit: 75% = \$2273.75

T8. SUF	RGICAL OPERAT	IONS	7. NEUROSURGICAL
		INTRA-CRAI	NIAL NEOPLASMS
	SKULL TUMOU	UR, benign or malignant, excision	n of, excluding cranioplasty (Anaes.) (Assist.)
39700	Fee: \$556.60	Benefit: 75% = \$417.45	
	INTRACRANIA (Anaes.) (Assist.	•	sue, burr-hole and biopsy of, or drainage of, or both
39703	Fee: \$519.00	Benefit: 75% = \$389.25	
		L tumour, biopsy or decompress f via osteoplastic flap (Anaes.) (A	ion of via osteoplastic flap OR biopsy and Assist.)
39706	Fee: \$1,112.85	Benefit: 75% = \$834.65	
			ic carcinoma or any other tumour in cerebrum, which another item in this Sub-group applies (Anaes.)
39709	Fee: \$1,586.75	Benefit: 75% = \$1190.10	
	intraventricular t		HOMA, pinealoma, cranio-pharyngioma, umour, not being a service to which another item in this
39712	Fee: \$2,865.00	Benefit: 75% = \$2148.75	
	PITUITARY TU	MOUR, removal of, by transcra	nial or transphenoidal approach (Anaes.) (Assist.)
39715	Fee: \$1,985.30	Benefit: 75% = \$1489.00	
	ARACHNOIDA	L CYST, craniotomy for (Anaes) (Assist.)
39718	Fee: \$872.30	Benefit: 75% = \$654.25	
	CRANIOTOMY etc (Anaes.) (Ass		re-opening post-operatively for haemorrhage, swelling,
39721	Fee: \$797.10	Benefit: 75% = \$597.85	
		CEREBROVA	SCULAR DISEASE
	ANEURYSM, cl	lipping or reinforcement of sac (A	Anaes.) (Assist.)
39800	Fee: \$2,857.55	Benefit: 75% = \$2143.20	
	INTRACRANIA	L ARTERIOVENOUS MALFO	RMATION, excision of (Anaes.) (Assist.)
39803	Fee: \$2,857.55	Benefit: 75% = \$2143.20	
			racranial proximal artery clipping of (Anaes.) (Assist.)
39806	Fee: \$1,285.75	Benefit: 75% = \$964.35	
			s fistula, ligation of cervical vessel or vessels (Anaes.)
39812	Fee: \$631.75	Benefit: 75% = \$473.85	
	CAROTID-CAV (Anaes.) (Assist.		n of - combined cervical and intracranial procedure

T8. SUF	RGICAL OPERATI	ONS 7. NEUROSURGICA		
	EXTRACRANIA	L TO INTRACRANIAL BYPASS using superficial temporal artery (Anaes.) (Assist		
39818	Fee: \$1,827.25	Benefit: 75% = \$1370.45		
	EXTRACRANIA	L TO INTRACRANIAL BYPASS using saphenous vein graft (Anaes.) (Assist.)		
39821	Fee: \$2,169.75	Benefit: 75% = \$1627.35		
		INFECTION		
	INTRACRANIA	L INFECTION, drainage of, via burr-hole - including burr-hole (Anaes.) (Assist.)		
39900	Fee: \$519.00	Benefit: 75% = \$389.25		
	INTRACRANIA	L ABSCESS, excision of (Anaes.) (Assist.)		
39903	Fee: \$1,586.75	Benefit: 75% = \$1190.10		
	OSTEOMYELIT	IS OF SKULL or removal of infected bone flap, craniectomy for (Anaes.) (Assist.)		
39906	Fee: \$797.10	Benefit: 75% = \$597.85		
		CEREBROSPINAL FLUID CIRCULATION DISORDERS		
	VENTRICULO-0	CISTERNOSTOMY (Torkildsen's operation) (Anaes.) (Assist.)		
40000	Fee: \$917.40	Benefit: 75% = \$688.05		
	CRANIAL OR C	ISTERNAL SHUNT DIVERSION, insertion of (Anaes.) (Assist.)		
40003	Fee: \$917.40	Benefit: 75% = \$688.05		
	LUMBAR SHUN	VT DIVERSION, insertion of (Anaes.) (Assist.)		
40006	Fee: \$721.95	Benefit: 75% = \$541.50		
	CRANIAL, CIST	ERNAL OR LUMBAR SHUNT, revision or removal of (Anaes.) (Assist.)		
40009	Fee: \$526.40	Benefit: 75% = \$394.80		
	THIRD VENTRICULOSTOMY (open or endoscopic) with or without endoscopic septum			
	pellucidotomy (Anaes.) (Assist.)			
40012	Fee: \$1,030.20	Benefit: 75% = \$772.65		
	SUBTEMPORAL	L DECOMPRESSION (Anaes.) (Assist.)		
40015	Fee: \$638.65	Benefit: 75% = \$479.00		
	LUMBAR CERE	BROSPINAL FLUID DRAIN, insertion of (Anaes.)		
40018	Fee: \$159.40	Benefit: 75% = \$119.55 85% = \$135.50		
		CONGENITAL DISORDERS		
	MENINGOCELE	E, excision and closure of (Anaes.) (Assist.)		
40100	Fee: \$691.75	Benefit: 75% = \$518.85		
	MYELOMENINGOCELE, excision and closure of, including skin flaps or Z plasty where performed			
	(Anaes.) (Assist.)			
40103	Fee: \$1,015.25	Benefit: 75% = \$761.45		
	ARNOLD-CHIA	RI MALFORMATION, decompression of (Anaes.) (Assist.)		
40106	Fee: \$1,030.20	Benefit: 75% = \$772.65		
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T8. SUF	RGICAL OPERATIONS	7. NEUROSURGICAL		
	ENCEPHALOCOELE, excision and closure of (Anaes.) (Ass	ist.)		
40109	Fee: \$1,112.85 Benefit: 75% = \$834.65			
	TETHERED CORD, release of, including lipomeningocele or	r diastematomyelia (Anaes.) (Assist.)		
40112	Fee: \$1,428.75 Benefit: 75% = \$1071.60			
	CRANIOSTENOSIS, operation for - single suture (Anaes.) (A	Assist.)		
40115	Fee: \$721.95 Benefit: 75% = \$541.50			
	CRANIOSTENOSIS, operation for - more than 1 suture (Ana	nes.) (Assist.)		
40118	Fee: \$955.00 Benefit: 75% = \$716.25			
	SKULL RECONSTRUC	TION		
	CRANIOPLASTY, reconstructive (Anaes.) (Assist.)			
40600	Fee: \$955.00 Benefit: 75% = \$716.25			
	EPILEPSY			
	CORPUS CALLOSUM, anterior section of, for epilepsy (Ana	aes.) (Assist.)		
40700	Fee: \$1,744.65 Benefit: 75% = \$1308.50			
	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, subcutaneous placement of electrical pulse generator, for:			
	(a) management of refractory generalised epilepsy; or			
	(b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.)			
40701	Fee: \$340.60 Benefit: 75% = \$255.45			
	Vagus nerve stimulation therapy through stimulation of the le removal of electrical pulse generator inserted for:	ft vagus nerve, surgical repositioning or		
	(a) management of refractory generalised epilepsy; or			
	(b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.)			
40702	Fee: \$159.40 Benefit: 75% = \$119.55			
	CORTICECTOMY, TOPECTOMY or PARTIAL LOBECTO	DMY for epilepsy (Anaes.) (Assist.)		
40703	Fee: \$1,466.30 Benefit: 75% = \$1099.75			
	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical placement of lead, including connection of lead to left vagus nerve and intra-operative test stimulation, for:			
	(a) management of refractory generalised epilepsy; or			
	(b) treatment of refractory focal epilepsy not suitable for research	ctive epilepsy surgery (Anaes.) (Assist.)		
40704	Fee: \$674.15 Benefit: 75% = \$505.65			
	Vagus nerve stimulation therapy through stimulation of the le removal of lead attached to left vagus nerve for:	ft vagus nerve, surgical repositioning or		
40705	(a) management of refractory generalised epilepsy; or			

T8. SUF	RGICAL OPERATI	ONS	7. NEUROSURGICAL	
	(b) treatment of re	efractory focal epilepsy not suitable	for resective epilepsy surgery (Anaes.) (Assist.)	
	Fee: \$605.35	Benefit: 75% = \$454.05		
		ΓΟΜΥ for intractable epilepsy (Ana	es.) (Assist.)	
40706	Fee: \$2,143.10	Benefit: 75% = \$1607.35 85% =		
40700	Vagus nerve stim		of the left vagus nerve, electrical analysis and	
	(a) management of refractory generalised epilepsy; or			
		efractory focal epilepsy not suitable		
40707	Fee: \$189.70	Benefit: 75% = \$142.30 85% = \$	161.25	
		ulation therapy through stimulation of all pulse generator inserted for:	of the left vagus nerve, surgical replacement of	
	(a) management of	of refractory generalised epilepsy; or		
	(b) treating refrac	tory focal epilepsy not suitable for re	esective epilepsy surgery (Anaes.) (Assist.)	
40708	Fee: \$340.60	Benefit: 75% = \$255.45		
	BURR-HOLE PL	ACEMENT of intracranial depth or	surface electrodes (Anaes.) (Assist.)	
40709	Fee: \$519.00	Benefit: 75% = \$389.25		
	INTRACRANIA	L ELECTRODE PLACEMENT via	craniotomy (Anaes.) (Assist.)	
40712	Fee: \$1,045.20	Benefit: 75% = \$783.90		
		STEREOTACTIC	PROCEDURES	
	STEREOTACTIO	C ANATOMICAL LOCALISATION	N, as an independent procedure (Anaes.) (Assist.)	
40800	Fee: \$638.65	Benefit: 75% = \$479.00 85% = \$	555.25	
	FUNCTIONAL STEREOTACTIC procedure including computer assisted anatomical localisation, physiological localisation, and lesion production in the basal ganglia, brain stem or deep white matter tracts, not being a service associated with deep brain stimulation for Parkinson's disease, essential tremor or dystonia (Anaes.) (Assist.)			
40801	Fee: \$1,745.80	Benefit: 75% = \$1309.35		
		L STEREOTACTIC PROCEDURE 801 applies (Anaes.) (Assist.)	BY ANY METHOD, not being a service to which	
40803	Fee: \$1,195.70	Benefit: 75% = \$896.80 85% = \$	1112.30	
40850	DEEP BRAIN STIMULATION (unilateral) functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes for the treatment of:			
		se where the patient's response to me notor fluctuations; or	dical therapy is not sustained and is accompanied	

T8. SUF	RGICAL OPERATIONS	7. NEUROSURGICAL		
	Essential tremor or dystonia where the patient's symptoms cause sev	rere disability (Anaes.) (Assist.)		
	Fee: \$2,264.45 Benefit: 75% = \$1698.35			
	DEEP BRAIN STIMULATION (bilateral) functional stereotactic pr anatomical localisation, physiological localisation including twist dr craniectomy and insertion of electrodes for the treatment of:			
	Parkinson's disease where the patient's response to medical therapy i by unacceptable motor fluctuations; or	is not sustained and is accompanied		
	Essential tremor or dystonia where the patient's symptoms cause sev	ere disability. (Anaes.) (Assist.)		
40851	Fee: \$3,963.00 Benefit: 75% = \$2972.25			
	DEEP BRAIN STIMULATION (unilateral) subcutaneous placemen pulse generator for the treatment of:	t of neurostimulator receiver or		
	Parkinson's disease where the patient's response to medical therapy i by unacceptable motor fluctuations; or	s not sustained and is accompanied		
	Essential tremor or dystonia where the patient's symptoms cause sev	ere disability. (Anaes.) (Assist.)		
40852	Fee: \$340.60 Benefit: 75% = \$255.45			
	DEEP BRAIN STIMULATION (unilateral) revision or removal of b	orain electrode for the treatment of:		
	Parkinson's disease where the patient's response to medical therapy i by unacceptable motor fluctuations; or	is not sustained and is accompanied		
	Essential tremor or dystonia where the patient's symptoms cause sev	ere disability. (Anaes.)		
40854	Fee: \$526.40 Benefit: 75% = \$394.80			
	DEEP BRAIN STIMULATION (unilateral) removal or replacement generator for the treatment of:	of neurostimulator receiver or pulse		
	Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or			
	Essential tremor or dystonia where the patient's symptoms cause sev	rere disability. (Anaes.)		
40856	Fee: \$255.45 Benefit: 75% = \$191.60			
	DEEP BRAIN STIMULATION (unilateral) placement, removal or the treatment of:	replacement of extension lead for		
40858	Parkinson's disease where the patient's response to medical therapy is by unacceptable motor fluctuations; or	is not sustained and is accompanied		

T8. SUF	RGICAL OPERATIONS 7. NEUROSURGIO	CAL		
	Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)			
	Fee: \$526.40 Benefit: 75% = \$394.80			
	DEEP BRAIN STIMULATION (unilateral) target localisation incorporating anatomical and physiological techniques, including intra-operative clinical evaluation, for the insertion of a single neurostimulation wire for the treatment of:			
	Parkinson's disease where the patient's response to medical therapy is not sustained and is accompan by unacceptable motor fluctuations; or	ied		
	Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)			
40860	Fee: \$2,022.70 Benefit: 75% = \$1517.05			
	DEEP BRAIN STIMULATION (unilateral) electronic analysis and programming of neurostimulator pulse generator for the treatment of:	r		
	Parkinson's disease where the patient's response to medical therapy is not sustained and is accompan by unacceptable motor fluctuations; or	ied		
	Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)			
40862	Fee: \$189.70 Benefit: 75% = \$142.30 85% = \$161.25			
	MISCELLANEOUS			
	NEUROENDOSCOPY, for inspection of an intraventricular lesion, with or without biopsy including burr hole (Anaes.) (Assist.)	3		
40903	Fee: \$554.55 Benefit: 75% = \$415.95			
	CRANIOTOMY, performed in association with items 45767, 45776, 45782 and 45785 for the correct of craniofacial abnormalities (Anaes.)	ction		
40905	Fee: \$601.70 Benefit: 75% = \$451.30 85% = \$518.30			
T8. SUF	RGICAL OPERATIONS 8. EAR, NOSE AND THRO	OAT		
	Group T8. Surgical Operations			
	Subgroup 8. Ear, Nose And Throat			
	EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.)			
41500	(See para TN.8.72 of explanatory notes to this Category) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15			
	EAR, foreign body in, removal of, involving incision of external auditory canal (Anaes.)			
41503	Fee: \$238.80 Benefit: 75% = \$179.10 85% = \$203.00			
	AURAL POLYP, removal of (Anaes.)			
41506	Fee: \$144.00 Benefit: 75% = \$108.00 85% = \$122.40			
41509	EXTERNAL AUDITORY MEATUS, surgical removal of keratosis obturans from, not being a servi to which another item in this Group applies (Anaes.)	ice		

T8. SUF	RGICAL OPERATION	ONS	8. EAR, NOSE AND THROAT
	Fee: \$162.95	Benefit: 75% = \$122.25	85% = \$138.55
		r involving removal of car s15 applies (Anaes.) (Assis	tilage or bone or both cartilage and bone, not being a service t.)
41512	Fee: \$585.90	Benefit: 75% = \$439.45	
			tilage or bone or both cartilage and bone, being a service 80, 41548, 41557, 41560 or 41563 applies (Anaes.) (Assist.)
41515	(See para TN.8.73 c Fee: \$384.55	of explanatory notes to this Ca Benefit: 75% = \$288.45	
	EXTERNAL AU	DITORY MEATUS, remo	val of EXOSTOSES IN (Anaes.) (Assist.)
41518	Fee: \$928.75	Benefit: 75% = \$696.60	
	Correction of AU (Anaes.) (Assist.)	DITORY CANAL STEN	OSIS, including meatoplasty, with or without grafting
41521	Fee: \$988.85	Benefit: 75% = \$741.65	
		TION OF EXTERNAL AU 557, 41560 and 41563 app	DITORY CANAL, being a service associated with a service oly (Anaes.) (Assist.)
41524	(See para TN.8.74 c	of explanatory notes to this Ca Benefit: 75% = \$214.30	
41324			Rosen incision) (Anaes.) (Assist.)
41527	Fee: \$587.60	Benefit: 75% = \$440.70	
		•	approach with or without mastoid inspection (Anaes.)
41530	Fee: \$957.30	Benefit: 75% = \$718.00	
	(Assist.)	without reconstruction of t	he bony defect, with or without myringoplasty (Anaes.)
41533	Fee: \$1,144.30	Benefit: 75% = \$858.25	
	ATTICOTOMY v	with reconstruction of the l	pony defect, with or without myringoplasty (Anaes.) (Assist.)
41536	Fee: \$1,281.70	Benefit: 75% = \$961.30	
	OSSICULAR CH	AIN RECONSTRUCTIO	N (Anaes.) (Assist.)
41539	Fee: \$1,089.90	Benefit: 75% = \$817.45	
	OSSICULAR CH	AIN RECONSTRUCTIO	N AND MYRINGOPLASTY (Anaes.) (Assist.)
41542	Fee: \$1,194.25	Benefit: 75% = \$895.70	
		MY (CORTICAL) (Anaes	
41545	Fee: \$521.25	Benefit: 75% = \$390.95	
<u> </u>	-	OF THE MASTOID CA	
41548	Fee: \$691.75	Benefit: 75% = \$518.85	
+1348			, with myringoplasty (Anaes.) (Assist.)
41.55		•	
41551	Fee: \$1,593.05	Benefit: 75% = \$1194.8	0

T8. SUF	RGICAL OPERATIO	NS	8. EAR, NOSE AND THROAT
	MASTOIDECTON (Anaes.) (Assist.)	MY, intact wall technique, wi	th myringoplasty and ossicular chain reconstruction
41554	Fee: \$1,876.95	Benefit: 75% = \$1407.75	
	MASTOIDECTON	MY (RADICAL OR MODIFI	ED RADICAL) (Anaes.) (Assist.)
41557	Fee: \$1,089.90	Benefit: 75% = \$817.45	
			ED RADICAL) AND MYRINGOPLASTY (Anaes.)
41560	Fee: \$1,194.25	Benefit: 75% = \$895.70	
41300	MASTOIDECTON	***************************************	ED RADICAL), MYRINGOPLASTY AND Anaes.) (Assist.)
41563	Fee: \$1,478.40	Benefit: 75% = \$1108.80	
	CAVITY, BLIND		ED RADICAL), OBLITERATION OF THE MASTOID NAL AUDITORY CANAL AND OBLITERATION
41564	Fee: \$1,911.80	Benefit: 75% = \$1433.85	
	REVISION OF MA (Anaes.) (Assist.)	ASTOIDECTOMY (radical, 1	modified radical or intact wall), including myringoplasty
41566	Fee: \$1,089.90	Benefit: 75% = \$817.45	
	DECOMPRESSIO	N OF FACIAL NERVE in it	s mastoid portion (Anaes.) (Assist.)
41569	Fee: \$1,194.25	Benefit: 75% = \$895.70	
	LABYRINTHOTO	OMY OR DESTRUCTION O	F LABYRINTH (Anaes.) (Assist.)
41572	Fee: \$1,033.20	Benefit: 75% = \$774.90	
	transmastoid, trans		removal of by 2 surgeons operating conjointly, by approach transmastoid, translabyrinthine or retromastoid.)
41575	Fee: \$2,435.70	Benefit: 75% = \$1826.80	
	retromastoid appro		, removal of, by transmastoid, translabyrinthine or including aftercare) not being a service to which item
41576	Fee: \$3,653.60	Benefit: 75% = \$2740.20	
	CEREBELLO PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, principal surgeon (Anaes.) (Assist.)		
41578	Fee: \$2,435.70	Benefit: 75% = \$1826.80	
			removal of, by transmastoid, translabyrinthine or - conjoint surgery, co-surgeon (Assist.)
41579	Fee: \$1,826.75	Benefit: 75% = \$1370.10	
	TUMOUR INVOL excision of (Anaes		FOSSA, removal of, involving craniotomy and radical
41581	Fee: \$2,801.55	Benefit: 75% = \$2101.20	

T8. SUF	RGICAL OPERATION	ONS	8. EAR, NOSE AND THROAT	
		ORAL BONE RESECTION for ression of facial nerve (Anaes.) (Ass	moval of tumour involving mastoidectomy with or ist.)	
41584	Fee: \$1,922.65	Benefit: 75% = \$1442.00		
	TOTAL TEMPORAL BONE RESECTION for removal of tumour (Anaes.) (Assist.)			
41587	Fee: \$2,618.60	Benefit: 75% = \$1963.95		
	ENDOLYMPHAT (Anaes.) (Assist.)	TIC SAC, TRANSMASTOID DEC	COMPRESSION with or without drainage of	
41590	Fee: \$1,194.25	Benefit: 75% = \$895.70		
	TRANSLABYRIN	THINE VESTIBULAR NERVE	SECTION (Anaes.) (Assist.)	
41593	Fee: \$1,556.50	Benefit: 75% = \$1167.40		
			SECTION or COCHLEAR NERVE SECTION, or	
41596	Fee: \$1,739.50	Benefit: 75% = \$1304.65		
	INTERNAL AUD decompression (A		middle cranial fossa approach with cranial nerve	
41599	Fee: \$1,739.50	Benefit: 75% = \$1304.65		
	OSSEO-INTEGRATION PROCEDURE - implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients:			
	- With a permanent or long term hearing loss; and			
	- Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and			
	- With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted.			
	Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.)			
41603	Fee: \$503.85	Benefit: 75% = \$377.90 85% =	\$428.30	
	OSSEO-INTEGRATION PROCEDURE - fixation of transcutaneous abutment implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients:			
	- With a permanent or long term hearing loss; and			
	- Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and			
	- With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted.			
	Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.)			
41604	Fee: \$186.50	Benefit: 75% = \$139.90 85% =	\$158.55	
		Y (Anaes.) (Assist.)		
41608	Fee: \$1,089.90	Benefit: 75% = \$817.45		

T8. SUF	RGICAL OPERATIONS	3	8. EAR, NOSE AND THROAT	
	STAPES MOBILISA	TION (Anaes.) (Assist	<i>i.</i>)	
41611	Fee: \$701.30	Benefit: 75% = \$526.00		
	ROUND WINDOW S	SURGERY including r	epair of cochleotomy (Anaes.) (Assist.)	
41614	Fee: \$1,089.90	Benefit: 75% = \$817.45	85% = \$1006.50	
	OVAL WINDOW SU to which any other iter		pair of fistula, not being a service associated with a service s (Anaes.) (Assist.)	
41615	Fee: \$1,089.90 I	Benefit: 75% = \$817.45	85% = \$1006.50	
	COCHLEAR IMPLA	NT, insertion of, inclu	ding mastoidectomy (Anaes.) (Assist.)	
41617	Fee: \$1,895.20	Benefit: 75% = \$1421.4	0	
	Middle ear implant, pa	artially implantable, in	sertion of, via mastoidectomy, for patients with:	
	(a) stable sensorineura	al hearing loss; and		
	(b) outer ear patholog	y that prevents the use	of a conventional hearing aid; and	
	(c) a PTA4 of less than 80 dBHL; and			
	(d) bilateral, symmetrical hearing loss with PTA thresholds in both ears within 20 dBHL (0.5-4kHz) of each other; and			
	(e) speech perception discrimination of at least 65% correct for word lists with appropriately amplified sound; and			
	(f) a normal middle ear; and			
	(g) normal tympanometry; and			
	(h) on audiometry, an air-bone gap of less than 10 dBHL (0.5-4kHz) across all frequencies; and			
	(i) no other inner ear disorders			
	(Anaes.) (Assist.)			
41618	Fee: \$1,876.95	Benefit: 75% = \$1407.7	5	
	GLOMUS TUMOUR	, transtympanic remov	al of (Anaes.) (Assist.)	
41620	Fee: \$824.55	Benefit: 75% = \$618.45		
			l of, including mastoidectomy (Anaes.) (Assist.)	
41623	Fee: \$1,194.25	Benefit: 75% = \$895.70		
			DLE EAR, operation for (excluding aftercare) (Anaes.)	
41626	(See para TN.8.4 of expl Fee: \$144.00	anatory notes to this Cate Benefit: 75% = \$108.00		
	MIDDLE EAR, EXPI	LORATION OF (Anae	es.) (Assist.)	
41629	Fee: \$521.25	Benefit: 75% = \$390.95		
41632			NAGE OF (including myringotomy) (Anaes.)	

T8. SUF	RGICAL OPERAT	IONS	8. EAR, NOSE AND THROAT	
	Fee: \$238.80	Benefit: 75% = \$179.	10 85% = \$203.00	
	CLEARANCE C	OF MIDDLE EAR FOR G	RANULOMA, CHOLESTEATOMA and POLYP, 1 or more,	
	with or without r	myringoplasty (Anaes.) (A	assist.)	
41635	Fee: \$1,144.30	Benefit: 75% = \$858.2	25 85% = \$1060.90	
			RANULOMA, CHOLESTEATOMA and POLYP, 1 or more, lar chain reconstruction (Anaes.) (Assist.)	
41638	Fee: \$1,428.35	Benefit: 75% = \$1071	.30	
	PERFORATION	OF TYMPANUM, caute	erisation or diathermy of (Anaes.)	
41641	Fee: \$47.45	Benefit: 75% = \$35.60	0 85% = \$40.35	
	EXCISION OF I myringoplasty (A		RFORATION, not being a service associated with	
41644	Fee: \$142.80	Benefit: 75% = \$107.3	10 85% = \$121.40	
		equiring use of operating nal anaesthesia (Anaes.)	nicroscope and microinspection of tympanic membrane with	
41647	Fee: \$109.90	Benefit: 75% = \$82.45	5 85% = \$93.45	
			ion of 1 or both ears under general anaesthesia, not being a another item in this Group applies (Anaes.)	
41650	Fee: \$109.90	Benefit: 75% = \$82.45	5 85% = \$93.45	
	POSTNASAL S		or POSTNASAL SPACE, or NASAL CAVITY AND AL ANAESTHESIA, not being a service associated with a p applies (Anaes.)	
41653	Fee: \$71.95	Benefit: 75% = \$54.00	0 85% = \$61.20	
			R, ARREST OF, with posterior nasal packing with or without pack (excluding aftercare) (Anaes.)	
		of explanatory notes to this C		
41656	Fee: \$122.85	Benefit: 75% = \$92.15		
	NOSE, removal	of FOREIGN BODY IN,	other than by simple probing (Anaes.)	
41659	Fee: \$77.55	Benefit: 75% = \$58.20	0 85% = \$65.95	
	NASAL POLYP	OR POLYPI (SIMPLE),	removal of	
	(See para TN.8.75	of explanatory notes to this	Category)	
41662	Fee: \$82.50	Benefit: 75% = \$61.90		
	NASAL POLYP	OR POLYPI, removal of	(Anaes.)	
41668	(See para TN.8.75 Fee: \$219.95	of explanatory notes to this Benefit: 75% = \$165.0		
	NASAL SEPTU (Anaes.)	M, SEPTOPLASTY, SUF	BMUCOUS RESECTION or closure of septal perforation	
41671	(See para TN.8.10- Fee: \$483.25	4 of explanatory notes to this Benefit: 75% = \$362.4		

T8. SUF	RGICAL OPERAT	IONS 8. EAR, NOSE AND THROAT		
	NASAL SEPTU	M, reconstruction of (Anaes.) (Assist.)		
41672	Fee: \$602.85	Benefit: 75% = \$452.15		
	general anaesthe	her than by chemical means) or cauterisation by chemical means when performed under sia or diathermy of septum or turbinates—one or more of these procedures (including on the same occasion) other than a service associated with another operation on the		
41674	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45		
	NASAL HAEM packing or both	ORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity (Anaes.)		
41677	Fee: \$90.00	Benefit: 75% = \$67.50 85% = \$76.50		
		JASAL ADHESIONS, with or without stenting not being a service associated with any on the nose and not performed during the postoperative period of a nasal operation		
41683	Fee: \$117.20	Benefit: 75% = \$87.90 85% = \$99.65		
		OF TURBINATE OR TURBINATES, 1 or both sides, not being a service associated which another item in this Group applies (Anaes.)		
41686	Fee: \$71.95	Benefit: 75% = \$54.00 85% = \$61.20		
	TURBINECTOMY or turbinectomies, partial or total, unilateral (Anaes.)			
41689	Fee: \$136.50	Benefit: 75% = \$102.40		
	TURBINATES, submucous resection of, unilateral (Anaes.)			
41692	Fee: \$178.05	Benefit: 75% = \$133.55		
	MAXILLARY A	NTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.)		
41698	Fee: \$32.55	Benefit: 75% = \$24.45 85% = \$27.70		
	MAXILLARY ANTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission to hospital) not being a service associated with a service to which another item in this Group applies (Anaes.)			
41701	Fee: \$91.90	Benefit: 75% = \$68.95		
		NTRUM, LAVAGE OF each attendance at which the procedure is performed, sociated consultation (Anaes.)		
41704 Fee: \$36.30 Benefit: 75% = \$27.25 85% = \$30.90		Benefit: 75% = \$27.25 85% = \$30.90		
	MAXILLARY ARTERY, transantral ligation of (Anaes.) (Assist.)			
41707 Fee: \$448.55 Benefit: 75% = \$336.45		Benefit: 75% = \$336.45		
	ANTROSTOMY	(RADICAL) (Anaes.) (Assist.)		
41710	Fee: \$521.25	Benefit: 75% = \$390.95		
	ANTROSTOMY (Anaes.) (Assist.	(RADICAL) with transantral ethmoidectomy or transantral vidian neurectomy		
41713	Fee: \$606.50	Benefit: 75% = \$454.90		

T8. SUF	RGICAL OPERAT	IONS 8. EAR, NOSE AND THROAT
	ANTRUM, intra	nasal operation on, or removal of foreign body from (Anaes.) (Assist.)
41716	Fee: \$295.70	Benefit: 75% = \$221.80
	ANTRUM, drain	nage of, through tooth socket (Anaes.)
41719	Fee: \$117.55	Benefit: 75% = \$88.20 85% = \$99.95
	OROANTRAL I	FISTULA, plastic closure of (Anaes.) (Assist.)
41722	Fee: \$587.60	Benefit: 75% = \$440.70 85% = \$504.20
	ETHMOIDAL A	ARTERY OR ARTERIES, transorbital ligation of (unilateral) (Anaes.) (Assist.)
41725	Fee: \$448.55	Benefit: 75% = \$336.45
	LATERAL RHI	NOTOMY with removal of tumour (Anaes.) (Assist.)
41728	Fee: \$897.30	Benefit: 75% = \$673.00
		NOSE, excision of, with intranasal extension (Anaes.) (Assist.)
41729	Fee: \$568.65	Benefit: 75% = \$426.50
11/2)		L ETHMOIDECTOMY by external approach with or without sphenoidectomy (Anaes.)
	(Assist.)	
41731	Fee: \$777.10	Benefit: 75% = \$582.85
	RADICAL FRO	NTOETHMOIDECTOMY with osteoplastic flap (Anaes.) (Assist.)
41734	Fee: \$1,014.05	Benefit: 75% = \$760.55
		US, OR ETHMOIDAL SINUSES ON THE ONE SIDE, intranasal operation on
	(Anaes.) (Assist.)
41737	Fee: \$483.25	Benefit: 75% = \$362.45
	FRONTAL SIN	US, catheterisation of (Anaes.)
41740	Fee: \$58.80	Benefit: 75% = \$44.10
	FRONTAL SIN	US, trephine of (Anaes.) (Assist.)
41743	Fee: \$337.45	Benefit: 75% = \$253.10
	FRONTAL SIN	US, radical obliteration of (Anaes.) (Assist.)
41746	Fee: \$777.10	Benefit: 75% = \$582.85 85% = \$693.70
	ETHMOIDAL SINUSES, external operation on (Anaes.) (Assist.)	
41749	Fee: \$606.50	Benefit: 75% = \$454.90
	SPHENOIDAL	SINUS, intranasal operation on (Anaes.) (Assist.)
41752	Fee: \$295.70	Benefit: 75% = \$221.80
		TUBE, catheterisation of (Anaes.)
41755	Fee: \$46.50	Benefit: 75% = \$34.90 85% = \$39.55
F1 / JJ		PY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX and
A1764		or more of these procedures, unilateral or bilateral examination (Anaes.)
41764		

T8. SUF	RGICAL OPERAT	ONS	8. EAR, NOSE AND THROAT
	Fee: \$122.85	Benefit: 75% = \$92.15 85	% = \$104.45
	NASOPHARYN	GEAL ANGIOFIBROMA, rea	moval of (Anaes.) (Assist.)
41767	Fee: \$737.00	Benefit: 75% = \$552.75 8	25% = \$653.60
	PHARYNGEAL	POUCH, removal of, with or	without cricopharyngeal myotomy (Anaes.) (Assist.)
41770	Fee: \$701.30	Benefit: 75% = \$526.00	
11770			SECTION OF (Dohlman's operation) (Anaes.) (Assist.)
41773	Fee: \$587.60	Benefit: 75% = \$440.70	•
41//3			without inversion of pharyngeal pouch (Anaes.) (Assist.)
41776			(* 11110 m. (* 11110 m.) (* 11110 m.)
41776	Fee: \$585.90	Benefit: $75\% = 439.45	total excision of tongue (Anaes.) (Assist.)
			total excision of toligue (Aliaes.) (Assist.)
41779	Fee: \$701.30	Benefit: 75% = \$526.00	
	PARTIAL PHAI	RYNGECTOMY via PHARYN	NGOTOMY (Anaes.) (Assist.)
41782	Fee: \$952.10	Benefit: 75% = \$714.10 8	5% = \$868.70
	PARTIAL PHAI (Assist.)	RYNGECTOMY via PHARYN	NGOTOMY with partial or total glossectomy (Anaes.)
41785	Fee: \$1,181.15	Benefit: 75% = \$885.90	
	(Assist.)	OPHARY NGOPLASTY, with	or without tonsillectomy, by any means (Anaes.)
41786	Fee: \$737.00	Benefit: 75% = \$552.75	
	UVULECTOMY AND PARTIAL PALATECTOMY WITH LASER INCISION OF THE PALATE, with or without tonsillectomy, 1 or more stages, including any revision procedures within 12 months (Anaes.) (Assist.)		
41787	Fee: \$568.65	Benefit: 75% = \$426.50 8	25% = \$485.25
	examination of the		a person aged less than 12 years (including any arynx and the infiltration of local anaesthetic), not being a
	(Anaes.)		
41789	Fee: \$295.70	Benefit: 75% = \$221.80	
	Tonsils or tonsils and adenoids, removal of, in a person 12 years of age or over (including any examination of the postnasal space and nasopharynx and the infiltration of local anaesthetic), not being service to which item 41764 applies (Anaes.)		
41793	Fee: \$371.50	Benefit: 75% = \$278.65	
		ONSILS AND ADENOIDS, A wing removal of (Anaes.)	RREST OF HAEMORRHAGE requiring general
41797	Fee: \$144.00	Benefit: 75% = \$108.00	
41801		al of (including any examination	on of the postnasal space and nasopharynx and the

T8. SUF	RGICAL OPERAT	IONS 8. EAR, NOSE AND THROAT
	infiltration of loc	cal anaesthetic), not being a service to which item 41764 applies (Anaes.)
	Fee: \$162.95	Benefit: 75% = \$122.25
	LINGUAL TON	SIL OR LATERAL PHARYNGEAL BANDS, removal of (Anaes.)
41804	Fee: \$90.00	Benefit: 75% = \$67.50
	PERITONSILLA	AR ABSCESS (quinsy), incision of (Anaes.)
41807	Fee: \$70.10	Benefit: 75% = \$52.60 85% = \$59.60
	UVULOTOMY	or UVULECTOMY (Anaes.)
41810	Fee: \$35.60	Benefit: 75% = \$26.70 85% = \$30.30
		OR PHARYNGEAL CYSTS, removal of (Anaes.) (Assist.)
41813	Fee: \$356.35	Benefit: 75% = \$267.30
		COPY (with rigid oesophagoscope) (Anaes.)
41816	Fee: \$185.60	Benefit: 75% = \$139.20 85% = \$157.80
11010		COPY (with rigid oesophagoscope), with biopsy (Anaes.)
41822	Fee: \$238.80	Benefit: 75% = \$179.10
41022		COPY (with rigid oesophagoscope), with removal of foreign body (Anaes.) (Assist.)
41825	Fee: \$356.35	Benefit: 75% = \$267.30 L STRICTURE, dilatation of, without oesophagoscopy (Anaes.)
41828	Fee: \$52.20	Benefit: 75% = \$39.15 85% = \$44.40
		loscopic pneumatic dilatation of, for treatment of achalasia (Anaes.) (Assist.)
41831	Fee: \$357.00	Benefit: 75% = \$267.75 85% = \$303.45
	OESOPHAGUS	, balloon dilatation of, using interventional imaging techniques (Anaes.)
41832	Fee: \$228.50	Benefit: 75% = \$171.40 85% = \$194.25
	LARYNGECTO	MY (TOTAL) (Anaes.) (Assist.)
41834	Fee: \$1,289.15	Benefit: 75% = \$966.90
	VERTICAL HE	MILARYNGECTOMY including tracheostomy (Anaes.) (Assist.)
41837	Fee: \$1,236.05	Benefit: 75% = \$927.05
	SUPRAGLOTT	IC LARYNGECTOMY including tracheostomy (Anaes.) (Assist.)
41840	Fee: \$1,519.80	Benefit: 75% = \$1139.85
	LARYNGOPHARYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUI after laryngopharyngectomy USING STOMACH OR BOWEL (Anaes.) (Assist.)	
41843	Fee: \$1,336.45	Benefit: 75% = \$1002.35
41846		t examination of the supraglottic, glottic and subglottic regions, not being a service any other procedure on the larynx or with the administration of a general anaesthetic

T8. SUF	RGICAL OPERAT	IONS	8. EAR, NOSE AND THROAT	
	(See para TN.8.76 Fee: \$185.60	of explanatory notes to this Category) Benefit: 75% = \$139.20 85% =	\$157.80	
	MICROLARYN	GOSCOPY (Anaes.) (Assist.)		
41855	Fee: \$288.20	Benefit: 75% = \$216.15		
	MICROLARYN	GOSCOPY with removal of juvenile	e papillomata (Anaes.) (Assist.)	
41858	(See para TN.8.77 Fee: \$494.15	of explanatory notes to this Category) Benefit: 75% = \$370.65		
	MICROLARYN (Assist.)	GOSCOPY with removal of benign	lesions of the larynx by laser surgery (Anaes.)	
41861	Fee: \$604.30	Benefit: 75% = \$453.25		
	MICROLARYN	GOSCOPY WITH REMOVAL OF	TUMOUR (Anaes.) (Assist.)	
41864	Fee: \$407.50	Benefit: 75% = \$305.65		
	MICROLARYN	GOSCOPY with arytenoidectomy (A	Anaes.) (Assist.)	
41867	Fee: \$613.40	Benefit: 75% = \$460.05		
11007		WEB, division of, using microlarygo	scopic techniques (Anaes.)	
41868	Fee: \$388.70	Benefit: 75% = \$291.55		
41000	-		C, COLLAGEN OR GELFOAM (Anaes.) (Assist.)	
41.070			, 0022.102.101.101.11(1.11.101.1)(1.11.101.1)	
41870	Fee: \$454.85	Benefit: 75% = \$341.15 CTURED, operation for (Anaes.) (A	coist)	
			,	
41873	Fee: \$587.60	Benefit: 75% = \$440.70 85% =	****	
	(Assist.)	nal operation on, OR LARYNGOFT	SSURE with or without cordectomy (Anaes.)	
41876	Fee: \$587.60	Benefit: 75% = \$440.70 85% =	\$504.20	
	LARYNGOPLA	STY or TRACHEOPLASTY, include	ling tracheostomy (Anaes.) (Assist.)	
41879	Fee: \$952.10	Benefit: 75% = \$714.10		
		MY by a percutaneous technique usin of a cuffed tracheostomy tube (Ana	ng sequential dilatation or partial splitting method les.)	
41880	Fee: \$254.15	Benefit: 75% = \$190.65		
		MY by open exposure of the trachea yroid isthmus, where performed (Ar	, including separation of the strap muscles or laes.) (Assist.)	
41881	Fee: \$401.75	Benefit: 75% = \$301.35		
	CRICOTHYRO	STOMY by direct stab or Seldinger	echnique, using mini tracheostomy device (Anaes.)	
41884	Fee: \$91.05	Benefit: 75% = \$68.30		
	TRACHE-OESC		f, as a secondary procedure following dures (Anaes.) (Assist.)	
41885	Fee: \$287.90	Benefit: 75% = \$215.95 85% =	\$244.75	

T8. SUF	RGICAL OPERAT	IONS	8. EAR, NOSE AND THROAT
	TRACHEA, rem	oval of foreign body in (Ana	aes.)
41886	Fee: \$178.05	Benefit: 75% = \$133.55	85% = \$151.35
	BRONCHOSCO	PY, as an independent proce	edure (Anaes.)
41889	Fee: \$178.05	Benefit: 75% = \$133.55	85% = \$151.35
	BRONCHOSCO (Anaes.)	PY with 1 or more endobro	nchial biopsies or other diagnostic or therapeutic procedures
41892	Fee: \$235.05	Benefit: 75% = \$176.30	85% = \$199.80
	BRONCHUS, re	moval of foreign body in (A	naes.) (Assist.)
41895	Fee: \$367.75	Benefit: 75% = \$275.85	
			more transbronchial lung biopsies, with or without without the use of interventional imaging (Anaes.) (Assist.)
41898	Fee: \$256.95	Benefit: 75% = \$192.75	85% = \$218.45
		LASER RESECTION OF E	NDOBRONCHIAL TUMOURS for relief of obstruction ares (Anaes.) (Assist.)
41901	Fee: \$604.30	Benefit: 75% = \$453.25	
	BRONCHOSCO	PY with dilatation of trache	al stricture (Anaes.)
41904	Fee: \$246.50	Benefit: 75% = \$184.90	85% = \$209.55
	TRACHEA OR	BRONCHUS, dilatation of s	stricture and endoscopic insertion of stent (Anaes.) (Assist.)
41905	Fee: \$453.35	Benefit: 75% = \$340.05	
	NASAL SEPTU	M BUTTON, insertion of (A	Anaes.)
41907	Fee: \$122.85	Benefit: 75% = \$92.15	85% = \$104.45
	DUCT OF MAJO	OR SALIVARY GLAND, tr	ransposition of (Anaes.) (Assist.)
41910	Fee: \$390.25	Benefit: 75% = \$292.70	
T8. SUF	RGICAL OPERAT	IONS	9. OPHTHALMOLOGY
	Group T8. Surgi	cal Operations	
	Subgroup 9. Ophthalmology		
		OGICAL EXAMINATION which another item in this C	under general anaesthesia, not being a service associated Group applies (Anaes.)
42503	Fee: \$102.50	Benefit: 75% = \$76.90	
	Complete removal from the eye of a trans-trabecular drainage device or devices, with or without replacement, following device related medical complications necessitating complete removal.		
	(Anaes.)		
42505	Fee: \$300.75 Extended Medic	Benefit: 75% = \$225.60 care Safety Net Cap: \$45.15	

T8. SUF	RGICAL OPERATI	ONS	9. OPHTHALMOLOGY
	EYE, ENUCLEA	ATION OF, with or without sphere implant (A	naes.) (Assist.)
42506	Fee: \$481.25	Benefit: 75% = \$360.95 85% = \$409.10	
		ATION OF, with insertion of integrated implar	nt (Anaes.) (Assist.)
42509	Fee: \$609.05	Benefit: 75% = \$456.80	
1230)		n of, with insertion of hydroxy apatite implant	or similar coralline implant (Anaes.)
	(Assist.)		• ` ` `
42510	Fee: \$702.05	Benefit: 75% = \$526.55	
	GLOBE, EVISC	ERATION OF (Anaes.) (Assist.)	
42512	Fee: \$481.25	Benefit: 75% = \$360.95 85% = \$409.10	
	GLOBE, EVISC (Anaes.) (Assist.)	ERATION OF, AND INSERTION OF INTRA)	ASCLERAL BALL OR CARTILAGE
42515	Fee: \$609.05	Benefit: 75% = \$456.80	
	procedure, or RE	IIC ORBIT, INSERTION OF CARTILAGE OF MOVAL OF IMPLANT FROM SOCKET, or PEG by drilling into an existing orbital impla	r PLACEMENT OF A MOTILITY
42518	Fee: \$353.35	Benefit: 75% = \$265.05	
		IIC SOCKET, treatment of, by insertion of a vs a secondary procedure (Anaes.) (Assist.)	vired-in conformer, integrated implant or
42521	Fee: \$1,203.20	Benefit: 75% = \$902.40	
	ORBIT, SKIN G	RAFT TO, as a delayed procedure (Anaes.)	
42524	Fee: \$204.60	Benefit: 75% = \$153.45 85% = \$173.95	
		SOCKET, RECONSTRUCTION INCLUDIN OULD (Anaes.) (Assist.)	NG MUCOUS MEMBRANE GRAFTING
42527	Fee: \$406.05	Benefit: 75% = \$304.55	
	ORBIT, EXPLO	RATION with or without biopsy, requiring RI	EMOVAL OF BONE (Anaes.) (Assist.)
42530	Fee: \$631.75	Benefit: 75% = \$473.85	
	ORBIT, EXPLO	RATION OF, with drainage or biopsy not requ	uiring removal of bone (Anaes.) (Assist.)
42533	Fee: \$406.05	Benefit: 75% = \$304.55	
	ORBIT, EXENTERATION OF, with or without skin graft and with or without temporalis muscle transplant (Anaes.) (Assist.)		with or without temporalis muscle
42536	Fee: \$834.60	Benefit: 75% = \$625.95	
	ORBIT, EXPLO	RATION OF, with removal of tumour or forei	ign body, requiring removal of bone
42539	Fee: \$1,188.20	Benefit: 75% = \$891.15	
	ORBIT, explorat	ion of anterior aspect with removal of tumour	or foreign body (Anaes.) (Assist.)
	Fee: \$503.85	Benefit: 75% = \$377.90	

T8. SUF	RGICAL OPERATI	ONS 9. OPHTHALMOLOGY		
	ORBIT, explorat	ion of retrobulbar aspect with removal of tumour or foreign body (Anaes.) (Assist.)		
42543	Fee: \$883.85	Benefit: 75% = \$662.90		
		ression of, for dysthyroid eye disease, by fenestration of 2 or more walls, or by the rbital peribulbar and retrobulbar fat from each quadrant of the orbit, 1 eye (Anaes.)		
42545	Fee: \$1,278.35	Benefit: 75% = \$958.80		
	OPTIC NERVE	MENINGES, incision of (Anaes.) (Assist.)		
42548	Fee: \$759.40	Benefit: 75% = \$569.55		
		TING WOUND OR RUPTURE OF, not involving intraocular structures repair of cornea or sclera, or both, not being a service to which item 42632 applies (Anaes.)		
42551	Fee: \$631.75	Benefit: 75% = \$473.85 85% = \$548.35		
	EYE, PENETRA repair (Anaes.) (A	TING WOUND OR RUPTURE OF, with incarceration or prolapse of uveal tissue Assist.)		
42554	Fee: \$737.00	Benefit: 75% = \$552.75		
	EYE, PENETRA (Anaes.) (Assist.)	TING WOUND OR RUPTURE OF, with incarceration of lens or vitreous repair		
42557	Fee: \$1,030.20	Benefit: 75% = \$772.65		
	INTRAOCULAR	INTRAOCULAR FOREIGN BODY, removal from anterior segment (Anaes.) (Assist.)		
42563	Fee: \$519.00	Benefit: 75% = \$389.25 85% = \$441.15		
	INTRAOCULA	R FOREIGN BODY, removal from posterior segment (Anaes.) (Assist.)		
42569	Fee: \$1,030.20	Benefit: 75% = \$772.65		
	ORBITAL ABSO	CESS OR CYST, drainage of (Anaes.)		
42572	Fee: \$117.35	Benefit: 75% = \$88.05 85% = \$99.75		
	DERMOID, peri	orbital, excision of, on a person 10 years of age or over (Anaes.)		
42573	Fee: \$227.45	Benefit: 75% = \$170.60 85% = \$193.35		
	DERMOID, orbi	tal, excision of (Anaes.) (Assist.)		
42574	Fee: \$483.25	Benefit: 75% = \$362.45 85% = \$410.80		
	TARSAL CYST,	extirpation of (Anaes.)		
42575	Fee: \$82.75	Benefit: 75% = \$62.10 85% = \$70.35		
	DERMOID, peri	orbital, excision of, on a person under 10 years of age (Anaes.)		
42576	Fee: \$295.70	Benefit: 75% = \$221.80 85% = \$251.35		
	ECTROPION OF	R ENTROPION, tarsal cauterisation of (Anaes.)		
42581	Fee: \$117.35	Benefit: 75% = \$88.05 85% = \$99.75		
42584	TARSORRHAPI	HY (Anaes.) (Assist.)		

T8. SUR	GICAL OPERAT	IONS	9. OPHTHALMOLOGY
	Fee: \$276.80	Benefit: 75% = \$207.60 85% = \$235.30	
	TRICHIASIS (deach eyelid (Ana	ue to causes other than trachoma), treatmennes.)	t of by cryotherapy, laser or electrolysis -
42587	Fee: \$51.95	Benefit: 75% = \$39.00 85% = \$44.20	
	TRICHIASIS (d	ue to trachoma), treatment of by cryotherap	y, laser or electrolysis - each eyelid (Anaes.)
42588 S	Fee: \$51.95	Benefit: 75% = \$39.00 85% = \$44.20	
	CANTHOPLAS	TY, medial or lateral (Anaes.) (Assist.)	
42590	Fee: \$338.35 Extended Medi	Benefit: 75% = \$253.80 85% = \$287.60 care Safety Net Cap: \$270.70)
	LACRIMAL GI	AND, excision of palpebral lobe (Anaes.)	
42593	Fee: \$204.60	Benefit: 75% = \$153.45	
	LACRIMAL SA	C, excision of, or operation on (Anaes.) (A	ssist.)
42596	Fee: \$503.85	Benefit: 75% = \$377.90 85% = \$428.30)
		ANALICULAR SYSTEM, establishment of 1 eye (Anaes.) (Assist.)	patency by closed operation using silicone
42599	Fee: \$631.75	Benefit: 75% = \$473.85 85% = \$548.35	5
	LACRIMAL CA (Assist.)	NALICULAR SYSTEM, establishment of	patency by open operation, 1 eye (Anaes.)
42602	Fee: \$631.75	Benefit: 75% = \$473.85 85% = \$548.35	5
	LACRIMAL CA	ANALICULUS, immediate repair of (Anaes	a.) (Assist.)
42605	Fee: \$466.10	Benefit: 75% = \$349.60 85% = \$396.20)
	LACRIMAL DI	RAINAGE by insertion of glass tube, as an i	independent procedure (Anaes.) (Assist.)
42608	Fee: \$300.75	Benefit: 75% = \$225.60 85% = \$255.65	5
		AL TUBE (unilateral), removal or replacen ruction, unilateral, with or without lavage -	
42610	Fee: \$96.25	Benefit: 75% = \$72.20 85% = \$81.85	
		AL TUBE (bilateral), removal or replacemental pilateral, with or without lavage - under gen	ent of, or LACRIMAL PASSAGES, probing aeral anaesthesia (Anaes.)
42611	Fee: \$144.35	Benefit: 75% = \$108.30 85% = \$122.70)
	probing to estab	AL TUBE (unilateral), removal or replacen lish patency of the lacrimal passage and/or s g a service associated with a service to whice	site of obstruction, unilateral, including
42614	(See para TN.8.4 Fee: \$48.30	of explanatory notes to this Category) Benefit: 75% = \$36.25 85% = \$41.10	
	to establish pate	AL TUBE (bilateral), removal or replacemency of the lacrimal passage and/or site of obsecutated with a service to which item 4261	
42615	Fee: \$72.25	Benefit: 75% = \$54.20 85% = \$61.45	

T8. SUF	RGICAL OPERATIO	NS	9. OPHTHALMOLOGY
	PUNCTUM SNIP	peration (Anaes.)	
42617	Fee: \$136.95	Benefit: 75% = \$102.75 85% = \$116.45	
	PUNCTUM, occlus	ion of, by use of a plug (Anaes.)	
42620	Fee: \$52.65	Benefit: 75% = \$39.50 85% = \$44.80	
	PUNCTUM, perma	nent occlusion of, by use of electrical caut	tery (Anaes.)
42622	Fee: \$82.75	Benefit: 75% = \$62.10 85% = \$70.35	
	DACRYOCYSTO	HINOSTOMY (Anaes.) (Assist.)	
42623	Fee: \$699.45	Benefit: 75% = \$524.60	
	DACRYOCYSTOI (Anaes.) (Assist.)	HINOSTOMY where a previous dacryoc	ystorhinostomy has been performed
42626	Fee: \$1,128.05	Benefit: 75% = \$846.05 85% = \$1044.65	
	CONJUNCTIVORI (Anaes.) (Assist.)	HINOSTOMY including dacryocystorhine	ostomy and fashioning of conjunctival flaps
42629	Fee: \$849.70	Benefit: 75% = \$637.30	
	CONJUNCTIVAL (Anaes.)	PERITOMY OR REPAIR OF CORNEAL	LACERATION by conjunctival flap
42632	Fee: \$117.35	Benefit: 75% = \$88.05 85% = \$99.75	
	CORNEAL PERFO	RATIONS, sealing of, with tissue adhesiv	ve (Anaes.) (Assist.)
42635	Fee: \$300.75	Benefit: 75% = \$225.60 85% = \$255.65	
	CONJUNCTIVAL	GRAFT OVER CORNEA (Anaes.) (Assis	st.)
42638	Fee: \$376.00	Benefit: 75% = \$282.00 85% = \$319.60	
	AUTOCONJUNCT	IVAL TRANSPLANT, or mucous membranes	rane graft (Anaes.) (Assist.)
42641	Fee: \$488.75	Benefit: 75% = \$366.60 85% = \$415.45	
		ERA, complete removal of embedded fore ne practitioner (excluding aftercare) (Anac	eign body from - not more than once on the es.)
42644	(See para TN.8.78, TI Fee: \$72.15	U.8.4 of explanatory notes to this Category) Benefit: 75% = \$54.15 85% = \$61.35	
	CORNEAL SCARS which item 42686 a		being a service associated with a service to
42647	Fee: \$204.60	Benefit: 75% = \$153.45 85% = \$173.95	
	CORNEA, epithelia	l debridement for corneal ulcer or corneal	erosion (excluding aftercare) (Anaes.)
42650	(See para TN.8.4 of e Fee: \$72.15	planatory notes to this Category) Benefit: 75% = \$54.15 85% = \$61.35	
	CORNEA, epithelia	l debridement for eliminating band kerato	pathy (Anaes.)
42651	Fee: \$160.80	Benefit: 75% = \$120.60 85% = \$136.70	
42652	Corneal collagen cr	oss linking, on a person with a corneal ect	atic disorder, with evidence of

	RGICAL OPERATION	S 9. OPHTHALMOLOGY
	progression—per ey	e. (Anaes.)
	(See para TN.8.136 of Fee: \$1,200.00	explanatory notes to this Category) Benefit: 75% = \$900.00 85% = \$1116.60
	CORNEA transplan	ation of (Anaes.) (Assist.)
42653	Fee: \$1,307.75	Benefit: 75% = \$980.85
	CORNEA, transplar	tation of, second and subsequent procedures (Anaes.) (Assist.)
42656	Fee: \$1,669.45	Benefit: 75% = \$1252.10
	· ·	ation of, full thickness, including collection of donor material (Anaes.) (Assist.)
42662	Fee: \$902.30	Benefit: 75% = \$676.75
		ation of, superficial or lamellar, including collection of donor material (Anaes.)
42665	Fee: \$601.65	Benefit: 75% = \$451.25 85% = \$518.25
		AL SUTURE, manipulation of, performed within 4 months of corneal grafting, to where a reduction of 2 dioptres of astigmatism is obtained, including any associated
42667	Fee: \$141.95	Benefit: 75% = \$106.50 85% = \$120.70
	CORNEAL SUTUR operating microscop	ES, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or e (Anaes.)
42668	Fee: \$75.30	Benefit: 75% = \$56.50 85% = \$64.05
		11
		NS, to correct corneal astigmatism of more than $1\frac{1}{2}$ dioptres following anterior luding appropriate measurements and calculations, performed as an independent Assist.)
42672	segment surgery, inc procedure (Anaes.)	luding appropriate measurements and calculations, performed as an independent
42672	segment surgery, incorprocedure (Anaes.) (See para TN.8.79 of 6 Fee: \$902.30 ADDITIONAL COL	luding appropriate measurements and calculations, performed as an independent Assist.) Explanatory notes to this Category) Benefit: 75% = \$676.75 85% = \$818.90 ENEAL INCISIONS, to correct corneal astigmatism of more than 1 1/2 dioptres, as measurements and calculations, performed in conjunction with other anterior
	segment surgery, inc procedure (Anaes.) (See para TN.8.79 of 6 Fee: \$902.30 ADDITIONAL COl including appropriate	luding appropriate measurements and calculations, performed as an independent Assist.) Explanatory notes to this Category) Benefit: 75% = \$676.75 85% = \$818.90 ENEAL INCISIONS, to correct corneal astigmatism of more than 1 1/2 dioptres, as measurements and calculations, performed in conjunction with other anterior
	segment surgery, inc procedure (Anaes.) ((See para TN.8.79 of e Fee: \$902.30 ADDITIONAL COl including appropriat segment surgery (An Fee: \$451.10	luding appropriate measurements and calculations, performed as an independent Assist.) Explanatory notes to this Category) Benefit: 75% = \$676.75 85% = \$818.90 ENEAL INCISIONS, to correct corneal astigmatism of more than 1 1/2 dioptres, a measurements and calculations, performed in conjunction with other anterior aes.) (Assist.)
	segment surgery, inc procedure (Anaes.) ((See para TN.8.79 of e Fee: \$902.30 ADDITIONAL COl including appropriat segment surgery (An Fee: \$451.10	luding appropriate measurements and calculations, performed as an independent Assist.) Explanatory notes to this Category) Benefit: 75% = \$676.75 85% = \$818.90 INEAL INCISIONS, to correct corneal astigmatism of more than 1 1/2 dioptres, e measurements and calculations, performed in conjunction with other anterior aes.) (Assist.) Benefit: 75% = \$338.35 85% = \$383.45
42673	segment surgery, inc procedure (Anaes.) ((See para TN.8.79 of e Fee: \$902.30 ADDITIONAL COI including appropriat segment surgery (An Fee: \$451.10 CONJUNCTIVA, b Fee: \$115.70 CONJUNCTIVA, CONJUNCTI	luding appropriate measurements and calculations, performed as an independent Assist.) Explanatory notes to this Category) Benefit: 75% = \$676.75 85% = \$818.90 INEAL INCISIONS, to correct corneal astigmatism of more than 1 1/2 dioptres, emeasurements and calculations, performed in conjunction with other anterior aes.) (Assist.) Benefit: 75% = \$338.35 85% = \$383.45 Opsy of, as an independent procedure
42673	segment surgery, inc procedure (Anaes.) ((See para TN.8.79 of e Fee: \$902.30 ADDITIONAL COI including appropriat segment surgery (An Fee: \$451.10 CONJUNCTIVA, b Fee: \$115.70 CONJUNCTIVA, CONJUNCTI	luding appropriate measurements and calculations, performed as an independent Assist.) Replanatory notes to this Category) Benefit: 75% = \$676.75 85% = \$818.90 INEAL INCISIONS, to correct corneal astigmatism of more than 1 1/2 dioptres, e measurements and calculations, performed in conjunction with other anterior aes.) (Assist.) Benefit: 75% = \$338.35 85% = \$383.45 Depty of, as an independent procedure Benefit: 75% = \$86.80 85% = \$98.35 AUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at
42673 42676	segment surgery, inc procedure (Anaes.) ((See para TN.8.79 of e Fee: \$902.30 ADDITIONAL COI including appropriat segment surgery (An Fee: \$451.10 CONJUNCTIVA, b Fee: \$115.70 CONJUNCTIVA, C which treatment is g Fee: \$60.95	luding appropriate measurements and calculations, performed as an independent Assist.) Explanatory notes to this Category) Benefit: 75% = \$676.75 85% = \$818.90 ENEAL INCISIONS, to correct corneal astigmatism of more than 1 1/2 dioptres, e measurements and calculations, performed in conjunction with other anterior aes.) (Assist.) Benefit: 75% = \$338.35 85% = \$383.45 Expression of the expression of the
42673 42676	segment surgery, inc procedure (Anaes.) ((See para TN.8.79 of e Fee: \$902.30 ADDITIONAL COI including appropriat segment surgery (An Fee: \$451.10 CONJUNCTIVA, b Fee: \$115.70 CONJUNCTIVA, C which treatment is g Fee: \$60.95	Assist.) Replanatory notes to this Category) Benefit: 75% = \$676.75 85% = \$818.90 NEAL INCISIONS, to correct corneal astigmatism of more than 1 1/2 dioptres, e measurements and calculations, performed in conjunction with other anterior aes.) (Assist.) Benefit: 75% = \$338.35 85% = \$383.45 Opsy of, as an independent procedure Benefit: 75% = \$86.80 85% = \$98.35 AUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at ven including any associated consultation (Anaes.) Benefit: 75% = \$45.75 85% = \$51.85
42673 42676 42677	segment surgery, inc procedure (Anaes.) ((See para TN.8.79 of e Fee: \$902.30 ADDITIONAL COI including appropriat segment surgery (An Fee: \$451.10 CONJUNCTIVA, b Fee: \$115.70 CONJUNCTIVA, C which treatment is g Fee: \$60.95 CONJUNCTIVA, cr	Assist.) Assist.) Assist.) Assist.) Assist.) Assist.) Assist.) Applanatory notes to this Category) Benefit: 75% = \$676.75

T8. SUF	RGICAL OPERAT	TIONS	9. OPHTHALMOLOGY
	PTERYGIUM, 1	removal of (Anaes.)	
42686	Fee: \$273.65	Benefit: 75% = \$205.25 85% = \$232.65	
	PINGUECULA	, removal of, not being a service associated with the	e fitting of contact lenses (Anaes.)
42689	Fee: \$117.35	Benefit: 75% = \$88.05 85% = \$99.75	
	LIMBIC TUMC	OUR, removal of, excluding Pterygium (Anaes.) (A	ssist.)
42692	Fee: \$276.80	Benefit: 75% = \$207.60 85% = \$235.30	
	LIMBIC TUMC (Assist.)	OUR, excision of, requiring keratectomy or sclerect	omy, excluding Pterygium (Anaes.)
42695	Fee: \$451.10	Benefit: 75% = \$338.35 85% = \$383.45	
		CTION, excluding surgery performed for the correct creater than 3 dioptres following the removal of cat	
42698	(See para TN.8.80 Fee: \$594.75	of explanatory notes to this Category) Benefit: 75% = \$446.10 85% = \$511.35	
		R LENS, insertion of, excluding surgery performed anisometropia greater than 3 dioptres following the	
42701	(See para TN.8.80 Fee: \$331.70	of explanatory notes to this Category) Benefit: 75% = \$248.80 85% = \$281.95	
	for the correction	CTION AND INSERTION OF INTRAOCULAR L n of refractive error except for anisometropia great fact in the first eye (Anaes.)	
42702	Fee: \$760.65 Extended Medi	Benefit: 75% = \$570.50 85% = \$677.25 care Safety Net Cap: \$114.10	
		R LENS or IRIS PROSTHESIS insertion of, into the (Anaes.) (Assist.)	he posterior chamber with fixation to
42703	Fee: \$572.05	Benefit: 75% = \$429.05 85% = \$488.65	
		R LENS, REMOVAL or REPOSITIONING of by a service to which item 42701 applies (Anaes.)	open operation, not being a service
42704	Fee: \$466.10	Benefit: 75% = \$349.60 85% = \$396.20	
	LENS EXTRACTION AND INSERTION OF INTRAOCULAR LENS, excluding surgery performe for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye, performed in association with insertion of a trans-trabecular drain device or devices, in a patient diagnosed with open angle glaucoma who is not adequately responsive topical anti-glaucoma medications or who is intolerant of anti-glaucoma medication. (Anaes.)		er than 3 dioptres following the nsertion of a trans-trabecular drainage a who is not adequately responsive to
42705	Fee: \$911.10 Extended Medi	Benefit: 75% = \$683.35 85% = \$827.70 (care Safety Net Cap: \$136.70	
	performed for th	R LENS, REMOVAL of and REPLACEMENT wine correction of refractive error except for anisomet moval of cataract in the first eye (Anaes.)	
42707	Fee: \$797.10	Benefit: 75% = \$597.85 85% = \$713.70	

T8. SUF	RGICAL OPERATI	ONS	9. OPHTHALMOLOGY	
		LENS, removal of, and repl iris or sclera (Anaes.) (Assis	acement with a lens inserted into the posterior chamber it.)	
42710	Fee: \$902.30	Benefit: 75% = \$676.75	85% = \$818.90	
	IRIS SUTURINO (Anaes.) (Assist.)		milar, for fixation of intraocular lens or repair of iris defect	
42713	Fee: \$376.00	Benefit: 75% = \$282.00	85% = \$319.60	
	CATARACT, JU	VENILE, removal of, includ	ing subsequent needlings (Anaes.) (Assist.)	
42716	Fee: \$1,195.70	Benefit: 75% = \$896.80	85% = \$1112.30	
		ssociated with a service to wh	LAR or LENS MATERIAL, via a limbal approach, not nich item 42698, 42702, 42716, 42725 or 42731 applies	
42719	Fee: \$519.00	Benefit: 75% = \$389.25	85% = \$441.15	
	Vitrectomy via pa	ars plana sclerotomy, includi	ng one or more of the following:	
	(a) removal of vit	reous;		
	(b) division of vit	reous bands;		
	(c) removal of ep	iretinal membranes;		
	(d) capsulotomy (Anaes.) (Assist.)			
42725	Fee: \$1,338.45	Benefit: 75% = \$1003.85		
		RS PLANA LENSECTOMY , 42702, 42719, or 42725 (A	combined with vitrectomy, not being a service associated naes.) (Assist.)	
42731	Fee: \$1,519.00	Benefit: 75% = \$1139.25		
		ner than by laser, and other th (Anaes.) (Assist.)	an a service associated with a service to which item 42725	
42734	Fee: \$300.75	Benefit: 75% = \$225.60	85% = \$255.65	
	PARACENTESIS OF ANTERIOR CHAMBER OR VITREOUS CAVITY, or both, for the injection of therapeutic substances, or the removal of aqueous or vitreous humours for diagnostic or therapeutic purposes, 1 or more of, as an independent procedure.			
42738	Fee: \$300.75	of explanatory notes to this Car Benefit: 75% = \$225.60 are Safety Net Cap: \$240.60	85% = \$255.65	
	therapeutic substa	ances, or the removal of aque	ER OR VITREOUS CAVITY, or both, for the injection of ous or vitreous humours for diagnostic or therapeutic redure, for a patient requiring anaesthetic services.	
40.500	(See para TN.8.121 of explanatory notes to this Category) Fee: \$300.75 Benefit: 75% = \$225.60 85% = \$255.65			
42739		are Safety Net Cap: \$240.60		
	INTKAVITKEA	L INJECTION OF THERAP.	EUTIC SUBSTANCES, or the removal of vitreous as a procedure associated with other intraocular surgery.	

T8. SUF	RGICAL OPERATION	DNS	9. OPHTHALMOLOGY	
	(Anaes.)			
	Fee: \$300.75	of explanatory notes to this Category) Benefit: 75% = \$225.60 85% = \$255.6 re Safety Net Cap: \$240.60	55	
		ral depot injection of a therapeutic subst due to age-related macular degeneration	ance, for the treatment of subfoveal choroidal n, 1 or more of (Anaes.)	
42741	(See para TN.8.81 o Fee: \$300.75	f explanatory notes to this Category) Benefit: 75% = \$225.60 85% = \$255.6	55	
	ANTERIOR CHA (Assist.)	MBER, IRRIGATION OF BLOOD FRO	OM, as an independent procedure (Anaes.)	
42743	Fee: \$631.75	Benefit: 75% = \$473.85 85% = \$548.3	35	
	Needle revision of	glaucoma filtration bleb, following glau	icoma filtering procedure (Anaes.)	
42744	Fee: \$300.55	Benefit: 75% = \$225.45 85% = \$255.5	50	
	GLAUCOMA, filt contraindicated (A		therapies have failed, are likely to fail, or are	
42746	Fee: \$955.00	Benefit: 75% = \$716.25		
	GLAUCOMA, filt (Assist.)	ering operation for, where previous filte	ring operation has been performed (Anaes.)	
42749	Fee: \$1,195.70	Benefit: 75% = \$896.80		
	GLAUCOMA, insertion of drainage device incorporating an extraocular reservoir for, such as a Molteno device (Anaes.) (Assist.)			
42752	(See para TN.8.83 o Fee: \$1,338.45	f explanatory notes to this Category) Benefit: 75% = \$1003.85		
	GLAUCOMA, rer device (Anaes.)	noval of drainage device incorporating a	n extraocular reservoir for, such as a Molteno	
42755	Fee: \$165.45	Benefit: 75% = \$124.10 85% = \$140.6	65	
		treatment of primary congenital glaucon aucoma drainage devices (Anaes.) (Assis		
42758	Fee: \$699.45	Benefit: 75% = \$524.60		
	DIVISION OF AN by laser (Anaes.) (AE, as an independent procedure, other than	
42761	Fee: \$519.00	Benefit: 75% = \$389.25 85% = \$441.1	15	
		ncluding excision of tumour of iris) OR I (Anaes.) (Assist.)	RIDOTOMY, as an independent procedure,	
42764	Fee: \$519.00	Benefit: 75% = \$389.25 85% = \$441.1	15	
	TUMOUR, INVO (Assist.)	LVING CILIARY BODY OR CILIARY	BODY AND IRIS, excision of (Anaes.)	
42767	Fee: \$1,090.35	Benefit: 75% = \$817.80		
42770	CYCLODESTRU	CTIVE procedures for the treatment of it	ntractable glaucoma, treatment to 1 eye, to a	

T8. SUF	RGICAL OPERATIONS	9. OPHTHALMOLOGY
	maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.)	
	(See para TN.8.82 of explanatory notes to this Category) Fee: \$294.80 Benefit: 75% = \$221.10 85% = \$250.60	
	DETACHED RETINA, pneumatic retinopexy for, not being a service assortem 42776 applies (Anaes.) (Assist.)	ociated with a service to which
42773	Fee: \$902.30 Benefit: 75% = \$676.75 85% = \$818.90	
	DETACHED RETINA, buckling or resection operation for (Anaes.) (Assi	ist.)
42776	Fee: \$1,338.45 Benefit: 75% = \$1003.85	
	DETACHED RETINA, revision of scleral buckling operation for (Anaes.	(Assist.)
42779	Fee: \$1,669.45 Benefit: 75% = \$1252.10	
	LASER TRABECULOPLASTY, for the treatment of glaucoma. Each treatments to that eye in a 2 year period (Anaes.) (Assist.)	atment to 1 eye, to a maximum
42782	(See para TN.8.84 of explanatory notes to this Category) Fee: \$451.10 Benefit: 75% = \$338.35 85% = \$383.45	
	LASER IRIDOTOMY - each treatment episode to 1 eye, to a maximum o year period (Anaes.) (Assist.)	f 3 treatments to that eye in a 2
42785	(See para TN.8.85 of explanatory notes to this Category) Fee: \$353.35 Benefit: 75% = \$265.05 85% = \$300.35	
	Laser capsulotomy—each treatment episode to one eye, to a maximum of year period—other than a service associated with a service to which item (Assist.)	
42788	(See para TN.8.86 of explanatory notes to this Category) Fee: \$353.35 Benefit: 75% = \$265.05 85% = \$300.35	
	Laser vitreolysis or corticolysis of lens material or fibrinolysis, excluding vitreous cavity—each treatment to one eye, to a maximum of 3 treatments (Anaes.) (Assist.)	
42791	(See para TN.8.87 of explanatory notes to this Category) Fee: \$353.35 Benefit: 75% = \$265.05 85% = \$300.35	
	DIVISION OF SUTURE BY LASER following glaucoma filtration surge a maximum of 2 treatments to that eye in a 2 year period (Anaes.)	ry, each treatment to 1 eye, to
42794	(See para TN.8.88 of explanatory notes to this Category) Fee: \$67.65 Benefit: 75% = \$50.75 85% = \$57.55	
	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125 choroidal melanomas, insertion of (Anaes.) (Assist.)	(), for the treatment of
42801	Fee: \$1,049.70 Benefit: 75% = \$787.30	
	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125 choroidal melanomas, removal of (Anaes.) (Assist.)	i), for the treatment of
42802	Fee: \$524.70 Benefit: 75% = \$393.55	
42805	TANTALUM MARKERS, surgical insertion to the sclera to localise the t planning of radiotherapy of choroidal melanomas, 1 or more (Anaes.) (As	

T8. SUF	RGICAL OPERAT	TIONS 9. OPHTHALMOLOGY
	Fee: \$586.50	Benefit: 75% = \$439.90 85% = \$503.10
	IRIS TUMOUR	, laser photocoagulation of (Anaes.) (Assist.)
42806	Fee: \$353.35	Benefit: 75% = \$265.05 85% = \$300.35
	PHOTOMYDR	ASIS, laser
42807	Fee: \$355.80	Benefit: 75% = \$266.85 85% = \$302.45
	Laser peripheral	
42808	Fee: \$355.80	Benefit: 75% = \$266.85 85% = \$302.45
	RETINA, photo verteporfin (Ana	coagulation of, not being a service associated with photodynamic therapy with
42809	Fee: \$451.10	Benefit: 75% = \$338.35 85% = \$383.45
	PHOTOTHERA for refractive err	PEUTIC KERATECTOMY, by laser, for corneal scarring or disease, excluding surgery for (Anaes.)
42810	Fee: \$567.70	Benefit: 75% = \$425.80 85% = \$484.30
	TRANSPUPILL malformations (ARY THERMOTHERAPY, for treatment of choroidal and retinal tumours or vascular Anaes.)
42811	Fee: \$451.10	Benefit: 75% = \$338.35 85% = \$383.45
	Removal of scle (Anaes.)	ral buckling material, from an eye having undergone previous scleral buckling surgery
42812	Fee: \$165.45	Benefit: 75% = \$124.10 85% = \$140.65
		VITY, removal of silicone oil or other liquid vitreous substitutes from, during a than that in which the vitreous substitute is inserted (Anaes.) (Assist.)
42815	Fee: \$631.75	Benefit: 75% = \$473.85
	RETINA, CRYO item 42809 or 42	OTHERAPY TO, as an independent procedure, or when performed in conjunction with 2770 (Anaes.)
42818	Fee: \$586.50	Benefit: 75% = \$439.90 85% = \$503.10
	OCULAR TRAI	NSILLUMINATION, for the diagnosis and measurement of intraocular tumours
42821	Fee: \$90.35	Benefit: 75% = \$67.80 85% = \$76.80
	RETROBULBA	R INJECTION OF ALCOHOL OR OTHER DRUG, as an independent procedure
42824	Fee: \$69.90	Benefit: 75% = \$52.45 85% = \$59.45
		RATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 patient aged 15 years or over (Anaes.) (Assist.)
42833	Fee: \$586.50	Benefit: 75% = \$439.90
	MUSCLES, on a	RATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 a patient aged 14 years or under, or where the patient has had previous squint, retinal or rations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.)
42836	Fee: \$729.45	Benefit: 75% = \$547.10

T8. SUF	RGICAL OPERATIONS	9. OPHTHALMOLOGY	
	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES MUSCLES on a patient aged 15 years or over (Anaes.)		
42839	Fee: \$699.45 Benefit: 75% = \$524.60		
	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES MUSCLES, on a patient aged 14 years or under, or whextra ocular operations on the eye or eyes, or on a patie (Assist.)	ere the patient has had previous squint, retinal or	
42842	Fee: \$872.30 Benefit: 75% = \$654.25		
	READJUSTMENT OF ADJUSTABLE SUTURES, 1 following an operation for correction of squint (Anaes.		
42845	(See para TN.8.89 of explanatory notes to this Category) Fee: \$189.40 Benefit: 75% = \$142.05 85% = \$1	61.00	
	SQUINT, muscle transplant for (Hummelsheim type, o over (Anaes.) (Assist.)	or similar operation) on a patient aged 15 years or	
42848	Fee: \$699.45 Benefit: 75% = \$524.60		
	SQUINT, muscle transplant for (Hummelsheim type, of under, or where the patient has had previous squint, ret or on a patient with concurrent thyroid eye disease (An	inal or extra ocular operations on the eye or eyes,	
42851	Fee: \$872.30 Benefit: 75% = \$654.25		
	RUPTURED MEDIAL PALPEBRAL LIGAMENT or (Anaes.) (Assist.)	ruptured EXTRAOCULAR MUSCLE, repair of	
42854	Fee: \$406.05 Benefit: 75% = \$304.55 85% = \$3	345.15	
	RESUTURING OF WOUND FOLLOWING INTRAC excision of prolapsed iris (Anaes.) (Assist.)	OCULAR PROCEDURES with or without	
42857	Fee: \$406.05 Benefit: 75% = \$304.55 85% = \$3	345.15	
	EYELID (upper or lower), scleral or Goretex or other retractors (Anaes.) (Assist.)	non-autogenous graft to, with recession of the lid	
42860	Fee: \$902.30 Benefit: 75% = \$676.75 85% = \$8	318.90	
	EYELID, recession of (Anaes.) (Assist.)		
42863	Fee: \$774.55 Benefit: 75% = \$580.95 85% = \$6	591.15	
	ENTROPION or TARSAL ECTROPION, repair of, by tightening, shortening or repair of inferior retractors by open operation across the entire width of the eyelid (Anaes.) (Assist.)		
42866	Fee: \$751.85 Benefit: 75% = \$563.90 85% = \$6	668.45	
	EYELID closure in facial nerve paralysis, insertion of	foreign implant for (Anaes.) (Assist.)	
42869	Fee: \$549.00 Benefit: 75% = \$411.75 85% = \$4	166.65	
	EYEBROW, elevation of, by skin excision, to correct to involutional, or traumatic eyebrow descent/ptosis to a particular and the state of the state	for a reduced field of vision caused by paretic,	
42872	Fee: \$240.70 Benefit: 75% = \$180.55 85% = \$2	204.60	
43021	Photodynamic therapy, one eye, including the infusion		

T8. SUF	RGICAL OPERAT	IONS	9. OPHTHALMOLOGY
	vein, using a non neovascularisation		n of 689nm, for the treatment of choroidal
	Fee: \$455.05	Benefit: 75% = \$341.30	85% = \$386.80
	Photodynamic th peripheral vein, u neovascularisation	using a non-thermal laser at a	e infusion of Verteporfin continuously through a wavelength of 689nm, for the treatment of choroidal
43022	Fee: \$546.15	Benefit: 75% = \$409.65	85% = \$464.25
			dynamic therapy, where a session of therapy which would 2 has been discontinued on medical grounds.
43023	Fee: \$88.50	Benefit: 75% = \$66.40 8	5% = \$75.25
T8. SUF	RGICAL OPERAT	IONS	10. OPERATIONS FOR OSTEOMYELITIS
	Group T8. Surgi	cal Operations	
		Subgroup 10.	Operations For Osteomyelitis
			ACUTE
	OPERATION O	N PHALANX (Anaes.)	
43500	Fee: \$123.35	Benefit: 75% = \$92.55	
			RIB, ULNA, RADIUS, CARPUS, TIBIA, FIBULA, LA (other than alveolar margins) 1 BONE (Anaes.)
43503	Fee: \$204.70	Benefit: 75% = \$153.55	
	OPERATION O	N HUMERUS OR FEMUR 1	BONE (Anaes.) (Assist.)
43506	Fee: \$356.35	Benefit: 75% = \$267.30	
	OPERATION O	N SPINE OR PELVIC BONE	S 1 BONE (Anaes.) (Assist.)
43509	Fee: \$356.35	Benefit: 75% = \$267.30	
			CHRONIC
	CARPUS, PHAI	ANX, TIBIA, FIBULA, ME	LAVICLE, RIB, ULNA, RADIUS, METACARPUS, FATARSUS, TARSUS, MANDIBLE OR MAXILLA Y COMBINATION OF ADJOINING BONES (Anaes.)
43512	Fee: \$356.35	Benefit: 75% = \$267.30	
	OPERATION O	N HUMERUS OR FEMUR 1	BONE (Anaes.) (Assist.)
43515	Fee: \$356.35	Benefit: 75% = \$267.30	85% = \$302.90
	OPERATION O	N SPINE OR PELVIC BONE	S 1 BONE (Anaes.) (Assist.)
43518	Fee: \$587.60	Benefit: 75% = \$440.70	
	OPERATION O	N SKULL (Anaes.) (Assist.)	
43521	Fee: \$464.50	Benefit: 75% = \$348.40	
43524			ADJOINING BONES, being bones referred to in item

T8. SUF	RGICAL OPERAT	IONS	10. OPERATIONS FOR OSTEOMYELITIS	
	43515, 43518 or	43521 (Anaes.) (Assist.)		
	Fee: \$587.60	Benefit: 75% = \$440.70	85% = \$504.20	
T8. SUF	RGICAL OPERAT	IONS	11. PAEDIATRIC	
	Group T8. Surg	ical Operations		
		Si	ubgroup 11. Paediatric	
		SURGERY IN	NEONATE OR YOUNG CHILD	
	INTESTINAL N resection (Anaes		ithout volvulus, laparotomy for, not involving bowel	
43801	Fee: \$957.30	Benefit: 75% = \$718.00		
		MALROTATION with or with or with or without formation of s	ithout volvulus, laparotomy for, with bowel resection and toma (Anaes.) (Assist.)	
43804	Fee: \$1,019.25	Benefit: 75% = \$764.45	5	
	UMBILICAL, E (Anaes.)	PIGASTRIC OR LINEA A	LBA HERNIA, repair of, on a person under 10 years of age	
43805	Fee: \$356.35	Benefit: 75% = \$267.30		
	DUODENAL A (Assist.)	TRESIA or STENOSIS, du	odenoduodenostomy or duodenojejunostomy for (Anaes.)	
43807	Fee: \$1,112.00	Benefit: 75% = \$834.00		
	JEJUNAL ATR	ESIA, bowel resection and	anastomosis for, with or without tapering (Anaes.) (Assist.)	
43810	Fee: \$1,297.35	Benefit: 75% = \$973.05	5	
		EUS, laparotomy for, compor without meconium perit	plicated by 1 or more of associated volvulus, atresia, intesinal onitis (Anaes.) (Assist.)	
43813	Fee: \$1,297.35	Benefit: 75% = \$973.05	5	
			OR MECONIUM ILEUS not being a service associated with rotomy for (Anaes.) (Assist.)	
43816	Fee: \$1,204.60	Benefit: 75% = \$903.45	5	
	Agangliosis Col (Anaes.) (Assist.	. 1	ithout frozen section biopsies and formation of stoma	
43819	Fee: \$972.95	Benefit: 75% = \$729.75	;	
	ANORECTAL I	MALFORMATION, laparo	tomy and colostomy for (Anaes.) (Assist.)	
43822	Fee: \$972.95	Benefit: 75% = \$729.75	5	
	NEONATAL ALIMENTARY OBSTRUCTION, laparotomy for, not being a service to which any other item in this Subgroup applies (Anaes.) (Assist.)			
43825	Fee: \$1,112.00	Benefit: 75% = \$834.00		
43828	ACUTE NEON	ATAL NECROTISING EN	TEROCOLITIS, laparotomy for, with resection, including	

T8. SUF	RGICAL OPERATION	NS 11. PAEDIATRI
	any anastomoses o	stoma formation (Anaes.) (Assist.)
	Fee: \$1,228.55	Benefit: 75% = \$921.45
	ACUTE NEONAT laparotomy for (A	AL NECROTISING ENTEROCOLITIS where no definitive procedure is possible, aes.) (Assist.)
43831	Fee: \$957.30	Benefit: 75% = \$718.00
	BRANCHIAL FIS	ΓULA, on a person under 10 years of age. Removal of, (Anaes.) (Assist.)
43832	Fee: \$652.95	Benefit: 75% = \$489.75
	BOWEL RESECT stoma formation (A	ION for necrotising enterocolitis stricture or strictures, including any anastomoses or (naes.) (Assist.)
43834	Fee: \$1,112.00	Benefit: 75% = \$834.00
		O, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel on under 10 years of age (Anaes.) (Assist.)
43835	Fee: \$677.65	Benefit: 75% = \$508.25
		APHRAGMATIC HERNIA, repair by thoracic or abdominal approach, with d in the first 24 hours of life (Anaes.) (Assist.)
43837	Fee: \$1,389.90	Benefit: 75% = \$1042.45
		nia, congential repair of, by thoracic or abdominal approach, not being a service to 31569 to 31581 apply, on a person under 10 years of age (Anaes.) (Assist.)
43838	Fee: \$1,244.50	Benefit: 75% = \$933.40
		APHRAGMATIC HERNIA, repair by thoracic or abdominal approach, diagnosed f life and before 20 days of age (Anaes.) (Assist.)
43840	Fee: \$1,204.60	Benefit: 75% = \$903.45
		GUINAL HERNIA OR INFANTILE HYDROCELE, repair of, not being a service to 43835 applies, on a person under 10 years of age (Anaes.) (Assist.)
43841	Fee: \$603.85	Benefit: 75% = \$452.90
		ATRESIA (with or without repair of tracheo-oesophageal fistula), complete eing a service to which item 43846 applies (Anaes.) (Assist.)
43843	Fee: \$1,853.35	Benefit: 75% = \$1390.05
		ATRESIA (with or without repair of tracheo-oesophageal fistula), complete ant of birth weight less than 1500 grams (Anaes.) (Assist.)
43846	Fee: \$1,992.30	Benefit: 75% = \$1494.25
	OESOPHAGEAL	ATRESIA, gastrostomy for (Anaes.) (Assist.)
43849	Fee: \$509.65	Benefit: 75% = \$382.25
	OESOPHAGEAL anastomosis (Anae	ATRESIA, thoracotomy for, and division of tracheo-oesophageal fistula without s.) (Assist.)
43852	Fee: \$1,621.55	Benefit: 75% = \$1216.20
43855	OESOPHAGEAL	ATRESIA, delayed primary anastomosis for (Anaes.) (Assist.)

RGICAL OPERATION	JNS	11. PAEDIATRIC	
Fee: \$1,714.35	Benefit: 75% = \$1285.80		
OESOPHAGEAL	ATRESIA, cervical oesophagostomy for (Anaes.) (Assist.)		
Fee: \$602.25	Benefit: 75% = \$451.70		
		ITAL LOBAR	
Fee: \$1,668.05	Benefit: 75% = \$1251.05		
GASTROSCHISI	S, operation for (Anaes.) (Assist.)		
Fee: \$1,251.05	Benefit: 75% = \$938.30		
GASTROSCHISI	S or Exomphalos, secondary operation for, with removal of	silo (Anaes.) (Assist.)	
Fee: \$695.00	Benefit: 75% = \$521.25		
EXOMPHALOS	containing small bowel only, operation for (Anaes.) (Assist.))	
Fee: \$972.95	Benefit: 75% = \$729.75		
EXOMPHALOS	containing small bowel and other viscera, operation for (Ana	nes.) (Assist.)	
Fee: \$1,297.35	Benefit: 75% = \$973.05		
SACROCOCCYC	SEAL TERATOMA, excision of, by posterior approach (An	aes.) (Assist.)	
Fee: \$1.112.00	Benefit: 75% = \$834.00		
	SEAL TERATOMA, excision of, by combined posterior and	abdominal approach	
Fee: \$1,297.35	Benefit: 75% = \$973.05		
CLOACAL EXST	ROPHY, operation for (Anaes.) (Assist.)		
Fee: \$1,668.05	Benefit: 75% = \$1251.05 85% = \$1584.65		
	THORACIC SURGERY		
TRACHEO-OESO	DPHAGEAL FISTULA without atresia, division and repair	of (Anaes.) (Assist.)	
Fee: \$1,112.00	Benefit: 75% = \$834.00		
		E, oesophageal	
Fee: \$1,853.35	Benefit: 75% = \$1390.05		
		anastomosis, not being a	
Fee: \$1,621.55	Benefit: 75% = \$1216.20		
TRACHEOMALA	ACIA, aortopexy for (Anaes.) (Assist.)		
Fee: \$1,621.55	Benefit: 75% = \$1216.20		
THORACOTOM		s cyst or mediastinal	
Fee: \$1,532.00	Benefit: 75% = \$1149.00		
	OESOPHAGEAL Fee: \$602.25 CONGENITAL CEMPHYSEMA, the Fee: \$1,668.05 GASTROSCHISIST Fee: \$1,251.05 GASTROSCHISIST Fee: \$695.00 EXOMPHALOS OF Fee: \$972.95 EXOMPHALOS OF Fee: \$1,297.35 SACROCOCCYCON (Anaes.) (Assist.) Fee: \$1,297.35 CLOACAL EXSTROSCHIST Fee: \$1,668.05 TRACHEO-OESON Fee: \$1,112.00 OESOPHAGEAL RESTROSCHIST Fee: \$1,668.05 TRACHEO-OESON Fee: \$1,112.00 OESOPHAGEAL RESTROSCHIST Fee: \$1,668.05 TRACHEO-OESON Fee: \$1,668.05 TRACHEO-OESON Fee: \$1,621.55 TRACHEOMALA FEE: \$1,621.55 TRACHEOMALA FEE: \$1,621.55 TRACHEOMALA FEE: \$1,621.55 THORACOTOM Teratoma (Anaes.)	OESOPHAGEAL ATRESIA, cervical oesophagostomy for (Anaes.) (Assist.) Fee: \$602.25 Benefit: 75% = \$451.70 CONGENITAL CYSTADENOMATOID MALFORMATION OR CONGEN EMPHYSEMA, thoracotomy and lung resection for (Anaes.) (Assist.) Fee: \$1,668.05 Benefit: 75% = \$1251.05 GASTROSCHISIS, operation for (Anaes.) (Assist.) Fee: \$1,251.05 Benefit: 75% = \$938.30 GASTROSCHISIS or Exomphalos, secondary operation for, with removal of Fee: \$695.00 Benefit: 75% = \$521.25 EXOMPHALOS containing small bowel only, operation for (Anaes.) (Assist.) Fee: \$972.95 Benefit: 75% = \$729.75 EXOMPHALOS containing small bowel and other viscera, operation for (Anaesence) (A	

T8. SUF	RGICAL OPERATI	ONS 11. PAEDIATRIC			
	EVENTRATION	, plication of diaphragm for (Anaes.) (Assist.)			
43915	Fee: \$1,158.30	Benefit: 75% = \$868.75			
13713	1 εε. φ1,130.30	ABDOMINAL SURGERY			
	HYPERTROPHI	C PYLORIC STENOSIS, pyloromyotomy for (Anaes.) (Assist.)			
42020	Fee: \$445.40	Benefit: 75% = \$334.05			
43930		TUSSUSCEPTION, laparotomy and manipulative reduction of (Anaes.) (Assist.)			
43933	Fee: \$521.40	Benefit: 75% = \$391.05			
	INTUSSUSCEPT	TION, laparotomy and resection with anastomosis (Anaes.) (Assist.)			
43936	Fee: \$972.95	Benefit: 75% = \$729.75			
	VENTRAL HER (Assist.)	NIA following neonatal closure of exomphalos or gastroschisis, repair of (Anaes.)			
43939	Fee: \$741.30	Benefit: 75% = \$556.00			
	ABDOMINAL W	ALL VITELLO INTESTINAL REMNANT, excision of (Anaes.)			
43942	Fee: \$231.70	Benefit: 75% = \$173.80			
		LO INTESTINAL DUCT, excision of (Anaes.) (Assist.)			
43945	Fee: \$972.95	Benefit: 75% = \$729.75			
43743		ANULOMA, excision of, under general anaesthesia (Anaes.)			
		•			
43948	Fee: \$139.10	Benefit: 75% = \$104.35			
		PHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, my (Anaes.) (Assist.)			
42051	Fee: \$871.30	Benefit: 75% = \$653.50			
43951					
	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (Anaes.) (Assist.)				
43954	Fee: \$1,065.75	Benefit: 75% = \$799.35			
,		PHAGEAL REFLUX, LAPAROTOMY AND FUNDOPLICATION for, with or			
	without hiatus hernia, in child with neurological disease, with gastrostomy (Anaes.) (Assist.)				
43957	Fee: \$1,158.30	Benefit: 75% = \$868.75			
		IALFORMATION, perineal anoplasty of (Anaes.) (Assist.)			
43960	Fee: \$407.50	Benefit: 75% = \$305.65			
43700		IALFORMATION, posterior sagittal anorectoplasty of (Anaes.) (Assist.)			
43963	Fee: \$1,621.55	Benefit: 75% = \$1216.20			
	(Assist.)	IALFORMATION, posterior sagittal anorectoplasty of, with laparotomy (Anaes.)			
43966	Fee: \$1,853.35	Benefit: 75% = \$1390.05			
43969	PERSISTENT CI	LOACA, total correction of, with genital repair using posterior sagittal approach, with			

T8. SUF	RGICAL OPERATION	ONS 11. PAEDIATRIC
	or without laparot	omy (Anaes.) (Assist.)
	Fee: \$2,548.35	Benefit: 75% = \$1911.30
	CHOLEDOCHAI	CYST, resection of, with 1 duct anastomosis (Anaes.) (Assist.)
43972	Fee: \$1,853.35	Benefit: 75% = \$1390.05
	CHOLEDOCHAI	CYST, resection of, with 2 duct anastomoses (Anaes.) (Assist.)
43975	Fee: \$2,177.70	Benefit: 75% = \$1633.30
	BILIARY ATRES	SIA, portoenterostomy for (Anaes.) (Assist.)
43978	Fee: \$1,853.35	Benefit: 75% = \$1390.05
		OMA, NEUROBLASTOMA OR OTHER MALIGNANT TUMOUR, laparotomy uding associated biopsies, where no other intra-abdominal procedure is performed
43981	Fee: \$509.65	Benefit: 75% = \$382.25
	NEPHROBLAST	OMA, radical nephrectomy for (Anaes.) (Assist.)
43984	Fee: \$1,297.35	Benefit: 75% = \$973.05
	NEUROBLASTO	MA, radical excision of (Anaes.) (Assist.)
43987	Fee: \$1,436.40	Benefit: 75% = \$1077.30
		li, definitive resection with pull-through anastomosis, with or without frozen section anglionic segment extends to sigmoid colon (Anaes.) (Assist.)
43990	Fee: \$1,760.75	Benefit: 75% = \$1320.60
		li, definitive resection with pull-through anastomosis, with or without frozen section anglionic segment extends into descending or transverse colon with or without resiting (Assist.)
43993	Fee: \$1,899.65	Benefit: 75% = \$1424.75
		li, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or le ileocolic anastomosis (Anaes.) (Assist.)
43996	Fee: \$2,131.35	Benefit: 75% = \$1598.55
	Aganglionosis Co	li, anal sphincterotomy as an independent procedure for (Anaes.) (Assist.)
43999	Fee: \$266.55	Benefit: 75% = \$199.95
	RECTUM, examination of, on a person under 2 years of age, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.)	
44101	Fee: \$334.05	Benefit: 75% = \$250.55
		nation of, on a person 2 years of age or over, under general anaesthesia with full or removal of polyp or similar lesion (Anaes.) (Assist.)
44102	Fee: \$256.95	Benefit: 75% = \$192.75
	RECTAL PROLA under general ana	PSE, SUBMUCOSAL or perirectal injection for, on a person under 2 years of age, esthesia (Anaes.)
44104	Fee: \$58.65	Benefit: 75% = \$44.00 85% = \$49.90

T8. SUF	RGICAL OPERATI	ONS	11. PAEDIATRIC
	RECTAL PROLA		perirectal injection for, on a person 2 years of age or over,
44105	Fee: \$45.10	Benefit: 75% = \$33.85	85% = \$38.35
	INGUINAL HER	NIA repair at age less than	12 months (Anaes.) (Assist.)
44108	Fee: \$491.45	Benefit: 75% = \$368.60	
		OR STRANGULATED INc pexy when performed (Ana	GUINAL HERNIA, repair, at age, less than 12 months tes.) (Assist.)
44111	Fee: \$575.65	Benefit: 75% = \$431.75	85% = \$492.25
	INGUINAL HER (Assist.)	NIA repair at age less than	12 months when orchidopexy also required (Anaes.)
44114	Fee: \$575.65	Benefit: 75% = \$431.75	
		MISCEI	LANEOUS SURGERY
	LYMPHADENE (Assist.)	CTOMY, for atypical myco	bacterial infection or other granulomatous disease (Anaes.)
44130	Fee: \$463.30	Benefit: 75% = \$347.50	85% = \$393.85
	TORTICOLLIS,	open division of sternomast	oid muscle for (Anaes.) (Assist.)
44133	Fee: \$367.75	Benefit: 75% = \$275.85	
	INGROWN TOE	NAIL, operation for, under	general anaesthesia (Anaes.)
44136	Fee: \$169.50	Benefit: 75% = \$127.15	85% = \$144.10
T8. SUF	RGICAL OPERATI	ONS	12. AMPUTATIONS
	Group T8. Surgical Operations		
	Subgroup 12. Amputations		
	HAND, MIDCAI	RPAL OR TRANSMETAC	ARPAL, amputation of (Anaes.) (Assist.)
44325	Fee: \$295.70	Benefit: 75% = \$221.80	85% = \$251.35
	HAND, FOREA	RM OR THROUGH ARM,	amputation of (Anaes.) (Assist.)
44328	Fee: \$356.35	Benefit: 75% = \$267.30	
	AMPUTATION .	AT SHOULDER (Anaes.) (Assist.)
44331	Fee: \$587.60	Benefit: 75% = \$440.70	
	INTERSCAPULO	OTHORACIC AMPUTATI	ON (Anaes.) (Assist.)
44334	Fee: \$1,194.25	Benefit: 75% = \$895.70	85% = \$1110.85
	-	amputation of (Anaes.)	
44338	Fee: \$144.00	Benefit: 75% = \$108.00	85% = \$122.40
		ot, amputation of (Anaes.)	
44342	Fee: \$219.95	Benefit: 75% = \$165.00	
オサンサム	1 (0. φ417.73	Denema /3/0 - \$103.00	

T8. SUF	RGICAL OPERA	IONS 12. AMPUTATIONS			
	3 DIGITS of 1	oot, amputation of (Anaes.) (Assist.)			
44346	Fee: \$254.00	Benefit: 75% = \$190.50			
	4 DIGITS of 1	oot, amputation of (Anaes.) (Assist.)			
44350	Fee: \$288.20	Benefit: 75% = \$216.15 85% = \$245.00			
	5 DIGITS of 1	oot, amputation of (Anaes.) (Assist.)			
44354	Fee: \$329.80	Benefit: 75% = \$247.35			
	TOE, including	netatarsal or part of metatarsal each toe, amputation of (Anaes.)			
44358	Fee: \$183.90	Benefit: 75% = \$137.95			
		TOES OF ONE FOOT, amputation of, including if performed, excision of 1 or more of the foot, performed for diabetic or other microvascular disease, excluding aftercare			
44359	Fee: \$263.95	Benefit: 75% = \$198.00			
	FOOT AT ANK	LE (Syme, Pirogoff types), amputation of (Anaes.) (Assist.)			
44361	Fee: \$356.35	Benefit: 75% = \$267.30			
	FOOT, MIDTA	RSAL OR TRANSMETATARSAL, amputation of (Anaes.) (Assist.)			
44364	Fee: \$295.70	Benefit: 75% = \$221.80			
	AMPUTATION	THROUGH THIGH, AT KNEE OR BELOW KNEE (Anaes.) (Assist.)			
44367	Fee: \$521.95	Benefit: 75% = \$391.50			
	AMPUTATION	AT HIP (Anaes.) (Assist.)			
44370	Fee: \$720.20	Benefit: 75% = \$540.15			
	HINDQUARTE	R, amputation of (Anaes.) (Assist.)			
44373	Fee: \$1,478.40	Benefit: 75% = \$1108.80 85% = \$1395.00			
	AMPUTATION	STUMP, reamputation of, to provide adequate skin and muscle cover (Assist.)			
44376	Derived Fee: 7	% of the original amputation fee			
T8. SUF	RGICAL OPERA	IONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY			
	Group T8. Sur	cal Operations			
		Subgroup 13. Plastic And Reconstructive Surgery			
	GENERAL				
	Single stage local muscle flap repair, on eyelid, nose, lip, neck, hand, thumb, finger or genitals not in association with any of items 31356 to 31376 (Anaes.)				
45000	Fee: \$541.35	Benefit: 75% = \$406.05 85% = \$460.15			
		l myocutaneous flap repair to one defect, simple and small not in association with any o 31376 (Anaes.)			
45003	Fee: \$601.65	Benefit: 75% = \$451.25 85% = \$518.25			

T8. SUF	RGICAL OPERATI	ONS 13	. PLASTIC AND RECONSTRUCTIVE SURGERY		
	Extended Medic	are Safety Net Cap: \$481.35			
		LARGE MYOCUTANEOUS Farge muscle) (Anaes.) (Assist.)	LAP REPAIR to 1 defect, (pectoralis major, latissimus		
45006	Fee: \$1,037.65	Benefit: 75% = \$778.25			
	SINGLE STAGE	LOCAL muscle flap repair to 1	defect, simple and small (Anaes.) (Assist.)		
45009	Fee: \$379.05	Benefit: 75% = \$284.30			
		LARGE MUSCLE FLAP REPArtage muscle) (Anaes.) (Assist.)	AIR to 1 defect, (pectoralis major, gastrocnemius,		
45012	Fee: \$635.00	Benefit: 75% = \$476.25			
	MUSCLE OR M	YOCUTANEOUS FLAP, delay	of (Anaes.)		
45015	Fee: \$300.75	Benefit: 75% = \$225.60			
			er of fat by injection), if the service is not associated entioned in any of items 51011 to 51171 (Anaes.)		
45018	Fee: \$473.65	Benefit: 75% = \$355.25 85%	6 = \$402.65		
	Full face chemica	l peel for severely sun-damaged	skin, if:		
	(a) the damage affects at least 75% of the facial skin surface area; and				
	(b) the damage in	(b) the damage involves photo-damage (dermatoheliosis); and			
	(c) the photo-dan	nage involves:			
	(i) a solar k	eratosis load exceeding 30 indivi	dual lesions; or		
	(ii) solar ler	ntigines; or			
	(iii) frecklir	g, yellowing or leathering of the	skin; or		
	(iv) solar ke	ertoses which have proven refract	tory to, or recurred following, medical therapies; and		
	(d) at least mediu	m depth peeling agents are used;	and		
		peel is performed in the operating pecialist in the specialty of derma	theatre of a hospital by a medical practitioner atology or plastic surgery.		
	Applicable once	only in any 12 month period (Ana	aes.)		
45019	Fee: \$396.70	Benefit: 75% = \$297.55			
	ABRASIVE THE to 1 aesthetic area	, ,	scarring resulting from trauma, burns or acne - limited		
45021	(See para TN.8.91 Fee: \$177.35	of explanatory notes to this Category Benefit: 75% = \$133.05 85%			
	ABRASIVE THE than 1 aesthetic a		scarring resulting from trauma, burns or acne - more		
45024	(See para TN.8.91	of explanatory notes to this Category	r)		

T8. SUF	RGICAL OPERAT	IONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	Fee: \$398.55	Benefit: 75% = \$298.95	85% = \$338.80
		ck for severely disfiguring s	LASER (not including fractional laser therapy) resurfacing carring resulting from trauma, burns or acne - limited to 1
45025	Fee: \$177.35	of explanatory notes to this Ca Benefit: 75% = \$133.05 care Safety Net Cap: \$141.	85% = \$150.75
	CARBON DIOX	TIDE LASER OR ERBIUM ck for severely disfiguring s	LASER (not including fractional laser therapy) resurfacing carring resulting from trauma, burns or acne - more than 1
45026	Fee: \$398.55	of explanatory notes to this Ca Benefit: 75% = \$298.95 care Safety Net Cap: \$318.	85% = \$338.80
43020			o, where undertaken in the operating theatre of a hospital
45027	Fee: \$120.35	Benefit: 75% = \$90.30	85% = \$102.30
			na or both) of skin and subcutaneous tissue (excluding facial excision and suture of (Anaes.)
45030	Fee: \$129.25	Benefit: 75% = \$96.95	85% = \$109.90
		emangioma or lymphangion excision and suture of (An	ma or both), large or involving deeper tissue including facial aes.)
45033	Fee: \$240.70	Benefit: 75% = \$180.55	85% = \$204.60
	ANGIOMA (hae excision of (Ana		na or both), large and deep, involving muscles or nerves,
45035	Fee: \$702.05	Benefit: 75% = \$526.55	
	ANGIOMA (hae	mangioma or lymphangion	na or both) of neck, deep, excision of (Anaes.) (Assist.)
45036	Fee: \$1,128.05	Benefit: 75% = \$846.05	
	ARTERIOVENO (Anaes.)	OUS MALFORMATION (3	3 centimetres or less) of superficial tissue, excision of
45039	Fee: \$240.70	Benefit: 75% = \$180.55	85% = \$204.60
	ARTERIOVENO	OUS MALFORMATION, (greater than 3 centimetres), excision of (Anaes.) (Assist.)
45042	Fee: \$308.40	Benefit: 75% = \$231.30	85% = \$262.15
	ARTERIOVENO excision of (Ana		n eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals,
45045	Fee: \$308.40	Benefit: 75% = \$231.30	85% = \$262.15
		ATOUS tissue or lymphand, major excision of (Anaes	giectasis, of lower leg and foot, or thigh, or upper arm, or .) (Assist.)
45048	Fee: \$774.55	Benefit: 75% = \$580.95	
45051	Contour reconstr	uction by open repair of co	ntour defects, due to deformity, if:
45051			

T8. SUR	RGICAL OPERATIONS 13	. PLASTIC AND RECONSTRUCTIVE SURGERY
	(a) contour reconstructive surgery is indicated becoff tissue or has arisen from trauma (other than tra	cause the deformity is secondary to congenital absence uma from previous cosmetic surgery); and
	(b) insertion of a non-biological implant is require	ed, other than one or more of the following:
	(i) insertion of a non-biological implant that T8;	is a component of another service specified in Group
	(ii) injection of liquid or semisolid material;	
	(iii) an oral and maxillofacial implant service	e to which item 52321 applies;
	(iv) a service to insert mesh; and	
	(c) photographic and/or diagnostic imaging evided documented in the patient notes (Anaes.) (Assist.)	nce demonstrating the clinical need for this service is
	Fee: \$473.75 Benefit: 75% = \$355.35	
	LIMB OR CHEST, decompression escharotomy of syndrome secondary to burn (Anaes.) (Assist.)	of (including all incisions), for acute compartment
45054	(See para TN.8.92 of explanatory notes to this Category Fee: \$246.10 Benefit: 75% = \$184.60	()
	Developmental breast abnormality, single stage co	prrection of, if:
	(a) the correction involves either:	
	(i) bilateral mastopexy for symmetrical tubu	lar breasts; or
	have at least a 10% volume difference), mas difference in breast volume, as demonstrated	on of insertion of one or more implants (which must topexy or reduction mammaplasty, if there is a d by an appropriate volumetric measurement technique, or 10% in tubular breasts or in breasts with abnormally
	(b) photographic and/or diagnostic imaging evide documented in the patient notes	nce demonstrating the clinical need for this service is
	Applicable only once per occasion on which the s	ervice is provided (Anaes.) (Assist.)
45060	Fee: \$1,271.30 Benefit: 75% = \$953.50	
		tion of, first stage, involving surgery on both breasts sue expanders, mastopexy or reduction mammaplasty,
	(a) there is a difference in breast volume, as demotechnique, of at least:	nstrated by an appropriate volumetric measurement
	(i) 20% in normally shaped breasts; or	
	(ii) 10% in tubular breasts or in breasts with	abnormally high inframammary folds; and
45061	(b) photographic and/or diagnostic imaging evide documented in the patient notes.	nce demonstrating the clinical need for this service is

Applicable only once per occasion on whice	ch the service is provided (Anaes.) (Assist.)
Fee: \$1,271.30 Benefit: 75% = \$953.5	50
	correction of, second stage, involving surgery on both breasts more tissue expanders for one or more implants (which must astopexy or reduction mammaplasty, if:
(a) there is a difference in breast volume, as technique, of at least:	s demonstrated by an appropriate volumetric measurement
(i) 20% in normally shaped breasts; o	or
(ii) 10% in tubular breasts or in breas	ts with abnormally high inframammary folds; and
(b) photographic and/or diagnostic imaging documented in the patient notes.	g evidence demonstrating the clinical need for this service is
Applicable only once per occasion on whic	th the service is provided (Anaes.) (Assist.)
Fee: \$920.00 Benefit: 75% = \$690.0	00
SI	KIN FLAP SURGERY
31376 (Anaes.) (See para TN.8.93 of explanatory notes to this C Fee: \$284.35 Benefit: 75% = \$213.3	80 85% = \$241.70
Muscle, myocutaneous or skin flap, where removal of a malignant or non-malignant sl 31002, 31003, 31004, 31005, 31358, 31359, 31376)-may be claimed only once per defer	clinically indicated to repair one surgical excision made in the kin lesion (only in association with items 31000, 31001, 9, 31360, 31363, 31364, 31369, 31370, 31371, 31373 or ct (Anaes.)
Fee: \$413.95 Benefit: 75% = \$310.5	
	clinically indicated to repair one surgical excision made in the kin lesion in a patient, if the clinical relevance of the tt's record and either:
(a) item 45201 applies and additional fla	p repair is required for the same defect; or
(b) item 45201 does not apply and either	.
(i) the patient has severe pre-existing s	scarring, severe skin atrophy or sclerodermoid changes; or
(ii) the repair is contiguous with a free	e margin (Anaes.)
(See para TN.8.93, TN.8.126 of explanatory not Fee: \$413.95 Benefit: 75% = \$310.5	
	r one defect, complicated or large, excluding flap for male ouble advancement flap not in association with any of items
(See para TN.8.93 of explanatory notes to this C	"otegory)
	Developmental breast abnormality, 2 stage with a combination of exchange of one or in have at least a 10% volume difference), may (a) there is a difference in breast volume, a technique, of at least: (i) 20% in normally shaped breasts; of (ii) 10% in tubular breasts or in breast (b) photographic and/or diagnostic imaging documented in the patient notes. Applicable only once per occasion on whice the series of the patient notes. Applicable only once per occasion on whice the series of

T8. SUF	RGICAL OPERAT	IONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	Fee: \$406.05 Extended Medic	Benefit: 75% = \$304.55 85% = \$345.15 care Safety Net Cap: \$324.85
		If flap if indicated to repair one defect, on eyelid, nose, lip, ear, neck, hand, thumb, and excluding H-flap or double advancement flap not in association with any of items (Anaes.)
45206	Fee: \$383.55	of explanatory notes to this Category) Benefit: 75% = \$287.70 85% = \$326.05 care Safety Net Cap: \$306.85
		advancement flap if indicated to repair one defect, on eyelid, eyebrow or forehead not th any of items 31356 to 31376 (Anaes.)
45207	Fee: \$383.55	Benefit: 75% = \$287.70 85% = \$326.05
	DIRECT FLAP	REPAIR (cross arm, abdominal or similar), first stage (Anaes.) (Assist.)
45209	Fee: \$473.75	Benefit: 75% = \$355.35 85% = \$402.70
	DIRECT FLAP	REPAIR (cross arm, abdominal or similar), second stage (Anaes.)
45212	Fee: \$235.05	Benefit: 75% = \$176.30 85% = \$199.80
13212		REPAIR, cross leg, first stage (Anaes.) (Assist.)
45215	Fee: \$1,014.05	Benefit: 75% = \$760.55
43213	-	REPAIR, cross leg, second stage (Anaes.) (Assist.)
45218	Fee: \$454.85	Benefit: 75% = \$341.15
43210		REPAIR, small (cross finger or similar), first stage (Anaes.)
45001		
45221	Fee: \$261.55	Benefit: 75% = \$196.20 85% = \$222.35 REPAIR, small (cross finger or similar), second stage (Anaes.)
45224	Fee: \$117.55 Benefit: 75% = \$88.20 85% = \$99.95	
	INDIRECT FLA	P OR TUBED PEDICLE, formation of (Anaes.) (Assist.)
45227	Fee: \$445.40	Benefit: 75% = \$334.05 85% = \$378.60
	DIRECT OR IN	DIRECT FLAP OR TUBED PEDICLE, delay of (Anaes.)
45230	Fee: \$222.75	Benefit: 75% = \$167.10 85% = \$189.35
	INDIRECT FLAP OR TUBED PEDICLE, preparation of intermediate or final site and attachment to the site (Anaes.) (Assist.)	
45233	Fee: \$473.75	Benefit: 75% = \$355.35 85% = \$402.70
_	INDIRECT FLA	P OR TUBED PEDICLE, spreading of pedicle, as a separate procedure (Anaes.)
45236	Fee: \$371.50	Benefit: 75% = \$278.65
	DIRECT, INDIR	EECT OR LOCAL FLAP, revision of, by incision and suture, not being a service to 0 applies (Anaes.)
45239	Fee: \$261.55	Benefit: 75% = \$196.20 85% = \$222.35
45240		EECT OR LOCAL FLAP, revision of, by liposuction, not being a service to which item

T8. SURGICAL OPERATIONS			13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	45239, 45497, 45498 or 45499 applies (Anae		es.)	
	Fee: \$261.55	Benefit: 75% = \$196.20	85% = \$222.35	
			FREE GRAFTS	
	FREE GRAFTI	NG (split skin) of a granulat	ing area, small (Anaes.)	
45400	Fee: \$204.70	Benefit: 75% = \$153.55	85% = \$174.00	
	FREE GRAFTI	NG (split skin) of a granulat	ing area, extensive (Anaes.) (Assist.)	
45403	Fee: \$407.50	Benefit: 75% = \$305.65	85% = \$346.40	
		NG (split skin) to burns, included body surface (Anaes.) (Assi	luding excision of burnt tissue - involving not more than 3 st.)	
45406	(See para TN.8.94 Fee: \$451.10	of explanatory notes to this Ca Benefit: 75% = \$338.35		
		NG (split skin) to burns, incler cent of total body surface	luding excision of burnt tissue - involving 3 per cent or more (Anaes.) (Assist.)	
45409	(See para TN.8.94 Fee: \$601.65	of explanatory notes to this Ca Benefit: 75% = \$451.25		
		NG (split skin) to burns, included cent of total body surface	luding excision of burnt tissue - involving 6 per cent or more (Anaes.) (Assist.)	
45412	(See para TN.8.94 Fee: \$827.30	of explanatory notes to this Ca Benefit: 75% = \$620.50		
		NG (split skin) to burns, incl per cent of total body surfac	luding excision of burnt tissue - involving 9 per cent or more e (Anaes.) (Assist.)	
45415	(See para TN.8.94 Fee: \$902.30	of explanatory notes to this Ca Benefit: 75% = \$676.75		
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 12 per cent or more but less than 15 per cent of total body surface (Anaes.) (Assist.)			
45418	(See para TN.8.94 Fee: \$977.55	of explanatory notes to this Ca Benefit: 75% = \$733.20		
	FREE GRAFTI	NG (split skin) to 1 defect, in	ncluding elective dissection, small (Anaes.)	
45439	Fee: \$284.35	Benefit: 75% = \$213.30	85% = \$241.70	
	FREE GRAFTI	NG (split skin) to 1 defect, in	ncluding elective dissection, extensive (Anaes.) (Assist.)	
45442	Fee: \$586.50	Benefit: 75% = \$439.90	85% = \$503.10	
	FREE GRAFTING (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of, and removal of mould) (Anaes.) (Assist.)			
45445	Fee: \$556.60	Benefit: 75% = \$417.45	85% = \$473.20	
			ncluding elective dissection on eyelid, nose, lip, ear, neck, service to which item 45442 or 45445 applies (Anaes.)	
45448	Fee: \$376.00	Benefit: 75% = \$282.00	85% = \$319.60	
45451	FREE GRAFTI	NG (full thickness), to 1 def	ect, excluding grafts for male pattern baldness (Anaes.)	

T8. SURGICAL OPERATIONS		13. PLASTIC AND RECONSTRUCTIVE SURGERY
	(Assist.)	
	Fee: \$473.75 Benefit: 75% = \$355.3	5 85% = \$402.70
	FREE GRAFTING (split skin) to burns, in more but less than 20 percent of total body	cluding excision of burnt tissue - involving 15 percent or surface - one surgeon (Anaes.) (Assist.)
45460	Fee: \$1,253.30 Benefit: 75% = \$940.0	0
		cluding excision of burnt tissue - involving 15 percent or surface - conjoint surgery, principal surgeon (Anaes.)
45461	Fee: \$893.25 Benefit: 75% = \$669.9	5
		cluding excision of burnt tissue - involving 15 percent or surface - conjoint surgery, co- surgeon (Assist.)
45462	Fee: \$674.05 Benefit: 75% = \$505.5	5
	FREE GRAFTING (split skin) to burns, in more but less than 30 percent of total body	cluding excision of burnt tissue - involving 20 percent or surface - one surgeon (Anaes.) (Assist.)
45464	Fee: \$1,913.10 Benefit: 75% = \$1434.	85
		cluding excision of burnt tissue - involving 20 percent or surface - conjoint surgery, principal surgeon (Anaes.)
45465	Fee: \$1,363.00 Benefit: 75% = \$1022.	25 85% = \$1279.60
		cluding excision of burnt tissue - involving 20 percent or surface - conjoint surgery, co-surgeon (Assist.)
45466	Fee: \$1,027.95 Benefit: 75% = \$771.0	0 85% = \$944.55
		cluding excision of burnt tissue - involving 30 percent or surface - conjoint surgery, principal surgeon (Anaes.)
45468	Fee: \$1,832.65 Benefit: 75% = \$1374.	50
		cluding excision of burnt tissue - involving 30 percent or surface - conjoint surgery, co-surgeon (Assist.)
45469	Fee: \$1,382.70 Benefit: 75% = \$1037.	05 85% = \$1299.30
		cluding excision of burnt tissue - involving 40 percent or surface - conjoint surgery, principal surgeon (Anaes.)
45471	Fee: \$2,303.65 Benefit: 75% = \$1727.	75 85% = \$2220.25
		cluding excision of burnt tissue - involving 40 percent or surface - conjoint surgery, co-surgeon (Assist.)
45472	Fee: \$1,737.60 Benefit: 75% = \$1303.	20 85% = \$1654.20
		cluding excision of burnt tissue - involving 50 percent or surface - conjoint surgery, principal surgeon (Anaes.)
45474		

T8. SUF	78. SURGICAL OPERATIONS		13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	Fee: \$2,773.30	Benefit: 75% = \$2080.00	85% = \$2689.90	
			ding excision of burnt tissue - involving 50 percent or urface - conjoint surgery, co-surgeon (Assist.)	
45475	Fee: \$2,092.45	Benefit: 75% = \$1569.35	85% = \$2009.05	
			ding excision of burnt tissue - involving 60 percent or rface - conjoint surgery, principal surgeon (Anaes.)	
45477	Fee: \$3,243.00	Benefit: 75% = \$2432.25	85% = \$3159.60	
			ding excision of burnt tissue - involving 60 percent or urface - conjoint surgery, co-surgeon (Assist.)	
45478	Fee: \$2,446.05	Benefit: 75% = \$1834.55	85% = \$2362.65	
		\ 1	ding excision of burnt tissue - involving 70 percent or urface - conjoint surgery, principal surgeon (Anaes.)	
45480	Fee: \$3,712.60	Benefit: 75% = \$2784.45	85% = \$3629.20	
			ding excision of burnt tissue - involving 70 percent or urface - conjoint surgery, co-surgeon (Assist.)	
45481	Fee: \$2,801.10	Benefit: 75% = \$2100.85	85% = \$2717.70	
			ding excision of burnt tissue - involving 80 percent or principal surgeon (Anaes.) (Assist.)	
45483	Fee: \$4,229.95	Benefit: 75% = \$3172.50	85% = \$4146.55	
		G (split skin) to burns, inclu y surface - conjoint surgery,	ding excision of burnt tissue - involving 80 percent or co-surgeon (Assist.)	
45484	Fee: \$3,191.50	Benefit: 75% = \$2393.65	85% = \$3108.10	
		G (split skin) to burns, inclund (Anaes.) (Assist.)	ding excision of burnt tissue - upper eyelid, nose, lip, ear	
45485	Fee: \$527.70	Benefit: 75% = \$395.80		
			ding excision of burnt tissue - forehead, cheek, anterior foot, heel or genitalia (Anaes.) (Assist.)	
45486	Fee: \$451.10	Benefit: 75% = \$338.35		
	FREE GRAFTIN (Assist.)	G (split skin) to burns, inclu	ding excision of burnt tissue - whole of toe (Anaes.)	
45487	Fee: \$406.05	Benefit: 75% = \$304.55	85% = \$345.15	
	FREE GRAFTIN hand (Anaes.) (A		ding excision of burnt tissue - the whole of 1 digit of the	
45488	Fee: \$451.10	Benefit: 75% = \$338.35		
	FREE GRAFTIN hand (Anaes.) (A		ding excision of burnt tissue - the whole of 2 digits of the	
	, , , , , ,			

T8. SUF	RGICAL OPERATI	ONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	FREE GRAFTIN hand (Anaes.) (A	G (split skin) to burns, including excision of burnt tissue - the whole of 3 digits of the ssist.)	
45490	Fee: \$902.50	Benefit: 75% = \$676.90	
	FREE GRAFTIN hand (Anaes.) (A	G (split skin) to burns, including excision of burnt tissue - the whole of 4 digits of the ssist.)	
45491	Fee: \$1,128.05	Benefit: 75% = \$846.05	
	FREE GRAFTIN hand (Anaes.) (A	G (split skin) to burns, including excision of burnt tissue - the whole of 5 digits of the ssist.)	
45492	Fee: \$1,353.60	Benefit: 75% = \$1015.20	
	FREE GRAFTIN (Anaes.) (Assist.)	G (split skin) to burns, including excision of burnt tissue - portion of digit of hand	
45493	Fee: \$406.05	Benefit: 75% = \$304.55	
	FREE GRAFTIN ears) (Anaes.) (A	G (split skin) to burns, including excision of burnt tissue - whole of face (excluding ssist.)	
45494	Fee: \$1,638.70	Benefit: 75% = \$1229.05 85% = \$1555.30	
		OTHER GRAFTS AND MISCELLANEOUS PROCEDURES	
	FLAP, free tissue	transfer using microvascular techniques - revision of, by open operation (Anaes.)	
45496	Fee: \$416.05	Benefit: 75% = \$312.05	
		transfer using microvascular techniques, <i>or</i> any autogenous breast reconstruction - <i>of</i> , by liposuction (Anaes.)	
45497	Fee: \$324.95	Benefit: 75% = \$243.75	
		transfer using microvascular techniques, <i>or</i> any autogenous breast reconstruction - f, by liposuction - first stage (Anaes.)	
45498	Fee: \$261.55	Benefit: 75% = \$196.20	
		transfer using microvascular techniques, <i>or</i> any autogenous breast reconstruction - <i>f</i> , by liposuction - second stage (Anaes.)	
45499	Fee: \$195.00	Benefit: 75% = \$146.25	
	MICROVASCULAR REPAIR using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.)		
45500	Fee: \$1,090.35	Benefit: 75% = \$817.80	
	MICROVASCUI limb or digit (Ana	LAR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of aes.) (Assist.)	
45501	Fee: \$1,774.70	Benefit: 75% = \$1331.05	
		LAR ANASTOMOSIS of vein using microsurgical techniques, for re-implantation of	
	limb or digit (Ana	aes.) (Assist.)	
45502	Fee: \$1,774.70	Benefit: 75% = \$1331.05	
	MICRO-ARTER	IAL OR MICRO-VENOUS GRAFT using microsurgical techniques (Anaes.) (Assist.)	
45503	Fee: \$2,030.35	Benefit: 75% = \$1522.80	
	4=,000.00		

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	MICROVASCULAR ANASTOL tissue including setting in of free	MOSIS of artery using microsurgical techniques, for free transfer of flap (Anaes.) (Assist.)
45504	Fee: \$1,774.70 Benefit: 75	% = \$1331.05
	MICROVASCULAR ANASTOL tissue including setting in of free	MOSIS of vein using microsurgical techniques, for free transfer of flap (Anaes.) (Assist.)
45505	Fee: \$1,774.70 Benefit: 75	% = \$1331.05
		than 3 cm in length, revision of, where undertaken in the operating rformed by a specialist in the practice of his or her specialty (Anaes.)
45506	(See para TN.8.95 of explanatory no Fee: \$219.95 Benefit: 75	tes to this Category) % = \$165.00 85% = \$187.00
		n 3 cm in length, revision of, where undertaken in the operating theatre d by a specialist in the practice of his or her specialty (Anaes.)
45512	(See para TN.8.95 of explanatory no Fee: \$295.70 Benefit: 75	tes to this Category) % = \$221.80 85% = \$251.35
		k, not more than 7 cms in length, revision of, as an independent the operating theatre of a hospital or where performed by a specialist in y (Anaes.)
45515	(See para TN.8.95 of explanatory no Fee: \$186.50 Benefit: 75	tes to this Category) % = \$139.90 85% = \$158.55
		k, more than 7 cms in length, revision of, as an independent procedure, g theatre of a hospital, or where performed by a specialist in the Anaes.)
45518	(See para TN.8.95 of explanatory no Fee: \$225.70 Benefit: 75	tes to this Category) % = \$169.30 85% = \$191.85
	EXTENSIVE BURN SCARS OF correction of scar contracture (A	F SKIN (more than 1 percent of body surface area), excision of, for naes.) (Assist.)
45519	Fee: \$429.05 Benefit: 75	% = \$321.80
	Reduction mammaplasty (unilate or developmental abnormality of	eral) with surgical repositioning of nipple, in the context of breast cancer the breast (Anaes.) (Assist.)
45520	Fee: \$900.45 Benefit: 75	% = \$675.35
	Reduction mammaplasty (unilate	eral) without surgical repositioning of the nipple:
	(a) excluding the treatment of gy	naecomastia; and
	(b) not with insertion of any pros	othesis (Anaes.) (Assist.)
45522	Fee: \$631.75 Benefit: 75	% = \$473.85
	Reduction mammaplasty (bilater	al) with surgical repositioning of the nipple:
	(a) for patients with macromastia	a and experiencing pain in the neck or shoulder region; and
	(b) not with insertion of any pros	othesis (Anaes.) (Assist.)
45523	Fee: \$1,350.70 Benefit: 75	% = \$1013.05

T8. SUR	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	Mammaplasty, augmentation (unilateral) in t	he context of:
	(a) breast cancer; or	
	(b) developmental abnormality of the breast, an appropriate volumetric measurement technique.	if there is a difference in breast volume, as demonstrated by nique, of at least:
	(i) 20% in normally shaped breasts; or	
	(ii) 10% in tubular breasts or in breasts	with abnormally high inframammary folds.
	Applicable only once per occasion on which	the service is provided (Anaes.) (Assist.)
45524	(See para TN.8.96 of explanatory notes to this Cat Fee: \$741.65 Benefit: 75% = \$556.25	egory)
	Breast reconstruction (unilateral), following	mastectomy, using a permanent prosthesis (Anaes.) (Assist.)
45527	(See para TN.8.96 of explanatory notes to this Cat Fee: \$741.65 Benefit: 75% = \$556.25	regory)
		than a service to which item 45527 applies), if:
	(a) reconstructive surgery is indicated because	e of:
	(i) developmental malformation of brea	st tissue (excluding hypomastia); or
	(ii) disease of or trauma to the breast (o surgery); or	ther than trauma resulting from previous elective cosmetic
	(iii) amastia secondary to a congenital e	endocrine disorder; and
	(b) photographic and/or diagnostic imaging e documented in the patient notes (Anaes.) (As	vidence demonstrating the clinical need for this service is sist.)
45528	(See para TN.8.96 of explanatory notes to this Cat Fee: \$1,112.35 Benefit: 75% = \$834.30	regory)
	including repair of secondary skin defect, if r	ssimus dorsi or other large muscle or myocutaneous flap, equired, excluding repair of muscular aponeurotic layer, to which item 30165, 30168, 30171, 30172, 30176, 30177
	(H) (Anaes.) (Assist.)	
45530	(See para TN.8.97 of explanatory notes to this Cat Fee: \$1,099.40 Benefit: 75% = \$824.55	regory)
		s sharing technique (first stage) including breast reduction, p, split skin graft to pedicle of flap or other similar
45533	(See para TN.8.8 of explanatory notes to this Cate Fee: \$1,245.10 Benefit: 75% = \$933.85	gory)
		sharing technique (second stage) including division of of donor site or other similar procedure (Anaes.) (Assist.)
45536	Fee: \$457.85 Benefit: 75% = \$343.40	

T8. SUF	GICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.)
45539	Fee: \$1,071.20 Benefit: 75% = \$803.40
	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - removal of tissue expansion unit and insertion of permanent prosthesis (Anaes.) (Assist.)
45542	Fee: \$613.40 Benefit: 75% = \$460.05
	NIPPLE OR AREOLA or both, reconstruction of, by any surgical technique (Anaes.) (Assist.)
45545	(See para TN.8.100 of explanatory notes to this Category) Fee: \$622.55 Benefit: 75% = \$466.95 85 % = \$539.15 Extended Medicare Safety Net Cap: \$498.05
13313	NIPPLE OR AREOLA or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple
45546	(See para TN.8.100 of explanatory notes to this Category) Fee: \$197.85 Benefit: 75% = \$148.40 85% = \$168.20
	BREAST PROSTHESIS, removal of, as an independent procedure (Anaes.)
45548	Fee: \$276.80 Benefit: 75% = \$207.60 85% = \$235.30
	Breast prosthesis, removal of, with excision of at least half of the fibrous capsule, not with insertion of any prosthesis. The excised specimen must be sent for histopathology and the volume removed must be documented in the histopathology report (Anaes.) (Assist.)
45551	Fee: \$443.70 Benefit: 75% = \$332.80
	Breast prosthesis, removal of and replacement with another prosthesis, following medical complications (for rupture, migration of prosthetic material or symptomatic capsular contracture), if:
	(a) either:
	(i) it is demonstrated by intra-operative photographs post-removal that removal alone would cause unacceptable deformity; or
	(ii) the original implant was inserted in the context of breast cancer or developmental abnormality; and
	(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.)
45553	(See para TN.8.98 of explanatory notes to this Category) Fee: \$571.60 Benefit: 75% = \$428.70
	Breast prosthesis, removal and replacement with another prosthesis, following medical complications (for rupture, migration of prosthetic material or symptomatic capsular contracture), including excision of at least half of the fibrous capsule or formation of a new pocket, or both, if:
	(a) either:
	(i) it is demonstrated by intra-operative photographs post-removal that removal alone would cause unacceptable deformity; or
	(ii) the original implant was inserted in the context of breast cancer or developmental abnormality;

and (b) the excised specimen is sent for histopathology report; and (c) photographic and/or diagnostic i documented in the patient notes (An	histopathology and the volume removed is documented in the		
histopathology report; and (c) photographic and/or diagnostic i			
	maging avidence demonstrating the clinical need for this coming is		
`			
(See para TN.8.98 of explanatory notes Fee: \$699.45 Benefit: 75% =			
photographic evidence (including ar	al), in the context of breast cancer or developmental abnormality, if nterior, left lateral and right lateral views) and/or diagnostic imaging need for this service is documented in the patient notes		
Applicable only once per occasion of	on which the service is provided (Anaes.) (Assist.)		
(See para TN.8.99 of explanatory notes Fee: \$766.05 Benefit: 75% =			
Breast ptosis, correction by mastope	exy of (bilateral), if:		
	issue, including the nipple, lies inferior to the infra-mammary fold ost dependent, inferior part of the breast contour; and		
	(b) if the patient has been pregnant—the correction is performed not less than 1 year, or more than 7 years, after completion of the most recent pregnancy of the patient; and		
	g anterior, left lateral and right lateral views), with a marker at the nonstrating the clinical need for this service, is documented in the		
Applicable only once per lifetime (A	Anaes.) (Assist.)		
(See para TN.8.99 of explanatory notes Fee: \$1,148.95 Benefit: 75% =			
	the treatment of alopecia of congenital or traumatic origin or due to lness, not being a service to which another item in this Group applies		
Fee: \$473.65 Benefit: 75% = 45560 Extended Medicare Safety Net Ca	= \$355.25 85% = \$402.65 p: \$165.80		
MICROVASCULAR ANASTOMO supercharging of pedicled flaps (An	OSIS of artery or vein using microsurgical techniques, for aes.) (Assist.)		
45561 Fee: \$1,774.70 Benefit: 75% =	= \$1331.05		
	rolving raising of tissue on vascular or neurovascular pedicle, cutaneous defect if performed, excluding flap for male pattern		
45562 Fee: \$1,099.40 Benefit: 75% =	= \$824.55 85% = \$1016.00		
NEUROVASCULAR ISLAND FLA	AP, including direct repair of secondary cutaneous defect if pattern baldness (Anaes.) (Assist.)		
45563 Fee: \$1,099.40 Benefit: 75% =	= \$824.55 85% = \$1016.00		

T8. SUF	RGICAL OPERATIO	NS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	deformity, surgery and including raisin transfer of tissue, in performed, other th 30176, 30177, 3017	or trauma, involving anastomoses of up to 2 vessels using microvascular techniques of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, asetting of tissue at recipient site and direct repair of secondary cutaneous defect if an a service associated with a service to which item 30165, 30168, 30171, 30172, 79, 45501, 45502, 45504, 45505 or 45562 applies-conjoint surgery, principal H) (Anaes.) (Assist.)
45564	(See para TN.8.8 of e Fee: \$2,546.30	explanatory notes to this Category) Benefit: 75% = \$1909.75
	deformity, surgery and including raisin transfer of tissue, in performed, other th	ue reconstructive surgery for the repair of major tissue defect due to congenital or trauma, involving anastomoses of up to 2 vessels using microvascular techniques ng of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, asetting of tissue at recipient site and direct repair of secondary cutaneous defect if an a service associated with a service to which item 30165, 30168, 30171, 30172, 79, 45501, 45502, 45504, 45505 or 45562 applies-conjoint surgery, conjoint specialist it.)
45565	(See para TN.8.8 of e Fee: \$1,909.80	explanatory notes to this Category) Benefit: 75% = \$1432.35
	TISSUE EXPANSI	ION not being a service to which item 45539 or 45542 applies - insertion of tissue all attendances for subsequent expansion injections (Anaes.) (Assist.)
45566	Fee: \$1,071.20	Benefit: 75% = \$803.40
	TISSUE EXPAND	ER, removal of, with complete excision of fibrous capsule (Anaes.) (Assist.)
45568	Fee: \$443.70	Benefit: 75% = \$332.80
		DOMEN WITH RECONSTRUCTION OF UMBILICUS, with or without lipectomy, ociated with items 45562, 45564, 45565 or 45530 (Anaes.) (Assist.)
45569	Fee: \$677.60	Benefit: 75% = \$508.20
	CLOSURE OF AB 45569 (Anaes.) (As	DOMEN, repair of musculoaponeurotic layer, being a service associated with item ssist.)
45570	Fee: \$914.95	Benefit: 75% = \$686.25 85% = \$831.55
	INTRA OPERATIVE TISSUE EXPANSION performed during an operation when combined with a service to which another item in Group T8 applies including expansion injections and excluding treatment of male pattern baldness (Anaes.)	
45572	Fee: \$291.70 Benefit: 75% = \$218.80 85% = \$247.95	
	FACIAL NERVE PARALYSIS, free fascia graft for (Anaes.) (Assist.)	
45575	Fee: \$720.20	Benefit: 75% = \$540.15 85% = \$636.80
	FACIAL NERVE I	PARALYSIS, muscle transfer for (Anaes.) (Assist.)
45578	Fee: \$834.05	Benefit: 75% = \$625.55
	FACIAL NERVE F	PALSY, excision of tissue for (Anaes.)
45581	Fee: \$276.80	Benefit: 75% = \$207.60 85% = \$235.30
45584		n assisted lipolysis) to one regional area (one limb or trunk), for treatment of post boma, if photographic and/or diagnostic imaging evidence demonstrating the clinical

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	need for this service is documented in the	ne patient notes (Anaes.)
	(See para TN.8.8, TN.8.101 of explanatory of Fee: \$631.75 Benefit: 75% = \$4	
	Liposuction (suction assisted lipolysis) associated with a service to which item	to one regional area (one limb or trunk), other than a service 31525 applies, if:
	(a) the liposuction is for:	
	(i) the treatment of Barraquer-Sim	ons syndrome, lymphoedema or macrodystrophia lipomatosa; or
	(ii) the reduction of a buffalo hum treatment of a medical condition;	p that is secondary to an endocrine disorder or pharmacological and
	(b) photographic and/or diagnostic imag documented in the patient notes (Anaes	ging evidence demonstrating the clinical need for this service is .)
45585	(See para TN.8.8, TN.8.101 of explanatory page 1.75% = \$431.75 Benefit: 75% = \$4	
	Meloplasty for correction of facial asym	nmetry if:
	(a) the asymmetry is secondary to traum medical condition (such as facial nerve	na (including previous surgery), a congenital condition or a palsy); and
	(b) the meloplasty is limited to one side	of the face (Anaes.) (Assist.)
45587	(See para TN.8.102 of explanatory notes to Fee: \$890.85 Benefit: 75% = \$66	
	Meloplasty (excluding browlifts and ch	inlift platysmaplasties), bilateral, if:
		tional impairment due to a congenital condition, disease a (other than trauma resulting from previous elective cosmetic
	(b) photographic and/or diagnostic imag documented in the patient notes (Anaes	ging evidence demonstrating the clinical need for this service is) (Assist.)
45588	(See para TN.8.102 of explanatory notes to Fee: \$1,336.40 Benefit: 75% = \$10	
	ORBITAL CAVITY, reconstruction of	a wall or floor, with or without foreign implant (Anaes.) (Assist.)
45590	Fee: \$483.25 Benefit: 75% = \$36	52.45
	ORBITAL CAVITY, bone or cartilage entrapped orbital contents (Anaes.) (Ass	graft to orbital wall or floor including reduction of prolapsed or sist.)
45593	Fee: \$567.65 Benefit: 75% = \$42	25.75
	MAXILLA, total resection of (Anaes.)	(Assist.)
45596	Fee: \$900.45 Benefit: 75% = \$67	75.35
	MAXILLA, total resection of both max	illae (Anaes.) (Assist.)
45597	Fee: \$1,205.40 Benefit: 75% = \$90	04.05

T8. SUR	GICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGER			
	MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.			
45599	Fee: \$936.55 Benefit: 75% = \$702.45 85% = \$853.15			
	MANDIBLE, including lower border, OR MAXILLA, sub-total resection of (Anaes.) (Assist.)			
45602	Fee: \$699.45 Benefit: 75% = \$524.60			
	MANDIBLE OR MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.)			
45605	Fee: \$587.60 Benefit: 75% = \$440.70			
	MANDIBLE, hemimandibular reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (Anaes.) (Assist.)			
45608	Fee: \$827.30 Benefit: 75% = \$620.50			
	MANDIBLE, condylectomy (Anaes.) (Assist.)			
45611	Fee: \$473.75 Benefit: 75% = \$355.35			
	EYELID, WHOLE THICKNESS RECONSTRUCTION OF other than by direct suture only (Anaes.) (Assist.)			
45614	Fee: \$587.60 Benefit: 75% = \$440.70 85% = \$504.20 Extended Medicare Safety Net Cap: \$470.10			
	Upper eyelid, reduction of, if:			
	(a) the reduction is for any of the following:			
	(i) skin redundancy that causes a visual field defect (confirmed by an optometrist or ophthalmologist) or intertriginous inflammation of the eyelid;			
	(ii) herniation of orbital fat in exophthalmos;			
	(iii) facial nerve palsy;			
	(iv) post-traumatic scarring;			
	(v) the restoration of symmetry of contralateral upper eyelid in respect of one of the conditions mentioned in subparagraphs (i) to (iv); and			
	(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)			
45617	(See para TN.8.103 of explanatory notes to this Category) Fee: \$235.05 Benefit: 75% = \$176.30 85% = \$199.80 Extended Medicare Safety Net Cap: \$188.05			
	Lower eyelid, reduction of, if:			
	(a) the reduction is for:			
	(i) herniation of orbital fat in exophthalmos, facial nerve palsy or post-traumatic scarring; or			
	(ii) the restoration of symmetry of the contralateral lower eyelid in respect of one of these conditions; and			
45620	(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is			

T8. SUF	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	documented in the patient notes (Anae	es.)	
	(See para TN.8.103 of explanatory notes to Fee: \$326.05 Benefit: 75% = \$. Extended Medicare Safety Net Cap:	244.55 85% = \$277.15	
	Ptosis of upper eyelid (unilateral), corr	rection of, by:	
	(a) sutured elevation of the tarsal plate aponeurosis); or	e on the eyelid retractors (Muller's or levator muscle or levator	
	(b) sutured suspension to the brow/fro	ntalis muscle;	
	Not applicable to a service for repair of	of mechanical ptosis to which item 45617 applies (Anaes.) (Assist.)	
45623	Fee: \$723.05 Benefit: 75% = \$. Extended Medicare Safety Net Cap:	542.30 85% = \$639.65 : \$578.45	
	Ptosis of upper eyelid, correction of, b	y:	
	(a) sutured elevation of the tarsal plate aponeurosis); or	e on the eyelid retractors (Muller's or levator muscle or levator	
	(b) sutured suspension to the brow/fro	ntalis muscle;	
	if a previous ptosis surgery has been p	erformed on that side (Anaes.) (Assist.)	
45624	Fee: \$937.40 Benefit: 75% = \$ Extended Medicare Safety Net Cap:	703.05 85% = \$854.00 : \$749.95	
		height by revision of levator sutures within one week of primary ment, performed in the operating theatre of a hospital (Anaes.)	
45625	Fee: \$187.55 Benefit: 75% = \$	140.70	
	ECTROPION OR ENTROPION, corr	rection of (unilateral) (Anaes.)	
45626	Fee: \$326.05 Benefit: 75% = \$2.05	244.55 85% = \$277.15	
	SYMBLEPHARON, grafting for (Ana	nes.) (Assist.)	
45629	Fee: \$473.75 Benefit: 75% = \$	355.35 85% = \$402.70	
	Rhinoplasty, partial, involving correct	ion of lateral or alar cartilages, if:	
	(a) the indication for surgery is:		
	(i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or		
	(ii) significant acquired, congeni	tal or developmental deformity; and	
	(b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)		
45632	(See para TN.8.104 of explanatory notes to Fee: \$511.95 Benefit: 75% = \$. Extended Medicare Safety Net Cap:	384.00 85% = \$435.20	
45635	Rhinoplasty, partial, involving correct		

T8. SUR	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	(a) the indication for surgery is:	
	(i) airway obstruction and the patient	has a self-reported NOSE Scale score of greater than 45; or
	(ii) significant acquired, congenital or	r developmental deformity; and
	(b) photographic and/or NOSE Scale evide documented in the patient notes (Anaes.)	ence demonstrating the clinical need for this service is
	(See para TN.8.104 of explanatory notes to this Fee: \$587.60 Benefit: 75% = \$440.7 Extended Medicare Safety Net Cap: \$470	70 85% = \$504.20
	Rhinoplasty, total, including correction of a or without autogenous cartilage or bone gra	all bony and cartilaginous elements of the external nose, with aft from a local site (nasal), if:
	(a) the indication for surgery is:	
	(i) airway obstruction and the patient	has a self-reported NOSE Scale score of greater than 45; or
	(ii) significant acquired, congenital or	r developmental deformity; and
	(b) photographic and/or NOSE Scale evide documented in the patient notes (Anaes.)	ence demonstrating the clinical need for this service is
45641	(See para TN.8.104 of explanatory notes to this Fee: \$1,066.00 Benefit: 75% = \$799.5	
		all bony and cartilaginous elements of the external nose ft obtained from distant donor site, including obtaining of
	(a) the indication for surgery is:	
	(i) airway obstruction and the patient	has a self-reported NOSE Scale score of greater than 45; or
	(ii) significant acquired, congenital or	r developmental deformity; and
	(b) photographic and/or NOSE Scale evide documented in the patient notes (Anaes.) (Anaes.)	ence demonstrating the clinical need for this service is Assist.)
45644	(See para TN.8.104 of explanatory notes to this Fee: \$1,279.45 Benefit: 75% = \$959.6	
	CHOANAL ATRESIA, repair of by puncti	
45645	Fee: \$223.60 Benefit: 75% = \$167.7	70
	CHOANAL ATRESIA - correction by ope	en operation with bone removal (Anaes.) (Assist.)
45646	Fee: \$900.45 Benefit: 75% = \$675.3	35 85% = \$817.05
	FACE, contour restoration of 1 region, using which item 45644 applies) (Anaes.) (Assist	ng autogenous bone or cartilage graft (not being a service to t.)
45647	(See para TN.8.105 of explanatory notes to this Fee: \$1,279.45 Benefit: 75% = \$959.6	
45650	Rhinoplasty, revision of, if:	

T8. SUF	RGICAL OPERATION	NS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	(a) the indication f	or surgery is:
	(i) airway ob	struction and the patient has a self-reported NOSE Scale score of greater than 45; or
	(ii) significar	at acquired, congenital or developmental deformity; and
		nd/or NOSE Scale evidence demonstrating the clinical need for this service is patient notes (Anaes.)
	(See para TN.8.104 o Fee: \$147.80	of explanatory notes to this Category) Benefit: 75% = \$110.85 85% = \$125.65
	Rhinophyma of a r (Anaes.)	noderate or severe degree, carbon dioxide laser or erbium laser excision - ablation of
45652	Fee: \$356.35 Extended Medica	Benefit: 75% = \$267.30 85% = \$302.90 re Safety Net Cap: \$285.10
	RHINOPHYMA, s	shaving of (Anaes.)
45653	Fee: \$356.35	Benefit: 75% = \$267.30 85% = \$302.90
	COMPOSITE GR.	AFT (Chondrocutaneous or chondromucosal) to nose, ear or eyelid (Anaes.) (Assist.)
45656	Fee: \$502.25	Benefit: 75% = \$376.70 85% = \$426.95
	Correction of a cor	ngenital deformity of the ear if:
	(a) the patient is le	ss than 18 years of age; and
	(b) the deformity is concha; and	s characterised by an absence of the antihelical fold and/or large scapha and/or large
	(c) photographic enotes (Anaes.) (As	vidence demonstrating the clinical need for this service is documented in the patient sist.)
45659	Fee: \$521.25	Benefit: 75% = \$390.95
	grafts to form a fra congenital absence	, COMPLEX TOTAL RECONSTRUCTION OF, using multiple costal cartilage mework, including the harvesting and sculpturing of the cartilage and its insertion, for , microtia or post-traumatic loss of entire or substantial portion of pinna (first stage) - cialist in the practice of his or her specialty (Anaes.) (Assist.)
45660	Fee: \$2,878.75	Benefit: 75% = \$2159.10
	framework using c flaps and full thick	, COMPLEX TOTAL RECONSTRUCTION OF, elevation of costal cartilage artilage previously stored in abdominal wall, including the use of local skin and fascia ness skin graft to cover cartilage (second stage) - performed by a specialist in the er specialty (Anaes.) (Assist.)
45661	Fee: \$1,279.45	Benefit: 75% = \$959.60
	CONGENITAL A	TRESIA, reconstruction of external auditory canal (Anaes.) (Assist.)
45662	Fee: \$701.30	Benefit: 75% = \$526.00
	LIP, EYELID OR (Anaes.)	EAR, FULL THICKNESS WEDGE EXCISION OF, with repair by direct sutures
45665	Fee: \$326.05	Benefit: 75% = \$244.55 85% = \$277.15
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T8. SURGICAL OPERATIONS		IONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	VERMILIONEO	CTOMY, by surgical excision	ı (Anaes.)	
45668	Fee: \$326.05	Benefit: 75% = \$244.55	85% = \$277.15	
	Vermilionectom excision - ablation		lar atypia, using carbon dioxide laser or erbium laser	
45669	(See para TN.8.10 Fee: \$326.05	6 of explanatory notes to this Ca Benefit: 75% = \$244.55		
	LIP OR EYELII (Assist.)	RECONSTRUCTION usin	ng full thickness flap (Abbe or similar), first stage (Anaes.)	
45671	Fee: \$834.05	Benefit: 75% = \$625.55	85% = \$750.65	
	LIP OR EYELII (Anaes.)	RECONSTRUCTION usin	ng full thickness flap (Abbe or similar), second stage	
45674	Fee: \$242.55	Benefit: 75% = \$181.95	85% = \$206.20	
	MACROCHEIL	IA or macroglossia, operatio	n for (Anaes.) (Assist.)	
45675	Fee: \$483.25	Benefit: 75% = \$362.45		
	MACROSTOM	A, operation for (Anaes.) (A	ssist.)	
45676	Fee: \$575.30	Benefit: 75% = \$431.50		
	CLEFT LIP, uni	lateral primary repair, 1 stag	ge, without anterior palate repair (Anaes.) (Assist.)	
45677	Fee: \$541.35	Benefit: 75% = \$406.05		
	CLEFT LIP, uni	lateral - primary repair, 1 sta	ge, with anterior palate repair (Anaes.) (Assist.)	
45680	Fee: \$676.80	Benefit: 75% = \$507.60		
	CLEFT LIP, bila	teral - primary repair, 1 stag	e, without anterior palate repair (Anaes.) (Assist.)	
45683	Fee: \$751.85	Benefit: 75% = \$563.90		
	CLEFT LIP, bila	teral - primary repair, 1 stag	e, with anterior palate repair (Anaes.) (Assist.)	
45686	Fee: \$887.50	Benefit: 75% = \$665.65		
	CLEFT LIP, lip	adhesion procedure, unilatera	al or bilateral (Anaes.) (Assist.)	
45689	Fee: \$261.75	Benefit: 75% = \$196.35		
	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.)			
45692	Fee: \$300.75	Benefit: 75% = \$225.60	85% = \$255.65	
	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.)			
45695	Fee: \$488.75	Benefit: 75% = \$366.60		
	CLEFT LIP, pri	mary columella lengthening p	procedure, bilateral (Anaes.)	
45698	Fee: \$458.75	Benefit: 75% = \$344.10		
45701			thickness flap (Abbe or similar), first stage (Anaes.)	

T8. SUF	8. SURGICAL OPERATIONS		13. PLASTIC AND RECONSTRUCTIVE SURGER	
	Fee: \$827.30	Benefit: 75% = \$620.50		
	CLEFT LIP RE	CONSTRUCTION using full	thickness flap (Abbe or similar), second stage (Anaes.)	
45704	Fee: \$300.75	Benefit: 75% = \$225.60	85% = \$255.65	
	CLEFT PALAT	E, primary repair (Anaes.) (A	Assist.)	
45707	Fee: \$781.95	Benefit: 75% = \$586.50		
	CLEFT PALAT	E, secondary repair, closure	of fistula using local flaps (Anaes.)	
45710	Fee: \$488.75	Benefit: 75% = \$366.60		
	CLEFT PALAT	E, secondary repair, lengther	ning procedure (Anaes.) (Assist.)	
45713	Fee: \$556.60	Benefit: 75% = \$417.45		
	ORO-NASAL F applies (Anaes.)		including services to which item 45200, 45203 or 45239	
45714	Fee: \$781.95	Benefit: 75% = \$586.50		
	VELO-PHARY	NGEAL INCOMPETENCE,	pharyngeal flap for, or pharyngoplasty for (Anaes.)	
45716	Fee: \$781.95	Benefit: 75% = \$586.50		
45720	and vessels and 47936 apply (Ar	bone grafts taken from the sa		
	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)			
45723	(See para TN.8.10 Fee: \$1,090.35	77 of explanatory notes to this C Benefit: 75% = \$817.80	ategory)	
		bone grafts taken from the sa	tomy or osteectomy of, including transposition of nerves ame site, and excluding services to which item 47933 or	
45726	(See para TN.8.10 Fee: \$1,232.05	77 of explanatory notes to this C Benefit: 75% = \$924.05	ategory)	
	and vessels and	bone grafts taken from the sa	tomy or osteectomy of, including transposition of nerves ame site and stabilisation with fixation by wires, screws, ding services to which item 47933 or 47936 apply (Anaes.)	
45729	(See para TN.8.10 Fee: \$1,383.65	7 of explanatory notes to this C Benefit: 75% = \$1037.75		
	1 jaw, including	transposition of nerves and	osteectomies of, involving 3 or more such procedures on the vessels and bone grafts taken from the same site, and 7936 apply (Anaes.) (Assist.)	
45731	(See para TN.8.10 Fee: \$1,402.70	7 of explanatory notes to this C Benefit: 75% = \$1052.05		

T8. SUR	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	the 1 jaw, including transposition of nerve	s or osteectomies of, involving 3 or more such procedures on s and vessels and bone grafts taken from the same site and s, plates or pins, or any combination, and excluding services to (Assist.)
45732	(See para TN.8.107 of explanatory notes to this Fee: \$1,579.20 Benefit: 75% = \$1184	
		ies or osteectomies of, involving 2 such procedures of each vessels and bone grafts taken from the same site, and 47936 apply (Anaes.) (Assist.)
45735	(See para TN.8.107 of explanatory notes to this Fee: \$1,611.05 Benefit: 75% = \$1208	
	jaw, including transposition of nerves and	ies or osteectomies of, involving 2 such procedures of each vessels and bone grafts taken from the same site and s, plates or pins, or any combination, and excluding services to (Assist.)
45738	(See para TN.8.107 of explanatory notes to this Fee: \$1,812.40 Benefit: 75% = \$1359	
	such procedures of 1 jaw and 2 such proce	bilateral osteotomies or osteectomies of, involving 3 or more edures of the other jaw, including genioplasty when performed d bone grafts taken from the same site, and excluding services es.) (Assist.)
45741	(See para TN.8.107 of explanatory notes to this Fee: \$1,772.30 Benefit: 75% = \$1329	
	such procedures of 1 jaw and 2 such proce and transposition of nerves and vessels and	bilateral osteotomies or osteectomies of, involving 3 or more edures of the other jaw, including genioplasty when performed d bone grafts taken from the same site and stabilisation with r any combination, and excluding services to which item
45744	(See para TN.8.107 of explanatory notes to this Fee: \$1,992.70 Benefit: 75% = \$1494	
	such procedures of each jaw, including ge	bilateral osteotomies or osteectomies of, involving 3 or more nioplasty (when performed) and transposition of nerves and ne site, and excluding services to which item 47933 or 47936
45747	(See para TN.8.107 of explanatory notes to this Fee: \$1,933.55 Benefit: 75% = \$1450	
	such procedures of each jaw, including ge- vessels and bone grafts taken from the san	bilateral osteotomies or osteectomies of, involving 3 or more nioplasty when performed and transposition of nerves and ne site and stabilisation with fixation by wires, screws, plates g services to which item 47933 or 47936 apply (Anaes.)
45752	(See para TN.8.107 of explanatory notes to this Fee: \$2,165.75 Benefit: 75% = \$1624	
45753		II, Modified Le Fort III (Nasomalar), Modified Le Fort g 3 or more osteotomies of the midface including transposition

T8. SUF	RGICAL OPERATION	ONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	of nerves and vess	sels and bone grafts taken from the same site (Anaes.) (Assist.)
	Fee: \$2,178.60	Benefit: 75% = \$1633.95 85% = \$2095.20
	(Malar-Maxillary) nerves and vessels	TEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III , Le Fort III involving 3 or more osteotomies of the midface including transposition of and bone grafts taken from the same site and stabilisation with fixation by wires, bins, or any combination (Anaes.) (Assist.)
45754	Fee: \$2,611.60	Benefit: 75% = \$1958.70
	TEMPOROMAN	DIBULAR PARTIAL OR TOTAL MENISCECTOMY (Anaes.) (Assist.)
45755	Fee: \$367.75	Benefit: 75% = \$275.85 85% = \$312.60
	TEMPORO-MAN	DIBULAR JOINT, arthroplasty (Anaes.) (Assist.)
45758	Fee: \$658.05	Benefit: 75% = \$493.55
		including transposition of nerves and vessels and bone grafts taken from the same site
45761	(See para TN.8.108 Fee: \$748.65	of explanatory notes to this Category) Benefit: 75% = \$561.50
	HYPERTELORIS	SM, correction of, intracranial (Anaes.) (Assist.)
45767	Fee: \$2,511.65	Benefit: 75% = \$1883.75 85% = \$2428.25
	-	SM, correction of, subcranial (Anaes.) (Assist.)
45770	Fee: \$1,923.90	Benefit: 75% = \$1442.95
	-	LLINS SYNDROME, PERIORBITAL CORRECTION OF, with rib and iliac bone
45773	Fee: \$1,753.40	Benefit: 75% = \$1315.05 85% = \$1670.00
	ORBITAL DYST intracranial (Anae	OPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, s.) (Assist.)
45776	Fee: \$1,753.40	Benefit: 75% = \$1315.05
	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, extracranial (Anaes.) (Assist.)	
45779	Fee: \$1,289.15	Benefit: 75% = \$966.90
	FRONTOORBITA	AL ADVANCEMENT, UNILATERAL (Anaes.) (Assist.)
45782	782 Fee: \$985.70 Benefit: 75% = \$739.30 85% = \$902.30	
		T RECONSTRUCTION for oxycephaly, brachycephaly, turricephaly or similar al frontoorbital advancement) (Anaes.) (Assist.)
45785	Fee: \$1,668.10	Benefit: 75% = \$1251.10
	GLENOID FOSS	A, ZYGOMATIC ARCH AND TEMPORAL BONE, RECONSTRUCTION OF, ique) (Anaes.) (Assist.)
45788	Fee: \$1,649.10	Benefit: 75% = \$1236.85
45791		YLE AND ASCENDING RAMUS in hemifacial microsomia, CONSTRUCTION OF,

T8. SUF	RGICAL OPERATION	1 S	13. PLASTIC AND RECONSTRUCTIVE SURGERY		
	not including harvesting of graft material (Ar		naes.) (Assist.)		
	Fee: \$890.85	Benefit: 75% = \$668.15	;		
		ΓΙΟΝ PROCEDURE - ε nduction hearing system	extra-oral, implantation of titanium fixture, not for n device (Anaes.)		
45794	Fee: \$503.85	Benefit: 75% = \$377.90	85% = \$428.30		
		ΓΙΟΝ PROCEDURE, fi system device (Anaes.)	xation of transcutaneous abutment, not for implantable bone		
45797	Fee: \$186.50	Benefit: 75% = \$139.90	85% = \$158.55		
		ORAL AND	MAXILLOFACIAL SURGERY		
	ASPIRATION BIOPSY of 1 or MORE JAW CYSTS as an independent procedure to obtain material for diagnostic purposes and not being a service associated with an operative procedure on the same day (Anaes.)				
45799	Fee: \$29.45	Benefit: 75% = \$22.10	85% = \$25.05		
	operation), in the ora subcutaneous tissue	l and maxillofacial region	ner than a scar removed during the surgical approach at an on, up to 3 cm in diameter, removal from cutaneous or rane, where the removal is by surgical excision and suture, olies (Anaes.)		
45801	(See para TN.8.109 of explanatory notes to this Category) Fee: \$126.90 Benefit: 75% = \$95.20 85% = \$107.90				
	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Anaes.) (Assist.)				
45803	(See para TN.8.109 of Fee: \$326.05	explanatory notes to this C Benefit: 75% = \$244.55			
TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgic operation), in the oral and maxillofacial region, more than 3 cm in diameter, remova subcutaneous tissue or from mucous membrane (Anaes.)		on, more than 3 cm in diameter, removal from cutaneous or			
45805	(See para TN.8.109 of Fee: \$172.50	explanatory notes to this C Benefit: 75% = \$129.40	C 17		
	TUMOUR, CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, removal of, not being a service to which another item in this Subgroup applies, involving muscle, bone, or other deep tissue (Anaes.)				
45807	(See para TN.8.109 of Fee: \$246.50	explanatory notes to this Benefit: 75% = \$184.90			
45809	TUMOUR OR DEEP CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), in the oral and maxillofacial region, removal of, requiring wide excision, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.)				

T8. SURGICAL OPERATIONS			13. PLASTIC AND RECONSTRUCTIVE SURGERY		
	(See para TN.8.109 of explan Fee: \$371.50 Bene	atory notes to this Ca fit: 75% = \$278.65			
	TUMOUR, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.)				
45811	(See para TN.8.109 of explan Fee: \$502.25 Bene	atory notes to this Ca fit: 75% = \$376.70			
			on, removal of, from soft tissue (including muscle, fascia with skin or mucosal graft (Anaes.) (Assist.)		
45813	(See para TN.8.109 of explan Fee: \$587.60 Bene	atory notes to this Ca fit: 75% = \$440.70			
	OPERATION ON MAND - 1 bone or in combination		LA (other than alveolar margins) for chronic osteomyelitis nes (Anaes.) (Assist.)		
45815	Fee: \$356.35 Bene	fit: 75% = \$267.30	85% = \$302.90		
	OPERATION on SKULL	for OSTEOMYEL	ITIS (Anaes.) (Assist.)		
45817	Fee: \$464.50 Bene	fit: 75% = \$348.40	85% = \$394.85		
			of ADJOINING BONES IN THE ORAL AND referred to in item 45817 (Anaes.) (Assist.)		
45819	Fee: \$587.55 Bene	fit: 75% = \$440.70	85% = \$504.15		
	BONE GROWTH STIMU (Anaes.) (Assist.)	LATOR IN THE O	ORAL AND MAXILLOFACIAL REGION, insertion of		
45821	Fee: \$380.80 Bene	fit: 75% = \$285.60	85% = \$323.70		
	ARCH BARS, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia where undertaken in the operating theatre of a hospital (Anaes.)				
45823	Fee: \$108.90 Bene	fit: 75% = \$81.70			
	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.)				
45825	Fee: \$338.35 Bene	fit: 75% = \$253.80	85% = \$287.60		
	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.)				
45827	Fee: \$323.40 Bene	fit: 75% = \$242.55	85% = \$274.90		
	MAXILLARY TUBEROS	ITY, reduction of	(Anaes.)		
45829	Fee: \$246.70 Bene	fit: 75% = \$185.05	85% = \$209.70		
	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes.) (Assist.)				
45831	Fee: \$323.40 Bene	fit: 75% = \$242.55	85% = \$274.90		
	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes.) (Assist.)				
45833	Fee: \$406.05 Bene	fit: 75% = \$304.55	85% = \$345.15		
- 300			LATE, removal of - more than 20 lesions (Anaes.) (Assist.)		
45835		fit: 75% = \$377.90			
10000	Delic φυσυσιού Delic	12.0 (2.70 \$311.70	0570 Ψ120.50		

T8. SUF	RGICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGEI	RY
	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.)	
45837	Fee: \$586.50 Benefit: 75% = \$439.90 85% = \$503.10	
	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle as skin or mucosal graft when performed - unilateral (Anaes.) (Assist.)	nd
45839	Fee: \$586.50 Benefit: 75% = \$439.90 85% = \$503.10	
	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.))
45841	Fee: \$473.65 Benefit: 75% = \$355.25 85% = \$402.65	
	ALVEOLAR RIDGE AUGMENTATION - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.)	
45843	Fee: \$290.50 Benefit: 75% = \$217.90 85% = \$246.95	
	OSSEO-INTEGRATION PROCEDURE - intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.)	
45845	Fee: \$503.85 Benefit: 75% = \$377.90 85% = \$428.30	
	OSSEO-INTEGRATION PROCEDURE - fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.)	
45847	Fee: \$186.50 Benefit: 75% = \$139.90 85% = \$158.55	
	MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lini (sinus lift procedure), (unilateral) (Anaes.) (Assist.)	ng
45849	Fee: \$580.90 Benefit: 75% = \$435.70 85% = \$497.50	
	TEMPOROMANDIBULAR JOINT, manipulation of, performed in the operating theatre of a hospital not being a service associated with a service to which another item in this Subgroup applies (Anaes.)	,
45851	Fee: \$142.95 Benefit: 75% = \$107.25	
	ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.)	
45853	Fee: \$890.85 Benefit: 75% = \$668.15 85% = \$807.45	
	TEMPOROMANDIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes.) (Assist.)	
45855	Fee: \$408.70 Benefit: 75% = \$306.55 85% = \$347.40	
	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatme of adhesions - 1 or more such procedure of that joint, not being a service associated with any other arthroscopic procedure of the temporomandibular joint (Anaes.) (Assist.)	nt
45857	Fee: \$653.80 Benefit: 75% = \$490.35 85% = \$570.40	
	TEMPOROMANDIBULAR JOINT, arthrotomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.)	
45859	Fee: \$329.60 Benefit: 75% = \$247.20 85% = \$280.20	
45861	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical	

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY			
	techniques (Anaes.) (Assist.)				
	Fee: \$872.30 Benefit: 75% =	\$654.25 85% = \$788.90			
	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.)				
45863	Fee: \$967.00 Benefit: 75% =	\$725.25 85% = \$883.60			
	ARTHROCENTESIS, irrigation of te appropriate joint space(s) (Anaes.) (A	emporomandibular joint after insertion of 2 cannuli into the assist.)			
45865	Fee: \$290.50 Benefit: 75% =	\$217.90 85% = \$246.95			
	TEMPOROMANDIBULAR JOINT, Subgroup applies (Anaes.) (Assist.)	synovectomy of, not being a service to which another item in this			
45867	Fee: \$312.30 Benefit: 75% =	\$234.25 85% = \$265.50			
		open surgical exploration of, with or without meniscus or capsular niscectomy when performed, with or without microsurgical			
45869	Fee: \$1,188.20 Benefit: 75% =	\$891.15 85% = \$1104.80			
	TEMPOROMANDIBULAR JOINT, head surgery, with or without micros	open surgical exploration of, with meniscus, capsular and condylar urgical techniques (Anaes.) (Assist.)			
45871	Fee: \$1,338.45 Benefit: 75% =	\$1003.85 85% = \$1255.05			
		surgery of, involving procedures to which items 45863, 45867, living the use of tissue flaps, or cartilage graft, or allograft implants, ques (Anaes.) (Assist.)			
45873	Fee: \$1,504.05 Benefit: 75% =	\$1128.05 85% = \$1420.65			
		stabilisation of, involving 1 or more of: repair of capsule, repair of g a service to which another item in this Subgroup applies (Anaes.)			
45875	Fee: \$470.70 Benefit: 75% = 5	\$353.05 85% = \$400.10			
	TEMPOROMANDIBULAR JOINT, to which another item in this Subgrou	arthrodesis of, with synovectomy if performed, not being a service up applies (Anaes.) (Assist.)			
45877	Fee: \$470.70 Benefit: 75% =	\$353.05 85% = \$400.10			
	TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than f treatment of fractures (Anaes.) (Assist.)				
45879	Fee: \$312.30 Benefit: 75% =	\$234.25 85% = \$265.50			
	The treatment of a premalignant lesion or carbon dioxide laser.	on of the oral mucosa by a treatment using cryotherapy, diathermy			
45882	Fee: \$43.00 Benefit: 75% =	\$32.25 85% = \$36.55			
	Facial, mandibular or lingual artery of item 41707 applies (Anaes.) (Assist.)	r vein or artery and vein, ligation of, not being a service to which			
45885	Fee: \$443.70 Benefit: 75% =	\$332.80 85% = \$377.15			
	FOREIGN BODY, in the oral and ma				

T8. SUF	RGICAL OPERATI	ONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY			
	techniques (Anae	s.) (Assist.)			
	Fee: \$413.55	Benefit: 75% = \$310.20 85% = \$351.55			
	SINGLE-STAGE (Assist.)	LOCAL FLAP where indicated, repair to 1 defect, using temporalis muscle (Anaes.)			
45891	Fee: \$602.45	Benefit: 75% = \$451.85 85% = \$519.05			
	FREE GRAFTIN (Anaes.)	G, in the oral and maxillofacial region, (mucosa or split skin) of a granulating area			
45894	Fee: \$204.70	Benefit: 75% = \$153.55 85% = \$174.00			
		EFT (congenital) unilateral, grafting of, including plastic closure of associated oro- ridge augmentation (Anaes.) (Assist.)			
45897	Fee: \$1,069.10	Benefit: 75% = \$801.85 85% = \$985.70			
	MANDIBLE, fix	ation by intermaxillary wiring, excluding wiring for obesity			
45900	Fee: \$241.15	Benefit: 75% = \$180.90 85% = \$205.00			
	PERIPHERAL B (Assist.)	RANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.)			
45939	Fee: \$447.10	Benefit: 75% = \$335.35 85% = \$380.05			
	MANDIBLE, trea	atment of a dislocation of, requiring open reduction (Anaes.)			
45945	Fee: \$118.70	Benefit: 75% = \$89.05 85% = \$100.90			
	MAXILLA, unila	teral or bilateral, treatment of fracture of, not requiring splinting			
45975	(See para TN.8.110 Fee: \$129.20	of explanatory notes to this Category) Benefit: 75% = \$96.90 85% = \$109.85			
	MANDIBLE, treatment of fracture of, not requiring splinting				
45978	(See para TN.8.110 Fee: \$157.85	of explanatory notes to this Category) Benefit: 75% = \$118.40 85% = \$134.20			
	ZYGOMATIC BONE, treatment of fracture of, not requiring surgical reduction				
45981	(See para TN.8.110 Fee: \$85.65	of explanatory notes to this Category) Benefit: 75% = \$64.25 85% = \$72.85			
	open reduction no	ment of a complicated fracture of, involving viscera, blood vessels or nerves requiring of involving plate(s) (Anaes.) (Assist.)			
45984	(See para TN.8.110 Fee: \$616.65	of explanatory notes to this Category) Benefit: 75% = \$462.50 85% = \$533.25			
	MANDIBLE, trea	atment of a complicated fracture of, involving viscera, blood vessels or nerves, duction not involving plate(s) (Anaes.) (Assist.)			
45987	(See para TN.8.110 Fee: \$616.65	of explanatory notes to this Category) Benefit: 75% = \$462.50 85% = \$533.25			
		ment of a complicated fracture of, involving viscera, blood vessels or nerves requiring volving the use of plate(s) (Anaes.) (Assist.)			
45990	(See para TN.8.110	of explanatory notes to this Category)			

T8. SUF	RGICAL OPERAT	IONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	Fee: \$842.25	Benefit: 75% = \$631.70	85% = \$758.85
		eatment of a complicated fraceduction involving the use of	cture of, involving viscera, blood vessels or nerves, f plate(s) (Anaes.) (Assist.)
45993	(See para TN.8.11) Fee: \$842.25	0 of explanatory notes to this C Benefit: 75% = \$631.70	
	MANDIBLE, tre	eatment of a closed fracture of	of, involving a joint surface (Anaes.)
45996	(See para TN.8.11) Fee: \$238.80	0 of explanatory notes to this C Benefit: 75% = \$179.10	
T8. SUF	RGICAL OPERAT	IONS	14. HAND SURGERY
	Group T8. Surg	ical Operations	
		Subg	group 14. Hand Surgery
	Note: Items 4630	00 to 46534 are restricted to	surgery on the hand/s.
		NGEAL JOINT or METAC performed (Anaes.) (Assist.)	ARPOPHALANGEAL JOINT, arthrodesis of, with
46300	Fee: \$338.40	Benefit: 75% = \$253.80	
	CARPOMETAC	CARPAL JOINT, arthrodesis	of, with synovectomy if performed (Anaes.) (Assist.)
46303	Fee: \$376.10	Benefit: 75% = \$282.10	
			ARPOPHALANGEAL JOINT, interposition arthroplasty of t on the 1 ray (Anaes.) (Assist.)
46306	Fee: \$526.50	Benefit: 75% = \$394.90	
			CARPOPHALANGEAL JOINT - volar plate arthroplasty for realignment on the 1 ray (Anaes.) (Assist.)
46307	Fee: \$526.50	Benefit: 75% = \$394.90	
		emiarthroplasty of, including	ARPOPHALANGEAL JOINT, total replacement g associated synovectomy, tendon transfer or realignment -
46309	Fee: \$526.50	Benefit: 75% = \$394.90	
		emiarthroplasty of, including	ARPOPHALANGEAL JOINT, total replacement g associated synovectomy, tendon transfer or realignment -
46312	Fee: \$676.95	Benefit: 75% = \$507.75	
		emiarthroplasty of, including	ARPOPHALANGEAL JOINT, total replacement g associated synovectomy, tendon transfer or realignment -
46315	Fee: \$902.55	Benefit: 75% = \$676.95	
46318	INTERPHALAN	GEAL JOINT or METACA	ARPOPHALANGEAL JOINT, total replacement

T8. SUF	RGICAL OPERAT	ONS 14. HAND SURGERY			
	arthroplasty or he 4 joints (Anaes.)	miarthroplasty of, including associated synovectomy, tendon transfer or realignment - (Assist.)			
	Fee: \$1,128.25	Benefit: 75% = \$846.20			
		GEAL JOINT OR METACARPOPHALANGEAL JOINT, total replacement miarthroplasty of, including associated synovectomy, tendon transfer or realignment - Anaes.) (Assist.)			
46321	Fee: \$1,353.90	Benefit: 75% = \$1015.45 85% = \$1270.50			
		REPLACEMENT ARTHROPLASTY including associated tendon transfer or performed (Anaes.) (Assist.)			
46324	Fee: \$807.35	Benefit: 75% = \$605.55			
		REPLACEMENT OR RESECTION ARTHROPLASTY using adjacent tendon or including associated tendon transfer or realignment when performed (Anaes.) (Assist.)			
46325	Fee: \$842.50	Benefit: 75% = \$631.90			
	INTER-PHALA	IGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of (Anaes.)			
46327	Fee: \$203.15	Benefit: 75% = \$152.40 85% = \$172.70			
		IGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous or capsular hout arthrotomy (Anaes.) (Assist.)			
46330	Fee: \$346.10	Benefit: 75% = \$259.60			
		IGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous repair of, using r implant (Anaes.) (Assist.)			
46333	Fee: \$564.05	Benefit: 75% = \$423.05			
		IGEAL JOINT or METACARPOPHALANGEAL JOINT, synovectomy, lebridement of, not being a service associated with any procedure related to that joint			
46336	Fee: \$263.30	Benefit: 75% = \$197.50 85% = \$223.85			
	EXTENSOR TE	NDONS or FLEXOR TENDONS of hand or wrist, synovectomy of (Anaes.) (Assist.)			
46339	Fee: \$466.20	Benefit: 75% = \$349.65 85% = \$396.30			
	DISTAL RADIO (Anaes.) (Assist.	ULNAR JOINT or CARPOMETACARPAL JOINT OR JOINTS, synovectomy of			
46342	Fee: \$466.20	Benefit: 75% = \$349.65			
	DISTAL RADIOULNAR JOINT, reconstruction or stabilisation of, including fusion, or ligamentous arthroplasty and excision of distal ulna, when performed (Anaes.) (Assist.)				
46345	Fee: \$564.05	Benefit: 75% = \$423.05			
	DIGIT, synovect	DIGIT, synovectomy of flexor tendon or tendons - 1 digit (Anaes.)			
46348	Fee: \$244.45	Benefit: 75% = \$183.35 85% = \$207.80			
		omy of flexor tendon or tendons - 2 digits (Anaes.) (Assist.)			
46351	Fee: \$364.80	Benefit: 75% = \$273.60			
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T8. SUF	RGICAL OPERAT	IONS 14. HAND SURGERY			
	DIGIT, synovect	omy of flexor tendon or tendons - 3 digits (Anaes.) (Assist.)			
46354	Fee: \$488.85	Benefit: 75% = \$366.65			
		omy of flexor tendon or tendons - 4 digits (Anaes.) (Assist.)			
46357	Fee: \$609.20	Benefit: 75% = \$456.90			
40337		omy of flexor tendon or tendons - 5 digits (Anaes.) (Assist.)			
46260					
46360	Fee: \$733.35	Benefit: 75% = \$550.05 ATH OF HAND OR WRIST, open operation on, for STENOSING TENOVAGINITIS			
	(Anaes.)	THE TIME OR WIGHT, OPEN OPEN ON SHEWOSHING TENOVACHIVITIS			
46363	Fee: \$210.60	Benefit: 75% = \$157.95 85% = \$179.05			
	DUPUYTREN'S	CONTRACTURE, subcutaneous fasciotomy for - each hand (Anaes.)			
46366	Fee: \$127.90	Benefit: 75% = \$95.95 85% = \$108.75			
10300		CONTRACTURE, palmar fasciectomy for - 1 hand (Anaes.)			
46369	Fee: \$210.60	Benefit: 75% = \$157.95 85% = \$179.05			
10307		CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - 1 hand			
	(Anaes.) (Assist.	, , , , , , , , , , , , , , , , , , , ,			
46372	Fee: \$427.95	Benefit: 75% = \$321.00 85% = \$363.80			
	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - 1 hand (Anaes.) (Assist.)				
46375	Fee: \$507.70	Benefit: 75% = \$380.80 85% = \$431.55			
	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves - 1 hand (Anaes.) (Assist.)				
46270	Fee: \$676.95	Benefit: 75% = \$507.75			
46378		NGEAL JOINT, joint capsule release when performed in conjunction with operation for			
	Dupuytren's Contracture - each procedure (Anaes.) (Assist.)				
46381	Fee: \$300.80	Benefit: 75% = \$225.60			
	Z PLASTY (or similar local flap procedure) when performed in conjunction with operation for				
	Dupuytren's Con	tracture - 1 such procedure (Anaes.) (Assist.)			
46384	Fee: \$300.80	Benefit: 75% = \$225.60			
		CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - urrence in that ray (Anaes.) (Assist.)			
46387	Fee: \$620.60	Benefit: 75% = \$465.45 85% = \$537.20			
	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves -				
	operation for rec	urrence in those rays (Anaes.) (Assist.)			
46390	Fee: \$827.50	Benefit: 75% = \$620.65			
		CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of n for recurrence in those rays (Anaes.) (Assist.)			
46393	Fee: \$959.00	Benefit: 75% = \$719.25			

T8. SUF	RGICAL OPERAT	IONS 14. HAND SURGERY			
		METACARPAL OF THE HAND, osteotomy or osteectomy of, and excluding services 933 or 47936 apply (Anaes.) (Assist.)			
46396	Fee: \$329.60	Benefit: 75% = \$247.20 85% = \$280.20			
	PHALANX OR (Assist.)	METACARPAL OF THE HAND, osteotomy of, with internal fixation (Anaes.)			
46399	Fee: \$517.80	Benefit: 75% = \$388.35			
	PHALANX or N graft material (A	METACARPAL, bone grafting of, for pseudarthrosis (non-union), including obtaining of naes.) (Assist.)			
46402	Fee: \$517.80	Benefit: 75% = \$388.35			
		METACARPAL, bone grafting of, for pseudarthrosis (non-union), involving internal uding obtaining of graft material (Anaes.) (Assist.)			
46405	Fee: \$631.90	Benefit: 75% = \$473.95			
	TENDON, recor	nstruction of, by tendon graft (Anaes.) (Assist.)			
46408	Fee: \$692.00	Benefit: 75% = \$519.00			
	FLEXOR TEND	ON PULLEY, reconstruction of, by graft (Anaes.) (Assist.)			
46411	Fee: \$406.15	Benefit: 75% = \$304.65			
		ENDON PROSTHESIS, INSERTION OF, in preparation for tendon grafting (Anaes.)			
46414	Fee: \$526.40	Benefit: 75% = \$394.80 85% = \$447.45			
	TENDON transf	er for restoration of hand function, each transfer (Anaes.) (Assist.)			
46417	Fee: \$488.85	Benefit: 75% = \$366.65			
	EXTENSOR TENDON OF HAND OR WRIST, primary repair of, each tendon (Anaes.)				
46420	Fee: \$204.60	Benefit: 75% = \$153.45 85% = \$173.95			
10 120		NDON OF HAND OR WRIST, secondary repair of, each tendon (Anaes.) (Assist.)			
46423					
40423	Fee: \$327.15 Benefit: 75% = \$245.40 85% = \$278.10 FLEXOR TENDON OF HAND OR WRIST, primary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.)				
46426	Fee: \$338.40	Benefit: 75% = \$253.80			
	FLEXOR TEND (Anaes.) (Assist	ON OF HAND OR WRIST, secondary repair of, proximal to A1 pulley, each tendon)			
46429	Fee: \$413.65	Benefit: 75% = \$310.25 85% = \$351.65			
	FLEXOR TENE	ON OF HAND, primary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.)			
46432	Fee: \$451.35	Benefit: 75% = \$338.55			
		ON OF HAND, secondary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.)			
46435	Fee: \$526.50	Benefit: 75% = \$394.90			
10133	1 00 φυ20.υ0	20000000 10/0 W071.70			

T8. SUF	RGICAL OPERAT	TIONS 14. HAND SURGERY			
	MALLET FING	ER, closed pin fixation of (Anaes.)			
46438	Fee: \$135.45	Benefit: 75% = \$101.60 85% = \$115.15			
	MALLET FING	ER, open repair of, including pin fixation when performed (Anaes.) (Assist.)			
46441	Fee: \$327.15	Benefit: 75% = \$245.40 85% = \$278.10			
	MALLET FING	ER with intra articular fracture involving more than one third of base of terminal eduction (Anaes.) (Assist.)			
46442	Fee: \$280.85	Benefit: 75% = \$210.65			
	BOUTONNIER	E DEFORMITY without joint contracture, reconstruction of (Anaes.) (Assist.)			
46444	Fee: \$488.85	Benefit: 75% = \$366.65			
	BOUTONNIER	E DEFORMITY with joint contracture, reconstruction of (Anaes.) (Assist.)			
46447	Fee: \$609.20	Benefit: 75% = \$456.90			
		ENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.)			
46450	Fee: \$225.70	Benefit: 75% = \$169.30			
		DON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) (Assist.)			
46453	Fee: \$376.10	Benefit: 75% = \$282.10			
10133		aneous tenotomy of (Anaes.)			
46456	Fee: \$97.80	Benefit: 75% = \$73.35 85% = \$83.15			
40430		or OSTEOMYELITIS on distal phalanx (Anaes.)			
16170					
46459	Fee: \$188.05	Benefit: 75% = \$141.05 85% = \$159.85			
	OPERATION for OSTEOMYELITIS on middle or proximal phalanx, metacarpal or carpus (Anaes.) (Assist.)				
46462	Fee: \$300.80	Benefit: 75% = \$225.60 85% = \$255.70			
	AMPUTATION	of a supernumerary complete digit (Anaes.)			
46464	Fee: \$225.70	Benefit: 75% = \$169.30 85% = \$191.85			
		of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and usue cover (Anaes.)			
46465	Fee: \$225.70	Benefit: 75% = \$169.30 85% = \$191.85			
	AMPUTATION tissue cover (An	of 2 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft aes.) (Assist.)			
46468	Fee: \$394.90	Benefit: 75% = \$296.20			
	AMPUTATION of 3 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.)				
46471	Fee: \$564.05	Benefit: 75% = \$423.05 85% = \$480.65			
46474	AMPUTATION tissue cover (An	of 4 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft aes.) (Assist.)			

T8. SUF	RGICAL OPERAT	ONS 14. HAND SURGERY			
	Fee: \$733.35	Benefit: 75% = \$550.05			
		of 5 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft			
	tissue cover (Ana	es.) (Assist.)			
46477	Fee: \$902.55	Benefit: 75% = \$676.95			
		of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and ue cover, including metacarpal (Anaes.) (Assist.)			
46480	Fee: \$376.10	Benefit: 75% = \$282.10 85% = \$319.70			
	REVISION of A	MPUTATION STUMP to provide adequate soft tissue cover (Anaes.) (Assist.)			
46483	Fee: \$300.80	Benefit: 75% = \$225.60 85% = \$255.70			
		rate reconstruction of nail bed laceration using magnification, undertaken in the of a hospital (Anaes.)			
46486	Fee: \$225.70	Benefit: 75% = \$169.30			
		ndary exploration and accurate repair of nail bed deformity using magnification, operating theatre of a hospital (Anaes.) (Assist.)			
46489	Fee: \$263.30	Benefit: 75% = \$197.50			
		E OF DIGITS OF HAND, flexor or extensor, correction of, involving tissues deeper cutaneous tissue (Anaes.) (Assist.)			
46492	Fee: \$361.05	Benefit: 75% = \$270.80			
	GANGLION OF in this Group app	HAND, excision of, not being a service associated with a service to which another item lies (Anaes.)			
46494	Fee: \$219.95	Benefit: 75% = \$165.00 85% = \$187.00			
	GANGLION OR MUCOUS CYST OF DISTAL DIGIT, excision of, other than a service associated with a service to which item 30107 applies (Anaes.)				
46495	Fee: \$203.15	Benefit: 75% = \$152.40 85% = \$172.70			
		FLEXOR TENDON SHEATH, excision of, other than a service associated with a tem 30107 applies (Anaes.)			
46498	Fee: \$219.95	Benefit: 75% = \$165.00 85% = \$187.00			
	GANGLION OF DORSAL WRIST JOINT, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.)				
46500	Fee: \$263.30	Benefit: 75% = \$197.50 85% = \$223.85			
		VOLAR WRIST JOINT, excision of, other than a service associated with a service to 7 applies (Anaes.) (Assist.)			
46501	Fee: \$329.20	Benefit: 75% = \$246.90 85% = \$279.85			
	RECURRENT GANGLION OF DORSAL WRIST JOINT, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.)				
46502	Fee: \$302.95	Benefit: 75% = \$227.25 85% = \$257.55			
46503		ANGLION OF VOLAR WRIST JOINT, excision of, other than a service associated which item 30107 applies (Anaes.) (Assist.)			

T8. SUF	RGICAL OPERAT	IONS	14. HAND SURGERY			
	Fee: \$378.40	Benefit: 75% = \$283.80 85% = \$321.65				
	NEUROVASCU	LAR ISLAND FLAP, for pulp innervation (Anaes.) (Assis	t.)			
46504	Fee: \$1,105.55	Benefit: 75% = \$829.20 85% = \$1022.15				
	DIGIT OR RAY	, transposition or transfer of, on vascular pedicle, complete	procedure (Anaes.) (Assist.)			
46507	Fee: \$1,286.20	Benefit: 75% = \$964.65				
10307	· ·	YLY, surgical reduction of enlarged elements - each digit (A	Anaes.) (Assist.)			
46510	Fee: \$351.00	Benefit: 75% = \$263.25	, , ,			
40310		OF FINGER OR THUMB, removal of, not being a service	e to which item 46516 annlies			
	(Anaes.)	of Thomas of Thomas, removal of, not being a service	to which item 405 to applies			
46513	Fee: \$56.50	Benefit: 75% = \$42.40 85% = \$48.05				
		OF FINGER OR THUMB, removal of, in the operating the	eatre of a hospital (Anaes.)			
46516	Fee: \$112.85	Benefit: 75% = \$84.65				
40310		IAR, THENAR OR HYPOTHENAR SPACES OF HAND,	drainage of (excluding			
	aftercare) (Anaes		urumage or (energaming			
46519	Fee: \$141.25	Benefit: 75% = \$105.95 85% = \$120.10				
	FLEXOR TEND	ON SHEATH OF FINGER OR THUMB, open operation a	and drainage for infection			
	(Anaes.) (Assist.)				
46522	Fee: \$421.20	Benefit: 75% = \$315.90				
	PULP SPACE INFECTION, PARONYCHIA OF HAND, incision for, when performed in an operating					
	care) (Anaes.)	ital, not being a service to which another item in this Group	applies (excluding after-			
46525	Fee: \$56.50	Benefit: 75% = \$42.40 85% = \$48.05				
40323			ding removal of segment of			
	INGROWING NAIL OF FINGER OR THUMB, wedge resection for, including removal of segment of nail, ungual fold and portion of the nail bed (Anaes.)					
46528	Fee: \$169.50	Benefit: 75% = \$127.15 85% = \$144.10				
	INGROWING N	AIL OF FINGER OR THUMB, partial resection of nail, in	acluding phenolisation but			
	not including excision of nail bed (Anaes.)					
46531	Fee: \$85.15	Benefit: 75% = \$63.90 85% = \$72.40				
	NAIL PLATE IN	JURY OR DEFORMITY, radical excision of nail germina	al matrix (Anaes.)			
46534	Fee: \$235.50	Benefit: 75% = \$176.65 85% = \$200.20				
T8. SUF	RGICAL OPERAT		15. ORTHOPAEDIC			
	Group T8. Surg	Group T8. Surgical Operations				
	Subgroup 15. Orthopaedic					
		TREATMENT OF DISLOCATIONS				
	MANDIDIE					
47000	MANDIBLE, tre	eatment of dislocation of, by closed reduction (Anaes.)				

T8. SUF	RGICAL OPERA	TIONS 15. ORTHOPAEDIC	
	Fee: \$70.65	Benefit: 75% = \$53.00 85% = \$60.10	
	CLAVICLE, tre	eatment of dislocation of, by closed reduction (Anaes.)	
47003	Fee: \$84.80	Benefit: 75% = \$63.60 85% = \$72.10	
	CLAVICLE, treatment of dislocation of, by open reduction (Anaes.)		
47006	Fee: \$170.25	Benefit: 75% = \$127.70 85% = \$144.75	
	SHOULDER, to item 47012 app	reatment of dislocation of, requiring general anaesthesia, not being a service to which lies (Anaes.)	
47009	Fee: \$169.50	Benefit: 75% = \$127.15 85% = \$144.10	
	SHOULDER, tr (Assist.)	reatment of dislocation of, requiring general anaesthesia, open reduction (Anaes.)	
47012	Fee: \$338.85	Benefit: 75% = \$254.15	
	SHOULDER, tr	reatment of dislocation of, not requiring general anaesthesia	
47015	Fee: \$84.80	Benefit: 75% = \$63.60 85% = \$72.10	
	ELBOW, treatn	nent of dislocation of, by closed reduction (Anaes.)	
47018	Fee: \$197.60	Benefit: 75% = \$148.20 85% = \$168.00	
	ELBOW, treatn	nent of dislocation of, by open reduction (Anaes.) (Assist.)	
47021	Fee: \$263.60	Benefit: 75% = \$197.70	
		R JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by closed reduction, not associated with fracture or dislocation in the same region (Anaes.)	
47024	Fee: \$197.60	Benefit: 75% = \$148.20 85% = \$168.00	
		R JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by open reduction, not associated with fracture or dislocation in the same region (Anaes.) (Assist.)	
47027	Fee: \$263.60	Benefit: 75% = \$197.70	
	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by closed reduction (Anaes.)		
47030	Fee: \$197.60	Benefit: 75% = \$148.20 85% = \$168.00	
		ARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of by open reduction (Anaes.) (Assist.)	
47033	Fee: \$263.60	Benefit: 75% = \$197.70 85% = \$224.10	
	INTERPHALA	NGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.)	
47036	Fee: \$84.80	Benefit: 75% = \$63.60 85% = \$72.10	
	INTERPHALA	NGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.)	
47039	Fee: \$112.85	Benefit: 75% = \$84.65 85% = \$95.95	
		PHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.)	
47042	Fee: \$112.85	Benefit: 75% = \$84.65 85% = \$95.95	
4/042	ree: \$112.85	Benefit: /5% = \$84.65 85% = \$95.95	

T8. SUF	RGICAL OPERA	TIONS 15. ORTHOPAEDIC
	METACARPO	PHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.)
47045	Fee: \$150.75	Benefit: 75% = \$113.10 85% = \$128.15
	HIP, treatment	of dislocation of, by closed reduction (Anaes.)
47048	Fee: \$324.80	Benefit: 75% = \$243.60 85% = \$276.10
	HIP, treatment	of dislocation of, by open reduction (Anaes.) (Assist.)
47051	Fee: \$432.95	Benefit: 75% = \$324.75
	KNEE, treatme	nt of dislocation of, by closed reduction (Anaes.) (Assist.)
47054	Fee: \$324.80	Benefit: 75% = \$243.60 85% = \$276.10
	PATELLA, trea	atment of dislocation of, by closed reduction (Anaes.)
47057	Fee: \$127.00	Benefit: 75% = \$95.25 85% = \$107.95
	PATELLA, trea	atment of dislocation of, by open reduction (Anaes.)
47060	Fee: \$169.50	Benefit: 75% = \$127.15 85% = \$144.10
	ANKLE or TA	RSUS, treatment of dislocation of, by closed reduction (Anaes.)
47063	Fee: \$254.20	Benefit: 75% = \$190.65 85% = \$216.10
	ANKLE or TA	RSUS, treatment of dislocation of, by open reduction (Anaes.) (Assist.)
47066	Fee: \$338.85	Benefit: 75% = \$254.15
	TOE, treatment	of dislocation of, by closed reduction (Anaes.)
47069	Fee: \$70.65	Benefit: 75% = \$53.00 85% = \$60.10
	TOE, treatment	of dislocation of, by open reduction (Anaes.)
47072	Fee: \$94.00	Benefit: 75% = \$70.50 85% = \$79.90
		TREATMENT OF FRACTURES
		e or proximal, treatment of fracture of, by closed reduction, requiring anaesthesia, not same occasion as a service described in item 47304, 47307, 47310, 47313, 47316 or
47301	(See para TN.8.1 Fee: \$86.80	24 of explanatory notes to this Category) Benefit: 75% = \$65.10 85% = \$73.80
		atment of fracture of, by closed reduction, requiring anaesthesia, not provided on the as a service described in item 47301, 47307, 47310, 47313, 47316 or 47319 (Anaes.)
47304	(See para TN.8.1 Fee: \$98.90	24 of explanatory notes to this Category) Benefit: 75% = \$74.20
	Phalanx or meta (Anaes.) (Assis	acarpal, treatment of fracture of, by closed reduction with percutaneous K wire fixation t.)
47307	(See para TN.8.1 Fee: \$200.00	24 of explanatory notes to this Category) Benefit: 75% = \$150.00
	Phalanx or met	acarpal, treatment of fracture of, by open reduction with fixation (Anaes.) (Assist.)
47310	(See para TN.8.1 Fee: \$330.00	24 of explanatory notes to this Category) Benefit: 75% = \$247.50

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
	Phalanx or metacarpal, treatment of intra articular fracture of, by closed red wire fixation (Anaes.) (Assist.)	uction with percutaneous K
47313	(See para TN.8.124 of explanatory notes to this Category) Fee: \$320.00 Benefit: 75% = \$240.00	
	Phalanx or metacarpal, treatment of intra articular fracture of, by open reduced provided on the same occasion as a service to which item 47319 applies (Articular fracture of the same occasion).	
47316	(See para TN.8.124 of explanatory notes to this Category) Fee: \$635.00 Benefit: 75% = \$476.25	
	Middle phalanx, proximal end, treatment of intra articular fracture of, by opnot provided on the same occasion as a service to which item 47316 applies	
47319	(See para TN.8.124 of explanatory notes to this Category) Fee: \$650.00 Benefit: 75% = \$487.50	
	CARPUS (excluding scaphoid), treatment of fracture of, not being a service (Anaes.)	to which item 47351 applies
47348	Fee: \$94.00 Benefit: 75% = \$70.50 85% = \$79.90	
	CARPUS (excluding scaphoid), treatment of fracture of, by open reduction	(Anaes.)
47351	Fee: \$235.50 Benefit: 75% = \$176.65 85% = \$200.20	
	CARPAL SCAPHOID, treatment of fracture of, not being a service to which (Anaes.)	h item 47357 applies
47354	Fee: \$169.50 Benefit: 75% = \$127.15 85% = \$144.10	
	CARPAL SCAPHOID, treatment of fracture of, by open reduction (Anaes.)	(Assist.)
47357	Fee: \$376.55 Benefit: 75% = \$282.45 85% = \$320.10	
	Radius or ulna, or radius and ulna, distal end of, treatment of fracture of, by than a service associated with a service to which item 47362, 47364, 47367,	
47361	(See para TN.8.124 of explanatory notes to this Category) Fee: \$131.85 Benefit: 75% = \$98.90 85% = \$112.10	
	Radius or ulna, or radius and ulna, distal end of, treatment of fracture of, by general or major regional anaesthesia, but excluding local infiltration, other with a service to which item 47361, 47364, 47367, 47370 or 47373 applies (than a service associated
47362	(See para TN.8.124 of explanatory notes to this Category) Fee: \$197.60 Benefit: 75% = \$148.20 85% = \$168.00	
	Radius or ulna, distal end of, not involving joint surface, treatment of fracture fixation, other than a service associated with a service to which item 47361 (Assist.)	
47364	(See para TN.8.124 of explanatory notes to this Category) Fee: \$280.00 Benefit: 75% = \$210.00	
	Radius, distal end of, treatment of fracture of, by closed reduction with perc a service associated with a service to which item 47361 or 47362 applies (A	
47367	(See para TN.8.124 of explanatory notes to this Category) Fee: \$223.60 Benefit: 75% = \$167.70	
47370	Radius, distal end of, treatment of intra articular fracture of, by open reducti	on with fixation, other than a

T8. SUF	RGICAL OPERAT	IONS	15. ORTHOPAEDIC
	service associate	d with a service to which item 47361 or 47362	applies (Anaes.) (Assist.)
	(See para TN.8.12 Fee: \$406.00	4 of explanatory notes to this Category) Benefit: 75% = \$304.50	
		of, treatment of intra articular fracture of, by op d with a service to which item 47361 or 47362	
47373	(See para TN.8.12 Fee: \$290.00	4 of explanatory notes to this Category) Benefit: 75% = \$217.50	
		LNA, shaft of, treatment of fracture of, by cast 1, 47384, 47385 or 47386 applies (Anaes.)	immobilisation, not being a service to
47378	Fee: \$169.50	Benefit: 75% = \$127.15 85% = \$144.10	
	RADIUS OR UI theatre of a hosp	NA, shaft of, treatment of fracture of, by close ital (Anaes.)	ed reduction undertaken in the operating
47381	Fee: \$254.20	Benefit: 75% = \$190.65	
	RADIUS OR UI	NA, shaft of, treatment of fracture of, by open	reduction (Anaes.) (Assist.)
47384	Fee: \$338.85	Benefit: 75% = \$254.15	
	ulnar joint or pro	LNA, shaft of, treatment of fracture of, in conjuction of the conjuction of the conjuct (Galeazzi or Montes) to perating the atre of a hospital (Anaes.) (Assistance)	ggia injury), by closed reduction
47385	Fee: \$291.75	Benefit: 75% = \$218.85	
		LNA, shaft of, treatment of fracture of, in conjunction in conjunction (Assist.)	
47386	Fee: \$470.70	Benefit: 75% = \$353.05	
		ULNA, shafts of, treatment of fracture of, by ca 0 or 47393 applies (Anaes.) (Assist.)	ast immobilisation, not being a service to
47387	Fee: \$272.95	Benefit: 75% = \$204.75 85% = \$232.05	
		ULNA, shafts of, treatment of fracture of, by cle of a hospital (Anaes.)	osed reduction undertaken in the
47390	Fee: \$409.55	Benefit: 75% = \$307.20	
	RADIUS AND I	JLNA, shafts of, treatment of fracture of, by on	pen reduction (Anaes.) (Assist.)
47393	Fee: \$546.00	Benefit: 75% = \$409.50	
	OLECRANON,	treatment of fracture of, not being a service to	which item 47399 applies (Anaes.)
47396	Fee: \$188.20	Benefit: 75% = \$141.15 85% = \$160.00	
	OLECRANON,	treatment of fracture of, by open reduction (Ar	naes.) (Assist.)
47399	Fee: \$376.55	Benefit: 75% = \$282.45	
	OLECRANON, tendon (Anaes.)	treatment of fracture of, involving excision of (Assist.)	olecranon fragment and reimplantation of
47402	Fee: \$282.35	Benefit: 75% = \$211.80 85% = \$240.00	

T8. SUF	RGICAL OPERAT	TIONS 15. ORTHOPAEDIC
	RADIUS, treatr	nent of fracture of head or neck of, closed reduction of (Anaes.)
47405	Fee: \$188.20	Benefit: 75% = \$141.15 85% = \$160.00
		nent of fracture of head or neck of, open reduction of, including internal fixation and performed (Anaes.) (Assist.)
47408	Fee: \$376.55	Benefit: 75% = \$282.45
	HUMERUS, tre (Anaes.)	eatment of fracture of tuberosity of, not being a service to which item 47417 applies
47411	Fee: \$112.85	Benefit: 75% = \$84.65 85% = \$95.95
	HUMERUS, tre	eatment of fracture of tuberosity of, by open reduction (Anaes.)
47414	Fee: \$226.00	Benefit: 75% = \$169.50 85% = \$192.10
	HUMERUS, tre reduction (Anae	eatment of fracture of tuberosity of, and associated dislocation of shoulder, by closed es.) (Assist.)
47417	Fee: \$263.60	Benefit: 75% = \$197.70 85% = \$224.10
	HUMERUS, tre reduction (Anae	eatment of fracture of tuberosity of, and associated dislocation of shoulder, by open es.) (Assist.)
47420	Fee: \$517.80	Benefit: 75% = \$388.35
	HUMERUS, pro 47432 applies (oximal, treatment of fracture of, not being a service to which item 47426, 47429 or Anaes.)
47423	Fee: \$216.50	Benefit: 75% = \$162.40 85% = \$184.05
	HUMERUS, proof a hospital (A	oximal, treatment of fracture of, by closed reduction, undertaken in the operating theatre naes.)
47426	Fee: \$324.80	Benefit: 75% = \$243.60
	HUMERUS, pro	oximal, treatment of fracture of, by open reduction (Anaes.) (Assist.)
47429	Fee: \$432.95	Benefit: 75% = \$324.75
	HUMERUS, pro	oximal, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.)
47432	Fee: \$541.30	Benefit: 75% = \$406.00
	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.)	
47435	Fee: \$414.25	Benefit: 75% = \$310.70 85% = \$352.15
	HUMERUS, proreduction (Anae	oximal, treatment of fracture of, and associated dislocation of shoulder, by open es.) (Assist.)
47438	Fee: \$659.15	Benefit: 75% = \$494.40
	· •	oximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by (Anaes.) (Assist.)
47441	Fee: \$823.75	Benefit: 75% = \$617.85
47444	HUMERUS, sh (Anaes.)	aft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies
47444		

T8. SUF	RGICAL OPERAT	ONS 15. ORTHOPAED
	Fee: \$226.00	Benefit: 75% = \$169.50 85% = \$192.10
	HUMERUS, sha a hospital (Anae	ft of, treatment of fracture of, by closed reduction, undertaken in the operating theatre s.)
47447	Fee: \$338.85	Benefit: 75% = \$254.15
	HUMERUS, sha	ft of, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.)
47450	Fee: \$451.95	Benefit: 75% = \$339.00
	HUMERUS, sha	ft of, treatment of fracture of, by intramedullary fixation (Anaes.) (Assist.)
47451	Fee: \$544.80	Benefit: 75% = \$408.60
		al, (supracondylar or condylar), treatment of fracture of, not being a service to which 459 applies (Anaes.) (Assist.)
47453	Fee: \$263.60	Benefit: 75% = \$197.70 85% = \$224.10
		al (supracondylar or condylar), treatment of fracture of, by closed reduction, undertake heatre of a hospital (Anaes.)
47456	Fee: \$395.50	Benefit: 75% = \$296.65
		al (supracondylar or condylar), treatment of fracture of, by open reduction, undertaken heatre of a hospital (Anaes.) (Assist.)
47459	Fee: \$527.25	Benefit: 75% = \$395.45
	CLAVICLE, tre	tment of fracture of, not being a service to which item 47465 applies (Anaes.)
47462	Fee: \$112.85	Benefit: 75% = \$84.65 85% = \$95.95
	CLAVICLE, tre	tment of fracture of, by open reduction (Anaes.) (Assist.)
47465	Fee: \$226.00	Benefit: 75% = \$169.50 85% = \$192.10
	STERNUM, trea	tment of fracture of, not being a service to which item 47467 applies (Anaes.)
47466	Fee: \$112.85	Benefit: 75% = \$84.65 85% = \$95.95
	STERNUM, trea	tment of fracture of, by open reduction (Anaes.)
47467	Fee: \$226.00	Benefit: 75% = \$169.50
	SCAPULA, nec	or glenoid region of, treatment of fracture of, by open reduction (Anaes.) (Assist.)
47468	Fee: \$432.95	Benefit: 75% = \$324.75 85% = \$368.05
), treatment of fracture of - each attendance
47471	Fee: \$43.00	Benefit: 75% = \$32.25 85% = \$36.55
		reatment of fracture of, not involving disruption of pelvic ring or acetabulum
47474	Fee: \$188.20	Benefit: 75% = \$141.15 85% = \$160.00
1, 1, T		treatment of fracture of, with disruption of pelvic ring or acetabulum
47477	Fee: \$235.50	Benefit: 75% = \$176.65 85% = \$200.20
7/7//		treatment of fracture of, requiring traction (Anaes.) (Assist.)
47400		, , , , , ,
47480	Fee: \$470.70	Benefit: 75% = \$353.05

T8. SUF	RGICAL OPERATI	ONS	15. ORTHOPAEDIC
	PELVIC RING, t	reatment of fracture of, requiring con	ntrol by external fixation (Anaes.) (Assist.)
47483	Fee: \$564.85	Benefit: 75% = \$423.65	
		reatment of fracture of, by open redug diastasis of pubic symphysis (Ana	nction and involving internal fixation of anterior es.) (Assist.)
47486	Fee: \$941.45	Benefit: 75% = \$706.10	
			action and involving internal fixation of posterior fixation of anterior segment (Anaes.) (Assist.)
47489	Fee: \$1,412.20	Benefit: 75% = \$1059.15	
	ACETABULUM	, treatment of fracture of, and associ	ated dislocation of hip (Anaes.)
47492	Fee: \$235.50	Benefit: 75% = \$176.65 85% = \$	3200.20
	ACETABULUM (Assist.)	, treatment of fracture of, and associ	ated dislocation of hip, requiring traction (Anaes.)
47495	Fee: \$470.70	Benefit: 75% = \$353.05 85% = \$	400.10
		, treatment of fracture of, and association (Anaes.) (Assist.)	ated dislocation of hip, requiring internal fixation,
47498	Fee: \$706.05	Benefit: 75% = \$529.55	
	including any ost		of, by open reduction and internal fixation, required for exposure and subsequent repair, and ly (Anaes.) (Assist.)
47501	Fee: \$941.45	Benefit: 75% = \$706.10	
	any osteotomy, o		open reduction and internal fixation, including for exposure and subsequent repair, and excluding (Assist.)
47504	Fee: \$1,412.20	Benefit: 75% = \$1059.15 85% =	\$1328.80
	any osteotomy, o		by open reduction and internal fixation, including or exposure and subsequent repair, and excluding (Assist.)
47507	Fee: \$1,412.20	Benefit: 75% = \$1059.15	
	including any ost		e of, by open reduction and internal fixation, required for exposure and subsequent repair, and ly (Anaes.) (Assist.)
47510	Fee: \$1,412.20	Benefit: 75% = \$1059.15	
		OINT DISRUPTION, treatment of, service to which items 47501 to 475	requiring internal fixation, being a service 10 apply (Anaes.) (Assist.)
47513	Fee: \$376.55	Benefit: 75% = \$282.45	
	FEMUR, treatme	nt of fracture of, by closed reduction	or traction (Anaes.) (Assist.)
47516	Fee: \$432.95	Benefit: 75% = \$324.75 85% = \$	3368.05
47519			ure of, by internal fixation (Anaes.) (Assist.)

T8. SUF	RGICAL OPERAT	IONS 15. ORTHOPAEDIC
	Fee: \$866.20	Benefit: 75% = \$649.65
	FEMUR, treatme	ent of subcapital fracture of, by hemi-arthroplasty (Anaes.) (Assist.)
47522	Fee: \$753.25	Benefit: 75% = \$564.95
	FEMUR, treatme	ent of fracture of, for slipped capital femoral epiphysis (Anaes.) (Assist.)
47525	Fee: \$866.20	Benefit: 75% = \$649.65
	FEMUR, treatme	ent of fracture of, by internal fixation or external fixation (Anaes.) (Assist.)
47528	Fee: \$753.25	Benefit: 75% = \$564.95
	FEMUR, treatme	ent of fracture of shaft, by intramedullary fixation and cross fixation (Anaes.) (Assist.)
47531	Fee: \$960.25	Benefit: 75% = \$720.20
		ar region of, treatment of intra-articular (T-shaped condylar) fracture of, requiring with or without internal fixation of 1 or more osteochondral fragments (Anaes.)
47534	Fee: \$1,082.70	Benefit: 75% = \$812.05
		ar region of, treatment of fracture of, requiring internal fixation of 1 or more agments, not being a service associated with a service to which item 47534 applies)
47537	Fee: \$432.95	Benefit: 75% = \$324.75 85% = \$368.05
	HIP SPICA OR	SHOULDER SPICA, application of, as an independent procedure (Anaes.)
47540	Fee: \$216.50	Benefit: 75% = \$162.40 85% = \$184.05
	TIBIA, plateau o 47549 applies (A	of, treatment of medial or lateral fracture of, not being a service to which item 47546 or mass.)
47543	Fee: \$226.00	Benefit: 75% = \$169.50 85% = \$192.10
	TIBIA, plateau o	of, treatment of medial or lateral fracture of, by closed reduction (Anaes.)
47546	Fee: \$338.85	Benefit: 75% = \$254.15 85% = \$288.05
	TIBIA, plateau o	of, treatment of medial or lateral fracture of, by open reduction (Anaes.) (Assist.)
47549	Fee: \$451.95	Benefit: 75% = \$339.00
	TIBIA, plateau of, treatment of both medial and lateral fractures of, not being a service to which item 47555 or 47558 applies (Anaes.) (Assist.)	
47552	Fee: \$376.55	Benefit: 75% = \$282.45 85% = \$320.10
	TIBIA, plateau o	of, treatment of both medial and lateral fractures of, by closed reduction (Anaes.)
47555	Fee: \$564.85	Benefit: 75% = \$423.65
	TIBIA, plateau o	of, treatment of both medial and lateral fractures of, by open reduction (Anaes.) (Assist.)
47558	Fee: \$753.25	Benefit: 75% = \$564.95
		treatment of fracture of, by cast immobilisation, not being a service to which item 7570 or 47573 applies (Anaes.)
47561	Fee: \$272.95	Benefit: 75% = \$204.75 85% = \$232.05

T8. SUF	RGICAL OPERATION	ONS 15. ORTHOPAEDIC
	TIBIA, shaft of, tr fracture (Anaes.)	eatment of fracture of, by closed reduction, with or without treatment of fibular
47564	Fee: \$409.55	Benefit: 75% = \$307.20 85% = \$348.15
	TIBIA, shaft of, tr	eatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.)
47565	Fee: \$712.40	Benefit: 75% = \$534.30
	TIBIA, shaft of, tr	eatment of fracture of, by intramedullary fixation and cross fixation (Anaes.) (Assist.)
47566	Fee: \$908.05	Benefit: 75% = \$681.05
	TIBIA, shaft of, tr fibular fracture (A	eatment of intra-articular fracture of, by closed reduction, with or without treatment of naes.) (Assist.)
47567	Fee: \$475.35	Benefit: 75% = \$356.55 85% = \$404.05
	TIBIA, shaft of, tr (Anaes.) (Assist.)	eatment of fracture of, by open reduction, with or without treatment of fibular fracture
47570	Fee: \$546.00	Benefit: 75% = \$409.50 85% = \$464.10
	TIBIA, shaft of, tr fibula fracture (Ar	eatment of intra-articular fracture of, by open reduction, with or without treatment of laes.) (Assist.)
47573	Fee: \$682.55	Benefit: 75% = \$511.95
	FIBULA, treatmen	nt of fracture of (Anaes.)
47576	Fee: \$112.85	Benefit: 75% = \$84.65 85% = \$95.95
	PATELLA, treatm	nent of fracture of, not being a service to which item 47582 or 47585 applies (Anaes.)
47579	Fee: \$160.05	Benefit: 75% = \$120.05 85% = \$136.05
	PATELLA, treatm (Assist.)	ent of fracture of, by excision of patella or pole with reattachment of tendon (Anaes.)
47582	Fee: \$329.60	Benefit: 75% = \$247.20
	PATELLA, treatm	nent of fracture of, by internal fixation (Anaes.) (Assist.)
47585	Fee: \$423.75	Benefit: 75% = \$317.85
		atment of fracture of, by internal fixation of intra-articular fractures of femoral articular surfaces and requiring repair or reconstruction of 1 or more ligaments
47588	Fee: \$1,317.80	Benefit: 75% = \$988.35
		atment of fracture of, by internal fixation of intra-articular fractures of femoral articular surfaces and requiring repair or reconstruction of 1 or more ligaments
47591	Fee: \$1,600.65	Benefit: 75% = \$1200.50
	ANKLE JOINT, t	reatment of fracture of, not being a service to which item 47597 applies (Anaes.)
47594	Fee: \$216.50	Benefit: 75% = \$162.40 85% = \$184.05
	ANKLE JOINT, t	reatment of fracture of, by closed reduction (Anaes.)
47597	Fee: \$324.80	Benefit: 75% = \$243.60 85% = \$276.10

T8. SUF	RGICAL OPERATI	ONS 15. ORTHOPAEDIC
	ANKLE JOINT, (Anaes.) (Assist.)	treatment of fracture of, by internal fixation of 1 of malleolus, fibula or diastasis
47600	Fee: \$432.95	Benefit: 75% = \$324.75
	ANKLE JOINT, diastasis (Anaes.)	treatment of fracture of, by internal fixation of more than 1 of malleolus, fibula or (Assist.)
47603	Fee: \$564.85	Benefit: 75% = \$423.65
		OR TALUS, treatment of fracture of, not being a service to which item 47609, 47612, pplies, with or without dislocation (Anaes.)
47606	Fee: \$235.50	Benefit: 75% = \$176.65 85% = \$200.20
	CALCANEUM ((Anaes.) (Assist.)	OR TALUS, treatment of fracture of, by closed reduction, with or without dislocation
47609	Fee: \$353.05	Benefit: 75% = \$264.80 85% = \$300.10
	CALCANEUM (dislocation (Anae	OR TALUS, treatment of intra-articular fracture of, by closed reduction, with or without is.) (Assist.)
47612	Fee: \$409.55	Benefit: 75% = \$307.20 85% = \$348.15
	CALCANEUM ((Anaes.) (Assist.)	DR TALUS, treatment of fracture of, by open reduction, with or without dislocation
47615	Fee: \$470.70	Benefit: 75% = \$353.05 85% = \$400.10
	CALCANEUM (dislocation (Anae	OR TALUS, treatment of intra-articular fracture of, by open reduction, with or without es.) (Assist.)
47618	Fee: \$588.45	Benefit: 75% = \$441.35
	TARSO-METAT dislocation (Anae	ARSAL, treatment of intra-articular fracture of, by closed reduction, with or without es.) (Assist.)
47621	Fee: \$409.55	Benefit: 75% = \$307.20 85% = \$348.15
	TARSO-METATARSAL, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.)	
47624	Fee: \$564.85	Benefit: 75% = \$423.65
	TARSUS (exclud	ling calcaneum or talus), treatment of fracture of (Anaes.)
47627	Fee: \$160.05	Benefit: 75% = \$120.05 85% = \$136.05
	TARSUS (excluding calcaneum or talus), treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.)	
47630	Fee: \$338.85	Benefit: 75% = \$254.15 85% = \$288.05
		1 of, treatment of fracture of (Anaes.)
47633	Fee: \$112.85	Benefit: 75% = \$84.65 85% = \$95.95
		1 of, treatment of fracture of, by closed reduction (Anaes.)
47636	Fee: \$169.50	Benefit: 75% = \$127.15 85% = \$144.10
., 050		1 of, treatment of fracture of, by open reduction (Anaes.)
47639	ĺ	

T8. SUF	RGICAL OPERAT	IONS 15. ORTHOPAEDIC
	Fee: \$226.00	Benefit: 75% = \$169.50 85% = \$192.10
	METATARSAL	S, 2 of, treatment of fracture of (Anaes.)
47642	Fee: \$150.75	Benefit: 75% = \$113.10 85% = \$128.15
	METATARSAL	S, 2 of, treatment of fracture of, by closed reduction (Anaes.)
47645	Fee: \$226.00	Benefit: 75% = \$169.50 85% = \$192.10
	METATARSAL	S, 2 of, treatment of fracture of, by open reduction (Anaes.) (Assist.)
47648	Fee: \$301.05	Benefit: 75% = \$225.80
		S, 3 or more of, treatment of fracture of (Anaes.)
47651	Fee: \$235.50	Benefit: 75% = \$176.65 85% = \$200.20
17031		S, 3 or more of, treatment of fracture of, by closed reduction (Anaes.) (Assist.)
47654	Fee: \$353.05	Benefit: 75% = \$264.80 85% = \$300.10
47034		S, 3 or more of, treatment of fracture of, by open reduction (Anaes.) (Assist.)
17.657	Fee: \$470.70	
47657		Benefit: 75% = \$353.05 GREAT TOE, treatment of fracture of, by closed reduction (Anaes.)
47663	Fee: \$141.25	Benefit: 75% = \$105.95 85% = \$120.10
	PHALANX OF C	GREAT TOE, treatment of fracture of, by open reduction (Anaes.)
47666	Fee: \$235.50	Benefit: 75% = \$176.65 85% = \$200.20
	PHALANX OF	ΓΟΕ (other than great toe), 1 of, treatment of fracture of, by open reduction (Anaes.)
47672	Fee: \$112.85	Benefit: 75% = \$84.65 85% = \$95.95
	PHALANX OF (Anaes.)	ΓΟΕ (other than great toe), more than 1 of, treatment of fracture of, by open reduction
47678	Fee: \$169.50	Benefit: 75% = \$127.15 85% = \$144.10
	BONE GRAFT, small quantity (A	harvesting of, via separate incision, in conjunction with another service - autogenous - anaes.)
47726	Fee: \$141.25	Benefit: 75% = \$105.95
	BONE GRAFT, large quantity (A	harvesting of, via separate incision, in conjunction with another service - autogenous - naes.)
47729	Fee: \$235.50	Benefit: 75% = \$176.65
	VASCULARISE (Anaes.) (Assist.)	D PEDICLE BONE GRAFT, harvesting of, in conjunction with another service
47732	Fee: \$376.55	Benefit: 75% = \$282.45
	NASAL BONES each attendance	, treatment of fracture of, not being a service to which item 47738 or 47741 applies -
47735	Fee: \$43.05	Benefit: 75% = \$32.30 85% = \$36.60
.==::	NASAL BONES	, treatment of fracture of, by reduction (Anaes.)
47738		

GICAL OPERAT	TIONS 15. ORTHOPAEDIC
Fee: \$235.50	Benefit: 75% = \$176.65 85% = \$200.20
NASAL BONES	S, treatment of fracture of, by open reduction involving osteotomies (Anaes.) (Assist.)
Fee: \$480.35	Benefit: 75% = \$360.30
	ttment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or (Anaes.) (Assist.)
Fee: \$406.65	Benefit: 75% = \$305.00
	eatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or (Anaes.) (Assist.)
Fee: \$406.65	Benefit: 75% = \$305.00
	BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or Anaes.)
Fee: \$238.80	Benefit: 75% = \$179.10 85% = \$203.00
	BONE, treatment of fracture of, requiring surgical reduction and involving internal or at 1 site (Anaes.) (Assist.)
Fee: \$392.10	Benefit: 75% = \$294.10
	BONE, treatment of fracture of, requiring surgical reduction and involving internal or or both at 2 sites (Anaes.) (Assist.)
Fee: \$480.35	Benefit: 75% = \$360.30
	BONE, treatment of fracture of, requiring surgical reduction and involving internal or or both at 3 sites (Anaes.) (Assist.)
Fee: \$551.85	Benefit: 75% = \$413.90
MAXILLA, trea	ttment of fracture of, requiring open operation (Anaes.) (Assist.)
Fee: \$435.65	Benefit: 75% = \$326.75
MANDIBLE, tro	eatment of fracture of, requiring open reduction (Anaes.) (Assist.)
Fee: \$435.65	Benefit: 75% = \$326.75
	the the thick that th
Fee: \$566.35	Benefit: 75% = \$424.80
MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.)	
Fee: \$566.35	Benefit: 75% = \$424.80 85% = \$482.95
	ttment of fracture of, requiring open reduction and internal fixation involving plate(s)
Fee: \$718.75	Benefit: 75% = \$539.10
	eatment of fracture of, requiring open reduction and internal fixation involving plate(s)
Fee: \$718.75	Benefit: 75% = \$539.10
	Fee: \$235.50 NASAL BONES Fee: \$480.35 MAXILLA, trea external fixation Fee: \$406.65 MANDIBLE, tre external fixation Fee: \$406.65 ZYGOMATIC For other approach (Fee: \$238.80 ZYGOMATIC Fee: \$392.10 ZYGOMATIC Fee: \$392.10 ZYGOMATIC Fee: \$392.10 ZYGOMATIC Fee: \$480.35 ZYGOMATIC Fee: \$551.85 MAXILLA, trea fee: \$551.85 MAXILLA, trea (Anaes.) (Assist. Fee: \$566.35 MANDIBLE, trea (Anaes.) (Assist. Fee: \$718.75

T8. SUF	RGICAL OPERATIONS 15. ORTHOPAEDIC
	GENERAL
	BONE CYST, injection into or aspiration of (Anaes.)
47900	Fee: \$169.50 Benefit: 75% = \$127.15 85% = \$144.10
	EPICONDYLITIS, open operation for (Anaes.)
47903	Fee: \$235.50 Benefit: 75% = \$176.65 85% = \$200.20
	DIGITAL NAIL OF TOE, removal of, not being a service to which item 47906 applies (Anaes.)
47904	Fee: \$56.50 Benefit: 75% = \$42.40 85% = \$48.05
	DIGITAL NAIL OF TOE, removal of, in the operating theatre of a hospital (Anaes.)
47906	Fee: \$112.85 Benefit: 75% = \$84.65
	PULP SPACE INFECTION, PARONYCHIA of FOOT, incision for, not being a service to which another item in this Group applies (excluding aftercare) (Anaes.)
47912	(See para TN.8.4 of explanatory notes to this Category) Fee: \$56.50 Benefit: 75% = \$42.40 85% = \$48.05
	INGROWING NAIL OF TOE, wedge resection for, with removal of segment of nail, ungual fold and portion of the nail bed (Anaes.)
47915	Fee: \$169.50 Benefit: 75% = \$127.15 85% = \$144.10
	INGROWING NAIL OF TOE, partial resection of nail, with destruction of nail matrix by phenolisation, electrocautery, laser, sodium hydroxide or acid but not including excision of nail bed (Anaes.)
47916	Fee: \$85.15 Benefit: 75% = \$63.90 85% = \$72.40
	INGROWING TOENAIL, radical excision of nailbed (Anaes.)
47918	Fee: \$235.50 Benefit: 75% = \$176.65 85% = \$200.20
	BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.)
47920	Fee: \$380.80 Benefit: 75% = \$285.60
	ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure (Anaes.)
47921	Fee: \$112.85 Benefit: 75% = \$84.65 85% = \$95.95
	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of requiring incision and suture, not being a service to which item 47927 or 47930 applies - per bone (Anaes.)
47924	Fee: \$37.65 Benefit: 75% = \$28.25 85% = \$32.05
	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of, in the operating theatre of a hospital - per bone (Anaes.)
47927	Fee: \$141.25 Benefit: 75% = \$105.95
	PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all of which were inserted for internal fixation purposes, <u>removal of</u> , not being a service associated with a service to which item 47924 or 47927 applies - per bone (Anaes.) (Assist.)
47930	Fee: \$263.60 Benefit: 75% = \$197.70
47933	SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision of, or

T8. SUF	RGICAL OPERAT	TIONS	15. ORTHOPAEDIC
	simple removal removal of burs	of bunion and any associated bursa, not being a sea (Anaes.)	rvice associated with a service for
	(See para TN.8.1 Fee: \$207.00	12 of explanatory notes to this Category) Benefit: 75% = \$155.25 85% = \$175.95	
	LARGE EXOS' (Assist.)	TOSIS (GREATER THAN 20MM GROWTH AB	OVE BONE), excision of (Anaes.)
47936	(See para TN.8.1 Fee: \$254.20	12 of explanatory notes to this Category) Benefit: 75% = \$190.65	
	EXTERNAL FI	XATION, removal of, in the operating theatre of a	h hospital (Anaes.)
47948	Fee: \$160.05	Benefit: 75% = \$120.05	
	EXTERNAL FI grafting or both	IXATION, removal of, in conjunction with operation (Anaes.)	ons involving internal fixation or bone
47951	Fee: \$188.20	Benefit: 75% = \$141.15 85% = \$160.00	
	TENDON, repa	ir of, as an independent procedure (Anaes.) (Assist	t.)
47954	Fee: \$376.55	Benefit: 75% = \$282.45 85% = \$320.10	
.,,,,,		e, lengthening of, as an independent procedure (An	naes.) (Assist.)
47957	Fee: \$282.35	Benefit: 75% = \$211.80	
4/93/		SUBCUTANEOUS, not being a service to which a	nother item in this Group applies
47960	Fee: \$131.85	Benefit: 75% = \$98.90 85% = \$112.10	
	TENOTOMY, Group applies (OPEN, with or without tenoplasty, not being a serv Anaes.)	rice to which another item in this
47963	Fee: \$216.50	Benefit: 75% = \$162.40 85% = \$184.05	
	TENDON OR I	LIGAMENT, TRANSFER, as an independent proc	edure (Anaes.) (Assist.)
47966	Fee: \$432.95	Benefit: 75% = \$324.75	
17500	TENOSYNOVECTOMY, not being a service to which another item in this Group applies (Anaes.) (Assist.)		em in this Group applies (Anaes.)
47969	Fee: \$263.60	Benefit: 75% = \$197.70	
TENDON SHEATH, open operation for teno-vaginitis, not being a service to v Group applies (Anaes.)		a service to which another item in this	
47972	Fee: \$210.60	Benefit: 75% = \$157.95	
	FOREARM OR CALF, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (Anaes.) (Assist.)		ompartment syndrome, requiring
47975	Fee: \$369.15	Benefit: 75% = \$276.90	
	FOREARM OR	CALF, decompression fasciotomy of, for chronic cele and deep tissue (Anaes.)	compartment syndrome, requiring
47978	Fee: \$224.20	Benefit: 75% = \$168.15	
47981		ALF OR INTEROSSEOUS MUSCLE SPACE OF	HAND, decompression fasciotomy of

T8. SUF	RGICAL OPERAT	TIONS 15. ORTHOPAEDIC		
	not being a serv	ice to which another item applies (Anaes.)		
	Fee: \$150.55	Benefit: 75% = \$112.95 85% = \$128.00		
	FORAGE (Drill	decompression), of NECK OR HEAD of FEMUR, or BOTH (Anaes.) (Assist.)		
47982	Fee: \$364.90	Benefit: 75% = \$273.70		
		BONE GRAFTS		
	FEMUR, bone g	graft to (Anaes.) (Assist.)		
48200	Fee: \$753.25	Benefit: 75% = \$564.95		
	FEMUR, bone g	graft to, with internal fixation (Anaes.) (Assist.)		
48203	Fee: \$913.25	Benefit: 75% = \$684.95		
	TIBIA, bone gra	aft to (Anaes.) (Assist.)		
48206	Fee: \$565.45	Benefit: 75% = \$424.10		
.0200	***************************************	aft to, with internal fixation (Anaes.) (Assist.)		
48209	Fee: \$724.95	Benefit: 75% = \$543.75		
40207		ne graft to (Anaes.) (Assist.)		
48212	Fee: \$565.45	Benefit: 75% = \$424.10		
46212		ne graft to, with internal fixation (Anaes.) (Assist.)		
10015				
48215	Fee: \$724.95	Benefit: 75% = \$543.75		
		ULNA, bone graft to (Anaes.) (Assist.)		
48218	Fee: \$565.45	Benefit: 75% = \$424.10		
	RADIUS AND	ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.)		
48221	Fee: \$753.25	Benefit: 75% = \$564.95		
	RADIUS OR U	LNA, bone graft to (Anaes.) (Assist.)		
48224	Fee: \$376.55	Benefit: 75% = \$282.45		
	RADIUS OR U	LNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.)		
48227	Fee: \$489.55	Benefit: 75% = \$367.20		
	SCAPHOID, bone graft to, for non-union (Anaes.) (Assist.)			
48230	Fee: \$423.75	Benefit: 75% = \$317.85		
	SCAPHOID, bo	ne graft to, for non-union, with internal fixation (Anaes.) (Assist.)		
48233	Fee: \$611.90	Benefit: 75% = \$458.95		
	SCAPHOID, bo (Assist.)	ne graft to, for mal-union, including osteotomy, bone graft and internal fixation (Anaes.)		
48236	Fee: \$800.20	Benefit: 75% = \$600.15		
		not being a service to which another item in this Group applies (Anaes.) (Assist.)		
48239	Fee: \$442.45	Benefit: 75% = \$331.85		
70233	1 εε. φ442.43	Denom. 1370 - \$331.03		

T8. SUR	GICAL OPERATI	ONS 15. ORTHOPAEDIO
	BONE GRAFT, (Anaes.) (Assist.)	with internal fixation, not being a service to which another item in this Group applies
48242	Fee: \$611.90	Benefit: 75% = \$458.95
		OSTEOTOMY AND OSTEECTOMY
		TATARSAL, ACCESSORY BONE OR SESAMOID BONE, osteotomy or osteectomy vices to which item 49848 or 49851 applies, any of items 49848, 49851, 47933 or aes.) (Assist.)
48400	Fee: \$329.60	Benefit: 75% = \$247.20
		METATARSAL, osteotomy or osteectomy of, with internal fixation, and excluding items 47933 or 47936 apply (Anaes.) (Assist.)
48403	Fee: \$517.80	Benefit: 75% = \$388.35
		US, ULNA, CLAVICLE, SCAPULA (other than acromion), RIB, TARSUS OR omy or osteectomy of, excluding services to which items 47933 or 47936 apply
48406	Fee: \$329.60	Benefit: 75% = \$247.20
	CARPUS, osteoto	US, ULNA, CLAVICLE, SCAPULA (other than Acromion), RIB, TARSUS OR omy or osteectomy of, with internal fixation, and excluding services to which items apply (Anaes.) (Assist.)
48409	Fee: \$517.80	Benefit: 75% = \$388.35
	HUMERUS, oste (Anaes.) (Assist.)	eotomy or osteectomy of, excluding services to which items 47933 or 47936 apply
48412	Fee: \$630.65	Benefit: 75% = \$473.00
		cotomy or osteectomy of, with internal fixation, and excluding services to which items apply (Anaes.) (Assist.)
48415	Fee: \$800.20	Benefit: 75% = \$600.15
	TIBIA, osteotom (Assist.)	y or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.)
48418	Fee: \$630.65	Benefit: 75% = \$473.00
	TIBIA, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47930 or 47936 apply (Anaes.) (Assist.)	
48421	Fee: \$800.20	Benefit: 75% = \$600.15
	Femur or pelvis, osteotomy or osteectomy of, other than a service associated with surgery for femoroacetabular impingement, or to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	
48424	(See para TN.8.127 Fee: \$753.25	of explanatory notes to this Category) Benefit: 75% = \$564.95
		LVIS, osteotomy or osteectomy of, with internal fixation, and excluding services to 33 or 47936 apply (Anaes.) (Assist.)
48427	Fee: \$913.25	Benefit: 75% = \$684.95

T8. SUF	RGICAL OPERATI	ONS 15. ORTHOPAEDIC
	FEMUR, epiphys	iodesis of (Anaes.) (Assist.)
48500	Fee: \$329.60	Benefit: 75% = \$247.20
	TIBIA AND FIB	JLA, epiphysiodesis of (Anaes.) (Assist.)
48503	Fee: \$329.60	Benefit: 75% = \$247.20
	FEMUR, TIBIA	AND FIBULA, epiphysiodesis of (Anaes.) (Assist.)
48506	Fee: \$489.55	Benefit: 75% = \$367.20
	EPIPHYSIODES	(S, staple arrest of hemiepiphysis (Anaes.)
48509	Fee: \$235.50	Benefit: 75% = \$176.65
	EPIPHYSIOLYS	S, operation to prevent closure of plate (Anaes.) (Assist.)
48512	Fee: \$894.40	Benefit: 75% = \$670.80
		SHOULDER
	SHOULDER, exc (Anaes.) (Assist.)	ision of coraco-acromial ligament or removal of calcium deposit from cuff or both
48900	Fee: \$282.35	Benefit: 75% = \$211.80 85% = \$240.00
		ompression of subacromial space by acromioplasty, excision of coraco-acromial ll clavicle, or any combination (Anaes.) (Assist.)
48903	Fee: \$564.85	Benefit: 75% = \$423.65
		air of rotator cuff, including excision of coraco-acromial ligament or removal of om cuff, or both - not being a service associated with a service to which item 48900 Assist.)
48906	Fee: \$564.85	Benefit: 75% = \$423.65
	excision of corac	air of rotator cuff, including decompression of subacromial space by acromioplasty, o-acromial ligament and distal clavicle, or any combination, not being a service service to which item 48903 applies (Anaes.) (Assist.)
48909	Fee: \$753.25	Benefit: 75% = \$564.95
	SHOULDER, art	protomy of (Anaes.) (Assist.)
48912	Fee: \$329.60	Benefit: 75% = \$247.20 85% = \$280.20
	SHOULDER, her	ni-arthroplasty of (Anaes.) (Assist.)
48915	Fee: \$753.25	Benefit: 75% = \$564.95
	SHOULDER, tot (Assist.)	ll replacement arthroplasty of, including any associated rotator cuff repair (Anaes.)
48918	Fee: \$1,506.45	Benefit: 75% = \$1129.85
	SHOULDER, tot	ll replacement arthroplasty, revision of (Anaes.) (Assist.)
48921	Fee: \$1,553.40	Benefit: 75% = \$1165.05
49024	SHOULDER, tot both (Anaes.) (As	ll replacement arthroplasty, revision of, requiring bone graft to scapula or humerus, or sist.)
48924		

T8. SUF	RGICAL OPERATI	ONS 15. ORTHOPAEDIC		
	Fee: \$1,788.85	Benefit: 75% = \$1341.65		
	SHOULDER pros	sthesis, removal of (Anaes.) (Assist.)		
48927	Fee: \$367.05	Benefit: 75% = \$275.30		
	SHOULDER, stal	bilisation procedure for recurrent anterior or posterior dislocation (Anaes.) (Assist.)		
48930	Fee: \$753.25	Benefit: 75% = \$564.95		
		bilisation procedure for multi-directional instability, including anterior or posterior (or		
	both) repair when	performed (Anaes.) (Assist.)		
48933	Fee: \$988.55	Benefit: 75% = \$741.45		
	SHOULDER, syr	ovectomy of, as an independent procedure (Anaes.) (Assist.)		
48936	Fee: \$753.25	Benefit: 75% = \$564.95		
	SHOULDER, artl	nrodesis of, with synovectomy if performed (Anaes.) (Assist.)		
48939	Fee: \$1,082.70	Benefit: 75% = \$812.05		
.0,5,	-	prodesis of, with synovectomy if performed, with removal of prosthesis, requiring bone		
	grafting or interna	al fixation (Anaes.) (Assist.)		
48942	Fee: \$1,412.20	Benefit: 75% = \$1059.15		
		gnostic arthroscopy of (including biopsy) - not being a service associated with any		
	other arthroscopic	e procedure of the shoulder region (Anaes.) (Assist.)		
48945	Fee: \$272.95	Benefit: 75% = \$204.75		
	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 (Anaes.)			
	(Assist.)			
48948	Fee: \$611.90	Benefit: 75% = \$458.95		
		proscopic division of coraco-acromial ligament including acromioplasty - not being a		
	service associated	with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.)		
48951	Fee: \$894.40	Benefit: 75% = \$670.80		
	SHOULDER, arthroscopic total synovectomy of, including release of contracture when performed - not			
	(Assist.)	sociated with any other arthroscopic procedure of the shoulder region (Anaes.)		
48954	Fee: \$941.45	Benefit: 75% = \$706.10		
40734		proscopic stabilisation of, for recurrent instability including labral repair or		
	reattachment when performed - not being a service associated with any other arthroscopic procedure of			
	the shoulder region	on (Anaes.) (Assist.)		
48957	Fee: \$1,082.70	Benefit: 75% = \$812.05		
	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 (Anaes.) (Assist.)			
	Fee: \$941.45	Benefit: 75% = \$706.10		

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
		ELBOW
	ELBOW, arthrotomy of, involving 1 or more of (Anaes.) (Assist.)	f lavage, removal of loose body or division of contracture
49100	Fee: \$329.60 Benefit: 75% = \$247.20	
	ELBOW, ligamentous stabilisation of (Anaes.)	(Assist.)
49103	Fee: \$706.05 Benefit: 75% = \$529.55	
	ELBOW, arthrodesis of, with synovectomy if p	erformed (Anaes.) (Assist.)
49106	Fee: \$941.45 Benefit: 75% = \$706.10	85% = \$858.05
	ELBOW, total synovectomy of (Anaes.) (Assis	t.)
49109	Fee: \$706.05 Benefit: 75% = \$529.55	
	ELBOW, silastic or other replacement of radia	head (Anaes.) (Assist.)
49112	Fee: \$706.05 Benefit: 75% = \$529.55	
	ELBOW, total joint replacement of (Anaes.) (A	assist.)
49115	Fee: \$1,129.65 Benefit: 75% = \$847.25	
	ELBOW, total replacement arthroplasty of, rev (Assist.)	ision procedure, including removal of prosthesis (Anaes.)
49116	Fee: \$1,491.15 Benefit: 75% = \$1118.40	
	ELBOW, total replacement arthroplasty of, revremoval of prosthesis (Anaes.) (Assist.)	ision procedure, requiring bone grafting, including
49117	Fee: \$1,789.35 Benefit: 75% = \$1342.05	
	ELBOW, diagnostic arthroscopy of, including other arthroscopic procedure of the elbow (Ana	piopsy and lavage, not being a service associated with any es.) (Assist.)
49118	Fee: \$272.95 Benefit: 75% = \$204.75	
	ELBOW, arthroscopic surgery involving any 1 or more of: drilling of defect, removal of lor release of contracture or adhesions; chondroplasty; or osteoplasty - not being a service ass any other arthroscopic procedure of the elbow (Anaes.) (Assist.)	
49121	Fee: \$611.90 Benefit: 75% = \$458.95	
		WRIST
	WRIST, arthrodesis of, with synovectomy if poof the radiocarpal joint (Anaes.) (Assist.)	erformed, with or without bone graft and internal fixation
49200	(See para TN.8.116 of explanatory notes to this Cate Fee: \$818.95 Benefit: 75% = \$614.25	egory)
	WRIST, limited arthrodesis of the intercarpal judgment (Anaes.) (Assist.)	pint, with synovectomy if performed, with or without
49203	(See para TN.8.116 of explanatory notes to this Cate Fee: \$611.90 Benefit: 75% = \$458.95	gory)
	WRIST, proximal carpectomy of, including sty	loidectomy when performed (Anaes.) (Assist.)
49206	(See para TN.8.116 of explanatory notes to this Cate	gory)

T8. SUF	RGICAL OPERATI	ONS	15. ORTHOPAEDIC
	Fee: \$564.85	Benefit: 75% = \$423.65	
	WRIST, total rep	lacement arthroplasty of (Anaes	.) (Assist.)
49209	(See para TN.8.116 Fee: \$753.25	of explanatory notes to this Categor Benefit: 75% = \$564.95	ry)
	WRIST, total rep (Assist.)	lacement arthroplasty of, revisio	n procedure, including removal of prosthesis (Anaes.)
49210	Fee: \$994.30	Benefit: 75% = \$745.75	
		lacement arthroplasty of, revisionesis (Anaes.) (Assist.)	n procedure, requiring bone grafting, including
49211	Fee: \$1,193.15	Benefit: 75% = \$894.90	
	WRIST, arthroto	my of (Anaes.)	
49212	(See para TN.8.116 Fee: \$235.50	6 of explanatory notes to this Catego Benefit: 75% = \$176.65	ry)
		uction of, including repair of sin comy (Anaes.) (Assist.)	gle or multiple ligaments or capsules, including
49215	(See para TN.8.116 Fee: \$649.70	of explanatory notes to this Categor Benefit: 75% = \$487.30	ry)
			ocarpal or midcarpal joints, or both (including biopsy) hroscopic procedure of the wrist joint (Anaes.)
49218	(See para TN.8.116 Fee: \$272.95	of explanatory notes to this Categor Benefit: 75% = \$204.75	ry)
	release of adhesion		or more of: drilling of defect; removal of loose body; dement of one area - not being a service associated t joint (Anaes.) (Assist.)
49221	(See para TN.8.116 Fee: \$611.90	6 of explanatory notes to this Categor Benefit: 75% = \$458.95	ry)
		al synovectomy, not being a serv	istinct areas; or osteoplasty including excision of the vice associated with any other arthroscopic procedure of
49224	(See para TN.8.116 Fee: \$706.05	of explanatory notes to this Categor Benefit: 75% = \$529.55	ry)
		eing a service associated with ar	agment or stabilisation procedure for ligamentous ny other arthroscopic procedure of the wrist joint
49227	(See para TN.8.116 Fee: \$706.05	of explanatory notes to this Categor Benefit: 75% = \$529.55	ry)
			HIP
	SACROILIAC JO	OINT arthrodesis of (Anaes.) (A	assist.)
49300	Fee: \$521.25	Benefit: 75% = \$390.95	
49303	Hip, arthrotomy	of, including lavage, drainage or	biopsy when performed, other than a service

T8. SUF	GICAL OPERATIONS	15. ORTHOPAEDIC
	associated with surgery for femoroac	etabular impingement (H) (Anaes.) (Assist.)
	(See para TN.8.127 of explanatory notes Fee: \$546.00 Benefit: 75% =	
	HIP arthrodesis of, with synovector	y if performed (Anaes.) (Assist.)
49306	Fee: \$1,082.70 Benefit: 75% =	\$812.05
	HIP, arthrectomy or excision arthrop (non cement)) (Anaes.) (Assist.)	lasty of, including removal of prosthesis (Austin Moore or similar
49309	Fee: \$753.25 Benefit: 75% =	\$564.95
	HIP, arthrectomy or excision arthrop or similar) (Anaes.) (Assist.)	lasty of, including removal of prosthesis (cemented, porous coated
49312	Fee: \$941.45 Benefit: 75% =	\$706.10
	HIP, arthroplasty of, unipolar or bipo	olar (Anaes.) (Assist.)
49315	Fee: \$847.35 Benefit: 75% =	\$635.55
	HIP, total replacement arthroplasty o	f, including minor bone grafting (Anaes.) (Assist.)
49318	Fee: \$1,317.80 Benefit: 75% =	\$988.35
	. ,	f, including associated minor grafting, if performed - bilateral
49319	Fee: \$2,315.30 Benefit: 75% =	\$1736.50
	HIP, total replacement arthroplasty o (Anaes.) (Assist.)	f, including major bone grafting, including obtaining of graft
49321	Fee: \$1,600.65 Benefit: 75% =	\$1200.50
	HIP, total replacement arthroplasty o (Assist.)	f, revision procedure including removal of prosthesis (Anaes.)
49324	Fee: \$1,882.95 Benefit: 75% =	\$1412.25
	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to acetabulum, including obtaining of graft (Anaes.) (Assist.)	
49327	Fee: \$2,165.35 Benefit: 75% =	\$1624.05
	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, including obtaining of graft (Anaes.) (Assist.)	
49330	Fee: \$2,165.35 Benefit: 75% =	\$1624.05
	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to both acetabulum and femur, including obtaining of graft (Anaes.) (Assist.)	
49333	Fee: \$2,447.85 Benefit: 75% =	\$1835.90
		mur where revision total hip replacement is required as part of the ng intra-operative fracture), being a service associated with a service (Anaes.) (Assist.)
49336	Fee: \$357.70 Benefit: 75% =	\$268.30
49339	HIP, revision total replacement of, re	quiring anatomic specific allograft of proximal femur greater than 5

T8. SUF	RGICAL OPERATION	ONS 15. ORTHOPAEDIC
	cm in length (Ana	es.) (Assist.)
	Fee: \$2,777.30	Benefit: 75% = \$2083.00
		l replacement of, requiring anatomic specific allograft of acetabulum (Anaes.) (Assist.)
49342	Fee: \$2,777.30	Benefit: 75% = \$2083.00
		l replacement of, requiring anatomic specific allograft of both femur and acetabulum
49345	Fee: \$3,295.10	Benefit: 75% = \$2471.35
		roplasty with replacement of acetabular liner or ceramic head, not requiring removal of nt or acetabular shell (Anaes.) (Assist.)
49346	Fee: \$847.35	Benefit: 75% = \$635.55
	HIP, diagnostic arthe hip (Anaes.) (throscopy of, not being a service associated with any other arthroscopic procedure of Assist.)
49360	Fee: \$343.95	Benefit: 75% = \$258.00
		throscopy of, with synovial biopsy, not being a service associated with any other edure of the hip (Anaes.) (Assist.)
49363	Fee: \$414.20	Benefit: 75% = \$310.65 85% = \$352.10
		surgery of, other than a service associated with another arthroscopic procedure of the ssociated with surgery for femoroacetabular impingement (H) (Anaes.) (Assist.)
49366	(See para TN.8.127 Fee: \$611.90	of explanatory notes to this Category) Benefit: 75% = \$458.95
		KNEE
		y of, involving 1 or more of; capsular release, biopsy or lavage, or removal of loose ody (Anaes.) (Assist.)
49500	Fee: \$376.55	Benefit: 75% = \$282.45
	chondroplasty of,	total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon (not which another item in this Group applies) - any 1 procedure (Anaes.) (Assist.)
49503	Fee: \$489.55	Benefit: 75% = \$367.20
	KNEE, partial or total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon (no being a service to which another item in this Group applies) - any 2 or more procedures (Anaes.) (Assist.)	
49506	Fee: \$734.40	Benefit: 75% = \$550.80
	KNEE, total syno	vectomy or arthrodesis with synovectomy if performed (Anaes.) (Assist.)
49509	Fee: \$753.25	Benefit: 75% = \$564.95
	KNEE, arthrodesi	s of, with synovectomy if performed, with removal of prosthesis (Anaes.) (Assist.)
49512	Fee: \$1,082.70	Benefit: 75% = \$812.05
49515		f prosthesis, cemented or uncemented, including associated cement, as the first stage

T8. SUF	RGICAL OPERATION	ONS 15. ORTHOPAEDIC
	of a 2 stage proce	dure (Anaes.) (Assist.)
	Fee: \$847.35	Benefit: 75% = \$635.55
		oplasty of (Anaes.) (Assist.)
49517	Fee: \$1,206.35	Benefit: 75% = \$904.80
.,,,,	-	cement arthroplasty of (Anaes.) (Assist.)
49518	Fee: \$1,317.80	Benefit: 75% = \$988.35
	- i	cement arthroplasty of, including associated minor grafting, if performed - bilateral
49519	Fee: \$2,315.30	Benefit: 75% = \$1736.50
	KNEE, total repla obtaining of graft	cement arthroplasty of, requiring major bone grafting to femur or tibia, including (Anaes.) (Assist.)
49521	Fee: \$1,600.65	Benefit: 75% = \$1200.50
	KNEE, total repla obtaining of graft	cement arthroplasty of, requiring major bone grafting to femur and tibia, including (Anaes.) (Assist.)
49524	Fee: \$1,882.95	Benefit: 75% = \$1412.25
	KNEE, total repla (Assist.)	cement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.)
49527	Fee: \$1,600.65	Benefit: 75% = \$1200.50
		cement arthroplasty of, revision procedure, requiring bone grafting to femur or tibia, eg of graft and including removal of prosthesis (Anaes.) (Assist.)
49530	Fee: \$1,977.20	Benefit: 75% = \$1482.90
		cement arthroplasty of, revision procedure, requiring bone grafting to both femur and training of graft and including removal of prosthesis (Anaes.) (Assist.)
49533	Fee: \$2,259.65	Benefit: 75% = \$1694.75
	KNEE, patello-fer	moral joint of, total replacement arthroplasty as a primary procedure (Anaes.) (Assist.)
49534	Fee: \$449.55	Benefit: 75% = \$337.20
	KNEE, repair or reconstruction of, for chronic instability (open or arthroscopic, or both) involving either cruciate or collateral ligaments, including notchplasty when performed, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.)	
49536	Fee: \$941.45	Benefit: 75% = \$706.10
	KNEE, reconstructive surgery of cruciate ligament or ligaments (open or arthroscopic, or both), including notchplasty when performed and surgery to other internal derangements, not being a service which another item in this Group applies or a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.)	
49539	Fee: \$941.45	Benefit: 75% = \$706.10
49542	including notchpla	etive surgery to cruciate ligament or ligaments (open or arthroscopic, or both), asty, meniscus repair, extracapsular procedure and debridement when performed, not sociated with any other arthroscopic procedure of the knee (Anaes.) (Assist.)

T8. SUF	RGICAL OPERATI	ONS	15. ORTHOPAEDIC
	Fee: \$1,317.80	Benefit: 75% = \$988.35	
	KNEE, revision a	rthrodesis of, with synovectom	y if performed (Anaes.) (Assist.)
49545	Fee: \$753.25	Benefit: 75% = \$564.95	
	KNEE, revision o	f patello-femoral stabilisation (Anaes.) (Assist.)
49548	Fee: \$941.45	Benefit: 75% = \$706.10	
	KNEE, revision o	f procedures to which item 495	36, 49539 or 49542 applies (Anaes.) (Assist.)
49551	Fee: \$1,317.80	Benefit: 75% = \$988.35	
	KNEE, revision o (Assist.)	f total replacement of, by anato	omic specific allograft of tibia or femur (Anaes.)
49554	Fee: \$1,882.95	Benefit: 75% = \$1412.25	
	being a service as	sociated with autologous chond	osy, simple trimming of meniscal margin or plica) - not drocyte implantation or matrix-induced autologous pic procedure of the knee region (Anaes.) (Assist.)
49557	(See para TN.8.117 Fee: \$272.95	of explanatory notes to this Categ Benefit: 75% = \$204.75	ory)
			ore of: debridement, osteoplasty or chondroplasty - not of the knee region (Anaes.) (Assist.)
49558	Fee: \$272.95	Benefit: 75% = \$204.75	
	similar) implant;		roplasty requiring multiple drilling or carbon fibre (or lement or oestoplasty - not associated with any other s.) (Assist.)
49559	Fee: \$408.70	Benefit: 75% = \$306.55	
		ease - not being a service assoc	nore of: partial or total meniscectomy, removal of loose stated with any other arthroscopic procedure of the knee
49560	Fee: \$551.60	Benefit: 75% = \$413.70	
	removal of loose	body or lateral release; where the ondroplasty - not associated with	lving 1 or more of: partial or total meniscectomy, ne procedure includes associated debridement, h any other arthroscopic procedure of the knee region
49561	Fee: \$674.00	Benefit: 75% = \$505.50	
	removal of loose drilling or carbon	body or lateral release; where the	lving 1 or more of: partial or total meniscectomy, ne procedure includes chondroplasty requiring multiple associated debridement or osteoplasty - not associated e region (Anaes.) (Assist.)
49562	Fee: \$735.50	Benefit: 75% = \$551.65	
49563	chondral graft (ex	cluding autologous chondrocytantation) -not associated with a	ore of: meniscus repair; osteochondral graft; or e implantation or matrix-induced autologous ny other arthroscopic procedure of the knee region

T8. SUF	RGICAL OPERATION	NS 15. ORTHOPAEDIC
	(See para TN.8.117 Fee: \$796.70	of explanatory notes to this Category) Benefit: 75% = \$597.55
	release, medial cap	noral stabilisation of, combined arthroscopic and open procedure, including lateral sulorrhaphy and tendon transfer, not being a service associated with any other dure of the knee (Anaes.) (Assist.)
49564	Fee: \$919.05	Benefit: 75% = \$689.30
	, 1	te total synovectomy of, not being a service associated with any other arthroscopic nee (Anaes.) (Assist.)
49566	Fee: \$753.25	Benefit: 75% = \$564.95
	KNEE, mobilisatio (Anaes.) (Assist.)	n for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty
49569	Fee: \$753.25	Benefit: 75% = \$564.95
		ANKLE
	ANKLE, diagnost	c arthroscopy of, including biopsy (Anaes.) (Assist.)
49700	Fee: \$272.95	Benefit: 75% = \$204.75
	ANKLE, arthrosco of the ankle (Anae	pic surgery of, not being a service associated with any other arthroscopic procedure s.) (Assist.)
49703	Fee: \$611.90	Benefit: 75% = \$458.95
	ANKLE, arthrotor (Anaes.) (Assist.)	ny of, involving 1 or more of: lavage, removal of loose body or division of contracture
49706	Fee: \$329.60	Benefit: 75% = \$247.20
	ANKLE, ligament	ous stabilisation of (Anaes.) (Assist.)
49709	Fee: \$706.05	Benefit: 75% = \$529.55
	ANKLE, arthrodes	is of, with synovectomy if performed (Anaes.) (Assist.)
49712	Fee: \$753.25	Benefit: 75% = \$564.95
	ANKLE, total join	t replacement of (Anaes.) (Assist.)
49715	Fee: \$1,129.65	Benefit: 75% = \$847.25
		acement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.)
49716	Fee: \$1,491.15	Benefit: 75% = \$1118.40
		acement arthroplasty of, revision procedure, requiring bone grafting, including sis (Anaes.) (Assist.)
49717	Fee: \$1,789.35	Benefit: 75% = \$1342.05
	ANKLE, Achilles'	tendon or other major tendon, repair of (Anaes.) (Assist.)
49718	Fee: \$376.55	Benefit: 75% = \$282.45
		tendon rupture managed by non-operative treatment
49721	Fee: \$235.50	Benefit: 75% = \$176.65 85% = \$200.20

T8. SUF	RGICAL OPERAT	IONS 15. ORTHOPAEDIC
	ANKLE, Achille	s' tendon, secondary repair or reconstruction of (Anaes.) (Assist.)
49724	Fee: \$659.15	Benefit: 75% = \$494.40
	ANKLE, Achille	s' tendon, operation for lengthening (Anaes.) (Assist.)
49727	Fee: \$282.35	Benefit: 75% = \$211.80
	, ,	ning of the gastrocnemius aponeurosis and soleus fascia, for the correction of equinus dren with cerebral palsy (Anaes.) (Assist.)
49728	Fee: \$564.70	Benefit: 75% = \$423.55
		FOOT
	FOOT, flexor or	extensor tendon, primary repair of (Anaes.)
49800	Fee: \$131.85	Benefit: 75% = \$98.90 85% = \$112.10
	FOOT, flexor or	extensor tendon, secondary repair of (Anaes.)
49803	Fee: \$169.50	Benefit: 75% = \$127.15 85% = \$144.10
	FOOT, subcutan	eous tenotomy of, 1 or more tendons (Anaes.)
49806	Fee: \$131.85	Benefit: 75% = \$98.90 85% = \$112.10
		otomy of, with or without tenoplasty (Anaes.)
49809	Fee: \$216.50	Benefit: 75% = \$162.40
.,, 00,		ligament transplantation of, not being a service to which another item in this Group
49812	Fee: \$432.95	Benefit: 75% = \$324.75
	FOOT, triple artl	prodesis of, with synovectomy if performed (Anaes.) (Assist.)
49815	Fee: \$753.25	Benefit: 75% = \$564.95
	FOOT, excision	of calcaneal spur (Anaes.) (Assist.)
49818	Fee: \$272.95	Benefit: 75% = \$204.75
.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	FOOT, correction	n of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar ateral (Anaes.) (Assist.)
49821	Fee: \$432.95	Benefit: 75% = \$324.75
		n of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar teral (Anaes.) (Assist.)
49824	Fee: \$757.95	Benefit: 75% = \$568.50
	FOOT, correction	n of hallux valgus by transfer of adductor hallucis tendon - unilateral (Anaes.) (Assist.)
49827	Fee: \$470.70	Benefit: 75% = \$353.05
	FOOT, correction	n of hallux valgus by transfer of adductor hallucis tendon - bilateral (Anaes.) (Assist.)
49830	Fee: \$823.75	Benefit: 75% = \$617.85
	FOOT, correction	n of hallux valgus by osteotomy of first metatarsal with or without internal fixation and
49833	with or without e	xcision of exostoses associated with the first metatarsophalangeal joint - unilateral

T8. SUF	RGICAL OPERATI	ONS 15. ORTHOPAEDIC	
	(Anaes.) (Assist.)		
	Fee: \$517.80	Benefit: 75% = \$388.35	
		n of hallux valgus by osteotomy of first metatarsal with or without internal fixation and xcision of exostoses associated with the first metatarsophalangeal joint - bilateral	
49836	Fee: \$894.40	Benefit: 75% = \$670.80	
	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - unilateral (Anaes.) (Assist.)		
49837	Fee: \$647.25	Benefit: 75% = \$485.45	
	tendon, with or w	n of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus vithout internal fixation and with or without excision of exostoses associated with the alangeal joint - bilateral (Anaes.) (Assist.)	
49838	Fee: \$1,117.75	Benefit: 75% = \$838.35	
	FOOT, correction (Assist.)	n of hallux rigidus or hallux valgus by prosthetic arthroplasty - unilateral (Anaes.)	
49839	Fee: \$517.80	Benefit: 75% = \$388.35	
	FOOT, correction (Assist.)	n of hallux rigidus or hallux valgus by prosthetic arthroplasty - bilateral (Anaes.)	
49842	Fee: \$894.40	Benefit: 75% = \$670.80	
	FOOT, arthrodes	is of, first metatarso-phalangeal joint, with synovectomy if performed (Anaes.) (Assist.)	
49845	Fee: \$470.70	Benefit: 75% = \$353.05	
	FOOT, correction	n of claw or hammer toe (Anaes.)	
49848	Fee: \$160.05	Benefit: 75% = \$120.05 85% = \$136.05	
	FOOT, correction	n of claw or hammer toe with internal fixation (Anaes.)	
49851	Fee: \$207.00	Benefit: 75% = \$155.25	
		antar fasciotomy or fasciectomy of (Anaes.) (Assist.)	
49854	Fee: \$376.55	Benefit: 75% = \$282.45	
		p-phalangeal joint replacement (Anaes.) (Assist.)	
49857	Fee: \$348.35	Benefit: 75% = \$261.30	
		omy of metatarso-phalangeal joint, single joint (Anaes.) (Assist.)	
49860	Fee: \$282.35	Benefit: 75% = \$211.80	
., 550		omy of metatarso-phalangeal joint, 2 or more joints (Anaes.) (Assist.)	
49863	Fee: \$423.75	Benefit: 75% = \$317.85	
17003		my for plantar or digital neuritis (Morton's or Bett's syndrome) (Anaes.) (Assist.)	
10066			
49866	Fee: \$301.05	Benefit: 75% = \$225.80	

	TALIDES EOUI		
		NOVARUS, calcaneo valgus or metatarus var ach attendance (Anaes.)	rus, treatment by cast, splint or
49878	Fee: \$56.50	Benefit: 75% = \$42.40 85% = \$48.05	
		OTHER JOINTS	
		ic arthroscopy of (including biopsy), not being and not being a service associated with any other	
50100	Fee: \$272.95	Benefit: 75% = \$204.75 85% = \$232.05	
	JOINT, arthroso (Assist.)	opic surgery of, not being a service to which a	nother item in this Group applies (Anaes.)
50102	Fee: \$611.90	Benefit: 75% = \$458.95	
	JOINT, arthroton	my of, not being a service to which another ite	em in this Group applies (Anaes.) (Assist.)
50103	Fee: \$329.60	Benefit: 75% = \$247.20	
	JOINT, synovec (Assist.)	tomy of, not being a service to which another	item in this Group applies (Anaes.)
50104	Fee: \$312.30	Benefit: 75% = \$234.25 85% = \$265.50	
		tion of, involving 1 or more of: repair of capsuce to which another item in this Group applies	
50106	Fee: \$470.70	Benefit: 75% = \$353.05	
		sis of, not being a service to which another ite performed (Anaes.) (Assist.)	m in this Group applies, with
50109	Fee: \$470.70	Benefit: 75% = \$353.05	
		FLEXION OR EXTENSION CONTRACTIO an skin and subcutaneous tissue, not being a s (Assist.)	
50112	Fee: \$361.05	Benefit: 75% = \$270.80	
		TS, manipulation of, performed in the operation a service to which another item in this Group a	
50115	Fee: \$142.95	Benefit: 75% = \$107.25	
	SUBTALAR JO	INT, arthrodesis of, with synovectomy if perfe	formed (Anaes.) (Assist.)
50118	Fee: \$432.95	Benefit: 75% = \$324.75	
		OCHANTER, transplantation of ileopsoas tend	lon to (Anaes.) (Assist.)
50121	Fee: \$847.35	Benefit: 75% = \$635.55	
		TTS, arthroplasty of, by any technique not beir	ng a service to which another item applies
50127	Fee: \$702.50	Benefit: 75% = \$526.90	
50130		ITS, application of external fixator to, other th	an for treatment of fractures (Anaes.)

T8. SUF	RGICAL OPERAT	IONS	15. ORTHOPAEDIC
	Fee: \$312.30	Benefit: 75% = \$234.25	
		MALIGNANT	DISEASE
		OR POTENTIALLY MALIGNANT cluding aftercare) (Anaes.)	BONE OR DEEP SOFT TISSUE TUMOUR,
50200	Fee: \$188.20	Benefit: 75% = \$141.15 85% = \$	160.00
			BONE OR DEEP SOFT TISSUE TUMOUR, ot including aftercare) (Anaes.) (Assist.)
50201	Fee: \$329.50	Benefit: 75% = \$247.15	
	BONE OR MAL (Assist.)	IGNANT DEEP SOFT TISSUE TU	MOUR, lesional or marginal excision of (Anaes.)
50203	Fee: \$414.25	Benefit: 75% = \$310.70 85% = \$	352.15
		R, lesional or marginal excision of, caft or cementation (Anaes.) (Assist.)	ombined with any 1 of: liquid nitrogen freezing,
50206	Fee: \$611.90	Benefit: 75% = \$458.95	
		R, lesional or marginal excision of, conft, allograft or cementation (Anaes.)	ombined with any 2 or more of: liquid nitrogen (Assist.)
50209	Fee: \$753.25	Benefit: 75% = \$564.95	
			MOUR affecting the long bones of leg or arm, sion of soft tissue, without reconstruction (Anaes.)
50212	Fee: \$1,647.55	Benefit: 75% = \$1235.70	
	enbloc resection		MOUR affecting the long bones of leg or arm, sion of soft tissue, with intercalary reconstruction
50215	Fee: \$2,071.20	Benefit: 75% = \$1553.40	
		TUMOUR of LONG BONE, enbloc r ith synovectomy if performed (Anaes	esection of, with replacement or arthrodesis of) (Assist.)
50218	Fee: \$2,730.30	Benefit: 75% = \$2047.75	
		or AGGRESSIVE SOFT TISSUE TU SHOULDER, enbloc resection of (Ar	MOUR of PELVIS, SACRUM or SPINE; or naes.) (Assist.)
50221	Fee: \$2,541.85	Benefit: 75% = \$1906.40	
		SHOULDER, enbloc resection of, wi	MOUR of PELVIS, SACRUM or SPINE; or th reconstruction by prosthesis, allograft or
50224	Fee: \$2,824.35	Benefit: 75% = \$2118.30 85% =	\$2740.95
		BONE TUMOUR, enbloc resection or without prosthetic replacement (An	f, with massive anatomic specific allograft or aes.) (Assist.)
50227	Fee: \$3,295.10	Benefit: 75% = \$2471.35	
50230	BENIGN TUMO	OUR, resection of, requiring anatomic	specific allograft, with or without internal fixation

T8. SUF	RGICAL OPERATION	INS 15. ORTHOPAEDIC	
	(Anaes.) (Assist.)		
	Fee: \$1,694.60	Benefit: 75% = \$1270.95	
		MOUR, amputation for, hemipelvectomy or interscapulo-thoracic (Anaes.) (Assist.)	
50233	Fee: \$2,165.35	Benefit: 75% = \$1624.05	
00233		MOUR, amputation for, hip disarticulation, shoulder disarticulation or proximal third	
50236	Fee: \$1,694.60	Benefit: 75% = \$1270.95	
	MALIGNANT TU applies (Anaes.) (A	MOUR, amputation for, not being a service to which another item in this Group assist.)	
50239	Fee: \$1,129.65	Benefit: 75% = \$847.25	
		LIMB LENGTHENING AND DEFORMITY CORRECTION	
		TY, slow correction of, using ring fixator or similar device, including all associated ble only once in any 12 month period (Anaes.) (Assist.)	
50300	Fee: \$1,157.70	Benefit: 75% = \$868.30	
	LIMB LENGTHENING, 5cm or less, by gradual distraction, with application of an external fixator or intra-medullary device, in the operating theatre of a hospital - payable only once per limb in any 12 month period (Anaes.) (Assist.)		
50303	Fee: \$1,580.60	Benefit: 75% = \$1185.45	
		NING, where the lengthening is bipolar, or bone transport is performed or where the to correct an adjacent joint deformity, or where the lengthening is greater than 5cm	
50306	Fee: \$2,467.90	Benefit: 75% = \$1850.95 85% = \$2384.50	
	fixation pins, perfo	OR SIMILAR DEVICE, adjustment of, with or without insertion or removal of ormed under general anaesthesia in the operating theatre of a hospital, not being a em 50303 or 50306 applies (Anaes.) (Assist.)	
50309	Fee: \$305.05	Benefit: 75% = \$228.80	
	, ,	omy of, by arthroscopic or open means - not associated with any other arthroscopic nkle (Anaes.) (Assist.)	
50312	Fee: \$700.10	Benefit: 75% = \$525.10	
	TALIPES EQUIN	OVARUS, posterior release of (Anaes.) (Assist.)	
50315	Fee: \$693.30	Benefit: 75% = \$520.00	
	TALIPES EQUIN	OVARUS, medial release of (Anaes.) (Assist.)	
50318	Fee: \$693.30	Benefit: 75% = \$520.00	
	· ·	OVARUS, combined postero-medial release of (Anaes.) (Assist.)	
50321	Fee: \$928.85	Benefit: 75% = \$696.65	
		OVARUS, combined postero-medial release of, revision procedure (Anaes.) (Assist.)	
50324	Fee: \$1,324.15	Benefit: 75% = \$993.15	
50324	1 66. \$1,324.13	Denem. 13/0 = \$773.13	

T8. SUF	RGICAL OPERATI	IONS 15. ORTHOPAEDIC
·	TALIPES EQUI	NOVARUS, bilateral procedures (Anaes.) (Assist.)
50327	Fee: \$1,615.15	Benefit: 75% = \$1211.40
30321	TALIPES EQUII plaster, performe	NOVARUS, or talus, vertical congenital - post operative manipulation and change of ed under general anaesthesia in the operating theatre of a hospital, not being a service to 5, 50318, 50321, 50324 or 50327 applies (Anaes.)
50330	Fee: \$228.70	Benefit: 75% = \$171.55
	TARSAL COAL (Assist.)	ITION, excision of, with interposition of muscle, fat graft or similar graft (Anaes.)
50333	Fee: \$616.85	Benefit: 75% = \$462.65
	TALUS, VERTION (Assist.)	CAL, CONGENITAL, combined anterior and posterior reconstruction (Anaes.)
50336	Fee: \$922.05	Benefit: 75% = \$691.55
	FOOT AND AND (Assist.)	KLE, tibialis anterior tendon (split or whole) transfer to lateral column (Anaes.)
50339	Fee: \$561.55	Benefit: 75% = \$421.20
		KLE, tibialis or tibialis posterior tendon transfer, through the interosseous membrane to rior aspect of foot (Anaes.) (Assist.)
50342	Fee: \$651.60	Benefit: 75% = \$488.70
		SION DEFORMITY OF TOE, release incorporating V-Y plasty of skin, lengthening of and release of capsule contracture (Anaes.) (Assist.)
50345	Fee: \$346.65	Benefit: 75% = \$260.00
		HIP, KNEE AND LEG PROCEDURES
	-	y of, post-operative manipulation and change of plaster, performed under general ne operating theatre of a hospital (Anaes.)
50348	Fee: \$228.70	Benefit: 75% = \$171.55
	HIP, congenital of	dislocation of, treatment of, by closed reduction (Anaes.)
#0# · ·	Fee: \$320.15	Benefit: 75% = \$240.15 85% = \$272.15
50349		Delicit: 7570 \$270.15 \$570 \$272.15
50349		ntal dislocation of, open reduction of (Anaes.) (Assist.)
50349	HIP, developmen Fee: \$1,597.25	htal dislocation of, open reduction of (Anaes.) (Assist.) Benefit: 75% = \$1197.95 dislocation of, treatment of, involving supervision of splint, harness or cast - each
	HIP, development Fee: \$1,597.25 HIP, congenital congenital congenital congenital congenital congenital congenital congenital congenital congenital congenital congenital congenital congenital congenital congenital congenit	htal dislocation of, open reduction of (Anaes.) (Assist.) Benefit: 75% = \$1197.95 dislocation of, treatment of, involving supervision of splint, harness or cast - each
50351	HIP, development Fee: \$1,597.25 HIP, congenital cattendance (Anaecate) Fee: \$56.50	htal dislocation of, open reduction of (Anaes.) (Assist.) Benefit: 75% = \$1197.95 dislocation of, treatment of, involving supervision of splint, harness or cast - each ess.)

T8. SUF	RGICAL OPERATI	ONS 15. ORTHOPAEDIC
	TIBIA, pseudarth	rosis of, congenital, resection and internal fixation (Anaes.) (Assist.)
50354	Fee: \$1,310.15	Benefit: 75% = \$982.65 85% = \$1226.75
	KNEE, LEG OR (Anaes.) (Assist.)	THIGH, rectus femoris tendon transfer, or medial or lateral hamstring tendon transfer
50357	Fee: \$561.55	Benefit: 75% = \$421.20
	KNEE, LEG OR	THIGH, combined medial and lateral hamstring tendon transfer (Anaes.) (Assist.)
50360	Fee: \$651.60	Benefit: 75% = \$488.70
	KNEE, contractur (Anaes.) (Assist.)	re of, posterior release involving multiple tendon lengthening or tenotomies, unilateral
50363	Fee: \$499.05	Benefit: 75% = \$374.30
	KNEE, contractur (Anaes.) (Assist.)	re of, posterior release involving multiple tendon lengthening or tenotomies, bilateral
50366	Fee: \$873.45	Benefit: 75% = \$655.10
		re of, posterior release involving multiple tendon lengthening with or without elease of joint capsule with or without cruciate ligaments, unilateral (Anaes.) (Assist.)
50369	Fee: \$651.60	Benefit: 75% = \$488.70
		re of, posterior release involving multiple tendon lengthening with or without clease of joint capsule with or without cruciate ligaments, bilateral (Anaes.) (Assist.)
50372	Fee: \$1,143.80	Benefit: 75% = \$857.85
		of, medial release, involving lengthening of, or division of the adductors and psoas with on of the obturator nerve, unilateral (Anaes.) (Assist.)
50375	Fee: \$499.05	Benefit: 75% = \$374.30
		of, medial release, involving lengthening of, or division of the adductors and psoas with on of the obturator nerve, bilateral (Anaes.) (Assist.)
50378	Fee: \$873.45	Benefit: 75% = \$655.10
		of, anterior release, involving lengthening of, or division of the hip flexors and psoas ivision of the joint capsule, unilateral (Anaes.) (Assist.)
50381	Fee: \$651.60	Benefit: 75% = \$488.70
	HIP, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, bilateral (Anaes.) (Assist.)	
50384	Fee: \$1,143.80	Benefit: 75% = \$857.85
		ndon transfer to greater trochanter, or transfer of abdominal musculature to greater nsfer of adductors to ischium (Anaes.) (Assist.)
50387	Fee: \$651.60	Benefit: 75% = \$488.70
		EBRAL PALSY, or other neuromuscular conditions, affecting hips or knees, at under general anaesthesia, performed in the operating theatre of a hospital (Anaes.)

T8. SUF	RGICAL OPERATI	ONS 15. ORTHOPAEDIC
	PELVIS, bone gr	raft or shelf procedures for acetabular dysplasia (Anaes.) (Assist.)
50393	Fee: \$845.60	Benefit: 75% = \$634.20
	ACETABULAR	DYSPLASIA, treatment of, by multiple peri-acetabular osteotomy, including internal erformed (Anaes.) (Assist.)
50394	Fee: \$2,777.30	Benefit: 75% = \$2083.00
		SHOULDER, ARM AND FOREARM PROCEDURES
		al abnormalities or duplication of digits, amputation or splitting of phalanx or igament or joint reconstruction (Anaes.) (Assist.)
50396	Fee: \$464.55	Benefit: 75% = \$348.45
	FOREARM, RA (Anaes.) (Assist.)	DIAL APLASIA OR DYSPLASIA (radial club hand), centralisation or radialisation of
50399	Fee: \$922.05	Benefit: 75% = \$691.55
	TORTICOLLIS, (Assist.)	bipolar release of sternocleidomastoid muscle and associated soft tissue (Anaes.)
50402	Fee: \$422.95	Benefit: 75% = \$317.25
	ELBOW, flexorp	lasty, or tendon transfer to restore elbow function (Anaes.) (Assist.)
50405	Fee: \$575.40	Benefit: 75% = \$431.55
	SHOULDER, co.	ngenital or developmental dislocation, open reduction of (Anaes.) (Assist.)
50408	Fee: \$998.25	Benefit: 75% = \$748.70
	AMP	UTATIONS OR RECONSTRUCTIONS FOR CONGENITAL DEFORMITIES
		DEFICIENCY, treatment of congenital deficiency of the femur by resection of the distal nal tibia followed by knee fusion (Anaes.) (Assist.)
50411	Fee: \$1,310.15	Benefit: 75% = \$982.65 85% = \$1226.75
		DEFICIENCY, treatment of congenital deficiency of the femur by resection of the distal nal tibia followed by knee fusion and rotationplasty (Anaes.) (Assist.)
50414	Fee: \$1,767.60	Benefit: 75% = \$1325.70 85% = \$1684.20
		DEFICIENCY, treatment of congenital deficiency of the tibia by reconstruction of the ransfer of fibula or tibia, and repair of quadriceps mechanism (Anaes.) (Assist.)
50417	Fee: \$1,310.15	Benefit: 75% = \$982.65 85% = \$1226.75
	PATELLA, cong	enital dislocation of, reconstruction of the quadriceps (Anaes.) (Assist.)
50420	Fee: \$1,081.35	Benefit: 75% = \$811.05
	TIBIA, FIBULA fixation (Anaes.)	OR BOTH, congenital deficiency of, transfer of the fibula to tibia, with internal (Assist.)

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
	Fee: \$998.25 Benefit: 75% = \$748.70 85% = \$914.85	
	TUMOROUS CONDITIONS	
	DIAPHYSEAL ACLASIA, removal of lesion or lesions from bone - 1 approach (Anaes.) (Assist.)
50426	Fee: \$464.55 Benefit: 75% = \$348.45	
	SINGLE EVEN MULTILEVEL SURGERY FOR CHILDREN WITH CEREI	BRAL PALSY
	UNILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less the hemiplegic cerebral palsy comprising three or more of the following:	an 18 years of age with
	(a) Lengthening of one or more contracted muscle tendon units by tendon length recession, fractional lengthening or intramuscular lengthening.	ening, muscle
	(b) Correction of muscle imbalance by tendon transfer/transfers.	
	(c) Correction of femoral torsion by rotational osteotomy of the femur.	
	(d) Correction of tibial torsion by rotational osteotomy of the tibia.	
	(e) Correction of joint instability by varus derotation osteotomy of the femur, sul synovectomy if performed, or os calcis lengthening.	btalar arthrodesis, with
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare	(Anaes.) (Assist.)
50450	(See para TN.8.118 of explanatory notes to this Category) Fee: \$1,226.90 Benefit: 75% = \$920.20	
	UNILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less the hemiplegic cerebral palsy comprising three or more of the following:	an 18 years of age with
	(a) Lengthening of one or more contracted muscle tendon units by tendon length recession, fractional lengthening or intramuscular lengthening.	ening, muscle
	(b) Correction of muscle imbalance by tendon transfer/transfers.	
	(c) Correction of femoral torsion by rotational osteotomy of the femur.	
	(d) Correction of tibial torsion by rotational osteotomy of the tibia.	
	(e) Correction of joint instability by varus derotation osteotomy of the femur, sul synovectomy if performed, or os calcis lengthening.	btalar arthrodesis, with
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding (Assist.)	g aftercare (Anaes.)
50451	(See para TN.8.118 of explanatory notes to this Category) Fee: \$1,226.90 Benefit: 75% = \$920.20	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than diplegic cerebral palsy that comprises:	18 years of age with
50455	(`) Lengthening of one or more contracted muscle tendon units by tendon length recession, fractional lengthening or intramuscular lengthening.	ening, muscle

T8. SUF	RGICAL OPERATIONS 15. ORTHOPAED
	(`) Correction of muscle imbalance by tendon transfer/transfers.
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)
	(See para TN.8.118 of explanatory notes to this Category) Fee: \$1,389.40 Benefit: 75% = \$1042.05
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises:
	(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.
	(b) Correction of muscle imbalance by tendon transfer/transfers.
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.)
50456	(See para TN.8.118 of explanatory notes to this Category) Fee: \$1,389.40 Benefit: 75% = \$1042.05
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilateral femoral osteotomies.
	(`) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.
	(`) Correction of muscle imbalance by tendon transfer/transfers.
	(`) Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation.
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)
50460	(See para TN.8.118 of explanatory notes to this Category) Fee: \$2,074.45 Benefit: 75% = \$1555.85
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilateral femoral osteotomies.
	(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.
	(b) Correction of muscle imbalance by tendon transfer/transfers.
	(c) Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation.
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.)
50461	(See para TN.8.118 of explanatory notes to this Category) Fee: \$2,074.45 Benefit: 75% = \$1555.85
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies.
50465	(`) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.

T8. SUR	GICAL OPERATIONS	15. ORTHOPAEDIC
	(`) Correction of muscle imbalance by tendon transfer/transfers.	
	(`) Correction of abnormal torsion of the femur by rotational osteotomy with	internal fixation.
	(') Correction of abnormal torsion of the tibia by rotational osteotomy with in	nternal fixation.
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and afterc	eare (Anaes.) (Assist.)
	(See para TN.8.118 of explanatory notes to this Category) Fee: \$2,921.80 Benefit: 75% = \$2191.35	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less the diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral fembilateral tibial osteotomies.	
	(a) Lengthening of one or more contracted muscle tendon units by tendon len recession, fractional lengthening or intramuscular lengthening.	gthening, muscle
	(b) Correction of muscle imbalance by tendon transfer/transfers.	
	(c) Correction of abnormal torsion of the femur by rotational osteotomy with	internal fixation.
	(d) Correction of abnormal torsion of the tibia by rotational osteotomy with in	nternal fixation.
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding (Assist.)	ling aftercare (Anaes.)
50466	(See para TN.8.118 of explanatory notes to this Category) Fee: \$2,921.80 Benefit: 75% = \$2191.35	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less the cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osterosteotomies and bilateral foot stabilisation.	
	(') Lengthening of one or more contracted muscle tendon units by tendon len recession, fractional lengthening or intramuscular lengthening.	gthening, muscle
	(`) Correction of muscle imbalance by tendon transfer/transfers.	
	(') Correction of abnormal torsion of the femur by rotational osteotomy with	internal fixation.
	(`) Correction of abnormal torsion of the tibia by rotational osteotomy with ir	nternal fixation.
	(`) Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion	on.
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and afterc	care (Anaes.) (Assist.)
50470	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,705.55 Benefit: 75% = \$2779.20	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less the cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osterosteotomies and bilateral foot stabilisation.	
50471	(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, fractional lengthening or intramuscular lengthening.	gthening, muscle

T8. SURGICAL OPERATIONS 15. ORTHOPAEDIC Correction of muscle imbalance by tendon transfer/transfers. Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation. Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation. Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) Fee: \$3,705.55 **Benefit:** 75% = \$2779.20SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy for the correction of crouch gait including: Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. Correction of muscle imbalance by tendon transfer/transfers. Correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation. Correction of patella alta and quadriceps insufficiency by patella tendon shortening/reconstruction. Correction of tibial torsion by rotational osteotomy of the tibia with internal fixation. Correction of foot instability by os calcis lengthening or subtalar fusion. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) 50475 Fee: \$4.275.85 **Benefit:** 75% = \$3206.90 SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy for the correction of crouch gait including: (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. Correction of muscle imbalance by tendon transfer/transfers. Correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation. Correction of patella alta and quadriceps insufficiency by patella tendon shortening/reconstruction. Correction of tibial torsion by rotational osteotomy of the tibia with internal fixation. Correction of foot instability by os calcis lengthening or subtalar fusion. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) (See para TN.8.118 of explanatory notes to this Category) **Benefit:** 75% = \$3206.90 50476 Fee: \$4,275.85

T8. SUF	RGICAL OPERATIONS 15. ORTHOPAEDIC		
	TREATMENT OF FRACTURES IN PAEDIATRIC PATIENTS		
	RADIUS OR ULNA, distal end of, with open growth plate, treatment of fracture of, by closed reduction (Anaes.)		
50500	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$276.65 Benefit: 75% = \$207.50 85% = \$235.20		
	RADIUS OR ULNA, distal end of, with open growth plate, treatment of fracture of, by open reduction (Anaes.) (Assist.)		
50504	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$369.05 Benefit: 75% = \$276.80 85% = \$313.70		
	RADIUS, distal end of, with open growth plate, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.)		
50508	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$395.25 Benefit: 75% = \$296.45 85% = \$336.00		
	RADIUS, distal end of, with open growth plate, treatment of Colles', Smith's or Barton's fracture of, by open reduction (Anaes.) (Assist.)		
50512	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$527.30 Benefit: 75% = \$395.50		
	RADIUS OR ULNA, shaft of, with open growth plate, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.)		
50516	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$355.85 Benefit: 75% = \$266.90		
	RADIUS OR ULNA, shaft of, with open growth plate, treatment of fracture of, by open reduction (Anaes.) (Assist.)		
50520	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$474.40 Benefit: 75% = \$355.80		
	RADIUS OR ULNA, shaft of, with open growth plate, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction undertaken in the operating theatre of a hospital (Anaes.) (Assist.)		
50524	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$408.50 Benefit: 75% = \$306.40		
	RADIUS OR ULNA, shaft of, with open growth plate, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.)		
50528	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$659.00 Benefit: 75% = \$494.25		
	RADIUS AND ULNA, shafts of, <i>with open growth plates</i> , treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.)		
50532	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$573.40 Benefit: 75% = \$430.05		
	RADIUS AND ULNA, shafts of, with open growth plates, treatment of fracture of, by open reduction (Anaes.) (Assist.)		
50536	(See para TN.8.119, TN.8.118 of explanatory notes to this Category)		

T8. SUF	RGICAL OPERATIONS 15. ORTHOPAEDIC	
	Fee: \$764.40 Benefit: 75% = \$573.30	
	OLECRANON, with open growth plate, treatment of fracture of, by open reduction (Anaes.) (Assist.)	
50540	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$527.30 Benefit: 75% = \$395.50	
	RADIUS, with open growth plate, treatment of fracture of head or neck of, by closed reduction of (Anaes.)	
50544	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$263.60 Benefit: 75% = \$197.70 85% = \$224.10	
	RADIUS, with open growth plate, treatment of fracture of head or neck of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.)	
50548	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$527.30 Benefit: 75% = \$395.50	
	HUMERUS, proximal, with open growth plate, treatment of fracture of, by closed reduction, undertaken in the operating theatre, neonatal unit or nursery of a hospital (Anaes.)	
50552	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$454.75 Benefit: 75% = \$341.10	
	HUMERUS, proximal, with open growth plate, treatment of fracture of, by open reduction (Anaes.) (Assist.)	
50556	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$606.20 Benefit: 75% = \$454.65	
	HUMERUS, shaft of, with open growth plate, treatment of fracture of, by closed reduction, undertaken in the operating theatre, neonatal unit or nursery of a hospital (Anaes.)	
50560	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$474.40 Benefit: 75% = \$355.80	
	HUMERUS, shaft of, with open growth plate, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.)	
50564	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$632.65 Benefit: 75% = \$474.50	
	HUMERUS, with open growth plate, supracondylar or condylar, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.)	
50568	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$553.60 Benefit: 75% = \$415.20	
	HUMERUS, with open growth plate, supracondylar or condylar, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means, undertaken in the operating theatre of a hospital (Anaes.) (Assist.)	
50572	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$738.10 Benefit: 75% = \$553.60	
	FEMUR, with open growth plate, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.)	
50576	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$606.20 Benefit: 75% = \$454.65 85% = \$522.80	
50580	TIBIA, with open growth plate, plateau or condyles, medial or lateral, treatment of fracture of, by	

T8. SUF	RGICAL OPERATIONS 15. ORTHOPAEDIC
	reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.)
	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$632.65 Benefit: 75% = \$474.50
	TIBIA, distal, with open growth plate, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.)
50584	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$606.20 Benefit: 75% = \$454.65
	TIBIA AND FIBULA, with open growth plates, treatment of fracture of, by internal fixation (Anaes.) (Assist.)
50588	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$790.70 Benefit: 75% = \$593.05
	SPINE SURGERY FOR SCOLIOSIS AND KYPHOSIS IN PAEDIATRIC PATIENTS
	SCOLIOSIS OR KYPHOSIS, in a growing child, manipulation of deformity and application of a localiser cast, under general anaesthesia, in a hospital (Anaes.) (Assist.)
50600	(See para TN.8.118 of explanatory notes to this Category) Fee: \$434.70 Benefit: 75% = \$326.05
	SCOLIOSIS or KYPHOSIS, in a child or adolescent, spinal fusion for (without instrumentation) (Anaes.) (Assist.)
50604	(See para TN.8.118 of explanatory notes to this Category) Fee: \$1,845.05 Benefit: 75% = \$1383.80
	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, treatment by segmental instrumentation and fusion of the spine, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.)
50608	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,426.95 Benefit: 75% = \$2570.25
	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, with spinal deformity, treatment by segmental instrumentation, utilising separate anterior and posterior approaches, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.)
50612	(See para TN.8.118 of explanatory notes to this Category) Fee: \$4,874.50 Benefit: 75% = \$3655.90
	SCOLIOSIS, in a child or adolescent, re-exploration for adjustment or removal of segmental instrumentation used for correction of spine deformity (Anaes.) (Assist.)
50616	(See para TN.8.118 of explanatory notes to this Category) Fee: \$619.35 Benefit: 75% = \$464.55
	SCOLIOSIS, in a child or adolescent, revision of failed scoliosis surgery, involving more than 1 of osteotomy, fusion, removal of instrumentation or instrumentation, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.)
50620	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,426.95 Benefit: 75% = \$2570.25
	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - not more than 4 levels (Anaes.) (Assist.)
50624	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,426.95 Benefit: 75% = \$2570.25

T8. SUF	RGICAL OPERATIONS 15. ORTHOPAEDIC		
	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (Anaes.) (Assist.)		
50628	(See para TN.8.118 of explanatory notes to this Category) Fee: \$4,233.20 Benefit: 75% = \$3174.90		
	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, requiring segmental instrumentation and fusion of the spine down to and including the pelvis or sacrum, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.)		
50632	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,558.65 Benefit: 75% = \$2669.00		
	SCOLIOSIS, in a child or adolescent, requiring anterior decompression of the spinal cord with vertebral resection and instrumentation in the presence of spinal cord involvement, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.)		
50636	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,954.10 Benefit: 75% = \$2965.60		
	SCOLIOSIS, in a child or adolescent, congenital, resection and fusion of abnormal vertebra via an anterior or posterior approach, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.)		
50640	(See para TN.8.118 of explanatory notes to this Category) Fee: \$2,185.80 Benefit: 75% = \$1639.35		
	SPINE, bone graft to, for a child or adolescent, associated with surgery for correction of scoliosis or kyphosis or both (Anaes.) (Assist.)		
50644	(See para TN.8.118 of explanatory notes to this Category) Fee: \$2,108.95 Benefit: 75% = \$1581.75		
	TREATMENT OF HIP DYSPLASIA OR DISLOCATION IN PAEDIATRIC PATIENTS		
	HIP DYSPLASIA or DISLOCATION, in a child, examination, manipulation and arthrography of the hip under anaesthesia (Anaes.)		
50650	(See para TN.8.118 of explanatory notes to this Category) Fee: \$414.75 Benefit: 75% = \$311.10 85% = \$352.55		
	HIP DYSPLASIA or DISLOCATION, in a child, application or reapplication of a hip spica, including examination of the hip (Anaes.) (Assist.)		
50654	(See para TN.8.118 of explanatory notes to this Category) Fee: \$496.65 Benefit: 75% = \$372.50		
	HIP DYSPLASIA or DISLOCATION, in a child, examination and manipulation of the hip under anaesthesia (Anaes.)		
50658	(See para TN.8.118 of explanatory notes to this Category) Fee: \$197.75 Benefit: 75% = \$148.35 85% = \$168.10		
T8. SUF	16. RADIOFREQUENCY AND MICROWAVE RGICAL OPERATIONS TISSUE ABLATION		
	Group T8. Surgical Operations		
	Subgroup 16. Radiofrequency And Microwave Tissue Ablation		
50950	Unresectable primary malignant tumour of the liver, destruction of, by percutaneous radiofrequency		

T8. SUF	16. RADIOFREQUENCY AND MICROWAVE RGICAL OPERATIONS TISSUE ABLATION
	ablation or percutaneous microwave tissue ablation (including any associated imaging services), other than a service associated with a service to which item 30419 or 50952 applies
	(Anaes.)
	Fee: \$817.10 Benefit: 75% = \$612.85 85% = \$733.70
	Unresectable primary malignant tumour of the liver, destruction of, by open or laparoscopic radiofrequency ablation or open or laparoscopic microwave tissue ablation (including any associated imaging services), if a multi-disciplinary team has assessed that percutaneous radiofrequency ablation or percutaneous microwave tissue ablation cannot be performed or is not practical because of one or more of the following clinical circumstances:
İ	(a) percutaneous access cannot be achieved;
	(b) vital organs or tissues are at risk of damage from the percutaneous radiofrequency ablation or percutaneous microwave tissue ablation procedure;
	(c) resection of one part of the liver is possible, however there is at least one primary liver tumour in an unresectable portion of the liver that is suitable for radiofrequency ablation or microwave tissue ablation;
	other than a service associated with a service to which item 30419 or 50950 applies.
İ	(Anaes.)
50952	(See para TN.8.120 of explanatory notes to this Category) Fee: \$817.10 Benefit: 75% = \$612.85 85% = \$733.70
T8. SUF	RGICAL OPERATIONS 17. SPINAL SURGERY
	Group T8. Surgical Operations
	Subgroup 17. Spinal Surgery
	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, one motion segment, not being a service associated with a service to which item 51012, 51013, 51014 or 51015 applies (Anaes.) (Assist.)
Fee 51011	(See para TN.8.141, TN.8.142 of explanatory notes to this Category) Fee: \$1,435.50 Benefit: 75% = \$1076.50
	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, 2 motion segments, not being a service associated with a service to which item 51011,
	51013, 51014 or 51015 applies (Anaes.) (Assist.)
51012	51013, 51014 or 51015 applies (Anaes.) (Assist.) (See para TN.8.141, TN.8.142 of explanatory notes to this Category) Fee: \$1,913.80 Benefit: 75% = \$1435.35
51012	(See para TN.8.141, TN.8.142 of explanatory notes to this Category)

T8. SUF	SURGICAL OPERATIONS 17. SPINAL SURG	
	Fee: \$2,392.25 Benefit: 75% = \$1794.20	
	Spinal decompression or exposure via partial or total laminectomy, spinal release, 4 motion segments, not being a service associated wi 51012, 51013 or 51015 applies (Anaes.) (Assist.)	
51014	(See para TN.8.141, TN.8.142 of explanatory notes to this Category) Fee: \$2,870.70 Benefit: 75% = \$2153.05	
	Spinal decompression or exposure via partial or total laminectomy, spinal release, more than 4 motion segments, not being a service ass 51011, 51012, 51013 or 51014 applies (Anaes.) (Assist.)	
(See para TN.8.141, TN.8.142 of explanatory notes to this Category) Fee: \$3,349.15 Benefit: 75% = \$2511.90		
	Simple fixation of part of one vertebra (not motion segment) includ process or pedicle, or simple interspinous wiring between 2 adjacen associated with:	
	(a) interspinous dynamic stabilisation devices; or	
	(b) a service to which item 51021, 51022, 51023, 51024, 51025 or 5	51026 applies (Anaes.) (Assist.)
51020	(See para TN.8.141, TN.8.143 of explanatory notes to this Category) Fee: \$765.45 Benefit: 75% = \$574.10	
	Fixation of motion segment with vertebral body screw, pedicle scre sublaminar tapes or wires, one motion segment, not being a service item 51020, 51022, 51023, 51024, 51025 or 51026 applies (Anaes.)	associated with a service to which
51021	(See para TN.8.141, TN.8.143 of explanatory notes to this Category) Fee: \$1,281.20 Benefit: 75% = \$960.90	
	Fixation of motion segment with vertebral body screw, pedicle scre sublaminar tapes or wires, 2 motion segments, not being a service a item 51020, 51021, 51023, 51024, 51025 or 51026 applies (Anaes.)	ssociated with a service to which
51022	(See para TN.8.141, TN.8.143 of explanatory notes to this Category) Fee: \$1,593.70 Benefit: 75% = \$1195.30	
	Fixation of motion segment with vertebral body screw, pedicle scre sublaminar tapes or wires, 3 or 4 motion segments, not being a serv item 51020, 51021, 51022, 51024, 51025 or 51026 applies (Anaes.)	rice associated with a service to which
51023	(See para TN.8.141, TN.8.143 of explanatory notes to this Category) Fee: \$1,896.60 Benefit: 75% = \$1422.45	
	Fixation of motion segment with vertebral body screw, pedicle scre sublaminar tapes or wires, 5 or 6 motion segments, not being a serv item 51020, 51021, 51022, 51023, 51025 or 51026 applies (Anaes.)	rice associated with a service to which
51024	(See para TN.8.141, TN.8.143 of explanatory notes to this Category) Fee: \$2,189.60 Benefit: 75% = \$1642.20	
	Fixation of motion segment with vertebral body screw, pedicle scre sublaminar tapes or wires, 7 to 12 motion segments, not being a ser which item 51020, 51021, 51022, 51023, 51024 or 51026 applies (A	vice associated with a service to
51025	(See para TN.8.141, TN.8.143 of explanatory notes to this Category) Fee: \$2,559.20 Benefit: 75% = \$1919.40	

T8. SUF	RGICAL OPERATIONS	17. SPINAL SURGERY
	Fixation of motion segment with vertebral body screw, pedicle screw of sublaminar tapes or wires, more than 12 motion segments, not being a sto which item 51020, 51021, 51022, 51023, 51024 or 51025 applies (A	service associated with a service
51026	(See para TN.8.141, TN.8.143 of explanatory notes to this Category) Fee: \$2,801.90 Benefit: 75% = \$2101.45	
	Spine, posterior and/or posterolateral bone graft to, one motion segmen with a service to which item 51032, 51033, 51034, 51035 or 51036 app	
51031	(See para TN.8.141, TN.8.144 of explanatory notes to this Category) Fee: \$941.45 Benefit: 75% = \$706.10	
	Spine, posterior and/or posterolateral bone graft to, 2 motion segments, not being a service associated with a service to which item 51031, 51033, 51034, 51035 or 51036 applies (Anaes.) (Assist.)	
51032	(See para TN.8.141, TN.8.144 of explanatory notes to this Category) Fee: \$1,129.75 Benefit: 75% = \$847.35	
	Spine, posterior and/or posterolateral bone graft to, 3 motion segments, with a service to which item 51031, 51032, 51034, 51035 or 51036 app	
51033	(See para TN.8.141, TN.8.144 of explanatory notes to this Category) Fee: \$1,318.05 Benefit: 75% = \$988.55	
	Spine, posterior and/or posterolateral bone graft to, 4 to 7 motion segm associated with a service to which item 51031, 51032, 51033, 51035 or	
51034	(See para TN.8.141, TN.8.144 of explanatory notes to this Category) Fee: \$1,412.20 Benefit: 75% = \$1059.15	
	Spine, posterior and/or posterolateral bone graft to, 8 to 11 motion segral associated with a service to which item 51031, 51032, 51033, 51034 or	
51035	(See para TN.8.141, TN.8.144 of explanatory notes to this Category) Fee: \$1,506.30 Benefit: 75% = \$1129.75	
	Spine, posterior and/or posterolateral bone graft to, 12 or more motion associated with a service to which item 51031, 51032, 51033, 51034 or	
51036	(See para TN.8.141, TN.8.144 of explanatory notes to this Category) Fee: \$1,600.50 Benefit: 75% = \$1200.40	
	Spinal fusion, anterior column (anterior, direct lateral or posterior interbeing a service associated with a service to which item 51042, 51043, 5 (Assist.)	277
51041	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) Fee: \$1,082.70 Benefit: 75% = \$812.05	
	Spinal fusion, anterior column (anterior, direct lateral or posterior interbeing a service associated with a service to which item 51041, 51043, 5 (Assist.)	
51042	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) Fee: \$1,515.80 Benefit: 75% = \$1136.85	
	Spinal fusion, anterior column (anterior, direct lateral or posterior interbeing a service associated with a service to which item 51041, 51042, 5 (Assist.)	
51043	(See para TN.8.141, TN.8.145 of explanatory notes to this Category)	

T8. SUF	GICAL OPERATIONS		17. SPINAL SURGERY
	Fee: \$1,894.75 Bene	efit: 75% = \$1421.10	
		lumn (anterior, direct lateral or posterior i with a service to which item 51041, 5104	
51044	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) Fee: \$2,057.15 Benefit: 75% = \$1542.90 Spinal fusion, anterior column (anterior, direct lateral or posterior interbody), 5 or more motion segments, not being a service associated with a service to which item 51041, 51042, 51043 or 51044 applies (Anaes.) (Assist.)		
51045		45 of explanatory notes to this Category) efit: 75% = \$1624.05	
	Pedicle subtraction osteoto	omy, one motion segment, not being a ser	rvice associated with:
	(a) anterior column fusion	when at the same motion segment; or	
	(b) a service to which item (Assist.)	n 51052, 51053, 51054, 51055, 51056, 51	1057, 51058 or 51059 applies (Anaes.)
51051		46 of explanatory notes to this Category) efit: 75% = \$1387.50	
	Pedicle subtraction osteoto	omy, 2 motion segments, not being a serv	vice associated with:
	(a) anterior column fusion	when at the same motion segment; or	
	(b) a service to which item (Assist.)	n 51051, 51053, 51054, 51055, 51056, 51	1057, 51058 or 51059 applies (Anaes.)
51052	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$2,250.00 Benefit: 75% = \$1687.50		
	Vertebral column resection segment, not being a servi-	on osteotomy performed through single poice associated with:	osterior approach, one motion
	(a) anterior column fusion	when at the same motion segment; or	
	(b) a service to which item (Assist.)	n 51051, 51052, 51054, 51055, 51056, 51	1057, 51058 or 51059 applies (Anaes.)
51053		46 of explanatory notes to this Category) efit: 75% = \$1920.00	
		l or subtotal excision of (where piecemea 6 of the vertebral body), one vertebra, not	
	(a) anterior column fusion	when at the same motion segment; or	
	(b) a service to which item (Assist.)	n 51051, 51052, 51053, 51055, 51056, 51	1057, 51058 or 51059 applies (Anaes.)
51054		46 of explanatory notes to this Category) efit: 75% = \$1023.75	
51055		l or subtotal excision of (where piecemea 6 of the vertebral body), 2 vertebrae, not l	

T8. SUF	GICAL OPERATIONS	17. SPINAL SURGERY
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51054, 51056, 51057, 51 (Assist.)	058 or 51059 applies (Anaes.)
	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$2,047.50 Benefit: 75% = \$1535.65	
	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtremoval of more than 50% of the vertebral body), 3 or more vertebrae, not with:	
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51054, 51055, 51057, 51 (Assist.)	058 or 51059 applies (Anaes.)
51056	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$2,388.75 Benefit: 75% = \$1791.60	
	Vertebral body, en bloc excision of (complete spondylectomy), one vertebral associated with:	ra, not being a service
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51 (Assist.)	058 or 51059 applies (Anaes.)
51057	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$2,400.00 Benefit: 75% = \$1800.00	
	Vertebral body, en bloc excision of (complete spondylectomy), 2 vertebrae associated with:	e, not being a service
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51 (Assist.)	057 or 51059 applies (Anaes.)
51058	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$2,700.50 Benefit: 75% = \$2025.40	
	Vertebral body, en bloc excision of (complete spondylectomy), 3 or more vassociated with:	vertebrae, not being a service
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51 (Assist.)	057 or 51058 applies (Anaes.)
51059	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$3,300.00 Benefit: 75% = \$2475.00	
	Spine fusion, anterior and posterior, including spinal instrumentation at one and/or posterolateral bone graft, and anterior column fusion, not being a se to which item 51062, 51063, 51064, 51065 or 51066 applies (Anaes.) (Ass	rvice associated with a service
51061	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) Fee: \$2,834.65 Benefit: 75% = \$2126.00	

T8. SUF	RGICAL OPERATIONS	17. SPINAL SURGERY
	Spine fusion, anterior and posterior, including spinal instrumentation and/or posterolateral bone graft, and anterior column fusion, not being to which item 51061, 51063, 51064, 51065 or 51066 applies (Anaes.)	g a service associated with a service
51062	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) Fee: \$3,674.35 Benefit: 75% = \$2755.80	
	Spine fusion, anterior and posterior, including spinal instrumentation and/or posterolateral bone graft, and anterior column fusion, not being to which item 51061, 51062, 51064, 51065 or 51066 applies (Anaes.)	g a service associated with a service
51063	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) Fee: \$4,450.35 Benefit: 75% = \$3337.80	
	Spine fusion, anterior and posterior, including spinal instrumentation posterior and/or posterolateral bone graft, and anterior column fusion with a service to which item 51061, 51062, 51063, 51065 or 51066 a	, not being a service associated
51064	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) Fee: \$4,952.85 Benefit: 75% = \$3714.65	
	Spine fusion, anterior and posterior, including spinal instrumentation posterior and/or posterolateral bone graft, and anterior column fusion with a service to which item 51061, 51062, 51063, 51064 or 51066 approximately	, not being a service associated
51065	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) Fee: \$5,477.80 Benefit: 75% = \$4108.35	
	Spine fusion, anterior and posterior, including spinal instrumentation posterior and/or posterolateral bone graft, and anterior column fusion a service to which item 51061, 51062, 51063, 51064 or 51065 applies	not being a service associated with
51066	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) Fee: \$5,767.50 Benefit: 75% = \$4325.65	
	Removal of intradural lesion, not being a service associated with a seapplies (Anaes.) (Assist.)	rvice to which item 51072 or 51073
51071	(See para TN.8.141 of explanatory notes to this Category) Fee: \$2,500.00 Benefit: 75% = \$1875.00	
	Craniocervical junction lesion, transoral approach for, not being a ser which item 51071 or 51073 applies (Anaes.) (Assist.)	vice associated with a service to
51072	(See para TN.8.141 of explanatory notes to this Category) Fee: \$2,600.00 Benefit: 75% = \$1950.00	
	Removal of intramedullary tumour or arteriovenous malformation, no service to which item 51071 or 51072 applies (Anaes.) (Assist.)	ot being a service associated with a
51073	(See para TN.8.141 of explanatory notes to this Category) Fee: \$3,300.00 Benefit: 75% = \$2475.00	
	Thoracoplasty in combination with thoracic scoliosis correction—3 o	or more ribs (Anaes.) (Assist.)
51102	(See para TN.8.141 of explanatory notes to this Category) Fee: \$1,183.40 Benefit: 75% = \$887.55	
	Odontoid screw fixation (Anaes.) (Assist.)	
51103	(See para TN.8.141, TN.8.148 of explanatory notes to this Category) Fee: \$2,079.75 Benefit: 75% = \$1559.85	

T8. SUF	RGICAL OPERATIONS	17. SPINAL SURGERY
	Spine, treatment of fracture, dislocation or fracture dislocation, with immot including application of skull tongs or calipers as part of operative po	2 1
51110	(See para TN.8.141 of explanatory notes to this Category) Fee: \$753.25 Benefit: 75% = \$564.95 85% = \$669.85	
	Skull calipers or halo, insertion of, as an independent procedure (Anaes.)	
51111	(See para TN.8.141 of explanatory notes to this Category) Fee: \$320.15 Benefit: 75% = \$240.15	
	Plaster jacket, application of, as an independent procedure (Anaes.)	
51112	(See para TN.8.141 of explanatory notes to this Category) Fee: \$216.50 Benefit: 75% = \$162.40 85% = \$184.05	
	Halo, application of, in addition to spinal fusion for scoliosis, or other cor	nditions (Anaes.)
51113	(See para TN.8.141 of explanatory notes to this Category) Fee: \$240.05 Benefit: 75% = \$180.05	
	Halo thoracic orthosis—application of both halo and thoracic jacket (Ana	nes.)
51114	(See para TN.8.141 of explanatory notes to this Category) Fee: \$423.75 Benefit: 75% = \$317.85	
	Halo femoral traction, as an independent procedure (Anaes.)	
51115	(See para TN.8.141 of explanatory notes to this Category) Fee: \$423.75 Benefit: 75% = \$317.85 85% = \$360.20	
	Bone graft, harvesting of autogenous graft, via separate incision or via su conjunction with spinal fusion, other than for the purposes of bone graft of thoracic, lumbar or sacral spine (Anaes.)	
51120	(See para TN.8.141 of explanatory notes to this Category) Fee: \$235.50 Benefit: 75% = \$176.65	
	Lumbar artificial intervertebral total disc replacement, at one motion segridisc and marginal osteophytes:	ment only, including removal of
	(a) for a patient who:	
	(i) has not had prior spinal fusion surgery at the same lumbar level; and	
	(ii) does not have vertebral osteoporosis; and	
	(iii) has failed conservative therapy; and	
	(b) not being a service associated with a service to which item 51011, 510 applies (Anaes.) (Assist.)	012, 51013, 51014 or 51015
51130	(See para TN.8.141 of explanatory notes to this Category) Fee: \$1,793.65 Benefit: 75% = \$1345.25	
	Cervical artificial intervertebral total disc replacement, at one motion segrof disc and marginal osteophytes, for a patient who:	ment only, including removal
	(a) has not had prior spinal surgery at the same cervical level; and	
	(b) is skeletally mature; and	
51131		

T8. SUF	RGICAL OPERATIONS	17. SPINAL SURGERY
	(c) has symptomatic degenerative disc disease with radiculopathy; and	
	(d) does not have vertebral osteoporosis; and	
	(e) has failed conservative therapy (Anaes.) (Assist.)	
	(See para TN.8.141 of explanatory notes to this Category) Fee: \$1,082.70 Benefit: 75% = \$812.05	
	Previous spinal fusion, re-exploration for, involving adjustment or removement of the motion segments, not being a service associated with a service to which (Assist.)	
51140	(See para TN.8.141 of explanatory notes to this Category) Fee: \$442.45 Benefit: 75% = \$331.85	
	Previous spinal fusion, re-exploration for, involving adjustment or removal motion segments, not being a service associated with a service to whice (Assist.)	
51141	(See para TN.8.141 of explanatory notes to this Category) Fee: \$818.55 Benefit: 75% = \$613.95	
	Wound debridement or excision for post operative infection or haemator (Anaes.)	ma following spinal surgery
51145	(See para TN.8.141 of explanatory notes to this Category) Fee: \$442.45 Benefit: 75% = \$331.85	
	Coccyx, excision of (Anaes.) (Assist.)	
51150	(See para TN.8.141 of explanatory notes to this Category) Fee: \$445.40 Benefit: 75% = \$334.05	
	Anterior exposure of thoracic or lumbar spine, one motion segment, not 51165 applies (Anaes.) (Assist.)	being a service to which item
51160	(See para TN.8.141, TN.8.149 of explanatory notes to this Category) Fee: \$1,150.00 Benefit: 75% = \$862.50	
	Anterior exposure of thoracic or lumbar spine, more than one motion seg which item 51160 applies (Anaes.) (Assist.)	gment, not being a service to
51165	(See para TN.8.141, TN.8.149 of explanatory notes to this Category) Fee: \$1,450.00 Benefit: 75% = \$1087.50	
	Syringomyelia or hydromyelia, craniotomy for, with or without duraplas plugging of obex or local cerebrospinal fluid shunt (Anaes.) (Assist.)	sty, intradural dissection,
51170	(See para TN.8.141 of explanatory notes to this Category) Fee: \$2,184.60 Benefit: 75% = \$1638.45	
	Syringomyelia or hydromyelia, treatment by direct cerebrospinal fluid sł syringosubarachnoid shunt, syringopleural shunt or syringoperitoneal sh	
51171	(See para TN.8.141 of explanatory notes to this Category) Fee: \$917.40 Benefit: 75% = \$688.05	
T9. ASS	SISTANCE AT OPERATIONS	
	Group T9. Assistance At Operations	

T9. ASS	SISTANCE AT OPERATIONS
	Assistance at any operation identified by the word "Assist." for which the fee does not exceed \$558.30 or at a series or combination of operations identified by the word "Assist." where the fee for the series or combination of operations identified by the word "Assist." does not exceed \$558.30
51300	(See para TN.9.2, TN.9.1 of explanatory notes to this Category) Fee: \$86.30 Benefit: 75% = \$64.75 85% = \$73.40
	Assistance at any operation identified by the word "Assist." for which the fee exceeds \$558.30 or at a series of operations identified by the word "Assist." for which the aggregate fee exceeds \$558.30.
51303	(See para TN.9.1, TN.9.3 of explanatory notes to this Category) Derived Fee: one fifth of the established fee for the operation or combination of operations
	Assistance at a birth involving Caesarean section
51306	(See para TN.9.1 of explanatory notes to this Category) Fee: \$124.65 Benefit: 75% = \$93.50 85% = \$106.00
	Assistance at a series or combination of operations that include "(Assist.)" and assistance at a birth involving Caesarean section
51309	(See para TN.9.1, TN.9.4 of explanatory notes to this Category) Derived Fee: one fifth of the established fee for the operation or combination of operations (the fee for item 16520 being the Schedule fee for the Caesarean section component in the calculation of the established fee)
	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615 and 16627
51312	(See para TN.4.11, TN.9.1 of explanatory notes to this Category) Derived Fee: one fifth of the established fee for the procedure or combination of procedures
	Assistance at cataract and intraocular lens surgery covered by item 42698, 42701, 42702, 42704 or 42707, when performed in association with services covered by item 42551 to 42569, 42653, 42656, 42725, 42746, 42749, 42752, 42776 or 42779
51315	(See para TN.9.1 of explanatory notes to this Category) Fee: \$272.40 Benefit: 75% = \$204.30 85% = \$231.55
	Assistance at cataract and intraocular lens surgery where patient has:
	- total loss of vision, including no potential for central vision, in the fellow eye; or
	- previous significant surgical complication in the fellow eye; or
	- pseudo exfoliation, subluxed lens, iridodonesis, phacodonesis, retinal detachment, corneal scarring, pre-existing uveitis, bound down miosed pupil, nanophthalmos, spherophakia, Marfan's syndrome, homocysteinuria or previous blunt trauma causing intraocular damage
51318	(See para TN.9.5, TN.9.1 of explanatory notes to this Category) Fee: \$179.75 Benefit: 75% = \$134.85 85% = \$152.80

1. HEAD

Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service

1. HEAD

	Subgroup 1. Head	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skir tissue, muscles, salivary glands or superficial vessels of the head including biopsy, r which another item in this Subgroup applies (5 basic units)	
20100	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for plastic repair of cleft l	ip (6 basic units)
20102	Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for electroconvulsive ther	apy (4 basic units)
20104	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on externa ear, including biopsy, not being a service to which another item in this Subgroup app	
20120	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for otoscopy (4 basic unit	s)
20124	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on eye, no which another item in this Group applies (5 basic units)	t being a service to
20140	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for lens surgery (6 basic u	inits)
201.42	Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00	
20142	Extended Medicare Safety Net Cap: \$95.05 INITIATION OF MANAGEMENT OF ANAESTHESIA for retinal surgery (6 basis	o unita)
		c units)
20143	Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for corneal transplant (8 b	easic units)
20144	Fee: \$158.40 Benefit: 75% = \$118.80 85% = \$134.65	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for vitrectomy (8 basic un	its)
20145	Fee: \$158.40 Benefit: 75% = \$118.80 85% = \$134.65	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of conjunctiva	(5 basic units)
20146	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for squint repair (6 basic to	units)
20147	Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for ophthalmoscopy (4 ba	sic units)
20148	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35	
	l	

1. HEAD

	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nose or accessory sinuses, not being a service to which another item in this Subgroup applies (6 basic units)		
20160	Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical surgery on the nose and accessory sinuses (7 basic units)		
20162	Fee: \$138.60 Benefit: 75% = \$103.95 85% = \$117.85		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of soft tissue of the nose and accessory sinuses (4 basic units)		
20164	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for intraoral procedures, including biopsy, not being a service to which another item in this Subgroup applies (6 basic units)		
20170	Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of cleft palate (7 basic units)		
20172	Fee: \$138.60 Benefit: 75% = \$103.95 85% = \$117.85		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision of retropharyngeal tumour (9 basic units)		
20174	Fee: \$178.20 Benefit: 75% = \$133.65 85% = \$151.50		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical intraoral surgery (10 basic units)		
20176	Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on facial bones, not being a service to which another item in this Subgroup applies (5 basic units)		
20190	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction) (10 basic units)		
20192	Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial procedures, not being a service to which another item in this Subgroup applies (15 basic units)		
20210	Fee: \$297.00 Benefit: 75% = \$222.75 85% = \$252.45		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for subdural taps (5 basic units)		
20212	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for burr holes of the cranium (9 basic units)		
20214	Fee: \$178.20 Benefit: 75% = \$133.65 85% = \$151.50		
20216	INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial vascular procedures including those for aneurysms or arterio-venous abnormalities (20 basic units)		

1. HEAD

	Fee: \$396.00	Benefit: 75% = \$297.00 85% = \$336.60
	INITIATION OI units)	MANAGEMENT OF ANAESTHESIA for spinal fluid shunt procedures (10 basic
20220	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30
	INITIATION OI units)	MANAGEMENT OF ANAESTHESIA for ablation of an intracranial nerve (6 basic
20222	Fee: \$118.80	Benefit: 75% = \$89.10 85% = \$101.00
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for all cranial bone procedures (12 basic units)
20225	Fee: \$237.60	Benefit: 75% = \$178.20 85% = \$202.00
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the head or face (12 basic units)	
	(See para TN.10.2	of explanatory notes to this Category)
20230	Fee: \$237.60	Benefit: 75% = \$178.20 85% = \$202.00

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

2. NECK

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	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 2. Neck
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the neck not being a service to which another item in this Subgroup applies (5 basic units)
20300	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for incision and drainage of large haematoma, large abscess, cellulitis or similar lesion or epiglottitis causing life threatening airway obstruction (15 basic units)
20305	Fee: \$297.00 Benefit: 75% = \$222.75 85% = \$252.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on oesophagus, thyroid, larynx, trachea, lymphatic system, muscles, nerves or other deep tissues of the neck, not being a service to which another item in this Subgroup applies (6 basic units)
20320	Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00
	INITIATION OF MANAGEMENT OF ANAESTHESIA for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy (10 basic units)
20321	Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30
20330	INITIATION OF MANAGEMENT OF ANAESTHESIA for laser surgery to the airway (excluding nose

ANAES	ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN
	LE SERVICE 2. NECH
	and mouth) (8 basic units)
	Fee: \$158.40 Benefit: 75% = \$118.80 85% = \$134.65
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major vessels of neck, not being a service to which another item in this Subgroup applies (10 basic units)
20350	Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for simple ligation of major vessels of neck (5 basic units)
20352	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the neck (12 basic units)
20355	(See para TN.10.28 of explanatory notes to this Category) Fee: $$237.60$ Benefit: $75\% = 178.20 $85\% = 202.00
PERFO	PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 3. THORAX
PERFO	RMED IN ASSOCIATION WITH AN
PERFO	RMED IN ASSOCIATION WITH AN LE SERVICE Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For
PERFO	RMED IN ASSOCIATION WITH AN LE SERVICE 3. THORA Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
PERFO	RMED IN ASSOCIATION WITH AN LE SERVICE 3. THORAX Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service Subgroup 3. Thorax INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this Subgroup applies
PERFO	RMED IN ASSOCIATION WITH AN LE SERVICE Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service Subgroup 3. Thorax INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this Subgroup applies (3 basic units)
PERFO	RMED IN ASSOCIATION WITH AN LE SERVICE 3. THORAX Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service Subgroup 3. Thorax INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this Subgroup applies (3 basic units) Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50 INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the breast, not being a
PERFO ELIGIB	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service Subgroup 3. Thorax INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this Subgroup applies (3 basic units) Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50 INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the breast, not being a service to which another item in this Subgroup applies (4 basic units)
PERFO ELIGIB	RMED IN ASSOCIATION WITH AN LE SERVICE 3. THORAX Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service Subgroup 3. Thorax INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this Subgroup applies (3 basic units) Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50 INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the breast, not being a service to which another item in this Subgroup applies (4 basic units) Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35 INITIATION OF MANAGEMENT OF ANAESTHESIA for reconstructive procedures on breast (5)
20400 20401	RMED IN ASSOCIATION WITH AN LE SERVICE 3. THORAX Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service Subgroup 3. Thorax INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this Subgroup applies (3 basic units) Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50 INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the breast, not being a service to which another item in this Subgroup applies (4 basic units) Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35 INITIATION OF MANAGEMENT OF ANAESTHESIA for reconstructive procedures on breast (5 basic units)
20400 20401	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service Subgroup 3. Thorax INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this Subgroup applies (3 basic units) Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50 INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the breast, not being a service to which another item in this Subgroup applies (4 basic units) Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35 INITIATION OF MANAGEMENT OF ANAESTHESIA for reconstructive procedures on breast (5 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 INITIATION OF MANAGEMENT OF ANAESTHESIA for removal of breast lump or for breast
20400 20401 20402	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service Subgroup 3. Thorax INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this Subgroup applies (3 basic units) Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50 INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the breast, not being a service to which another item in this Subgroup applies (4 basic units) Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35 INITIATION OF MANAGEMENT OF ANAESTHESIA for reconstructive procedures on breast (5 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 INITIATION OF MANAGEMENT OF ANAESTHESIA for removal of breast lump or for breast segmentectomy where axillary node dissection is performed (5 basic units)
20400 20401 20402	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service Subgroup 3. Thorax INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this Subgroup applies (3 basic units) Fee: \$59.40 Benefit: 75% = \$44.55

3. THORAX

ELIGIB	LE SERVICE	3. IHURAX	
	using myocutane	eous flaps (8 basic units)	
	Fee: \$158.40	Benefit: 75% = \$118.80 85% = \$134.65	
		F MANAGEMENT OF ANAESTHESIA for radical or modified radical procedures on nal mammary node dissection (13 basic units)	
20406	Fee: \$257.40	Benefit: 75% = \$193.05 85% = \$218.80	
	INITIATION OI basic units)	F MANAGEMENT OF ANAESTHESIA for electrical conversion of arrhythmias (5	
20410	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15	
		F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous rerior part of the chest not being a service to which another item in this Subgroup applies	
20420	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15	
	INITIATION OI sternum (4 basic	F MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the units)	
20440	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35	
		F MANAGEMENT OF ANAESTHESIA for procedures on clavicle, scapula or sternum, ce to which another item in this Subgroup applies (5 basic units)	
20450	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical surgery on clavicle, scapula or sternum (6 basic units)		
20452	Fee: \$118.80	Benefit: 75% = \$89.10 85% = \$101.00	
		F MANAGEMENT OF ANAESTHESIA for partial rib resection, not being a service to em in this Subgroup applies (6 basic units)	
20470	Fee: \$118.80	Benefit: 75% = \$89.10 85% = \$101.00	
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for thoracoplasty (10 basic units)	
20472	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30	
	INITIATION OF units)	F MANAGEMENT OF ANAESTHESIA for radical procedures on chest wall (13 basic	
20474	(See para TN.10.2: Fee: \$257.40	2 of explanatory notes to this Category) Benefit: 75% = \$193.05 85% = \$218.80	
		F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery terior or posterior thorax (10 basic units)	
20475	(See para TN.10.2 Fee: \$198.00	8 of explanatory notes to this Category) Benefit: 75% = \$148.50 85% = \$168.30	

4. INTRATHORACIC

	LE SERVICE	4. INTRATHORACIC
		tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service
		Subgroup 4. Intrathoracic
	INITIATION OF basic units)	MANAGEMENT OF ANAESTHESIA for open procedures on the oesophagus (15
20500	Fee: \$297.00	Benefit: 75% = \$222.75 85% = \$252.45
		MANAGEMENT OF ANAESTHESIA for all closed chest procedures (including rigid or bronchoscopy), not being a service to which another item in this Subgroup applies (6
20520	Fee: \$118.80	Benefit: 75% = \$89.10 85% = \$101.00
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for needle biopsy of pleura (4 basic units)
20522	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for pneumocentesis (4 basic units)
20524	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for thoracoscopy (10 basic units)
20526	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for mediastinoscopy (8 basic units)
20528	Fee: \$158.40	Benefit: 75% = \$118.80 85% = \$134.65
		MANAGEMENT OF ANAESTHESIA for thoracotomy procedures involving lungs, n, or mediastinum, not being a service to which another item in this Subgroup applies
20540	Fee: \$257.40	Benefit: 75% = \$193.05 85% = \$218.80
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for pulmonary decortication (15 basic units)
20542	Fee: \$297.00	Benefit: 75% = \$222.75 85% = \$252.45
	INITIATION OF (15 basic units)	MANAGEMENT OF ANAESTHESIA for pulmonary resection with thoracoplasty
20546	Fee: \$297.00	Benefit: 75% = \$222.75 85% = \$252.45
	INITIATION OF and bronchi (15 b	MANAGEMENT OF ANAESTHESIA for intrathoracic repair of trauma to trachea pasic units)
20548	Fee: \$297.00	Benefit: 75% = \$222.75 85% = \$252.45
	Initiation of the r	nanagement of anaesthesia for:
	(a) open procedu	res on the heart, pericardium or great vessels of the chest; or
20560	(b) percutaneous	insertion of a valvular prosthesis (20 basic units)

4. INTRATHORACIC

Fee: \$396.00	Benefit: 75% = \$297.00	85% = \$336.60

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN FLIGIBLE SERVICE

5. SPINE AND SPINAL CORD

ELIGIB	LE SERVICE	5. SPINE AND SPINAL CORD
		ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For rformed In Association With An Eligible Service
		Subgroup 5. Spine And Spinal Cord
	not being a servi	F MANAGEMENT OF ANAESTHESIA for procedures on cervical spine and/or cord, ce to which another item in this Subgroup applies (for myelography and discography and 21914) (10 basic units)
20600	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30
		F MANAGEMENT OF ANAESTHESIA for posterior cervical laminectomy with the ing position (13 basic units)
20604	Fee: \$257.40	Benefit: 75% = \$193.05 85% = \$218.80
		F MANAGEMENT OF ANAESTHESIA for procedures on thoracic spine and/or cord, ce to which another item in this Subgroup applies (10 basic units)
20620	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30
	INITIATION Of units)	F MANAGEMENT OF ANAESTHESIA for thoracolumbar sympathectomy (13 basic
20622	Fee: \$257.40	Benefit: 75% = \$193.05 85% = \$218.80
		F MANAGEMENT OF ANAESTHESIA for procedures in lumbar region, not being a another item in this Subgroup applies (8 basic units)
20630	Fee: \$158.40	Benefit: 75% = \$118.80 85% = \$134.65
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for lumbar sympathectomy (7 basic units)
20632	Fee: \$138.60	Benefit: 75% = \$103.95 85% = \$117.85
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for chemonucleolysis (10 basic units)
20634	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30
	INITIATION OF procedures (13 b	F MANAGEMENT OF ANAESTHESIA for extensive spine and/or spinal cord asic units)
20670	(See para TN.10.2 Fee: \$257.40	3 of explanatory notes to this Category) Benefit: 75% = \$193.05 85% = \$218.80
	INITIATION OF MANAGEMENT OF ANAESTHESIA for manipulation of spine when performed in the operating theatre of a hospital (3 basic units)	
20680	Fee: \$59.40	Benefit: 75% = \$44.55 85% = \$50.50
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5. SPINE AND SPINAL CORD

INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous spinal procedures, not being a service to which another item in this Subgroup applies (5 basic units)

20690 **Fee:** \$99.00 **Benefit:** 75% = \$74.25 85% = \$84.15

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

6. UPPER ABDOMEN

Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service		
Subgroup 6. Upper Abdomen		
INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper anterior abdominal wall, not being a service to which another item in this Subgroup applies (3 basic units)		
Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50		
INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units)		
Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35		
INITIATION OF MANAGEMENT OF ANAESTHESIA for all procedures on the nerves, muscles, tendons and fascia of the upper abdominal wall, not being a service to which another item in this Subgroup applies (4 basic units)		
Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35		
INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior upper abdomen (10 basic units)		
(See para TN.10.28 of explanatory notes to this Category)		
Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30		
INITIATION OF MANAGEMENT OF ANAESTHESIA for diagnostic laparoscopy procedures (6 basiunits)		
Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00		
INITIATION OF MANAGEMENT OF ANAESTHESIA for laparoscopic procedures in the upper abdomen, not being a service to which another item in this Subgroup applies (7 basic units)		
Fee: \$138.60 Benefit: 75% = \$103.95 85% = \$117.85		
INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper posterior abdominal wall, not being a service to which another item in this Subgroup applies (5 basic units)		
Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15		
INITIATION OF MANAGEMENT OF ANAESTHESIA for upper gastrointestinal endoscopic		

6. UPPER ABDOMEN

ELIGIB	SIBLE SERVICE 6. UPPER ABDUMEN			
	procedures (5 basic units)			
	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for upper gastrointestinal endoscopic			
	procedures in association with acute gastrointestinal haemorrhage (6 basic units)			
20745	Fee: \$118.80	Benefit: 75% = \$89.10 85% = \$101.00		
		F MANAGEMENT OF ANAESTHESIA for hernia repairs in upper abdomen, not being		
	a service to which another item in this Subgroup applies (4 basic units)			
20750	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35		
		F MANAGEMENT OF ANAESTHESIA for repair of incisional hernia and/or wound		
	dehiscence (6 ba	asic units)		
20752	Fee: \$118.80	Benefit: 75% = \$89.10 85% = \$101.00		
		F MANAGEMENT OF ANAESTHESIA for procedures on an omphalocele (7 basic		
	units)			
20754	Fee: \$138.60	Benefit: 75% = \$103.95 85% = \$117.85		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for transabdominal repair of diaphragmatic			
	hernia (9 basic u	inits)		
20756	Fee: \$178.20	Benefit: 75% = \$133.65 85% = \$151.50		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major upper abd			
	blood vessels (1	5 basic units)		
20770	Fee: \$297.00	Benefit: 75% = \$222.75 85% = \$252.45		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures within the peritoneal cavity in			
	upper abdomen including cholecystectomy, gastrectomy, laparoscopic nephrectomy or bowel shunts (8 basic units)			
20790	Fee: \$158.40	Benefit: 75% = \$118.80 85% = \$134.65		
	Initiation of the management of anaesthesia for bariatric surgery in a patient with clinically severe obesity (10 basic units)			
20791	(See para TN.8.29 Fee: \$198.00	O of explanatory notes to this Category) Benefit: 75% = \$148.50 85% = \$168.30		
20771		F MANAGEMENT OF ANAESTHESIA for partial hepatectomy (excluding liver		
biopsy) (13 basic units)				
20792	Fee: \$257.40	Benefit: 75% = \$193.05 85% = \$218.80		
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for extended or trisegmental hepatectomy (15		
	basic units)			
20793	Fee: \$297.00	Benefit: 75% = \$222.75 85% = \$252.45		
20794	INITIATION O	F MANAGEMENT OF ANAESTHESIA for pancreatectomy, partial or total (12 basic		
20177	11.111111111111111111111111111111111111	The state of the s		

6. UPPER ABDOMEN

	units)	
	Fee: \$237.60	Benefit: 75% = \$178.20 85% = \$202.00
	INITIATION Of upper abdomen (F MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the (10 basic units)
20798	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30
		F MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra- in the upper abdomen (6 basic units)
20799	Fee: \$118.80	Benefit: 75% = \$89.10 85% = \$101.00

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

7. LOWER ABDOMEN

LLIOID	L SERVICE 7. LOWER ADDOMEN		
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service		
	Subgroup 7. Lower Abdomen		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the lower anterior abdominal walls, not being a service to which another item in this Subgroup applies (3 basic units)		
20800	Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for lipectomy of the lower abdomen (5 basic units)		
20802	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for all procedures on the nerves, muscles, tendons and fascia of the lower abdominal wall, not being a service to which another item in this Subgroup applies (4 basic units)		
20803	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior lower abdomen (10 basic units)		
	(See para TN.10.28 of explanatory notes to this Category)		
20804	Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for diagnostic laparoscopic procedures (6 basic units)		
20805	Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00		
20806	INITIATION OF MANAGEMENT OF ANAESTHESIA for laparoscopic procedures in the lower abdomen (7 basic units)		

7. LOWER ABDOMEN

	Fee: \$138.60	Benefit: 75% = \$103.95 85% = \$117.85
	INITIATION OF basic units)	MANAGEMENT OF ANAESTHESIA for lower intestinal endoscopic procedures (4
20810	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION OF urinary tract (6 ba	MANAGEMENT OF ANAESTHESIA for extracorporeal shock wave lithotripsy to asic units)
20815	Fee: \$118.80	Benefit: 75% = \$89.10 85% = \$101.00
		MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or the lower posterior abdominal wall (5 basic units)
20820	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
		MANAGEMENT OF ANAESTHESIA for hernia repairs in lower abdomen, not being another item in this Subgroup applies (4 basic units)
20830	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35
		MANAGEMENT OF ANAESTHESIA for repair of incisional herniae and/or wound lower abdomen (6 basic units)
20832	Fee: \$118.80	Benefit: 75% = \$89.10 85% = \$101.00
		MANAGEMENT OF ANAESTHESIA for all procedures within the peritoneal cavity in including appendicectomy, not being a service to which another item in this Subgroup inits)
20840	Fee: \$118.80	Benefit: 75% = \$89.10 85% = \$101.00
		MANAGEMENT OF ANAESTHESIA for bowel resection, including laparoscopic not being a service to which another item in this Subgroup applies (8 basic units)
20841	Fee: \$158.40	Benefit: 75% = \$118.80 85% = \$134.65
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for amniocentesis (4 basic units)
20842	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35
		MANAGEMENT OF ANAESTHESIA for abdominoperineal resection, including pull es, ultra low anterior resection and formation of bowel reservoir (10 basic units)
20844	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30
_	INITIATION OF	MANAGEMENT OF ANAESTHESIA for radical prostatectomy (10 basic units)
20845	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for radical hysterectomy (10 basic units)
20846	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for ovarian malignancy (10 basic units)
20847	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30

7. LOWER ABDOMEN

	INITIATION OF MANAGEMENT OF ANAESTHESIA for pelvic exenteration (10 basic units)
20848	Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean section (12 basic units)
20850	Fee: \$237.60 Benefit: 75% = \$178.20 85% = \$202.00
	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean hysterectomy or hysterectomy within 24 hours of birth (15 basic units)
20855	Fee: \$297.00 Benefit: 75% = \$222.75 85% = \$252.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA for extraperitoneal procedures in lower abdomen, including those on the urinary tract, not being a service to which another item in this Subgroup applies (6 basic units)
20860	Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00
	INITIATION OF MANAGEMENT OF ANAESTHESIA for renal procedures, including upper 1/3 of ureter (7 basic units)
20862	Fee: \$138.60 Benefit: 75% = \$103.95 85% = \$117.85
	INITIATION OF MANAGEMENT OF ANAESTHESIA for nephrectomy (10 basic units)
20863	Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for total cystectomy (10 basic units)
20864	Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for adrenalectomy (10 basic units)
20866	Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the lower abdomen (10 basic units)
20867	Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for renal transplantation (donor or recipient) (10 basic units)
20868	Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major lower abdominal vessels, not being a service to which another item in this subgroup applies (15 basic units)
20880	Fee: \$297.00 Benefit: 75% = \$222.75 85% = \$252.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA for inferior vena cava ligation (10 basic units)
20882	Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous umbrella insertion (5 basic units)
20884	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15

7. LOWER ABDOMEN

INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra-
abdominal organ in the lower abdomen (6 basic units)

20886 **Fee:** \$118.80 **Benefit:** 75% = \$89.10 85% = \$101.00

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

8. PERINEUM

		ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For erformed In Association With An Eligible Service	
	Subgroup 8. Perineum		
		F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous ineum not being a service to which another item in this Subgroup applies (3 basic units)	
20900	Fee: \$59.40	Benefit: 75% = \$44.55 85% = \$50.50	
	INITIATION Of and/or biopsy) (F MANAGEMENT OF ANAESTHESIA for anorectal procedures (including endoscopy 4 basic units)	
20902	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical perineal procedures including radical perineal prostatectomy or radical vulvectomy (7 basic units)		
20904	Fee: \$138.60	Benefit: 75% = \$103.95 85% = \$117.85	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the perineum (10 basic units)		
20905	(See para TN.10.2 Fee: \$198.00	28 of explanatory notes to this Category) Benefit: 75% = \$148.50 85% = \$168.30	
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for vulvectomy (4 basic units)	
20906	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral procedures (including urethrocystoscopy), not being a service to which another item in this Subgroup applies (4 basic units		
20910	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35	
INITIATION OF MANAGEMENT OF ANAESTHESIA for endoscopic ureteroscop including laser procedures (5 basic units)			
20911	(See para TN.10.2 Fee: \$99.00	29 of explanatory notes to this Category) Benefit: 75% = \$74.25 85% = \$84.15	
	INITIATION Of tumour(s) (5 bas	F MANAGEMENT OF ANAESTHESIA for transurethral resection of bladder sic units)	
20912	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15	

8. PERINEUM

	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral resection of prostate (7 basic units)
20914	Fee: \$138.60 Benefit: 75% = \$103.95 85% = \$117.85
	INITIATION OF MANAGEMENT OF ANAESTHESIA for bleeding post-transurethral resection (7 basic units)
20916	Fee: \$138.60 Benefit: 75% = \$103.95 85% = \$117.85
	Initiation of management of anaesthesia for procedures on external genitalia, not being a service to which another item in this Subgroup applies. (4 basic units)
20920	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on undescended testis, unilateral or bilateral (4 basic units)
20924	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, inguinal approach (4 basic units)
20926	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, abdominal approach (6 basic units)
20928	Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00
	INITIATION OF MANAGEMENT OF ANAESTHESIA for orchiopexy, unilateral or bilateral (4 basic units)
20930	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis (4 basic units)
20932	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis with bilateral inguinal lymphadenectomy (6 basic units)
20934	Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00
	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy (8 basic units)
20936	Fee: \$158.40 Benefit: 75% = \$118.80 85% = \$134.65
	INITIATION OF MANAGEMENT OF ANAESTHESIA for insertion of penile prosthesis (4 basic units)
20938	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35
20940	INITIATION OF MANAGEMENT OF ANAESTHESIA for per vagina and vaginal procedures (including biopsy of vagina, cervix or endometrium), not being a service to which another item in this

8. PERINEUM

LLIGID	GIBLE SERVICE 0. FERINGUIN		
	Subgroup applies (4 basic units)		
	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35	
		F MANAGEMENT OF ANAESTHESIA for vaginal procedures including repair rinary incontinence procedures (perineal) (5 basic units)	
20942	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15	
	INITIATION OF (4 basic units)	F MANAGEMENT OF ANAESTHESIA for transvaginal assisted reproductive services	
20943	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35	
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for vaginal hysterectomy (6 basic units)	
20944	Fee: \$118.80	Benefit: 75% = \$89.10 85% = \$101.00	
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for vaginal birth (8 basic units)	
20946	Fee: \$158.40	Benefit: 75% = \$118.80 85% = \$134.65	
		MANAGEMENT OF ANAESTHESIA for purse string ligation of cervix, or removal gature (4 basic units)	
20948	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35	
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for culdoscopy (5 basic units)	
20950	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15	
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for hysteroscopy (4 basic units)	
20952	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for endometrial ablation or resection in association with hysteroscopy (5 basic units)		
20953	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15	
	INITIATION OF units)	F MANAGEMENT OF ANAESTHESIA for correction of inverted uterus (10 basic	
20954	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for evacuation of retained products of conception, as a complication of confinement (4 basic units)		
20956	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35	
		F MANAGEMENT OF ANAESTHESIA for manual removal of retained placenta or for or perineal tear following birth (5 basic units)	
20958	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15	
		F MANAGEMENT OF ANAESTHESIA for vaginal procedures in the management of norrhage (blood loss > 500mls) (7 basic units)	
20960	Fee: \$138.60	Benefit: 75% = \$103.95 85% = \$117.85	
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9. PELVIS (EXCEPT HIP)

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 9. Pelvis (Except Hip)
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior pelvic region (anterior to iliac crest), except external genitalia (3 basic units)
21100	Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum (5 basic units)
21110	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units)
21112	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units)
21114	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow harvesting from the pelvis (6 basic units)
21116	Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the bony pelvis (6 basic units)
21120	Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00
	INITIATION OF MANAGEMENT OF ANAESTHESIA for body cast application or revision when performed in the operating theatre of a hospital (3 basic units)
21130	Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50
	INITIATION OF MANAGEMENT OF ANAESTHESIA for interpelviabdominal (hind-quarter) amputation (15 basic units)
21140	Fee: \$297.00 Benefit: 75% = \$222.75 85% = \$252.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures for tumour of the pelvis, except hind-quarter amputation (10 basic units)
21150	Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior pelvis (10 basic units)
21155	(See para TN.10.28 of explanatory notes to this Category) Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30
21160	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving symphysis

9. PELVIS (EXCEPT HIP)

	pubis or sacroiliac joint when performed in the operating theatre of a hospital (4 basic units)		
	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35		
		MANAGEMENT OF ANA c joint (8 basic units)	AESTHESIA for open procedures involving symphysis
21170	Fee: \$158.40 Benefit: 75% = \$118.80 85% = \$134.65		

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

10. UPPER LEG (EXCEPT KNEE)

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service		
	Subgroup 10. Upper Leg (Except Knee)		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper leg (3 basic units)		
21195	Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg (4 basic units)		
21199	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving hip joint whe performed in the operating theatre of a hospital (4 basic units)		
21200	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the hip joint (a basic units)		
21202	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving hip joint, not being a service to which another item in this Subgroup applies (6 basic units)		
21210	Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for hip disarticulation (10 basic units)		
21212	Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for total hip replacement or revision (10 basiunits)		
21214	Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for bilateral total hip replacement (14 basic units)		
21216			

10. UPPER LEG (EXCEPT KNEE)

	E \$277.20	Daniel 750/ #207.00 050/ #225.65
	Fee: \$277.20	Benefit: 75% = \$207.90 85% = \$235.65
		MANAGEMENT OF ANAESTHESIA for closed procedures involving upper 2/3 of
	femur when perfo	ormed in the operating theatre of a hospital (4 basic units)
21220	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35
		MANAGEMENT OF ANAESTHESIA for open procedures involving upper 2/3 of
	femur, not being	a service to which another item in this Subgroup applies (6 basic units)
21230	Fee: \$118.80	Benefit: 75% = \$89.10 85% = \$101.00
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for above knee amputation (5 basic units)
21232	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for radical resection of the upper 2/3 of femur
	(8 basic units)	
21234	Fee: \$158.40	Benefit: 75% = \$118.80 85% = \$134.65
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for procedures involving veins of upper leg,
		ation (4 basic units)
21260	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for procedures involving arteries of upper leg,
	including bypass	graft, not being a service to which another item in this Subgroup applies (8 basic units)
21270	Fee: \$158.40	Benefit: 75% = \$118.80 85% = \$134.65
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for femoral artery ligation (4 basic units)
21272	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for femoral artery embolectomy (6 basic units)
21274	Fee: \$118.80	of explanatory notes to this Category) Benefit: 75% = \$89.10 85% = \$101.00
2127.		MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery
		per leg (10 basic units)
	(Saa para TNI 10 20	of aunianatory nates to this Catagory)
21275	Fee: \$198.00	8 of explanatory notes to this Category) Benefit: 75% = \$148.50 85% = \$168.30
,0		MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper leg
	(15 basic units)	and the second s
21280	Fee: \$297.00	Benefit: 75% = \$222.75 85% = \$252.45
21200	1.66. \$297.00	Denem. 13/0 - \$222.13 83/0 - \$232.43

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

11. KNEE AND POPLITEAL AREA

Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For

11. KNEE AND POPLITEAL AREA

	Anaesthesia Performed In Association With An Eligible Service	
	Subgroup 11. Knee And Popliteal Area	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneou tissue of the knee and/or popliteal area (3 basic units)	ıs
21300	Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendon fascia or bursae of knee and/or popliteal area (4 basic units)	ıs,
21321	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on lower 1/3 of fem when performed in the operating theatre of a hospital (4 basic units)	ur
21340	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on lower 1/3 of femu basic units)	r (5
21360	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on knee joint when performed in the operating theatre of a hospital (3 basic units)	
21380	Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of knee joint (basic units)	(4
21382	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on upper ends of tib fibula, and/or patella when performed in the operating theatre of a hospital (3 basic units)	ia,
21390	Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on upper ends of tibia fibula, and/or patella (4 basic units)	ì,
21392	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on knee joint, not bei service to which another item in this Subgroup applies (4 basic units)	ng a
21400	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for knee replacement (7 basic units)	
21402	Fee: \$138.60 Benefit: 75% = \$103.95 85% = \$117.85	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for bilateral knee replacement (10 basic un	nits)
21403	Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30	
21404	INITIATION OF MANAGEMENT OF ANAESTHESIA for disarticulation of knee (5 basic units)	

11. KNEE AND POPLITEAL AREA

	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
		MANAGEMENT OF ANAESTHESIA for cast application, removal, or repair sint, undertaken in a hospital (3 basic units)
21420	Fee: \$59.40	Benefit: 75% = \$44.55 85% = \$50.50
		MANAGEMENT OF ANAESTHESIA for procedures on veins of knee or popliteal service to which another item in this Subgroup applies (4 basic units)
21430	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION Of popliteal area (5	MANAGEMENT OF ANAESTHESIA for repair of arteriovenous fistula of knee or basic units)
21432	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
		MANAGEMENT OF ANAESTHESIA for procedures on arteries of knee or poplited service to which another item in this Subgroup applies (8 basic units)
21440	Fee: \$158.40	Benefit: 75% = \$118.80 85% = \$134.65
		MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery ee and/or popliteal area (10 basic units)
	(See para TN.10.2	3 of explanatory notes to this Category)
21445	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

12. LOWER LEG (BELOW KNEE)

LLIGIB	12. LOWER ELG (BLEOW RIVE)
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 12. Lower Leg (Below Knee)
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of lower leg, ankle, or foot (3 basic units)
21460	Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, or fascia of lower leg, ankle, or foot, not being a service to which another item in this Subgroup applies (4 basic units)
21461	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on lower leg, ankle, or foot (3 basic units)
21462	Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50
21464	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedure of ankle joint (4

12. LOWER LEG (BELOW KNEE)

	LL SLIVICL	12. LOWER LLG (BLLOW RIVLE)
	basic units)	
	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for repair of Achilles tendon (5 basic units)
21472	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for gastrocnemius recession (5 basic units)
21474	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
		F MANAGEMENT OF ANAESTHESIA for open procedures on bones of lower leg, acluding amputation, not being a service to which another item in this Subgroup applies
21480	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION O leg, ankle or for	F MANAGEMENT OF ANAESTHESIA for radical resection of bone involving lower t (5 basic units)
21482	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION O (5 basic units)	F MANAGEMENT OF ANAESTHESIA for osteotomy or osteoplasty of tibia or fibula
21484	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for total ankle replacement (7 basic units)
21486	Fee: \$138.60	Benefit: 75% = \$103.95 85% = \$117.85
		F MANAGEMENT OF ANAESTHESIA for lower leg cast application, removal or en in a hospital (3 basic units)
21490	Fee: \$59.40	Benefit: 75% = \$44.55 85% = \$50.50
		F MANAGEMENT OF ANAESTHESIA for procedures on arteries of lower leg, s graft, not being a service to which another item in this Subgroup applies (8 basic units)
21500	Fee: \$158.40	Benefit: 75% = \$118.80 85% = \$134.65
	INITIATION O units)	F MANAGEMENT OF ANAESTHESIA for embolectomy of the lower leg (6 basic
21502	Fee: \$118.80	Benefit: 75% = \$89.10 85% = \$101.00
		F MANAGEMENT OF ANAESTHESIA for procedures on veins of lower leg, not o which another item in this Subgroup applies (4 basic units)
21520	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION O basic units)	F MANAGEMENT OF ANAESTHESIA for venous thrombectomy of the lower leg (5
21522	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
21530	INITIATION O	F MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of lower leg,

12. LOWER LEG (BELOW KNEE)

		·
	ankle or foot (15 b	asic units)
	Fee: \$297.00	Benefit: 75% = \$222.75 85% = \$252.45
	INITIATION OF basic units)	MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of toe (8
21532	Fee: \$158.40	Benefit: 75% = \$118.80 85% = \$134.65
		MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery r leg (10 basic units)
	(See para TN.10.28	of explanatory notes to this Category)
21535	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

13. SHOULDER AND AXILLA

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 13. Shoulder And Axilla
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the shoulder or axilla (3 basic units)
21600	Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla including axillary dissection (5 basic units)
21610	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, or shoulder joint when performed in the operating theatre of a hospital (4 basic units)
21620	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of shoulder joint (5 basic units)
21622	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint, not being a service to which another item in this Subgroup applies (5 basic units)
21630	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
21632	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection involving humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint (6 basic units)

13. SHOULDER AND AXILLA

	Fee: \$118.80	Benefit: 75% = \$89.10 85% = \$101.00
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for shoulder disarticulation (9 basic units)
21634	Fee: \$178.20	Benefit: 75% = \$133.65 85% = \$151.50
		MANAGEMENT OF ANAESTHESIA for interthoracoscapular (forequarter)
	amputation (15 b	asic units)
21636	Fee: \$297.00	Benefit: 75% = \$222.75 85% = \$252.45
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for total shoulder replacement (10 basic units)
21638	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30
		MANAGEMENT OF ANAESTHESIA for procedures on arteries of shoulder or
	axilla, not being a	a service to which another item in this Subgroup applies (8 basic units)
21650	Fee: \$158.40	Benefit: 75% = \$118.80 85% = \$134.65
		MANAGEMENT OF ANAESTHESIA for procedures for axillary-brachial aneurysm
	(10 basic units)	
21652	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30
	INITIATION OF axilla (8 basic un	MANAGEMENT OF ANAESTHESIA for bypass graft of arteries of shoulder or its)
21654	Fee: \$158.40	Benefit: 75% = \$118.80 85% = \$134.65
	INITIATION OF units)	MANAGEMENT OF ANAESTHESIA for axillary-femoral bypass graft (10 basic
21656	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30
	INITIATION OF (4 basic units)	MANAGEMENT OF ANAESTHESIA for procedures on veins of shoulder or axilla
21670	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35
		MANAGEMENT OF ANAESTHESIA for shoulder cast application, removal or a service to which another item in this Subgroup applies, when undertaken in a hospital
21680	Fee: \$59.40	Benefit: 75% = \$44.55 85% = \$50.50
		MANAGEMENT OF ANAESTHESIA for shoulder spica application when ospital (4 basic units)
21682	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35
		MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery sulder or the axilla (10 basic units)
21685	(See para TN.10.28 Fee: \$198.00	8 of explanatory notes to this Category) Benefit: 75% = \$148.50 85% = \$168.30

14. UPPER ARM AND ELBOW

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 14. Upper Arm And Elbow
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper arm or elbow (3 basic units)
21700	Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of upper arm or elbow, not being a service to which another item in this Subgroup applies (4 basic units)
21710	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open tenotomy of the upper arm or elbow (5 basic units)
21712	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for tenoplasty of the upper arm or elbow (5 basic units)
21714	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for tenodesis for rupture of long tendon of biceps (5 basic units)
21716	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on the upper arm or elbow when performed in the operating theatre of a hospital (3 basic units)
21730	Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50
	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of elbow joint (4 basic units)
21732	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the upper arm or elbow, not being a service to which another item in this Subgroup applies (5 basic units)
21740	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures on the upper arm or elbow (6 basic units)
21756	Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00
	INITIATION OF MANAGEMENT OF ANAESTHESIA for total elbow replacement (7 basic units)
21760	Fee: \$138.60 Benefit: 75% = \$103.95 85% = \$117.85
21770	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of upper arm, not

14. UPPER ARM AND ELBOW

	being a service to	which another item in this Subgroup applies (8 basic units)
	Fee: \$158.40	Benefit: 75% = \$118.80 85% = \$134.65
	INITIATION OF (6 basic units)	F MANAGEMENT OF ANAESTHESIA for embolectomy of arteries of the upper arm
21772	Fee: \$118.80	Benefit: 75% = \$89.10 85% = \$101.00
		F MANAGEMENT OF ANAESTHESIA for procedures on veins of upper arm, not o which another item in this Subgroup applies (4 basic units)
21780	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35
		F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery per arm or elbow (10 basic units)
	(See para TN.10.28	8 of explanatory notes to this Category)
21785	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30
	INITIATION OF (15 basic units)	F MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper arm
21790	Fee: \$297.00	Benefit: 75% = \$222.75 85% = \$252.45

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

15. FOREARM WRIST AND HAND

LLIGID	LL SLIVIOL	13.1 OKLAKWI WKISI AND HAND
		ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For erformed In Association With An Eligible Service
		Subgroup 15. Forearm Wrist And Hand
		F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous earm, wrist or hand (3 basic units)
21800	Fee: \$59.40	Benefit: 75% = \$44.55 85% = \$50.50
		F MANAGEMENT OF ANAESTHESIA for procedures on the nerves, muscles, or bursae of the forearm, wrist or hand (4 basic units)
21810	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35
		F MANAGEMENT OF ANAESTHESIA for closed procedures on the radius, ulna, ones when performed in the operating theatre of a hospital (3 basic units)
21820	Fee: \$59.40	Benefit: 75% = \$44.55 85% = \$50.50
		F MANAGEMENT OF ANAESTHESIA for open procedures on the radius, ulna, wrist, not being a service to which another item in this Subgroup applies (4 basic units)
21830	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35

15. FOREARM WRIST AND HAND

Benefit: 75% = \$103.95 85% = \$117.85 OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the wrist joint Benefit: 75% = \$59.40 85% = \$67.35 OF MANAGEMENT OF ANAESTHESIA for procedures on the arteries of forearm, wrist eing a service to which another item in this Subgroup applies (8 basic units) Benefit: 75% = \$118.80 85% = \$134.65 OF MANAGEMENT OF ANAESTHESIA for embolectomy of artery of forearm, wrist or units) Benefit: 75% = \$89.10 85% = \$101.00 OF MANAGEMENT OF ANAESTHESIA for procedures on the veins of forearm, wrist eing a service to which another item in this Subgroup applies (4 basic units) Benefit: 75% = \$59.40 85% = \$67.35 OF MANAGEMENT OF ANAESTHESIA for forearm, wrist, or hand cast application, pair when rendered to a patient as part of an episode of hospital treatment (3 basic units) Benefit: 75% = \$44.55 85% = \$50.50 OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery forearm, wrist or hand (10 basic units)
Benefit: 75% = \$59.40 85% = \$67.35 OF MANAGEMENT OF ANAESTHESIA for procedures on the arteries of forearm, wrist eing a service to which another item in this Subgroup applies (8 basic units) Benefit: 75% = \$118.80 85% = \$134.65 OF MANAGEMENT OF ANAESTHESIA for embolectomy of artery of forearm, wrist or units) Benefit: 75% = \$89.10 85% = \$101.00 OF MANAGEMENT OF ANAESTHESIA for procedures on the veins of forearm, wrist eing a service to which another item in this Subgroup applies (4 basic units) Benefit: 75% = \$59.40 85% = \$67.35 OF MANAGEMENT OF ANAESTHESIA for forearm, wrist, or hand cast application, pair when rendered to a patient as part of an episode of hospital treatment (3 basic units) Benefit: 75% = \$44.55 85% = \$50.50 OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery
OF MANAGEMENT OF ANAESTHESIA for procedures on the arteries of forearm, wrist eing a service to which another item in this Subgroup applies (8 basic units) Benefit: 75% = \$118.80 85% = \$134.65 OF MANAGEMENT OF ANAESTHESIA for embolectomy of artery of forearm, wrist or units) Benefit: 75% = \$89.10 85% = \$101.00 OF MANAGEMENT OF ANAESTHESIA for procedures on the veins of forearm, wrist eing a service to which another item in this Subgroup applies (4 basic units) Benefit: 75% = \$59.40 85% = \$67.35 OF MANAGEMENT OF ANAESTHESIA for forearm, wrist, or hand cast application, pair when rendered to a patient as part of an episode of hospital treatment (3 basic units) Benefit: 75% = \$44.55 85% = \$50.50 OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery
Benefit: 75% = \$118.80 85% = \$134.65 OF MANAGEMENT OF ANAESTHESIA for embolectomy of artery of forearm, wrist or units) Benefit: 75% = \$89.10 85% = \$101.00 OF MANAGEMENT OF ANAESTHESIA for procedures on the veins of forearm, wrist eing a service to which another item in this Subgroup applies (4 basic units) Benefit: 75% = \$59.40 85% = \$67.35 OF MANAGEMENT OF ANAESTHESIA for forearm, wrist, or hand cast application, pair when rendered to a patient as part of an episode of hospital treatment (3 basic units) Benefit: 75% = \$44.55 85% = \$50.50 OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery
OF MANAGEMENT OF ANAESTHESIA for embolectomy of artery of forearm, wrist or units) Benefit: 75% = \$89.10 85% = \$101.00 OF MANAGEMENT OF ANAESTHESIA for procedures on the veins of forearm, wrist eing a service to which another item in this Subgroup applies (4 basic units) Benefit: 75% = \$59.40 85% = \$67.35 OF MANAGEMENT OF ANAESTHESIA for forearm, wrist, or hand cast application, pair when rendered to a patient as part of an episode of hospital treatment (3 basic units) Benefit: 75% = \$44.55 85% = \$50.50 OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery
Benefit: 75% = \$89.10 85% = \$101.00 OF MANAGEMENT OF ANAESTHESIA for procedures on the veins of forearm, wrist eing a service to which another item in this Subgroup applies (4 basic units) Benefit: 75% = \$59.40 85% = \$67.35 OF MANAGEMENT OF ANAESTHESIA for forearm, wrist, or hand cast application, pair when rendered to a patient as part of an episode of hospital treatment (3 basic units) Benefit: 75% = \$44.55 85% = \$50.50 OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery
OF MANAGEMENT OF ANAESTHESIA for procedures on the veins of forearm, wrist eing a service to which another item in this Subgroup applies (4 basic units) **Benefit: 75% = \$59.40
Benefit: 75% = \$59.40 85% = \$67.35 OF MANAGEMENT OF ANAESTHESIA for forearm, wrist, or hand cast application, pair when rendered to a patient as part of an episode of hospital treatment (3 basic units) Benefit: 75% = \$44.55 85% = \$50.50 OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery
OF MANAGEMENT OF ANAESTHESIA for forearm, wrist, or hand cast application, pair when rendered to a patient as part of an episode of hospital treatment (3 basic units) Benefit: 75% = \$44.55 85% = \$50.50 OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery
pair when rendered to a patient as part of an episode of hospital treatment (3 basic units) Benefit: 75% = \$44.55 85% = \$50.50 OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery
OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery
0.28 of explanatory notes to this Category) Benefit: 75% = \$148.50 85% = \$168.30
OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of forearm, (15 basic units)
Benefit: 75% = \$222.75 85% = \$252.45
OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of a finger (8
Benefit: 75% = \$118.80 85% = \$134.65
(

16. ANAESTHESIA FOR BURNS

LLIGIB	LE SERVICE	16. ANAEST HESIA FOR BURNS	
	without skin graftin units)	g where the area of burn involves not more than 3% of total body surface (3 basic	
	Fee: \$59.40	Benefit: 75% = \$44.55 85% = \$50.50	
		MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or ug, where the area of burn involves more than 3% but less than 10% of total body ts)	
21879	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15	
		MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or ug, where the area of burn involves 10% or more but less than 20% of total body ts)	
21880	Fee: \$138.60	Benefit: 75% = \$103.95 85% = \$117.85	
		MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or ug, where the area of burn involves 20% or more but less than 30% of total body ts)	
21881	Fee: \$178.20	Benefit: 75% = \$133.65 85% = \$151.50	
		MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or ug, where the area of burn involves 30% or more but less than 40% of total body nits)	
21882	Fee: \$217.80	Benefit: 75% = \$163.35 85% = \$185.15	
		MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or ug, where the area of burn involves 40% or more but less than 50% of total body nits)	
21883	Fee: \$257.40	Benefit: 75% = \$193.05 85% = \$218.80	
		MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or ug, where the area of burn involves 50% or more but less than 60% of total body nits)	
21884	Fee: \$297.00	Benefit: 75% = \$222.75 85% = \$252.45	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 60% or more but less than 70% of total body surface (17 basic units)		
21885	Fee: \$336.60	Benefit: 75% = \$252.45 85% = \$286.15	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 70% or more but less than 80% of total body surface (19 basic units)		
21886	Fee: \$376.20	Benefit: 75% = \$282.15 85% = \$319.80	
21000			
21000		MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or eg, where the area of burn involves 80% or more of total body surface (21 basic units)	

17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 17. Anaesthesia For Radiological Or Other Diagnostic Or Therapeutic Procedures
	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for hysterosalpingography (3 basic units)
21900	Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50
	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: lumbar or thoracic (5 basic units)
21906	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: cervical (6 basic units)
21908	Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00
	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: posterior fossa (9 basic units)
21910	Fee: \$178.20 Benefit: 75% = \$133.65 85% = \$151.50
	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for discography: lumbar or thoracic (5 basic units)
21912	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for discography: cervical (6 basic units)
21914	Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00
	INITIATION OF MANAGEMENT OF ANAESTHESIA for peripheral arteriogram (5 basic units)
21915	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for arteriograms: cerebral, carotid or vertebral (5 basic units)
21916	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde arteriogram: brachial or femoral (5 basic units)
21918	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for computerised axial tomography scanning, magnetic resonance scanning, digital subtraction angiography scanning (7 basic units)
21922	Fee: \$138.60 Benefit: 75% = \$103.95 85% = \$117.85
21925	INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde cystography, retrograde urethrography or retrograde cystourethrography (4 basic units)

17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES

	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for fluoroscopy (5 basic units)
21926	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION O small bowel (5 l	F MANAGEMENT OF ANAESTHESIA for barium enema or other opaque study of the pasic units)
21927	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for bronchography (6 basic units)
21930	Fee: \$118.80	Benefit: 75% = \$89.10 85% = \$101.00
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for phlebography (5 basic units)
21935	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
		F MANAGEMENT OF ANAESTHESIA for heart, 2 dimensional real time all examination (6 basic units)
		26 of explanatory notes to this Category)
21936	Fee: \$118.80	Benefit: 75% = \$89.10 85% = \$101.00
	INITIATION O units)	F MANAGEMENT OF ANAESTHESIA for peripheral venous cannulation (3 basic
21939	Fee: \$59.40	Benefit: 75% = \$44.55 85% = \$50.50
		F MANAGEMENT OF ANAESTHESIA for cardiac catheterisation including coronary entriculography, cardiac mapping, insertion of automatic defibrillator or transvenous asic units)
21941	(See para TN.10.2 Fee: \$138.60	25 of explanatory notes to this Category) Benefit: 75% = \$103.95 85% = \$117.85
		F MANAGEMENT OF ANAESTHESIA for cardiac electrophysiological procedures frequency ablation (10 basic units)
21942	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30
		F MANAGEMENT OF ANAESTHESIA for central vein catheterisation or insertion of on catheter (via jugular, subclavian or femoral vein) by percutaneous or open exposure
21943	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
		F MANAGEMENT OF ANAESTHESIA for lumbar puncture, cisternal puncture, or on (5 basic units)
21945	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
		F MANAGEMENT OF ANAESTHESIA for harvesting of bone marrow for the purpose on (5 basic units)
21949	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
21952	INITIATION O	F MANAGEMENT OF ANAESTHESIA for muscle biopsy for malignant hyperpyrexia

17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES

ELIGIB	LE SERVICE	PROCEDURES
	(10 basic units)	
	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for electroencephalography (5 basic units)
21955	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION Of basic units)	F MANAGEMENT OF ANAESTHESIA for brain stem evoked response audiometry (5
21959	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
		F MANAGEMENT OF ANAESTHESIA for electrocochleography by extratympanic ympanic membrane insertion method (5 basic units)
21962	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
		F MANAGEMENT OF ANAESTHESIA as a therapeutic procedure if there is a clinical esia, not for headache of any etiology (5 basic units)
21965	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
		F MANAGEMENT OF ANAESTHESIA during hyperbaric therapy where the medical of confined in the chamber (including the administration of oxygen) (8 basic units)
21969	Fee: \$158.40	Benefit: 75% = \$118.80 85% = \$134.65
		F MANAGEMENT OF ANAESTHESIA during hyperbaric therapy where the medical onfined in the chamber (including the administration of oxygen) (15 basic units)
21970	Fee: \$297.00	Benefit: 75% = \$222.75 85% = \$252.45
	INITIATION Of sources (5 basic	F MANAGEMENT OF ANAESTHESIA for brachytherapy using radioactive sealed units)
21973	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION Of units)	F MANAGEMENT OF ANAESTHESIA for therapeutic nuclear medicine (5 basic
21976	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for radiotherapy (5 basic units)
21980	Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
ANAES ONLY F PERFO	PAYABLE FOR A	ARE BENEFITS ARE

Subgroup 18. Miscellaneous

Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service

18. MISCELLANEOUS

	INITIATION OF MANAGEMENT OF ANAESTHESIA when no procedure ensues (3 basic units)
21000	(See para TN.10.12 of explanatory notes to this Category)
21990	Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50
	INITIATION OF MANAGEMENT OF ANAESTHESIA performed on a person under the age of 10 years in connection with a procedure covered by an item which has not been identified as attracting an anaesthetic (4 basic units)
21992	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA in connection with a procedure covered by an item that does not include the word "(Anaes.)", other than a service to which item 21965 or 21992 applies, if there is a clinical need for anaesthesia (4 basic units)
	(See para TN.10.13 of explanatory notes to this Category)
21997	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN

19. THERAPEUTIC AND DIAGNOSTIC SERVICES

ELIGIB	LE SERVICE 19. THERAPEUTIC AND DIAGNOSTIC SERVICES
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 19. Therapeutic And Diagnostic Services
	COLLECTION OF BLOOD FOR AUTOLOGOUS TRANSFUSION or when homologous blood is required for immediate transfusion in an emergency situation, when performed in association with the administration of anaesthesia (3 basic units)
22001	(See para TN.10.8 of explanatory notes to this Category) Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50
22002	ADMINISTRATION OF BLOOD or bone marrow already collected when performed in association with the administration of anaesthesia (4 basic units) (See para TN.10.8 of explanatory notes to this Category) Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35
	ENDOTRACHEAL INTUBATION with flexible fibreoptic scope associated with difficult airway when performed in association with the administration of anaesthesia (4 basic units)
22007	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35
	DOUBLE LUMEN ENDOBRONCHIAL TUBE OR BRONCHIAL BLOCKER, insertion of when performed in association with the administration of anaesthesia (4 basic units)
22008	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35
22012	BLOOD PRESSURE MONITORING (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - once only for each type of pressure on any calendar day, up to a maximum of 4 pressures (not being a service to which item 13876 applies) when performed in

19. THERAPEUTIC AND DIAGNOSTIC SERVICES

LE SERVICE	19. THERAPEUTIC AND DIAGNOSTIC SERVICES
association with the administration of an	naesthesia (3 basic units)
(See para TN.10.8 of explanatory notes to th Fee: \$59.40 Benefit: 75% = \$44	
intracavity), by indwelling catheter - one maximum of 4 pressures (not being a ser	central venous, pulmonary arterial, systemic arterial or cardiac ce only for each type of pressure on any calendar day, up to a rvice to which item 13876 applies) when performed in naesthesia relating to another discrete operation on the same day
(See para TN.10.8 of explanatory notes to th Fee: \$59.40 Benefit: 75% = \$44	C .,
	ER, insertion of, including pulmonary wedge pressure and ormed in association with the administration of anaesthesia (6
(See para TN.10.8 of explanatory notes to th Fee: \$118.80 Benefit: 75% = \$89	is Category) 0.10 85% = \$101.00
RESPIRATORY SYSTEM, using meas concentrations in inspired or expired air analysis and a written record of the result	ICAL OR GAS EXCHANGE FUNCTION OF THE urements of parameters, including pressures, volumes, flow, gas, alveolar gas or blood and incorporating serial arterial blood gas lts, when performed in association with the administration of ed with a service to which item 11503 applies (7 basic units)
Fee: \$138.60 Benefit: 75% = \$10	3.95 85% = \$117.85
	N by percutaneous or open exposure, not being a service to ned in association with the administration of anaesthesia (4 basic
(See para TN.1.6, TN.10.8 of explanatory no Fee: \$79.20 Benefit: 75% = \$59	
anaesthesia (4 basic units)	when performed in association with the administration of
Fee: \$79.20 Benefit: 75% = \$59	
without insertion of a catheter, in associa	eTION (initial) of a therapeutic substance or substances, with or ation with anaesthesia and surgery, for postoperative pain ated with a service to which 22036 applies (5 basic units)
(See para TN.10.19 of explanatory notes to t Fee: \$99.00 Benefit: 75% = \$74	
	·····
INTRATHECAL or EPIDURAL INJECtusing an in-situ catheter, in association v	ection (subsequent) of a therapeutic substance or substances, with anaesthesia and surgery, for postoperative pain ated with a service to which 22031 applies (3 basic units)
	(See para TN.10.8 of explanatory notes to the Fee: \$59.40 BLOOD PRESSURE MONITORING (intracavity), by indwelling catheter - one maximum of 4 pressures (not being a see association with the administration of an (3 basic units) (See para TN.10.8 of explanatory notes to the Fee: \$59.40 RIGHT HEART BALLOON CATHETT cardiac output measurement, when perfebasic units) (See para TN.10.8 of explanatory notes to the Fee: \$118.80 Benefit: 75% = \$89 MEASUREMENT OF THE MECHAN RESPIRATORY SYSTEM, using meast concentrations in inspired or expired air analysis and a written record of the resu anaesthesia, not being a service associate Fee: \$138.60 Benefit: 75% = \$10 CENTRAL VEIN CATHETERISATIO which item 13318 applies, when performants) (See para TN.1.6, TN.10.8 of explanatory notes to the Fee: \$79.20 Benefit: 75% = \$59 INTRAARTERIAL CANNULATION of anaesthesia (4 basic units) (See para TN.10.8 of explanatory notes to the Fee: \$79.20 Benefit: 75% = \$59 INTRATHECAL or EPIDURAL INJECtive without insertion of a catheter, in associant management, not being a service associate service service service service service service service service service service service service s

19. THERAPEUTIC AND DIAGNOSTIC SERVICES

LLIGIDI	19. THERAPEUTIC AND DIAGNOSTIC SERVICES
	INTRODUCTION OF A REGIONAL OR FIELD NERVE BLOCK peri-operatively performed in the induction room theatre or recovery room for the control of post operative pain via the femoral OR sciatic nerves, in conjunction with hip, knee, ankle or foot surgery (2 basic units)
22040	(See para TN.10.17, TN.10.21 of explanatory notes to this Category) Fee: \$39.60 Benefit: 75% = \$29.70 85% = \$33.70
	INTRODUCTION OF A REGIONAL OR FIELD NERVE BLOCK peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the femoral AND sciatic nerves, in conjunction with hip, knee, ankle or foot surgery (3 basic units)
22045	(See para TN.10.17, TN.10.21 of explanatory notes to this Category) Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50
	INTRODUCTION OF A REGIONAL OR FIELD NERVE BLOCK peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the brachial plexus in conjunction with shoulder surgery (2 basic units)
22050	(See para TN.10.17, TN.10.21 of explanatory notes to this Category) Fee: \$39.60 Benefit: 75% = \$29.70 85% = \$33.70
	INTRA-OPERATIVE TRANSOESOPHAGEAL ECHOCARDIOGRAPHY - Monitoring in real time of the structure and function of the heart chambers, valves and surrounding structures, including assessment of blood flow, with appropriate permanent recording during procedures on the heart, pericardium or great vessels of the chest (not in association with items 55130, 55135 or 21936) (9 basic units)
22051	Fee: \$178.20 Benefit: 75% = \$133.65 85% = \$151.50
	PERFUSION OF LIMB OR ORGAN using heart-lung machine or equivalent, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (12 basic units)
22055	(See para TN.10.10 of explanatory notes to this Category) Fee: \$237.60 Benefit: 75% = \$178.20 85% = \$202.00
	WHOLE BODY PERFUSION, CARDIAC BYPASS, where the heart-lung machine or equivalent is continuously operated by a medical perfusionist, other than a service associated with anaesthesia to which an item in Subgroup 21 applies. (20 basic units) (20 basic units)
22060	(See para TN.10.10 of explanatory notes to this Category) Fee: \$396.00 Benefit: 75% = \$297.00 85% = \$336.60
	INDUCED CONTROLLED HYPOTHERMIA total body, being a service to which item 22060 applies, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (5 basic units)
22065	(See para TN.10.10 of explanatory notes to this Category) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
	CARDIOPLEGIA, blood or crystalloid, administration by any route, being a service to which item 22060 applies, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (10 basic units)
22070	(See para TN.10.10 of explanatory notes to this Category) Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30
22075	DEEP HYPOTHERMIC CIRCULATORY ARREST, with core temperature less than 22°c, including management of retrograde cerebral perfusion if performed, not being a service associated with
22075	

19. THERAPEUTIC AND DIAGNOSTIC SERVICES

anaesthesia to which an item in Subgroup 21 applies (15 basic units)

(See para TN.10.10 of explanatory notes to this Category)

Fee: \$297.00 **Benefit:** 75% = \$222.75 85% = \$252.45

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

20. ADMINISTRATION OF ANAESTHESIA IN CONNECTION WITH A DENTAL SERVICE

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service	
	Subgroup 20. Administration Of Anaesthesia In Connection With A Dental Service	
	INITIATION OF MANAGEMENT BY A MEDICAL PRACTITIONER OF ANAESTHESIA for extraction of tooth or teeth with or without incision of soft tissue or removal of bone (6 basic units)	
22900	(See para TN.10.14 of explanatory notes to this Category) Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for restorative dental work (6 basic units)	
	(See para TN.10.14 of explanatory notes to this Category)	
22905	Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00	

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

21. ANAESTHESIA/PERFUSION TIME UNITS

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 21. Anaesthesia/Perfusion Time Units
	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA
	(a) administration of anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or
	(b) perfusion performed in association with item 22060; or
	(c) for assistance at anaesthesia performed in association with items 25200 to 25205
	For a period of:
23010	

(FIFTEEN MINUTES OR LESS) (1 basic units) (Sce para TN.10.3 of explanatory notes to this Category) Fee: \$19.80 Benefit: 75% = \$14.85 85% = \$16.85 16 MINUTES TO 20 MINUTES (2 basic units) 23021 Fee: \$39.60 Benefit: 75% = \$29.70 85% = \$33.70 21 MINUTES TO 25 MINUTES (2 basic units) 23022 Fee: \$39.60 Benefit: 75% = \$29.70 85% = \$33.70 26 MINUTES TO 30 MINUTES (2 basic units) 23023 Fee: \$39.60 Benefit: 75% = \$29.70 85% = \$33.70 31 MINUTES TO 35 MINUTES (2 basic units) 23023 Fee: \$39.60 Benefit: 75% = \$29.70 85% = \$33.70 31 MINUTES TO 35 MINUTES (3 basic units) 23031 Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50 41 MINUTES TO 40 MINUTES (3 basic units) 23032 Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50 41 MINUTES TO 45 MINUTES (3 basic units) 23033 Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50 46 MINUTES TO 50 MINUTES (4 basic units) 23041 Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35 51 MINUTES TO 55 MINUTES (4 basic units) 23042 Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35 56 MINUTES TO 1:00 HOUR (4 basic units) 23043 Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35 1:01 HOURS TO 1:05 HOURS (5 basic units) 23051 Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 1:10 HOURS TO 1:15 HOURS (5 basic units) Benefit: 75% = \$74.25 85% = \$84.15 1:11 HOURS TO 1:15 HOURS (6 basic units) Benefit: 75% = \$74.25 85% = \$84.15 1:11 HOURS TO 1:20 HOURS (6 basic units) Benefit: 75% = \$74.25 85% = \$84.15 1:11 HOURS TO 1:21 HOURS (6 basic units) Benefit: 75% = \$74.25 85% = \$84.15 1:11 HOURS TO 1:25 HOURS (6 basic units) Benefit: 75% = \$84.25 85% = \$84.15 1:11 HOURS TO 1:21 HOURS (6 basic units) Benefit: 75% = \$89.10 Benefit: 75% = \$89.10 Benefit: 75% = \$89.10 Benefit: 75% = \$89.10 Benefit: 75% = \$89.10 Benefit: 75% = \$89.10 Benefit: 75% = \$89.10 Benefit: 75% = \$89.10 Benefit: 75% = \$89.10 Benefit: 75% = \$89.10 Benefit: 75% = \$89.10 Benefit: 75% = \$89.10 Benefit: 75% = \$89.10 Benefit: 75% = \$89.10 Benefit: 75% = \$89.10 Benefit: 75% = \$84.55 1:1		
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31 MINUTES TO 35 MINUTES (3 basic units) Fee: \$59.40		26 MINUTES TO 30 MINUTES (2 basic units)
23031	23023	Fee: \$39.60 Benefit: 75% = \$29.70 85% = \$33.70
36 MINUTES TO 40 MINUTES (3 basic units) 23032		31 MINUTES TO 35 MINUTES (3 basic units)
23032	23031	Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50
41 MINUTES TO 45 MINUTES (3 basic units) 23033		36 MINUTES TO 40 MINUTES (3 basic units)
23033	23032	Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50
46 MINUTES TO 50 MINUTES (4 basic units) Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35 51 MINUTES TO 55 MINUTES (4 basic units) 23042 Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35 56 MINUTES TO 1:00 HOUR (4 basic units) 23043 Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35 1:01 HOURS TO 1:05 HOURS (5 basic units) 23051 Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 1:06 HOURS TO 1:10 HOURS (5 basic units) 23052 Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 1:11 HOURS TO 1:15 HOURS (5 basic units) 23053 Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 1:16 HOURS TO 1:20 HOURS (6 basic units) 23061 Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00		41 MINUTES TO 45 MINUTES (3 basic units)
Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35	23033	Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50
51 MINUTES TO 55 MINUTES (4 basic units) Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35 56 MINUTES TO 1:00 HOUR (4 basic units) Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35 1:01 HOURS TO 1:05 HOURS (5 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 1:06 HOURS TO 1:10 HOURS (5 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 1:11 HOURS TO 1:15 HOURS (5 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 1:16 HOURS TO 1:20 HOURS (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 1:16 HOURS TO 1:20 HOURS (6 basic units) Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00		46 MINUTES TO 50 MINUTES (4 basic units)
Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35 56 MINUTES TO 1:00 HOUR (4 basic units) 23043 Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35 1:01 HOURS TO 1:05 HOURS (5 basic units) 23051 Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 1:06 HOURS TO 1:10 HOURS (5 basic units) 23052 Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 1:11 HOURS TO 1:15 HOURS (5 basic units) 23053 Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 1:16 HOURS TO 1:20 HOURS (6 basic units) 23061 Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00	23041	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35
56 MINUTES TO 1:00 HOUR (4 basic units) Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35 1:01 HOURS TO 1:05 HOURS (5 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 1:06 HOURS TO 1:10 HOURS (5 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 1:11 HOURS TO 1:15 HOURS (5 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 1:16 HOURS TO 1:20 HOURS (6 basic units) Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00		51 MINUTES TO 55 MINUTES (4 basic units)
23043	23042	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35
1:01 HOURS TO 1:05 HOURS (5 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 1:06 HOURS TO 1:10 HOURS (5 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 1:11 HOURS TO 1:15 HOURS (5 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 1:16 HOURS TO 1:20 HOURS (6 basic units) Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00		56 MINUTES TO 1:00 HOUR (4 basic units)
23051	23043	Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35
1:06 HOURS TO 1:10 HOURS (5 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 1:11 HOURS TO 1:15 HOURS (5 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15 1:16 HOURS TO 1:20 HOURS (6 basic units) Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00		1:01 HOURS TO 1:05 HOURS (5 basic units)
23052	23051	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
1:11 HOURS TO 1:15 HOURS (5 basic units) 23053		1:06 HOURS TO 1:10 HOURS (5 basic units)
23053	23052	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
1:16 HOURS TO 1:20 HOURS (6 basic units) 23061 Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00		1:11 HOURS TO 1:15 HOURS (5 basic units)
23061 Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00	23053	Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
		1:16 HOURS TO 1:20 HOURS (6 basic units)
1.21 HOURS TO 1.25 HOURS (6 basic units)	23061	Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00
1.21 HOOKS 10 1.23 HOOKS (0 basic units)		1:21 HOURS TO 1:25 HOURS (6 basic units)
23062 Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00	23062	Fee: \$118.80 Benefit: 75% = \$89.10 85% = \$101.00

ELIGID	LE SERVICE	21. ANAESTHESIA/PERFUSION TIME UNITS
	1:26 HOURS T	O 1:30 HOURS (6 basic units)
23063	Fee: \$118.80	Benefit: 75% = \$89.10 85% = \$101.00
	1:31 HOURS T	O 1:35 HOURS (7 basic units)
23071	Fee: \$138.60	Benefit: 75% = \$103.95 85% = \$117.85
	1:36 HOURS T	O 1:40 HOURS (7 basic units)
23072	Fee: \$138.60	Benefit: 75% = \$103.95 85% = \$117.85
	1:41 HOURS T	O 1:45 HOURS (7 basic units)
23073	Fee: \$138.60	Benefit: 75% = \$103.95 85% = \$117.85
	1:46 HOURS T	O 1:50 HOURS (8 basic units)
23081	Fee: \$158.40	Benefit: 75% = \$118.80 85% = \$134.65
	1:51 HOURS T	O 1:55 HOURS (8 basic units)
23082	Fee: \$158.40	Benefit: 75% = \$118.80 85% = \$134.65
	1:56 HOURS T	O 2:00 HOURS (8 basic units)
23083	Fee: \$158.40	Benefit: 75% = \$118.80 85% = \$134.65
	2:01 HOURS T	O 2:10 HOURS (9 basic units)
23091	Fee: \$178.20	Benefit: 75% = \$133.65 85% = \$151.50
	2:11 HOURS T	O 2:20 HOURS (10 basic units)
23101	Fee: \$198.00	Benefit: 75% = \$148.50 85% = \$168.30
	2:21 HOURS T	O 2:30 HOURS (11 basic units)
23111	Fee: \$217.80	Benefit: 75% = \$163.35 85% = \$185.15
	2:31 HOURS T	O 2:40 HOURS (12 basic units)
23112	Fee: \$237.60	Benefit: 75% = \$178.20 85% = \$202.00
	2:41 HOURS T	O 2:50 HOURS (13 basic units)
23113	Fee: \$257.40	Benefit: 75% = \$193.05 85% = \$218.80
	2:51 HOURS T	O 3:00 HOURS (14 basic units)
23114	Fee: \$277.20	Benefit: 75% = \$207.90 85% = \$235.65
	3:01 HOURS T	O 3:10 HOURS (15 basic units)
23115	Fee: \$297.00	Benefit: 75% = \$222.75 85% = \$252.45
	3:11 HOURS T	O 3:20 HOURS (16 basic units)
23116	Fee: \$316.80	Benefit: 75% = \$237.60 85% = \$269.30
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ELIGID	LE SERVICE		21. ANAESTRESIA/PERFUSION TIME UNITS
	3:21 HOURS T	O 3:30 HOURS (17 basic units)	
23117	Fee: \$336.60	Benefit: 75% = \$252.45 85%	% = \$286.15
	3:31 HOURS T	O 3:40 HOURS (18 basic units)	
23118	Fee: \$356.40	Benefit: 75% = \$267.30 85%	% = \$302.95
	3:41 HOURS T	O 3:50 HOURS (19 basic units)	
23119	Fee: \$376.20	Benefit: 75% = \$282.15 85%	% = \$319.80
	3:51 HOURS T	O 4:00 HOURS (20 basic units)	
23121	Fee: \$396.00	Benefit: 75% = \$297.00 85%	% = \$336.60
	4:01 HOURS T	O 4:10 HOURS (21 basic units)	
23170	Fee: \$415.80	Benefit: 75% = \$311.85 85%	% = \$353.45
	4:11 HOURS T	O 4:20 HOURS (22 basic units)	
23180	Fee: \$435.60	Benefit: 75% = \$326.70 85%	% = \$370.30
	4:21 HOURS T	O 4:30 HOURS (23 basic units)	
23190	Fee: \$455.40	Benefit: 75% = \$341.55 85%	% = \$387.10
	4:31 HOURS T	O 4:40 HOURS (24 basic units)	
23200	Fee: \$475.20	Benefit: 75% = \$356.40 85%	% = \$403.95
	4:41 HOURS T	O 4:50 HOURS (25 basic units)	
23210	Fee: \$495.00	Benefit: 75% = \$371.25 85%	% = \$420.75
	4:51 HOURS T	O 5:00 HOURS (26 basic units)	
23220	Fee: \$514.80	Benefit: 75% = \$386.10 85%	√₀ = \$437.60
	5:01 HOURS T	O 5:10 HOURS (27 basic units)	
23230	Fee: \$534.60	Benefit: 75% = \$400.95 85%	% = \$454.45
	5:11 HOURS T	O 5:20 HOURS (28 basic units)	
23240	Fee: \$554.40	Benefit: 75% = \$415.80 85%	% = \$471.25
	5:21 HOURS T	O 5:30 HOURS (29 basic units)	
23250	Fee: \$574.20	Benefit: 75% = \$430.65 85%	√ ₆ = \$490.80
	5:31 HOURS T	O 5:40 HOURS (30 basic units)	
23260	Fee: \$594.00	Benefit: 75% = \$445.50 85%	% = \$510.60
	5:41 HOURS T	O 5:50 HOURS (31 basic units)	
23270	Fee: \$613.80	Benefit: 75% = \$460.35 85%	% = \$530.40
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	(5:51 HOURS T	O 6:00 HOURS (32 basic units)	
23280	Fee: \$633.60	Benefit: 75% = \$475.20 856	% = \$550.20
	6:01 HOURS TO	6:10 HOURS (33 basic units)	
23290	Fee: \$653.40	Benefit: 75% = \$490.05 856	% = \$570.00
	6:11 HOURS TO	6:20 HOURS (34 basic units)	
23300	Fee: \$673.20	Benefit: 75% = \$504.90 859	% = \$589.80
	6:21 HOURS TO	6:30 HOURS (35 basic units)	
23310	Fee: \$693.00	Benefit: 75% = \$519.75 859	% = \$609.60
	6:31 HOURS TO	6:40 HOURS (36 basic units)	
23320	Fee: \$712.80	Benefit: 75% = \$534.60 859	% = \$629.40
	6:41 HOURS TO	6:50 HOURS (37 basic units)	
23330	Fee: \$732.60	Benefit: 75% = \$549.45 859	% = \$649.20
	6:51 HOURS TO	7:00 HOURS (38 basic units)	
23340	Fee: \$752.40	Benefit: 75% = \$564.30 859	% = \$669.00
	7:01 HOURS TO	7:10 HOURS (39 basic units)	
23350	Fee: \$772.20	Benefit: 75% = \$579.15 859	% = \$688.80
	7:11 HOURS TO	7:20 HOURS (40 basic units)	
23360	Fee: \$792.00	Benefit: 75% = \$594.00 859	% = \$708.60
	7:21 HOURS TO	7:30 HOURS (41 basic units)	
23370	Fee: \$811.80	Benefit: 75% = \$608.85 85	% = \$728.40
	7:31 HOURS TO	7:40 HOURS (42 basic units)	
23380	Fee: \$831.60	Benefit: 75% = \$623.70 859	% = \$748.20
	7:41 HOURS TO	7:50 HOURS (43 basic units)	
23390	Fee: \$851.40	Benefit: 75% = \$638.55 859	% = \$768.00
	7:51 HOURS TO	0 8:00 HOURS (44 basic units)	
23400	Fee: \$871.20	Benefit: 75% = \$653.40 859	% = \$787.80
	8:01 HOURS TO	9 8:10 HOURS (45 basic units)	
23410	Fee: \$891.00	Benefit: 75% = \$668.25 856	% = \$807.60
	8:11 HOURS TO	0 8:20 HOURS (46 basic units)	
23420	Fee: \$910.80	Benefit: 75% = \$683.10 859	% = \$827.40

LLIGID	LL SLIVICL		21. ANALSTITESIA/FERT USION TIME UNITS
	8:21 HOURS TO	8:30 HOURS (47 basic uni	its)
23430	Fee: \$930.60	Benefit: 75% = \$697.95	85% = \$847.20
	8:31 HOURS TO	8:40 HOURS (48 basic uni	its)
23440	Fee: \$950.40	Benefit: 75% = \$712.80	85% = \$867.00
	8:41 HOURS TO	8:50 HOURS (49 basic uni	its)
23450	Fee: \$970.20	Benefit: 75% = \$727.65	85% = \$886.80
	8:51 HOURS TO	9:00 HOURS (50 basic uni	its)
23460	Fee: \$990.00	Benefit: 75% = \$742.50	85% = \$906.60
	9:01 HOURS TO	9:10 HOURS (51 basic uni	its)
23470	Fee: \$1,009.80	Benefit: 75% = \$757.35	85% = \$926.40
	9:11 HOURS TO	9:20 HOURS (52 basic uni	its)
23480	Fee: \$1,029.60	Benefit: 75% = \$772.20	85% = \$946.20
	9:21 HOURS TO	9:30 HOURS (53 basic uni	its)
23490	Fee: \$1,049.40	Benefit: 75% = \$787.05	85% = \$966.00
	9:31 HOURS TO	9:40 HOURS (54 basic uni	its)
23500	Fee: \$1,069.20	Benefit: 75% = \$801.90	85% = \$985.80
	9:41 HOURS TO	9:50 HOURS (55 basic uni	its)
23510	Fee: \$1,089.00	Benefit: 75% = \$816.75	85% = \$1005.60
	9:51 HOURS TO	10:00 HOURS (56 basic ur	nits)
23520	Fee: \$1,108.80	Benefit: 75% = \$831.60	85% = \$1025.40
	10:01 HOURS T	O 10:10 HOURS (57 basic t	units)
23530	Fee: \$1,128.60	Benefit: 75% = \$846.45	· · · · · · · · · · · · · · · · · · ·
	10:11 HOURS T	O 10:20 HOURS (58 basic u	units)
23540	Fee: \$1,148.40	Benefit: 75% = \$861.30	85% = \$1065.00
	10:21 HOURS T	O 10:30 HOURS (59 basic u	units)
23550	Fee: \$1,168.20	Benefit: 75% = \$876.15	85% = \$1084.80
	10:31 HOURS T	O 10:40 HOURS (60 basic u	units)
23560	Fee: \$1,188.00	Benefit: 75% = \$891.00	85% = \$1104.60
	10:41 HOURS T	O 10:50 HOURS (61 basic t	units)
23570	Fee: \$1,207.80	Benefit: 75% = \$905.85	85% = \$1124.40

LL OLIVIOL		21. ANALSTITESIA/FERI USION TIME UNITS
10:51 HOURS TO	O 11:00 HOURS (62 basic un	its)
Fee: \$1,227.60	Benefit: 75% = \$920.70 8	35% = \$1144.20
11:01 HOURS TO	O 11:10 HOURS (63 basic un	its)
Fee: \$1,247.40	Benefit: 75% = \$935.55 8	35% = \$1164.00
11:11 HOURS TO	O 11:20 HOURS (64 basic un	its)
Fee: \$1,267.20	Benefit: 75% = \$950.40 8	35% = \$1183.80
11:21 HOURS TO	O 11:30 HOURS (65 basic un	its)
Fee: \$1,287.00	Benefit: 75% = \$965.25	35% = \$1203.60
11:31 HOURS TO	O 11:40 HOURS (66 basic un	its)
Fee: \$1,306.80	Benefit: 75% = \$980.10 8	35% = \$1223.40
11:41 HOURS TO	O 11:50 HOURS (67 basic un	its)
Fee: \$1,326.60	Benefit: 75% = \$994.95 8	35% = \$1243.20
11:51 HOURS TO	O 12:00 HOURS (68 basic un	its)
Fee: \$1,346.40	Benefit: 75% = \$1009.80	85% = \$1263.00
12:01 HOURS TO	O 12:10 HOURS (69 basic un	its)
Fee: \$1,366.20	Benefit: 75% = \$1024.65	85% = \$1282.80
12:11 HOURS TO	O 12:20 HOURS (70 basic un	its)
Fee: \$1,386.00	Benefit: 75% = \$1039.50	85% = \$1302.60
12:21 HOURS TO	O 12:30 HOURS (71 basic un	its)
Fee: \$1,405.80	Benefit: 75% = \$1054.35	85% = \$1322.40
12:31 HOURS TO	O 12:40 HOURS (72 basic un	its)
Fee: \$1,425.60	Benefit: 75% = \$1069.20	85% = \$1342.20
12:41 HOURS TO	O 12:50 HOURS (73 basic un	its)
Fee: \$1,445.40	Benefit: 75% = \$1084.05	85% = \$1362.00
12:51 HOURS TO	O 13:00 HOURS (74 basic un	its)
Fee: \$1,465.20	Benefit: 75% = \$1098.90	85% = \$1381.80
13:01 HOURS TO	O 13:10 HOURS (75 basic un	its)
Fee: \$1,485.00	Benefit: 75% = \$1113.75	85% = \$1401.60
13:11 HOURS TO	O 13:20 HOURS (76 basic un	its)
Fee: \$1,504.80	Benefit: 75% = \$1128.60	85% = \$1421.40
	Fee: \$1,227.60 11:01 HOURS TO Fee: \$1,247.40 11:11 HOURS TO Fee: \$1,267.20 11:21 HOURS TO Fee: \$1,287.00 11:31 HOURS TO Fee: \$1,306.80 11:41 HOURS TO Fee: \$1,326.60 11:51 HOURS TO Fee: \$1,346.40 12:01 HOURS TO Fee: \$1,346.20 12:11 HOURS TO Fee: \$1,386.00 12:21 HOURS TO Fee: \$1,405.80 12:31 HOURS TO Fee: \$1,425.60 12:41 HOURS TO Fee: \$1,445.40 12:51 HOURS TO Fee: \$1,445.40 12:51 HOURS TO Fee: \$1,445.40 12:51 HOURS TO Fee: \$1,445.40 12:51 HOURS TO Fee: \$1,445.40 12:51 HOURS TO Fee: \$1,445.40 12:51 HOURS TO Fee: \$1,445.40 12:51 HOURS TO Fee: \$1,465.20 13:11 HOURS TO Fee: \$1,485.00 13:11 HOURS TO	10:51 HOURS TO 11:00 HOURS (62 basic un Fee: \$1,227.60

LL SLIVICL		21. ANALSTITESIA/FERT USION TIME UNITS
13:21 HOURS TO 1	3:30 HOURS (77 basic ur	nits)
Fee: \$1,524.60	Benefit: 75% = \$1143.45	85% = \$1441.20
13:31 HOURS TO 1	3:40 HOURS (78 basic ur	nits)
Fee: \$1,544.40	Benefit: 75% = \$1158.30	85% = \$1461.00
13:41 HOURS TO 1	3:50 HOURS (79 basic ur	nits)
Fee: \$1,564.20	Benefit: 75% = \$1173.15	85% = \$1480.80
13:51 HOURS TO 1	4:00 HOURS (80 basic ur	nits)
Fee: \$1,584.00	Benefit: 75% = \$1188.00	85% = \$1500.60
14:01 HOURS TO 1	4:10 HOURS (81 basic ur	nits)
Fee: \$1,603.80	Benefit: 75% = \$1202.85	85% = \$1520.40
14:11 HOURS TO 1	4:20 HOURS (82 basic ur	nits)
Fee: \$1,623.60	Benefit: 75% = \$1217.70	85% = \$1540.20
14:21 HOURS TO 1	4:30 HOURS (83 basic ur	nits)
Fee: \$1,643.40	Benefit: 75% = \$1232.55	85% = \$1560.00
14:31 HOURS TO 1	4:40 HOURS (84 basic ur	nits)
Fee: \$1,663.20	Benefit: 75% = \$1247.40	85% = \$1579.80
14:41 HOURS TO 1	4:50 HOURS (85 basic ur	nits)
Fee: \$1,683.00	Benefit: 75% = \$1262.25	85% = \$1599.60
14:51 HOURS TO 1	5:00 HOURS (86 basic un	nits)
Fee: \$1,702.80	Benefit: 75% = \$1277.10	85% = \$1619.40
15:01 HOURS TO 1	5:10 HOURS (87 basic un	nits)
Fee: \$1,722.60	Benefit: 75% = \$1291.95	85% = \$1639.20
15:11 HOURS TO 1	5:20 HOURS (88 basic un	nits)
Fee: \$1,742.40	Benefit: 75% = \$1306.80	85% = \$1659.00
15:21 HOURS TO 1	5:30 HOURS (89 basic un	nits)
Fee: \$1,762.20	Benefit: 75% = \$1321.65	85% = \$1678.80
15:31 HOURS TO 1	5:40 HOURS (90 basic ur	nits)
Fee: \$1,782.00	Benefit: 75% = \$1336.50	85% = \$1698.60
15:41 HOURS TO 1	5:50 HOURS (91 basic un	nits)
Fee: \$1,801.80	Benefit: 75% = \$1351.35	85% = \$1718.40
	13:21 HOURS TO 1: Fee: \$1,524.60 13:31 HOURS TO 1: Fee: \$1,544.40 13:41 HOURS TO 1: Fee: \$1,564.20 13:51 HOURS TO 1: Fee: \$1,584.00 14:01 HOURS TO 1: Fee: \$1,603.80 14:11 HOURS TO 1: Fee: \$1,623.60 14:21 HOURS TO 1: Fee: \$1,643.40 14:31 HOURS TO 1: Fee: \$1,663.20 14:41 HOURS TO 1: Fee: \$1,663.20 14:51 HOURS TO 1: Fee: \$1,702.80 15:01 HOURS TO 1: Fee: \$1,702.80 15:21 HOURS TO 1: Fee: \$1,702.80 15:21 HOURS TO 1: Fee: \$1,762.20 15:31 HOURS TO 1: Fee: \$1,762.20 15:41 HOURS TO 1: Fee: \$1,762.20	13:21 HOURS TO 13:30 HOURS (77 basic unifere: \$1,524.60 Benefit: 75% = \$1143.45 13:31 HOURS TO 13:40 HOURS (78 basic unifere: \$1,544.40 Benefit: 75% = \$1158.30 13:41 HOURS TO 13:50 HOURS (79 basic unifere: \$1,564.20 Benefit: 75% = \$1173.15 13:51 HOURS TO 14:00 HOURS (80 basic unifere: \$1,584.00 Benefit: 75% = \$1188.00 14:01 HOURS TO 14:10 HOURS (81 basic unifere: \$1,603.80 Benefit: 75% = \$1202.85 14:11 HOURS TO 14:20 HOURS (82 basic unifere: \$1,623.60 Benefit: 75% = \$1217.70 14:21 HOURS TO 14:30 HOURS (83 basic unifere: \$1,643.40 Benefit: 75% = \$1232.55 14:31 HOURS TO 14:40 HOURS (84 basic unifere: \$1,663.20 Benefit: 75% = \$1247.40 14:41 HOURS TO 14:50 HOURS (85 basic unifere: \$1,683.00 Benefit: 75% = \$1247.40 15:01 HOURS TO 15:00 HOURS (86 basic unifere: \$1,702.80 Benefit: 75% = \$1277.10 15:01 HOURS TO 15:10 HOURS (87 basic unifere: \$1,722.60 Benefit: 75% = \$1291.95 15:11 HOURS TO 15:20 HOURS (88 basic unifere: \$1,742.40 Benefit: 75% = \$1306.80 15:21 HOURS TO 15:30 HOURS (89 basic unifere: \$1,762.20 Benefit: 75% = \$131.65 15:31 HOURS TO 15:40 HOURS (90 basic unifere: \$1,762.20 Benefit: 75% = \$1336.50 15:41 HOURS TO 15:50 HOURS (91 basic unifere: \$1,742.40 Benefit: 75% = \$1336.50 15:41 HOURS TO 15:50 HOURS (91 basic unifere: \$1,762.20 Benefit: 75% = \$1336.50 15:41 HOURS TO 15:50 HOURS (91 basic unifere: \$1,762.20 Benefit: 75% = \$1336.50 15:41 HOURS TO 15:50 HOURS (91 basic unifere: \$1,762.20 Benefit: 75% = \$1336.50 15:41 HOURS TO 15:50 HOURS (91 basic unifere: \$1,762.20 Benefit: 75% = \$1336.50 15:41 HOURS TO 15:50 HOURS (91 basic unifere: \$1,762.20 Benefit: 75% = \$1336.50 15:41 HOURS TO 15:50 HOURS (91 basic unifere: \$1,762.20 Benefit: 75% = \$1336.50 15:41 HOURS TO 15:50 HOURS (91 basic unifere: \$1,762.20 Benefit: 75% = \$1336.50 15:41 HOURS TO 15:50 HOURS (91 basic unifere: \$1,762.20 Benefit: 75% = \$1336.50 15:41 HOURS TO 15:50 HOURS (91 basic unifere: \$1,762.20 Benefit:

LL SLIVICE		21. ANALSTILSIA/FLKI USION TIME UNITS
15:51 HOURS TO) 16:00 HOURS (92 basic ur	nits)
Fee: \$1,821.60	Benefit: 75% = \$1366.20	85% = \$1738.20
16:01 HOURS TO) 16:10 HOURS (93 basic ur	nits)
Fee: \$1,841.40	Benefit: 75% = \$1381.05	85% = \$1758.00
16:11 HOURS TO) 16:20 HOURS (94 basic ur	nits)
Fee: \$1,861.20	Benefit: 75% = \$1395.90	85% = \$1777.80
16:21 HOURS TO) 16:30 HOURS (95 basic ur	nits)
Fee: \$1,881.00	Benefit: 75% = \$1410.75	85% = \$1797.60
16:31 HOURS TO) 16:40 HOURS (96 basic ur	nits)
Fee: \$1,900.80	Benefit: 75% = \$1425.60	85% = \$1817.40
16:41 HOURS TO) 16:50 HOURS (97 basic ur	nits)
Fee: \$1,920.60	Benefit: 75% = \$1440.45	85% = \$1837.20
16:51 HOURS TO	17:00 HOURS (98 basic ur	nits)
Fee: \$1,940.40	Benefit: 75% = \$1455.30	85% = \$1857.00
17:01 HOURS TO	17:10 HOURS (99 basic ur	nits)
Fee: \$1,960.20	Benefit: 75% = \$1470.15	85% = \$1876.80
17:11 HOURS TO	17:20 HOURS (100 basic u	units)
Fee: \$1,980.00	Benefit: 75% = \$1485.00	85% = \$1896.60
17:21 HOURS TO) 17:30 HOURS (101 basic t	units)
Fee: \$1,999.80	Benefit: 75% = \$1499.85	85% = \$1916.40
17:31 HOURS TO) 17:40 HOURS (102 basic ι	units)
Fee: \$2,019.60	Benefit: 75% = \$1514.70	85% = \$1936.20
17:41 HOURS TO) 17:50 HOURS (103 basic t	units)
Fee: \$2,039.40	Benefit: 75% = \$1529.55	85% = \$1956.00
17:51 HOURS TO	18:00 HOURS (104 basic u	units)
Fee: \$2,059.20	Benefit: 75% = \$1544.40	85% = \$1975.80
18:01 HOURS TO) 18:10 HOURS (105 basic 1	units)
Fee: \$2,079.00	Benefit: 75% = \$1559.25	85% = \$1995.60
18:11 HOURS TO) 18:20 HOURS (106 basic u	units)
Fee: \$2,098.80	Benefit: 75% = \$1574.10	85% = \$2015.40
	15:51 HOURS TO Fee: \$1,821.60 16:01 HOURS TO Fee: \$1,841.40 16:11 HOURS TO Fee: \$1,861.20 16:21 HOURS TO Fee: \$1,881.00 16:31 HOURS TO Fee: \$1,900.80 16:41 HOURS TO Fee: \$1,920.60 16:51 HOURS TO Fee: \$1,940.40 17:01 HOURS TO Fee: \$1,940.40 17:01 HOURS TO Fee: \$1,960.20 17:11 HOURS TO Fee: \$1,980.00 17:21 HOURS TO Fee: \$1,980.00 17:21 HOURS TO Fee: \$2,019.60 17:41 HOURS TO Fee: \$2,019.60 17:51 HOURS TO Fee: \$2,039.40 17:51 HOURS TO Fee: \$2,039.40 17:51 HOURS TO Fee: \$2,059.20 18:01 HOURS TO Fee: \$2,079.00 18:11 HOURS TO	15:51 HOURS TO 16:00 HOURS (92 basic to Fee: \$1,821.60 Benefit: 75% = \$1366.20 16:01 HOURS TO 16:10 HOURS (93 basic to Fee: \$1,841.40 Benefit: 75% = \$1381.05 16:11 HOURS TO 16:20 HOURS (94 basic to Fee: \$1,861.20 Benefit: 75% = \$1395.90 16:21 HOURS TO 16:30 HOURS (95 basic to Fee: \$1,881.00 Benefit: 75% = \$1410.75 16:31 HOURS TO 16:40 HOURS (96 basic to Fee: \$1,900.80 Benefit: 75% = \$1425.60 16:41 HOURS TO 16:50 HOURS (97 basic to Fee: \$1,920.60 Benefit: 75% = \$1440.45 16:51 HOURS TO 17:00 HOURS (98 basic to Fee: \$1,940.40 Benefit: 75% = \$1455.30 17:01 HOURS TO 17:10 HOURS (99 basic to Fee: \$1,960.20 Benefit: 75% = \$1470.15 17:11 HOURS TO 17:20 HOURS (100 basic to Fee: \$1,980.00 Benefit: 75% = \$1485.00 17:21 HOURS TO 17:30 HOURS (101 basic to Fee: \$1,999.80 Benefit: 75% = \$1499.85 17:31 HOURS TO 17:50 HOURS (103 basic to Fee: \$2,019.60 Benefit: 75% = \$1514.70 17:41 HOURS TO 17:50 HOURS (103 basic to Fee: \$2,039.40 Benefit: 75% = \$1592.55 17:51 HOURS TO 18:00 HOURS (105 basic to Fee: \$2,059.20 Benefit: 75% = \$1559.25 18:01 HOURS TO 18:20 HOURS (106 basic to Fee: \$2,079.00 Benefit: 75% = \$1559.25 18:11 HOURS TO 18:20 HOURS (106 basic to Fee: \$2,079.00 Benefit: 75% = \$1559.25 18:11 HOURS TO 18:20 HOURS (106 basic to Fee: \$2,079.00 Benefit: 75% = \$1559.25 18:11 HOURS TO 18:20 HOURS (106 basic to Fee: \$2,079.00 Benefit: 75% = \$1559.25 18:11 HOURS TO 18:20 HOURS (106 basic to Fee: \$2,079.00 Benefit: 75% = \$1559.25 18:11 HOURS TO 18:20 HOURS (106 basic to Fee: \$2,079.00 Benefit: 75% = \$1559.25 18:11 HOURS TO 18:20 HOURS (106 basic to Fee: \$2,079.00 Benefit: 75% = \$1559.25 18:11 HOURS TO 18:20 HOURS (106 basic to Fee: \$2,079.00 Benefit: 75% = \$1559.25 18:11 HOURS TO 18:20 HOURS (106 basic to Fee: \$2,079.00 Benefit: 75% = \$1559.25 18:11 HOURS TO 18:20 HOURS (106 basic to Fee: \$2,079.00 Benefit: 75% = \$1559.25 18:11 HOURS TO 18:20 HOURS (106 basic to Fee: \$2,079.00 Benefit: 75% = \$

LLIGID	LL SLIVICL		21. ANALSTITESIA/FERT USION TIME UNITS
	18:21 HOURS T	O 18:30 HOURS (107 basic t	units)
24103	Fee: \$2,118.60	Benefit: 75% = \$1588.95	85% = \$2035.20
	18:31 HOURS T	O 18:40 HOURS (108 basic t	units)
24104	Fee: \$2,138.40	Benefit: 75% = \$1603.80	85% = \$2055.00
	18:41 HOURS T	O 18:50 HOURS (109 basic t	units)
24105	Fee: \$2,158.20	Benefit: 75% = \$1618.65	85% = \$2074.80
	18:51 HOURS T	O 19:00 HOURS (110 basic t	units)
24106	Fee: \$2,178.00	Benefit: 75% = \$1633.50	85% = \$2094.60
	19:01 HOURS T	O 19:10 HOURS (111 basic t	units)
24107	Fee: \$2,197.80	Benefit: 75% = \$1648.35	85% = \$2114.40
	19:11 HOURS T	O 19:20 HOURS (112 basic t	units)
24108	Fee: \$2,217.60	Benefit: 75% = \$1663.20	85% = \$2134.20
	19:21 HOURS T	O 19:30 HOURS (113 basic t	units)
24109	Fee: \$2,237.40	Benefit: 75% = \$1678.05	85% = \$2154.00
	19:31 HOURS T	O 19:40 HOURS (114 basic)	units)
24110	Fee: \$2,257.20	Benefit: 75% = \$1692.90	85% = \$2173.80
	19:41 HOURS T	O 19:50 HOURS (115 basic t	units)
24111	Fee: \$2,277.00	Benefit: 75% = \$1707.75	85% = \$2193.60
	19:51 HOURS T	O 20:00 HOURS (116 basic 1	units)
24112	Fee: \$2,296.80	Benefit: 75% = \$1722.60	85% = \$2213.40
	20:01 HOURS T	O 20:10 HOURS (117 basic)	units)
24113	Fee: \$2,316.60	Benefit: 75% = \$1737.45	
	20:11 HOURS T	O 20:20 HOURS (118 basic 1	units)
24114	Fee: \$2,336.40	Benefit: 75% = \$1752.30	85% = \$2253.00
	20:21 HOURS T	O 20:30 HOURS (119 basic 1	units)
24115	Fee: \$2,356.20	Benefit: 75% = \$1767.15	85% = \$2272.80
	20:31 HOURS T	O 20:40 HOURS (120 basic t	units)
24116	Fee: \$2,376.00	Benefit: 75% = \$1782.00	
	20:41 HOURS T	O 20:50 HOURS (121 basic t	units)
24117	Fee: \$2,395.80	Benefit: 75% = \$1796.85	85% = \$2312.40

LLIGID	LL SLIVICL		21. ANALSTITESIA/FERT USION TIME UNITS
	20:51 HOURS T	O 21:00 HOURS (122 basic t	units)
24118	Fee: \$2,415.60	Benefit: 75% = \$1811.70	85% = \$2332.20
	21:01 HOURS T	O 21:10 HOURS (123 basic u	units)
24119	Fee: \$2,435.40	Benefit: 75% = \$1826.55	85% = \$2352.00
	21:11 HOURS T	O 21:20 HOURS (124 basic u	units)
24120	Fee: \$2,455.20	Benefit: 75% = \$1841.40	85% = \$2371.80
	21:21 HOURS T	O 21:30 HOURS (125 basic u	units)
24121	Fee: \$2,475.00	Benefit: 75% = \$1856.25	85% = \$2391.60
	21:31 HOURS T	O 21:40 HOURS (126 basic u	units)
24122	Fee: \$2,494.80	Benefit: 75% = \$1871.10	85% = \$2411.40
	21:41 HOURS T	O 21:50 HOURS (127 basic u	units)
24123	Fee: \$2,514.60	Benefit: 75% = \$1885.95	85% = \$2431.20
	21:51 HOURS T	O 22:00 HOURS (128 basic u	units)
24124	Fee: \$2,534.40	Benefit: 75% = \$1900.80	85% = \$2451.00
	22:01 HOURS T	O 22:10 HOURS (129 basic u	units)
24125	Fee: \$2,554.20	Benefit: 75% = \$1915.65	85% = \$2470.80
	22:11 HOURS T	O 22:20 HOURS (130 basic u	units)
24126	Fee: \$2,574.00	Benefit: 75% = \$1930.50	85% = \$2490.60
	22:21 HOURS T	O 22:30 HOURS (131 basic t	units)
24127	Fee: \$2,593.80	Benefit: 75% = \$1945.35	85% = \$2510.40
	22:31 HOURS T	O 22:40 HOURS (132 basic u	units)
24128	Fee: \$2,613.60	Benefit: 75% = \$1960.20	85% = \$2530.20
	22:41 HOURS T	O 22:50 HOURS (133 basic u	units)
24129	Fee: \$2,633.40	Benefit: 75% = \$1975.05	85% = \$2550.00
	22:51 HOURS T	O 23:00 HOURS (134 basic u	units)
24130	Fee: \$2,653.20	Benefit: 75% = \$1989.90	85% = \$2569.80
	23:01 HOURS T	O 23:10 HOURS (135 basic u	units)
24131	Fee: \$2,673.00	Benefit: 75% = \$2004.75	85% = \$2589.60
	23:11 HOURS T	O 23:20 HOURS (136 basic u	units)
24132	Fee: \$2,692.80	Benefit: 75% = \$2019.60	85% = \$2609.40

21. ANAESTHESIA/PERFUSION TIME UNITS

	23:21 HOURS TO 23:30 HOURS (137 basic units)		
24133	Fee: \$2,712.60	Benefit: 75% = \$2034.45	85% = \$2629.20
	23:31 HOURS TO	O 23:40 HOURS (138 basic u	units)
24134	Fee: \$2,732.40	Benefit: 75% = \$2049.30	85% = \$2649.00
	23:41 HOURS TO	O 23:50 HOURS (139 basic v	units)
24135	Fee: \$2,752.20	Benefit: 75% = \$2064.15	85% = \$2668.80
	23:51 HOURS TO 24:00 HOURS (140 basic units)		
24136	Fee: \$2,772.00	Benefit: 75% = \$2079.00	85% = \$2688.60

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

22. ANAESTHESIA/PERFUSION MODIFYING UNITS - PHYSICAL STATUS

LLIGIB	LE SERVICE UNITS - PHISICAL STATUS
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 22. Anaesthesia/Perfusion Modifying Units - Physical Status
	ANAESTHESIA, PERFUSION or ASSISTANCE AT ANAESTHESIA
	(a) for anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or
	(b) for perfusion performed in association with item 22060; or
	(c) for assistance at anaesthesia performed in association with items 25200 to 25205
	Where the patient has severe systemic disease equivalent to ASA physical status indicator 3 (1 basic units)
25000	(See para TN.10.3 of explanatory notes to this Category) Fee: \$19.80 Benefit: 75% = \$14.85 85% = \$16.85
	Where the patient has severe systemic disease which is a constant threat to life equivalent to ASA physical status indicator 4 (2 basic units)
25005	(See para TN.10.3 of explanatory notes to this Category) Fee: \$39.60 Benefit: 75% = \$29.70 85% = \$33.70
	For a patient who is not expected to survive for 24 hours with or without the operation, equivalent to ASA physical status indicator 5 (3 basic units)
25010	(See para TN.10.3 of explanatory notes to this Category) Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50

PERFO	PAYABLE FOR ANAESTHESIA DRMED IN ASSOCIATION WITH AN 23. ANAESTHESIA/PERFUSION MODIFYIN BLE SERVICE UNITS - OTHE			
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service			
	Subgroup 23. Anaesthesia/Perfusion Modifying Units - Other			
	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA			
	- where the patient is less than 12 months of age or 70 years or greater (1 basic units)			
25015	Fee: \$19.80 Benefit: 75% = \$14.85 85% = \$16.85			
	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA			
	- where the patient requires immediate treatment without which there would be significant threat to life or body part - not being a service associated with a service to which item 25025 or 25030 or 25050 applies (2 basic units)			
25020	(See para TN.10.3 of explanatory notes to this Category) Fee: \$39.60 Benefit: 75% = \$29.70 85% = \$33.70			
ANAES ONLY F PERFO	ELATIVE VALUE GUIDE FOR STHESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA DRMED IN ASSOCIATION WITH AN 24. ANAESTHESIA AFTER HOURS EMERGENC BLE SERVICE MODIFIE			
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service			
	Subgroup 24. Anaesthesia After Hours Emergency Modifier			
	EMERGENCY ANAESTHESIA performed in the after hours period where the patient requires immediate treatment without which there would be significant threat to life or body part and where mor than 50% of the time for the emergency anaesthesia service is provided in the after hours period, being			

EMERGENCY ANAESTHESIA performed in the after hours period where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the time for the emergency anaesthesia service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25030 or 25050 applies (0 basic units)

(See para TN.10.3 of explanatory notes to this Category)

25025

Derived Fee: An additional amount of 50% of the fee for the anaesthetic service. That is: (a) an anaesthesia item/s in the range 20100 - 21997 or 22900, plus (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000-25015, plus (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001-22051

ASSISTANCE AT AFTER HOURS EMERGENCY ANAESTHESIA where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the time for which the assistant is in professional attendance on the patient is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25025 or 25050 applies (0 basic units)

(See para TN.10.3 of explanatory notes to this Category)

25030 **Derived Fee:** An additional amount of 50% of the fee for assistance at anaesthesia. That is:

24. ANAESTHESIA AFTER HOURS EMERGENCY MODIFIER

- (a) an assistant anaesthesia item in the range 25200 25205, plus
- (b) an item in the range 23010 24136, plus
- (c) where applicable, an item in the range 25000-25015, plus
- (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001-22051

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

25. PERFUSION AFTER HOURS EMERGENCY MODIFIER

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 25. Perfusion After Hours Emergency Modifier
	AFTER HOURS EMERGENCY PERFUSION where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the perfusion service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25025 or 25030 applies (0 basic units)
	(See para TN.10.3 of explanatory notes to this Category) Derived Fee: An additional amount of 50% of the fee for the perfusion service. That is: (a) item 22060, plus (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000 - 25015, plus
25050	(d) where performed, any associated therapeutic or diagnostic service/s in the range 22001-22051 or 22065-22075

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

26. ASSISTANCE AT ANAESTHESIA

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 26. Assistance At Anaesthesia
	ASSISTANCE IN THE ADMINISTRATION OF ANAESTHESIA on a patient in imminent danger of death requiring continuous life saving emergency treatment, to the exclusion of all other patients (5 basic units)
	(See para TN.10.9 of explanatory notes to this Category)
25200	Derived Fee: An amount of \$99.0 (5 basic units) plus an item in the range 23010 - 24136 plus, where applicable - an item in the range 25000 - 25020 plus, where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22051
	ASSISTANCE IN THE ADMINISTRATION OF ELECTIVE ANAESTHESIA where:
25205	(i) the patient has complex airway problems; or

26. ASSISTANCE AT ANAESTHESIA

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

and the assistance is provided to the exclusion of all other patients (5 basic units)

(See para TN.10.9 of explanatory notes to this Category)

Derived Fee: An amount of \$99.0 (5 basic units) plus an item in the range 23010 - 24136 plus, where applicable -

	an item in the range 25000 - 25020 plus, where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22051			
T11. BOTULINUM TOXIN INJECTIONS				
	Group T11. Botulinum Toxin Injections			
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of hemifacial spasm in a patient who is at least 12 years of age, including all such injections on any one day			
18350	(See para TN.11.1 of explanatory notes to this Category) Fee: \$124.85 Benefit: 75% = \$93.65 85% = \$106.15			
	Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport), injection of, for the treatment of hemifacial spasm in a patient who is at least 18 years of age, including all such injections on any one day			
18351	(See para TN.11.1 of explanatory notes to this Category) Fee: \$124.85 Benefit: 75% = \$93.65 85% = \$106.15			
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of cervical dystonia (spasmodic torticollis), including all such injections on any one day			
18353	(See para TN.11.1 of explanatory notes to this Category) Fee: \$249.75 Benefit: 75% = \$187.35 85% = \$212.30			
	Botulinum Toxin Type A Purified Neurotixin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport), injection of, for the treatment of dynamic equinus foot deformity (including equinovarus and equinovalgus) due to spasticity in an ambulant cerebral palsy patient, if:			
	(a) the patient is at least 2 years of age; and			
	(b) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each lower limb), including all injections per set (Anaes.)			
18354	(See para TN.11.1 of explanatory notes to this Category) Fee: \$124.85 Benefit: 75% = \$93.65 85% = \$106.15			
18360	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), or Clostridium Botulinum Type A			

T11. BOT	ULINUM TOXIN INJECTIONS					
	Toxin Haemagglutinin Complex (Dysport), injection of, for the treatment of moderate to severe focal spasticity, if:					
	(a) the patient is at least 18 years of age; and					
	(b) the spasticity is associated with a previously diagnosed neurological disorder; and					
	(c) treatment is provided as:					
	(i) second line therapy when standard treatment for the conditions has failed; or					
	(ii) an adjunct to physical therapy; and					
	(d) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each limb), including all injections per set; and					
	(e) the treatment is not provided on the same occasion as a service mentioned in item 18365					
	(See para TN.11.1 of explanatory notes to this Category) Fee: \$124.85 Benefit: 75% = \$93.65 85% = \$106.15					
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of moderate to severe upper limb spasticity due to cerebral palsy if:					
	(a) the patient is at least 2 years of age, and					
	(b) for a patient who is at least 18 years of age - before the patient turned 18, the patient had commenced treatment for the spasticity with botulinum toxin supplied under the pharmaceutical benefits scheme; and					
	(c) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set (Anaes.)					
18361	(See para TN.11.1 of explanatory notes to this Category) Fee: \$124.85 Benefit: 75% = \$93.65 85% = \$106.15					
	Botulinum Toxin type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of severe primary axillary hyperhidrosis, including all injections on any one day, if:					
	(a) the patient is at least 12 years of age; and					
	(b) the patient has been intolerant of, or has not responded to, topical aluminium chloride hexahydrate; and					
	(c) the patient has not had treatment with botulinum toxin within the immediately preceding 4 months; and					
	(d) if the patient has had treatment with botulinum toxin within the previous 12 months - the patient had treatment on no more than 2 separate occasions (Anaes.)					
18362	(See para TN.11.1 of explanatory notes to this Category) Fee: \$246.70 Benefit: 75% = \$185.05 85% = \$209.70					
18365	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the					

T11. BO	TULINUM TOXIN INJECTIONS
	treatment of moderate to severe spasticity of the upper limb following a stroke, if:
	(a) the patient is at least 18 years of age; and
	(b) treatment is provided as:
	(i) second line therapy when standard treatment for the condition has failed; or
	(ii) an adjunct to physical therapy; and
	(c) the patient does not have established severe contracture in the limb that is to be treated; and
	(d) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set; and
	(e) for a patient who has received treatment on 2 previous separate occasions - the patient has responded to the treatment
	(See para TN.11.1 of explanatory notes to this Category) Fee: \$124.85 Benefit: 75% = \$93.65 85% = \$106.15
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of strabismus, including all such injections on any one day and associated electromyography (Anaes.)
18366	(See para TN.11.1 of explanatory notes to this Category) Fee: \$156.40 Benefit: 75% = \$117.30 85% = \$132.95
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of spasmodic dysphonia, including all such injections on any one day
18368	(See para TN.11.1 of explanatory notes to this Category) Fee: \$267.05 Benefit: 75% = \$200.30 85% = \$227.00
	Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of unilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.)
18369	(See para TN.11.1 of explanatory notes to this Category) Fee: \$45.05 Benefit: 75% = \$33.80 85% = \$38.30
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of unilateral blepharospasm in a patient who is at least 12 years of age, including all such injections on any one day (Anaes.)
18370	(See para TN.11.1 of explanatory notes to this Category) Fee: \$45.05 Benefit: 75% = \$33.80 85% = \$38.30
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of bilateral blepharospasm, in a patient who is at least 12 years of age; including all such injections on any one day (Anaes.)
18372	(See para TN.11.1 of explanatory notes to this Category) Fee: \$124.85 Benefit: 75% = \$93.65 85% = \$106.15
	Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of bilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.)
18374	(See para TN.11.1 of explanatory notes to this Category)

T11. BO	TULINUM TOXIN INJECTIONS
	Fee: \$124.85 Benefit: 75% = \$93.65 85% = \$106.15
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), intravesical injection of, with cystoscopy, for the treatment of urinary incontinence, including all such injections on any one day, if:
	(a) the urinary incontinence is due to neurogenic detrusor overactivity as demonstrated by urodynamic study of a patient with:
	(i) multiple sclerosis; or
	(ii) spinal cord injury; or
	(iii) spina bifida and who is at least 18 years of age; and
	(b) the patient has urinary incontinence that is inadequately controlled by anti-cholinergic therapy, as manifested by having experienced at least 14 episodes of urinary incontinence per week before commencement of treatment with botulinum toxin type A; and
	(c) the patient is willing and able to self-catheterise; and
	(d) the requirements relating to botulinum toxin type A under the Pharmaceutical Benefits Scheme are complied with; and
	(e) treatment is not provided on the same occasion as a service described in item 104, 105, 110, 116, 119, 11900 or 11919
	For each patient - applicable not more than once except if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment (Anaes.)
18375	(See para TN.11.1 of explanatory notes to this Category) Fee: \$229.85 Benefit: 75% = \$172.40
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of chronic migraine, including all injections in 1 day, if:
18377	(a) the patient is at least 18 years of age; and

T11. BOTULINUM TOXIN INJECTIONS

- (b) the patient has experienced an inadequate response, intolerance or contraindication to at least 3 prophylactic migraine medications before commencement of treatment with botulinum toxin, as manifested by an average of 15 or more headache days per month, with at least 8 days of migraine, over a period of at least 6 months, before commencement of treatment with botulinum toxin; and
- (c) the requirements relating to botulinum toxin type A under the Pharmaceutical Benefits Scheme are complied with

For each patient-applicable not more than twice except if the patient achieves and maintains at least a 50% reduction in the number of headache days per month from baseline after 2 treatment cycles (each of 12 weeks duration)

(See para TN.11.1 of explanatory notes to this Category)

Fee: \$124.85 **Benef**

Benefit: 75% = \$93.65 85% = \$106.15

Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), intravesical injection of, with cystoscopy, for the treatment of urinary incontinence, including all such injections on any one day, if:

- (a) the urinary incontinence is due to idiopathic overactive bladder in a patient: and
- (b) the patient is at least 18 years of age; and
- (c) the patient has urinary incontinence that is inadequately controlled by at least 2 alternative anti-

cholinergic agents, as manifested by having experienced at least 14 episodes of urinary incontinence per week

before commencement of treatment with botulinum toxin; and

- (d) the patient is willing and able to self-catheterise; and
- (e) treatment is not provided on the same occasion as a service mentioned in item 104, 105, 110, 116, 119, 11900 or 11919

For each patient-applicable not more than once except if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment

(H) (Anaes.)

(See para TN.11.1 of explanatory notes to this Category)

18379 **Fee:** \$229.85

Benefit: 75% = \$172.40

INDEX

(other han acromion), ostecotomy/ostectormy 48406, 48609 controlled hydroditation of bladder a face of the controlled hydroditation of bladder thorours a face of the controlled hydroditation of bladder thorours a face of the controlled hydroditation of bladder thorours a face of the controlled hydroditation of the co	(-4141	10400		(2(2,45052
. dilahermy or resection of bladder tumour's ol823, 36845 endoscoping incision/resection of 36825, 36854 injection into bladder wall solventiated of the properties of underly of the properties of underly of the properties of underly of the properties of size and attachment to size of preparation of size and attachment to size of preparation of size and attachment to size of preparation of size and attachment to size of preparation of size and attachment to size of preparation of size and attachment to size of the preparation of predicts of the preparation of predicts of the preparation of				
- endoscopic micsion/resection 36825, 36854 ranseft of, for restore elbow function 50405 injection into bladder wall 36851 ranseft of, for restore elbow function 50405 injection into bladder wall 36851 ranseft of, for restore elbow function 50405 injection 70405 injection 704				
Formation of urderir stenth, or brush biopsy 36821 insertion of urderiral prosthesis 36811 insertion of size and attachment to size 45233 with appropriation of size and attachment to size 45233 with mastoidectomy 41867 vitil division of laryngeal web 41868 vitil division of laryng				
- insertion of ureferic stent, or brush biopsy 36821 - ransfer of f, to restore hand function 44157 41578				
- insertion of urether is stent, or brush biopsy 36821				
Insertion of urethral prosthesis 36814 arransplantation of 47966 lavage of blood clots from bladder 36842 arransplantation of 47956 lavage of blood clots from bladder 36842 arransplantation of 47956 arransplantation of 47956 arransplantation of 47956 arransplantation of 47956 arransplantation of 47956 arransplantation of 47956 arransplantation of 47956 arransplantation of 47957 47950 arransp				46417
lavage of bload clost from bladder 36842 vimit arytenoidectomy 41867 virginary restoration of alimentary continuity after 41843 vimit arytenoidectomy 41867 virginary restoration of alimentary continuity after 41843 vimit arytenoidectomy and ossicular chain recon 41554 virginary restoration of site and attachment to site 418533 vimit mastoidectomy and ossicular chain recon 41554 virginary restoration of site and attachment to site 41863 vimit removal of juvenile papillomata 41858 vimit removal of juvenile papillomata 41858 vimit removal of papillomata	- insertion of ureteric stent, or brush biopsy	36821	- translabyrinthine removal 41575-41576, 4	11578-41579
lavage of blood clots from bladder 36842 with arystonidectomy 41867 or primary restoration of alimentary continuity after 41843 with arystonidectomy and ossicular chain recon 41854 removal of foreign body 36833 removal of foreign body 36833 removal of foreign body 36833 removal of foreign body 36833 removal of foreign body 36833 removal of foreign body 41867 removal of foreign body 41867 removal of foreign body 41867 removal of foreign body 41867 removal of foreign body 41867 removal of foreign body 41867 removal of foreign body 41867 removal of foreign body 41867 removal of foreign body 41867 removal of foreign body 41867 removal of foreign body 41867 removal of foreign body 41867 removal of foreign body 41867 removal of foreign body 41867 removal of foreign body 41867 removal of foreign body 41867 removal of foreign body 41867 removal of papallomata by laser surgery 41867 removal of fumour 41868 removal of papallomata by laser surgery 41867 removal of papallomata by laser surgery 41867 removal of papallomata by laser surgery 41867 removal of papallomata by laser surgery 41867 removal of papallomata by laser surgery 41867 removal of papallomata by laser surgery 41864 removal of papallomata by laser surgery 41864 removal of papallomata by laser surgery 41864 removal of papallomata by laser surgery 41864 removal of papallomata by laser surgery 41864 removal of papallomata by laser surgery 41864 removal of papallomata by laser surgery 41864 removal of papallomata by laser surgery 41864 removal of papallomata by laser surgery 41864 removal of papallomata by laser surgery 41864 removal of papallomata by laser surgery 41864 removal of papallomata by laser surgery 41864 removal of papallomata by laser surgery 41864 removal of papallomata by laser surgery 41864 removal of papallomata by laser surgery 41864 removal of papallomat	- insertion of urethral prosthesis	36811	- transmastoid removal 41575-41576, 4	11578-41579
- lavage of blood clots from bladder or or primary restoration of alimentary continuity after of primary restoration of alimentary continuity after or primary restoration of alimentary continuity after or primary restoration of alimentary continuity after or primary restoration of alimentary continuity after or primary restoration of alimentary continuity after or primary restoration of foreign body or primary and adatachment to site or promoval of freely beyears or over 14759 and 14759 are removal of, under twelve years 14789 are resection of ureterocede 3684 spreading of pedicle 45236 ureteric metatoriany 36812 ureteric metatoriany 36812 ureteric metatoriany 36812 ureteric metatoriany 36812 ureteric metatory 36862 ureteric metatory 36863 ureteric metatory 36863 ureteric metatory 36863 ureteric metatory 36863 ureteric metatory 36863 ureteric metatory 36863 ureteric metatory 41554, 47572 and mastoidectomy 41554, 47572 and mastoidectomy 41554, 47572 and resvision of mastoidectomy 41554, 47572 and resvision of mastoidectomy 41554, 47572 and resvision of mastoidectomy 41564 activities a state of the provided and the primary 41564 activities		36840	- transplantation of	47966
- or primary restoration of alimentary continuity after preparation of size and attachment to site 45233 - with division of largingeal web 41858 removal of foreign body 36833 41554 - removal of freely eyears or over 41793 - with removal of juvenile papillomata 41858 - removal of pedicle 36818 36824 - with removal of juvenile papillomata 41858 - wi	 lavage of blood clots from bladder 	36842		41867
- preparation of site and attachment to site	- or primary restoration of alimentary continuity after	41843		
- removal of f. twolev years or over 41793 - removal of, twolev years or over 41793 - rescention of ureterocele 36848 - spreading of pedicle 45226 - ureteric catheterisation 36818, 36824 - ureteric catheterisation 36818, 36824 - ureteric catheterisation 36818, 36824 - ureteric catheterisation 36818, 36824 - ureteric catheterisation 36812 - urethroscopy with/without urethral dilatation 36812 - urethroscopy with/without urethral dilatation 36812 - with transferostomy and plastic reconstruction 30294 - without litholapaxy 36863 - urethroscopy with without urethral dilatation 36812 - Achilles, repair of 49718, 49721, 49724 - and mastoidectomy 41551, 41560 - and mastoidectomy 41554 - and revision of mastoidectomy 41566 - and ossicular chain reconstruction 41542 - and revision of mastoidectomy 41566 - following incumcision, with GA 30663 - following incumcision, with GA 30663 - following incumcision, with GA 30663 - following incumcision, with GA 30663 - following incumcision, with GA 30663 - following incumcision, with GA 30663 - following incumcision, with GA 30663 - following incumcision, with GA 30663 - following incumcision, with GA 30663 - following incumcision, with GA 30663 - following incumcision, with GA 30663 - following incumcision, with GA 30663 - following incumcision, with GA 30663 - following incumcision, with GA 30663 - following incumcision, with GA 30663 - following incumcision, with GA 30663 - following incumcision, with GA 30663 - following incumcision, with GA 30663 - following incumcision, with GA 401797 - foot, repair of 49800, 49803, 49806, 49809, 49812 - foot, repair of 49800, 49803, 49806, 49809, 49812 - foot, repair of 49800, 49803, 49806, 49809, 49812 - foot, repair of 49800, 49803, 49806, 49809, 49812 - into intestina segment 36600, 36683 - intrauterine growth retardation 16508 - land obtained intestinal segment 36600, 36683 - intrauterine growth retardation 16508 - land obtained intestinal segment 36600, 36683 - intrauterine growth retardation 16508 - laparroomy for control of 49718, 49		45233		
- removal of, twelve years or over		36833	<u>.</u>	
- removal of, under twelve years				41858
- resection of ureterocele				
- spreading of pedicle 45236 ureteric catheterisation 36818, 36824 ureteric meatotomy 36830 urethroscopy with/without urethral dilatation 36812 with transferor of 30294 without litholapaxy 36863 without urethroscopy 36815 and mastoidectomy 49718, 49721, 49724, 49727 and revision of mastoidectomy 41551, 41560 and ossicular chain reconstruction 41542 and revision of mastoidectomy 41551, 41560 artificial prosthesis, insertion of for grafting 46414 control under GA, independent 30058 dilabetes or anaemia 16502 following circumcision, with GA 3063 rololwing circumcision, with GA 40348, 46351, 46354, 46357, 46360 hand/digit, synovectomy of 46336, 46339, 46342, 46345 hand/digit, synovectomy of 46346, 46429, 46423 de423, 46426, 46429, 46432 into isolated intestinal segment 36600, 36603 rolo isolated intestinal segment 36600, 36603 lengthening of 47957, 47960, 47963 and prostitution of by tendon graft 46414 reconstruction of foreign body, incision 41553 reconstruction of py tendon graft 46404 reconstruction of py tendon graft 46404 reconstruction of py tendon graft 46408 reconstruction of py tendon graft 46408 reconstruction of py tendon graft 46408 reconstruction of py tendon graft 46408 reconstruction of py tendon graft 46408 reconstruction of py tendon graft 46408 reconstruction of py tendon graft 46408 reconstruction of py tendon graft 46408 reconstruction of py tendon graft 46408 reconstruction of py tendon graft 46408 reconstruction of py tendon graft 46408 reconstruction of py tendon graft 46408 reconstruction of py tendon graft 46408 reconstruction of py tendon graft 46408 reconstruction of py tendon graft 44508 reconstruction of py tendon graft 44508 reconstruction of py tendon graft 44508 reconstruction of py tendon graft 44508 reconstruction of py tendon graft 44508 reconstruction of py tendon graft 44508 reconstruction of py tendon graft 44508 reconstruction of py tendon graft 44508 reconstruction of py tendon graft 44508 reconstruction of py tendon graft 44508 reconstruction of py tendon graft 44508 reconst				
- ureteric meatotomy 36818, 36824 - ureteric meatotomy 36830 - urethroscopy with/without urethral dilatation 36812 - with tracheostomy and plastic reconstruction 30294 - without litholapaxy 36863 - without urethroscopy 36815 - Achilles, repair of 49718, 49721, 49724, 49727 - and mastoidectomy 41551, 41560 - and revision of mastoidectomy 41566 - and revision of mastoidectomy 41566 - artificial prosthesis, insertion of for grafting 46414 - control under GA, independent 30058 - diabetes or anaemia 16502 - following circumcision, with GA 30663 - following insillectomy, with GA 41797 - foot, adductor hallueis, transfer of 49800, 49804, 49804, 49804, 49804, 49804, 49804, 49804, 49804, 49804, 49804, 49804, 49804, 49804, 49804, 49804, 46345 - hand/wiist, repair of 49800, 46423, 46426, 46429, 46432 - instriction of pressure regulating balloon, pump 1 37387 - into bladder 1 36508 - laparotomy for control of 1 49718, 49721, 49724, 49724 - into isolated intestinal segment 36690 - laparotomy for control of 1 49718, 49721, 49724, 49726 - prosthesis, artificial, insertion for grafting 46414 - reconstruction of by tendor grafting 46414 - reconstruction of pytendor gra				
- ureteric meatotomy			4.	3/01, 43/04
- with tracheostomy and plastic reconstruction 30294 - without urethroscopy 36863 - without urethroscopy 36863 - without urethroscopy 36863 - without urethroscopy 36863 - without urethroscopy 49718, 49721, 49724, 49727 - and mastoidectomy 41551, 41560 - and revision of mastoidectomy 41564 - and revision of mastoidectomy 41566 - and revision of mastoidectomy 41566 - following circumcision, with GA 30663 - following circumcision, with GA 30663 - following tonsillectomy, with GA 41797 - foot, adductor hallucis, transfer of 49800, 49803, 49804, 49804 - foot, adductor hallucis, transfer of 49800, 49803, 49804, 49804 - foot, adductor hallucis, transfer of 49800, 49803, 49804, 49804 - foreign body in, removal - hand/wrist, repair of 46420, 46423, 46426, 46429 - inio ristestine - inio solated intestinal segment 36600, 36603 - inito skin 36585 - intrauterine growth retardation lengthening of 47954, 47974 - prosthesis, artificial, insertion for grafting 46414 - reconstruction, congenital atresia 46602 - removal of foreign body, incision repair of 47954, 49718 - retromastoid removal of 41575-41576, 41578, 41579 - retromastoid removal of 41575-41576, 41578, 41579 - retromastoid removal of 41575-41576, 41578, 41579 - retromastoid removal of 41575-41576, 41578, 41579 - and mastoidectomy and bladder and assignation and assignation abdominal contouring post diabetic injections 3116, 33119 - Abdominal apricu acurysm, endovascular repair 3116, 33119 - Abdominal contouring post diabetic injections 31366 - Abdomino-perineal resection, rectum and anus 32093, 32042 - Abdomino-perineal resection, rectum and anus 32093, 32045 - Abdomino-perineal resection, rectum and anus 32093, 32045 - Abdomino-perineal resection, rectum and anus 32049 - Abdomino-perineal resection, rectum and anus 32049 - Abdomino-perineal resection, rectum and anus 32049 - Abdomino-perineal resection, rectum and anus 32049 - Abdomino-perineal resection, rectum and anus 32049 - Abdomino-perineal resection, rectum and anus 32049 - Abdomino-perineal resection protein				
- with tracheostomy and plastic reconstruction 30294 without litholapaxy 36815 without litholapaxy 36815 without litholapaxy 36815 without litholapaxy 36815 without litholapaxy 36815 without urethroscopy 36815 without urethroscopy 41515 41560 and mastoidectomy 415142 and revision of mastoidectomy 41561 and revision of mastoidectomy 41562 and revision of mastoidectomy 41566 artificial prosthesis, insertion of for grafting 46414 control under GA, independent 30058 diabetes or anaemia 16502 abdome, upper 20700, 20702-20706, 20730, 20754 20756, 20770, 20790-20794 20799-20799 abdomen, upper 30700, 20702-20706, 20730, 20759-20799 abdomen, upper 20700, 20702-20706, 20730, 20759-20799 abdominal aortic aneurysm, endovascular repair 33116, 33119 4000 abdominal contouring post diabetic injections 31346 abdominal contouring post diabetic injections 31346 abdominal contouring post diabetic injections 31346 abdominal contouring post diabetic injections 31346 foot, repair of 49800, 49803, 49806, 49809, 49812 foot, repair of 49800, 49803, 49806, 49809, 49812 foot, repair of 49800, 49803, 49806, 49809, 49812 hand/digit, synovectomy of 46336, 46339, 46342, 46345 hand/digit, synovectomy of 46336, 46339, 46342, 46345 hand/digit, synovectomy of 46420, 46423, 46426, 46429, 46423 hand/digit, synovectomy of 464040, 46423, 46426, 46429, 46425 hand/wrist, repair of 46420, 46423, 46426, 46429, 46425 hand/wrist, repair of 46420, 46423, 46426, 46429, 46425 hand/wrist, repair of 46420, 46423, 46426, 46429, 46425 hand/wrist, repair of 46420, 46423, 46426, 46429, 46425 hand/wrist, repair of 46420, 46423, 46426, 46429, 46425 hand/wrist, repair of 46420, 46423, 46426, 46429, 46425 hand/wrist, repair of 46420, 46423, 46426, 46429, 46425 hand/wrist, repair of 46420, 46423, 46426, 46429, 46425 hand/wrist, repair of 46420, 46423, 46426, 46429, 46425 hand/wrist, repair of 46420, 46423, 46426, 46429, 46425 hand/wrist, repair of 46420, 46423, 46426, 46429, 46425 hand/wrist, repair of 46420, 46423, 46426, 46429, 46425 hand/wrist, repair of 46420, 46423			Α	
- without litholapaxy 36863 without urethroscopy 36815 without urethroscopy 36815 without urethroscopy 36815 without urethroscopy 36815 Achilles, repair of 49718, 49721, 497274 49727 29830, 20832, 20842-20864, 20862-20864, 20864-20848, 20850, 20852 20864, 20866 20864, 20866-20868, 20880, 20882, 20884 abdomen, lower 20800, 20802-20864, 20864-20864, 20866-20868, 20880, 20882, 20884 abdomen, upper 20700, 20702-20706, 20730, 20740, 20745 20750, 20752-20746, 20752, 20752-20756, 20770, 20790-20794 20798-20799 abdominal aortic aneurysm, endovascular repair of 30058 abdominal aortic aneurysm, endovascular repair of 49800, 49803, 49804, 49834, 46351, 463543, 46357, 46360 hand/wrist, repair of 46420, 46423, 46426, 46429, 46435 instration of pressure regulating balloon, pump 37387 into bladder 36588, 36591 into skin 10 intestine 36594 into isolated intestinal segment 36600, 36603 into skin 10 intestine 36594 into intestine 36594 into skin 10 intes				
- without urethroscopy			Abbe flap, reconstruction of cleft lip	45701
- Achilles, repair of 49718, 49721, 49724, 49727 and mastoidectomy 41551, 41560 and ossicular chain reconstruction 41542 and revision of masteidectomy 41566 artificial prosthesis, insertion of for grafting 46414 control under GA, independent 5000, adductor hallucis, transfer of 49800, 49804, 46335, 46351, 46354, 46357, 46360 hand/digit, synovectomy of 46348, 46357, 46360 hand/wrist, repair of 46420, 46423, 46426, 46429, 46432 hinto intestine 36604, 36603 linto skin 36585 intrauterine growth retardation 16508 laparotomy for control of 47918, 49721, 49724, 49727 or ligament transfer 47966 prosthesis, artificial, insertion for grafting 46414 reconstruction, congenital atresia 47966 repromoval of 41575-41576, 41578-41579, 41578, 41579, 47940, 47948 and osciolar production of 47954, 49718 retromastoid removal of 41575-41576, 41578-41579, 41578, 41579, 47940 and hose included and subciousing the product of 47954, 49718 and of 47954, 49718 retromastoid removal of 41575-41576, 41578-41579, 41578, 41578, 41579, 41578, 41578, 41579, 41578,			Abdomen, burst, repair of	30403
- and mastoidectomy			abdomen, lower 20800, 20802-20806, 20810, 20	0815, 20820
- and mastoidectomy			20830, 20832, 20840-20842, 20844-20848, 20850, 2	20855
- and revision of mastoidectomy 41566 - and revision of mastoidectomy 41566 - and revision of mastoidectomy 41566 - artificial prosthesis, insertion of for grafting 46414 20798-20750, 20752, 20756, 20770, 20790-20794 20750, 20750, 20750, 20770, 20790-20794 20798-20799 abdominal acritic aneurysm, endovascular repair 33116, 33119 Abdominal gorticumcision, with GA 3063 - following circumcision, with GA 41797 49800, 49803, 49806, 49809, 49812 - foreign body in, removal 5 foot, repair of 49800, 49803, 49806, 49809, 49812 - foreign body in, removal 6 foreign body in, removal 7 foreign body in, removal 8 for 10 sloaded roll intestine 8 for 10 sloaded roll intestine 9 into isolated intestinal segment 36600, 36603 - into skin 3658 - intrauterine growth retardation 16508 - langthening of 47957, 47960, 47963 - lengthening of 47918, 49721, 49724 - or ligament transfer 49766 reconstruction, congenital atresia 45662 removal of 41575-41576, 41578-41579 adhesion of the promotor of 41575-41576, 41578-41579 adhesiolsy is, with hysteroscopy 36503 and socass device, prostheur, correction of 41575-41576, 41578-41579 adhesiolsy is, with hysteroscopy 36503 and socass device, prostheur, correction of 41575-41576, 41578-41579 adhesiolsy is, with hysteroscopy 36503 and socass device, prostheur, correction of 41575-41576, 41578-41579 adhesiolsy is, with hysteroscopy 36503 and socass device, prostheur, correction of 41575-41576, 41578-41579 adhesiolsy is, with hysteroscopy 36503 and socass device, prostheur, correction of 41575-41576, 41578-41579 adhesiolsy is, with hysteroscopy 36503 and socass device, prostheur, correction of 41575-41576, 41578-41579 adhesiolsy is, with hysteroscopy 36503				
- and revision of mastoidectomy		41542		
- artificial prosthesis, insertion of for grafting - control under GA, independent - diabetes or anaemia - following circumcision, with GA - following circumcision, with GA - following tonsillectomy, with GA - following tonsillectomy, with GA - foot, adductor hallucis, transfer of - foot, adductor hallucis, transfer of - foot, repair of - foreign body in, removal - foreign body in, removal - hand/digit, synovectomy of - d6336, 46339, 46342, 46345 - 46348, 46351, 46354, 46357, 46360 - hand/wrist, repair of - hand/wrist, repair of - foreign bodder - into bladder - into intestine - into intestine - into intestine - into intestine - into intestine - into skin - intrauterine growth retardation - laparotomy for control of - laparotomy for control of - laparotomy for control of - laparotomy for control of - laparotomy for control of - laparotomy for control of - prosthesis, artificial, insertion for grafting - reconstruction, congenital attesia - removal of foreign body, incision - repair of - 47954, 49718 - reconstruction, congenital attesia - removal of foreign body, incision - repair of - 41575-41576, 41578-41579 - retromastoid removal of - 41575-41576, 41578-41579 - adhesiolysis, with hysteroscopy - addominal aortic aneurysm, endovascular repair and abdominal contouring post diabetic injections - Abdominal contouring post diabetic injections - Abdominal contouring post diabetic injections - Abdominal contouring post diabetic injections - Abdominal contouring post diabetic injections - Abdominal contouring post diabetic injections - Abdominal contouring post diabetic injections - Abdominal contouring post diabetic injections - Abdominal contouring post diabetic injections - Abdominal contouring post diabetic injections - Abdominal contouring post diabetic injections - Abdominal contouring post diabetic injections - Abdominal contouring post diabetic injections - Abdominal contouring post diabetic injections - Abdominal contouring post diabetic injections - Abdominal contouring post diabetic injections - Abdominal c	- and revision of mastoidectomy	41566		07.10, 207.12
- control under GA, independent	- artificial prosthesis, insertion of for grafting	46414		
- diabetes or anaema	- control under GA, independent	30058		3116 33119
- following circumcision, with GA following tonsillectomy, with GA following tonsillectomy, with GA foot, adductor hallucis, transfer of foot, repair of foot, repair of foot, repair of hand/digit, synovectomy of hand/digit, synovectomy of hand/wrist, repair of han	- diabetes or anaemia	16502		
- following tonsillectomy, with GA	- following circumcision, with GA	30663		
- foot, adductor hallucis, transfer of 49827, 49830 - foot, repair of 49800, 49803, 49806, 49809, 49812 - foreign body in, removal - hand/digit, synovectomy of 46336, 46339, 46342, 46345 46348, 46351, 46354, 46357, 46360 - hand/wrist, repair of 46420, 46423, 46426, 46429, 46432 - insertion of pressure regulating balloon, pump 37387 - insertion of pressure regulating balloon, pump 37387 - into intestine 36594 - into intestine 36594 - into skin 36555 - intrauterine growth retardation 16508 - laparotomy for control of 30385 - lengthening of 47957, 47960, 47963 - major, of ankle, repair of 49718, 49721, 49724, 49727 - prosthesis, artificial, insertion for grafting 46414 - reconstruction of, by tendon graft - reconstruction of, by tendon graft - reconstruction of of foreign body, incision - repair of 47954, 49718 - retromastoid removal of 41575-41576, 41578-41579 - adhesiolysis, with hysteroscopy 35633		41797		
- foot, repair of 49800, 49803, 49806, 49809, 49812 - foreign body in, removal 30068 - hand/digit, synovectomy of 46336, 46339, 46342, 46345 46348, 46351, 46357, 46360 - hand/wrist, repair of 46420, 46423, 46426, 46429, 46432 - insertion of pressure regulating balloon, pump 37387 - into bladder 36588, 36591 - into intestine 36594 - into isolated intestinal segment 36600, 36603 - laparotomy for control of 16508 - laparotomy for control of 2018 and 16508 - langtoning of 47957, 47960, 47963 - major, of ankle, repair of 49718, 49721, 49727 - or ligament transfer 47966 - prosthesis, artificial, insertion for grafting 46414 - reconstruction of, by radiofrequency electrosurgery 35616 - ablation of, by radiofrequency electrosurgery 35616 - Abortion, threatened, treatment of 16508 - Aborsion, threatened, treatment of 32174-32175 - abscess, anal, drainage of 32174-32175 - abscess, incision with drainage 30223 - abscess, open drainage of 330394 - abscess, open drainage of 332174-32175 - access device, prosthetic, correction of 34518 - access device, prosthetic, correction of 34518 - access device, thrombectomy of 34515 - Accetabular dysplasia, pelvis, bone graft/shelf procedure 50393 - Acetabulum, treatment of fracture of 47492, 47495, 47498 - 47501, 47504, 47507, 47510 - accessory bone, osteotomy or osteectomy of 47510, 47504, 47507, 47510 - accessory bone, osteotomy or osteectomy of 47501, 47504, 47507, 47510 - accessory bone, osteotomy or osteectomy of 47518, 49721 - Achilles' tendon, operation for lengthening 49727 - Achilles' tendon, operation for lengthening 49727 - Achilles' tendon, operation for lengthening 49727 - Achilles' tendon, operation for lengthening 49727 - Achilles' tendon, operation for lengthening 49727 - Adenoids and tonsils, removal of 41589, 41793 - Additional incisions for astigmatism 42673 - Additional incisions for astigmatism 42673 - Ad			- · · · · · · · · · · · · · · · · · · ·	2039, 32042
- foreign body in, removal - hand/digit, synovectomy of 46336, 46339, 46342, 46345 46348, 46351, 46354, 46357, 46360 - hand/wrist, repair of 46420, 46423, 46426, 46429, 46432 46435 - insertion of pressure regulating balloon, pump 37387 - into bladder 36588, 36591 - into intestine 36500, 36603 - into intestine 36600, 36603 - into intestine 36600, 36603 - into skin 36585 - intrauterine growth retardation 16508 - lengthening of 47957, 47960, 47963 - major, of ankle, repair of 49718, 49721, 49724, 49727 - or ligament transfer 47966 - prosthesis, artificial, insertion for grafting 46414 - reconstruction, congenital atresia 1eroonstruction, congenital atresia 2 removal of foreign body, incision 41503 - repair of 41575-41576, 41578-41579 - retromastoid removal of 41575-41576, 41578-41579 - retromastoid removal of 41575-41576, 41578-41579 - addition of, by radiofrequency electrosurgery 35618 - ablation of, by radiofrequency electrosurgery 35618 - ablation of, by radiofrequency electrosurgery 35618 - blatlion of, by radiofrequency electrosurgery 35614 - bloader 4522, 46425 - Abcress incision with drainage of 3221, 45024 - Abscess, incision with drainage of access device, prosthetic, correction of access device, prosthetic, co				5602 25605
hand/digit, synovectomy of 46336, 46339, 46342, 46345 46348, 46351, 46357, 46360 hand/wrist, repair of 46420, 46423, 46426, 46429, 46432 46435 insertion of pressure regulating balloon, pump 37387 into bladder 36588, 36591 into intestine 36594 into intestine 36694 into intestine 36694 into abscess, aparotomy for drainage of 30394 abscess, laparotomy for drainage of 30394 abscess, open drainage of 37212 access device, prosthetic, correction of 30385 intrauterine growth retardation 16508 laparotomy for control of 30385 lengthening of 47957, 47960, 47963 major, of ankle, repair of 49718, 49721, 49724, 49727 or ligament transfer 47966 prosthesis, artificial, insertion for grafting 46414 reconstruction of, by tendon graft 46408 reconstruction of, by tendon graft 46408 removal of foreign body, incision repair of 47954, 49718 retromastoid removal of 41575-41576, 41578-41579 adhesiolysis, with hysteroscopy 35633		-		
46348, 46351, 46354, 46357, 46360 - hand/wrist, repair of				
- hand/wrist, repair of 46420, 46423, 46426, 46429, 46432 46435 - insertion of pressure regulating balloon, pump 37387 - into bladder 36588, 36591 - into intestine 36594 - into isolated intestinal segment 36600, 36603 - into skin 36585 - intrauterine growth retardation 16508 - laparotomy for control of 30385 - lengthening of 47957, 47960, 47963 - major, of ankle, repair of 49718, 49721, 49724, 49727 - or ligament transfer 47966 - prosthesis, artificial, insertion for grafting 46414 - reconstruction of, by tendon graft 46408 - removal of foreign body, incision repair of 47954, 49718 - retromastoid removal of 41575-41576, 41578-41579 - retromastoid removal of 41575-41576, 41578-41579 - retromastoid removal of 41575-41576, 41578-41579 - adhesiolysis, with hysteroscopy 35633		2, 103 13		
Abscess, anal, drainage of 32174-32175 - insertion of pressure regulating balloon, pump 37387 - into bladder 36588, 36591 - into intestine 36594 - into isolated intestinal segment 36600, 36603 - intrauterine growth retardation 16508 - laparotomy for control of 30393 - lengthening of 47957, 47960, 47963 - major, of ankle, repair of 49718, 49721, 49724 - or ligament transfer 47966 - prosthesis, artificial, insertion for grafting 46414 - reconstruction of, by tendon graft 46408 - removal of foreign body, incision 1 erepair of 41575-41576, 41578-41579 - retromastoid removal of 41575-41576, 41578-41579 - retromastoid removal of 41575-41576, 41578-41579 Abscess, anal, drainage of 32174-32175 abscess, incision with drainage of 30223 abscess, liparotomy for drainage of 30394 abscess, laparotomy for drainage of 30394 abscess, open drainage of 4082 access device, prosthetic, correction of 34518 access device, thrombectomy of 48400 Accetabular dysplasia, pelvis, bone graft/shelf procedure 50393 Acetabulum, treatment of fracture of 47492, 47495, 47498 47501, 47504, 47507, 47510 achilles tendon, operation for lengthening 49717 Acoustic neuroma, removal of 41575-41576, 41578-41579 Adductors to ischium transfer 50387 Adductors to ischium transfer 50387 Adenoids and tonsils, removal of 41789, 41793 adhesiolysis, with hysteroscopy 35633		16/32		
- insertion of pressure regulating balloon, pump into bladder into bladder into intestine into isolated intestinal segment into skin intrauterine growth retardation laparotomy for control of laparotomy for control of major, of ankle, repair of prosthesis, artificial, insertion for grafting reconstruction of, by tendon graft reconstruction, congenital atresia removal of foreign body, incision repair of retromastiod removal of Abscess, alan, drantage of abscess, lination with drainage abscess, laparotomy for drainage of access device, prosthetic, correction of access device, prosthetic, correction of access device, prosthetic, orrection of access device, prosthet		, 40432		
- into bladder 36588, 36591 - into intestine 36594 - into isolated intestinal segment 36600, 36603 - into skin 36585 - intrauterine growth retardation 16508 - laparotomy for control of laparotomy for control of - major, of ankle, repair of 49718, 49721, 49724, 49727 - or ligament transfer 47966 - prosthesis, artificial, insertion for grafting reconstruction of, by tendon graft reconstruction, congenital atresia repair of 47954, 49718 - retromastiod removal of 41575-41576, 41578, 41579 - retromastiod removal of 41575-41576, 41578, 41		27297		
- into intestine 36594 - into isolated intestinal segment 36600, 36603 - into skin 36585 - intrauterine growth retardation 16508 - laparotomy for control of 1697 1697, 47960, 47963 - lengthening of 47957, 47960, 47963 - major, of ankle, repair of 49718, 49721, 49724, 49727 - or ligament transfer 47966 - prosthesis, artificial, insertion for grafting 1790 1790 1790 1790 1790 1790 1790 1790				
- into isolated intestinal segment - into skin - into skin - intrauterine growth retardation - laparotomy for control of - langarotomy for control of - lengthening of - major, of ankle, repair of - prosthesis, artificial, insertion for grafting - reconstruction of, by tendon graft - reconstruction, congenital atresia - removal of foreign body, incision - repair of - retromastoid removal of - intrauterine growth retardation - 16508 - Accessory bone, osteotomy or osteectomy of - Accessory bone, osteotomy or osteectomy of - Accetabulum, treatment of fracture of - 47492, 47495, 47498 - 47501, 47504, 47507, 47510 - achilles tendon, repair of - 47918, 49721, 49724 - Achilles' tendon, operation for lengthening - Acoustic neuroma, removal of - Adductors to ischium transfer - Adenoids and tonsils, removal of - Adenoids and tonsils, removal of - 41575-41576, 41578-41579 - adhesiolysis, with hysteroscopy - 35633				
- into skin 36585 - intrauterine growth retardation 16508 - laparotomy for control of 30385 - lengthening of 47957, 47960, 47963 - major, of ankle, repair of 49718, 49721, 49724, 49727 - or ligament transfer 47966 - prosthesis, artificial, insertion for grafting reconstruction, congenital atresia removal of foreign body, incision repair of 47954, 49718 - retromastoid removal of 41575-41576, 41578-41579 - retrom			abscess, open drainage of	
- intrauterine growth retardation 16508 - laparotomy for control of 30385 - lengthening of 47957, 47960, 47963 - major, of ankle, repair of 49718, 49721, 49724, 49727 - or ligament transfer 47966 - prosthesis, artificial, insertion for grafting reconstruction of, by tendon graft reconstruction, congenital atresia removal of foreign body, incision repair of 47954, 49718 - retromastoid removal of 41575-41576, 41578-41579 - retromastoid removal of 41575-41576, 41578-41579 - retromastoid removal of 41575-41576, 41578-41579 - retromastored a 4562 - removal of a 41575-41576, 41578-41579 - retromastored a 4562 - removal of a 41575-41576, 41578-41579 - retromastored a 4562 - removal of a 41575-41576, 41578-41579 - retromastored a 4562 - removal of a 41575-41576, 41578-41579 - retromastored a 4562 - removal of a 41575-41576, 41578-41579 - retromastored a 4562 - removal of a 41575-41576, 41578-41579 - retromastored a 4562 - removal of a 41575-41576, 41578-41579 - retromastored a 4562 - removal of a 41575-41576, 41578-41579 - retromastored a 4562 - removal of a 41575-41576, 41578-41579 - retromastored a 4562 - removal of a 41575-41576, 41578-41579 - retromastored a 4562 - removal of a 41575-41576, 41578-41579 - retromastored a 4562 - removal of a 41575-41576, 41578-41579 - retromastored a 4562 - removal of a 41575-41576, 41578-41579 - retromastored a 4562 - removal of a 41575-41576, 41578-41579 - retromastored a 4562 - removal of a 41575-41576, 41578-41579 - retromastored a 4562 - removal of a 41575-41576, 41578-41579 - retromastored a 4562 - removal of a 41575-41576, 41578-41579 - retromastored a 4562 - removal of a 4575-41576, 41578-41579 - retromastored a 4562 - removal of a 4575-41576, 41578-41579 - retromastored a 4562 - removal of a 4575-41576, 41578-41579 - retromastored a 4562 - removal of a 4575-41576, 41578-41579 - retromastored a 4562 - removal of a 4575-41576, 41578-41579 - retromastored a 4562 - removal of a 4575-41576, 41578-41579 - retromastored a 4562 - removal of a 4575-41576, 41578-41579 - removal of a 4			access device, prosthetic, correction of	34518
- laparotomy for control of 30385 - lengthening of 47957, 47960, 47963 - major, of ankle, repair of 49718, 49721, 49724, 49727 - or ligament transfer 47966 - prosthesis, artificial, insertion for grafting reconstruction of, by tendon graft 46408 - reconstruction, congenital atresia 45662 - removal of foreign body, incision repair of 47954, 49718 - retromastoid removal of 41575-41576, 41578-41579 - retromastoid			access device, thrombectomy of	34515
- laparotomy for control of 30385 - lengthening of 47957, 47960, 47963 - major, of ankle, repair of 49718, 49721, 49724 49727 - or ligament transfer 47966 - prosthesis, artificial, insertion for grafting 46414 - reconstruction of, by tendon graft 46408 - removal of foreign body, incision - repair of 47954, 49718 - retromastoid removal of 41575-41576, 41578-41579 - retromastoid removal of 41575-41576, 41578-41579 - retromastoid removal of 41575-41576, 41578-41579 adhesiolysis, with hysteroscopy 35633			Accessory bone, osteotomy or osteectomy of	48400
- lengthening of 47957, 47960, 47963 - major, of ankle, repair of 49718, 49721, 49724, 49727 - or ligament transfer 47966 - prosthesis, artificial, insertion for grafting 46414 - reconstruction of, by tendon graft 46408 - removal of foreign body, incision repair of 47954, 49718 - retromastoid removal of 41575-41576, 41578-41579 - retromastoid removal of 41575-4				e 50393
- major, of ankle, repair of 49718, 49721, 49727 47966 - or ligament transfer 47966 - prosthesis, artificial, insertion for grafting 46414 - reconstruction of, by tendon graft 46408 - reconstruction, congenital atresia 45662 - removal of foreign body, incision repair of 47954, 49718 - retromastoid removal of 41575-41576, 41578-41579 - retromastoid removal of 41575-41576, 41578-41579 additional incisions for astigmatism 42673 Adductors to ischium transfer 50387 - Adenoids and tonsils, removal of 41789, 41793 adhesiolysis, with hysteroscopy 35633				
- or ligament transfer 47966 - prosthesis, artificial, insertion for grafting 46414 - reconstruction of, by tendon graft 46408 - reconstruction, congenital atresia 45662 - removal of foreign body, incision repair of 47954, 49718 - retromastoid removal of 41575-41576, 41578-41579 - retromastoid removal of 41575-		1, 49727		•
- prosthesis, artificial, insertion for grafting - reconstruction of, by tendon graft - reconstruction, congenital atresia - removal of foreign body, incision - repair of - retromastoid removal of - r				9721, 49724
- reconstruction of, by tendon graft - reconstruction, congenital atresia - removal of foreign body, incision - repair of - retromastoid removal of				
- reconstruction, congenital atresia 45662 - removal of foreign body, incision 41503 - repair of 47954, 49718 - retromastoid removal of 41575-41576, 41578-41579 - retromastoid removal of 41575-41576, 41578-41579				
- removal of foreign body, incision - repair of - retromastoid removal		45662		
- repair of 47954, 49718 Adenoids and tonsils, removal of 41789, 41793 adhesiolysis, with hysteroscopy 35633	- removal of foreign body, incision	41503		
- retromastoid removal of 41575-41576, 41578-41579 adhesiolysis, with hysteroscopy 35633		1, 49718		
action of the control				-
Aulicsions, division of, via raparoscope 31430, 31432, 3303/				
			runesions, division of, via taparoscope 31430, 3	1704, 00001

44 . 4 . 4	27/20		_
adhesions, laparoscopic division	35638	21402-21404, 21420, 21430, 21432, 21440, 2144	
Administration of	16018	21460-21462, 21464, 21472, 21474, 21480, 21482	
adnexae, removal, with abdominal hysterectomy	35653	21486, 21490, 21500, 21502, 21520, 21522, 2153	
alba hernia, repair of, over 10 years	30621	21535, 21600, 21610, 21620, 21622, 21630, 2163	
alcohol, cortisone, phenol into trigeminal nerve	39100	21636, 21638, 21650, 21652, 21654, 21656, 2167	•
Alcohol, injection of trigeminal nerve/s	39100	21682, 21685, 21700, 21710, 21712, 21714, 2171	
alcohol, retrobulbar	42824	21732, 21740, 21756, 21760, 21770, 21772, 2178	
Alimentary continuity, primary restoration	41843	21790, 21800, 21810, 21820, 21830, 21832, 2183	
Alopecia, hair transplantation for	45560	21842, 21850, 21860, 21865, 21870, 21872, 2187	
Alveolar ridge augmentation	45841, 45843	21900, 21906, 21908, 21910, 21912, 21914-21910	-
Amnio-infusion	16621	21922, 21925-21927, 21930, 21935-21936, 21939	
Amniocentesis, diagnostic	16600	21945, 21949, 21952, 21955, 21959, 21962, 2196	
	3, 44331, 44334	21969-21970, 21973, 21976, 21980, 21990, 21992	
44338, 44342, 44346, 44350, 44354, 44358-44359	9, 44361	22001-22002, 22007-22008, 22012, 22014-22015	
44364, 44367, 44370, 44373, 44376	21070 21007	22025, 22031, 22036, 22040, 22045, 22050-2205	
anaesthesia in connection with burns	21878-21887	22060, 22065, 22070, 22075, 22900, 22905, 2301	
anaesthesia in connection with dental services 22905	22900	23021-23023, 23031-23033, 23041-23043, 23051	
		23061-23063, 23071-23073, 23081-23083, 23091	
anaesthesia in connection with radiological diagno		23111-23119, 23121, 23170, 23180, 23190, 23200 23220, 23230, 23240, 23250, 23260, 23270, 2328	
therapeutic procedures 21900, 21906, 21908 21914-21916, 21918, 21922, 21925-21927, 2193			
		23300, 23310, 23320, 23330, 23340, 23350, 2336	•
21935-21936, 21939, 21941-21943, 21945, 2194		23380, 23390, 23400, 23410, 23420, 23430, 2344	
21955, 21959, 21962, 21965, 21969-21970, 2197	73, 21970	23460, 23470, 23480, 23490, 23500, 23510, 2352	•
21980 anaesthesia modifiers 25000, 25005, 25010	25015 25020	23540, 23550, 23560, 23570, 23580, 23590, 2360 23620, 23630, 23640, 23650, 23660, 23670, 2368	
	0, 23013, 23020		
25025, 25030 anaesthesia time 23010, 23021-23023	2 22021 22022	23700, 23710, 23720, 23730, 23740, 23750, 2376 23780, 23790, 23800, 23810, 23820, 23830, 2384	
23041-23043, 23051-23053, 23061-23063, 2307	,	23860, 23870, 23880, 23890, 23900, 23910, 2392	
23081-23083, 23091, 23101, 23111-23119, 2312		23940, 23950, 23960, 23970, 23980, 23990, 2410	*
23180, 23190, 23200, 23210, 23220, 23230, 2324	*	25940, 25950, 25960, 25970, 25980, 25990, 2410	
23260, 23270, 23280, 23290, 23300, 23310, 2332		25200, 25205 25200, 25205	0, 23030
23200, 23270, 23280, 23270, 23300, 23310, 233	20, 23330		
23340 23350 23360 23370 23380 23390 2340	00. 23/10		355/12 355/15
23340, 23350, 23360, 23370, 23380, 23390, 2340	·	Anal canal, laser therapy (restriction) 35539	9, 35542, 35545 2, 32165-32166
23420, 23430, 23440, 23450, 23460, 23470, 2348	80, 23490	Anal canal, laser therapy (restriction) 35539 anal, excision/repair 32159, 3216	2, 32165-32166
23420, 23430, 23440, 23450, 23460, 23470, 2348 23500, 23510, 23520, 23530, 23540, 23550, 2356	80, 23490 60, 23570	Anal canal, laser therapy (restriction) 35539 anal, excision/repair 32159, 3216 anal, stretching of	2, 32165-32166 32153
23420, 23430, 23440, 23450, 23460, 23470, 2348 23500, 23510, 23520, 23530, 23540, 23550, 2356 23580, 23590, 23600, 23610, 23620, 23630, 2364	80, 23490 60, 23570 40, 23650	Anal canal, laser therapy (restriction) 35539 anal, excision/repair 32159, 3216 anal, stretching of anastomosis of upper or lower limb	2, 32165-32166 32153 34503, 34509
23420, 23430, 23440, 23450, 23460, 23470, 2348 23500, 23510, 23520, 23530, 23540, 23550, 2356 23580, 23590, 23600, 23610, 23620, 23630, 2362 23660, 23670, 23680, 23690, 23700, 23710, 2372	80, 23490 60, 23570 40, 23650 20, 23730	Anal canal, laser therapy (restriction) 35539 anal, excision/repair 32159, 3216 anal, stretching of anastomosis of upper or lower limb Anastomosis, aorta, congenital heart disease	2, 32165-32166 32153 34503, 34509 38706, 38709
23420, 23430, 23440, 23450, 23460, 23470, 2348 23500, 23510, 23520, 23530, 23540, 23550, 2356 23580, 23590, 23600, 23610, 23620, 23630, 2364 23660, 23670, 23680, 23690, 23700, 23710, 2372 23740, 23750, 23760, 23770, 23780, 23790, 2380	80, 23490 60, 23570 40, 23650 20, 23730 00, 23810	Anal canal, laser therapy (restriction) 35539 anal, excision/repair 32159, 3216 anal, stretching of anastomosis of upper or lower limb Anastomosis, aorta, congenital heart disease and ankle, tibialis tendon transfer	2, 32165-32166 32153 34503, 34509 38706, 38709 50339, 50342
23420, 23430, 23440, 23450, 23460, 23470, 2348 23500, 23510, 23520, 23530, 23540, 23550, 2356 23580, 23590, 23600, 23610, 23620, 23630, 2364 23660, 23670, 23680, 23690, 23700, 23710, 2372 23740, 23750, 23760, 23770, 23780, 23790, 2380 23820, 23830, 23840, 23850, 23860, 23870, 2388	80, 23490 60, 23570 40, 23650 20, 23730 00, 23810 80, 23890	Anal canal, laser therapy (restriction) 35539 anal, excision/repair 32159, 3216 anal, stretching of anastomosis of upper or lower limb Anastomosis, aorta, congenital heart disease and ankle, tibialis tendon transfer and excision of cyst/teratoma	2, 32165-32166 32153 34503, 34509 38706, 38709 50339, 50342 43912
23420, 23430, 23440, 23450, 23460, 23470, 2348 23500, 23510, 23520, 23530, 23540, 23550, 2356 23580, 23590, 23600, 23610, 23620, 23630, 2362 23660, 23670, 23680, 23690, 23700, 23710, 2372 23740, 23750, 23760, 23770, 23780, 23790, 2380 23820, 23830, 23840, 23850, 23860, 23870, 2388 23900, 23910, 23920, 23930, 23940, 23950, 2396	80, 23490 60, 23570 40, 23650 20, 23730 00, 23810 80, 23890	Anal canal, laser therapy (restriction) 35539 anal, excision/repair 32159, 3216 anal, stretching of anastomosis of upper or lower limb Anastomosis, aorta, congenital heart disease and ankle, tibialis tendon transfer and excision of cyst/teratoma and foot, tibialis tendon transfer	2, 32165-32166 32153 34503, 34509 38706, 38709 50339, 50342 43912 50339, 50342
23420, 23430, 23440, 23450, 23460, 23470, 2348 23500, 23510, 23520, 23530, 23540, 23550, 2356 23580, 23590, 23600, 23610, 23620, 23630, 2362 23660, 23670, 23680, 23690, 23700, 23710, 2372 23740, 23750, 23760, 23770, 23780, 23790, 2380 23820, 23830, 23840, 23850, 23860, 23870, 2388 23900, 23910, 23920, 23930, 23940, 23950, 2396 23980, 23990, 24100-24136	80, 23490 60, 23570 40, 23650 20, 23730 00, 23810 80, 23890 60, 23970	Anal canal, laser therapy (restriction) 35539 anal, excision/repair 32159, 3216 anal, stretching of anastomosis of upper or lower limb Anastomosis, aorta, congenital heart disease and ankle, tibialis tendon transfer and excision of cyst/teratoma and foot, tibialis tendon transfer and sclerectomy, for glaucoma (Lagrange's op)	2, 32165-32166 32153 34503, 34509 38706, 38709 50339, 50342 43912 50339, 50342 42746
23420, 23430, 23440, 23450, 23460, 23470, 2348 23500, 23510, 23520, 23530, 23540, 23550, 2356 23580, 23590, 23600, 23610, 23620, 23630, 2362 23660, 23670, 23680, 23690, 23700, 23710, 2372 23740, 23750, 23760, 23770, 23780, 23790, 2380 23820, 23830, 23840, 23850, 23860, 23870, 2388 23900, 23910, 23920, 23930, 23940, 23950, 2396 23980, 23990, 24100-24136 Anaesthetic, Relative Value Guide 20100, 20102	80, 23490 60, 23570 40, 23650 20, 23730 00, 23810 80, 23890 60, 23970 2, 20104, 20120	Anal canal, laser therapy (restriction) 35539 anal, excision/repair 32159, 3216 anal, stretching of anastomosis of upper or lower limb Anastomosis, aorta, congenital heart disease and ankle, tibialis tendon transfer and excision of cyst/teratoma and foot, tibialis tendon transfer and sclerectomy, for glaucoma (Lagrange's op) Aneurysm, cerebrovascular, clipping/reinforcement	2, 32165-32166 32153 34503, 34509 38706, 38709 50339, 50342 43912 50339, 50342 42746 39800
23420, 23430, 23440, 23450, 23460, 23470, 2348 23500, 23510, 23520, 23530, 23540, 23550, 2356 23580, 23590, 23600, 23610, 23620, 23630, 2362 23660, 23670, 23680, 23690, 23700, 23710, 2372 23740, 23750, 23760, 23770, 23780, 23790, 2380 23820, 23830, 23840, 23850, 23860, 23870, 2388 23900, 23910, 23920, 23930, 23940, 23950, 2396 23980, 23990, 24100-24136	80, 23490 60, 23570 40, 23650 20, 23730 00, 23810 80, 23890 60, 23970 2, 20104, 20120 4, 20170	Anal canal, laser therapy (restriction) anal, excision/repair 32159, 3216 anal, stretching of anastomosis of upper or lower limb Anastomosis, aorta, congenital heart disease and ankle, tibialis tendon transfer and excision of cyst/teratoma and foot, tibialis tendon transfer and sclerectomy, for glaucoma (Lagrange's op) Aneurysm, cerebrovascular, clipping/reinforcement aneurysm, clipping or reinforcement of sac	2, 32165-32166 32153 34503, 34509 38706, 38709 50339, 50342 43912 50339, 50342 42746 39800 39800
23420, 23430, 23440, 23450, 23460, 23470, 2348 23500, 23510, 23520, 23530, 23540, 23550, 2356 23580, 23590, 23600, 23610, 23620, 23630, 2362 23660, 23670, 23680, 23690, 23700, 23710, 2372 23740, 23750, 23760, 23770, 23780, 23790, 2380 23820, 23830, 23840, 23850, 23860, 23870, 2388 23900, 23910, 23920, 23930, 23940, 23950, 2396 23980, 23990, 24100-24136 Anaesthetic, Relative Value Guide 20100, 20102 20124, 20140, 20142-20148, 20160, 20162, 20164 20172, 20174, 20176, 20190, 20192, 20210, 20212	80, 23490 60, 23570 40, 23650 20, 23730 00, 23810 80, 23890 60, 23970 2, 20104, 20120 4, 20170 2, 20214	Anal canal, laser therapy (restriction) 35539 anal, excision/repair 32159, 3216 anal, stretching of anastomosis of upper or lower limb Anastomosis, aorta, congenital heart disease and ankle, tibialis tendon transfer and excision of cyst/teratoma and foot, tibialis tendon transfer and sclerectomy, for glaucoma (Lagrange's op) Aneurysm, cerebrovascular, clipping/reinforcement aneurysm, clipping or reinforcement of sac aneurysm, endovascular coiling	2, 32165-32166 32153 34503, 34509 38706, 38709 50339, 50342 43912 50339, 50342 42746 39800 39800 35412
23420, 23430, 23440, 23450, 23460, 23470, 23482 23500, 23510, 23520, 23530, 23540, 23550, 2356 23580, 23590, 23600, 23610, 23620, 23630, 2364 23660, 23670, 23680, 23690, 23700, 23710, 2372 23740, 23750, 23760, 23770, 23780, 23790, 2388 23820, 23830, 23840, 23850, 23860, 23870, 2388 23900, 23910, 23920, 23930, 23940, 23950, 2396 23980, 23990, 24100-24136 Anaesthetic, Relative Value Guide 20100, 20102 20124, 20140, 20142-20148, 20160, 20162, 20164 20172, 20174, 20176, 20190, 20192, 20210, 20212 20216, 20220, 20222, 20225, 20230, 20300, 20305	80, 23490 60, 23570 40, 23650 20, 23730 00, 23810 80, 23890 60, 23970 2, 20104, 20120 4, 20170 2, 20214 5	Anal canal, laser therapy (restriction) 35539 anal, excision/repair 32159, 3216 anal, stretching of anastomosis of upper or lower limb Anastomosis, aorta, congenital heart disease and ankle, tibialis tendon transfer and excision of cyst/teratoma and foot, tibialis tendon transfer and sclerectomy, for glaucoma (Lagrange's op) Aneurysm, cerebrovascular, clipping/reinforcement aneurysm, clipping or reinforcement of sac aneurysm, endovascular coiling aneurysm, ligation of cervical vessel/s	2, 32165-32166 32153 34503, 34509 38706, 38709 50339, 50342 43912 50339, 50342 42746 39800 39800 35412 39812
23420, 23430, 23440, 23450, 23460, 23470, 2348 23500, 23510, 23520, 23530, 23540, 23550, 2356 23580, 23590, 23600, 23610, 23620, 23630, 2362 23660, 23670, 23680, 23690, 23700, 23710, 2372 23740, 23750, 23760, 23770, 23780, 23790, 2380 23820, 23830, 23840, 23850, 23860, 23870, 2388 23900, 23910, 23920, 23930, 23940, 23950, 2390 23980, 23990, 24100-24136 Anaesthetic, Relative Value Guide 20100, 20102 20124, 20140, 20142-20148, 20160, 20162, 20164 20172, 20174, 20176, 20190, 20192, 20210, 20212 20216, 20220, 20222, 20225, 20230, 20300, 20305 20320-20321, 20330, 20350, 20352, 20355, 20400	80, 23490 60, 23570 40, 23650 20, 23730 00, 23810 80, 23890 60, 23970 2, 20104, 20120 4, 20170 2, 20214 5 0-20406	Anal canal, laser therapy (restriction) anal, excision/repair 32159, 3216 anal, stretching of anastomosis of upper or lower limb Anastomosis, aorta, congenital heart disease and ankle, tibialis tendon transfer and excision of cyst/teratoma and foot, tibialis tendon transfer and sclerectomy, for glaucoma (Lagrange's op) Aneurysm, cerebrovascular, clipping/reinforcement aneurysm, clipping or reinforcement of sac aneurysm, endovascular coiling aneurysm, ligation of cervical vessel/s aneurysm, resection	2, 32165-32166 32153 34503, 34509 38706, 38709 50339, 50342 43912 50339, 50342 42746 39800 39800 35412 39812 38507-38508
23420, 23430, 23440, 23450, 23460, 23470, 23482 23500, 23510, 23520, 23530, 23540, 23550, 2356 23580, 23590, 23600, 23610, 23620, 23630, 2362 23660, 23670, 23680, 23690, 23700, 23710, 2372 23740, 23750, 23760, 23770, 23780, 23790, 2380 23820, 23830, 23840, 23850, 23860, 23870, 23882 23900, 23910, 23920, 23930, 23940, 23950, 2396 23980, 23990, 24100-24136 Anaesthetic, Relative Value Guide 20100, 20102 20124, 20140, 20142-20148, 20160, 20162, 20164 20172, 20174, 20176, 20190, 20192, 20210, 20212 20216, 20220, 20222, 20225, 20230, 20300, 20305 20320-20321, 20330, 20350, 20352, 20355, 20400 20410, 20420, 20440, 20450, 20452, 20470, 20472	80, 23490 60, 23570 40, 23650 20, 23730 00, 23810 80, 23890 60, 23970 2, 20104, 20120 4, 20170 2, 20214 5 0-20406 2	Anal canal, laser therapy (restriction) anal, excision/repair anal, excision/repair anal, stretching of anastomosis of upper or lower limb Anastomosis, aorta, congenital heart disease and ankle, tibialis tendon transfer and excision of cyst/teratoma and foot, tibialis tendon transfer and sclerectomy, for glaucoma (Lagrange's op) Aneurysm, cerebrovascular, clipping/reinforcement aneurysm, clipping or reinforcement of sac aneurysm, endovascular coiling aneurysm, ligation of cervical vessel/s aneurysm, resection Angiofibroma, face/neck, removal by laser excision	2, 32165-32166 32153 34503, 34509 38706, 38709 50339, 50342 43912 50339, 50342 42746 39800 39800 35412 39812 38507-38508
23420, 23430, 23440, 23450, 23460, 23470, 2348 23500, 23510, 23520, 23530, 23540, 23550, 2356 23580, 23590, 23600, 23610, 23620, 23630, 2362 23660, 23670, 23680, 23690, 23700, 23710, 2372 23740, 23750, 23760, 23770, 23780, 23790, 2380 23820, 23830, 23840, 23850, 23860, 23870, 2388 23900, 23910, 23920, 23930, 23940, 23950, 2390 23980, 23990, 24100-24136 Anaesthetic, Relative Value Guide 20100, 20102 20124, 20140, 20142-20148, 20160, 20162, 20164 20172, 20174, 20176, 20190, 20192, 20210, 20212 20216, 20220, 20222, 20225, 20230, 20300, 20305 20320-20321, 20330, 20350, 20352, 20355, 20400	80, 23490 60, 23570 40, 23650 20, 23730 00, 23810 80, 23890 60, 23970 2, 20104, 20120 4, 20170 2, 20214 5 0-20406 2 6, 20528	Anal canal, laser therapy (restriction) anal, excision/repair anal, excision/repair anal, stretching of anastomosis of upper or lower limb Anastomosis, aorta, congenital heart disease and ankle, tibialis tendon transfer and excision of cyst/teratoma and foot, tibialis tendon transfer and sclerectomy, for glaucoma (Lagrange's op) Aneurysm, cerebrovascular, clipping/reinforcement aneurysm, clipping or reinforcement of sac aneurysm, endovascular coiling aneurysm, ligation of cervical vessel/s aneurysm, resection Angiofibroma, face/neck, removal by laser excision angiography, selected coronary 38215, 38218	2, 32165-32166 32153 34503, 34509 38706, 38709 50339, 50342 43912 50339, 50342 42746 39800 39800 35412 39812 38507-38508 1 30190 3, 38220, 38222
23420, 23430, 23440, 23450, 23460, 23470, 23482 23500, 23510, 23520, 23530, 23540, 23550, 2356 23580, 23590, 23600, 23610, 23620, 23630, 2364 23660, 23670, 23680, 23690, 23700, 23710, 2372 23740, 23750, 23760, 23770, 23780, 23790, 2388 23820, 23830, 23840, 23850, 23860, 23870, 2388 23900, 23910, 23920, 23930, 23940, 23950, 2396 23980, 23990, 24100-24136 Anaesthetic, Relative Value Guide 20100, 20102 20124, 20140, 20142-20148, 20160, 20162, 20164 20172, 20174, 20176, 20190, 20192, 20210, 20212 20216, 20220, 20222, 20225, 20230, 20300, 20302 20320-20321, 20330, 20350, 20352, 20355, 20400 20410, 20420, 20440, 20450, 20452, 20470, 20472 20474-20475, 20500, 20520, 20522, 20524, 20526 20540, 20542, 20546, 20548, 20560, 20600, 20604	80, 23490 60, 23570 40, 23650 20, 23730 00, 23810 80, 23890 60, 23970 2, 20104, 20120 4, 20170 2, 20214 5 0-20406 2 6, 20528 4, 20620	Anal canal, laser therapy (restriction) anal, excision/repair anal, excision/repair anal, stretching of anastomosis of upper or lower limb Anastomosis, aorta, congenital heart disease and ankle, tibialis tendon transfer and excision of cyst/teratoma and foot, tibialis tendon transfer and sclerectomy, for glaucoma (Lagrange's op) Aneurysm, cerebrovascular, clipping/reinforcement aneurysm, clipping or reinforcement of sac aneurysm, endovascular coiling aneurysm, ligation of cervical vessel/s aneurysm, resection Angiofibroma, face/neck, removal by laser excision	2, 32165-32166 32153 34503, 34509 38706, 38709 50339, 50342 43912 50339, 50342 42746 39800 39800 35412 39812 38507-38508 1 30190 3, 38220, 38222
23420, 23430, 23440, 23450, 23460, 23470, 23482 23500, 23510, 23520, 23530, 23540, 23550, 2356 23580, 23590, 23600, 23610, 23620, 23630, 2362 23660, 23670, 23680, 23690, 23700, 23710, 2372 23740, 23750, 23760, 23770, 23780, 23790, 2380 23820, 23830, 23840, 23850, 23860, 23870, 2388 23900, 23910, 23920, 23930, 23940, 23950, 2396 23980, 23990, 24100-24136 Anaesthetic, Relative Value Guide 20100, 20102 20124, 20140, 20142-20148, 20160, 20162, 20164 20172, 20174, 20176, 20190, 20192, 20210, 20212 20216, 20220, 20222, 20225, 20230, 20300, 20302 20320-20321, 20330, 20350, 20352, 20355, 20400 20410, 20420, 20440, 20450, 20452, 20470, 20472 20474-20475, 20500, 20520, 20522, 20524, 20526	80, 23490 60, 23570 40, 23650 20, 23730 00, 23810 80, 23890 60, 23970 2, 20104, 20120 4, 20170 2, 20214 5 0-20406 2 6, 20528 4, 20620 0, 20700	Anal canal, laser therapy (restriction) anal, excision/repair anal, excision/repair anal, stretching of anastomosis of upper or lower limb Anastomosis, aorta, congenital heart disease and ankle, tibialis tendon transfer and excision of cyst/teratoma and foot, tibialis tendon transfer and sclerectomy, for glaucoma (Lagrange's op) Aneurysm, cerebrovascular, clipping/reinforcement aneurysm, clipping or reinforcement of sac aneurysm, endovascular coiling aneurysm, ligation of cervical vessel/s aneurysm, resection Angiofibroma, face/neck, removal by laser excision angiography, selected coronary 38215, 38218 38225, 38228, 38231, 38234, 38237, 38240-3824	2, 32165-32166 32153 34503, 34509 38706, 38709 50339, 50342 43912 50339, 50342 42746 39800 39800 35412 39812 38507-38508 1 30190 3, 38220, 38222 1, 38243
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23420, 23430, 23440, 23450, 23460, 23470, 23482 23500, 23510, 23520, 23530, 23540, 23550, 2356 23580, 23590, 23600, 23610, 23620, 23630, 2362 23660, 23670, 23680, 23690, 23700, 23710, 2372 23740, 23750, 23760, 23770, 23780, 23790, 23882 23820, 23830, 23840, 23850, 23860, 23870, 23882 23900, 23910, 23920, 23930, 23940, 23950, 23962 23980, 23990, 24100-24136 Anaesthetic, Relative Value Guide 20100, 20102 20124, 20140, 20142-20148, 20160, 20162, 20164 20172, 20174, 20176, 20190, 20192, 20210, 20212 20216, 20220, 20222, 20225, 20230, 20300, 20302 20320-20321, 20330, 20350, 20352, 20355, 20400 20410, 20420, 20440, 20450, 20452, 20470, 20472 20474-20475, 20500, 20520, 20522, 20524, 20526 20540, 20542, 20546, 20548, 20560, 20600, 20604 20622, 20630, 20632, 20634, 20670, 20680, 20690 20702-20706, 20730, 20740, 20745, 20750, 20752 20756, 20770, 20790-20794, 20798-20800, 20802 20815, 20820, 20830, 20832, 20840-20842, 20844 20850, 20855, 20860, 20862-20864, 20866-20868 20882, 20884, 20886, 20900, 20902, 20904-20906 20910-20912, 20914, 20916, 20920, 20924, 20926 20930, 20932, 20934, 20936, 20938, 20940, 20942 20946, 20948, 20950, 20952-20954, 20956, 20958 21100, 21110, 21112, 21114, 21116, 21120, 21130 21150, 21155, 21160, 21170, 21195, 21199-21200	80, 23490 60, 23570 40, 23650 20, 23730 00, 23810 80, 23890 60, 23970 2, 20104, 20120 4, 20170 2, 20214 5 0-20406 2 6, 20528 4, 20620 0, 20700 2, 20754 2-20806, 20810 4-20848 8, 20880 6, 20928 2-20944 8, 20960 0, 21140 0, 21202	Anal canal, laser therapy (restriction) anal, excision/repair anal, excision/repair anal, stretching of anastomosis of upper or lower limb Anastomosis, aorta, congenital heart disease and ankle, tibialis tendon transfer and excision of cyst/teratoma and foot, tibialis tendon transfer and sclerectomy, for glaucoma (Lagrange's op) Aneurysm, cerebrovascular, clipping/reinforcement aneurysm, clipping or reinforcement of sac aneurysm, endovascular coiling aneurysm, ligation of cervical vessel/s aneurysm, resection Angiofibroma, face/neck, removal by laser excision angiography, selected coronary 38215, 38218, 38221, 38225, 38228, 38231, 38234, 38237, 38240-3824 38246 angiography, selective 38215, 38218, 38226 38228, 38231, 38234, 38237, 38240-38241, 3824 Angioma, cauterisation/injection into angioplasty, peripheral Angioplasty, peripheral Angioplasty, peripheral laser Angioscopy Ankle, achilles tendon, operation for lengthening Annuloplasty, heart valve 3847 Anophthalmic orbit, insertion cartilage/implant anophthalmic, placement of motility integrating per	2, 32165-32166 32153 34503, 34509 38706, 38709 50339, 50342 43912 50339, 50342 42746 39800 35412 39812 38507-38508 1 30190 3, 38220, 38222 1, 38243 2), 38222, 38225 43, 38246 45027 35315 35315 35324, 35327 49727 5, 38477-38478 42518 eg 42518
23420, 23430, 23440, 23450, 23460, 23470, 23482 23500, 23510, 23520, 23530, 23540, 23550, 2356 23580, 23590, 23600, 23610, 23620, 23630, 2362 23660, 23670, 23680, 23690, 23700, 23710, 2372 23740, 23750, 23760, 23770, 23780, 23790, 23882 23820, 23830, 23840, 23850, 23860, 23870, 23882 23900, 23910, 23920, 23930, 23940, 23950, 23962 23980, 23990, 24100-24136 Anaesthetic, Relative Value Guide 20100, 20102 20124, 20140, 20142-20148, 20160, 20162, 20164 20172, 20174, 20176, 20190, 20192, 20210, 20212 20216, 20220, 20222, 20225, 20230, 20300, 20302 20320-20321, 20330, 20350, 20352, 20355, 20400 20410, 20420, 20440, 20450, 20452, 20470, 20472 20474-20475, 20500, 20520, 20522, 20524, 20526 20540, 20542, 20546, 20548, 20560, 20600, 20604 20622, 20630, 20632, 20634, 20670, 20680, 20690 20702-20706, 20730, 20740, 20745, 20750, 20752 20756, 20770, 20790-20794, 20798-20800, 20802 20815, 20820, 20830, 20832, 20840-20842, 20844 20850, 20855, 20860, 20862-20864, 20866-20868 20882, 20884, 20886, 20900, 20902, 20904-20906 20910-20912, 20914, 20916, 20920, 20924, 20926 20930, 20932, 20934, 20936, 20938, 20940, 20942 20946, 20948, 20950, 20952-20954, 20956, 20958 21100, 21110, 21112, 21114, 21116, 21120, 21130 21150, 21155, 21160, 21170, 21195, 21199-21200 21210, 21212, 21214, 21216, 21220, 21230, 21230	80, 23490 60, 23570 40, 23650 20, 23730 00, 23810 80, 23890 60, 23970 2, 20104, 20120 4, 20170 2, 20214 5 0-20406 2 6, 20528 4, 20620 0, 20700 2, 20754 2-20806, 20810 4-20848 8, 20880 6 6, 20928 2-20944 8, 20960 0, 21140 0, 21202 2, 21234	Anal canal, laser therapy (restriction) anal, excision/repair anal, excision/repair anal, stretching of anastomosis of upper or lower limb Anastomosis, aorta, congenital heart disease and ankle, tibialis tendon transfer and excision of cyst/teratoma and foot, tibialis tendon transfer and sclerectomy, for glaucoma (Lagrange's op) Aneurysm, cerebrovascular, clipping/reinforcement aneurysm, clipping or reinforcement of sac aneurysm, endovascular coiling aneurysm, ligation of cervical vessel/s aneurysm, resection Angiofibroma, face/neck, removal by laser excision angiography, selected coronary 38215, 38218, 38225, 38228, 38231, 38234, 38237, 38240-3824 38246 angiography, selective 38215, 38218, 38226 38228, 38231, 38234, 38237, 38240-38241, 3824 Angioma, cauterisation/injection into angioplasty, peripheral Angioplasty, peripheral Angioplasty, peripheral laser Angioscopy Ankle, achilles tendon, operation for lengthening Annuloplasty, heart valve 3847 Anophthalmic orbit, insertion cartilage/implant anophthalmic, placement of motility integrating period	2, 32165-32166 32153 34503, 34509 38706, 38709 50339, 50342 43912 50339, 50342 42746 39800 35412 39812 38507-38508 1 30190 3, 38220, 38222 1, 38243 2), 38222, 38225 43, 38246 45027 35315 35315 35324, 35327 49727 5, 38477-38478 42518 eg 42518 32123
23420, 23430, 23440, 23450, 23460, 23470, 23482 23500, 23510, 23520, 23530, 23540, 23550, 2356 23580, 23590, 23600, 23610, 23620, 23630, 2362 23660, 23670, 23680, 23690, 23700, 23710, 2372 23740, 23750, 23760, 23770, 23780, 23790, 23882 23820, 23830, 23840, 23850, 23860, 23870, 23882 23900, 23910, 23920, 23930, 23940, 23950, 23962 23980, 23990, 24100-24136 Anaesthetic, Relative Value Guide 20100, 20102 20124, 20140, 20142-20148, 20160, 20162, 20164 20172, 20174, 20176, 20190, 20192, 20210, 20212 20216, 20220, 20222, 20225, 20230, 20300, 20302 20320-20321, 20330, 20350, 20352, 20355, 20400 20410, 20420, 20440, 20450, 20452, 20470, 20472 20474-20475, 20500, 20520, 20522, 20524, 20526 20540, 20542, 20546, 20548, 20560, 20600, 20604 20622, 20630, 20632, 20634, 20670, 20680, 20690 20702-20706, 20730, 20740, 20745, 20750, 20752 20756, 20770, 20790-20794, 20798-20800, 20802 20815, 20820, 20830, 20832, 20840-20842, 20844 20850, 20855, 20860, 20862-20864, 20866-20868 20882, 20884, 20886, 20900, 20902, 20904-20906 20910-20912, 20914, 20916, 20920, 20924, 20926 20930, 20932, 20934, 20936, 20938, 20940, 20942 20946, 20948, 20950, 20952-20954, 20956, 20958 21100, 21110, 21112, 21114, 21116, 21120, 21130 21150, 21155, 21160, 21170, 21195, 21199-21200	80, 23490 60, 23570 40, 23650 20, 23730 00, 23810 80, 23890 60, 23970 2, 20104, 20120 4, 20170 2, 20214 5 0-20406 2 6, 20528 4, 20620 0, 20700 2, 20754 2-20806, 20810 4-20848 8, 20880 6 6, 20928 2-20944 8, 20960 0, 21140 0, 21202 2, 21234 0, 21321	Anal canal, laser therapy (restriction) anal, excision/repair anal, excision/repair anal, stretching of anastomosis of upper or lower limb Anastomosis, aorta, congenital heart disease and ankle, tibialis tendon transfer and excision of cyst/teratoma and foot, tibialis tendon transfer and sclerectomy, for glaucoma (Lagrange's op) Aneurysm, cerebrovascular, clipping/reinforcement aneurysm, clipping or reinforcement of sac aneurysm, endovascular coiling aneurysm, ligation of cervical vessel/s aneurysm, resection Angiofibroma, face/neck, removal by laser excision angiography, selected coronary 38215, 38218, 38221, 38225, 38228, 38231, 38234, 38237, 38240-3824 38246 angiography, selective 38215, 38218, 38226 38228, 38231, 38234, 38237, 38240-38241, 3824 Angioma, cauterisation/injection into angioplasty, peripheral Angioplasty, peripheral Angioplasty, peripheral laser Angioscopy Ankle, achilles tendon, operation for lengthening Annuloplasty, heart valve 3847 Anophthalmic orbit, insertion cartilage/implant anophthalmic, placement of motility integrating per	2, 32165-32166 32153 34503, 34509 38706, 38709 50339, 50342 43912 50339, 50342 42746 39800 35412 39812 38507-38508 1 30190 3, 38220, 38222 1, 38243 2), 38222, 38225 43, 38246 45027 35315 35315 35324, 35327 49727 5, 38477-38478 42518 eg 42518

antenatal		16500	arteriovenous, upper or lower limb	34503, 34509
Antenatal cardiotocography (restriction)		16514	artery bypass vein graft, dissection	38637
Antepartum haemorrhage, treatment of		16509	artery catheterisation	13818
Anterior chamber, irrigation of blood from		42743	3	35406, 35408
anterior or posterior chamber or both		42740	artery embolisation	35410
	024-32026,	32028	Artery, anastomosis of, microvascular	45502
antireflux operation by	31464,		Artery, great ligation/exploration,other	34103
	527, 30529·		artery, internal, transection/resection	32703
Antrectomy and/or vagotomy	30497,		artery, transantral ligation of	41707
Antrobuccal fistula operation	,	41722		49309, 49312
antrobuccol, operation for		41722	arthrectomy or arthrodesis 4	48939, 48942
Antroscopy of temporomandibular joint	45855,	45857		49309, 49312
Antrostomy, radical	41710,	41713	Arthrocentesis. with irrigation of temporomandibular	joint 45865
Antrum, drainage of, through tooth socket		41719	arthrodesis 4	45877, 49306
antrum, proof puncture and lavage of	41698,	41701	arthrodesis of 49512, 49545, 49712, 49815, 4	19845, 50109
Anus, dilatation of (Lord's procedure)		32153	Arthrodesis, ankle	49712
Aorta, anastomosis, congenital heart disease	38706,	38709	arthroplasty 49309, 49312, 49315, 49318-4	49319, 49321
aorta, operative management of rupture/dissecti	on	38572	49324, 49327, 49330, 49333, 49336, 49339, 49342	
aorta, repair or replacement procedures	38550,	38553	49345-49346	
38556, 38559, 38562, 38565, 38568, 38571			arthroplasty of 49209, 49518-49519, 49521, 4	19524, 49527
aortic aneurysm, endovascular repair of	33116,		49530, 49533-49534	
	708, 32710		arthroplasty of, not otherwise covered	50127
	160, 34163,		Arthroplasty, ankle	49715
	160, 34163,		arthroplasty, revision	49346
Aorto-femoral endarterectomy		33515	arthroscopic surgery 48948, 48951, 48954, 4	18957, 48960
Aorto-iliac endarterectomy		33512	49221, 49224, 49227	
Aortopexy for tracheomalacia		43909	1 6 7	49121, 49703
Appendiceal abscess, laparotomy for drainage		30394	arthroscopy 48945, 49360, 4	
appendiceal, laparotomy for drainage		30394	arthroscopy of 45855, 45857, 49218, 49557-4	19564, 49566
	572, 30574,		50100	40110 40700
Appendicectomy, laparoscopic		30646		49118, 49700
Appendix, ruptured, laparotomy for drainage		30394		49700, 49703
application of a localiser cast to		50600	arthrotomy 45859, 46327, 46330, 4	
application of formalin		32212	arthrotomy of 49100, 49212, 49500, 4	49706, 50103
Arachnoidal cyst, craniotomy for		39718	Arthrotomy, ankle	
Arch Bars, to maxilla or mandible, removal of area, exploration of		45823 36537	· · · · · · · · · · · · · · · · · · ·	37426, 37429 37426, 37429
Areola, reconstruction of	45545-		artificial erection device, revision or removal of	37420, 37429
Arm, amputation or disarticulation of	43343	44328		42707, 42710
arm, upper (and elbow) 21700, 21710, 217	712 21714		artificial, removal or repositioning	42707, 42710
21730, 21732, 21740, 21756, 21760, 21770, 2			Arytenoidectomy with microlaryngoscopy	41867
21730, 21732, 21740, 21730, 21700, 21770, 2	1772, 2170	O	aspiration biopsy of cyst/s	45799
Arnold Chiari malformation, decompression of		40106	Aspiration biopsy, bone marrow	30087
arrest of post-operative haemorrhage		30663	* * * * * * * * * * * * * * * * * * * *	38615, 38618
	287, 38290,			38621, 38624
arrhythmia, surgery for 38287, 38290, 382				25200, 25205
38512, 38515, 38518	, ,		Assistance at operations 51300, 51303, 51306, 5	
Arterial anastomosis, not otherwise covered	32766,	32769	51315, 51318	,
arterial catheterisation	,	35321	assistance time 23010, 23021-23023, 2	23031-23033
arterial, collection for pathology	13839,	13842	23041-23043, 23051-23053, 23061-23063, 23071-2	23073
arterial/venous, independent		32766	23081-23083, 23091, 23101, 23111-23119, 23121,	
arterial/venous, with other operation		32769	23180, 23190, 23200, 23210, 23220, 23230, 23240	, 23250
Arteries, major, access as part of re-operation		35202	23260, 23270, 23280, 23290, 23300, 23310, 23320,	, 23330
Arteriography, operative		35200	23340, 23350, 23360, 23370, 23380, 23390, 23400	, 23410
Arteriography, preparation for	38215,	38218	23420, 23430, 23440, 23450, 23460, 23470, 23480	, 23490
Arteriovenous access device, insertion of		34512	23500, 23510, 23520, 23530, 23540, 23550, 23560	, 23570
arteriovenous malformation, excision of		39803	23580, 23590, 23600, 23610, 23620, 23630, 23640,	
	112, 34115,		23660, 23670, 23680, 23690, 23700, 23710, 23720	
	121, 34124,	34127	23740, 23750, 23760, 23770, 23780, 23790, 23800	
34130			23820, 23830, 23840, 23850, 23860, 23870, 23880	
arteriovenous, external, insertion/removal	34500,		23900, 23910, 23920, 23930, 23940, 23950, 23960,	, 23970
arteriovenous, ligation cervical vessel/s		39812	23980, 23990, 24100-24136	

assistance, modifiers 25000, 25005, 25010, 25015, 25020	biopsy of vertebra 30093
25025, 25030 25005, 25010, 25013, 25020	biopsy of with hysteroscopy 35630
Assisted reproductive technologies 13200, 13203, 13206	biopsy of with hysteroscopy 35030 biopsy of, with cystoscopy 36836
13209, 13212, 13215, 13218, 13221	
atherectomy, peripheral 35312	Biopsy, aggressive bone/deep tissue tumour 50200-50201
Atherectomy, peripheral arterial 35312	biopsy, by cardiac catherterisation 38275
atresia, auditory canal reconstruction 45662	biopsy, deep organ, imaging guided 30094
Atresia, choanal, repair/correction 45645-45646	biopsy, using ABBI 31539, 31545
atresia/corrosive stricture, replacement for 43903	bladder stress, suprapubic operation 37044
Atrial chamber/s, operations for arrhythmia 38512, 38515	Bladder, aspiration of, by needle 37041
Atticotomy 41533, 41536	bladder, cystoscopic removal of 36833
auditory canal, correction of 41521	bladder, diathermy/resection with cystoscopy 36840, 36845
Auditory canal, external 41524	bladder, endoscopic incision/resection 36854
auditory meatus, removal of exostoses 41518	bladder, laser destruction with cystoscopy 36840
augmentation 38766	bladder, removal of 36863
Augmentation mammaplasty 45524, 45527-45528	Bladder, stress incontinence, sling procedure 37040, 37338
Aural polyp, removal of 41506	blepharospasm 18369-18370, 18372, 18374
aural, removal of 41506, 41509	blood pressure monitoring 13876
Autoconjunctival transplant 42641	body tumour, resection of 34148, 34151, 34154
Avulsion, penis, repair of 37411	bone conduction hearing system 41603-41604
Axilla, lymph glands, excision of 30332	bone graft to 50644
	bone grafting for pseudarthrosis 46405
Axillary hyperhidrosis, vessle, ligation/exploration, other 34103	bone grafting of phalanx for 46402, 46405
Axillofemoral graft, infected, excision of 34172	bone marrow 30081, 30084, 30087
_	bone, benign, requiring allograft, resection of 50230
В	Bone, cysts, injection into or aspiration of 47900
	bone, fracture, treatment of 45981, 47762, 47765, 47768
Baker's cyst, excision of 30114	47771
Baker's, excision of 30114	bone, injection into or aspiration of 47900
Balloon catheter, right heart, insertion of 13818	bone, innocent, excision of 30241
balloon dilatation of 41832	bone, malignant, operations for 50200-50201, 50203, 50206
Balloon enteroscopy 30680, 30682, 30684, 30686	50209, 50212, 50215, 50218, 50221, 50224, 50227, 50230
balloon pump, insertion of 38362, 38609	50233, 50236, 50239
balloon pump, removal of 38612-38613	bone, operation on, for osteomyelitis 43509, 43518
bands or lingual tonsils, removal of 41804	bone, osteectomy or osteotomy of 48424, 48427
& ,	bone, reconstruction of 45788
Bariatric Surgery 31569, 31572, 31575, 31578, 31581, 31584	bone, removal of styloid process of 30244
Bariatric surgery, surgical reversal of 31584	bone, resection for removal of tumour 41584, 41587
Bartholin's abscess, incision of 35520	bones, bone grafting, pseudarthrosis 46402, 46405
Bartholin's, cautery destruction of 35517	bones, fracture, treatment of 47735, 47738, 47741
Bartholin's, excision of 35513	
Bartholin's, incision of 35520	bones, operation for osteomyelitis 46462
Bartholin's, marsupialisation of 35517	bones, osteotomy/osteectomy 46396, 46399
base tumour, removal, infra-temporal 41581	Botulinum toxin, injection for 18350-18351, 18353-18354
Bat ear or similar deformity, correction of 45659	18360, 18362, 18365-18366, 18368-18370, 18372, 18374
bed, reconstruction of laceration 46486	18377, 18379
benign lesion 31500, 31503	Boutonniere deformity, reconstruction of 46444, 46447
benign, of soft tissue, removal 31350	bowel intubation 30488
Bicornuate uterus, plastic reconstruction for 35680	bowel stricture plasty 30564
bicornuate, plastic reconstruction for 35680	Bowel, colectomy, total 30608, 30622, 32009, 32012, 32015
Bile duct, common, radical resection 30461, 30463-30464	32018, 32021
Biliary atresia, paediatric, portoenterostomy for 43978	bowel, endoscopic examination of 32095
biliary dilatation 30495	Brachial fistula 43832
biliary drainage 30440, 30451, 30495	Brachial plexus, exploration of 39333
biliary stenting 30492	Brachial, removal of 30287
	Brachycephaly, cranial vault reconstruction for 45785
biliary/renal tract, extraction of 30450	Brachytherapy planning 15536
biopsies, multiple, with infracolic omentectomy 35726	brain, operations for 39703
biopsy 30409, 30411-30412	Branchial cyst, removal of 30286-30287
biopsy (closed) 36561	branchial, removal of 30286, 30289
biopsy of 30075, 30081, 30084, 30087, 42676	breast 31530, 31533, 31548
biopsy of for suspected malignancy 35620	
biopsy of prostate 37212, 37218	Breast, biopsy, fine needle, imaging guided 31533
biopsy of solid tumour, vacuum-assisted, image guided 31530	breast, correction of (unilateral) 45556

breast, exploration and drainage	31551	capsulotomy 42788
Breast, malignant tumour, targeted intraoperative ra	diotherapy	Capsulotomy, laser 42788
	15900	Carbon dioxide laser resurfacing, face or neck 45025-45026
Breast, malignant tumuor, complete local excision	31516	Carbuncle, incision and drainage, with GA 30223
breast, removal and/or replacement 45553-45554	45548, 45551	cardiac 38200, 38203, 38206, 38209, 38212-38213, 38215 38218, 38220, 38222
Broad ligament cyst/tumour, excision/removal	35713, 35717	Cardiac by-pass, whole body perfusion 22060
broad ligament, excision of	35713, 35717	cardiac, excision of 38670, 38673, 38677, 38680
broad ligament, removal of	35713, 35717	Cardiopexy, antireflux operation 30530
Brodie's abscess, operation for	43515	Cardioplegia, retrograde administration of 22070
bronchgenic, thoracotomy and excision	43912	Cardiopulmonary bypass, cannulation for 38600, 38603
Bronchial tree, intrathoracic operation on, other	38456	Cardiotocography, antenatal (restriction) 16514
Bronchoscopy, as an independent procedure	41889	Cardioversion 13400
Bronchus, dilatation of stricture and stent insertion	41905	care, independent of confinement 16500 Carotid artery, aneurysm, graft replacement 33100
bronchus, removal of Broviac catheter, insertion of, for chemotherapy	41895 34527-34528	J, J, E 1
34540	34327-34328	carotid body, resection of 34148, 34151, 34154 carotid-cavernous, obliteration of 39815
Bubonocele operation	30614	carpal bone 46324-46325
Bunion, excision of	47933	Carpal bone, replacement arthroplasty 46324-46325
Burch colposuspension	37044	Carpometacarpal joint, arthrodesis of 46303
Burns, dressing of (not involving grafting)	30003, 30006	carpus 48406, 48409
30010, 30014	20002, 20000	Carpus dislocation, treatment of 47030, 47033
Burr-hole craniotomy, intracranial haemorrhage	39600	carpus, operation for 46462
burr-hole for intracranial haemorrhage	39600	caruncle, cauterisation of 35523
Burst abdomen, repair of	30403	caruncle, excision of 35527
by open exposure of the trachea	41881	Caruncle, urethral, cauterisation of 35523
	6-30467, 38627	Cataract, juvenile, removal of 42716
bypass for venous stenosis or occlusion	34812	catheter, insertion and fixation of 13109
bypass grafting, occlusive arterial disease	32700, 32703	catheter, insertion of 39140
32708, 32710-32712, 32715, 32718, 32721, 3272		catheter, insertion of for infusion device 39125, 39128
32733, 32736, 32739, 32742, 32745, 32748, 327	51, 32754	Catheter, peritoneal insertion and fixation 13109
32757, 32760, 32763		catheter, removal of 13110, 34530, 34540
Bypass, extracranial to intracranial	39818	catheterisation 38200, 38203, 38206, 38209, 38212-38213
	0, 32703, 32708	38215, 38218, 38220, 38222
32710-32712, 32715, 32718, 32721, 32724, 3273		catheterisation - for myocardial biopsy 38275
32736, 32739, 32742, 32745, 32748, 32751, 3275	54, 32/5/	catheterisation of 36800, 38200, 38203, 38206
32760, 32763		catheterisation with cystoscopy 36818, 36824 Catheterisation, bladder, independent procedure 36800
С		catheterisation, peripheral 35317, 35319-35321
C		cauterisation of, for ectropion or entropion 42581
Connectorus	20275 20627	cauterisation of, other than by chemical means 35608
Caecostomy,	30375, 30637	Cauterisation, angioma (restriction applies) 45027
Caesarean section calcaneal spur, excision of	16520, 16522 49818	Cautery, conjunctiva, including treatment of pannus 42677
Calcaneal spur, of foot, excision of	49818	caval filter, insertion of 35330
Calcanean bursa, excision of	30111	cavernous fistula, obliteration of 39815
· · · · · · · · · · · · · · · · · · ·	, 47612, 47615	Cavernous sinus, tumour or vascular lesion, excision 39660
47618	, ., 012, ., 010	cavity and/or post nasal space, examination of 41653
	5, 30457-30458	cavity, aspiration of 38800, 38803
Caldwell-Luc operation	41710	cavity, packing for arrest of haemorrhage 41677
	5, 47978, 47981	cavity, reconstruction of 45590
canal external, blind sac closure	41564	Cavopulmonary shunt, creation of 38733, 38736
canal stenosis, correction of, with meatoplasty	41521	Cellulitis, incision with drainage, under GA 30223
canaliculus, immediate repair of	42605	Central cannulation for cardiopulmonary bypass 38600
Cancer of skin/mucous membrane, removal	30196, 30202	central ducts, excision for benign condition 31557
cancer, treatment of	30196, 30202	central vein 13318-13319, 13815
Cannulae, membrane oxygenation	38627	central vein, for haemodialysis or parenteral nutrition 34538
cannulation for cardiopulmonary bypass	38603	central vein, subcutaneous tunnel 34527-34528
cannulation for infusion chemotherapy, open	34524	central vein, tunnelled cuffed 34538 central vein, tunnelled cuffed catheter 34538
cannulation of, in a neonate	13300	central vein, tunnelled cuffed catheter 34538 central, catheterisation 13318-13319, 13815
Cannulation, arterial, for infusion chemotherapy	34524	central, catheterisation, subcutaneous tunnel 34527-34528
Canthoplasty	42590	cephalic version 34327-34328
Capsulectomy	42719, 42731	cophane version 10501

Cerebello-pontine angle tumour 41575-41576	11570 11570	alagura of	1102 20562
	, 41578-41579 41575-41576	closure of 30 closure of and repair of musculoaponeurotic layer	0103, 30562 45570
cerebello-pontine angle, removal of	413/3-413/6		
41578-41579	1 64 50200	closure of, in conjunction with free tissue transfer or b	
Cerebral palsy, hips or knees, application of cast und		reconstruction	45569
Cerebrospinal fluid drain, lumbar, insertion of	40018		2063, 32066
cervical	30294	closure of, without resection of bowel	30562
cervical, neonatal oesophageal atresia	43858	closure or plastic repair of	30293
cervix	35608, 35646	Club hand, radial, centralisation/radialisation	50399
Cervix, amputation or repair of	35618	coalition, excision of	50333
cervix, cone	35618	Coccyx, excision of	30672
cervix, punch	35608	Cochlear implant, insertion with mastoidectomy	41617
cervix, removal of	35611	Cochleotomy, or repair of round window	41614
cervix-residual, removal of, abdominal approach	35612	Coeliac artery, decompression of	34142
cervix-residual, removal of, vaginal approach	35613	coeliac, decompression of	34142
Chalazion, extirpation of	42575	coil, insertion of	37223
chamber, operation for arrhythmia	38518		2004-32005
chemical peel	45019		9503, 49506
Chemical peel, full face	45019	collection of blood for	13709
Chemotherapy 13915, 13918, 13921, 13924, 13927,	, 13930, 13933	collection of, for transfusion	13709
13936, 34529, 34534	24521 24524	collection of, in infants, for pathology	13312
chemotherapy, cannulation for	34521, 34524	Colonic atresia, neonatal, laparotomy for	43816
Chest, or limb, decompression escharotomy	45054	Colonic stent, insertion of	32023
Chloasma, full face chemical peel	45019	colonic, total, intra-operative	32186
Choanal atresia, repair/correction	45645-45646	colonoscopy 32084, 32087, 32	
cholangio-pancreatography	30484	Colonoscopy, fibreoptic 32084, 32087, 32	2090, 32093
Cholangiogram, percutaneous transhepatic	30440	Colorectal strictures, endoscopic dilatation of	32094
cholangiography or pancreatography	30439	colostomy	30375
Cholangiography, operative	30439	Colostomy, closure of 30	0562, 30639
Cholangiopancreatography	30484	Colotomy	30375
Cholecystectomy 30443, 30445-30446	, 30448-30449	Colpoperineorrhaphy 35	5571, 35573
Cholecystoduodenostomy	30460, 31472	colpopexy	35597
Cholecystoenterostomy	30460, 31472	Colpopexy, sacral	35597
Cholecystostomy	30375	colposcopic examination of	35614
Choledochal cyst, resection of	43972, 43975	colposcopy with biopsy and diathermy	35646
choledochal, resection of	43972, 43975	Colposcopy, using Hinselmann-type instrument	35614
Choledochoduodenostomy	30460-30461	Colpotomy	35572
Choledochoenterostomy	30460-30461	compartment repair, anterior	35572
Choledochogastrostomy	30461		35573
	30460-30461	compartment repair, anterior/posterior	
Choledochojejunostomy		compartment repair, posterior	35571
Choledochoscopy	30442, 30452	complicated by previous surgery	37444
	-30455, 30457		5638, 35641
Chondro-cutaneous or chondro-mucosal graft	45656	composite (chondro-cutaneous/mucosal)	45656
Chondroplasty of knee	49503, 49506	composite graft to	45656
Chordee, correction of	37417	Composite graft to nose, ear or eyelid	45656
Chorionic villus sampling	16603	conduit, revision of	36609
cicatricial flexion contracture of, correction	50112		3406, 48424
Cicatricial flexion/extension contracture, joint, corre	ection 50112	Condylectomy/condylotomy	45863
Ciliary body and/or iris, excision of tumour	42767	cone biopsy of	35618
Circulatory support device, management of	13851, 13854	Cone biopsy of cervix	35618
Circumcision 30649,	30654, 30658	Confinement 16515, 16518-16	5520, 16522
Cisternal puncture	39003	congenital abnormalities, amputation of phalanges	50396
clavicle	48406, 48409	congenital abnormalities, splitting of phalanges	50396
Clavicle, dislocation, treatment of	47003, 47006	Congenital absence of vagina, reconstruction for	35565
claw or hammer toe, correction of	49848, 49851		0414, 50417
Claw toe, correction of	49848	50423	, , ,
Cleft lip, operations for 45677, 45680, 45683,		congenital deformity, post-op manipulation, plaster	50348
45692, 45695, 45698, 45701, 45704	43000, 43007	congenital dislocation, open reduction	50351
Clitoris, amputation of, medically indicated	35530	congenital dislocation, open reduction congenital dislocation, reconstruction of quadriceps	50420
Clitoroplasty, reduction, ambiguous genitalia	37845, 37848	congenital dislocation, reconstruction of quadriceps congenital pseudarthritis, resection, fixation	50354
	, 39656, 39658	congenital, vertebral resection and fusion for	50640
Cloaca, persistent, correction of	43969	conjunctiva	42676
Cloacal exstrophy, neonatal, operation for	43882	Conjunctiva, cautery of	42677

conjunctiva, cautery of	42	2677	cyst, anastomosis to Roux loop of jejunum	30587
Conjunctival cysts, removal of		2683	cyst, anastomosis to stomach or duodenum	30586
conjunctival graft		2638	Cyst, anasomosis to stomach of duodenam Cyst, arachnoidal, craniotomy for other, removal o	
conjunctival over cornea		2638	31225, 39718	31220
Conjunctivorhinostomy		2629	cyst, drainage of via burr-hole	39703
Contour reconstruction, insertion of foreign implan		5051	cyst, excision of	35513, 36558
Contraceptive device, intra-uterine, introduction of		5503	cyst, excision of, with hysterectomy	35673
contraceptive device, removal of under GA		5506	cyst, excision of, with laparotomy	35713, 35717
Contracted socket, reconstruction		2527	cyst, extirpation of	42575
contracture of, medial/anterior release	50375, 50	0378	cyst, liver, removal of contents of	30434, 30436
50381, 50384	,		cyst, lungs, enucleation of	38424
	3, 50366, 50	0369	cyst, puncture of, via laparoscope	35637
50372			cyst/s, laparoscopic marsupialisation	30416-30417
Contracture, cicatricial flexion/extension of joint, of	correction 50	0112	Cystadenomatoid malformation, neonatal, thoracot	tomy 43861
cord, teflon injection into		1870	cystectomy, laparoscopic	35638
cordotomy	39	9121	Cystocoele, repair of	35570
Cordotomy, laminectomy for	39	9124	cystoscopy of	36825
core biopsy of solid tumour or tissue	31	1548	Cystoscopy, with	36836
cornea or sclera, imbedded, removal of	42	2644	cystostomy or cystotomy	37008
cornea or sclera, superficial, removal of	30	0061	Cystostomy, suprapubic	37008
Cornea, conjunctival graft over	42	2638	Cystotomy, suprapubic	37008, 37011
corneal	42653, 42	2656	cysts, removal of	41813
Coronary artery bypass operations 38497-3849	98, 38500-38	8501	Cytotoxic agent, instillation into body cavity	13948
38503-38504				
Coronary pressure wire		8241	D	
coronary sinus, for admin of blood or crystalloid		8588		
	98, 38500-38	8501	D and C	35640
38503-38504			Dacryocystectomy	42596
coronary, open operation		8505	Dacryocystorhinostomy	42623, 42626
Corpus callosum, anterior section of, for epilepsy		0700	Debridement of contaminated wound	30023
correction of chordee	37417-37		debridement/eliminating band keratyoplasty	42651
Corticectomy, for epilepsy		0703	Debulking operation, gynaecological malignancy	35720
Corticolysis of lens material		2791	debulking prior to vaginal hysterectomy	35658
corticolysis, laser, of lens material		2791	decompression fasciotomy	47981
Costo-transverse joint, injection into		9013		5, 47978, 47981
Counterpulsation, intra-aortic balloon, managemen			*	5, 47978, 47981
Cranial nerve, intracranial decompression of		9112	decortication with thoracotomy	38421
cranial or cisternal, insertion of		0003	deep hypothermic circulatory arrest	22075
cranial or cisternal, revision or removal of		0009 9112	Deep organ, percutaneous aspiration biopsy	30094
cranial, intracranial decompression Craniectomy and removal of haematoma		9603	deep, percutaneous drainage	30224
Craniopharyngioma, craniotomy for removal of		9712	deep, peripheral nerve, removal of	39327
Craniopharyngionia, craniotomy for removal of Cranioplasty and repair of fractured skull		9615	defect, ventricular, closure of	38751
Craniostenosis, operations for	40115, 40		Defibrillator generator, insertion/replacement	38393
Craniotomy and tumour removal	39709, 39		deformity, correction of	50300
Cricopharyngeal myotomy		1776	Delorme procedure	32111
Cricothyrostomy		1884	Dermabrasion	45021, 45024
	6, 49539, 49		dermis, dermo-fat or fascia	45018
Cruciate ligaments, reconstruction/repair	49536, 49		Dermo-fat or fascia graft	45018
49542	1,550, 1,	,,,,,	dermoid of, congenital, excision of dermoid, congenital, excision of	41729 42573-42574
Cryotherapy for detached retina	42	2773	Dermoid, excision of	42573-42574
cryotherapy to		2680	dermoid, excision of	42573-42574
Crystalloid, retrograde admin for cardioplegia		8588	destruction by radiofrequency ablation	50950, 50952
curettage of		5640	destruction of bladder tumour with cystoscopy	36840, 36845
curettage of uterus	35640, 35		destruction of bladder turnour with cystoscopy	37318
Curettage, for evacuation of gravid uterus		5643	destruction/non-resectable liver cancer	50950, 50952
cutaneous, nerve graft to		9318	detached retina	42773
cutaneous, repair of	39300, 39		Detached retina, diathermy/cryotherapy	42773
cutaneous, salivary gland, repair of		0269	detached, diathermy or cryotherapy for	42773
Cyclodestructive procedures treatment of glaucoma		2770	detached, removal of encircling silicone band	42812
cyst aspiration		5518	detached, resection or buckling operation for	42776
cyst or gland, marsupialisation of		5517	detached, revision operation for	42779
				,,,

device for delivery of therapeutic agents 14221, 14224	division of, with laparoscopy 30393
14227, 14230, 14233, 14236, 14239, 14242	division of, with laparotomy 30376, 30378-30379
device for drug delivery, loading of 13939, 13942, 13945	Dohlman's operation 41773
device, automated, spinal, insertion of 39125-39128	Donald-Fothergill operation 35577
device, insertion, central vein catheterisation 34527-34529, 34534	Donor haemapheresis 13755
device, intra-uterine, removal under GA 35506	donor, continuous perfusion of 22055
device, introduction of, for idiopathic menorrhagia 35502	Double vagina, excision of septum 35566
device, removal of 34530	drainage by insertion of glass tube 42608
diagnostic 30390	drainage of deep abscess, imaging guided 30224
dialysis in hospital 13100, 13103	drainage of empyema, without rib resection 38806, 38809
Diaphragm, plication of for eventration 43915	drainage of, transthoracic 38450
Diaphragmatic hernia, neonatal, repair of 43837, 43840	drainage tube exchange, imaging guided 30451
diaphragmatic, neonatal, repair of 43837, 43840	drainage tube, exchange of 30225
diaphragmatic, repair of 30600-30601, 43838	drainage tube, exchange of, imaging guided 36649
Diaphyseal aclasia, removal of lesion/s from bone 50426	dressing and removal of, requiring GA 30055
Diastematomyelia, tethered cord, release of 40112	dressing of, requiring GA 30055 Drez lesion, operation for 39124
diathermy of 35608, 35646, 37318 Diathermy of bladder tumours 36840, 36845	Drez lesion, operation for 39124 Drill biopsy of lymph gland/deep tissue/organ 30078
diathermy or visual laser destruction of 37224	drill decompression of head/neck or both 47982
diathermy/visual laser for lesion of prostate 37224	drill, lymph gland, deep tissue/organ 30078
Digit, amputation of 46464-46465, 46468, 46471, 46474, 46477	Drug delivery device, loading of 13939, 13942, 13945
46480	drug delivery system 39125-39126, 39128, 39133
digital nail, removal of 46513, 46516	drug delivery system for spasticity management 14227
Digital nail, toe, removal of 47904, 47906	14230, 14233, 14236, 14239, 14242
digital, of finger or thumb, removal of 46513, 46516	drum perforation, excision of rim 41644
digital, of toe, removal of 47904, 47906	duct, common, repair of 30472
digits, flexor/extensor contracture, correction 46492	duct, endoscopic stenting of 30491
dilatation 36821	duct, meatotomy or marsupialisation 30266
dilatation of 41822, 41825, 41828, 41831	duct, patent vitello, excision of 43945
dilatation of colorectal strictures 32094	duct, removal of calculus 30266
dilatation of, as an independent procedure 35554	duct, repair of, 30246
dilatation with cystoscopy 36812	Duct, salivary gland, diathermy/dilatation 30262
dilatation, endoscopic 30494	Ducts submandibular, removal of 30255
dilatation, percutaneous 30495	ducts, relocation of 30255
Direct flap repair 45209, 45212, 45215, 45218, 45221, 45224	ducts, Roux-en-Y bypass 30466-30467
direct, indirect or local, revision of 45239-45240	ductus arteriosus, division/ligation 38700, 38703
discontinuation of surgical procedure on medical groups 30001	Duodenal atresia, duodeno-duodenostomy/jejunostomy 43807
disease, neonatal, laparotomy for 43819	duodenal, perforated, suture of 30375
disease, paediatric, operations for 43990, 43993, 43996 43999	Duodenoduodenostomy for duodenal atresia/stenosis 43807 Duodenojejunostomy for duodenal atresia/stenosis 43807
Disimpaction of faeces under GA 32153 dislocation, acetabulum fracture, treatment 47495, 47498	Duodenoscopy 30473, 30478 duplication of digits, amputation of phalanges 50396
dislocation, congenital, treatment of 50349, 50352	duplication of digits, splitting of phalanges 50396 duplication of digits, splitting of phalanges 50396
dislocation, congenital, treatment of including paediatric 50650,	Dupuytren's contracture, operations for 46366, 46369, 46372
50654, 50658	46375, 46378, 46381, 46384, 46387, 46390, 46393
dislocation, treatment of 41686, 47009, 47012, 47015	Dupuytren's, subcutaneous fasciotomy for 46366
47018, 47021, 47024, 47027, 47030, 47033, 47036, 47039	dynamic equinus foot deformity 18354
47042, 47045, 47048, 47051, 47054, 47057, 47060, 47063	Dysthyroid eye disease, decompression of orbit 42545
47066, 47069, 47072	dystopia, correction of 45776, 45779
dislocations, treatment of 47000	
Dissection, lymph nodes of neck 30618, 31423, 31426, 31429 31432, 31435, 31438	E
distal, devascularisation of 32200	E.C.T. 14224
distal, excision of ganglion/mucous cyst 46495	ear, complex total reconstruction of 45660-45661
distal, for osteomyelitis 46459	Ear, composite graft to 45656
diverticulum of, excision or obliteration 37020	ear, exploration of 41629
Diverticulum, bladder, excision/obliteration 37020	ear, insertion of tube for drainage of 41632
diverticulum, excision of 37372	ear, operation for abscess or inflammation of 41626
divided, repair of 36573	ear, removal of 41500, 41503
division of adhesions 30393, 35637	Eclampsia, treatment of 16509
division of suture, eye 42794	Ectopic bladder, 'turning-in' operation 37842
division of suture, laser 42794	ectopic, 'turning-in' operation 37842

ectropion or entropion, correction of	45626	Enterotomy, intra-operative, for endoscopy	30568
Ectropion, correction of	45626	Entropion, correction of	45626
	, 49118, 49121		2506, 42509-42510
Elbow, arthrodesis of	49106	Enucleation of eye	42506, 42509
electrical stimulation of	13400	Epicondylitis, open operation for	47903
electrocoagulation diathermy	35644-35645	Epididymal cyst, excision of	37601
electrocoagulation, of cervix	35644-35645	epididymal, removal of	37601
Electroconvulsive therapy	14224	Epididymectomy	37613
electrode placement	40709, 40712	Epidural blood patch	18233
Electrode(s), epidural, insertion by laminectomy	39139	epidural electrode, insertion	39130
electrode, insertion	39130, 39139	epidural electrodes, management of	39131
electrode, management, adjustment etc.	39131	epidural implant, removal	39136
Electrolysis epilation, for trichiasis	42587-42588	epidural, for pain management, removal of	39136
	, 38212-38213	epidural, insertion of	39140
Electrophysiological studies, cardiac 38209	, 38212-38213	epidural, percutaneous insertion of	39130
Embolectomy	33803, 33806	epidural, percutaneous, management of	39131
	, 33803, 33806	Epigastric hernia, repair of	30621
Embolus, removal from artery of neck	33800	Epilation electrolysis, for trichiasis	42587-42588
Emphysema, lobar, neonatal, thoracotomy & lung re			10700-40709, 40712
Empyema, intercostal drainage of	38806, 38809		8503, 48506, 48509
Enbloc resection of tumour 50212, 50215, 50218,	, 50221, 50224		8500, 48503, 48506
50227			8500, 48503, 48506
Encephalocoele, excision and closure of	40109	Epiphysiolysis, to prevent closure of plate	48512
Endarterectomy 33500, 33506, 33509, 33512			7836, 37839, 37842
33521, 33524, 33527, 33530, 33533, 33536, 33539		Epistaxis, treatment of	41656, 41677
endarterectomy	33509, 33521	Epithelial debridement for corneal ulcer/erosion	
endarterectomy of 33500, 33506, 33509, 33512		epithelial debridement for corneal ulcer/erosic	
33521, 33524, 33527, 33530, 33533, 33536, 3353		epithelial debridement for keratoplasty	42651
endarterectomy, open operation	38505		0318, 50321, 50324
Endobronchial tumour, endoscopic laser resection	41901	50327, 50330	27.422
endobronchial ultrasound, lung tumours	30710	erection device, revision or removal of	37432
Endocarditis, operative management of	38493	ESWL	36546 41725
	3, 30580-30581 3, 30580-30581	Ethmoidal artery, transorbital ligation of	41723
endocrine, exploration of 30578 Endolymphatic sac, transmastoid decompression	41590	ethmoidal, external operation on ethmoidal, transorbital ligation of	41749
endometrial	35616	Ethmoidectomy, fronto-nasal	41723
Endometrial biopsy for suspected malignancy	35620	Etonogestral, subcutaneous implant, removal o	
endometrial, for suspected malignancy	35620	eustachian tube	41755
Endometriosis, laparoscopic ablation	35638	Eustachian tube, catheterisation of	41755
Endometrium, ablation of, endoscopic	35622	Evacuation of retained products of conception	16564
endoscopic	30485, 36854	Eventration, plication of diaphragm for	43915
Endoscopic biliary dilatation	30494	Evisceration of globe of eye	42512, 42515
endoscopic examination and ablation by microway		examination of intestinal conduit/reservoir	36860
balloon	35616	examination of small bowel	30569, 32095
endoscopic examination with cystoscopy	36812	examination under GA, paediatric	44101-44102
endoscopic gastrostomy	30481-30482	examination, under GA	32171
endoscopic laser ablation	37207-37208	excavatum, repair or radical correction	38457-38458
Endoscopic ultrasound fine needle aspiration	30696	excision of 30099, 30103, 30226, 30229, 3	
Endoscopy with balloon dilatation gastric stricture	30475	30448-30449, 30583, 37000, 37014, 45030,	
enlargement of, using intestine	37047	45035-45036	
entero-	30515	excision of infected by-pass graft	34157
Enterocoele, repair of	35571	excision of lip, eyelid or ear, full thickness	45665
Enterocolitis, acute neonatal necrotising, laparotomy	43828	excision of rectal tumour 3	32103-32104, 32106
43831		excision of tumour of	42764
Enterocolostomy	30515	excision of under GA (not involving grafting)	
Enterocutaneous fistula, radical repair of	30382	excision of, in oral & maxillofacial region	45801, 45803
enterocutaneous, radical resection	30382	45805, 45807, 45809	
Enteroenterostomy	30515	excision of, oral & maxillofacial region	45801, 45803
enterogenous, thoracotomy and excision	43912	45805, 45807, 45809	
enterostomy	30375	excision of, with melanoma	31340
Enterostomy, closure of	30562	excision of, with melanoma	31340
enterotomy	30375	excision, repair, without cardiopulmonary byp	bass 38453

excision, tumours of face/neck Exenteration of orbit of eye	30190 42536	Fasciectomy, for Dupuytren's Contracture 46369, 46372, 46375 46378, 46381, 46384, 46387, 46390, 46393
	0, 43873	Fasciotomy, forearm or calf 47975, 47978, 47981
Exostoses in external auditory meatus, removal	41518	fasciotomy, hand 47981
	3, 47936	feeding jejunostomy 31462
expander, insertion of	45566	femoral bypass, saphenous vein anastomosis 34809
expander, removal of	45568	Femoral hernia, repair of 30609, 30614
expansion, intra-operative	45572	Femoral hernia, vessel, ligation/exploration, other 34103
exploration of 36537, 3661		femoral or inguinal, repair of 30609, 30614, 43841
	8, 30320	Femoro-femoral crossover bypass grafting 32718
exploration/drainage, operating theatre	31551	femoro-femoral, infected, excision of 34172
exploratory	30373	femur 48424, 48427
exstrophy closure	37050	Femur, bone graft to 48200, 48203
exstrophy of, repair of	37842	Fetal blood sampling 16606
Exstrophy, cloacal, neonatal, operation for	43882	Feto-amniotic shunt, insertion of 16627
extension, percutaneous gastrostomy tube	31460	Fibreoptic bronchoscopy 41898
extensive, multiple injections of hydrocortisone	30210	fibreoptic examination of 41764
	0, 46423	fibreoptic, with examination of larynx 41764
extensor tendon of, repair of 4642	0, 46423	Fibrinolysis 42791
extensor tendon of, tenolysis of	46450	fibrinolysis 42791
	4, 45662	fibula 48406, 48409
external auditory canal, reconstruction	45662	Fibula, congenital deficiency, transfer fibula to tibia 50423
external auditory, removal of keratosis obturans	41509	field setting 15500, 15503, 15506, 15509, 15512-15513
External cephalic version	16501	15515
external operation on	41876	Filtering and allied operations for glaucoma 42746
	0-45661	Fimbrial cyst, removal of 35713, 35717
Extra digit, amputation of	46464	fimbrial, excision of 35713, 35717
extra, amputation of	46464	Finger, amputation of 46465, 46468, 46471, 46474, 46477
extra-ocular, ruptured, repair of	42854	46480, 46483
	7, 38760	finger, open repair of text test 46441
Extracorporeal shock wave lithotripsy	36546	finger, with intra-articular fracture, open reduction 46442
**	8, 39821	finger/hand 46300, 46303, 46306-46307, 46309, 46312, 46315
extraction	42698	46318, 46321, 46327, 46330
extraction and insertion of artificial lens	42702	finger/hand, debridement of 46336
extremity, reoperation for control of	33848	first, resection of portion 34136
Eye, capsulotomy, laser	42788	Fissure in ano, operation for 32150
eye, decompression of	42545 42536	fissure, operation for, including excision 32150
eye, exenteration of eye, exploration of 4253	0, 42533	fistula extremity, surgically created, closure 34130 fistula in ano, excision of 32156
eye, removal tumour/foreign body 42539, 4254	•	Fistula, alimentary, repair of 35596, 37834
eye, skin graft to	42524	fistula, closure of 37038, 37333, 37336, 37833
Eyeball, repair of perforating wound 42551, 4255		fistula, dissection and ligation/repair 34112, 34115
Eyebrow, elevation of	42872	34118, 34121, 34124, 34127
Eyelashes, ingrowing, operation for	45626	fistula, excision/repair 32156, 32159, 32162, 32165
Eyelid closure in facial nerve paralysis, implant insertion	42869	fistula, ligation of cervical vessel/s 39812
face or neck, revision of (restriction applies)	45506	fistula, readjustment of Seton 32166
45512		fistula, removal of 30289
		fistula, repair of 30269
F		fistula, repair or closure of 35596, 37029, 37333
		fistula, stenosis of, correction of 34518
Face, injections of poly-L-Lactic acid	14201	Fixation, external, removal of 47948, 47951
	3-45754	fixation, orthopaedic, removal 47948, 47951
face/neck, laser excision	30190	flap for velo-pharyngeal incompetence 45716
Facet joint denervation by percutaneous neurotomy	39118	flap repair 45000, 45003, 45006, 45009, 45012, 45200
Facial, nerve, decompression of	41569	45203, 45206
facio-hypoglossal or facio-accessory, anastomosis of	39503	flap revision 45239-45240
facio-hypoglossal/accessory nerve	39503	flap, delay of 45015
Facio-hypoglossal/accessory nerve, anastomosis of	39503	flap, infected, craniectomy for 39906
	3-32218	flexor tendon of, repair of 46423, 46426, 46429, 46432
Fallopian tubes, catheterisation, with hysteroscopy	35633	46435
Falloposcopy, unilateral/bilateral	35710	flexor tendon of, tenolysis of 46453
Fascia, deep, repair of, for herniated muscle	30238	flexor tendon sheath, open operation 46522

Flexor tendon, hand, repair of 46426, 46429, 46432,	46435	23770, 23780, 23790, 23800, 23810, 23820, 23830	23840
flexor/extensor contracture, correction of	46492	23850, 23860, 23870, 23880, 23890, 23900, 23910	
flexor/extensor, digits of hand, correction of	46492	23930, 23940, 23950, 23960, 23970, 23980, 23990	*
Flexorplasty to restore elbow function	50405	24100-24136, 25000, 25005, 25010, 25015, 25020	
flexorplasty/tendon transfer to restore function	50405	25030, 25050, 25200, 25205	
floor repair, laparoscopic or abdominal	35595	for arachnoidal cyst	39718
Fluid Filled Cavity, drainage of	16624	for cardiopulmonary bypass	38600, 38603
fluid filled cavity, drainage of	16624	for congenital cystadenomatoid malformation	43861
fluid reservoir, insertion of	39018	for congenital lobar emphysema	43861
focal spasticity	18360	for control of post-operative haemorrhage	30385, 33845
following gynaecological surgery, under GA	35759	for cordotomy or myelotomy	39124
following intraocular procedures	42857	for drainage	30394
foot 49815, 49833, 49836-49839, 49842,	, 49845	for grading of lymphoma	30384
foot deformities due to spasticity	18354	for gross intra-peritoneal sepsis	30396
Foot, amputation or disarticulation of 44359, 44361,	•	for implantable bone conduction hearing system	41603-41604
For anaesthesia 20100, 20102, 20104, 20120, 20124,	, 20140	for intussusception, paediatric	43933, 43936
20142-20148, 20160, 20162, 20164, 20170, 20172, 20174		for neonatal conditions 43801, 43804, 43807	, 43810, 43813
20176, 20190, 20192, 20210, 20212, 20214, 20216, 20220	1	43816, 43819, 43822, 43825, 43828, 43831	
20222, 20225, 20230, 20300, 20305, 20320-20321, 20330		for oesophageal atresia, neonatal	43852
20350, 20352, 20355, 20400-20406, 20410, 20420, 20440		for osteomyelitis/removal infected bone	39906
20450, 20452, 20470, 20472, 20474-20475, 20500, 20520		1	, 15539, 37220
20522, 20524, 20526, 20528, 20540, 20542, 20546, 20548		for removal of thymus or mediastinal tumour	38446
20560, 20600, 20604, 20620, 20622, 20630, 20632, 20634		for reopening post-op for haemorrhage/swelling	39721
20670, 20680, 20690, 20700, 20702-20706, 20730, 20740		for retrograde cerebral perfusion	38577
20745, 20750, 20752, 20754, 20756, 20770, 20790-20794		for staging of gynaecological malignancy	35726
20798-20800, 20802-20806, 20810, 20815, 20820, 20830		for supercharging of pedicled flaps	45561 45629
20832, 20840-20842, 20844-20848, 20850, 20855, 20860		for symblepharon for thrombosis	33845
20862-20864, 20866-20868, 20880, 20882, 20884, 20886 20900, 20902, 20904-20906, 20910-20912, 20914, 20916		for trauma, involving 3 or more organs	30388
20920, 20924, 20926, 20928, 20930, 20932, 20934, 20936		for trichiasis	42587-42588
20938, 20940, 20942-20944, 20946, 20948, 20950	•	for tumour	36532
20952-20954, 20956, 20958, 20960, 21100, 21110, 21112		for tumour, complicated	36533
21114, 21116, 21120, 21130, 21140, 21150, 21155, 21160		ioi tumoui, complicated	30333
	(Foramen Magnum, tumour or vascular lesion, excisi	ion 39662
		Foramen Magnum, tumour or vascular lesion, excisi	
21170, 21195, 21199-21200, 21202, 21210, 21212, 21214		Forearm, amputation or disarticulation of	44328
21170, 21195, 21199-21200, 21202, 21210, 21212, 21214 21216, 21220, 21230, 21232, 21234, 21260, 21270, 21272		Forearm, amputation or disarticulation of forearm, wrist & hand 21800, 21810, 21820	44328 , 21830, 21832
21170, 21195, 21199-21200, 21202, 21210, 21212, 21214 21216, 21220, 21230, 21232, 21234, 21260, 21270, 21272 21274-21275, 21280, 21300, 21321, 21340, 21360, 21380		Forearm, amputation or disarticulation of forearm, wrist & hand 21800, 21810, 21820 21834, 21840, 21842, 21850, 21860, 21865, 2187	44328 , 21830, 21832 70, 21872
21170, 21195, 21199-21200, 21202, 21210, 21212, 21214 21216, 21220, 21230, 21232, 21234, 21260, 21270, 21272 21274-21275, 21280, 21300, 21321, 21340, 21360, 21380 21382, 21390, 21392, 21400, 21402-21404, 21420, 21430		Forearm, amputation or disarticulation of forearm, wrist & hand 21800, 21810, 21820 21834, 21840, 21842, 21850, 21860, 21865, 2187 foreign body in cornea or sclera, removal of	44328 , 21830, 21832 70, 21872 42644
21170, 21195, 21199-21200, 21202, 21210, 21212, 21214 21216, 21220, 21230, 21232, 21234, 21260, 21270, 21272 21274-21275, 21280, 21300, 21321, 21340, 21360, 21380 21382, 21390, 21392, 21400, 21402-21404, 21420, 21430 21432, 21440, 21445, 21460-21462, 21464, 21472, 21474		Forearm, amputation or disarticulation of forearm, wrist & hand 21800, 21810, 21820 21834, 21840, 21842, 21850, 21860, 21865, 2187 foreign body in cornea or sclera, removal of foreign body in, removal of	44328 , 21830, 21832 70, 21872
21170, 21195, 21199-21200, 21202, 21210, 21212, 21214 21216, 21220, 21230, 21232, 21234, 21260, 21270, 21272 21274-21275, 21280, 21300, 21321, 21340, 21360, 21380 21382, 21390, 21392, 21400, 21402-21404, 21420, 21430		Forearm, amputation or disarticulation of forearm, wrist & hand 21800, 21810, 21820 21834, 21840, 21842, 21850, 21860, 21865, 2187 foreign body in cornea or sclera, removal of	44328 , 21830, 21832 70, 21872 42644 42563, 42569
21170, 21195, 21199-21200, 21202, 21210, 21212, 21214 21216, 21220, 21230, 21232, 21234, 21260, 21270, 21272 21274-21275, 21280, 21300, 21321, 21340, 21360, 21380 21382, 21390, 21392, 21400, 21402-21404, 21420, 21430 21432, 21440, 21445, 21460-21462, 21464, 21472, 21474 21480, 21482, 21484, 21486, 21490, 21500, 21502, 21520		Forearm, amputation or disarticulation of forearm, wrist & hand 21800, 21810, 21820 21834, 21840, 21842, 21850, 21860, 21865, 2187 foreign body in cornea or sclera, removal of foreign body in, removal of foreign body in, removal of, other than simple	44328 , 21830, 21832 70, 21872 42644 42563, 42569 41659
21170, 21195, 21199-21200, 21202, 21210, 21212, 21214 21216, 21220, 21230, 21232, 21234, 21260, 21270, 21272 21274-21275, 21280, 21300, 21321, 21340, 21360, 21380 21382, 21390, 21392, 21400, 21402-21404, 21420, 21430 21432, 21440, 21445, 21460-21462, 21464, 21472, 21474 21480, 21482, 21484, 21486, 21490, 21500, 21502, 21520 21522, 21530, 21532, 21535, 21600, 21610, 21620, 21622		Forearm, amputation or disarticulation of forearm, wrist & hand 21800, 21810, 21820 21834, 21840, 21842, 21850, 21860, 21865, 2187 foreign body in cornea or sclera, removal of foreign body in, removal of foreign body in, removal of, other than simple foreign body in, superficial, removal of	44328 , 21830, 21832 70, 21872 42644 42563, 42569 41659 30061
21170, 21195, 21199-21200, 21202, 21210, 21212, 21214 21216, 21220, 21230, 21232, 21234, 21260, 21270, 21272 21274-21275, 21280, 21300, 21321, 21340, 21360, 21380 21382, 21390, 21392, 21400, 21402-21404, 21420, 21430 21432, 21440, 21445, 21460-21462, 21464, 21472, 21474 21480, 21482, 21484, 21486, 21490, 21500, 21502, 21520 21522, 21530, 21532, 21535, 21600, 21610, 21620, 21622 21630, 21632, 21634, 21636, 21638, 21650, 21652, 21654		Forearm, amputation or disarticulation of forearm, wrist & hand 21800, 21810, 21820 21834, 21840, 21842, 21850, 21860, 21865, 2187 foreign body in cornea or sclera, removal of foreign body in, removal of foreign body in, removal of, other than simple foreign body in, superficial, removal of Foreign body, antrum, removal of	44328 , 21830, 21832 70, 21872 42644 42563, 42569 41659 30061 41716
21170, 21195, 21199-21200, 21202, 21210, 21212, 21214 21216, 21220, 21230, 21232, 21234, 21260, 21270, 21272 21274-21275, 21280, 21300, 21321, 21340, 21360, 21380 21382, 21390, 21392, 21400, 21402-21404, 21420, 21430 21432, 21440, 21445, 21460-21462, 21464, 21472, 21474 21480, 21482, 21484, 21486, 21490, 21500, 21502, 21520 21522, 21530, 21532, 21535, 21600, 21610, 21620, 21622 21630, 21632, 21634, 21636, 21638, 21650, 21652, 21654 21656, 21670, 21680, 21682, 21685, 21700, 21710, 21712		Forearm, amputation or disarticulation of forearm, wrist & hand 21800, 21810, 21820 21834, 21840, 21842, 21850, 21860, 21865, 2187 foreign body in cornea or sclera, removal of foreign body in, removal of foreign body in, removal of, other than simple foreign body in, superficial, removal of Foreign body, antrum, removal of foreign body, removal not otherwise covered foreign body, removal of foreign, insertion for contour reconstruction	44328 , 21830, 21832 70, 21872 42644 42563, 42569 41659 30061 41716 30064
21170, 21195, 21199-21200, 21202, 21210, 21212, 21214 21216, 21220, 21230, 21232, 21234, 21260, 21270, 21272 21274-21275, 21280, 21300, 21321, 21340, 21360, 21380 21382, 21390, 21392, 21400, 21402-21404, 21420, 21430 21432, 21440, 21445, 21460-21462, 21464, 21472, 21474 21480, 21482, 21484, 21486, 21490, 21500, 21502, 21520 21522, 21530, 21532, 21535, 21600, 21610, 21620, 21622 21630, 21632, 21634, 21636, 21638, 21650, 21652, 21654 21656, 21670, 21680, 21682, 21685, 21700, 21710, 21712 21714, 21716, 21730, 21732, 21740, 21756, 21760, 21770 21772, 21780, 21785, 21790, 21800, 21810, 21820, 21830 21832, 21834, 21840, 21842, 21850, 21860, 21865, 21870		Forearm, amputation or disarticulation of forearm, wrist & hand 21800, 21810, 21820 21834, 21840, 21842, 21850, 21860, 21865, 2187 foreign body in cornea or sclera, removal of foreign body in, removal of foreign body in, removal of, other than simple foreign body in, superficial, removal of Foreign body, antrum, removal of foreign body, removal not otherwise covered foreign body, removal of foreign, insertion for contour reconstruction formation of, including enoscopic procedures	44328 , 21830, 21832 70, 21872 42644 42563, 42569 41659 30061 41716 30064 42563, 42569 45051 41885
21170, 21195, 21199-21200, 21202, 21210, 21212, 21214 21216, 21220, 21230, 21232, 21234, 21260, 21270, 21272 21274-21275, 21280, 21300, 21321, 21340, 21360, 21380 21382, 21390, 21392, 21400, 21402-21404, 21420, 21430 21432, 21440, 21445, 21460-21462, 21464, 21472, 21474 21480, 21482, 21484, 21486, 21490, 21500, 21502, 21520 21522, 21530, 21532, 21535, 21600, 21610, 21620, 21622 21630, 21632, 21634, 21636, 21638, 21650, 21652, 21654 21656, 21670, 21680, 21682, 21685, 21700, 21710, 21712 21714, 21716, 21730, 21732, 21740, 21756, 21760, 21770 21772, 21780, 21785, 21790, 21800, 21810, 21820, 21830 21832, 21834, 21840, 21842, 21850, 21860, 21865, 21870 21872, 21878-21887, 21900, 21906, 21908, 21910, 21912		Forearm, amputation or disarticulation of forearm, wrist & hand 21800, 21810, 21820 21834, 21840, 21842, 21850, 21860, 21865, 2187 foreign body in cornea or sclera, removal of foreign body in, removal of foreign body in, removal of, other than simple foreign body in, superficial, removal of Foreign body, antrum, removal of foreign body, removal not otherwise covered foreign body, removal of foreign, insertion for contour reconstruction formation of, including enoscopic procedures fracture, treatment of 47348, 47351	44328 , 21830, 21832 70, 21872 42644 42563, 42569 41659 30061 41716 30064 42563, 42569 45051 41885 , 47378, 47381
21170, 21195, 21199-21200, 21202, 21210, 21212, 21214 21216, 21220, 21230, 21232, 21234, 21260, 21270, 21272 21274-21275, 21280, 21300, 21321, 21340, 21360, 21380 21382, 21390, 21392, 21400, 21402-21404, 21420, 21430 21432, 21440, 21445, 21460-21462, 21464, 21472, 21474 21480, 21482, 21484, 21486, 21490, 21500, 21502, 21520 21522, 21530, 21532, 21535, 21600, 21610, 21620, 21622 21630, 21632, 21634, 21636, 21638, 21650, 21652, 21654 21656, 21670, 21680, 21682, 21685, 21700, 21710, 21712 21714, 21716, 21730, 21732, 21740, 21756, 21760, 21770 21772, 21780, 21785, 21790, 21800, 21810, 21820, 21830 21832, 21834, 21840, 21842, 21850, 21860, 21865, 21870 21872, 21878-21887, 21900, 21906, 21908, 21910, 21912 21914-21916, 21918, 21922, 21925-21927, 21930, 21935-	-21936	Forearm, amputation or disarticulation of forearm, wrist & hand 21800, 21810, 21820 21834, 21840, 21842, 21850, 21860, 21865, 2187 foreign body in cornea or sclera, removal of foreign body in, removal of foreign body in, removal of, other than simple foreign body in, superficial, removal of Foreign body, antrum, removal of foreign body, removal not otherwise covered foreign body, removal of foreign, insertion for contour reconstruction formation of, including enoscopic procedures fracture, treatment of 47348, 47351 47384-47387, 47390, 47393, 47396, 47399, 4740	44328 , 21830, 21832 70, 21872 42644 42563, 42569 41659 30061 41716 30064 42563, 42569 45051 41885 , 47378, 47381 2, 47405
21170, 21195, 21199-21200, 21202, 21210, 21212, 21214 21216, 21220, 21230, 21232, 21234, 21260, 21270, 21272 21274-21275, 21280, 21300, 21321, 21340, 21360, 21380 21382, 21390, 21392, 21400, 21402-21404, 21420, 21430 21432, 21440, 21445, 21460-21462, 21464, 21472, 21474 21480, 21482, 21484, 21486, 21490, 21500, 21502, 21520 21522, 21530, 21532, 21535, 21600, 21610, 21620, 21622 21630, 21632, 21634, 21636, 21638, 21650, 21652, 21654 21656, 21670, 21680, 21682, 21685, 21700, 21710, 21712 21714, 21716, 21730, 21732, 21740, 21756, 21760, 21770 21772, 21780, 21785, 21790, 21800, 21810, 21820, 21830 21832, 21834, 21840, 21842, 21850, 21860, 21865, 21870 21872, 21878-21887, 21900, 21906, 21908, 21910, 21912 21914-21916, 21918, 21922, 21925-21927, 21930, 21935- 21939, 21941-21943, 21945, 21949, 21952, 21955, 21959	21936	Forearm, amputation or disarticulation of forearm, wrist & hand 21800, 21810, 21820 21834, 21840, 21842, 21850, 21860, 21865, 2187 foreign body in cornea or sclera, removal of foreign body in, removal of, other than simple foreign body in, superficial, removal of Foreign body, antrum, removal of foreign body, removal not otherwise covered foreign body, removal of foreign, insertion for contour reconstruction formation of, including enoscopic procedures fracture, treatment of 47348, 47351 47384-47387, 47390, 47393, 47396, 47399, 47404 47408, 47411, 47414, 47417, 47420, 47423, 4742	44328 , 21830, 21832 70, 21872 42644 42563, 42569 41659 30061 41716 30064 42563, 42569 45051 41885 , 47378, 47381 2, 47405 26, 47429
21170, 21195, 21199-21200, 21202, 21210, 21212, 21214 21216, 21220, 21230, 21232, 21234, 21260, 21270, 21272 21274-21275, 21280, 21300, 21321, 21340, 21360, 21380 21382, 21390, 21392, 21400, 21402-21404, 21420, 21430 21432, 21440, 21445, 21460-21462, 21464, 21472, 21474 21480, 21482, 21484, 21486, 21490, 21500, 21502, 21520 21522, 21530, 21532, 21535, 21600, 21610, 21620, 21622 21630, 21632, 21634, 21636, 21638, 21650, 21652, 21654 21656, 21670, 21680, 21682, 21685, 21700, 21710, 21712 21714, 21716, 21730, 21732, 21740, 21756, 21760, 21770 21772, 21780, 21785, 21790, 21800, 21810, 21820, 21830 21832, 21834, 21840, 21842, 21850, 21860, 21865, 21870 21872, 21878-21887, 21900, 21906, 21908, 21910, 21912 21914-21916, 21918, 21922, 21925-21927, 21930, 21935- 21939, 21941-21943, 21945, 21949, 21952, 21955, 21959 21962, 21965, 21969-21970, 21973, 21976, 21980, 21990	21936	Forearm, amputation or disarticulation of forearm, wrist & hand 21800, 21810, 21820 21834, 21840, 21842, 21850, 21860, 21865, 2187 foreign body in cornea or sclera, removal of foreign body in, removal of, other than simple foreign body in, superficial, removal of Foreign body, antrum, removal of foreign body, removal not otherwise covered foreign body, removal of foreign, insertion for contour reconstruction formation of, including enoscopic procedures fracture, treatment of 47348, 47351 47384-47387, 47390, 47393, 47396, 47399, 47404 47408, 47411, 47414, 47417, 47420, 47423, 47424 47432, 47435, 47438, 47441, 47444, 47444, 47447, 4745	44328 , 21830, 21832 70, 21872 42644 42563, 42569 41659 30061 41716 30064 42563, 42569 45051 41885 , 47378, 47381 2, 47405 26, 47429 50-47451
21170, 21195, 21199-21200, 21202, 21210, 21212, 21214 21216, 21220, 21230, 21232, 21234, 21260, 21270, 21272 21274-21275, 21280, 21300, 21321, 21340, 21360, 21380 21382, 21390, 21392, 21400, 21402-21404, 21420, 21430 21432, 21440, 21445, 21460-21462, 21464, 21472, 21474 21480, 21482, 21484, 21486, 21490, 21500, 21502, 21520 21522, 21530, 21532, 21535, 21600, 21610, 21620, 21622 21630, 21632, 21634, 21636, 21638, 21650, 21652, 21654 21656, 21670, 21680, 21682, 21685, 21700, 21710, 21712 21714, 21716, 21730, 21732, 21740, 21756, 21760, 21770 21772, 21780, 21785, 21790, 21800, 21810, 21820, 21830 21832, 21834, 21840, 21842, 21850, 21860, 21865, 21870 21872, 21878-21887, 21900, 21906, 21908, 21910, 21912 21914-21916, 21918, 21922, 21925-21927, 21930, 21935- 21939, 21941-21943, 21945, 21949, 21952, 21955, 21959 21962, 21965, 21969-21970, 21973, 21976, 21980, 21990 21992, 21997, 22001-22002, 22007-22008, 22012, 22014-	21936	Forearm, amputation or disarticulation of forearm, wrist & hand 21800, 21810, 21820 21834, 21840, 21842, 21850, 21860, 21865, 2187 foreign body in cornea or sclera, removal of foreign body in, removal of, other than simple foreign body in, superficial, removal of Foreign body, antrum, removal of foreign body, removal not otherwise covered foreign body, removal of foreign, insertion for contour reconstruction formation of, including enoscopic procedures fracture, treatment of 47348, 47351 47384-47387, 47390, 47393, 47396, 47399, 47404 47408, 47411, 47414, 47417, 47420, 47423, 47424 47432, 47435, 47438, 47441, 47444, 47447, 4745 47453, 47456, 47459, 47462, 47465-47467, 4747	44328 , 21830, 21832 70, 21872 42644 42563, 42569 41659 30061 41716 30064 42563, 42569 45051 41885 , 47378, 47381 2, 47405 26, 47429 50-47451 71, 47474
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21170, 21195, 21199-21200, 21202, 21210, 21212, 21214, 21216, 21220, 21230, 21232, 21234, 21260, 21270, 21272, 21274-21275, 21280, 21300, 21321, 21340, 21360, 21380, 21382, 21390, 21392, 21400, 21402-21404, 21420, 21430, 21432, 21440, 21445, 21460-21462, 21464, 21472, 21474, 21480, 21482, 21484, 21486, 21490, 21500, 21502, 21520, 21522, 21530, 21532, 21535, 21600, 21610, 21620, 21622, 21630, 21632, 21634, 21636, 21638, 21650, 21652, 21654, 21656, 21670, 21680, 21682, 21685, 21700, 21710, 21712, 21714, 21716, 21730, 21732, 21740, 21756, 21760, 21770, 21772, 21780, 21785, 21790, 21800, 21810, 21820, 21832, 21834, 21840, 21842, 21850, 21860, 21865, 21870, 21872, 21878-21887, 21900, 21906, 21908, 21910, 21912, 21914-21916, 21918, 21922, 21925-21927, 21930, 21935-21939, 21941-21943, 21945, 21949, 21952, 21955, 21959, 21962, 21965, 21969-21970, 21973, 21976, 21980, 21990, 21992, 21997, 22001-22002, 22007-22008, 22012, 22014-22018, 22020, 22025, 22031, 22036, 22040, 22045, 22050-22051, 22055, 22060, 22065, 22070, 22075, 22900, 22905, 23010, 23021-23023, 23031-23033, 23041-23043, 23051-23053, 23061-23063, 23071-23073, 23081-23083, 23101, 23111-23119, 23121, 23170, 23180, 23190, 23200, 23210, 23220, 23230, 23240, 23250, 23260, 23270, 23280, 23290, 23300, 23310, 23320, 23330, 23340, 23350, 23360, 23310, 23310, 23310, 23310, 23320, 23320, 23330, 23340, 23350, 23360, 23370, 23350, 233	21936 -22015 23091	Forearm, amputation or disarticulation of forearm, wrist & hand 21800, 21810, 21820 21834, 21840, 21842, 21850, 21860, 21865, 2187 foreign body in cornea or sclera, removal of foreign body in, removal of of foreign body in, removal of, other than simple foreign body in, superficial, removal of foreign body, antrum, removal of foreign body, removal not otherwise covered foreign body, removal of foreign, insertion for contour reconstruction formation of, including enoscopic procedures fracture, treatment of 47348, 47351 47384-47387, 47390, 47393, 47396, 47399, 4740447408, 47411, 47414, 47417, 47420, 47423, 47424, 47432, 47435, 47438, 47441, 47441, 47444, 47447, 47453, 47456, 47459, 47462, 47465-47467, 47474, 47477, 47480, 47483, 47486, 47489, 47492, 474528, 47531, 47534, 47537, 47510, 47516, 47519, 47528, 47531, 47534, 47537, 47543, 47546, 4754, 47555, 47558, 47561, 47564-47567, 47570, 47579, 47582, 47585, 47588, 47591, 47594, 47594, 47630, 47637, 47630, 47633, 47636, 47639, 47648, 47651, 47654, 47657, 47735, 47738, 47748, 47631, 47654, 47657, 47735, 47738, 47748, 47631, 47654, 47657, 47735, 47738, 47748, 47631, 47654, 47657, 47735, 47738, 47748, 47631, 47654, 47657, 47735, 47738, 47748, 47631, 47654, 47657, 47735, 47738, 47748, 47631, 47654, 47657, 47735, 47738, 47748, 47651, 47654, 47657, 47735, 47738, 47748, 47654, 47651, 47654, 47657, 47735, 47738, 47748, 47631, 47654, 47657, 47735, 47738, 47748, 47631, 47654, 47657, 47735, 47738, 47748, 47631, 47654, 47657, 47735, 47738, 47748, 47631, 47654, 47657, 47735, 47738, 47748, 47631, 47654, 47657, 47735, 47738, 47748, 47631, 47654, 47657, 47735, 47738, 47748, 47631, 47654, 47657, 47735, 47738, 47748, 47631, 47654, 47657, 47735, 47738, 47748, 47648, 47651, 47654, 47657, 47735, 47738, 47748, 47648, 47651, 47654, 47657, 47735, 47738, 47748, 47648, 47651, 47654, 47657, 47735, 47738, 47748, 47648, 47651, 47654, 47657, 47735, 47738, 47748, 47648, 47651, 47654, 47657, 47735, 47738, 47748, 47648, 47651, 47654, 47657, 47735, 47738, 47748, 47648, 47651, 47654, 47657, 47735, 4	44328 , 21830, 21832 70, 21872 42644 42563, 42569 41659 30061 41716 30064 42563, 42569 45051 41885 , 47378, 47381 2, 47405 26, 47429 50-47451 71, 47474 95, 47498 22, 47525 19, 47552 73, 47576 97, 47600 12, 47645 11, 49336
21170, 21195, 21199-21200, 21202, 21210, 21212, 21214 21216, 21220, 21230, 21232, 21234, 21260, 21270, 21272 21274-21275, 21280, 21300, 21321, 21340, 21360, 21380 21382, 21390, 21392, 21400, 21402-21404, 21420, 21430 21432, 21440, 21445, 21460-21462, 21464, 21472, 21474 21480, 21482, 21484, 21486, 21490, 21500, 21502, 21520 21522, 21530, 21532, 21535, 21600, 21610, 21620, 21622 21630, 21632, 21634, 21636, 21638, 21650, 21652, 21654 21656, 21670, 21680, 21682, 21685, 21700, 21710, 21712 21714, 21716, 21730, 21732, 21740, 21756, 21760, 21770 21772, 21780, 21785, 21790, 21800, 21810, 21820, 21830 21832, 21834, 21840, 21842, 21850, 21860, 21865, 21870 21872, 21878-21887, 21900, 21906, 21908, 21910, 21912 21914-21916, 21918, 21922, 21925-21927, 21930, 21935- 21939, 21941-21943, 21945, 21949, 21952, 21955, 21959 21962, 21965, 21969-21970, 21973, 21976, 21980, 21990 21992, 21997, 22001-22002, 22007-22008, 22012, 22014- 22018, 22020, 22025, 22031, 22036, 22040, 22045 22050-22051, 22055, 22060, 22065, 22070, 22075, 22900 22905, 23010, 23021-23023, 23031-23033, 23041-23043 23051-23053, 23061-23063, 23071-23073, 23081-23083, 2 23101, 23111-23119, 23121, 23170, 23180, 23190, 23200 23210, 23220, 23230, 23240, 23250, 23260, 23270, 23280 23290, 23300, 23310, 23320, 23330, 23340, 23350, 23360 23370, 23380, 23390, 23400, 23410, 23420, 23430, 23440	21936 -22015 23091	Forearm, amputation or disarticulation of forearm, wrist & hand 21800, 21810, 21820 21834, 21840, 21842, 21850, 21860, 21865, 2187 foreign body in cornea or sclera, removal of foreign body in, removal of of foreign body in, removal of, other than simple foreign body in, superficial, removal of foreign body, antrum, removal of foreign body, removal not otherwise covered foreign body, removal of foreign, insertion for contour reconstruction formation of, including enoscopic procedures fracture, treatment of 47348, 47351 47384-47387, 47390, 47393, 47396, 47399, 4740447408, 47411, 47414, 47417, 47420, 47423, 4742447432, 47435, 47438, 47441, 474414, 47444, 47447, 47453, 47456, 47459, 47462, 47465-47467, 474747, 47480, 47483, 47486, 47489, 47492, 474528, 47531, 47534, 47537, 47510, 47516, 47519, 47528, 47531, 47534, 47537, 47543, 47546, 475447579, 47582, 47585, 47588, 47591, 47594, 47594, 47630, 47637, 47630, 47633, 47636, 47639, 47648, 47651, 47654, 47657, 47735, 47738, 477450552, 50556, 50560, 50564, 50568, 50572, 50556	44328 , 21830, 21832 70, 21872 42644 42563, 42569 41659 30061 41716 30064 42563, 42569 45051 41885 , 47378, 47381 2, 47405 26, 47429 50-47451 71, 47474 95, 47498 22, 47525 19, 47552 73, 47576 97, 47600 12, 47645 11, 49336
21170, 21195, 21199-21200, 21202, 21210, 21212, 21214 21216, 21220, 21230, 21232, 21234, 21260, 21270, 21272 21274-21275, 21280, 21300, 21321, 21340, 21360, 21380 21382, 21390, 21392, 21400, 21402-21404, 21420, 21430 21432, 21440, 21445, 21460-21462, 21464, 21472, 21474 21480, 21482, 21484, 21486, 21490, 21500, 21502, 21520 21522, 21530, 21532, 21535, 21600, 21610, 21620, 21622 21630, 21632, 21634, 21636, 21638, 21650, 21652, 21654 21656, 21670, 21680, 21682, 21685, 21700, 21710, 21712 21714, 21716, 21730, 21732, 21740, 21756, 21760, 21770 21772, 21780, 21785, 21790, 21800, 21810, 21820, 21830 21832, 21834, 21840, 21842, 21850, 21860, 21865, 21870 21872, 21878-21887, 21900, 21906, 21908, 21910, 21912 21914-21916, 21918, 21922, 21925-21927, 21930, 21935- 21939, 21941-21943, 21945, 21949, 21952, 21955, 21959 21962, 21965, 21969-21970, 21973, 21976, 21980, 21990 21992, 21997, 22001-22002, 22007-22008, 22012, 22014- 22018, 22020, 22025, 22031, 22036, 22040, 22045 22050-22051, 22055, 22060, 22065, 22070, 22075, 22900 22905, 23010, 23021-23023, 23031-23033, 23041-23043 23051-23053, 23061-23063, 23071-23073, 23081-23083, 2 23101, 23111-23119, 23121, 23170, 23180, 23190, 23200 23210, 23220, 23230, 23240, 23250, 23260, 23270, 23280 23290, 23300, 23310, 23320, 23330, 23340, 23350, 23360 23370, 23380, 23390, 23400, 23410, 23420, 23430, 23440 23450, 23460, 23470, 23480, 23490, 23500, 23510, 23520	21936 222015 23091	Forearm, amputation or disarticulation of forearm, wrist & hand 21800, 21810, 21820 21834, 21840, 21842, 21850, 21860, 21865, 2187 foreign body in cornea or sclera, removal of foreign body in, removal of, other than simple foreign body in, superficial, removal of foreign body, antrum, removal of foreign body, removal not otherwise covered foreign body, removal of foreign, insertion for contour reconstruction formation of, including enoscopic procedures fracture, treatment of 47348, 47351 47384-47387, 47390, 47393, 47396, 47399, 4740447408, 47411, 47414, 47417, 47420, 47423, 47424, 47432, 47435, 47438, 47441, 474414, 47444, 47447, 47453, 47456, 47459, 47462, 47465-47467, 47474, 47453, 474504, 47507, 47510, 47516, 47519, 47528, 47531, 47534, 47537, 47543, 47546, 4754, 47555, 47558, 47561, 47564-47567, 47570, 47579, 47582, 47585, 47588, 47591, 47594, 47594, 47630, 47637, 47630, 47633, 47636, 47639, 47648, 47651, 47654, 47657, 47735, 47738, 477450552, 50556, 50560, 50564, 50568, 50572, 5056 fracture, treatment of paediatric 50500	44328 , 21830, 21832 70, 21872 42644 42563, 42569 41659 30061 41716 30064 42563, 42569 45051 41885 , 47378, 47381 2, 47405 26, 47429 50-47451 71, 47474 95, 47498 22, 47525 19, 47552 73, 47576 97, 47600 12, 47645 11, 49336 76 , 50504, 50508
21170, 21195, 21199-21200, 21202, 21210, 21212, 21214, 21216, 21220, 21230, 21232, 21234, 21260, 21270, 21272, 21274-21275, 21280, 21300, 21321, 21340, 21360, 21380, 21382, 21390, 21392, 21400, 21402-21404, 21420, 21430, 21432, 21440, 21445, 21460-21462, 21464, 21472, 21474, 21480, 21482, 21484, 21486, 21490, 21500, 21502, 21520, 21522, 21530, 21532, 21535, 21600, 21610, 21620, 21622, 21630, 21632, 21634, 21636, 21638, 21650, 21652, 21654, 21656, 21670, 21680, 21682, 21685, 21700, 21710, 21712, 21714, 21716, 21730, 21732, 21740, 21756, 21760, 21770, 21772, 21780, 21785, 21790, 21800, 21810, 21820, 21832, 21834, 21840, 21842, 21850, 21860, 21865, 21870, 21872, 21878-21887, 21900, 21906, 21908, 21910, 21912, 21914-21916, 21918, 21922, 21925-21927, 21930, 21935-21939, 21941-21943, 21945, 21949, 21952, 21955, 21959, 21962, 21965, 21969-21970, 21973, 21976, 21980, 21990, 21992, 21997, 22001-22002, 22007-22008, 22012, 22014-22018, 22020, 22025, 22031, 22036, 22040, 22045, 22050-22051, 22055, 22060, 22065, 22070, 22075, 22900, 22905, 23010, 23021-23023, 23031-23033, 23041-23043, 23051-23053, 23061-23063, 23071-23073, 23081-23083, 23101, 23111-23119, 23121, 23170, 23180, 23190, 23200, 23210, 23220, 23230, 23240, 23250, 23260, 23270, 23280, 23370, 23380, 23310, 23320, 23340, 23340, 23350, 23360, 23370, 23380, 23340, 23440, 23450, 23460, 23470, 23480, 23490, 23500, 23510, 23520, 23530, 23540, 23550, 23560, 23570, 23580, 23590, 23600, 23550, 23560, 23570, 23580, 23590, 23600, 23550, 23560, 23570, 23580, 23590, 23600, 23550, 23560, 23570, 23580, 23590, 23600, 23550, 23560, 23570, 23580, 23590, 23600, 23550, 23560, 23570, 23580, 23590, 23600, 23550, 23560, 23570, 23580, 23590, 23600, 23550, 23560, 23570, 23580, 23590, 23600, 23550, 23560, 23570, 23580, 23590, 23600, 23550, 23560, 23570, 23580, 23590, 23500, 23550, 23560, 23570, 23580, 23590, 23500, 23550, 23560, 23570, 23580, 23590, 23500, 23550, 23560, 23570, 23580, 23590, 23500, 23550, 23560, 23570, 23580, 23590, 23600	21936 222015 23091	Forearm, amputation or disarticulation of forearm, wrist & hand 21800, 21810, 21820 21834, 21840, 21842, 21850, 21860, 21865, 2187 foreign body in cornea or sclera, removal of foreign body in, removal of foreign body in, superficial, removal of foreign body, antrum, removal of foreign body, removal not otherwise covered foreign body, removal of foreign, insertion for contour reconstruction formation of, including enoscopic procedures fracture, treatment of 47348, 47351 47384-47387, 47390, 47393, 47396, 47399, 47404 47408, 47411, 47414, 47417, 47420, 47423, 47424, 47432, 47435, 47438, 47441, 474414, 47444, 47447, 47453, 47456, 47459, 47462, 47465-47467, 47474, 47453, 474504, 47507, 47510, 47516, 47519, 47528, 47531, 47534, 47537, 47543, 47546, 4754, 47555, 47558, 47561, 47564-47567, 47570, 47579, 47582, 47585, 47588, 47591, 47594, 47594, 47630, 47637, 47630, 47633, 47636, 47639, 47648, 47651, 47654, 47657, 47735, 47738, 47745, 50552, 50556, 50560, 50564, 50568, 50572, 5056 fracture, treatment of paediatric 50500 50512, 50516, 50520, 50524, 50528, 50532, 50532	44328 , 21830, 21832 70, 21872 42644 42563, 42569 41659 30061 41716 30064 42563, 42569 45051 41885 , 47378, 47381 2, 47405 26, 47429 50-47451 71, 47474 95, 47498 22, 47525 19, 47552 73, 47576 97, 47600 12, 47645 11, 49336 76 , 50504, 50508
21170, 21195, 21199-21200, 21202, 21210, 21212, 21214 21216, 21220, 21230, 21232, 21234, 21260, 21270, 21272 21274-21275, 21280, 21300, 21321, 21340, 21360, 21380 21382, 21390, 21392, 21400, 21402-21404, 21420, 21430 21432, 21440, 21445, 21460-21462, 21464, 21472, 21474 21480, 21482, 21484, 21486, 21490, 21500, 21502, 21520 21522, 21530, 21532, 21535, 21600, 21610, 21620, 21622 21630, 21632, 21634, 21636, 21638, 21650, 21652, 21654 21656, 21670, 21680, 21682, 21685, 21700, 21710, 21712 21714, 21716, 21730, 21732, 21740, 21756, 21760, 21770 21772, 21780, 21785, 21790, 21800, 21810, 21820, 21830 21832, 21834, 21840, 21842, 21850, 21860, 21865, 21870 21872, 21878-21887, 21900, 21906, 21908, 21910, 21912 21914-21916, 21918, 21922, 21925-21927, 21930, 21935- 21939, 21941-21943, 21945, 21949, 21952, 21955, 21959 21962, 21965, 21969-21970, 21973, 21976, 21980, 21990 21992, 21997, 22001-22002, 22007-22008, 22012, 22014- 22018, 22020, 22025, 22031, 22036, 22040, 22045 22050-22051, 22055, 22060, 22065, 22070, 22075, 22900 22905, 23010, 23021-23023, 23031-23033, 23041-23043 23051-23053, 23061-23063, 23071-23073, 23081-23083, 2 23101, 23111-23119, 23121, 23170, 23180, 23190, 23200 23210, 23220, 23230, 23240, 23250, 23260, 23270, 23280 23290, 23300, 23310, 23320, 23330, 23340, 23350, 23360 23370, 23380, 23390, 23400, 23410, 23420, 23430, 23440 23450, 23460, 23470, 23480, 23490, 23500, 23510, 23520	21936 222015 23091	Forearm, amputation or disarticulation of forearm, wrist & hand 21800, 21810, 21820 21834, 21840, 21842, 21850, 21860, 21865, 2187 foreign body in cornea or sclera, removal of foreign body in, removal of, other than simple foreign body in, superficial, removal of foreign body, antrum, removal of foreign body, removal not otherwise covered foreign body, removal of foreign, insertion for contour reconstruction formation of, including enoscopic procedures fracture, treatment of 47348, 47351 47384-47387, 47390, 47393, 47396, 47399, 4740447408, 47411, 47414, 47417, 47420, 47423, 47424, 47432, 47435, 47438, 47441, 474414, 47444, 47447, 47453, 47456, 47459, 47462, 47465-47467, 47474, 47453, 474504, 47507, 47510, 47516, 47519, 47528, 47531, 47534, 47537, 47543, 47546, 4754, 47555, 47558, 47561, 47564-47567, 47570, 47579, 47582, 47585, 47588, 47591, 47594, 47594, 47630, 47637, 47630, 47633, 47636, 47639, 47648, 47651, 47654, 47657, 47735, 47738, 477450552, 50556, 50560, 50564, 50568, 50572, 5056 fracture, treatment of paediatric 50500	44328 , 21830, 21832 70, 21872 42644 42563, 42569 41659 30061 41716 30064 42563, 42569 45051 41885 , 47378, 47381 2, 47405 26, 47429 50-47451 71, 47474 95, 47498 22, 47525 19, 47552 73, 47576 97, 47600 12, 47645 11, 49336 76 , 50504, 50508

fractured, operations for 39606, 3960	09, 39612, 39615	Gastric bypass, by Biliopancreatic diversion, with	or without
	63, 47666, 47672	duodenal switch	31581
47678		gastric ulcer, suture of	30375
free fascia for facial nerve paralysis	45575, 45578	gastric, in the treatment of ingested poison	14200
free grafting 45406, 45409, 45412, 4541		gastric, perforated, suture of	30375
45442, 45445, 45448, 45451, 45460-45462, 454		gastric, removal of	30520
45468-45469, 45471-45472, 45474-45475, 454	77-45478	Gastro-camera investigation	30473
45480-45481, 45483-45494		Gastro-oesophageal balloon intubation	13506
Free grafts 45400, 45403, 45406, 45409, 4541		gastrocnemius aponeurosis, operation for lengthe	
45439, 45442, 45445, 45448, 45451, 45460-4540		Gastroduodenal stricture, balloon dilatation	30475
45464-45466, 45468-45469, 45471-45472, 4547	4-454/5	Gastrontongtomy	30515 30515
45477-45478, 45480-45481, 45483-45494 free tissue transfer, complete revision of	45497	Gastroplacty	31578
free tissue transfer, first stage revision of	45498	Gastroplasty Gastroschisis, operations for	43864, 43867
free tissue transfer, revision of	45496-45499	Gastroscopy	30473, 30478
free tissue transfer, second stage revision	45499	gastrosomy	30375
free transfer of	45563-45565	Gastrostomy button, non-endoscopic insertion/rep	
free, split skin 45400, 45403, 45406, 4540		30636	,
45418, 45439, 45442, 45445, 45448, 45451, 45		gastrostomy tube, jejunal extension	31460
45464-45466, 45468-45469, 45471-45472, 454		gastrostomy, percutaneous	30481-30482
45477-45478, 45480-45481, 45483-45494		Genioplasty	45761
frenuloplasty	37435	genito-urinary, repair	35596
Frenulum, mandibular or maxillary, repair	30281	Gilliam's operation	35684
frenulum, repair of	30281	gland bearing area, excision of	30180, 30183
frontal sinus	41740	gland tumour, excision of	30324
Frontal sinus, catheterisation of	41740	gland, excision of palpebral lobe	42593
frontal, catheterisation of	41740	gland, extirpation of	30256, 30259
frontal, radical obliteration of	41746	gland, meatotomy or marsupialisation	30266
frontal, trephine of	41743		52, 30266, 30269
Fronto-ethmoidectomy, radical	41734 41731	gland, superficial lobectomy/removal of tumour	30253
Fronto-nasal ethmoidectomy Fronto-orbital advancement	45782, 45785	gland, total extirpation of glands, biopsy of	30247, 30250
fronto-radical	43782, 43783	glands, groin, excision of	30075, 30078 30329-30330
full face chemical peel	45019	glands, pelvic, radical excision of	35551
Full thickness grafts, free	45451	Glaucoma, filtering and allied operations for	42746, 42749
full thickness laceration, repair	30052	Glenoid fossa, reconstruction of	45788
full thickness laceration, repair of	30052	Glioma, craniotomy for removal of	39709
full thickness repair of laceration (restriction)	30052	Globe of eye, evisceration of	42512, 42515
full thickness wedge excision	45665	globe of, evisceration of	42512
full thickness wedge excision of	45665	Glomus tumour, transmastoid removal of	41623
Fundoplasty/plication, antireflux operation	30527	glomus, removal of	41620, 41623
30529-30530		Glossectomy, with partial pharyngectomy	41785
Funnel chest, elevation of	38457-38458	Gonadal dysgenesis, vaginoplasty for	37851
Furuncle, incision with drainage of	30219, 30223	Goniotomy	42758
_		gracilis neosphincter	32210
G		graciloplasty	32203, 32209
		Graciloplasty procedures 32200, 32203, 3220	
Gallbladder, drainage of	30375	graciloplasty, insert. stimulator & electrode	32209
Galvanocautery of skin lesions	30192	graciloplasty, insertion of	32206
	03, 13206, 13209	graciloplasty, insertion of stimulator & electrode Grafenberg's (or Graf) ring, introduction of	32209 35503
13212, 13215, 13218, 13221	20107	graft	45018
Ganglion, excision of	30107	graft for priapism	37396
ganglion, excision of	46494	graft over cornea	42638
Gangliotomy, radiofrequency trigeminal Gangrenous tissue, debridement of	39109 35100, 35103	graft to femur	48200, 48203
Gartner duct cyst, removal of	35100, 35103	graft to humerus	48212, 48215
Gastrectomy, partial	30518	graft to lid	42860
Gastrectomy, sleeve	31575	graft to nerve trunk	39315
Gastric band reservoir, adjustment of	31590	graft to orbit	42524
Gastric band, adjustable, placement of	31569	graft to other bones	48239
Gastric band, adjustment of	31587	graft to phalanx or metacarpal	46402, 46405
Gastric bypass by Roux-en-Y	31572	graft to radius and ulna	48221
** *			

graft to radius or ulna	48218, 48224, 48227	harvesting, leg/arm, for bypass, not same limb	32760
graft to radius or ulna graft to scaphoid	48230, 48233, 48236		33551
graft to scaphold graft to tibia	48206, 48209	head 20100, 20102, 20104, 20120, 20124, 20140, 20142-	
Graft, axillo-femoral, infected, excision of	34172	20160, 20162, 20164, 20170, 20172, 20174, 20176, 20190	
graft, harvesting of	47726, 47729, 47732	20192, 20210, 20212, 20214, 20216, 20220, 20222, 20225	
graft, infected, excision of	34172	Heart arrhythmia, ablation of 38287, 38290,	
graft, infected, of extremities, excision of	34175	heart disease, operations for 38700, 38703, 38706,	
graft, infected, of neck, excision of	34157	38712, 38715, 38718, 38721, 38724, 38727, 38730, 38733	3
graft, infected, of trunk, excision of	34169	38736, 38739, 38742, 38745, 38748, 38751, 38754, 38757	
graft, with internal fixation	48242	38760, 38763, 38766	
grafting for aneurysm	33050, 33055	Heller's operation 30532-	-30533
grafting for symblepharon	45629	1 2	48915
grafting to artery or vein	33545, 33548	hemi-mandibular reconstruction with bone graft	45608
grafting, arterial, for occlusive arterial dise		hemiarthroplasty of	49517
32703, 32708, 32710-32712, 32715, 327		Hemiarthroplasty, hand 46309, 46312, 46315, 46318,	
32730, 32733, 32736, 32739, 32742, 327	45, 32748, 32751	, , , , ,	37354
32754, 32757, 32760, 32763		Hemicolectomy 32000, 32003,	
grafting, cross leg, saphenous to iliac or fe		hemicolectomy 32000, 32003,	
Granuloma, cautery of	42677	11 2 / 1	48509
granuloma, excision under GA	43948	,	45791
granulomatous disease	44130	hemifacial spasm 18350-	
granuloplasty, meatal advancement	37818-37819		41837
Gravid uterus, evacuation of contents by cu	•	1 1 1 1	40706
gravid, evacuation of contents	35643		30306
Great vessel, intrathoracic operation on, oth		Hemivulvectomy Hepatic duct, common, resection for carcinoma 30463-	35536
Great vessel, ligation or exploration, other Greater trochanter, transplant of ileopsoas to		hepatic, destruction of liver tumours	30419
greater trochanter, transplant of neopsoas a	50121	Hernia, antireflux operations for 30527, 30529-30530,	
Groin, lymph, excision of	30329-30330	43841	43030
growth retardation, attendance for	16508		43805
growth stimulator	45821	hernia, repair of 30403, 30600-30601, 30609, 30614,	
Gunderson flap operation	42638	hernia, repair, age less than 3 months 44108, 44111,	
Gynaecological examination under GA	35500	Hernia. scrotal, large and irreducible, repair of	30640
gynaecological, radical or debulking opera			30238
Gynatresia, vaginal reconstruction for	35565	Hiatus hernia, antireflux operations for 30527, 30529-	
, ,		Hickman catheter, insertion of, for chemotherapy 34527-	
Н		High dose rate brachytherapy	37227
			37230
Haemangioma, cauterisation of (restriction)	45027	37233	
Haemapheresis	13750, 13755	1 / 1	44373
Haematoma, aspiration of	30216	1 1 7	35614
haematoma, drainage of	30387	hip 49303, 49306, 49309, 49312, 49315, 49318-49319,	
Haemochromatosis	13757	49324, 49327, 49330, 49333, 49346, 49360, 49363, 49360	
Haemodialysis, in hospital	13100, 13103		44370
Haemofiltration, continuous (ICU)	13885, 13888		30375
Haemoperfusion, in hospital	13100, 13103	, ,	13104
Haemorrhage, antepartum, treatment of	16509	1 , 3	14206
haemorrhage, arrest of	41656, 41677	hormone or living tissue 14203,	
haemorrhage, burr-hole craniotomy for	39600, 39603	humerus 48412, Humerus, bone graft to 48212,	
Haemorrhoidectomy	32138-32139	·	48213
Hair transplants, congenital/traumatic alope		Hydatid cyst, liver, total excision of 30437-	
Hallux rigidus/valgus, correction of	49821, 49824, 49827	hydatid cyst, removal of contents of 30434,	
49830, 49833, 49836-49839, 49842	-f 40921	hydatid cyst, total excision of 30437-	
hallux valgus or hallux rigidus, correction		hydatid cysts of lung	38424
49824, 49827, 49830, 49833, 49836-4983			38424
hammer or claw, correction of Hammer toe, correction of	49848, 49851 49848	hydatid, liver, treatment of 30434, 30436-	
hamstring tendon transfer	50357, 50360	hydatid, lungs, enucleation of	38424
Hand, amputation or disarticulation of	44325, 44328		31245
hand, excision of	46494-46495, 46498		30614
Hartmann's operation	32030	Hydrocephalus, operations for 40000, 40003, 40006,	40009
harvesting for coronary bypass	38496		30210
J J - J P			

Hydrodilatation of bladder with cystoscopy 36827	in oral & maxillofacial, uncomplicated, removal of 45801
Hydrotubation of Fallopian tubes 35703, 35709	in oral & maxillofacial, uncomplicated, removal of 45801 45803, 45805, 45807, 45809
Hymenectomy 35509	in oral and maxillofacial region 45801, 45803, 45805
Hyperbaric oxygen therapy 13020, 13025, 13030	45807
Hyperemesis gravidarum, treatment of 16505	in relation to eye 42734
Hyperextension deformity of toe, release, lengthening 50345	in situ in drum, removal of 41500
hyperextension deformity, release, lengthening 50345	Incidental appendicectomy 30574
Hyperhidrosis, axillary, excision for 30180, 30183	incision and drainage, without GA 30219
Hyperparathyroidism, operations for 30315, 30317-30318	incision of palate 41787
30320	incision/resection, external sphincter/bladder neck 36854
hyperplasia, congenital, vaginoplasty for 37851	Incisional hernia, repair of 30403
Hyperplasia, papillary, of palate, removal of 45831, 45833	incisions for astigmatism 42672
45835	Incomplete confinement 16518
Hypertelorism, correction, intra/sub-cranial 45767, 45770 Hypertension, portal, treatment of 30602-30603, 30605-30606	incomplete, curettage for 35640 Incontinence, anal, Parks' intersphincteric procedure 32126
hypertension, portar, treatment of 30002-30003, 30003-30000 hypertrophic obstructive cardiomyopathy 38650	incontinence, Parks' procedure 32126
Hypertrophied tissue, removal of 45801, 45803, 45805, 45807	indirect 45227, 45230, 45233, 45236
Hypospadias, examination under GA 37815-37816, 37819, 37822	Indirect flap 45227, 45230, 45233, 45236, 45239
37825, 37828	Indwelling oesophageal tube, gastrostomy for fixation 30375
Hypothenar spaces of hand, drainage of 46519	Infantile hydrocele, repair of 30614
Hysterectomy 35653, 35657-35658, 35661, 35664, 35667, 35670	Infection, acute intercurrent, complicating pregnancy 16508
35673	infection, drainage of via burr-hole 39900
hysterectomy 35657, 35673	Inferior vena cava, thrombectomy 33810-33811
Hysteroscopic resection of myoma or uterine septum 35623	Inflammation of middle ear, operation for 41626
35634	Infliximab 14245
Hysteroscopy 35626-35627, 35630, 35633-35636	Infusion chemotherapy 13915, 13918, 13921, 13924, 13927
Hysterotomy 35649	13930, 13933, 13936 infusion chemotherapy 13927, 13930, 13933, 13936
ı	infusion, cannulation for 34521, 34524
·	infusion, of sympatholytic agent 14209
IGRT 15715	Ingrowing eyelashes, operation for 45626
Ileal atresia, neonatal, laparotomy for 43816	ingrowing nail, resection 46528, 46531
Ileo-femoral by-pass grafting 32712, 32718	ingrowing nail, resection of 46528, 46531
ileo-rectal, with total colectomy 32012	ingrowing, of finger or thumb, resection 46528, 46531
Ileorectal anastomosis 32012	ingrowing, of toe, excision/resection 47915-47916, 47918
Ileostomy 30639, 32009, 32012, 32015, 32018, 32021	ingrown, of toe, operation under GA, paediatric 44136
ileostomy closure/reservoir 32060, 32063, 32066, 32069	ingrown, operation with GA, paediatric 44136
Iliac endarterectomy 33518	Inguinal abscess, incision of 30223
Iliac vessel, ligation or exploration not otherwise covered 34103	inguinal, repair, age less than 3 months 44108, 44111
Iliopsoas tendon transfer to greater trochanter 50387	44114 injection for impotence 37415
iliopsoas tendon transfer to greater trochanter 50387	injection of alcohol 42824
impalpable, exploration of groin 37812 Implanon, removal of 30062	injection of alcohol 42824 injection of sclerosant fluid under anaesthesia 30679
Implanon, removal of 30062 Implant, cochlear, insertion of 41617	injection, peri-urethral 37339
implant, contour reconstruction, insertion 45051	Injections, multiple, for skin lesions 30207
implant, enucleation of eye 42506, 42509	Inlay graft, using a mould 45445
implant, evisceration of eye and insertion of 42515	inlay, using a mould 45445
implant, removal of 39136	Innocent bone tumour, excision of 30241
implantable bone conduction hearing system 41603-41604	Innominate artery, endarterectomy of 33506
Implantable Cardioverter Defibrillator 38371, 38384, 38387	insemination services 13203, 13209, 13221
implantation of Fallopian tubes into 35694, 35697	insertion of 41632
implantation, direct, incision and suture 14203	insertion of nasogastric/nasoenteral tube 31456, 31458 insertion of patches for 38390
Implantation, fallopian tubes into uterus 35694, 35697	insertion of patches for insertion of, for drainage of middle ear 41632
implanted drug delivery system 14227, 14230, 14233, 14236	insertion or removal from eye socket 42518
14239, 14242 Impotence, injection for investigation/treatment 37415	insertion, transluminal 35306-35307, 35309
IMRT 15275, 15555, 15565	insertion, transluminal, rotational atherectomy 38312
in ano, subcutaneous, excision of 32156	38318
in conjunction with Caesarean section 35691	Insufflation Fallopian tubes, for patency (Rubin test) 35706
in hospital 13100, 13103	intact wall technique, with myringoplasty 41551, 41554
in oral & maxillofacial, complicated, removal 45811	Intensive care management/procedures 13815, 13818, 13830
45813	13839, 13842, 13847-13848, 13851, 13854, 13857, 13870

13873, 13876, 13881-13882, 13885, 13888			20540, 20542, 20546, 20548, 20560	
intensive care unit (specialist)	13870.	13873	Intrathoracic operation on heart, lungs, etc, other	38456
Intercostal drain, insertion of		38809	intrathoracic operation on, not otherwise covered	38456
Internal auditory meatus, exploration of	•	41599	intrathoracic operation, not otherwise covered	38456
internal auditory, exploration of		41599	intrathoracic, congenital heart disease	38727, 38730
	, 35406,	35408	Intrauterine contraceptive device, introduction of	35503
interosseous muscle space of hand		47981	intravascular blood transfusion	16609
Interosseous muscle space of hand, fasciotomy of		47981	Intravenous infusion chemotherapy 13915, 13918,	, 13921, 13924
Interphalangeal joint, arthrodesis of		46300	Intraventricular baffle, insertion of	38754
interruption, repair of		38712	intubation	30488
Interscapulothoracic amputation or disarticulation		44334	intubation, gastro-oesophageal	13506
Interventional endovascular procedures	35300,	35303	Intubation, small bowel	30488
35306-35307, 35309, 35312, 35315, 35317, 35319	9-35321		Intussusception, reduction of	30375
35324, 35327, 35330, 35414, 38306			inverted, surgical eversion of	31563
Intestinal conduit or reservoir, endoscopic examinat	tion	36860	Invitro fertilisation 13200, 13203, 13206,	, 13209, 13212
intestinal remnant, abdominal wall, excision of		43942	13215, 13218, 13221	
intestine, resection of		-30566	involving ciliary body an/or iris, excision of	42767
intestine, subtotal colectomy	32004	-32005	involving division of adhesions	38643, 38647
into angioma (restriction applies)		45027	involving gynaecology (exc. hysterectomy)	35713, 35717
into prostate		37218	involving procedures via laparoscope	35637-35638
into spinal joints or nerves		39013	ionisation of	35608
Intra-abdominal artery/vein, cannulation, chemothe	rapy	34521	Ionisation, cervix	35608
intra-abdominal vessel, for chemotherapy		34521	Iridectomy	42764
intra-abdominal, cannulation, infusion chemothera		34521	iridectomy and sclerectomy for	42746
Intra-anal abscess, drainage of		-32175	iridectomy or iridotomy	42764
Intra-aortic balloon, counterpulsation, management	13847		Iridencleisis	42746
Intra-arterial cannulisation for blood collection		13842	Iridocyclectomy	42767
intra-arterial, sympatholytic agent		14209	Iridotomy	42764
Intra-atrial baffle, insertion of	25520	38745	iridotomy	42785
Intra-epithelial neoplasia, laser therapy for	33339,	, 35542	iridotomy, laser	42785
35545		12571	Iris and ciliary body, excision of tumour of	42767
Intra-ocular excision of dermoid of eye intra-ocular, removal of	12562	42574 , 42569	iris tumour, laser photocoagulation iris, excision of	42806 42764
Intra-operative ultrasound, biliary tract	42303,	30439	Ischaemic limb, debridement of deep tissue	35100
Intra-oral tumour, radical excision of		30439	ischaemic, debridement of tissue	35100, 35103
intra-oral, radical excision of		30275	Ischio-rectal abscess, drainage of	32174-32175
Intra-orbital abscess, drainage of		42572	ischio-rectal, drainage of	32174-32175
intra-orbital, drainage of		42572	island flap, with vascular pedicle	45563
intra-temporal fossa, removal of		41578	isiand hap, with vascular pedicie	43303
Intracerebral tumour, craniotomy and removal of		39709	J	
intracerebral, craniotomy and removal of		39709	v	
Intracranial abscess, excision of		39903	Jaw, dislocation, treatment of	47000
intracranial placement	40709.	40712	Jejunal atresia, bowel resection and anastomosis	43810
intracranial proximal artery clipping		39806	Jejunostomy, operative feeding	31462
intracranial, biopsy/decompression, osteoplastic fl	ap	39706	joint disruption, treatment of	47513
intracranial, burr-hole biopsy or drainage	1	39703	Joint, application of external fixator, not for fracture	
intracranial, burr-hole craniotomy for		39600	joint, arthroplasty 46306-46307, 46309.	
intracranial, craniotomy and removal of	39709.	39712	46318, 46321	, 10312, 10313
intracranial, excision of		39903	joint, arthrotomy	46327, 46330
intracranial, for pressure monitoring		13830	joint, arthrotomy of	46327, 46330
intracranial, for trigeminal neuralgia		39106		, 47033, 47036
intracranial, ligation cervical vessels		39812	47039, 47042, 47045	, .,, ., .,
intracranial, needling and drainage of		39703	joint, distal, reconstruction/stabilisation	46345
Intrahepatic bypass	30466	-30467	joint, distal, synovectomy	46342
intranasal operation on		41737	joint, external fixation, application of	45879
Intranasal operation on antrum/removal offoreign b	ody	41716	joint, hemiarthroplasty 46309, 46312, 46315,	, 46318, 46321
intranasal, operation on		41716	joint, interposition arthroplasty of	46306
intraocular, repositioning of		42713	joint, irrigation of	45865
intraperitoneal blood transfusion	16612,	, 16615	joint, joint capsule release of	46381
Intrascleral ball or cartilage, insertion of		42515	joint, ligamentous repair	46333
Intrathecal infusion device, revision of		39133	joint, ligamentous repair of	46333
intrathoracic 20500, 20520, 20522, 20524	, 20526,	, 20528	joint, Lisfranc's amputation of	44364

joint, manipulation of	45851	Laryngeal web, division of	41868
	5861, 45863, 45865	Laryngectomy	41834
45867, 45869, 45871, 45873	3001, 13003, 13003	Laryngofissure, external operation on	41876
	0103, 50109, 50127	Laryngopharyngectomy	41843
joint, synovectomy of	46342	Laryngoplasty	41876, 41879
joint, synovectomy/capsulectomy/debridemen	t 46336	Laryngoscopy	41846
joint, total replacement arthroplasty of	46309, 46312	Larynx, direct examination of	41846
46315, 46318, 46321		laser	30191, 42785
joint, total replacement of	49857	laser ablation of prostate	37207-37208
joint, volar plate arthroplasty	46307	laser angioplasty	35315
juice, collection of	30488	laser photocoagulation laser resection of endobronchial tumours	42806
Juvenile cataract, removal of juxtasceral Depot injection	42716 42741		41901 39, 35542, 35545
	42/41	laser therapy for intraepithelial neoplasia	35539, 35542
K		35545	20470
		laser therapy of gastrointestinal tract laser therapy, intraepithelial neoplasia	30479 35539, 35542
Keratectomy, partial, for corneal scars	42647	35545	33339, 33342
Keratoplasty	42653, 42656	Laser: ablation of prostate, endoscopic	37207-37208
keratoplasty, epithelial debridement for Keratosis, obturans, surgical removal	42651 41509	Lateral pharyngeal bands, removal of	41804
Kidney, dialysis, in hospital	13100, 13103	Lavage and proof puncture of maxillary antrum	41698, 41701
kidney, removal from	36558	lavage in the treatment of ingested poison	14200
kidney, removal of	36540, 36543	lavage, total, intra-operative	32186
Kirschner wire, insertion of	47921	Le Fort osteotomies	45753-45754
knee 49500, 49509, 49512, 49517-49519, 49	9521, 49524, 49527	leaflet/s, aortic, decalcification of	38483
49530, 49533-49534, 49545, 49557-49564, 4		left ventricular, plication of	38506
	1340, 21360, 21380	left ventricular, resection	38507-38508
21382, 21390, 21392, 21400, 21402-21404,	21420, 21430	Leg, amputation	44367, 44370
21432, 21440	440.5	leg, lower (below knee) 21460-21462, 214 21480, 21482, 21484, 21486, 21490, 21500, 21	
Knee, amputation at or below	44367	21522, 21530, 21532	1302, 21320
knee, removal of	49515	leg,upper (except knee) 21195, 21199-212	
L	49313	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280	1234, 21260
L		leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora	1234, 21260 37423
	49515 41572 41572	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures	37423 50303, 50306
L Labyrinth, destruction of	41572 41572	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of	37423 50303, 50306 42701, 42703
L Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, re lacerations not involving sclera	41572 41572 epair 30052 30032	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of	37423 50303, 50306 42701, 42703 42701
L Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, re lacerations not involving sclera Lacrimal canalicular system, establishment pate	41572 41572 epair 30052 30032	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of	37423 50303, 50306 42701, 42703 42701 42704
L Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, re lacerations not involving sclera Lacrimal canalicular system, establishment pate 42602	41572 41572 epair 30052 30032 ency 42599	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of lens, removal, replacement different lens	37423 50303, 50306 42701, 42703 42701 42704 42707
L Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, re lacerations not involving sclera Lacrimal canalicular system, establishment pate 42602 lacrimal, excision of palpebral lobe	41572 41572 epair 30052 30032 ency 42599	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of lens, removal, replacement different lens lens, repositioning of, open operation	37423 50303, 50306 42701, 42703 42701 42704 42707 42704
Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, re lacerations not involving sclera Lacrimal canalicular system, establishment pate 42602 lacrimal, excision of palpebral lobe Lagrange's operation (iridectomy and sclerector)	41572 41572 41572 epair 30052 30032 ency 42599 42593 my) 42746	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of lens, removal, replacement different lens lens, repositioning of, open operation Lensectomy	37423 50303, 50306 42701, 42703 42701 42704 42707
Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, re lacerations not involving sclera Lacrimal canalicular system, establishment pate 42602 lacrimal, excision of palpebral lobe Lagrange's operation (iridectomy and sclerector Laminectomy and insertion of epidural implan	41572 41572 41572 epair 30052 30032 ency 42599 42593 my) 42746 t 39139	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of lens, removal, replacement different lens lens, repositioning of, open operation	37423 50303, 50306 42701, 42703 42701 42704 42707 42704 42731
Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, relacerations not involving sclera Lacrimal canalicular system, establishment pate 42602 lacrimal, excision of palpebral lobe Lagrange's operation (iridectomy and sclerector Laminectomy and insertion of epidural implant Laparascopic division of adhesions 3	41572 41572 epair 30052 30032 ency 42599 42593 my) 42746 t 39139 1450, 31452, 35637	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of lens, removal, replacement different lens lens, repositioning of, open operation Lensectomy lesion, pre-op localisation, for ABBI lesion, pre-op localisation, imaging guided lesion/s, removal, diaphyseal aclasia	37423 50303, 50306 42701, 42703 42701 42704 42707 42704 42731 31542 31536 50426
Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, relacerations not involving sclera Lacrimal canalicular system, establishment pate 42602 lacrimal, excision of palpebral lobe Lagrange's operation (iridectomy and sclerector Laminectomy and insertion of epidural implant Laparascopic division of adhesions 3 laparoscopic 36	41572 41572 epair 30052 30032 ency 42599 42593 my) 42746 t 39139 1450, 31452, 35637 0391, 31470, 35638	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of lens, removal, replacement different lens lens, repositioning of, open operation Lensectomy lesion, pre-op localisation, for ABBI lesion, pre-op localisation, imaging guided lesion/s, removal, diaphyseal aclasia lesions, multiple injections for	37423 50303, 50306 42701, 42703 42701 42704 42707 42704 42731 31542 31536 50426 30207
Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, relacerations not involving sclera Lacrimal canalicular system, establishment pate 42602 lacrimal, excision of palpebral lobe Lagrange's operation (iridectomy and sclerector Laminectomy and insertion of epidural implant Laparascopic division of adhesions 3 laparoscopic 30 Laparoscopic resection of	41572 41572 epair 30052 30032 ency 42599 42593 my) 42746 t 39139 1450, 31452, 35637 0391, 31470, 35638 35641	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of lens, removal, replacement different lens lens, repositioning of, open operation Lensectomy lesion, pre-op localisation, for ABBI lesion, pre-op localisation, imaging guided lesion/s, removal, diaphyseal aclasia lesions, multiple injections for Lesions, skin, multiple injections for	37423 50303, 50306 42701, 42703 42701 42704 42707 42704 42731 31542 31536 50426 30207 30207
Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, relacerations not involving sclera Lacrimal canalicular system, establishment pate 42602 lacrimal, excision of palpebral lobe Lagrange's operation (iridectomy and sclerector Laminectomy and insertion of epidural implant Laparascopic division of adhesions 3 laparoscopic 30 Laparoscopic resection of laparoscopically assisted 35750, 3	41572 41572 epair 30052 30032 ency 42599 42593 my) 42746 t 39139 1450, 31452, 35637 0391, 31470, 35638	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of lens, removal, replacement different lens lens, repositioning of, open operation Lensectomy lesion, pre-op localisation, for ABBI lesion, pre-op localisation, imaging guided lesion/s, removal, diaphyseal aclasia lesions, multiple injections for Lesions, skin, multiple injections for lesions, treatment of	37423 50303, 50306 42701, 42703 42701 42704 42707 42704 42731 31542 31536 50426 30207 30207 30192
Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, relacerations not involving sclera Lacrimal canalicular system, establishment pate 42602 lacrimal, excision of palpebral lobe Lagrange's operation (iridectomy and sclerector Laminectomy and insertion of epidural implant Laparascopic division of adhesions 3 laparoscopic 30 Laparoscopic resection of laparoscopically assisted 35750, 3	41572 41572 epair 30052 30032 ency 42599 42593 my) 42746 t 39139 1450, 31452, 35637 0391, 31470, 35638 35641 5753-35754, 35756	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of lens, removal, replacement different lens lens, repositioning of, open operation Lensectomy lesion, pre-op localisation, for ABBI lesion, pre-op localisation, imaging guided lesion/s, removal, diaphyseal aclasia lesions, multiple injections for Lesions, skin, multiple injections for lesions, treatment of Leveen shunt, insertion of	37423 50303, 50306 42701, 42703 42701 42704 42707 42704 42731 31542 31536 50426 30207 30207 30192 30408
Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, relacerations not involving sclera Lacrimal canalicular system, establishment pate 42602 lacrimal, excision of palpebral lobe Lagrange's operation (iridectomy and sclerector Laminectomy and insertion of epidural implan Laparascopic division of adhesions 3 laparoscopic 30 Laparoscopic resection of laparoscopically assisted 35750, 3 laparoscopically assisted hysterectomy 35756 Laparoscopy and hysteroscopy under GA	41572 41572 epair 30052 30032 ency 42599 42593 my) 42746 t 39139 1450, 31452, 35637 0391, 31470, 35638 35641 5753-35754, 35756	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of lens, removal, replacement different lens lens, repositioning of, open operation Lensectomy lesion, pre-op localisation, for ABBI lesion, pre-op localisation, imaging guided lesion/s, removal, diaphyseal aclasia lesions, multiple injections for Lesions, skin, multiple injections for lesions, treatment of Leveen shunt, insertion of Lid, ophthalmic, suturing of	37423 50303, 50306 42701, 42703 42701 42704 42707 42704 42731 31542 31536 50426 30207 30207 30192 30408 42584
Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, relacerations not involving sclera Lacrimal canalicular system, establishment pate 42602 lacrimal, excision of palpebral lobe Lagrange's operation (iridectomy and sclerector Laminectomy and insertion of epidural implant Laparascopic division of adhesions 3 laparoscopic 33 Laparoscopic resection of laparoscopically assisted 35750, 3 laparoscopically assisted hysterectomy 35756 Laparoscopy and hysteroscopy under GA laparoscopy, complicated	41572 41572 41572 epair 30052 30032 ency 42599 42593 my) 42746 t 39139 1450, 31452, 35637 0391, 31470, 35638 35641 5753-35754, 35756 5750, 35753-35754	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of lens, removal, replacement different lens lens, repositioning of, open operation Lensectomy lesion, pre-op localisation, for ABBI lesion, pre-op localisation, imaging guided lesion/s, removal, diaphyseal aclasia lesions, multiple injections for Lesions, skin, multiple injections for lesions, treatment of Leveen shunt, insertion of Lid, ophthalmic, suturing of ligament or tendon transfer	37423 50303, 50306 42701, 42703 42701 42704 42707 42704 42731 31542 31536 50426 30207 30207 30192 30408 42584 49503, 49506
Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, relacerations not involving sclera Lacrimal canalicular system, establishment pate 42602 lacrimal, excision of palpebral lobe Lagrange's operation (iridectomy and sclerector Laminectomy and insertion of epidural implan Laparascopic division of adhesions 3 laparoscopic 36 Laparoscopic resection of laparoscopically assisted 35750, 3 laparoscopically assisted hysterectomy 35756 Laparoscopy and hysteroscopy under GA laparoscopy, complicated Laparoscopy, diagnostic	41572 41572 41572 epair 30052 30032 ency 42599 42593 my) 42746 t 39139 1450, 31452, 35637 0391, 31470, 35638 35641 5753-35754, 35756 5750, 35753-35754 35636 35641 30627	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of lens, removal, replacement different lens lens, repositioning of, open operation Lensectomy lesion, pre-op localisation, for ABBI lesion, pre-op localisation, imaging guided lesion/s, removal, diaphyseal aclasia lesions, multiple injections for Lesions, skin, multiple injections for lesions, treatment of Leveen shunt, insertion of Lid, ophthalmic, suturing of ligament or tendon transfer Ligament, finger joint, repair of	37423 50303, 50306 42701, 42703 42701 42704 42707 42704 42731 31542 31536 50426 30207 30207 30192 30408 42584 49503, 49506 46333
Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, relacerations not involving sclera Lacrimal canalicular system, establishment pate 42602 lacrimal, excision of palpebral lobe Lagrange's operation (iridectomy and sclerector Laminectomy and insertion of epidural implant Laparascopic division of adhesions 3 laparoscopic 33 Laparoscopic alaparoscopic alaparoscopic alaparoscopic 35750, 3 laparoscopically assisted 35750, 3 laparoscopically assisted hysterectomy 35756 Laparoscopy and hysteroscopy under GA laparoscopy, complicated Laparoscopy, diagnostic Laparoscomy	41572 41572 41572 epair 30052 30032 ency 42599 42593 my) 42746 t 39139 1450, 31452, 35637 0391, 31470, 35638 35641 5753-35754, 35756 5750, 35753-35754 35636 35641 30627 30397, 30399	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of lens, removal, replacement different lens lens, repositioning of, open operation Lensectomy lesion, pre-op localisation, for ABBI lesion, pre-op localisation, imaging guided lesion/s, removal, diaphyseal aclasia lesions, multiple injections for Lesions, skin, multiple injections for lesions, treatment of Leveen shunt, insertion of Lid, ophthalmic, suturing of ligament or tendon transfer Ligament, finger joint, repair of ligament, transverse, division of	37423 50303, 50306 42701, 42703 42701 42704 42707 42704 42731 31542 31536 50426 30207 30207 30192 30408 42584 49503, 49506 46333 39331
Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, relacerations not involving sclera Lacrimal canalicular system, establishment pate 42602 lacrimal, excision of palpebral lobe Lagrange's operation (iridectomy and sclerector Laminectomy and insertion of epidural implan Laparascopic division of adhesions 3 laparoscopic 36 Laparoscopic resection of laparoscopically assisted 35750, 3 laparoscopically assisted hysterectomy 35756 Laparoscopy and hysteroscopy under GA laparoscopy, complicated Laparoscopy, diagnostic Laparostomy Laparotomy and division of adhesions 3	41572 41572 41572 epair 30052 30032 ency 42599 42593 my) 42746 t 39139 1450, 31452, 35637 0391, 31470, 35638 35641 5753-35754, 35756 5750, 35753-35754 35636 35641 30627	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of lens, removal, replacement different lens lens, repositioning of, open operation Lensectomy lesion, pre-op localisation, for ABBI lesion, pre-op localisation, imaging guided lesion/s, removal, diaphyseal aclasia lesions, multiple injections for Lesions, skin, multiple injections for lesions, treatment of Leveen shunt, insertion of Lid, ophthalmic, suturing of ligament or tendon transfer Ligament, finger joint, repair of	37423 50303, 50306 42701, 42703 42701 42704 42707 42704 42731 31542 31536 50426 30207 30207 30192 30408 42584 49503, 49506 46333
Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, relacerations not involving sclera Lacrimal canalicular system, establishment pate 42602 lacrimal, excision of palpebral lobe Lagrange's operation (iridectomy and sclerector Laminectomy and insertion of epidural implan Laparascopic division of adhesions 3 laparoscopic 36 Laparoscopic resection of laparoscopically assisted 35750, 3 laparoscopically assisted hysterectomy 35756 Laparoscopy and hysteroscopy under GA laparoscopy, complicated Laparoscopy, diagnostic Laparostomy Laparotomy and division of adhesions 3 30623, 30626	41572 41572 41572 epair 30052 30032 ency 42599 42593 my) 42746 t 39139 1450, 31452, 35637 0391, 31470, 35638 35641 5753-35754, 35756 5750, 35753-35754 35636 35641 30627 30397, 30399 0376, 30378-30379	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of lens, removal, replacement different lens lens, repositioning of, open operation Lensectomy lesion, pre-op localisation, for ABBI lesion, pre-op localisation, imaging guided lesion/s, removal, diaphyseal aclasia lesions, multiple injections for Lesions, skin, multiple injections for lesions, treatment of Leveen shunt, insertion of Lid, ophthalmic, suturing of ligament or tendon transfer Ligament, finger joint, repair of ligament, transverse, division of ligamentous stabilisation of	37423 50303, 50306 42701, 42703 42701 42704 42707 42704 42731 31542 31536 50426 30207 30207 30192 30408 42584 49503, 49506 46333 39331 49103, 49709
Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, relacerations not involving sclera Lacrimal canalicular system, establishment pate 42602 lacrimal, excision of palpebral lobe Lagrange's operation (iridectomy and sclerector Laminectomy and insertion of epidural implan Laparascopic division of adhesions 3 laparoscopic 36 Laparoscopic resection of laparoscopically assisted 35750, 3 laparoscopically assisted hysterectomy 35756 Laparoscopy and hysteroscopy under GA laparoscopy, complicated Laparoscopy, diagnostic Laparostomy Laparotomy and division of adhesions 30623, 30626 laparotomy for drainage of	41572 41572 41572 epair 30052 30032 ency 42599 42599 42593 my) 42746 t 39139 1450, 31452, 35637 0391, 31470, 35638 35641 5753-35754, 35756 5750, 35753-35754 35636 35641 30627 30397, 30399 0376, 30378-30379	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of lens, removal, replacement different lens lens, repositioning of, open operation Lensectomy lesion, pre-op localisation, for ABBI lesion, pre-op localisation, imaging guided lesion/s, removal, diaphyseal aclasia lesions, multiple injections for Lesions, skin, multiple injections for lesions, treatment of Leveen shunt, insertion of Lid, ophthalmic, suturing of ligament or tendon transfer Ligament, finger joint, repair of ligament, transverse, division of ligation of maxillary artery ligation or exploration not otherwise covered Ligation, great vessel	37423 50303, 50306 42701, 42703 42701 42704 42707 42704 42731 31542 31536 50426 30207 30207 30192 30408 42584 49503, 49506 46333 39331 49103, 49709 41707
Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, relacerations not involving sclera Lacrimal canalicular system, establishment pate 42602 lacrimal, excision of palpebral lobe Lagrange's operation (iridectomy and sclerector Laminectomy and insertion of epidural implant Laparascopic division of adhesions 3 laparoscopic 36 Laparoscopic resection of laparoscopically assisted 35750, 3 laparoscopically assisted hysterectomy 35756 Laparoscopy and hysteroscopy under GA laparoscopy, complicated Laparoscopy, diagnostic Laparostomy Laparotomy and division of adhesions 30623, 30626 laparotomy for drainage of Large intestine, resection of	41572 41572 41572 epair 30052 30032 ency 42599 42593 my) 42746 t 39139 1450, 31452, 35637 0391, 31470, 35638 35641 5753-35754, 35756 5750, 35753-35754 35636 35641 30627 30397, 30399 0376, 30378-30379 30394 32000, 32003	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of lens, removal, replacement different lens lens, repositioning of, open operation Lensectomy lesion, pre-op localisation, for ABBI lesion, pre-op localisation, imaging guided lesion/s, removal, diaphyseal aclasia lesions, multiple injections for Lesions, skin, multiple injections for lesions, treatment of Leveen shunt, insertion of Lid, ophthalmic, suturing of ligament or tendon transfer Ligament, finger joint, repair of ligament, transverse, division of ligamentous stabilisation of ligation of maxillary artery ligation or exploration not otherwise covered Ligation/exploration not otherwise covered	37423 50303, 50306 42701, 42703 42701 42704 42707 42704 42731 31542 31536 50426 30207 30207 30192 30408 42584 49503, 49506 46333 39331 49103, 49709 41707 34106 34103 34106
Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, relacerations not involving sclera Lacrimal canalicular system, establishment pate 42602 lacrimal, excision of palpebral lobe Lagrange's operation (iridectomy and sclerector Laminectomy and insertion of epidural implant Laparascopic division of adhesions 3 laparoscopic 36 Laparoscopic resection of laparoscopically assisted 35750, 3 laparoscopically assisted hysterectomy 35756 Laparoscopy and hysteroscopy under GA laparoscopy, complicated Laparoscopy, diagnostic Laparostomy Laparotomy and division of adhesions 30623, 30626 laparotomy for drainage of Large intestine, resection of large loop excision	41572 41572 41572 epair 30052 30032 ency 42599 42593 my) 42746 t 39139 1450, 31452, 35637 0391, 31470, 35638 35641 5753-35754, 35756 5750, 35753-35754 35636 35641 30627 30397, 30399 0376, 30378-30379 30394 32000, 32003 35647-35648	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of lens, removal, replacement different lens lens, repositioning of, open operation Lensectomy lesion, pre-op localisation, for ABBI lesion, pre-op localisation, imaging guided lesion/s, removal, diaphyseal aclasia lesions, multiple injections for Lesions, skin, multiple injections for lesions, treatment of Leveen shunt, insertion of Lid, ophthalmic, suturing of ligament or tendon transfer Ligament, finger joint, repair of ligament, transverse, division of ligamentous stabilisation of ligation of maxillary artery ligation or exploration not otherwise covered Ligation/exploration not otherwise covered Ligature of cervix, purse string, removal of	37423 50303, 50306 42701, 42703 42701 42704 42707 42704 42731 31542 31536 50426 30207 30207 30192 30408 42584 49503, 49506 46333 39331 49103, 49709 41707 34106 34103 34106 16512
Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, relacerations not involving sclera Lacrimal canalicular system, establishment pate 42602 lacrimal, excision of palpebral lobe Lagrange's operation (iridectomy and sclerector Laminectomy and insertion of epidural implant Laparascopic division of adhesions 3 laparoscopic 36 Laparoscopic resection of laparoscopically assisted 35750, 3 laparoscopically assisted hysterectomy 35756 Laparoscopy and hysteroscopy under GA laparoscopy, complicated Laparoscopy, diagnostic Laparostomy Laparotomy and division of adhesions 30623, 30626 laparotomy for drainage of Large intestine, resection of large loop excision large, excision of	41572 41572 41572 epair 30052 30032 ency 42599 42593 my) 42746 t 39139 1450, 31452, 35637 0391, 31470, 35638 35641 5753-35754, 35756 5750, 35753-35754 35636 35641 30627 30397, 30399 0376, 30378-30379 30394 32000, 32003	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of lens, removal, replacement different lens lens, repositioning of, open operation Lensectomy lesion, pre-op localisation, for ABBI lesion, pre-op localisation, imaging guided lesion/s, removal, diaphyseal aclasia lesions, multiple injections for Lesions, skin, multiple injections for lesions, treatment of Leveen shunt, insertion of Lid, ophthalmic, suturing of ligament or tendon transfer Ligament, finger joint, repair of ligament, transverse, division of ligamentous stabilisation of ligation of maxillary artery ligation or exploration not otherwise covered Ligation, great vessel ligation/exploration not otherwise covered Ligature of cervix, purse string, removal of light coagulation for	37423 50303, 50306 42701, 42703 42701 42704 42707 42704 42731 31542 31536 50426 30207 30207 30192 30408 42584 49503, 49506 46333 39331 49103, 49709 41707 34106 34103 34106 16512 42782
Labyrinth, destruction of Labyrinthotomy Laceration, ear/eyelid/nose/lip, full thickness, relacerations not involving sclera Lacrimal canalicular system, establishment pate 42602 lacrimal, excision of palpebral lobe Lagrange's operation (iridectomy and sclerector Laminectomy and insertion of epidural implant Laparascopic division of adhesions 3 laparoscopic 36 Laparoscopic resection of laparoscopically assisted 35750, 3 laparoscopically assisted hysterectomy 35756 Laparoscopy and hysteroscopy under GA laparoscopy, complicated Laparoscopy, diagnostic Laparostomy Laparotomy and division of adhesions 30623, 30626 laparotomy for drainage of Large intestine, resection of large loop excision	41572 41572 41572 epair 30052 30032 ency 42599 42593 my) 42746 t 39139 1450, 31452, 35637 0391, 31470, 35638 35641 5753-35754, 35756 5750, 35753-35754 3636 35641 30627 30397, 30399 0376, 30378-30379 30394 32000, 32003 35647-35648 30111	leg,upper (except knee) 21195, 21199-212 21212, 21214, 21216, 21220, 21230, 21232, 21 21270, 21272, 21274-21275, 21280 lengthening by translocation of corpora lengthening procedures Lens, artificial, insertion of lens, insertion of lens, removal of lens, removal, replacement different lens lens, repositioning of, open operation Lensectomy lesion, pre-op localisation, for ABBI lesion, pre-op localisation, imaging guided lesion/s, removal, diaphyseal aclasia lesions, multiple injections for Lesions, skin, multiple injections for lesions, treatment of Leveen shunt, insertion of Lid, ophthalmic, suturing of ligament or tendon transfer Ligament, finger joint, repair of ligament, transverse, division of ligamentous stabilisation of ligation of maxillary artery ligation or exploration not otherwise covered Ligation/exploration not otherwise covered Ligature of cervix, purse string, removal of	37423 50303, 50306 42701, 42703 42701 42704 42707 42704 42731 31542 31536 50426 30207 30207 30192 30408 42584 49503, 49506 46333 39331 49103, 49709 41707 34106 34103 34106 16512

Limbic tumour, removal or excision of	42692, 42695		
limbic, removal of	42692	Macrocheilia, operation for	45675
line for blood pressure monitoring	13876	Macrodactyly, surgical reduction of enlarged elem	
Lingual tonsil, removal of	41804	Macroglossia, operation for	45675
Lip, cleft, operations for 45677, 45680, 4568		Macrostomia, operation for	45676
45692, 45695, 45698, 45701, 45704	-,,		0, 33055, 33070
Lipectomy, circumferential	30179	33075, 33080, 33100, 33103, 33109, 33112, 331	
Lipectomy, radical abdominoplasty	30176-30177	33118-33119, 33121, 33124, 33127, 33130, 331	
lipoma, liposuction or surgical removal of	31345	33139, 33142, 33145, 33148, 33151, 33154, 331	
Lipomeningocoele, tethered cord, release of	40112	33163, 33166, 33169, 33172, 33175, 33178, 331	
Liposuction, for post-traumatic pseudolipoma	45584-45585	major tendon repair	49718
Lippe's loop, introduction of	35503	major, of neck, ligation/exploration, other	34100
Lisfranc's amputation	44364		8, 33821, 33824
Litholapaxy, with or without cystoscopy	36863	33827, 33830, 33833, 33836, 33839	,
Lithotripsy, extracorporeal shock wave (ESWL)	36546	male urinary, injection for treatment of	37339
Little's Area, cautery of	41674		9, 45042, 45045
liver	30409, 30411	malformation, intracranial artery clipping of	39806
Liver abscess, open abdominal drainage of	30431, 30433	malformation, intracranial, excision of	39803
liver biopsy	30409	malformation, neonatal, laparotomy and coloston	ny 43822
liver, destruction of by cryotherapy	30419	malformation, paediatric, operations 4396	0, 43963, 43966
liver, laparoscopic marsupialisation	30416-30417	malignancy, radical or debulking operation	30392
liver, open abdominal drainage of	30431	malignant of soft tissue, removal of	31355
liver, other than for trauma	30418, 30421	malignant tumour	31509, 31512
Living tissue, implantation of	14203, 14206		0, 31403, 31406
living, implantation of	14203, 14206	Malignant upper aerodigestive tract tumour	31400, 31403
Lobar emphysema, neonatal, thoracotomy & lung		31406	
lobe of lacrimal gland, excision of	42593		1, 50203, 50206
lobectomy of, for trauma	30428, 30430	50209, 50212, 50215, 50218, 50221, 50224, 502	227, 50230
lobectomy of, other than for trauma	30418, 30421	50233, 50236, 50239	16120
Lobectomy, liver, for trauma	30428, 30430	Mallet finger, closed pin fixation of	46438
local excision for tumour	30559	mallet, fixation/repair	46438, 46441
loop, removal of under GA	35506 45659	malrotation, neonatal, laparotomy for	43801, 43804
Lop ear or similar deformity, correction of	45659 45659		24, 45527-45528
lop, bat or similar deformity, correction of Lord's procedure, massive dilatation of anus	32153		24, 45527-45528
lower, congenital deficiency, treatment of	50411, 50414	Mammary prosthesis, removal of	45548, 45551 14212
50417	30411, 30414	management fluid/gas reduction for Manchester operation for genital prolapse	35577
Lumbar cerebrospinal fluid drain, insertion of	40018		3, 45726, 45729
lumbar, insertion of	40006	45731-45732, 45735, 45738, 45741, 45744, 457	
lumbar, revision or removal of	40009	Mandible, condylectomy	45611
Lunate bone, osteectomy or osteotomy of	48406	mandible, segmental resection for	45605
lung	38438, 38441	mandibular or palatal	45825
lung, percutaneous needle	38812	Mandibular, frenulum, repair of, under GA	30281
lymph gland, muscle, other deep tissue/organ	30075	manipulation of	50115
	32, 30335-30336	manipulation/extraction of ureteric calculus	36857
lymph glands, excision of 3555	1, 35664, 35670	marrow, administration of	13706
lymph node biopsies	35723	marrow, aspiration biopsy of	30087
lymph node dissection	37607, 37610	marrow, harvesting of for transplantation	13700
lymph node of neck	31420	marrow, in vitro processing/cryopreservation	13760
lymph nodes, excision of	30335-30336	Marshall-Marchetti operation for urethropexy	35599, 37044
lymph, biopsy of	30075	Marshall-Marchetti, urethropexy	35599, 37044
lymph, drill biopsy of	30078	Marsupialisation of Bartholin's cyst or gland	35517
lymph, pelvic, excision of	35551	Mastitis, granulomatous, exploration and drainage	31551
lymph, pelvic, excision of, with hysterectomy	35664	Mastoid cavity, obliteration of	41548, 41564
Lymphadenectomy, atypical mycobacterial infection		Mastoidectomy, cortical	41545
Lymphangiectasis, limbs, major excision	45048	Maxilla, operation on, for acute osteomyelitis	43503
	33, 45035-45036	maxillary antrum	41704
Lymphoedema, major excision of	45048	Maxillary antrum, lavage of	41704
	3, 45805, 45807	maxillary sinus, removal of	41716
45809		maxillary, drainage of, through tooth socket	41719
R.A		maxillary, lavage of	41704
M		maxillary, proof puncture, lavage	41698, 41701

maxillary, transantral ligation of	41707	middle, exploration of	41629
Meatoplasty, with correction of auditory canal sten		middle, insertion of tube for drainage of	41632
meatotomy	36830	middle, operation for abscess or inflammation of	
meatotomy and hemi-circumcision	37354	midfacial	45753-45754
Meatotomy and hemi-circumcision, hypospadias	37354	Midtarsal amputation of foot	44364
Meatus, external auditory, removal of exostoses in	41518	Miles' operation	32039
meatus, external, removal of exostoses in	41518	Minitracheostomy insertion	41884
meatus, internal, exploration	41599	Minnesota tube, insertion of	13506
Meckel's diverticulum, removal of	30375	miscarriage, purse string ligation of cervix	16511
Meckel's, removal of	30375	miscarriage, treatment of	16505
Meconium ileus, laparotomy for	43813, 43816	Mitral annulus, reconstruction after decalcification	
Medial palpebral ligament, ruptured, repair of	42854	mitral annulus, reconstruction after decalcification	
Median bar, endoscopic resection of	36854	mitral, open valvotomy of	38487
median, for post-operative bleeding	38656	Mitrofanoff continent valve, formation of	37045
mediastinal, removal by thoracotomy or sternotom		mobilisation, for post-traumatic stiffness	49569
Mediastinum, cervical exploration of	38448	Moh's procedure	31000-31005
Meibomian cyst, extirpation of	42575	Molluscum contagiosum, removal in operating the	
Melasma, full face chemical peel	45019	Molteno valve, insertion of	42752
Meloplasty, for correction of facial asymmetry	45587-45588	Molteno valve, removal of	42755
membrane, cancer, treatment	30196, 30202	monitoring, intravascular	13876
membrane, graft	42641	mucous membrane	30072
membrane, micro-inspection with ear toilet	41647	mucous, of mouth, removal	30283
membrane, punch biopsy of	30087	multiple, attendance other than routine antenatal	16502
	6, 30029, 30032	Multiple, injections for varicose veins	32500
30035, 30038, 30042, 30045, 30049	0, 20022, 20022	muscle	30226
Membranes, retained, evacuation of	16564	muscle, repair of	30232, 30235
membranes, threatened premature labour	16508	muscle/deep tissue, removal of	30068
Meningeal haemorrhage, operations for	39600, 39603	musculature transfer to greater trochanter	50387
Meningocele, excision and closure of	40100	Myelomeningocele, excision and closure of	40103
meniscectomy	45755	Myelotomy, laminectomy for	39124
meniscectomy of	49503, 49506	Mylohyloid ridge, reduction of	45827
Meniscectomy, knee	49503, 49506	Myocardial electrode, permanent, insertion, thorac	
Mesenteric artery, inferior, operation on	32736	myocardial, by cardiac catherterisation	38275
Meso caval shunt for portal hypertension	30603	myocardial, permanent, insertion, thoracotomy	38470
Metacarpal bones, amputation of	44325	Myocutaneous flap, delay of	45015
metacarpal, operation for	46462	myocutaneous, delay of	45015
Metacarpophalangeal joint, arthrodesis	46300	myocutaneous, for breast reconstruction	45530
Metacarpus, operation on, for chronic osteomyelitis	43512	Myoma, hysteroscopic resection	35623
metastases, selective internal radiation therapy for		myomectomy	35649, 38763
35406, 35408		Myomectomy, hypertrophic obstructive cardiomy	
Metastatic carcinoma, craniotomy for removal of	39709	Myotomy, cricopharyngeal	41770, 41776
metatarsal	48400, 48403	Myringoplasty	41527, 41530
Metatarsal bones, osteotomy or osteectomy of	48400, 48403	Myringotomy	41626
metatarso-phalangeal joint, replacement of	49857	, ,	
Metatarso-phalangeal joint, synovectomy of	49860, 49863	N	
metatarso-phalangeal joint, synovectomy of	49860, 49863		
Metatarsus, amputation or disarticulation of	44358	Nail bed, exploration and repair of deformity	46489
Micro-arterial graft	45503	nail of finger or thumb, resection of	46528, 46531
micro-arterial or micro-venous	45503	nail of toe, resection of	47915-47916
microdochotomy	31554	Nasal adhesions, division of	41683
Microdochotomy of breast, benign or malignant con		nasal, arrest of	41656, 41677
Microlaryngoscopy	41855	nasal, cauterisation/diathermy	41674
microlaryngoscopy with removal of	41864	nasal, division of	41683
Microsomia, construction of condyle and ramus	45791	nasal, excision of	41729
Microvascular anastomosis using microsurgical tec		nasal, for arrest of haemorrhage	41729
microvascular, in plastic surgery	45502	nasal, for affect of flacificating nasal, reconstruction of	41677
Microvenous graft	45503	nasal, reconstruction of nasal, removal of	
Middle ear, clearance of	41635, 41638	,	41662, 41668
middle ear, operation for	41626	nasal, septoplasty or submucous resection	41671
middle or proximal, for osteomyelitis	46462	Nasendoscopy	41764
middle palmar/thenar/hypothenar spaces, drainage 46519		Naso-lacrimal tube, replacement of 42610-42611, 42614-42615 Nasopharyngeal angiofibroma, transpalatal removal 41767	
middle, clearance of	41635, 41638	Nasopharyngeal angiofibroma, transpalatal remov	
	.1000, 11000	nasopharyngeal, removal	41767

Nasopharynx, fibreoptic examination of	41764	Neurovascular island flap, for pulp innervation	46504
neck 20300, 20305, 20320-20321, 20330,		Nipple, accessory, excision of	31566
neck reconstruction, prostatectomy	37210-37211	nipple, accessory, excision of	31566
neck resection, endoscopic	36854	Noble type intestinal plication with enterolysis	30375
Neck, deep-seated haemangioma, excision of	45036	node biopsies, retroperitoneal	35723
neck, reoperation for bleeding/thrombosis	33842	node dissection, retroperitoneal	37607, 37610
necrosectomy	30577	node of neck, biopsy of	31420
Necrosectomy, pancreatic	30577	Node, lymph, biopsy of	30075
Necrotic material, debridement of	35100, 35103	nodes of axilla, excision of	30335-30336
necrotising stricture, bowel resection	43834	nodes of neck, dissection of 31423, 31426,	31429, 31432
needle biopsy of	38812	31435, 31438	35551
needle biopsy of lung Needling of cataract	38812 42734	Nodes, lymph, pelvic, excision of Non-gravid uterus, suction curettage of	35640
needling of encysted bleb	42734	Nose, cauterisation or packing, for haemorrhage	41677
Neonatal alimentary obstruction, laparotomy for	43825	nose, removal of	41659
neonatal, repair of	30387	not otherwise covered, removal of (OMS)	45801, 45803
Neoplasia, intraepithelial, laser therapy	35539, 35542	45805, 45807, 45809	43601, 43603
35545	33339, 33342	obliteration of	41564
Nephrectomy 36516, 36519, 36522	36525 36520	obstruction, neonatal, laparotomy for	43825
Nephro-ureterectomy, complete, with bladder repair		obstruction, neonatal, laparotomy for obstruction, surgical relief of	30387
Nephroblastoma, operations for	43981, 43984	obstruction, surgical tener of	30307
Nephrolithotomy	36540, 36543	0	
Nephroscopy 36627, 36630, 36633, 36636, 36639,		O	
36648	, 50042, 50045	Osulan musala tama manain af	12051
Nephrostomy	36552	Ocular muscle, torn, repair of ocular muscles 42833.	42854 42839, 42851
nerve	39315, 39318		
Nerve block, regional or field 18213, 18216,		oesophageal atresia, neonatal Oesophageal atresia, neonatal, operations for	43855 43843, 43846
18225-18228, 18230, 18232-18234, 18236, 18238,		43849, 43852, 43855, 43858	43043, 43040
18242, 18244, 18248, 18250, 18252, 18254, 18256			30490
18260, 18262, 18264, 18266, 18268, 18270, 18272		oesophageal, insertion of Oesophagectomy 30535-30536, 30538-30539	
18276, 18278, 18280, 18282, 18284, 18286, 18288		Oesophagectomy 30535-30536, 30538-30539 30544-30545, 30547-30548, 30550-30551, 30553-	
18292, 18294, 18296, 18298	, 102>0	30556-30557	30334
nerve meninges, incision of	42548	oesophagectomy	30294
nerve palsy, excision of tissue for	45581	oesophagogastric (Heller's operation)	30532-30533
nerve paralysis, plastic operation for	45575, 45578	Oesophagogastric myotomy	30532-30533
nerve section, translabyrinthine	41593		30475, 30478
nerve section, via posterior fossa	39500	Oesophagostomy, cervical	30293-30294
nerve stimulation for faecal incontinence	32213-32218	oesophagostomy, closure or plastic repair of	30293
nerve, injection with alcohol, cortisone etc	39100	oesophagus, removal of	41825
nerve, nerve graft to	39318	Oesophagus, resection of stricture, paediatric	43906
nerve, neurectomy/neurotomy/tumour	39324, 39327	of Arnold-Chiari malformation	40106
nerve, repair of	39300, 39303		33806, 33812
nerves, injection into	39013	of bladder, closure	37050
nerves, percutaneous neurotomy	39115	of bladder, needle	37041
neuralgia, intracranial neurectomy	39106	of bladder, repair of	37842
neurectomy for plantar digital neuritis	49866	of elbow	49109
Neurectomy, foot, for plantar digital neuritis	49866	of facial nerve, mastoid portion	41569
neurectomy, for trigeminal neuralgia	39106	of finger joints	46336
Neuroblastoma, operations for 43981,	, 43984, 43987	of foot, repair of	49812
neuroendocrine tumour, removal of	30323	of haematoma	30216
Neuroendocrine tumour, retroperitoneal, removal of	30323	of hand tendons	46336, 46342
neuroendocrine, removal of	30323	of hand, incision for	46525
Neuroendoscopy	40903	of intracranial tumour	39706
Neurolysis, by open operation	39330	of joint, not otherwise covered	50104
	, 41578-41579	of joints	50115
Neurostimulator receiver, spinal, subcutaneous place		of limb or organ	22055
neurostimulator receiver, subcutaneous placement	39134	of mandible	45611
neurotomy for facet joint denervation	39118	of metatarso-phalangeal joint	49860, 49863
neurotomy of peripheral nerves	39323	of neck, deep-seated, excision of	45036
neurotomy of spinal nerves	39115	of nerve	39321
Neurotomy, of peripheral nerves	39327	of nerve trunk	39312
neurovascular island	45563, 46504	of Oddi, transduodenal operation on	30458

of novimbored novices	39323	orbit, removal of implant from socket	42518
of peripheral nerves	48936		45593
of shoulder of skin lesions 30189		Orbital cavity, bone or cartilage graft to orbital, excision of	42574
	, 30192		42530, 42533
of tendons of digit 46348, 46351, 46354, 46357 of thoracic cavity 38800	, 38803	Orbitotomy Orchidectomy	30641-30642
	, 35103		1, 37806-37807
of tympanum	41626	37809-37810	f, 37800-37807
of ureteric calculus, endoscopic	36857	orifice, plastic repair to enlarge	35569
of xenon arc	42782	Oro-antral fistula, plastic closure of	41722
Olecranon, excision of bursa of	30111	oro-antral, plastic closure of	41722
Omentectomy, infra-colic	35726	Oro-nasal fistula, plastic closure of	45714
	, 30387	Orthopaedic pin or wire, insertion of	47921
oncology treatment 15211, 15214-15215, 15218, 15221	*		, 49503, 49506
15227, 15230, 15233, 15236, 15239, 15242, 15245, 1524		•	, 45797, 45847
15251, 15254, 15257, 15260, 15263, 15266, 15269, 1527		Ossicular chain reconstruction	41539, 41542
one or more jaw cysts	45799	Osteectomy of accessory bone	48400
Oophorectomy, laparoscopic	35638		, 45726, 45729
open	37200	45731-45732, 45735, 45738, 45741, 45744, 4574	
Open heart surgery, not otherwise covered	38653		, 45726, 45729
open reduction for congenital dislocation	50408	45731-45732, 45735, 45738, 45741, 45744, 4574	
open, of mitral valve	38487	46399, 48400, 48403, 48406, 48409, 48418, 4842	
operation (intrathoracic), other	38456	osteectomy/osteotomy 46396, 46399, 48406	
operation by fundoplasty 31464	, 31466	48415, 48424, 48427	
operation for 42833, 42836, 42839, 42842	, 44133	osteectomy/osteotomy of	48406, 48409
	, 43503	Osteomyelitis, acute or chronic, operations for	43500, 43503
operation for chronic osteomyelitis	43512	43506, 43509, 43512, 43515, 43518, 43521, 43524	1
operation for genital prolapse	35578	osteomyelitis, acute, operation for	43503
	, 43515	osteomyelitis, chronic, operation for	43521
operation for priapism	37393	osteomyelitis, craniectomy for	39906
operation on frontal sinus or ethmoid sinuses	41737	osteoplasty	49224
operation on sphenoidal sinus	41752	Osteoplasty of knee	49503, 49506
	, 46462	Osteotomy of accessory bone	48400
	, 46462	osteotomy or osteectomy of	48424, 48427
operation on, for acute osteomyelitis 43500, 43503		other than face or neck, revision of (restriction)	45515
*	, 43518	45518	
45815	12.51.5	other than laser	42734
operation on, for osteomyelitis 43503, 43506, 43512		Otitis media, acute, operation for	41626
operations for, in oral and maxillofacial region	45815	outlet compression, removal operation	34139
45817	41005	Oval window surgery	41615
operations on 30663, 30666, 41889, 41892		Ovarian biopsy by laparoscopy	35637
operations, other 41659, 41662, 41668, 41671-41672 41677, 41683, 41686, 41689, 41692	, 416/4	ovarian, aspiration of	35518
	35200	ovarian, excision of, with laparotomy ovarian, radical or debulking operation for	35713, 35717 35720
Operative arteriography or venography Ophthalmological examination under GA	42503	ovaries, operation for	30387
optical, for urethral stricture	37327	Ovaries, operation for	30387
or chest, decompression escharotomy	45054	Oxycephaly, cranial vault reconstruction for	45785
or mandible, fractures, treatment of 47753, 47756		Oxycephary, cramar vaunt reconstruction for	43703
47765, 47768, 47771, 47774, 47777, 47780, 47783, 4778		Р	
47789	50	•	
or maxilla, fractures, treatment of 47753, 47756	. 47762	Pacemaker electrode, permanent, insertion, sub-xyp	hoid 38473
47765, 47768, 47771, 47774, 47777, 47780, 47783, 4778		pacemaker, insertion/replacement	38353
47789		pacemaker, permanent, insertion sub xyphoid	38473
or median sternotomy for post-operative bleeding	38656	Pacemaking electrode, temporary transvenous, inser	
or palatal exostosis, excision of	45825	pacemaking electrode, temporary, insertion of	38256
or pump, loading of	14218	paediatric, operations for	43933, 43936
or ray, transposition/transfer, vascular pedicle	46507	paediatric/neonatal	13306, 13309
or tendon transfer	47966	Pain management, implanted drug delivery system	39125-39128
or tonsils and adenoids	41797	39130-39131, 39133	
oral and maxillofacial region 45801, 45803, 45805		Palatal exostosis, excision of	45825
Orbit, anophthalmic, insertion of cartilage or implant	42518		, 45710, 45713
orbit, insert/remove implant	42518		, 45710, 45713
orbit, placement of motility integrating peg	42518	palmar or plantar, removal of	30187
71 7 2 21 2		paintar of plantar, removar of	30107

Palmar warrs, removal of 30187 Palporhal ligament, medial, ruptured, repair of 42854 Pancreac, drainage of 30582 30593 30594 Pancreacticolity 30583 30593 30594 Pancreacticolity 30583 30593 30594 Pancreactic abscess, laparotomy and external drainage of 30575 30585 30595 Pancreactic, laparotomy, external drainage of 30575 30585 30595 Pancreactico-lejumostomy 30585 30595 Pancreactico-lejumostomy 30585 30595 Pancreactico-lejumostomy 30585 30595 Pancreactico-lejumostomy 30585 30596 Pancreactico-lejumostomy 30585 30596 Pancreactico-lejumostomy 30585 30595 Pancreactico-lejumostomy 30585 30596 Pancreactico-lejumostomy 30473 30486 Pancreacto-lejumostomy 30473 30486 Pancreactoro 30484 30484 Pancreactoro 304864 30484 30484 Pancreactoro 304864 araphimosa, reduction of under GA 30666 Paraphimosa, reduction of u	palmar spaces of hand, drainage of	46519	Pedicle, tubed, or indirect flap 45230
Palpehral ligament, medial, ruptured, repair of Pancreate, famingse of North Pancreate change of North Pancreate changes of North Pancreate changes of North Pancreatic anastomosis and Secs. Inparotomy and external drainage of North Pancreatic anastomosis and Secs. So. North Pancreatic anastomosis and Secs. So. North Pancreatic plejumostomy (Whipple's operation) and Secs. So. North Pancreatic plejumostomy (Whipple's operation) and Secs. So. North Pancreatic plejumostomy (Whipple's operation) and Secs. So. North Pancreatic plejumostomy (Whipple's operation) and Secs. So. North Pancreatic plejumostomy (Whipple's operation) and Secs. So. North Pancreatic plejumostomy (Whipple's operation) and Secs. So. North Pancreatic plejumostomy (Whipple's operation) and Secs. So. North Pancreatic plejumostomy (Whipple's operation) and Secs. So. North Pancreatic plejumostomy (Whipple's operation) and Secs. So. North Pancreatic plejumostomy (Whipple's operation) and Secs. So. North Pancreatic plejumostomy (Whipple's operation) and Secs. So. North Pancreatic plejumostomy (Whipple's operation) and Secs. So. North Pancreatic plejumostomy (Whipple's operation) and Secs. So. North Pancreatic plejumostomy (Whipple's operation) and Secs. So. North Pancreatic plejumostal			
Puncreates drainage of 30583 30593 30594 Puncreateit abscess, laparotomy and external drainage of 30575 Puncreatic abscess, laparotomy external drainage of 30575 puncreatic, laparotomy external drainage of 30585 305867 puncreatic, laparotomy external drainage of 30585 puncreatic, laparotomy (whipple's operation) 30584 Puncreaticio-jejinnostomy (hipple's operation) 30584 Puncreaticio-jejinnostomy (hipple's operation) 30584 Puncreaticio-jejinnostomy (hipple's operation) 30585 Puncreaticio-jejinnostomy (hipple's operation) 30584 Puncreaticio-jejinnostomy (hipple's operation) 30584 Puncreaticio-jejinnostomy (hipple's operation) 30584 Puncreaticio-jejinnostomy (hipple's operation) 30585 Puncreaticio-jejinnostomy (hipple's operation) 30585 Puncreaticio-jejinnostomy (hipple's operation) 30585 Puncreaticio-jejinnostomy (hipple's operation) 30585 Puncreaticio-jejinnostomy (hipple's operation) 30484 Puncreaticio-jejinnostomy (hipple's operation) 30483 Puncreaticio-jejinnostomy (hipple's operation) 30483 Puncreaticio-jejinnostomy (hipple's operation) 30483 Puncreaticio-jejinnostomy (hipple's operation) 30483 Puncreaticio-jejinnostomy (hipple's operation) 30483 Puncreaticio-jejinnostomy (hipple's operation) 30483 Puncreaticio-jejinnostomy (hipple's operation) 30483 Puncreaticio-jejinnostomy (hipple's operation) 30483 Puncreaticio-jejinnostomy (hipple's operation) 304844 Puncreaticio-jejinnostomy (hipple's operation) 304844 Puncreaticio-jejinnostomy (hipple's operation) 304844 Puncreaticio-jejinnostomy (hipple's operation) 304844 Puncreaticio-jejinnostomy (hipple's operation) 30484 Puncreaticio-jejinnostomy (hipple's operation) 30484 Puncreaticio-jejinnostomy (hipple's operation) 30484 Puncreaticio-jejinnostomy (hipple's operation) 30484 Puncreaticio-jejinnostomy (hipple's operation) 30484 Puncreaticio-jejinnostomy (hipple's operation) 30484 Puncreaticio-jejinnostomy (hipple's operation) 30484 Puncreaticio-jejinnostomy (hipple's operation) 30484 Puncreaticio-jejinnostomy (hipple's operation) 30484 Puncreaticio-jejinnostomy			
Pancreatectomy			
Pancreatic abscess, laparotomy and external drainage of 30585087 pancreactic, laparotomy, external drainage 30585087 pancreactic, laparotomy, external drainage 30585087 pancreactic, laparotomy, external drainage 30585087 pancreactic, laparotomy, external drainage 30585087 pancreactic, laparotomy, external drainage 30585087 pancreactic, laparotomy, external drainage 30585 pancreactic, laparotomy, external drainage 30585 pancreactic, laparotomy, external drainage 30585 pancreactic, laparotomy, external drainage 30585 pancreactic, laparotomy, external drainage 30585 pancreactic, laparotomy, endoscopic 30439 pancreactic, laparotomy, endoscopic 30473 panully, endoscopic 30473 panully, endoscopic 30473 panully, endoscopic 30473 panully, endoscopic 30473 panully, endoscopic 30473 panully, endoscopic 30485 panully, endoscopic			, 6
pancreatic, panarotomy, external drainage 30875 pelvic, laparotomy for drainage of 30394 pancreatic-duodencetomy (Whitpple's operation) 30584 pelvic, laparotomy for drainage of 30394 pelvic, laparotomy for drainage of 30394 pelvic, laparotomy for drainage of 30394 pelvis (paratomy for drainage of 30844 pelvis (paratomy for drainage of 30844 pelvis (paratomy for drainage of 30844 pelvis (paratomy for drainage of 30844 pelvis (paratomy for drainage of 30844 pelvis (paratomy for drainage of 30844 pelvis (paratomy for drainage of 30844 pelvis (paratomy for drainage of 30844 pelvis (paratomy for 30844 pelvis (paratomy for 30844 pelvis (paratomy			
Pancreatic-alparotomy, external drainage 30575 Pancreatic-alparotomy (oxfarianage of 30394 203084 203			
Pancreatico-duodenectomy (Whitpiple's operation) 30584 pelvis, operation involving laparotomy 30887 20889-30990 pelvis 20889-30990 pelvis 20889-30990 pelvis 20889-30990 pelvis 20889-30990 pelvis 20889-30990 pelvis 20889-30990 pelvis 20889-30990 pelvis 20889-30990 pelvis 20889-30990 pelvis 20889-30990 pelvis 20889-30990 pelvis 20889-30990 pelvis 20889-30990 pelvis 20889-30990 21100, 21110, 2110, 21110, 21110, 21110, 21110, 21110, 21110, 21110, 21110, 21110, 21110, 21110, 21110, 21110, 21110, 21110, 21110, 21110, 2110, 21110,		30575	
Pancreato-cholangiography, endoscopic 30484 Pancreatography, operative 30493 21100, 21130, 21101, 21110,		30584	
Pancetography, operative 3043, 30478 Panendoscopy 30473, 30478 Panendoscopy 30473, 30478 Panendoscopy 30473, 30478 Panilysterectomy 30473, 30478 Panilysterectomy 30473, 30478 Panilysterectomy 30473, 30478 Panilysterectomy 30473, 30478 Panilysterectomy 30473, 30478 Panilysterectomy 30473, 30478 Panilysterectomy 30473, 30478 Panilysterectomy 30473, 30478 Papilloma, bladder, transurethral resection 36840, 36845 Papilloma, bladder, transurethral resection 36840, 36845 Papilloma, bladder, transurethral resection 30480, 36845 Papilloma, bladder, transurethral resection 30480, 36845 Papilloma, bladder, transurethral resection 30480, 36845 Papilloma, bladder, transurethral resection 30480, 36845 Paran-cosphageal, hiatus hernia, repair of 31468 Paran-cosphageal, repair of 31468 Paran-cosphageal, repair of 31468 Paran-cestion and 3046, 42734 Paracentesis adominis 30406, 42734 Pararapharyageal tumour, excision of 31409, 31412 Parapharyageal tumour, excision of 31409, 31412 Parapharyageal tumour, excision of 31409, 31412 Parapharyageal tumour, excision of 30666 Paraphyriod operation for under GA 30666 Paraphyriod operation for hyperparathyroidism paraphyroid, removal of 30306 Parathyroid operation for hyperparathyroidism parantyroid, removal of 30306 Paracentesis atases, cyebrows, elevation of 30306 Paracentesis, excision of pulp space infection, incision for 42872 Parotid duct, diathermy or dilatation 30262 Parotid duct, diathermy or dilatation 30263 Parotid duct, diathermy or dilatation 30264 Parotid duct, diathermy or dilatation 30264 Parotid duct, diathermy or dilatation 30264 Parotid duct, diathermy or dilatation of 30247, 30250 Parotid, superficial lobectomy/tumour removal 30251 Parotid duct, diathermy or dilatation of 30247, 30250 Parotid, superficial lobectomy/tumour removal 30251 Parotid parotid, excision of 30471, 30250 Parotid, superficial lobectomy/tumour removal 30251 Parotid parotid, excision of 30471, 30250 Parotid parotid, excision of 30481, 30251 Parotid parotid, excision of 30481, 30251 Parotid parotid, e	Pancreatico-jejunostomy	30589-30590	pelvis 48427
Panendoscopy	Pancreato-cholangiography, endoscopic	30484	pelvis (except hip) 21100, 21110, 21112, 21114, 21116
Panhysterectomy	Pancreatography, operative	30439	21120, 21130, 21140, 21150, 21155, 21160, 21170
Pannus, treatment of, with cautery of conjunctiva appaillarly hyperplasia removal of 4581, 45831, 45833, 45835 penile or urethral, cystoscopy for treatment of 36815 Papilloma, bladder, transurethral resection 36840, 36845 Papillomata, juvenile, removal with microlaryngoscopy 41858 Penile warts, cystoscopy for treatment of 36815 Papillomata, juvenile, removal with microlaryngoscopy 41858 Panilomata, juvenile, removal with microlaryngoscopy 41858 Penile warts, cystoscopy for treatment of 36815 Papillomata, juvenile, removal with microlaryngoscopy 41858 Penile warts, cystoscopy for treatment of 36815 Papillomata, juvenile, removal with microlaryngoscopy 41858 Penile warts, cystoscopy for treatment of 3702, 37045 Paraco-cosphageal, histus hermia, repair of 31468 31468 Penile warts, cystoscopy for treatment of 30053, 30658, 30508 Paracles stabdominis 30406 30464 42734 Penile warts, cystoscopy for treatment of 30053, 30508, 30508 30375 Paralysis, facial nerve, plastic operations for 45575, 45578 peptic ulcer, bleeding, control of 30505-30506, 30508-30509 30375 Parapharyngeal, excision of cervical approach 31409 31409 Per anal release, rectal stricture 32114 23114 Parathyroid operation for hyperparathyroidism parathyroid, removal of Parotypine, cycloroscopic operation of 30306 30366 Percutaneous sapiration biopsy of deep organ parations, cyclor	Panendoscopy	30473, 30478	
papillary hyperplasia removal of 45813, 45833, 45835 Papilloma, bladder, transurchiral resection 36840, 36845 Papillomata, juvenile, removal with microlaryngoscopy 41858 Papillomata, juvenile, removal with microlaryngoscopy 41858 Papillomata, juvenile, removal with microlaryngoscopy 41858 Penis, circumcision of 37402, 37405 Penis, amputation of 37502, 37605 37605		35664	
Papilloma, bladder, transurethral resection 36840, 36845 penis erection test with examination 37815 Papillomata, juvenile, removal with microlaryogoscopy 41858 Penis, amputation of 37402, 37405 Para-oesophageal, hiatus hernia, repair of para-oesophageal, repair of para-centesis 31468 Penis, circumcision of 3055, 30506, 30508, 30509 Paracentesis abdominis 30406, 42734 peptic ulcer, bleeding, control of 3055, 30506, 30508, 30509 Parapharyngeal tumour, excision of parapharyngeal, excision of cervical approach araphimosis, reduction of under GA 3066 peptic, bleeding, control of 3055, 30506, 30508, 30509 Parapharyngeal, excision of vervical approach araphimosis, reduction of under GA 30666 percutaneous spiration, deep organ 30094 Parathyroid operation for hyperparathyroid ism parathyroid, removal of 30315 percutaneous stender on the percutaneous technique, sequential dilation, partial splitting method 41880 Parki intersphincteric operation 32126 percutaneous tenotomy of percutaneous tentomy of floor, incision for 4525 percutaneous tentomy of floor, incision for 45252 percutaneous tentomy of floor, incision for 30269 percutaneous, using interventional imaging 35307 Parotid duct, diath			
Papillomata, juvenile, removal with microlaryngoscopy 41858 Para-oesophageal, hiatus hernia, repair of a 31468 Penis, amputation of 30543, 30658 30654, 30658 Para-oesophageal, repair of 30406, 42734 Pepic uleer, bleeding, control of 30505-30506, 30508-30509 Paralysis, facial nerve, plastic operations for 45575, 45578 Pepic, lededing, control of 30505-30506, 30508-30509 Paralysis, facial nerve, plastic operations for 45575, 45578 Pepic, lededing, control of 30505-30506, 30508-30509 Parapharyngeal tumour, excision of 31409 31412 Per anal release, rectal stricture 32114 Parapharyngeal, excision of, cervical approach 31409 Paraphimosis, reduction of under GA 30666 Paraphimosis, reduction of under GA 30666 Paraphimosis, reduction of under GA 30666 Paraphimosis, reduction of under GA 30666 Paraphimosis, reduction of or hyperparathyroidism parathyroid, removal of 30306 Paraphimosis, reduction of properation 30306 Paraphimosis, reduction of under GA 30666 Paretitaneous aspiration biopsy of deep organ 30094 Percutaneous aspiration biopsy of deep organ 30094 Percutaneous tenchique, sequential dilation, partial splitting Percutaneous tenchique, sequential dilation, partial splitting Percutaneous tenchique, sequential dilation, partial splitting Percutaneous tenchique, sequential dilation, partial splitting Percutaneous tenchique, sequential dilation, partial splitting Percutaneous tenchique, sequential dilation, partial splitting Percutaneous tenchique, sequential dilation, partial splitting Percutaneous tenchique, sequential dilation, partial splitting Percutaneous tenchique, sequential dilation, partial splitting Percutaneous tenchique, sequential dilation, partial splitting Percutaneous tenchique, sequential dilation, partial splitting Percutaneous tenchique, sequential dilation, partial splitting Percutaneous tenchique, sequential dilation, partial splitting Percutaneous tenchique, sequential dilation, partial splitting	papillary hyperplasia removal of 45831,	45833, 45835	
Para-cesophageal, intatus hernia, repair of para-cesophageal, repair of para-cesophageal, repair of para-cesophageal, repair of para-centesis 31468 and 31468 peptic ulcer, sluter of 30505-30506, 30508-30509 para-centesis abdominis 30406, 42734 peptic ulcer, sluter of 30505-30506, 30508-30509 peptic ulcer, suture of 30375 peral-para-para-para-para-para-para-para-p			
para-oesophageal, repair of paracentesis 30406 42734 peptic ulcer, bleeding, control of 30505-30506, 30508-30509 paracentesis abdominis 30406 42734 peptic, bleeding, control of 30505-30506, 30508-30509 peptica leader peptic peptic peptic peptic peptic peptic peptic pep			
paracentesis 30406, 42734 peptic ulcer, suture of 30375 Paracentesis abdominis 30406 peptic, bleeding, control of 30505-30506, 30508-30509 Paralysis, facial nerve, plastic operations for Parapharyngeal tumour, excision of parapharyngeal, excision of, cervical approach 31409 Per anal release, rectal stricture 32114 Paraphimosis, reduction of under GA 30666 Percutaneous aspiration biopsy of deep organ 30094 Parathyroid operation for hyperparathyroidism parathyroid, removal of 30315 percutaneous aspiration biopsy of deep organ 30094 Parathyroid operation for hyperparathyroidism parathyroid, removal of 30306 percutaneous sepiration biopsy of deep organ 30094 Parathyroid operation for hyperparathyroidism parathyroid, removal of 30306 percutaneous sepiration biopsy of deep organ 30094 Parktyroid, removal of 30306 percutaneous sepiration biopsy of deep organ 30094 Parktyroid, removal of 42872 percutaneous sepiration biopsy of deep organ 30094 Parktyroid, removal of 42872 percutaneous technique, sequential dilation, partial splitting 41880 Partolid dict, diathermy of dilatation 47912 percutaneous tentomy of fo			
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Paralysis, facial nerve, plastic operations for Parapharyngeal tumour, excision of parapharyngeal tumour, excision of a 31409, 31412 Per anal release, rectal stricture 32114 percutaneous on G, exvical approach 31419 31499 percutaneous aspiration biopsy of deep organ 30094 paraphimosis, reduction of under GA 30666 percutaneous aspiration biopsy of deep organ 30094 paraphimosis, reduction of under GA 30666 percutaneous endoscopic 30481-30482 Persultaneous aspiration biopsy of deep organ 30094 percutaneous endoscopic 30481-30482 Parathyroid operation for hyperparathyroidism parathyroid, removal of 30306 30306 percutaneous endoscopic 30481-30482 Parki, intersphincteric operation of foot, incision for 242872 percutaneous technique, sequential dilation, partial splitting percutaneous for foot, incision for 47912 percutaneous tenotomy of 46456 percutaneous tenotomy of 46456 percutaneous, percutaneous tenotomy of 46456 percutaneous, percutaneous, for facet joint denervation 39118 paronychia/pulp space infection, incision for 4652 percutaneous, of finger 46456 30166 percutaneous spiration denervation 3918 percutaneous, of facet joint denervation 39118 parotid gland, removal of 30262 percutaneous, of spinal nerves 39115 parotid gland, repair of 30269 percutaneous, of spinal nerves 39115 parotid, superficial lobectomy/tumour removal parotid, superficial lobectomy/tumour removal parotid, superficial lobectomy/tumour removal parotid, superficial lobectomy/tumour removal parotid, superficial lobectomy/tumour removal parotid, superficial lobectomy/tumour of 30247, 30250 perforation, closure of 42551, 42554, 42557 parotid, excision of 37402 perforation of ympanum 41641 41671 Parovarian excision of parotarial excision of parotarial excision of parotarial excision of	*		
Parapharyngeal tumour, excision of parapharyngeal, excision of, cervical approach 31409 31410 Per anal release, rectal stricture percutaneous 32114 Parapharyngeal, excision of, cervical approach 31412 31409 Per anal release, rectal stricture percutaneous analysis percutaneous aspiration biopsy of deep organ and 30094 30094 Paraphimosis, reduction of under GA paraphimosis, reduction of under GA Parathyroid, removal of paraphyroid, removal of atteits, eyebrows, elevation of atteits, eyebrows, elevation of atteits, eyebrows, elevation of atteits phincteric operation and paraphyroid, p			
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Percutaneous aspiration biopsy of deep organ 30094 Paraphimosis, reduction of under GA 30666 paraphimosis, reduction of under GA 30666 paraphimosis, reduction of under GA 30666 paraphimosis, reduction of under GA 30666 Parathyroid operation for hyperparathyroidism parathyroid, removal of 30306 Paretic states, eyebrows, elevation of 42872 Paretic states, eyebrows, elevation of 42872 Paronychia of foot, incision for 47912 paronychia of foot, incision for 47912 paronychia of foot, incision for 47912 paronychia of foot, incision for 47912 paronychia of foot, incision for 46525 Parotid duct, diathermy or dilatation 30262 parotid gland, removal of 30253 parotid gland, repair of 30269 parotid, excision of 30269 parotid,			
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parathyroid, removal of Paretic states, eyebrows, elevation of Paretic states, eyebrows, elevation of 42872 percutaneous tenotomy of 46456 Paretic states, eyebrows, elevation of 32126 percutaneous tenotomy of 46456 Parks' intersphincteric operation 32106 percutaneous tube, jejunal extension 31460 paronychia of, pulp space infection, incision of 47912 percutaneous, of racet joint denervation 39118 paronychia/pulp space infection, incision for 46525 percutaneous, of finger 46456 Parotid duct, diathermy or dilatation 30262 percutaneous, of spinal nerves 39115 parotid gland, removal of 30253 percutaneous, of spinal nerves 39115 parotid gland, repair of 30269 perforated duodenal ulcer, suture of 30375 parotid, excision of 30251 perforated duodenal ulcer, suture of 30375 parotid, excision of 30247, 30250 perforation of tympanum 41641 parotid, superficial lobectomy/tumour removal 30253 perforation of tympanum 41641 parotarian cyst, removal of 35713, 35717 perforation, repair of, by thoracotomy 30560 parovarian, excision of, with laparotomy 35713, 35717 perforation, repair of, by thoracotomy 30560 partial excision of, with laparotomy 3573, 35717 perforation, repair of, by thoracotomy 42635 partial amputation of 37402 perfusion of 37402 perfusion of 37402 perfusion of 2005, 34533 partial excision of 400703 perfusion, modifiers 25000, 25005, 25010, 25015, 25025 partial or complete removal of 35560 perfusion, modifiers 25000, 25005, 25010, 25015, 25025 partial, for epilepsy 40703 perfusion, retrograde, cannulation for 3626144-42615 perfusion, retrograde, cannulation for 362614 perfusion, time 23010, 23021-23023, 23031-23033 patch, to artery or vein stenosis 3545, 33548 23041-23043, 23051-23053, 23061-23063, 23071-23073 patch, to artery or vein 49503, 49506 23340, 23350, 23360, 23370, 23380, 23390, 23310, 23330, 23330 Patclla, bursa, excision of 400000000000000000000000000000000000			· · · · · · · · · · · · · · · · · · ·
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Parks' intersphincteric operation 32126 percutaneous transluminal angioplasty with stenting percutaneous to foot, incision for paronychia of foot, incision for paronychia of, pulp space infection, incision for paronychia/pulp space infection, incision for de525 percutaneous, for facet joint denervation percutaneous, of finger de6456 39118 Parotid duct, diathermy or dilatation parotid gland, removal of parotid gland, repair of parotid, excision of parotid, excision of 30261 parotid, excision of 30251 parotid, excision of 30251 parotid, excision of 30251 perforation, closure of 30251 parotid, excision of 30247, 30250 parotid, excision of 30247, 30250 perforation, closure of 42551, 42554, 42557 parotid, superficial lobectomy/tumour removal parovarian, excision of, with laparotomy 35713, 35717 perforation, repair of, by thoracotomy 30560 partial amputation of 37438 partial excision of with laparotomy 357438 partial or complete removal of 37488 partial or complete removal of 35560 partial, for epilepsy 40703 passages, obstruction, probing for 42610-42611 25050 passages, obstruction, probing for 42610-42611 25050 partial, for epilepsy 33545, 33548 23041-23043, 23051-23053, 23061-23063, 23071-23073 patch grafting to 33545, 33548 23041-23043, 23091, 23111-23119, 23121, 23170 Patella, bursa, excision of 30111 23180, 23290, 23290, 23290, 23300, 23310, 23320, 23230, 23200, 23			
Paronychia of foot, incision for paronychia of, pulp space infection, incision paronychia, of, pulp space infection, incision of 46525 47912 percutaneous, for facet joint denervation 39118 percutaneous, for facet joint denervation 39118 percutaneous, for facet joint denervation 39118 percutaneous, definger 46456 Parotid duct, diathermy or dilatation paronychia/pulp space infection, incision for 46525 30262 percutaneous, of spinal nerves 39115 percutaneous, of spinal nerves 39115 percutaneous, of spinal nerves 39115 percutaneous, using interventional imaging 36624 parotid gland, repair of 30269 percutaneous, using interventional imaging 36624 parotid, excision of 30253 perforated duodenal ulcer, suture of 30375 parotid, superficial lobectomy/tumour removal 30253 perforation of tympanum 41641 parotid, total extirpation of 30247, 30250 perforation of tympanum 41641 parotid, total extirpation of 35713, 35717 perforation, repair of, by thoracotomy 30560 parovarian, excision of, with laparotomy 35713, 35717 perforations, sealing of 42635 partial amputation of 37438 perfusion of a sympatholytic agent 14209 partial or complete removal of 35560 partial, for epilepsy 40703 perfusion of donor kidney, continuous 22055 partial, for epilepsy 40703 perfusion, retrograde, cannulation for 9070 perfusion, retrograde, cannulation for 38577 perfusion patch, to artery or vein 33545, 33548 23041-23043, 23051-23053, 23061-23063, 23071-23073 patch, to artery or vein 33545, 33548 23041-23043, 23051-23053, 23061-23063, 23071-23073 patch, to artery or vein 33545, 33548 23081-23083, 23091, 23101, 23111-23119, 23121, 23170 Patella, bursa, excision of 30111 23180, 23190, 23200, 23200, 23200, 23230, 23240, 23250 Patellertomy 49503, 49506 23340, 23350, 23360, 23370, 23380, 23390, 23400, 23410.			1
paronychia of, pulp space infection, incision paronychia/pulp space infection, incision for paronychia/pulp space infection, incision for 46525 percutaneous, of facet joint denervation 39118 Parotid duct, diathermy or dilatation parotid gland, removal of parotid gland, repair of 30253 30253 percutaneous, of spinal nerves 39115 parotid, excision of parotid, excision of parotid, excision of parotid, superficial lobectomy/tumour removal parotid, total extirpation of 30247, 30250 Perforated duodenal ulcer, suture of 30375 Parovarian cyst, removal of parotial amputation of parotial amputation of yardial amputation of yardial excision of, with laparotomy 35713, 35717 perforation, repair of, by thoracotomy 30560 partial excision of yardial excision of 37402 perfusion of yardial excision of yardial excision of 37438 perfusion of a sympatholytic agent 14209 partial or complete removal of 35560 Perfusion of donor kidney, continuous 22055 partial, for epilepsy 40703 perfusion, modifiers 25000, 25005, 25010, 25015, 25020 perfusion, probing for 42610-42611 25050 perfusion, retrograde, cannulation for perfusion, time 23010, 23021-23023, 23031-23033 patch grafting to 33545, 33548 23041-23043, 23051-23053, 23061-23063, 23071-23073 patch, to artery or vein 33545, 33548 23081-23083, 23091, 23110, 23111, 23112, 23170 Patella, bursa, excision of 30111 23180, 23190, 23200, 23210, 23220, 23230, 23320, 23330, 23310, 23320, 23330 Patellectomy 49503, 49506 23340, 23350, 23360, 23370, 23380, 23390, 23400, 23410			
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parotid gland, removal of parotid gland, repair of parotid gland, repair of parotid, excision of parotid, excision of parotid, excision of parotid, excision of superficial lobectomy/tumour removal parotid, total extirpation of 30253 perforation of tympanum 41641 parotid, total extirpation of 30247, 30250 perforation, closure of 41671 parovarian cyst, removal of 35713, 35717 perforation, repair of, by thoracotomy 30560 parovarian, excision of, with laparotomy 35713, 35717 perforation, repair of, by thoracotomy 30560 partial amputation of 37402 perfusion of a sympatholytic agent 14209 partial or complete removal of 35560 partial, for epilepsy 42614-42615 partial angioplasty for vein stenosis 34815 partial angioplasty for vein stenosis 34815 partial angioplasty for vein stenosis 33545, 33548 23041-23043, 23051-23063, 23071-23023, 23031-23033 patch, to artery or vein 33545, 33548 23081-23083, 23091, 23111-23119, 23121, 23170 Patella, bursa, excision of 30111 23180, 23190, 23200, 23200, 23200, 23340, 23390, 23340, 23390, 23340, 23390, 23340, 23390, 23400, 23410 parotid, excision of parotid, excision of parotid, excision of superfusion of superforation of tympanum 41641 perforation of tympanum 41641 perforation, closure of 41671 perforation, closure of 42615 perfusion of a sympatholytic agent 14209 perfusion of a sympatholytic agent 14209 perfusion of donor kidney, continuous 22055 perfusion, modifiers 25000, 25005, 25010, 25015, 25020 perfusion, retrograde, cannulation for 38577 perfusion, time 23010, 23021-23023, 23031-23033 patch grafting to 33545, 33548 23081-23043, 23051-23053, 23061-23063, 23071-23073 patch, to artery or vein 33545, 33548 23081-23083, 23091, 23111, 23111-23119, 23121, 23170 perfusion, retrograde, cannulation for 32010, 23020, 23200, 23300, 23300, 23300, 23300, 23300, 23300, 2330			
parotid gland, repair of parotid, excision of parotid, excision of parotid, excision of parotid, excision of parotid, superficial lobectomy/tumour removal parotid, total extirpation of 30247, 30250 perforation, closure of 41671 Perforating wound of eyeball, repair of 42551, 42554, 42557 perforation, superficial lobectomy/tumour removal parotid, total extirpation of 30247, 30250 perforation, closure of 41671 Perforating wound of eyeball, repair of 42551, 42554, 42557 perforation, closure of 41671 Parovarian cyst, removal of parovarian, excision of, with laparotomy parovarian, excision of, with laparotomy parovarian, excision of 35713, 35717 perforations, sealing of 42635 partial amputation of 37402 perfusion of a sympatholytic agent perfusion of a sympatholytic agent 14209 partial or complete removal of 35560 partial, for epilepsy 40703 perfusion of donor kidney, continuous 22055 partial, for epilepsy 40703 perfusion, modifiers 25000, 25005, 25010, 25015, 25020 passages, obstruction, probing for 42614-42611 25050 perfusion, retrograde, cannulation for 38577 patch angioplasty for vein stenosis 33545, 33548 23041-23043, 23051-23053, 23061-23063, 23071-23073 patch, to artery or vein 33545, 33548 23081-23083, 23091, 23101, 23111-23119, 23121, 23170 Patellar, bursa, excision of 30111 23180, 23190, 23200, 23210, 23220, 23230, 23240, 23250 Patellar bursa, excision of 30111 23260, 23270, 23280, 23390, 23310, 23320, 23330 Patellectomy 49503, 49506 23340, 23350, 23360, 23370, 23380, 23390, 23400, 23410			
parotid, excision of parotid, excision of parotid, superficial lobectomy/tumour removal parotid, total extirpation of 30247, 30250 perforation, closure of 41671 perforation, repair of, by thoracotomy 30560 parovarian, excision of, with laparotomy 35713, 35717 perforation, repair of, by thoracotomy 30560 partial amputation of 37402 perfusion of perfusion of 202055, 34533 partial excision of 37408 perfusion of a sympatholytic agent 14209 partial or complete removal of 35560 partial, for epilepsy 40703 perfusion, repair of, by thoracotomy 20555 partial, for epilepsy 40703 perfusion of a sympatholytic agent 14209 passages, obstruction, probing for 42610-42611 42614-42615 perfusion, modifiers 25000, 25005, 25010, 25015, 25020 perfusion, probing for 42614-42615 perfusion, retrograde, cannulation for 38577 patch angioplasty for vein stenosis 33545, 33548 23041-23043, 23051-23053, 23061-23063, 23071-23073 patch, to artery or vein 33545, 33548 23081-23083, 23091, 23111-23119, 23121, 23170 Patella, bursa, excision of 30111 23180, 23190, 23200, 23210, 23220, 23230, 23240, 23250 Patellectomy 49503, 49506 23340, 23350, 23360, 23370, 23380, 23390, 23410, 23410			
parotid, superficial lobectomy/tumour removal parotid, total extirpation of 30247, 30250 perforation of tympanum 41641 Parovarian cyst, removal of parovarian, excision of, with laparotomy partial amputation of partial amputation of partial excision of partial excision of a syntal excision of partial excision of partial excision of partial or complete removal of partial, for epilepsy passages, obstruction, probing for 42614-42615 37402 perfusion of a sympatholytic agent perfusion of a sympatholytic agent perfusion, modifiers 25000, 25005, 25010, 25015, 25020 perfusion, modifiers 25000, 25005, 25010, 25015, 25020 perfusion, retrograde, cannulation for perfusion, retrograde, cannulation for perfusion, time 23010, 23021-23023, 23031-23033 patch grafting to 33545, 33548 23041-23043, 23051-23053, 23061-23063, 23071-23073 patch, to artery or vein 33545, 33548 23081-23083, 23091, 23101, 23111-23119, 23121, 23170 Patella, bursa, excision of 30111 23180, 23190, 23200, 23210, 23220, 23230, 23240, 23250 Patellar bursa, excision of 30111 23260, 23270, 23280, 23290, 23300, 23310, 23320, 23330 Patellectomy 49503, 49506 30111 23260, 23270, 23280, 23360, 23370, 23380, 23390, 23400, 23410			· · · · · · · · · · · · · · · · · · ·
parotid, total extirpation of 30247, 30250 perforation, closure of 41671 Parovarian cyst, removal of 35713, 35717 perforation, repair of, by thoracotomy 30560 parovarian, excision of, with laparotomy 35713, 35717 perforations, sealing of 42635 partial amputation of 37402 perfusion of 22055, 34533 partial excision of 37438 perfusion of a sympatholytic agent 14209 partial or complete removal of 35560 Perfusion of donor kidney, continuous 22055 partial, for epilepsy 40703 perfusion, modifiers 25000, 25005, 25010, 25015, 25020 passages, obstruction, probing for 42610-42611 25050 42614-42615 perfusion, retrograde, cannulation for 38577 Patch angioplasty for vein stenosis 34815 perfusion, time 23010, 23021-23023, 23031-23073 patch, to artery or vein 33545, 33548 23041-23043, 23051-23053, 23061-23063, 23071-23073 Patella, bursa, excision of 30111 23180, 23190, 23200, 23210, 23220, 23230, 23240, 23250 Patellar bursa, excision of 30111 23260, 23270, 23280, 23290, 23300, 23310, 23320, 23330			
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partial amputation of 37402 perfusion of 22055, 34533 partial excision of 37438 perfusion of a sympatholytic agent 14209 partial or complete removal of 35560 Perfusion of donor kidney, continuous 22055 partial, for epilepsy 40703 perfusion, modifiers 25000, 25005, 25010, 25015, 25020 passages, obstruction, probing for 42610-42611 25050 perfusion, retrograde, cannulation for 38577 Patch angioplasty for vein stenosis patch grafting to 33545, 33548 23041-23043, 23051-23053, 23061-23063, 23071-23073 patch, to artery or vein 33545, 33548 23081-23083, 23091, 23101, 23111-23119, 23121, 23170 Patella, bursa, excision of 30111 23180, 23190, 23200, 23210, 23220, 23230, 23240, 23250 Patellar bursa, excision of 49503, 49506 23340, 23350, 23360, 23370, 23380, 23390, 23410, 23410			
partial excision of partial excision of partial excision of partial or complete removal of partial or complete removal of partial, for epilepsy passages, obstruction, probing for 42610-42611 partial, for epilepsy passages, obstruction, probing for 42614-42615 perfusion, modifiers 25000, 25005, 25010, 25015, 25020 perfusion, probing for 42614-42615 perfusion, retrograde, cannulation for 38577 patch angioplasty for vein stenosis patch grafting to 33545, 33548 23041-23043, 23051-23053, 23061-23063, 23071-23073 patch, to artery or vein 33545, 33548 23081-23083, 23091, 23101, 23111-23119, 23121, 23170 Patella, bursa, excision of 30111 23180, 23190, 23200, 23210, 23220, 23230, 23240, 23250 Patellar bursa, excision of 49503, 49506 23340, 23350, 23360, 23370, 23380, 23390, 23400, 23410			
partial or complete removal of partial, for epilepsy 40703 passages, obstruction, probing for 42610-42611 25050 perfusion, modifiers 25000, 25005, 25010, 25015, 25020 passages, obstruction, probing for 42614-42615 perfusion, retrograde, cannulation for 38577 perfusion time 23010, 23021-23023, 23031-23033 patch grafting to 33545, 33548 23041-23043, 23051-23053, 23061-23063, 23071-23073 patch, to artery or vein 33545, 33548 23081-23083, 23091, 23111, 23119, 23121, 23170 Patella, bursa, excision of 30111 23180, 23190, 23200, 23210, 23220, 23230, 23240, 23250 Patellar bursa, excision of 30111 23260, 23270, 23280, 23290, 23300, 23310, 23320, 23330 Patellectomy 49503, 49506 23340, 23350, 23360, 23370, 23380, 23390, 23400, 23410			
partial, for epilepsy passages, obstruction, probing for 42610-42611 25050 perfusion, retrograde, cannulation for 38577 Patch angioplasty for vein stenosis patch grafting to patch, to artery or vein patchla, bursa, excision of Patellar bursa, excision of Patellectomy 49503, 49506 perfusion, modifiers 25000, 25005, 25010, 25015, 25020 perfusion, retrograde, cannulation for 38577 perfusion, time 23010, 23021-23023, 23031-23033 patch grafting to 23041-23043, 23051-23053, 23061-23063, 23071-23073 patch, to artery or vein 33545, 33548 23041-23043, 23051-23053, 23061-23063, 23071-23073 patchla, bursa, excision of 30111 23180, 23190, 23200, 23210, 23220, 23230, 23240, 23250 Patellectomy 49503, 49506 23340, 23350, 23360, 23370, 23380, 23390, 23400, 23410			
passages, obstruction, probing for 42614-42615 42610-42611 25050 perfusion, retrograde, cannulation for perfusion, retrograde, cannulation for perfusion, time perfusion, time 23010, 23021-23023, 23031-23033 patch grafting to patch, to artery or vein 33545, 33548 23041-23043, 23051-23053, 23061-23063, 23071-23073 patch, to artery or vein 33545, 33548 23081-23083, 23091, 23101, 23111-23119, 23121, 23170 patchla, bursa, excision of 30111 23180, 23190, 23200, 23210, 23220, 23230, 23240, 23250 patchlar bursa, excision of 30111 23260, 23270, 23280, 23290, 23300, 23310, 23320, 23330 patchlar bursa, excision of 23340, 23350, 23360, 23370, 23380, 23390, 23400, 23410			
42614-42615 perfusion, retrograde, cannulation for 38577 Patch angioplasty for vein stenosis patch grafting to patch, to artery or vein 33545, 33548 23041-23043, 23051-23053, 23061-23063, 23071-23073 patchla, bursa, excision of Patellar bursa, excision of Patellectomy 30111 23180, 23190, 23200, 23210, 23220, 23230, 23240, 23250 Patellectomy 49503, 49506 23340, 23350, 23360, 23370, 23380, 23390, 23400, 23410			
Patch angioplasty for vein stenosis 34815 perfusion, time 23010, 23021-23023, 23031-23033 patch grafting to patch, to artery or vein 33545, 33548 23041-23043, 23051-23053, 23061-23063, 23071-23073 patch, to artery or vein 33545, 33548 23081-23083, 23091, 23101, 23111-23119, 23121, 23170 Patella, bursa, excision of Patellar bursa, excision of Patellectomy 30111 23180, 23190, 23200, 23210, 23220, 23230, 23240, 23250 Patellectomy 49503, 49506 23340, 23350, 23360, 23370, 23380, 23390, 23400, 23410			
patch grafting to 33545, 33548 23041-23043, 23051-23053, 23061-23063, 23071-23073 patch, to artery or vein 33545, 33548 23081-23083, 23091, 23101, 23111-23119, 23121, 23170 Patella, bursa, excision of Patellar bursa, excision of Patellectomy 30111 23180, 23190, 23200, 23210, 23220, 23230, 23240, 23250 Patellectomy 49503, 49506 23340, 23350, 23360, 23370, 23380, 23390, 23400, 23410		34815	
patch, to artery or vein 33545, 33548 23081-23083, 23091, 23101, 23111-23119, 23121, 23170 Patella, bursa, excision of Patellar bursa, excision of Patellectomy 30111 23180, 23190, 23200, 23210, 23220, 23230, 23240, 23250 Patellar bursa, excision of Patellectomy 30111 23260, 23270, 23280, 23290, 23300, 23310, 23320, 23330 Patellar bursa, excision of Patellectomy 49503, 49506 23340, 23350, 23360, 23370, 23380, 23390, 23400, 23410			
Patella, bursa, excision of 30111 23180, 23190, 23200, 23210, 23220, 23230, 23240, 23250 Patellar bursa, excision of 30111 23260, 23270, 23280, 23290, 23300, 23310, 23320, 23330 Patellectomy 49503, 49506 23340, 23350, 23360, 23370, 23380, 23390, 23400, 23410			
Patellar bursa, excision of 30111 23260, 23270, 23280, 23290, 23300, 23310, 23320, 23330 Patellectomy 49503, 49506 23340, 23350, 23360, 23370, 23380, 23390, 23400, 23410			
Patellectomy 49503, 49506 23340, 23350, 23360, 23370, 23380, 23390, 23400, 23410		30111	
Patello-femoral stabilisation 49503, 49506, 49564 23420, 23430, 23440, 23450, 23460, 23470, 23480, 23490	Patellectomy	49503, 49506	
	•	49506, 49564	
patello-femoral stabilisation 49503, 49506, 49564 23500, 23510, 23520, 23530, 23540, 23550, 23560, 23570		49506, 49564	
patello-femoral stabilisation, revision of 49548 23580, 23590, 23600, 23610, 23620, 23630, 23640, 23650			
Patent diseased coronary bypass vein graft, dissection 38637 23660, 23670, 23680, 23690, 23700, 23710, 23720, 23730			23660, 23670, 23680, 23690, 23700, 23710, 23720, 23730
Patent ductus arteriosus, transcatheter closure 38273 23740, 23750, 23760, 23770, 23780, 23790, 23800, 23810			23740, 23750, 23760, 23770, 23780, 23790, 23800, 23810
Patent Urachus 37801 23820, 23830, 23840, 23850, 23860, 23870, 23880, 23890			
Pectus carinatum, repair or radical correction 38457 23900, 23910, 23920, 23930, 23940, 23950, 23960, 23970	Pectus carinatum, repair or radical correction	38457	23900, 23910, 23920, 23930, 23940, 23950, 23960, 23970

23980, 23990, 24100-24136		phototherapeutic keratectomy, laser	42810
perfusion, whole body, cardiac bypass	22060	Phototherapeutic, keratectomy	42810
Perianal abscess, drainage of	32174-32175	Pigeon chest, correction of	38457
Pericardectomy	38447, 38449	Pilonidal cyst or sinus, excision of	30676
Pericardium, drainage of, sub-xyphoid	38452	pilonidal, excision of	30676
Perineal anoplasty, ano-rectal malformation	43960	pin or screw, buried, removal of	47924, 47927
perineal proctectomy	32047	pin or wire, insertion of	47921
perineal resection of	32047	Pin, orthopaedic, insertion of	47921
perineal, for rectal prolapse	32112	Pinealoma, craniotomy for removal of	39712
Perineorrhaphy	35571	Pinguecula, removal of	42689
Perinephric abscess, drainage of	36537	pinguecula, surgical excision	42689
perineum 20900, 20902, 20904-20906, 2091		Pinhole urinary meatus, dilatation of	37300
20916, 20920, 20924, 20926, 20928, 20930, 209		pinhole urinary, dilatation of	37300
20936, 20938, 20940, 20942-20944, 20946, 2094	18, 20950	Pirogoff's amputation of foot	44361
20952-20954, 20956, 20958, 20960		Pituitary tumour, removal of	39715
Periorbital correction of Treacher Collins Syndrome		pituitary, hypophysectomy or removal of	39715
periorbital, excision of	42573, 42576		0, 38222, 38243
	7, 35319-35321	placement of catheters and injection of opaque ma	
Peripheral arterial atherectomy	35312	placement of intracranial electrodes	40709
peripheral nerve	39324, 39327	Placenta, retained, evacuation of	16564
	1, 39133-39137	Placentography, preparation for	36800
peripheral nerve, removal from	39324, 39327	planning 15500, 15503, 15506, 15509, 1551	
	7, 35319-35320	15518, 15521, 15524, 15527, 15530, 15533, 155	
peripheral, invitro processing, cryopreservation	13760	Plantar fasciotomy, radical	49854
peripheral, removal of tumour from	39324, 39327 42632	plantar, radical	49854
peritomy Peritomy, conjunctival	42632	plastic operations 45632, 45635, 45641, 4564 45652-45653	4-43047, 43030
Peritoneal adhesions, division, with laparotomy	30376	Plastic procedures to pelvi-ureteric junction	36564
30378-30379	30370	plate injury/deformity, radical excision	46534
peritoneal, for dialysis	13109-13110	plate or rod, removal of	47930
Peritoneo venous (Leveen) shunt, insertion of	30408	plate, prevention of closure	48512
Peritonitis, laparotomy for	30394	Plate, rod or nail, removal of	47930
Peritonsillar abscess, incision of	41807	pleura	30090
peritonsillar, incision of	41807	Pleura, percutaneous biopsy of	30090
Periurethral injection for urinary incontinence	37339	Pleural effusion	38803
permanent, insertion or replacement	38353	Pleurectomy with thoracotomy	38424
Perthes, hips or knees, application of cast under GA		pleurodesis	38424, 38436
Petro-clival and clival tumour, removal of	39653-39654	Plexus, brachial, exploration of	39333
39656		Plication, intestinal, with enterolysis, Noble type	30375
Peyronie's plaque, operation for	37417	plication, Noble type, with enterolysis	30375
Phalanges, amputation/splitting, congenital abnorm		Pneumonectomy	38438, 38441
phalanx	48400, 48403	Poison, ingested, gastric-lavage in the treatment of	
phalanx of, operation for acute osteomyelitis	43500	Polycythemia	13757
Phalanx, bone grafting of, for pseudarthrosis	46402, 46405	Polyhydramnios, attendance, not routine antenatal	16502
phalanx, operation for	46459, 46462	polyp or polypi, removal of	41662, 41668
pharyngeal, for velo-pharyngeal incompetence	45716	Polyp, anal, excision of	32142, 32145
pharyngeal, removal of	41813	Polypectomy, with hysteroscopy	35633
Pharyngectomy, partial	41782, 41785	Popliteal artery, exploration of, for popliteal entrap	
Pharyngoplasty	45716	Popliteal artery, vessel, ligation or exploration, of	
pharyngotomy	41779	popliteal, exploration for popliteal entrapment	34145
Pharyngotomy (lateral)	41779	Porta hepatitis, radical resection for carcinoma	30461
photocoagulation of	42809 42806	Portacath, laparatomy with insertion of	30400 3, 30605-30606
photocoagulation of iris tumour photocoagulation of vascular lesions 14100	42806), 14106, 14115	Portal hypertension, operations for 30602-3060 portion, decompression of facial nerve	41569
14118, 14124), 14100, 14113	Porto caval shunt for portal hypertension	30602
Photocoagulation, laser, vascular lesions	14100, 14106	Portoenterostomy for biliary atresia	43978
14115, 14118, 14124	14100, 14100	post-op, control under GA, independent	30058
photoiridosyneresis	42808	post-op, control under GA, independent post-operative, following gynaecological surgery	35759
Photoiridosyneresis, laser	42808	post-operative, laparotomy for	30385
photomydriasis	42807	Posterior chamber, removal of silicone oil	42815
Photomydriasis, laser	42807	Postnasal space, examination under GA	41653
phototherapeutic	42810	Postnatal care 16564, 16567, 1657	
*		, , ,	,

Postoperative haemorrhage	30058	ptosis, correction of	45623
Postpartum haemorrhage, treatment of	16567	ptosis, correction of (bilateral)	45558
postpartum, treatment of	16567	pulmonary artery	13818
pouch, endoscopic resection (Dohlman's op)	41773	Pulmonary artery, banding of	38715, 38718
pouch, removal of	41770	Pulp space infection of foot, incision for	47912
Pre-auricular sinus, excision of	30104-30105	Pulse generator, subcutaneous placement	39134
Pre-auricular, excision of	30105	pump or reservoir, loading of	14218
pre-auricular, excision of	30104	Pump or resevoir, loading of	14218
pre-detachment of, cryotherapy for	42818	punch biopsy	35608
Preeclampsia, treatment of	16509	Punch biopsy of synovial membrane	30087
Pregnancy, attendance for complication by	16508	punch, of synovial membrane	30087
pregnancy, removal of	35677-35678	Punctum, occlusion of	42620, 42622
pregnancy, ultrasound guided needling and injection	n 35674	puncture	39000, 39006
Premalignant skin lesions, treatment of	30192	puncture and blood collection, diagnostic	13839
Premature labour, attendances not routine antenatal	16502	purse string ligation	16511
16508		Purse string ligation, cervix	16511
premature labour, treatment of	16502, 16508	purse string, cervix	16511
Prepuce, breakdown of adhesions of	30649	Puva therapy	14050
Prepuce, operations on	30654, 30658	Pyelography retrograde, preparation for	36824
Presacral and sacrococcygeal tumour, excision of	32036	Pyelolithotomy	36540, 36543
pressure monitoring	13876	Pyeloplasty, by open exposure 3	6564, 36567, 36570
pressure monitoring device, insertion of	39015		66652, 36654, 36656
pressure monitoring, catheter/subarachnoid bolt	13830	Pyelostomy, open	36552
pressure monitoring, indwelling catheter (ICU only		Pyloromyotomy for pyloric stenosis	43930
Pressure monitoring, intracranial	13830	Pyloroplasty	30375
Priapism, decompression of	37393	Pylorus, dilation of, with vagotomy	30502
Primary repair of cutaneous nerve	39300	Pyonephrosis, drainage of	36537
procedure, intestinal, prior to radiotherapy	32183		
procedures, resuturing of wound after	42857	Q	
processing of bone marrow	13760		
Proctectomy, perineal	32047	Quadriceps, patella, reconstruction, congenital	dislocation 50420
proctitis, anorectal application of formalin	32212	Quadricepsplasty, for knee mobilisation	49569
	32018, 32021	Quinsy, incision of	41807
Products of conception, retained, evacuation of	16564	radial aplasia/dysplasia, centralisation/radialis	sation 50399
Progesterone implant	14203, 14206	radial head, replacement of	49112
prolapse, abdominal rectopexy of	32117		
prolapse, Delorme procedure for	32111	R	
prolapse, paediatric, injection under GA	44105		
prolapse, perineal recto-sigmoidectomy for	32112	Radial vessel, ligation or exploration, other	34106
prolapse, perineal repair of	32120	Radiation dosimetry 15518, 15521, 15524, 1	5527, 15530, 15533
prolapse, rubber band ligation of	32135	15536	
prolapse, sclerotherapy for	32132	radical	37210-37211
prolapsed, excision of	37369	radical for malignancy	35548
Proof puncture of maxillary antrum prostate 37212,	41698, 41701	radical operation for	38415
1	37215, 37218		41560, 41563-41564
Prostate, biopsy of 37212, 37215, prostate, drainage of	, 37218-37219	radical plantar fasciotomy or fasciectomy of	49854
	37212, 37221	radical, for nephroblastoma, paediatric	43984
Prostate, impantation of gold fiducial markers	37217	radioactive plaques, construction, insertion &	removal 42801
	37203, 37206	42802	
Prostatectomy, endoscopic	37203, 37206	radioactive sources, sealed 15303-1	15304, 15307-15308
Prostatic abscess, endoscopic drainage of prosthesis operations 45548, 45551.	37221 45552 45554	15311-15312, 15315-15316, 15319-15320, 1	
prosthesis, insertion of	, 45553-45554 30490	15327-15328, 15331-15332, 15335-15336, 1	15338-15339
prosthesis, operation on	49315	15342, 15345, 15348, 15351, 15354, 15357	
prostnesis, operation on prosthesis, removal of	48927, 49515		6006, 16009, 16012
prosthesis, replacement of	45553-45554	16015, 16018	
prosthesis, replacement of prosthesis, with cystoscopy	36811	Radioisotope, therapeutic dose, administration	of 16003
proximal carpectomy	49206	16006, 16009, 16012	
Pseudarthrosis, bone grafting of metatarsal for	46402, 46405	Radiosurgery, stereotactic	15600
pstosis, correction of (unilateral)	45556	12: 1	5100, 15103, 15106
Pterygium, removal of	42686	15109, 15112, 15115	
	12000	D - d 1 d - d - d d	47024 47027
Ptosis of eyelid, correction of	45623-45625	Radioulnar joint, dislocation, treatment of radius	47024, 47027 48406, 48409

Radiuls, bone graft to 48218, 48221, 48224, 48227 reconstruction for hyperparathyroidism re-exploration for ryperparathyroidism readjustment of adjustable sutures 42845 reconstruction of biocomutate uterus 42845 reconstruction of biocomutate uterus 42845 reconstruction of policy of the properties of
re-exploration for hyperparathyroidism readjustment of adjustable sutures reconstruction 45530, 45533, 45536, 45539, 45542, 45671 45674 reconstruction of bicornuate uterus reconstruction of for bicornuate uterus reconstruction of lacinial canaliculus reconstruction of lacinial canaliculus reconstruction of, whole thickness 45614, 45671, 45674 reconstruction of, whole thickness 45618, 45611 reconstruction, or, whole thickness 45618, 45611 reconstruction, physpapadias/epispadias 37815-37828, 37830 reconstruction, physpapadias/epispadias 37815-37816 37827-37828, 37830 reconstruction/repair reconstruction/repair reconstruction repair reconstruction repair reconstruction for a 32099, 32102, 32045-32046 Rectal prolapse, submucosal or perirectal injection retal, excision of rectal, excision of rectal, excision of rectal, excision of solva, addition of solva, addition of rectal, dilatation of rectal, excision of solva, addition of solva,
readjustment of adjustable sutures reconstruction of 45530, 45533, 45536, 45539, 45542, 45671 reconstruction of bicomuate uterus reconstruction of lorizimal canaliculus reconstruction of lorizimal canaliculus reconstruction of lorizimal canaliculus reconstruction of lorizimal canaliculus reconstruction of propertion reconstruction operation reconstruction operation reconstruction operation reconstruction operation reconstruction with oesophagectomy 30535 reconstruction, congenital absence/gynatresia reconstruction, physospadias/epispadias 37815-37816 reconstruction, physospadias/epispadias 37815-37816 reconstruction, physospadias/epispadias 37815-37816 reconstruction, physospadias/epispadias 37815-37816 reconstruction of littickness reconstruction of littickness reconstruction of littickness reconstruction of littickness reconstruction of littickness reconstruction physospadias/epispadias 37815-37816 reconstruction of littickness reconstruction of littickness reconstruction of littickness reconstruction of littickness reconstruction of littickness reconstruction of littickness reconstruction of littickness reconstruction of littickness reconstruction of littickness reconstruction of littickness reconstruction of littickness reconstruction of littickness reconstruction of littickness reconstruction of littickness reconstruction of littickness reconstruction of littickness reconstruction of littickness reconstruction of littickness reconstruction of littickness reconstruction with oesophagectomy reconstruction of littickness reconstruction with oesophagectomy removal of purse string ligature removal of purse string ligature removal of purse littic play littickness removal of purse string ligature removal of purse string ligature removal of purse string ligature removal of purse string ligature removal of purse string ligature removal of purse string ligature removal of purse string ligature removal of purse string ligature removal of purse string ligature removal of purse string ligature removal of purse translat
reconstruction 45530, 45533, 45536, 45539, 45542, 45671 reconstruction of bicomuate uterus 3680 reconstruction of particular and analysis of rectum, perineal repair of 32024, 32042,
reconstruction for bicomuate uterus 35680 reconstruction of another and an aliculus 42602 reconstruction of farrimal canaliculus 42602 reconstruction of profession 45594, 45545-45546, 49215 reconstruction of profession 45594, 45574, 45574 reconstruction operation 45596-44597, 45599, 45602, 45605 45608, 45611 reconstruction with oesophagectomy 35556 reconstruction, whose bindered as 37815-37816 and 37827-37828, 37830 reconstruction, propagatiase 37815-37816 reconstruction, propagatiase 37815-37816 reconstruction, propagatiase 37815-37816 reconstruction, propagatiase 37815-37816 reconstruction, propagatiase 37815-37816 reconstruction, propagatiase 37815-37816 reconstruction and an according a special profession 495304 reconstruction and an according a special profession 495304 reconstruction and according a special profession 495304 reconstructive 40600 Rectal prolapse, submucosal or perirectal injection 4104 rectal, dilatation of 32099, 32102, 32108 recto-sigmoidectomy for rectal prolapse 32112 rectosigmoidectomy (Hartmann's oph 32030 Rectosigmoidectomy (Hartmann's oph 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 rectum, palatic operation to 32034, 32042, 32045-32046 rectum, palatic operation to 32034, 32042, 32045-32046 rectum, palatic operation to 32034, 32042, 32045-32046 rectum, perineal repair of 32034, 32042, 32045-32046 rectum, perineal repair of 32036, 45504, 45504, 45024 required flating and anus, resection of 32034, 32042, 32045-32046 rectum, perineal repair of 32036, 45504, 45024 required flating and profession of 32034, 32042, 32045-32046 rectum, perineal repair of 32036, 45504, 45504, 45604 required flating and profession of 32034, 35042, 30045, 30042, 30045
reconstruction for bicomutae uterus reconstruction of 1 30517, 45545-45546, 49215 reconstruction of lacrimal canaliculus 42602 reconstruction of lacrimal canaliculus 42602 reconstruction of lacrimal canaliculus 42602 reconstruction of whole thickness 45614, 45671, 45674 reconstruction operation 45596, 45597, 45599, 45602, 45605 45608, 45611 reconstruction, congenital absence/gynatresia reconstruction, phyospadias 37815-37816 reconstruction, phyospadias/epispadias 37815-37816 37827-37828, 37830 reconstruction/repair 49536, 49539 reconstruction/repair 49536, 49539 reconstructive 40600 Rectal biopsy, full thickness 22096 Rectal prolapse, submucosal or perirectal injection rectal, excision of rectal, excision of rectal, excision of rectal, excision of rectal, excision of submitted properties and annual and annual
reconstruction of 30517, 45545-45546, 49215 reconstruction of lip or eyelid reconstruction of lip or eyelid reconstruction of, whole thickness 45614, 45674 reconstruction operation 45596-45597, 45599, 45602, 45604 45608, 45611 reconstruction with escophagectomy 30535 reconstruction, congenital absence/gynatresia 35565 reconstruction, typospadias/epispadias 37815-37816 37827-37828, 37830 reconstruction, congenital absence/gynatresia 49536, 49539 reconstruction/repair 49536, 49539 reconstructive 40600 Rectal biopsy, full thickness 32096 Rectal prolapse, submucosal or perirectal injection 4104 rectal, dilatation of 32015 rectal, excision of 32099, 32102, 32105 rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's op) 32030 Rectovaginal fistula, repair of 32039, 32042, 32045-32046, 44101 rectum, abdominal rectopexy 32039, 32042, 32045-32046, 4206 rectum, palsic operation to 32039, 32042, 32045-32046 rectum, perineal repair of 32120 rectum, perineal repair of 32120 rectum, perineal repair of 32039, 32042, 32045-32046 rectum, resection of 32034-32026, 32028 rectum, resection of 32034-32026, 32028 rectum, resection of 32034-32035, 346286 Recurrent hermia, repair of 32036 Reduction mammaplasty (unilateral) 45520, 45522-45523 Reduction mammaplasty (unilateral) 45520, 45522-45523 refulx, correction of 32054, 45224 refalshioning of 30563 reture, repair of rection of the device of the repair of rectioner thermia, repair of repair of rectioner thermia, repair of repair of repair of repair of repair of repair of repair of repair of repair of repair of repair of repair of repair of repair of repair of repair of repair of
reconstruction of lacrimal canaliculus
reconstruction of lip or eyelid reconstruction of, whole thickness 45614, 45671, 45674 reconstruction operation 45596-45597, 45599, 45602, 45605 45608, 45611 reconstruction with oesophagectomy 30535 reconstruction, congenital absence/gynatresia 35565 reconstruction, physopadias (prispadias 37815-37816 37827-37828, 37830 reconstruction/repair 49536, 49539 reconstructive 40600 Rectal biopsy, full thickness 32096 Rectal prolapse, submucosal or perirectal injection 41104 rectal, dilatation of rectal prolapse, submucosal or perirectal injection 4104 rectal, excision of 32099, 32102, 32108 recto-sigmoidectomy for rectal prolapse 32112 Rectocele, perineal repair of 32131 Rectopexy, abdominal, of rectal prolapse as 21117 rectusing and amus, abdomino-perineal resection of suction biopsy of 32039, 32042, 32045-32046, 44101 rectum, and anus, resection 32039, 32042, 32045-32046, 44101 rectum, abdominal rectopexy rectum, perineal repair of 32120 rectum, pastic operation to 30387 rectum, prineal repair of 32121 rectum, pastic operation to 30387 rectum, perineal repair of 32121 rectum, pastic operation to 30387 rectum, perineal repair of 32121 rectum, pastic operation of 32024-32026, 32028 rectum, pastic operation of 32024-32026, 32028 rectum, pastic operation to 45520, 45522, 45523 rectum, perineal repair of 32120 rectum, perineal repair of 3203
reconstruction of, whole thickness
reconstruction operation 45596-45597, 45599, 45602, 45605 45608, 45611 reconstruction with oesophagectomy 30535 reconstruction, congenital absence/gynatresia 35565 reconstruction, pypospadias/epispadias 37815-37816 37827-37828, 37830 reconstructive 40600 Rectal biopsy, full thickness 32096 Rectal prolapse, submucosal or perirectal injection 44104 rectal, dilatation of 32015 rectal, excision of 32099, 32102, 32108 recto-sigmoidectomy for rectal prolapse 32112 Rectocele, perineal repair of 32030 Rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's op) 32030 Rectovaginal fistula, repair of 32039, 32042, 32045-32046 rectum, abdominal rectopexy of 32039, 32042, 32045-32046 rectum, full thickness 32096 rectum, perineal repair of 32120 rectum, perineal repair of 32120 rectum, perineal repair of 32039, 32042, 32045-32046 rectum, perineal repair of 32120 rectum, perineal repair of 32120 rectum, perineal repair of 32120 rectum, perineal repair of 32024-32026, 32028 rectum, rubber band ligation of 45520, 45522-45523 rectum, repair of 45500, 45522-45523 Reduction mammaplasty (unilateral) 45520, 45522-45523 reduction of 45617, 45620 Reduction ureteroplasty 45600 rectum, correction of 36688 removal of, by neuretomy, neurotomy removal of, by neuretomy, neuroval of, by neuretomy, neurotomy removal of, by neuretoms, composal of, by neuretoms, perineal of, by neuretomy, neurotal of, by neuretoms, neurotomy removal of, by neuretomy, neurotomy removal of, by neuretoms, perineal of, by neuretoal of, by neuretoal of, by neuretoms, perineal of, by neuretoactomy, neurotal of, by neuretoactomy netwoal of, by neuretoactomy, neurotal of, by neuretoactomy netwoal of, by neuretoactomy netwoal of, by neuretoactomy netwoal of, by neuretoactomy netwoal of, by neuretoactomy netwoal of, by neuretoactomy netwoal of, by neuretoal of, by neuretoactomy netwoal of, by neuretoactomy netwoal
reconstruction with osophagectomy reconstruction, congenital absence/gynatresia 35565 reconstruction, hypospadias/epispadias 37815-37816 reconstruction, hypospadias/epispadias 37815-37816 reconstruction/repair 49536, 49539 reconstructive 40600 Rectal biopsy, full thickness 32096 Rectal prolapse, submucosal or perirectal injection 44104 rectal, dilatation of 32019, 32102, 32108 recto-sigmoidectomy for rectal prolapse 32112 Rectocele, perineal repair of 32099, 32102, 32108 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 rectum, abdominal rectopexy rectum, plastic operation to 32039, 32042, 32045-32046, 44101 rectum and anus, resection 32039, 32042, 32045-32046 rectum, plastic operation to 32039 rectum, plastic operation to 32030 rectum, plastic operation to 32030 rectum, plastic operation to 45520, 45522-45523 rectum, sclerotherapy for 232132 rectum, sclerotherapy for 24281 rectum, sclerotherapy for 24281 rectum, sclerotherapy for 24281 rectum, sclerotherapy for 24281 rectum, sclerotherapy for 24281 rectum, sclerotherapy for 24281 rectum, sclerotherapy for 24281 rectum, sclerotherapy for 24281 rectum, sclerotherapy for 24281 rectum, sclerotherapy for 24281 rectum, sclerotherapy for 24281 rectum, sclerotherapy for 24281 rectum, sclerotherapy for 24281 rectum, sclerotherapy for 24281 rectum, sclerotherapy for 24281 rectum, sclerotherapy for 24281 rectum, sclerotherapy for 24281 rectum, sclerotherapy for 24281 rectum, sclerotherapy for 24281 rectum, sclerotherapy for 32132 rectum, sclerotherapy for 32132 rectum, sclerotherapy for 32132 rectum, sclerotherapy for 32132 rectum sclerotherapy for 32132 rectum sclerotherapy for 32132 rectum sclerotherapy for 32132 rectum sclerotherapy for 32132 rectum sclerotherapy for 32132 rectum sclerotherapy for 32132 rectum sclerotherapy for 32132 rectum sclerotherapy for 32132 rectum sclerother
reconstruction, congenital absence/gynatresia 35565 reconstruction, congenital absence/gynatresia 35565 reconstruction, congenital absence/gynatresia 35565 reconstruction, hypospadias/epispadias 37815-37816 37827-37828, 37830 reconstruction/repair 49536, 49539 reconstructive 40600 Rectal biopsy, full thickness 32096 Rectal prolapse, submucosal or perirectal injection 44104 rectal, dilatation of 32099, 32102, 32108 recto-sigmoidectomy for rectal prolapse 32112 Rectocele, perineal repair of 32099, 32102, 32108 Rectosely abdominal, of rectal prolapse 32117 rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's op) 32030 Rectovaginal fistula, repair of 32039, 32042, 32045-32046, 44101 rectum and anus, resection 32039, 32042, 32045-32046 rectum, palatic operation to 32039, 32042, 32045-32046 rectum, perineal repair of 32030 rectum, plastic operation to 32030 rectum, sclerotherapy for 32120 rectum, sclerotherapy for 32135 rectum, repair of 30403 recurrent, eprair of 30403 recurrent, eprair of 30403 recurrent hernia, repair of 42851 reduction 45520, 45522-45523 Reduction mammaplasty (unilateral) 45520, 45522-45523 Reduction ureteroplasty 36618 removal of, by urethroscopy removal of, by urethroscopy 36540, 45801, 4580
reconstruction, congenital absence/gynatresia 35565 reconstruction, hypospadias/epispadias 37815-37816 reconstruction, hypospadias/epispadias 37815-37816 reconstructive 49536, 49539 reconstructive 40600 Rectal biopsy, full thickness 32096 Rectal prolapse, submucosal or perirectal injection 44104 rectal, dilatation of 32115 rectal, exision of 32099, 32102, 32108 recto-sigmoidectomy for rectal prolapse 32111 rectosigmoidectomy (Fartmann's op) 32030 Rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's op) 32030 30042, 30045, 30049 repair of 32039, 32042, 32045-32046, 44101 rectum, abdominal rectopexy 32117 rectum, abdominal rectopexy 32107 rectum, plastic operation of 32039, 32042, 32045-32046, 44101 rectum, plastic operation of 32039, 32042, 32045-32046 rectum, plastic operation of 32039, 32042, 32045-32046 rectum, plastic operation of 32034-32026, 32028 rectum, plastic operation of 32034-32026, 32028 rectum, primeal repair of 32034-32026, 32028 rectum, rubber band ligation of rectum, rubber band ligation of rectum, resection of 32034-32026, 32028 rectum, repair of abdominal plastic operation for 42881 rectum, repair of 45520, 45522-45523 Reduction mammaplasty (unilateral) 45520, 45522-45523 reduction of 45617, 45620 reduction of 45617, 45620 reduction of 45617, 45620 refusion of 36588 reduction graph of 45224 repair of increturing a 45209, 45212, 45215, 45218, 45218, refashioning of 36588 remaid and mamililofacial region of 45840, 45805, 45807, 45809, 45801, 45805, 45807, 45809, 45801, 45805, 45807, 45809, 45801, 45805, 45807, 45809, 45801, 45805, 45807, 45809, 45801, 45805, 45807, 45809, 45801, 45805, 45807, 45809, 45801, 45805, 45807, 45809, 45801, 45805, 45807, 45809, 45801, 45805, 45807, 45809, 45801, 45805, 45807, 45809, 45801, 45805, 45807, 45809, 45801, 45805, 45807, 45809, 45801, 45805, 45807, 45809, 45801, 45801, 45805, 45807, 45801, 45801, 45801, 45801, 45801, 45801, 45801, 45801, 45801, 4
reconstruction, hypospadias/epispadias 37815-37816 37827-37828, 37830 reconstruction/repair 49536, 49539 reconstruction/repair 49600 Rectal biopsy, full thickness Rectal prolapse, submucosal or perirectal injection 44104 rectal, dilatation of 32015 rectal, excision of 32099, 32102, 32108 recto-sigmoidectomy for rectal prolapse recto-sigmoidectomy for rectal prolapse recto-sigmoidectomy (Hartmann's op) 32030 Rectospery, abdominal, of rectal prolapse 32117 rectosigmoidectomy (Hartmann's op) 32030 Rectovaginal fistula, repair of 32039, 32042, 32045-32046, 44101 rectum and anus, abdomino-perineal resection of suction biopsy of rectum, perineal repair of 32039, 32042, 32045-32046, 44101 rectum, pastic operation to 32039, 32042, 32045-32046, 44101 rectum, plastic operation to 32034-32026, 32028 rectum, rubber band ligation of 32024-32026, 32028 rectum, rubber band ligation of 32024-32026, 32028 rectum, rubber band ligation of 32034-32039, 32035 Recurrent hernia, repair of 32039, 32042, 32045-32046 rectum, plastic operation for 4520, 45522-45523 rectum, sclerotherapy for 32132 rectum, sclerotherapy for 32132 rectum, sclerotherapy for 32132 rectum, sclerotherapy for 32132 rectum, sclerotherapy for 32132 rectum, sclerotherapy for 32132 rectum, sclerotherapy for 32132 rectum fundation of 4520, 45522-45523 Reduction mammaplasty (unilateral) 45520, 45522-45523 Reduction mammaplasty (unilateral) 45520, 45522-45523 reduction of 45617, 45620 Reduction ureteroplasty 36618 reflux, correction of 36588
37827-37828, 37830 reconstruction/repair 49536, 49539 reconstructive 40600 Rectal biopsy, full thickness 32096 Rectal prolapse, submucosal or perirectal injection 4104 rectal, excision of 32115 rectal, excision of 32099, 32102, 32108 recto-sigmoidectomy for rectal prolapse 32117 recto-sigmoidectomy for rectal prolapse 32117 rectosigmoidectomy (Hartmann's op) 32030 Rectosaginal fistula, repair of 32030, 32042, 32045-32046, 44101 rectum, and anus, abdomino-perineal resection of suction biopsy of 32039, 32042, 32045-32046, 44101 rectum, full thickness 32096 rectum, perineal repair of 32120 rectum, perineal repair of 32120 rectum, perineal repair of 32120 rectum, perineal repair of 32120 rectum, perineal repair of 32039, 32042, 32045-32046, 44101 rectum, perineal repair of 32120 rectum, perineal repair of 32120 rectum, perineal repair of 32120 rectum, perineal repair of 32120 rectum, perineal repair of 32120 rectum, perineal repair of 32135 rectum, sclerotherapy for 32135 rectum, sclerotherapy for 32135 rectum, sclerotherapy for 32132 rectum, sclerotherapy for 32132 rectum, of the method of 45520, 45522-45523 reduction mammaplasty (unilateral) 45520, 45522-45523 reduction mammaplasty (unilateral) 45520, 45522-45523 reduction mammaplasty (unilateral) 45520, 45522-45523 reduction of 45617, 45620 repair of, not otherwise covered repair of, not otherwise covered repair of, not otherwise covered repair, direct 45209, 45212, 45215, 45218, 452214, refashioning of 30588 45224 45224 45221, 45215, 45218, 45221, 45215, 45218, 45221, 45215, 45218, 45221, 45215, 45218, 45221, 45215, 45218, 45221, 45215, 45218, 45221, 45215, 45218, 45224 45224
reconstruction/repair 49536, 49539 reconstructive 40600 Rectal biopsy, full thickness 32096 Rectal prolapse, submucosal or perirectal injection 44104 rectal, dilatation of 32099, 32102, 32108 recto-sigmoidectomy for rectal prolapse 32112 Rectocele, perineal repair of 32099, 32102, 32108 recto-sigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectowaginal fistula, repair of 32039, 32042, 32045-32046, 44101 rectum, and anus, resection 32039, 32042, 32045-32046, 44101 rectum, plastic operation to 32039, 32042, 32045-32046, 44101 rectum, plastic operation to 32039, 32042, 32045-32046, 44101 rectum, plastic operation to 32039, 32042, 32045-32046, 44101 rectum, plastic operation to 32039, 32042, 32045-32046, 44101 rectum, plastic operation to 32039, 32042, 32045-32046, 44101 rectum, plastic operation to 32039, 32042, 32045-32046, 44101 rectum, plastic operation to 32039, 32042, 32045-32046, 44101 rectum, plastic operation to 32039, 32042, 32045-32046, 44101 rectum, plastic operation to 32039, 32042, 32045-32046, 44101 rectum, plastic operation to 32039, 32042, 32045-32046, 44101 rectum, plastic operation to 32039, 32042, 32045-32046, 44101 repair of fexor tendon of hand or wrist repair of extensive laceration/s rectum, resection of 32039, 32042, 32045-32046, 44101 repair of extensive laceration/s repair of extensive laceration/s repair of fexor tendon of hand or wrist repair of fexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of laceration/s, for trauma and and and precipation of a 4851, 45520, 45522-45523 reduction mammaplasty (unilateral) 45520, 45522-45523 reduction of 4551, 45620 repair of rectocele repair using microsurgical techniques 45500-45501, reflux, correction of 45617, 45620 repair of rectoretion of
reconstructive 40600 Rectal biopsy, full thickness 32096 Rectal prolapse, submucosal or perirectal injection 44104 rectal, dilatation of 32099, 32102, 32108 rectal, excision of 32099, 32102, 32108 Rectocele, perineal repair of 32131 Rectopexy, abdominal, of rectal prolapse 32117 rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectovaginal fistula, repair of 32039, 32042, 32045-32046, 44101 rectum and anus, resection 32039, 32042, 32045-32046, rectum, perineal repair of 32039, 32042, 32045-32046 rectum, perineal repair of 32120 rectum, perineal repair of 32030 rectum, resection of 32034, 32045-32046, 44101 rectum, perineal repair of 32120 rectum, perineal repair of 32120 rectum, perineal repair of 32034, 32045-32046 rectum, perineal repair of 32039, 32042, 32045-32046 rectum, perineal repair of 32120 rectum, resection of 32034-32026, 32028 rectum, resection of 32034-32026, 32028 rectum, resection of 32034-32026, 32028 rectum, resection of 32034-32026, 32028 rectum, resection of 32034-32036, 32035 Recurrent hernia, repair of 30403 recurrent, operation for 42851 reduction of 45520, 45522-45523 reduction of 45617, 45620 Reduction mammaplasty (unilateral) 45520, 45522-45523 reduction of 45617, 45620 Reduction ureteroplasty 36618 rectal, excision of recal prolapse and recursion of 36688 rectal repair of rectal prolapse and sutriction of 36688 rectal repair of rectal prolapse and sutriction of 36688 rectal repair of adouble advancement repair of about advancement repair of a 35570, 35573, 37821-37822, 37824 37827-37828, 37830, 37833, 37833, 37833, 37833, 37833, 37833, 37833, 37833, 37833, 37833, 37837, 37821-37822, 37824 repair of extensive laceration/s repair of extensive laceration of repair of extensive laceration of repair of nerve trunk repair of nerve trunk repair of nerve trunk repair of recorder repair of recorder repair of recorder repair of recorder repair of recorder repair of recorder repair of recorder repair of recorder repair of recorder repair of recorder repair
Rectal biopsy, full thickness Rectal prolapse, submucosal or perirectal injection 44104 rectal, dilatation of 32115 rectal, excision of 32099, 32102, 32108 recto-sigmoidectomy for rectal prolapse Rectoele, perineal repair of Rectopexy, abdominal, of rectal prolapse Rectosigmoidectomy (Hartmann's op) Rectosigmoidectomy (Hartmann's operation) Rectovaginal fistula, repair of 32030, Rectovaginal fistula, repair of Rectum and anus, abdomino-perineal resection of suction biopsy of rectum, abdominal rectopexy rectum, plastic operation to rectum, perineal repair of rectum, resection of rectum, resection of 32024-32026, 32028 rectum, resertion of 32024-32026, 32028 rectum, repair of asteroic of rectum, reservation of 32024-32026, 32028 rectum, repair of asteroic of 32030, 32042, 32045-32046 rectum, perineal repair of 32120 rectum, perineal repair of 32120 rectum, reservation of 32024-32026, 32028 rectum, reservation of 32024-32026, 32028 rectum, repair of asteroic of 32030, 32042, 32045-32046 rectum, reservation of 32024-32026, 32028 rectum, repair of 32135 rectum, perineal repair of 32135 rectum, reservation of 32024-32026, 32028 rectum, repair of 32135 rectum, reservation of 32024-32026, 32028 rectum, repair of 32135 rectum, perineal repair of 32135 rectum, perineal repair of 32136 rectum, perineal repair of 32137 rectum, perineal repair of 32136 rectum, perineal repair of 32137 rectum, perineal repair of 32136 rectum, perineal resection of 32024-32026, 32028 repair of extensive laceration/s repair of extensive laceration of hand or wrist repair of laceration of cavernous tissue, or fracture repair of laceration of cavernous tissue, or fracture repair of recent wound of 30026, 30029, 30032, 30042, 30045, 30049 repair of recent wound of 30038, 30042, 30045, 30049 repair of recent wound of 30038, 30042, 30045, 30049 repair of rectent wound of 30038, 30042, 30045, 30049 repair of rectorent wound of 30038, 30042, 30045, 30049 repair of rectorent wound of 30038, 30042, 30045, 30049 repair of rectorent wound of 30038, 30042
Rectal prolapse, submucosal or perirectal injection 44104 rectal, dilatation of 32115 rectal, excision of 32099, 32102, 32108 recto-sigmoidectomy for rectal prolapse 32112 Rectocele, perineal repair of 32131 Rectopexy, abdominal, of rectal prolapse 32117 rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's opo) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectowaginal fistula, repair of 32039, 32042, 32045-32046, 44101 rectum and anus, resection 32039, 32042, 32045-32046, 44101 rectum, abdominal rectopexy 32117 rectum, full thickness 32096 rectum, perineal repair of 32024-32026, 32028 rectum, perineal repair of 32024-32026, 32028 rectum, perineal repair of 32024-32026, 32028 rectum, rubber band ligation of 32024-32026, 32028 rectum, selerotherapy for 32132 rectum, selerotherapy for 32132 rectum, correction for 42851 reduction 45520, 45522-45523 reduction of 45520, 45522-45523 reduction of 45617, 45620 Reduction mammaplasty (unilateral) 45520, 45522-45523 reduction of 30563 reflux, correction of 36627, 36630, 36633, 36636, 36642, 36645, 36648, reoperation for dehiscence or infection recperation for debiscence or infection recperation of oxtremity for repair of advancement repair of about acuturing of 30026, 30029, 30035, 30035, 30042, 30045, 30049 repair of extensor tendon of hand or wrist repair of lexeration of cavernous tissue, or fracture repair of laceration of cavernous tissue, or fracture repair of nerve trunk repair of record would of 30026, 30029, 30032, 30038, 30042, 30045, 30049 repair of rectoc
rectal, dilatation of 32115 rectal, excision of 32099, 32102, 32108 rectoral, excision of 32099, 32102, 32108 recto-sigmoidectomy for rectal prolapse 32117 rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectovaginal fistula, repair of 32039, 32042, 32045-32046, 44101 rectum and anus, abdomino-perineal resection of suction biopsy of 32039, 32042, 32045-32046, 44101 rectum and anus, resection 32039, 32042, 32045-32046, 44101 rectum, plastic operation of 32039, 32042, 32045-32046 rectum, perineal repair of 32120 rectum, plastic operation to 30387 rectum, perineal repair of 32120 rectum, plastic operation to 30387 rectum, resection of 3204-32026, 32028 rectum, resection of 3204-32026, 32028 rectum, perineal repair of 32135 rectum, sclerotherapy for 32132 rectum, sclerotherapy for 32132 rectum, certus femoris tendon transfer 50357 Recurrent hernia, repair of 45520, 45522-45523 reduction of 45520, 45522-45523 reduction mammaplasty (unilateral) 45520, 45522-45523 reduction mammaplasty (unilateral) 45520, 45522-45523 reduction ureteroplasty 36618 reflux, correction of 36688 45224
rectal, excision of rectal prolapse recto-sigmoidectomy for rectal prolapse Rectocele, perineal repair of 32131 rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's op) 32030 Rectovaginal fistula, repair of 35596 Rectum and anus, abdomino-perineal resection of suction biopsy of 32039, 32042, 32045-32046, 44101 rectum, abdominal rectopexy 32117 rectum, abdominal rectopexy 32117 rectum, full thickness 32096 rectum, perineal repair of 32039, 32042, 32045-32046 rectum, perineal repair of 32120 rectum, perineal repair of 32039, 32042, 32045-32046 rectum, perineal repair of 32039, 32042, 32045-32046 repair of abdominal aortic aneurysm 33116, repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of laceration/s, for trauma 30422, rectum, sclerotherapy for 32132 rectum, sclerotherapy for 32132 rectum, certom femoris tendon transfer 50357 repair of recent wound of 30026, 30029, 30032, 30038, 30042, 30045, 30049 recurrent, operation for 45520, 45522-45523 reduction of 45517, 45620 reduction mammaplasty (unilateral) 45504, 45522-45523 reduction mammaplasty (unilateral) 45504, 45522-45523 reduction of 30563 reflux, correction of 36588 45224
recto-sigmoidectomy for rectal prolapse Rectocele, perineal repair of 32131 Rectocely, perineal repair of 32131 Rectopexy, abdominal, of rectal prolapse 32117 rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's oposation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectovaginal fistula, repair of 35596 Rectum and anus, abdomino-perineal resection of suction biopsy of 32039, 32042, 32045-32046, 44101 rectum and anus, resection 32039, 32042, 32045-32046 rectum, abdominal rectopexy 32117 rectum, perineal repair of 32120 rectum, perineal repair of 32024-32026, 32028 rectum, perineal repair of 32024-32026, 32028 rectum, sclerotherapy for 32132 rectum, sclerotherapy for 32132 recturent hernia, repair of 30403 recurrent hernia, repair of 45520, 45522-45523 Reduction mammaplasty (unilateral) 45520, 45522-45523 reduction of 45617, 45620 Reduction ureteroplasty 36618 reflux, correction of 306363 reflux, correction of 32014-32048 rectum, correction of 36588 32117 reoperation for dehiscence or infection reoperation of extremity for repair of advancement repear of abudonical and suturing of 30026, 30029, 30032, 30042, 30045, 30049 repair of abdominal aortic aneurysm 33116, repair of aventson of hand or wrist repair of extensor tendon of hand or wrist 46426, 46432 repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of aceration/s, for trauma 30422, repair of nerve trunk repair of recent wound of 30026, 30029, 30032, 30038, 30042, 30045, 30049 recurrent, operation for recorrele repair of recorrele repair of recorrele repair of, not otherwise covered repair using microsurgical techniques 45500-45501, repair, direct 45209, 45212, 45215, 45218, 45221, refair, direct flap 45209, 45212, 45215, 45218, 45221, 45215, 45218, 45224
Rectocele, perineal repair of Rectopexy, abdominal, of rectal prolapse 32117 rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectovaginal fistula, repair of 35596 Rectum and anus, abdomino-perineal resection of suction biopsy of 32039, 32042, 32045-32046, 44101 rectum and anus, resection 32039, 32042, 32045-32046 rectum, abdominal rectopexy 32117 rectum, full thickness 32096 rectum, perineal repair of 32120 rectum, plastic operation to 32034-32026, 32028 rectum, rubber band ligation of 32034-32026, 32028 rectum, rubber band ligation of 32135 rectum, sclerotherapy for 32132 rectum, sclerotherapy for 32132 rectum, femoris tendon transfer 50357 Recurrent hermia, repair of 30043, 30045, 30049 repair of fieceration of severation for 42851 reduction 45520, 45522-45523 reduction of 45617, 45620 Reduction ureteroplasty 36618 reflux, correction of 36588 45224
Rectopexy, abdominal, of rectal prolapse rectosigmoidectomy (Hartmann's opp) 32030 rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectovaginal fistula, repair of 35596 Rectum and anus, abdomino-perineal resection of suction biopsy of 32039, 32042, 32045-32046, 44101 rectum and anus, resection 32039, 32042, 32045-32046 rectum, abdominal rectopexy 32117 rectum, full thickness 32096 rectum, perineal repair of 32024-32026, 32028 rectum, rubber band ligation of 32024-32026, 32028 rectum, rubber band ligation of 32034-32026, 32028 rectum, selerotherapy for 32132 rectum, selerotherapy for 32132 rectum, selerotherapy for 32132 rectum, perineal femalia, repair of 30038, 30042, 30045, 30049 recurrent, operation for 42851 reduction mammaplasty (unilateral) 45520, 45522-45523 reduction ureteroplasty affects of 30563 reflux, correction of 30588 reflux, correction of 30588 repair of double advancement repair of a0026, 30029, 30032, 30035, 30042, 30045, 30049 repair of a0026, 30029, 30032, 300345, 30049 repair of a0026, 30029, 30032, 30034, 30038, 30042, 30045, 30049 repair of recturent repair of recturent repair of recturent repair of recturent repair of recturent repair of recturent repair of averaginal acritic aneurysm 33116, repair of extensive laceration/s repair of avallation of substance lac
rectosigmoidectomy (Hartmann's op) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectosigmoidectomy (Hartmann's operation) 32030 Rectovaginal fistula, repair of 35596 Rectum and anus, abdomino-perineal resection of suction biopsy of 32039, 32042, 32045-32046, 44101 rectum and anus, resection 32039, 32042, 32045-32046 rectum, abdominal rectopexy 32117 rectum, perineal repair of 32039, 32042, 32045-32046 rectum, plastic operation to 30387 rectum, resection of 32024-32026, 32028 rectum, rubber band ligation of 32135 rectum, resection of 32034-32026, 32028 rectum, resection of 32034-32026, 32028 rectum, resection of 32034-32035 rectum, resection of 32034-32035 rectum, resection of 32034-32035 rectum, resection of 32034-32035 rectum, resection of 32034-32035 rectum, resection of 32034-32035 rectum, resection of 32034-32036 rectum, resection of 32034-32036 rectum, resection of 32034-32038 repair of laceration of cavernous tissue, or fracture repair of nerve trunk repair of recent wound of 30026, 30029, 30032, 30032, 30038, 30042, 30045, 30049 recurrent, operation for 42851 reduction mammaplasty (unilateral) 45520, 45522-45523 Reduction mammaplasty (unilateral) 45520, 45522-45523 Reduction ureteroplasty 36618 repair of recent wound of 4500-45501, repair of rectocele repair of rupture repair of rupture repair of rectocele repair of, not otherwise covered repair using microsurgical techniques 45500-45501, repair, direct 45209, 45212, 45215, 45218, 45218, repair, direct flap 45209, 45212, 45215, 45218, 45218, repair, direct flap 45209, 45212, 45215, 45218, 45224
Rectosigmoidectomy (Hartmann's operation) Rectovaginal fistula, repair of 35596 Rectum and anus, abdomino-perineal resection of suction biopsy of 32039, 32042, 32045-32046, 44101 rectum and anus, resection 32039, 32042, 32045-32046 rectum, abdominal rectopexy 32117 rectum, full thickness 32096 rectum, perineal repair of 32120 rectum, plastic operation to 30387 rectum, resection of 32024-32026, 32028 rectum, resection of 32024-32026, 32028 rectum, sclerotherapy for 32132 rectum, sclerotherapy for 32132 rectum, sclerotherapy for 32132 rectum, sclerotherapy for 32132 rectum, operation for 42851 reduction mammaplasty (unilateral) 45520, 45522-45523 reduction of 45617, 45620 Reduction mammaplasty (unilateral) 4550, 45522-45523 reflux, correction of 30563 reflux, correction of 36588 45224
Rectovaginal fistula, repair of Rectum and anus, abdomino-perineal resection of suction biopsy of 32039, 32042, 32045-32046, 44101 rectum and anus, resection 32039, 32042, 32045-32046 rectum, abdominal rectopexy 32117 rectum, full thickness 32096 rectum, perineal repair of 32120 rectum, perineal repair of 32024-32026, 32028 rectum, resection of 32034-32026, 32028 rectum, rubber band ligation of 32135 rectum, rubber band ligation of 32132 rectum, selerotherapy for 32132 rectum, selerotherapy for 32132 rectum, perineal renair of 30403 recurrent hernia, repair of 30403 recurrent, operation for 42851 reduction mammaplasty (unilateral) 45520, 45522-45523 reduction of 45617, 45620 reduction of 45617, 45620 reflux, correction of 30638 reflux, correction of 36588 45224
Rectum and anus, abdomino-perineal resection of suction biopsy of 32039, 32042, 32045-32046, 44101 rectum and anus, resection 32039, 32042, 32045-32046 rectum, abdominal rectopexy 32117 rectum, full thickness 32096 rectum, perineal repair of 32120 rectum, plastic operation to 30387 rectum, rubber band ligation of 32024-32026, 32028 rectum, sclerotherapy for 32132 rectus femoris tendon transfer 50357 Recurrent hernia, repair of 45520, 45522-45523 Reduction mammaplasty (unilateral) reduction of 45617, 45620 reflux, correction of 30563 reflux, correction of 30588 45224
rectum and anus, resection rectum, abdominal rectopexy rectum, full thickness 32096 rectum, perineal repair of 32120 rectum, perineal repair of 32024-32026, 32028 rectum, resection of 32024-32026, 32028 rectum, resection of 32024-32026, 32028 rectum, rubber band ligation of rectum, selerotherapy for rectus femoris tendon transfer Recurrent hernia, repair of 30403 recurrent, operation for recturent, operation for recurrent, operation for recution of 45520, 45522-45523 Reduction mammaplasty (unilateral) reflaction of Reduction ureteroplasty refashioning of reflux, correction of 36588 repair of abdominal aortic aneurysm repair of abdominal aortic aneurysm repair of avulsion repair of abdominal aortic aneurysm 33116, repair of avulsion repair of avulsion repair of extensive laceration/s repair of extensive laceration/s repair of extensive laceration/s repair of flexor tendon of hand or wrist 46426, repair of laceration of cavernous tissue, or fracture repair of nerve trunk repair of nerve trunk repair of recent wound of 30026, 30029, 30032, 30038, 30042, 30045, 30049 repair of rectocele repair of rectocele repair of not otherwise covered repair of, not otherwise covered repair using microsurgical techniques 45500-45501, repair, direct 45209, 45212, 45215, 45218, 45221, refashioning of 30563 repair, direct 45209, 45212, 45215, 45218, 45221, refashioning of 36588 45224
rectum and anus, resection rectum, abdominal rectopexy rectum, full thickness rectum, perineal repair of rectum, perineal repair of rectum, plastic operation to rectum, rubber band ligation of rectus femoris tendon transfer Recurrent hernia, repair of reduction Reduction mammaplasty (unilateral) reduction of Reduction ureteroplasty refashioning of reflux, correction of 32039, 32042, 32045-32046 32117 repair of avulsion repair of extensive laceration/s repair of extensor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of laceration/s, for trauma 30422, repair of nerve trunk repair of nerve trunk repair of recent wound of 30026, 30029, 30032, 30038, 30042, 30045, 30049 repair of rectocele repair of rupture repair of, not otherwise covered repair using microsurgical techniques repair, direct 45209, 45212, 45215, 45218, 45221, repair, direct flap 45209, 45212, 45215, 45218, 45224
rectum, abdominal rectopexy rectum, full thickness rectum, perineal repair of rectum, perineal repair of rectum, plastic operation to rectum, resection of rectum, resection of rectum, sclerotherapy for rectus femoris tendon transfer Recurrent hernia, repair of reduction Reduction mammaplasty (unilateral) reduction of Reduction ureteroplasty refashioning of reflux, correction of reflux, correction of rectum, abdominal rectopexy 32096 repair of extensive laceration/s repair of extensor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of laceration of cavernous tissue, or fracture repair of laceration of cavernous tissue, or fracture repair of laceration of cavernous tissue, or fracture repair of neve trunk repair of recent wound of 30026, 30029, 30032, 30038, 30042, 30045, 30049 repair of rectoccle repair of rectoccle repair of rupture repair of, not otherwise covered repair using microsurgical techniques repair, direct 45209, 45212, 45215, 45218, 45221, repair, direct 45209, 45212, 45215, 45218, 45221, repair, direct flap 45209, 45212, 45215, 45218, repair, direct flap 45209, 45212, 45215, 45218, repair, direct flap 45209, 45212, 45215, 45218, repair, direct flap
rectum, full thickness rectum, perineal repair of rectum, perineal repair of rectum, plastic operation to rectum, resection of rectum, resection of rectum, rubber band ligation of rectum, sclerotherapy for rectus femoris tendon transfer Recurrent hernia, repair of recurrent, operation for reduction Reduction mammaplasty (unilateral) reduction of Reduction ureteroplasty refashioning of reflux or tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist repair of flexor tendon of hand or wrist 46426, repair of flexor tendon of hand or wrist 46426, repair of flexor tendon of hand or wrist 46426, repair of flexor tendon of hand or wrist 46426, repair of flexor tendon of hand or wrist 46426, repair of flexor tendon of hand or wrist 46426, repair of flexor tendon of hand or wrist 46426, repair of flexor tendon of hand or wrist 46426, repair of laceration of cavernous tissue, or fracture repair of laceration of cavernous tissue, or fracture repair of laceration of cavernous tissue, or fracture repair of laceration of cavernous tissue, or fracture repair of laceration of cavernous tissue, or fracture repair of laceration of cavernous tissue, or fracture repair of laceration of cavernous tissue, or fracture repair of nerve trunk repair of recent wound of 30026, 30029, 30032, 30038, 30042, 30045, 30049 repair of rectocele repair of rupture repair of, not otherwise covered repair using microsurgical techniques 45500-45501, repair, direct 45209, 45212, 45215, 45218, 45221, repair, direct flap 45209, 45212, 45215, 45218, repair, direct flap 45209, 45212, 45215, 45218, repair, direct flap 45209, 45212, 45215, 45218, repair, direct flap 45209, 45212, 45215, 45218, repair, direct flap 45209, 45212, 45215, 45218, repair of repair direct flap 45209, 45212, 45215, 45218, repair of rectocele repair of rectocele repair of repair using microsurgical techniques 45500-45501, repair, direct flap 45209, 45212, 45215, 45218, repair of rectocele
rectum, perineal repair of rectum, plastic operation to 30387 and 46426, rectum, plastic operation to 30387 and 46432 repair of laceration of cavernous tissue, or fracture rectum, rubber band ligation of 32135 repair of laceration/s, for trauma 30422, rectum, sclerotherapy for 32132 repair of nerve trunk rectus femoris tendon transfer 50357 recurrent hernia, repair of 30403 and 30038, 30042, 30045, 30049 recurrent, operation for 42851 repair of rectocele reduction 45520, 45522-45523 repair of not otherwise covered reduction of 45617, 45620 repair using microsurgical techniques 45500-45501, repair, direct 45209, 45212, 45215, 45218, 45221, refashioning of 30563 repair, direct flap 45209, 45212, 45215, 45218, repair, direct flap 45209, 45212,
rectum, plastic operation to rectum, resection of rectum, rubber band ligation of rectum, sclerotherapy for rectus femoris tendon transfer Recurrent hernia, repair of reduction Reduction mammaplasty (unilateral) reduction of Reduction ureteroplasty refashioning of reflux, correction of 30387 46432 repair of laceration of cavernous tissue, or fracture repair of laceration/s, for trauma 30422, repair of nerve trunk repair of recent wound of 30026, 30029, 30032, 30038, 30042, 30045, 30049 repair of rectocele repair of retocele repair of rupture repair of rupture repair of, not otherwise covered repair using microsurgical techniques 45500-45501, repair, direct 45209, 45212, 45215, 45218, 45221, refashioning of 30563 repair, direct flap 45209, 45212, 45215, 45218, 45224
rectum, resection of 32024-32026, 32028 repair of laceration of cavernous tissue, or fracture rectum, rubber band ligation of 32135 repair of laceration/s, for trauma 30422, rectum, sclerotherapy for 32132 repair of nerve trunk rectus femoris tendon transfer 50357 repair of recent wound of 30026, 30029, 30032, Recurrent hernia, repair of 30403 and 30038, 30042, 30045, 30049 recurrent, operation for 42851 repair of rectocele reduction 45520, 45522-45523 repair of rupture repair of rupture reduction of 45617, 45620 repair using microsurgical techniques 45500-45501, repair, direct 45209, 45212, 45215, 45218, 45221, refashioning of 30563 repair, direct flap 45209, 45212, 45215, 45218, reflux, correction of 36588 45224
rectum, rubber band ligation of rectum, rubber band ligation of rectum, sclerotherapy for solution is tenden transfer securrent hernia, repair of solution for recurrent, operation for reduction mammaplasty (unilateral) reduction of seduction ureteroplasty refashioning of reflex, correction of solution soluti
rectum, sclerotherapy for rectus femoris tendon transfer 50357 repair of nerve trunk repair of recent wound of 30026, 30029, 30032, 30038, 30042, 30045, 30049 recurrent, operation for 42851 repair of rectocele reduction 45520, 45522-45523 repair of rupture reduction of 45617, 45620 repair of, not otherwise covered reduction ureteroplasty refashioning of 30563 repair, direct 45209, 45212, 45215, 45218, reflux, correction of 36588 45224
rectus femoris tendon transfer Recurrent hernia, repair of 30403 recurrent, operation for 42851 reduction mammaplasty (unilateral) reduction of 45520, 45522-45523 reduction ureteroplasty refashioning of 30563 reflux, correction of 36588 repair of recent wound of 30026, 30029, 30032, 30038, 30042, 30045, 30049 repair of rectocele repair of rupture repair of rupture repair of rupture repair of rupture repair of rupture repair of rupture repair of rupture repair of rupture repair of rupture repair of rupture repair of rupture repair of rupture repair of rupture repair of rectocele repair of rupture repair of rupture repair of rupture repair of rupture repair of rupture repair of rupture repair of rupture repair of rupture repair of rupture repair of rupture repair of rectocele repair of rupture
Recurrent hernia, repair of recurrent, operation for reduction 30403 30038, 30042, 30045, 30049 reduction reduction mammaplasty (unilateral) reduction of Reduction ureteroplasty refashioning of reflux, correction of 45520, 45522-45523 repair of rupture repair of, not otherwise covered repair using microsurgical techniques repair, direct repair, direct repair, direct repair, direct repair, direct repair, direct flap repair, direct fl
recurrent, operation for reduction 42851 repair of rectocele reduction 45520, 45522-45523 repair of rupture repair of, not otherwise covered reduction of 45617, 45620 repair using microsurgical techniques 45500-45501, refashioning of 30563 repair, direct 45209, 45212, 45215, 45218, reflux, correction of 36588 45224
reduction 45520, 45522-45523 repair of rupture Reduction mammaplasty (unilateral) 45520, 45522-45523 repair of, not otherwise covered reduction of 45617, 45620 repair using microsurgical techniques 45500-45501, Reduction ureteroplasty 36618 repair, direct 45209, 45212, 45215, 45218, 45221, refashioning of 30563 repair, direct flap 45209, 45212, 45215, 45218, reflux, correction of 36588 45224
Reduction mammaplasty (unilateral) reduction of Reduction ureteroplasty refashioning of reflux, correction of 45520, 45522-45523 repair of, not otherwise covered repair using microsurgical techniques repair, direct repair, direct flap repair, direct flap 45209, 45212, 45215, 45218, reflux, correction of 36588 45224
reduction of 45617, 45620 repair using microsurgical techniques 45500-45501, Reduction ureteroplasty 36618 repair, direct 45209, 45212, 45215, 45218, 45221, refashioning of reflux, correction of 30563 repair, direct flap 45209, 45212, 45215, 45218, 45224 45224
Reduction ureteroplasty 36618 repair, direct 45209, 45212, 45215, 45218, 45221, refashioning of reflux, correction of 30563 repair, direct flap 45209, 45212, 45215, 45218, 45209, 45212, 45215, 45218, 45224
reflux, correction of 36588 45224
reflux, correction of 36588 45224
Defluy gastra assurbased correction 42051 42054 42057 remain boost 22400
Reflux, gastro-oesophageal, correction 43951, 43954, 43957 repair, heart 38480
reflux, operations for 43951, 43954, 43957 repair, local, single stage 45200, 45203,
regional anaesthesia of limb 18213 repair, muscle, single stage 45000, 45003, 45006,
remnant, abdominal wall vitello, excision of 43942 45012
removal 34539 repair, of cervical oesophagostomy
removal from eye, surgical excision 42689 repair, rectal prolapse
removal in operating theatre 30189 repair, single stage, local flap 45200, 45203,
removal in oral & maxillofacial region 45801, 45803, 45805 repair, to enlarge vaginal orifice
45807, 45809 replacement procedures 49318-49319, 49321, 49324,
removal of 30631, 32138-32139, 41801, 47904, 47906 49330, 49333, 49336, 49339, 49342, 49345, 49518-49519
removal of by laser surgery 41861 49521, 49524, 49527, 49530, 49533-49534
removal of calcium deposit from cuff 48900 replacement, heart 38488
removal of cancer of skin/mucous membrane 30196 requiring anterior decompression of spinal cord

resection arthroplasty 463.	25 rib, removal of 34139
resection for enterocolitis stricture, neonatal 438.	8
resection for jejunal atresia, neonatal 438	e , ,
resection of 45599, 45602, 4560	
resection of pharyngeal pouch 417	
resection of rectum 32024-3202	
resection of turbinates 4169	ring, removal under GA 35506
resection of uterine septem 3563	Rod, plate or nail, removal of 47930
resection of, segmental, for tumour/cyst 4560	Rosen incision, myringoplasty 41527
resection of, sub-total 4560	
resection of, total 45596-4559	
resection, congenital cystadenomatoid malformation 4386	
resection, congenital lobar emphysema 4386	
resection, large 32000, 3200	
*	, , , , , , , , , , , , , , , , , , , ,
resection, with radical operation for empyema 384	, 1
reservoir or external drain, insertion of 390	, 1
reservoir, construction of 3202	
reservoir, continent type, creation of 3200	
reservoir, formation of 3660	Rovsing's operation 36537
residual stump, removal of, abdominal approach 356	rubber band ligation of 32135
residual stump, removal of, vaginal approach 356	rubber band, of haemorrhoids or rectal prolapse 32135
restoration following Hartmann's op 32029, 3202	
restoration of alimentary continuity 418	* * *
restoration of face, autologous bone/cartilage graft 4564	
resurfacing, carbon dioxide, face or neck 45025-4502	
resuturing following intraocular procedures 428:	1 ' 1
	1 1 1
resynchronisation therapy 38365, 38368, 38371, 386	
retained, evacuation of 1650	
Retina, cryotherapy of 428	
retina, removal of silicone band 428	
retina, resection/buckling/revision 427	50005
retrieval of foreign body 35360-3536	Sacral sinus, excision of 30676
retrieval of inferior vena caval filter 3533	sacral, stimulation for faecal incontinence 32213-32218
Retrobulbar abscess, operation for 425'	72 sacro-iliac joint 49300
retrobulbar injection of 4282	Sacro-iliac joint, arthrodesis of 49300
retrocaval, correction of, by open exposure 36564, 3656	Sacro-mac joint, artificaciós or
retrograde admin for cardioplegia 3850	Swero mae, aramouests
retrograde, cerebral (if performed) 220'	sacro-mac, disruption of 47515
retrograde, intravenous, sympatholytic agent 1420	Sucrococcygear and presucrar tumour, excision or 32030
Retrolabyrinthine vestibular nerve section 415	sucrococcygeur und presucrur, excision or
	sacrococcygcar, excision or
Retroperitoneal abscess, drainage of 304	
retroperitoneal, drainage of 3040	
Retropharyngeal abscess, incision with drainage 3022	
Retropubic prostatectomy 3720	salivary gland 30266
Retroversion, operation for 3568	salivary gland duct 30262
revision arthroplasty 49116-49117, 49210-492	salivary gland, major, transposition of 41910
49716-49717	Salivary gland, major, transposition of duct 41910
7/10-7/11	
revision of 3666	salivary gland, marsupialisation 30266
revision of revision of failed surgery 3660	salivary gland, marsupialisation 30266 salivary gland, meatotomy 30266
revision of revision of failed surgery 5066 revision of orthopaedic procedures 49551, 4955	09salivary gland, marsupialisation3026620salivary gland, meatotomy3026654salivary gland, removal of calculus30266
revision of revision of failed surgery 5062 revision of orthopaedic procedures revision of, by incision and suture 4523	09salivary gland, marsupialisation3026620salivary gland, meatotomy3026654salivary gland, removal of calculus3026639salivary, duct, dilatation or diathermy of30262
revision of revision of failed surgery 5062 revision of orthopaedic procedures 49551, 4952 revision of, by incision and suture 4522 revision of, by liposuction 4524	salivary gland, marsupialisation 30266 salivary gland, meatotomy 30266 salivary gland, removal of calculus 30266 salivary, duct, dilatation or diathermy of 30262 salivary, duct, marsupialisation 30266
revision of revision of failed surgery 5062 revision of orthopaedic procedures 49551, 4952 revision of, by incision and suture 4522 revision of, by liposuction 4524 revision of, with myringoplasty 4156	salivary gland, marsupialisation 30266 salivary gland, meatotomy 30266 salivary gland, removal of calculus 30266 salivary, duct, dilatation or diathermy of 30262 salivary, duct, marsupialisation 30266 salivary, duct, meatotomy 30266
revision of revision of failed surgery 5062 revision of orthopaedic procedures 49551, 4953 revision of, by incision and suture 4522 revision of, by liposuction 4524 revision of, with myringoplasty 4156 Rhinophyma, carbon dioxide laser ablation/excision 4566	09salivary gland, marsupialisation3026620salivary gland, meatotomy3026654salivary gland, removal of calculus3026639salivary, duct, dilatation or diathermy of3026240salivary, duct, marsupialisation3026656salivary, duct, meatotomy3026652salivary, duct, removal of calculus30266
revision of revision of failed surgery 5062 revision of orthopaedic procedures 49551, 4952 revision of, by incision and suture 4522 revision of, by liposuction 4524 revision of, with myringoplasty 4156 Rhinophyma, carbon dioxide laser ablation/excision 4562 Rhinoplasty procedures 45632, 45635, 45641, 45644, 4564	salivary gland, marsupialisation 30266 salivary gland, meatotomy 30266 salivary gland, removal of calculus 30266 salivary, duct, dilatation or diathermy of 30262 salivary, duct, marsupialisation 30266 salivary, duct, meatotomy 30266 salivary, duct, removal of calculus 30266 salivary, duct, removal of calculus 30266 salivary, operations on 30262, 30266, 30269
revision of revision of failed surgery 5062 revision of orthopaedic procedures 49551, 4952 revision of, by incision and suture 4522 revision of, by liposuction 4524 revision of, with myringoplasty 4156 Rhinophyma, carbon dioxide laser ablation/excision 4562 Rhinoplasty procedures 45632, 45635, 45641, 45644, 4563 rhinotomy with removal of tumour 4172	09 salivary gland, marsupialisation 30266 20 salivary gland, meatotomy 30266 54 salivary gland, removal of calculus 30266 39 salivary, duct, dilatation or diathermy of 30262 40 salivary, duct, marsupialisation 30266 56 salivary, duct, meatotomy 30266 52 salivary, duct, removal of calculus 30266 50 salivary, operations on 30262, 30266, 30269 28 Salpingectomy, laparoscopic 35638
revision of revision of failed surgery 5062 revision of orthopaedic procedures 49551, 4952 revision of, by incision and suture 4522 revision of, by liposuction 4524 revision of, with myringoplasty 4156 Rhinophyma, carbon dioxide laser ablation/excision 4561 Rhinoplasty procedures 45632, 45635, 45641, 45644, 4562 rhinotomy with removal of tumour 4172 Rhinotomy, lateral, with removal of tumour 4172	09 salivary gland, marsupialisation 30266 20 salivary gland, meatotomy 30266 54 salivary gland, removal of calculus 30266 39 salivary, duct, dilatation or diathermy of 30262 40 salivary, duct, marsupialisation 30266 56 salivary, duct, meatotomy 30266 52 salivary, duct, removal of calculus 30266 50 salivary, operations on 30262, 30266, 30269 28 Salpingectomy, laparoscopic 35638 28 Salpingo-oophorectomy not with hysterectomy 35713, 35717
revision of revision of failed surgery 5062 revision of orthopaedic procedures 49551, 4952 revision of, by incision and suture 4522 revision of, by liposuction 4524 revision of, with myringoplasty 4156 Rhinophyma, carbon dioxide laser ablation/excision 4562 Rhinoplasty procedures 45632, 45635, 45641, 45644, 4563 rhinotomy with removal of tumour 4172	09 salivary gland, marsupialisation 30266 20 salivary gland, meatotomy 30266 54 salivary gland, removal of calculus 30266 39 salivary, duct, dilatation or diathermy of 30262 40 salivary, duct, marsupialisation 30266 56 salivary, duct, meatotomy 30266 52 salivary, duct, removal of calculus 30266 50 salivary, operations on 30262, 30266, 30269 28 Salpingectomy, laparoscopic 35638 28 Salpingo-oophorectomy not with hysterectomy 35713, 35717
revision of revision of failed surgery 5062 revision of orthopaedic procedures 49551, 4952 revision of, by incision and suture 4522 revision of, by liposuction 4524 revision of, with myringoplasty 4156 Rhinophyma, carbon dioxide laser ablation/excision 4561 Rhinoplasty procedures 45632, 45635, 45641, 45644, 4562 rhinotomy with removal of tumour 4172 Rhinotomy, lateral, with removal of tumour 4172	09 salivary gland, marsupialisation 30266 20 salivary gland, meatotomy 30266 54 salivary gland, removal of calculus 30266 39 salivary, duct, dilatation or diathermy of 30262 40 salivary, duct, marsupialisation 30266 56 salivary, duct, meatotomy 30266 52 salivary, duct, removal of calculus 30266 50 salivary, operations on 30262, 30266, 30269 28 Salpingectomy, laparoscopic 35638 28 Salpingo-oophorectomy not with hysterectomy 35713, 35717 30 Salpingolysis 35694, 35697
revision of revision of failed surgery 5062 revision of orthopaedic procedures 49551, 4952 revision of, by incision and suture 4552 revision of, by liposuction 4552 revision of, with myringoplasty 4156 Rhinophyma, carbon dioxide laser ablation/excision 4562 Rhinoplasty procedures 45632, 45635, 45641, 45644, 4562 rhinotomy with removal of tumour 4172 Rhinotomy, lateral, with removal of tumour 4172 rhythm, restoration, electrical stimulation 1346	09 salivary gland, marsupialisation 30266 20 salivary gland, meatotomy 30266 54 salivary gland, removal of calculus 30266 39 salivary, duct, dilatation or diathermy of 30262 40 salivary, duct, marsupialisation 30266 56 salivary, duct, meatotomy 30266 52 salivary, duct, removal of calculus 30266 50 salivary, operations on 30262, 30266, 30269 28 Salpingectomy, laparoscopic 35638 28 Salpingo-oophorectomy not with hysterectomy 35713, 35717 90 Salpingolysis 35694, 35697 99 Salpingostomy 35694, 35697

Saphenous vein anastomosis	34809	gentum hyptomagaania regestion	35623
saphenous vein, for femoral vein bypass	34809	septum, hysteroscopic resection septum, reconstruction of	41672
saphenous, cross leg by-pass graft	34806	septum, reconstruction of septum, septoplasty or submucous resection	41671
scalene node	30096	Sequestrectomy 43512, 43515, 435	
Scalene node biopsy	30096	Seroma, breast, exploration, drainage, operating t	
scalene, biopsy	30096	service provided by a midwife, nurse or ATSI h	
Scalenotomy	34133	service provided by a findwire, nurse of ATSI in	16400
Scalp vein catheterisation in a neonate	13300	sesamoid bone	48400
scalp, catheterisation of	13300	Sesamoid bone, osteotomy or osteectomy of	48400
A -	0, 48233, 48236	Seton, readjustment of, in anal fistula	32166
scaphoid, fracture, treatment of	47354, 47357	shaving of	45653
scapiloid, fracture, freatment of scapula (other than acromion)	48406, 48409	shirodkar	16511
Scapula, fracture, treatment of	47468	Shirodkar suture	16511
	5, 45021, 45024	shoulder 48912, 48915, 48918, 48921, 489	
scar, revision of (restriction applies)	45506, 45512	48945, 48948, 48951, 48954, 48957, 48960	24, 40939, 40942
Scars, corneal, removal of, by partial keratectomy	42647	shoulder & axilla 21600, 21610, 21620, 216	222 21630 21632
scars, excision of	42647, 45519		
Sclera, removal of imbedded foreign body	42644	21634, 21636, 21638, 21650, 21652, 21654, 21 21680, 21682	1030, 21070
		Shoulder, amputation or disarticulation at	44331
scleral graft to Sclerectomy and iridectomy for glaucoma	42860 42746	shoulder, removal of	48927
	30679		
sclerosant fluid into pilonidal sinus Sclerosant fluid, injection of into pilonidal sinus	30679	shunt diversion, insertion of shunt for hydrocephalus	40003, 40006 40006
	32132	shunt operation for	37396
sclerotherapy for	42734	*	
sclerotomy Screw, pin or wire, buried, removal of		Shunt, aorto-pulmonary or cavo-pulmonary	38733, 38736
	47924, 47927 37604	shunt, declotting of	13106
Scrotal contents, exploration of Scrotum, excision of abscess of	30223	shunt, external, insertion/removal shunt, revision or removal of	34500, 34506 40009
	45650		32072, 32075
secondary revision of		Sigmoidoscopic examination	
Secondary, repair of extensor tendon of hand or wr	40700	Sigmoidoscopy, fibreoptic, flexible	32084, 32087 retina 42812
section of corpus callosum for epilepsy	41596	Silicone band, encircling, removal from detached	
section, retrolabyrinthine, vestibular/cochlear	41593	single event multilevel surgery 50450-504 50460-50461, 50465-50466, 50470-50471, 504	451, 50455-50456 475, 50476
section, translabyrinthine, vestibular segmental resection of 3041	4-30415, 30427	single, preparatory to ventricular puncture	39012
	45605		41764
segmental resection of, for tumours Segmentectomy	38438	Sinoscopy sinus lift procedure	45849
			41719
	8, 38220, 38222	sinus, drainage of, through tooth socket	30679
38225, 38228, 38231, 38234, 38237, 38240-3824 38246	1, 38243	sinus, injection of sclerosant fluid sinus, intranasal operation on	41737
Semen, collection of	13290, 13292	sinus, operations on 41710, 41713, 417	
Semimembranosus bursa, excision of	30114	sinus, radical obliteration of	41746
semimembranosus, excision of	30114	sinus, trephine of	41743
Seminal vesicle/ampulla of vas, total excision of	37209	sinuses, operation on	41737, 41749
Sengstaken-Blakemore tube, insertion of	13506		104, 35406, 35408
Sentinel lymph node biopsy for breast cancer	30299-30300		42, 45445, 45448
30302-30303	30299-30300	skin tags or polyps, excision of	32142, 32145
sentinel lymph node, for breast cancer	30299-30300	Skin, biopsy of	30071
30302-30303	30277-30300	skin, micrographic serial excision	31000-31005
sentinel node biopsy for breast cancer	30299-30300	skin, to orbit	42524
30302-30303	30277-30300	skin/subcutaneous/mucuous membrane, removal	
septal defect closure, surgical	38742		540, 39642, 39646
septal defect closure, transcatheter approach	38272	39650, 39653-39654, 39656, 39658, 39660, 396	, ,
Septal defect, atrial, closure of	38742		542, 39646, 39650
septal defect, atrial, closure of	38751	39653-39654, 39656, 39658, 39660, 39662	142, 37040, 37030
septal rupture, ischaemic, repair of	38509	skull, craniectomy for	39906
septent rupture, ischaenie, repair of septectomy	38739, 38748	skull, excision of	39700
Septectomy, cardiac	38739, 38748	sling operation	35599, 37042
Septoplasty of nasal septum	41671	Sling operation for stress incontinence	35599, 37042
Septostomy, or balloon valvuloplasty	38270	sling procedure prior to radiotherapy	32183
septum	41674	Slough, debridement of	35100, 35103
septum septum septum button, insertion of			
	41907	Small bone, exostosis, excision of	47933
Septum button, masal, insertion of septum, excision for correction of double vagina			

small, intubation	30488	Stent, external, application restore valve competency	34824
	30565-30566	34827, 34830, 34833	7. 26021
small, strictureplasty	30564	stent, insertion of 36605, 3660'	
	47924, 47927	stent, removal/replacement of	36825
snip operation	42617	stent, through nephrostomy tube	36604
Socket, eye, contracted, reconstruction of	42527	stenting of bile duct	30491
socket, treatment as secondary procedure	42521	stenting, percutaneous	30492
solitary, pyeloplasty by open exposure	36567	Stereotactic procedures 40800-4080	
sounds, passage of, as an independent procedure	37300		0, 40803
space infection of hand, incision for	46525	Sterilisation (female)	35688
	30643-30644	sterilisation via	35688
Spermatocele, excision of	37601	Sternal wire/s, removal of	38460
Sphenoidal sinus, intranasal operation on	41752	Sternocleidomastoid muscle, bipolar release, torticollis	50402
sphenoidal, intranasal operation on	41752	sternotomy for post-operative bleeding	38656
Sphincter, anal, direct repair of	32129	Sternotomy for removal of thymus or mediastinal tumour	38446
	37381, 37384	Sternum and mediastinum, reoperation for infection 3846	
sphincter, direct repair of	32129	steroid injection	18232
sphincter, reconstruction of	37375	stimulation for pain 39130-39131, 3913	
sphincterotomy	30485	stimulation, restoration cardiac rhythm	13400
Sphincterotomy, anal, independent procedure	43999	stimulator, revision of	39133
sphincterotomy, independent, Hirschsprung's	43999	Strabismus, operation for 42833, 42830	
1 7 11	47540, 50564	strangulated, incarcerated or obstructed, repair of	30615
	50353, 50564	43835	
	30403, 30405		2, 35605
1 1 1	39130-39131	stress incontinence, sling procedure	37042
39133-39139		stress incontinence, Stamey or similar	37043
1 . 1	39133-39139	stress incontinence, suprapubic procedure	37044
spine & spinal cord 20600, 20604, 20620,	20622, 20630	stress, sling operation for	35599
20632, 20634, 20670, 20680, 20690		Stricture, anal, anoplasty for	32123
Spleen, ruptured, repair of	30375	stricture, anoplasty for	32123
Splenectomy 30597,	30599, 30619		5, 37303
splenectomy	31470	stricture, dilatation of with bronchoscopy	41904
Spleno renal shunt, selective, for portal hypertension	30605	stricture, endoscopy with balloon dilatation	30475
Splenorrhaphy	30596	stricture, optical urethrotomy for	37327
Split skin free grafts, granulating areas	45400, 45403	stricture, per anal release of	32114
split skin, to burns 45460-45462, 45464-45466,		stricture, plastic repair of 37342-37343, 37345	5, 37348
45471-45472, 45474-45475, 45477-45478, 45480-	45481	37351	
45483-45493		stricture, repair of	30469
Squint, muscle transplant (Hummelsheim type)	42848	Strictureplasty, small bowel	30564
stab cystotomy	37011	string ligature of cervix, removal	16512
stabilisation of	45875	Strontium 89, administration of	16015
Stabilisation procedure for recurrent anterior or post		Stump, amputation, reamputation of	44376
dislocation	48930	stump, reamputation of	44376
stabilisation, for multidirection instability	48933	stump, revision of	46483
stabilisation, repair capsule/ligament	50106	Styloid process of temporal bone, removal of	30244
stabilisation, revision of	49548	sub-total, radical, for carcinoma	30523
staghorn, nephrolithotomy and/or pyelolithotomy	36543	Sub-valvular structures, heart, reconstruction, re-implant	38490
Staging laparotomy for gynaecological malignancy	35726	Subclavian artery, endarterectomy	33506
staging of intra-abdominal tumours	30441	Subclavian artery, vessel, ligation/exploration, other	34103
Stamey or similar type needle colposuspension	37043	subcutaneous	31524
Stapedectomy	41608	Subcutaneous fasciotomy, Dupuytren's contracture	46366
Stapes mobilisation	41611	subcutaneous tissue, extensive excision	31245
Staple arrest of hemi-epiphysis	48509	subcutaneous, Dupuytren's contracture	46366
staple arrest of hemi-epiphysis	48509	subcutaneous, removal of	30064
stem tumour, craniotomy for removal	39709	subcutaneous, repair of recent wound of 30020	6, 30029
Stenosing tendovaginitis, hand/wrist, open operation	46363	30032, 30035, 30038, 30042, 30045, 30049	
stenosis or occlusion, vein bypass for	34812	Subdural haemorrhage, tap for	39009
Stenosis, arteriovenous fistula/access device, correction		subdural, tap for	39009
stenosis, duodeno-duodenostomy/jejunostomy	43807	Sublingual gland, duct, removal of calculus	30266
stenosis, patch angioplasty for	34815	sublingual, extirpation of	30259
	35306, 35309	sublingual/salivary gland duct, removal of	30266
stent, application 34824, 34827,		Submandibular abscess, incision of	30223
, Tr	,	, w-	

submandibular, extirpation of	30256	synovectomy of tendon/s 46348, 46351, 46354,	46357, 46360
Submaxillary gland, repair of cutaneous fistula	30269	synovectomy of, not otherwise covered	50104
submucous resection of	41692	Synovectomy, of ankle	50312
Submucous resection of nasal septum	41671	tags, anal, excision of	32142, 32145
subperiosteal 43500, 43503, 43506, 43509, 43512	, 43515	_	
43518, 43521, 43524		T	
Subperiosteal abscess 43500, 43503, 43506, 43509	, 43512		
43515, 43518, 43521, 43524	20204	Talipes equinovarus, cast/manipulation/splint	49878
Subphrenic abscess, laparotomy for drainage of	30394	Talus fracture, treatment of 47606, 47609,	47612, 47615
subphrenic, laparotomy for drainage	30394	47618	
Subtalar arthrodesis	50118	tantalum marker, insertion and removal	42805
subtalar joint	50118 50118	Tantalum markers, surgical insertion of	42805
subtalar, arthrodesis of	40015	tapping of	30628
subtemporal Subtemporal decompression	40015	tarsal cauterisation for	42581
Subungual haematoma, incision of	30219	tarsal, extirpation of	42575
subvalvular structures, reconstruction, re-implantation	38490		47621, 47624
Suction biopsy of rectum	30071	Tarsorrhaphy	42584
superficial 15000, 15003, 15006, 15009		tarsorrhaphy	42584
superficial, of parotid gland	30253		48406, 48409 47063, 47066
superficial, removal of	30061	tarsus, for ectropian/entropian	47063, 47066 42581
supervision in home	13104	Tear duct, probing of 42610-42611,	
	, 13103	Teflon injection, into vocal cord	41870
support procedures 13815, 13818, 13830, 13839	*	Temporal artery, biopsy of	34109
13847-13848, 13851, 13854, 13857, 38362, 38600, 3860		temporal, biopsy of	34109
38609, 38612-38613, 38615, 38618, 38621, 38624		temporo-mandibular	45755
supraglottic	41840	temporomandibular joint	45758
Supraglottic laryngectomy with tracheostomy	41840	Temporomandibular joint, arthroplasty	45758
Suprapubic cystostomy or cystotomy	37008	tenckhoff peritoneal dialysis, removal of	13110
suprapubic procedure for	37044	Tendon 49718, 49721,	
surgery 38390, 38393, 38512, 38515, 38518, 42702	, 43801	tendon of hand, tenolysis of	46450
43804, 43807, 43810, 43813, 43816, 43819, 43822			49800, 49803
surgery for congenital heart disease 38700, 38703		tendon or ligament transplantation of	49812
38709, 38712, 38715, 38718, 38721, 38724, 38727, 3873		tendon pulley, reconstruction	46411
38733, 38736, 38739, 38742, 38745, 38748, 38751, 3875	54	tendon sheath, finger or thumb, open operation	46522
38757, 38760, 38763, 38766	27.420	tendon sheath, open operation	46363
surgery for penile drainage causing impotence	37420	tendon sheath, operation for tendovaginitis	46363
surgery, for congenital heart disease 38700, 38703	,	tendon transfer for restoration of function	46417
38709, 38712, 38715, 38718, 38721, 38724, 38727, 3873		tendon, hand, tenolysis of	46453
38733, 38736, 38739, 38742, 38745, 38748, 38751, 3875 38757, 38760, 38763, 38766	04	tendon, hand/wrist, synovectomy of	46339
surgery, open, not otherwise covered	38653	tendon, removal of	30068
surgery, re-operation via median sternotomy	38640	tendon, repair of 46420, 46423, 46426, 46429,	46432, 46435
surgical 35000, 35003, 35006, 35009		49718, 49721, 49724	46220
Surgical reduction of enlarged elements, macrodactyly	46510	tendon, synovectomy of tendon, wrist, repair of	46339 46426, 46429
Suspension of uterus	35684	tendon, wrist, repair of tendon/s, digit, synovectomy of 46348, 46351,	
suspension or fixation of	35684	46360 40348, 40331,	40334, 40337
Suture, laser division of, eye, following trabeculoplasty	42794		46450, 46453
suture, running, manipulation of	42667	Tenoplasty	47963
Sutures, adjustable, readjustment of, for squint	42845	Tenosynovectomy	47969
sutures, removal of	42668	Tenosynovitis, open operation, tendon sheath hand/w	
Swann-Ganz catheterisation	13818	Tenotomy 47960, 47963,	
Sycosis barbae/nuchae, excision of	31245	tenotomy	47960
Symblepharon, grafting for	45629		49806, 49809
Syme's amputation of foot	44361	•	46363, 47972
sympathectomy 35000, 35003, 35006, 35009		Teratoma, mediastinal, thoracotomy and excision	43912
Symphysis pubis, fracture, treatment of 47474, 47477	, 47480		43876, 43879
47483, 47486, 47489	2005-	Testicular implant	45051
Synacthen stimulation testing	30097		37810, 37813
Synechiae, division of	42761	Testopexy	37803
synechiae, division of	42761	Tethered cord, release of	40112
synovectomy of 45867, 48936, 49509	, 50512	Thenar spaces of hand, drainage of	46519

therapeutic 13757, 16618	Tongue, partial or complete excision of 30272, 41779, 41782
Therapeutic haemapheresis 13750	41785
Therapeutic venesection 13757	Tonsils, lingual, removal of 41804
therapy for intraepithelial neoplasia 35539, 35542, 35545	Topectomy, for epilepsy 40703 Torkildsen's operation 40000
therapy, hyperbaric 13020, 13025, 13030 thickness wedge excision of lip, eyelid or ear 45665	
thickness wedge excision of lip, eyelid or ear 45665 Thigh, amputation through 44367	Torticollis, bipolar release sternocleidomastoid muscle 50402 total 30521, 30524, 30526
Third degree tear, repair of 16573	total body 22065
third degree, repair of 16573	total excision of 37209-37211
Thompson arthroplasty of hip 49315	total joint replacement 49715
Thoracic aneurysm, replacement by graft 33103	total replacement of 48918, 48921, 48924, 49115
thoracic aorta, operative management of 38572	total synovectomy of 49109
thoracic cavity 38803	total, for Hirschsprung's, paediatric 43996
thoracic, management of rupture/dissection 38572	total, of knee 49509
thoracic, repair/replacement procedures 38550, 38553	total, of wrist 49224
38556, 38559, 38562, 38565, 38568, 38571	total, with excision rectum/anastomosis 32051, 32054
Thoracoplasty 38427, 38430	32057
Thoracoscopy 38436	total, with excision rectum/ileostomy 32015, 32018, 32021
Thoracotomy 38418, 38421, 38424	total, with ileo-rectal anastomosis 32012
thorax 20400-20406, 20410, 20420, 20440, 20450, 20452	total, with ileostomy 32009
20470, 20472, 20474	Trabeculectomy for glaucoma 42746
Threatened abortion, treatment of 16505	trabeculoplasty 42782
threatened, ligation of cervix 16511	trabeculoplasty, laser 42782
threatened, treatment of 16505	Trabeculoplasty, laser, of eye 42782
Three snip operation 42617	Trachea, dilatation of stricture and stent insertion 41905
thrombectomy of 33803, 33806, 33810-33812 Thrombectomy of arteriovenous access device 34515	trachea, removal of 41886 Tracheal excision, repair, with cardiopulmonary bypass 38455
thrombosis, incision of 32147	Tracheal excision, repair, with cardiopulmonary bypass tracheal, dilatation of, with bronchoscopy 41904
Thrombosis, peri-anal, incision of 32147	Trachelorrhaphy 35618
Thrombus, removal of 33803, 33806, 33812	Tracheo-oesophageal fistula, division and repair 43900
Thumb, digital nail, removal of 46513, 46516	tracheo-oesophageal, division and repair 43900
Thymectomy 38456	Tracheomalacia, aortopexy for 43909
Thymoma, malignant, removal from mediastinum 38456	Tracheoplasty or laryngoplasty with tracheostomy 41879
Thymus, removal of by thoracotomy or sternotomy 38446	transanal endoscopic microsurgery 32103-32104, 32106
Thyroglossal cyst and/or fistula, removal of 30314, 30326	Transantral ethmoidectomy with radical antrostomy 41713
Thyroglossal, radical removal of 30326	transantral vidian, with antrostomy 41713
thyroglossal, radical removal of 30314	transantral, of maxillary artery 41707
thyroglossal, removal of 30314	transantral, with radical antrostomy 41713
thyroid, removal of 30310	transection for portal hypertension 30606
Thyroidectomy 30296-30297, 30299-30300, 30302-30303, 30306	transection, with re-anastomosis to trigone 37053
30310	transfer for facial nerve paralysis 45578
tibia 48418, 48421	transfer of abdominal musculature to greater trochanter 50387
Tibia, bone graft to 48206, 48209	transfer of adductors to ischium 50387
Tibial vessel, ligation/exploration not otherwise covered 34106	transfer of tissue 45562-45565
tibialis tendon transfer 50339, 50342	transfer of tissue, anastomosis artery/vein 45502
Tic douloureux, injection for 39100	Transfusion 13703, 13706
tie, repair of 30278, 30281	transfusion 13703, 13706
tissue or organ, biopsy of 30075, 30078	transfusion, fetal 16609, 16612, 16615
tissue, accessory, excision of 31560 Tissue, expansion for breast reconstruction 45539, 45542	transfusion, paediatric/neonatal 13306, 13309 transhepatic cholangiogram, imaging guided 30440
Tissue, expansion for breast reconstruction 45539, 45542 tissue, repair of recent wound of 30026, 30029, 30032	Transillumination, ocular 42821
30035, 30038, 30042, 30045, 30049	transillumuination 42821
to femoral bypass grafting 32715	Translabyrinthine vestibular nerve section 41593
to haemorrhoids with rubber band ligation 32135	transluminal balloon 35300, 35303
to prepare bypass site for anastomosis 33554	Transluminal balloon angioplasty 35300, 35303
to retina, independent procedure 42818	Transmastoid decompression of endolymphatic sac 41590
Toe, amputation or disarticulation of 44338, 44342, 44346	Transmetacarpal amputation of hand 44325
44350, 44354, 44358	Transmetatarsal amputation of foot 44364
toe, fracture, treatment of 47663, 47666, 47672, 47678	Transorbital ligation of ethmoidal arteries 41725
Toenail, ingrowing, excision or resection for 47915-47916	transplant 36503, 36506, 36509
47918	transplant (Hummelsheim type), for squint 42848
toilet, using operating microscope 41647	transplant to restore valvular function 34821

transplantation 47966	tumour, malignant, operations for 50200-50201, 50203
transplantation 36597, 42653, 42656, 42662, 42665	50206, 50209, 50212, 50215, 50218, 50221, 50224, 50227
Transplantation, cornea 42653, 42656	50230, 50233, 50236, 50239
transposition of 39321	tumour, radical or debulking operation for 35720
Transposition of digit 46507	tumour, removal of 4000 tumour, removal of 30520
transposition with hysterectomy for malignancy 35729	tumour, removal of by urethrectomy 37330
transposition/transfer, vascular pedicle 46507	tumour, transtympanic, removal of 41620
Transpupilliary thermotherapy 42811	tumour/s, diathermy/resection 36840, 36845
Transthoracic drainage of pericardium 38450	tumour/s, laser destruction with cystoscopy 36840
Transtympanic removal of glomus tumour 41620	tumours destruction by radiofrequency ablation 50950
Transurethral injection for urinary incontinence 37339	50952
transurethral microwave thermotherapy 37230, 37233	tumours, destruction of by cryotherapy 30419
Transvenous electrode/s, permanent, insertion of 38350	tunnel release 39331
38356	turbinates 41674
transvenous, insertion of 38256, 38356	Turbinates, cauterisation or diathermy of 41674
traumatic wounds 30026, 30029, 30032, 30035, 30038, 30042	Turbinectomy 41689
30045, 30049	Turricephaly, cranial vault reconstruction for 45785
traumatic, suture of 30026, 30029, 30032, 30035, 30038	Tympani, paracentesis of 41626
30042, 30045, 30049	Tympanic membrane, micro-inspection of 41650
Treacher Collins Syndrome, peri-orbital correction of 45773	Tympanum, perforation, cauterisation or diathermy 41641
treatment of including paediatric 50600, 50604, 50608	Tympunum, perioranom, eauterioanton or anamering
50612, 50616, 50620, 50624, 50628, 50632, 50636, 50640	U
50644, 50650, 50654, 50658	U
treatment of paediatric 50508, 50512	Ulcer, corneal, epithelial debridement for 31220, 31225
treatment, eye 42782, 42785, 42788, 42791, 42794	42650
42801-42802, 42805-42806	ulcer, epithelial debridement of cornea for 42650
Trephine of frontal sinus 41743	ulcer, perforated, suture 30375
Trichiasis, treatment of 42587-42588	ulcer, perforated, suture of 30375
Trichoepitheliomas, face/neck, removal by laser excision 30190	ulna 48406, 48409
Trigeminal gangliotomy, radiofrequency/balloon/glycerol 39109	Ulna, bone graft to 48218, 48221, 48224, 48227
trigeminal, primary branch, injection with alcohol etc 39100	Ulnar vessel, ligation/exploration not otherwise covered 34106
Trigger finger, correction of 46363	ultrasound 30688, 30690, 30692, 30694
trigger, correction of 46363	Ultrasound, intraoperative, biliary tract 30439
trunk, internal (interfasicular), neurolysis of 39312	umbilical artery 13303
trunk, microsurgical repair 39306, 39309	Umbilical artery catheterisation 13303
trunk, nerve graft to 39315	umbilical or scalp vein in a neonate 13300
tube, indwelling, gastrostomy for fixation 30375	umbilical, catheterisation of 13300
Tubed pedicle or indirect flap 45230	umbilical, epigastric, or linea alba, repair of 30621
tuberosity, reduction of 45829	umbilical, excision under GA 43948
tubes, hydrotubation of 35703, 35709	umbilical/scalp vein in neonate 13300
tubes, implantation of, into uterus 35694, 35697	Undescended testis, orchidopexy for 37803-37804, 37806-37807
tubes, insufflation of, for patency (Rubin test) 35706	37809-37810
tubes, microsurgical anastomosis 35700	undescended, orchidopexy for 37803, 37806, 37809-37810
tubes, Rubin test for patency 35706	Unstable lie, attendances other than routine antenatal 16502
tubes, sterilisation 35688	upper prolapse, sacrospinous colpopexy for 35568
tubes, sterilisation with Caesarean section 35691	upper recession of 42863
Tuboplasty 35694, 35697	upper vault prolapse, pelvic floor repair 35595
tubuerous, tubular or constricted breast, treatment by 45060-45062	upper vault prolapse, sacral colpopexy 35597
tubuerous, tubular or constricted, correction of 45060-45062	urachus, excision of 37800
tumour site, re-excision 31515	Urachus, patent, excision of 37800
Tumour, adrenal gland, excision of other, removal of 30324	ureter 36585, 36588, 36591, 36594, 36597, 36600, 36603
31220, 31225	Ureter, brush biopsy of, with cystoscopy 36821
Tumour, benign of soft tissue removal 30611	ureter, removal of 36549
tumour, benign, resection of 50230	Ureterectomy 36579
tumour, biopsy and/or decompression 39706	Ureteric calculus, endoscopic extraction/manipulation 36857
tumour, burr-hole biopsy for 39703, 39706	ureteric stent exchange 36608
tumour, craniotomy and removal of 39709, 39712	ureteric, endoscopic removal/manipulation 36857
tumour, craniotomy for removal 39712	ureteric, passage through nephrostomy tube 36604
tumour, excision of 30251, 32099, 32102-32104, 32106	ureteric, with cystoscopy 30266, 36824, 36830
32108, 38670, 38673, 38677, 38680, 39700	Ureterolithotomy 36549
tumour, innocent, excision of 30241	Ureterolysis 36615
tumour, laser photocoagulation of 42806	Ureteroplasty 36618

Ureteroscopy	36803, 36806, 36809		9-30500, 30502-30503
ureterostomy, closure of	36621	Vallecular cysts, removal of	41813
Ureterostomy, cutaneous, closure of	36621	vallecular, removal of	41813
urethra	35570, 35573, 37318	Valve annuloplasty, heart	38475, 38477-38478
urethra or urethral caruncle	35523	valve leaflet/s, decalcification of	38483
Urethra, cauterisation of	35523	valve replacement	38488-38489
urethra, excision of	37369	valve, open valvotomy of	38487
urethra, removal of	37318	valve, plication or repair to restore compete	
urethra, repair of	37306, 37309	valve, repair	38480-38481
urethral	37321	valves, destruction of	37854
Urethral abscess, drainage of	30223, 37816, 37828	Valvotomy for pulmonary stenosis	38456
urethral fistula repair	37833	valvuloplasty or septostomy	38270
Urethral sling, division or removal of	37340-37341	Valvuloplasty, balloon or septostomy	38270
urethral, closure of	37833	Varicocele, surgical correction of	30635
urethral, dilatation of	37303		, 32526, 32528-32529
urethral, excision of	35527, 37372	varicose, multiple injections	32500
urethral, reconstruction	37375	varicose, operations for	32500
Urethrectomy	37330	Vas deferens, operations on	37616, 37619, 37623
urethro-rectal	37336	Vasectomy	37623
urethro-vaginal	37333	Vasoepididymostomy (unilateral)	37616, 37619
Urethrocoele, repair of	35570	Vasotomy	37623
Urethropexy (Marshall-Marchetti operation)		Vasovasotomy	37616, 37619
	5, 37345, 37348, 37351	vault reconstruction	45785
Urethroscopy, as an independent procedure	37315	vein catheterisation	13318-13319, 13815
Urethrostomy	37324	vein catheterisation in a neonate	13300
Urethrotomy, external or internal	37324	vein catheterisation, via subcutaneous tunne	
Urinary conduit or reservoir, endoscopic exa		vein puncture in infants, blood collection	13312
urinary conduit, revision	36609	Vein, anastomosis, microsurgical	45502
urinary reservoir, continent, formation	36606	Vein, great, ligation or exploration not othe	
urinary sphincter, insertion	37381, 37384, 37387	vein, thrombectomy	33810-33811
urinary sphincter, revision/removal	37390	Veins, major, access as part of re-operation	35202
urinary, artificial, insertion	37381, 37384, 37387	veins, multiple injections	32500
urinary, artificial, revision or removal	37390		, 32507-32508, 32511
Urogenital sinus, vaginal reconstruction for	35565	32514, 32517	1 / 45716
urogenital, vaginal reconstruction for	35565	Velopharyngeal incompetence, flap or phary	
using Minitrach or similar device	41884	vena cava, for congenital heart disease	38721, 38724
Uterine adenomyoma, excision of	35649	Vena cava, inferior, operations on	34800, 34803
uterine, abdominal	35649 35638	vena caval filter, insertion of	35330
uterine, laparoscopic Utero-sacral ligaments, laparoscopic divisio		Venography, operative	35200
		Venous anastomosis, not otherwise covered	32766, 32769
uterus (D and C) Uterus, acute inversion, vaginal correction	35640 16570	venous catheterisation	35317, 35319-35320
	16570 35640	venous, operations for	34812, 34815
uterus, removal of	14050	Ventilation, mechanical, intensive care	13857, 13881-13882 s, repair of 43939
UVB therapy Uvula, excision of	41810	Ventral hernia following closure exomphalos ventral or incisional, repair of	30403, 30405
Uvulectomy and partial palatectomy	41787	ventral, following closure exomphalos, repa	
Uvulopalatopharyngoplasty	41786	ventricle, puncture of	39006
Uvulotomy	41810	Ventricular aneurysm, plication of	38506
Ovulotomy	41010	ventricular aneurysm, pheation of ventricular assist	38627
V		Ventricular assist Ventricular septal defect, transcatheter closur	
•		ventricular septal rupture, repair of	38509
X7 : ('C' : 1 C (' C	25565	Ventricular septar rupture, repair of Ventriculo-cisternostomy	40000
Vagina, artificial formation of	35565	ventriculostomy	40012
vaginal compartment repair	35557	Ventriculostomy, third	40012
vaginal compartment repair	35571, 35573	Vermilionectomy	45668-45669
vaginal compartment repair of	35571 16570	Version, external cephalic	16501
Vaginal correction of acute inversion of uter		vertebra, needle	30093
	0-35573, 35577-35578	Vertebra, needle biopsy of	30093
vaginal, excision of	35557	vertical, congenital, reconstruction	50336
vaginal, excision of, for correction of doub vaginal, repair of 35568-35573, 3557	le vagina 35566 7-35578, 35595-35597	Vesical fistula, cutaneous, operation for	37023
Vaginal, repair of 33368-333/3, 333/ Vaginectomy, radical, for malignancy	35561-35562, 35564	vesical fistula, operation for	37023
Vaginoplasty for congenital adrenal hyperpl		vesical, cutaneous, operation for	37023
v agmopiasty for congenital autenai hyperpi	asia 3/031	,	57025

Vesico-intestinal fistula, closure of	37038	with laparotomy, neonatal anorectal malformatic	
vesico-intestinal, closure of	37038	with laparotomy, not with hysterectomy	35713, 35717
vesico-ureteric, correction	36588	with laryngoplasty or tracheoplasty	41879
vesico-vaginal, closure of	37029	with laser destruction of stone	37318
Vesicostomy, cutaneous, establishment of	37026	with other procedures	35644-35647
vesicostomy, establishment of	37026	with ovarian transposition, malignancy	35729
Vesicovaginal fistula, closure of	37029	with proctocolectomy	32015
vessel, ligation/exploration, other	34106	with removal of cartilage and/or bone	41512, 41515
vessels, anastomosis/repair	38727, 38730		16, 41822, 41825
vessels, by-pass grafting to	32730, 32733	with supraglottic laryngectomy	41840
Vestibular nerve section, retrolabyrinthine	41596	with surgical repositioning of nipple	45520, 45523
vestibular, section of, via posterior fossa	39500	with total colectomy	32009
Vestibular, section of, via posterior rossa Vestibuloplasty, unilaterla or bilateral	45837	with total collectority with transbronchial lung biopsy	41898
	41713	with transection/resection Fallopian tubes	35688
vidian neurectomy			
Vidian neurectomy, transantral, with antrostomy	41713	with transmastoid removal of glomus tumour	41623
Villus, chorionic, sampling	16603	with vaginal hysterectomy	35673
Viscera, abdominal, operation involving laparotom		with vertical hemi-laryngectomy	41837
viscera, operations involving laparotomy	30387	without surgical repositioning of nipple	45522
Viscus, ruptured, simple repair of	30375	Wolfe graft	45451
viscus, simple repair of	30375	wound, debridement of	38462, 38464
Vitello intestinal duct, patent, excision of	43945	Wound, debridement under GA or major block	30023
Vitrectomy	42719, 42725	wound, review under GA, independent	32168
Vitreolysis of lens material	42791	wrist 49200, 49203, 49209, 49212, 492	18, 49221, 49224
vitreolysis, laser, of lens material	42791	49227	
vitreolysis/corticolysis	42791	wrist joint, excision of	46500-46503
Volvulus, reduction of	30375	Wrist, arthrodesis of	49200, 49203
Vulva, biopsy of, with colposcopy	35615	Wry neck, operation for	44133
Vulval warts, removal under GA or nerve block	35507-35508	with neek, operation for	11133
vulval/vaginal, removal, GA or nerve block	35507-35508	X	
Vulvectomy, hemi	35536	^	
Vulvoplasty, for localised gigantism	35534		40.500
		Xenon arc photo-coagulation	42782
Vulvoplasty, for repair of female genital mutilation	or anomalies	-	42/82
Vulvoplasty, for repair of female genital mutilation of the uro-gyn	or anomalies 35533	Xenon arc photo-coagulation	42782
Vulvoplasty, for repair of female genital mutilation	or anomalies	-	42/82
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of	or anomalies 35533	-	
Vulvoplasty, for repair of female genital mutilation of the uro-gyn	or anomalies 35533	Z Z-plasty, in association with Dupuytren's Contract	
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of	or anomalies 35533	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into	ture 46384 39013
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of	or anomalies 35533	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572	ture 46384 39013 20, 45723, 45726
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of	or anomalies 35533 43942	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572 45729, 45731-45732, 45735, 45738, 45741, 4574	ture 46384 39013 20, 45723, 45726
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of	or anomalies 35533 43942 32177, 32180	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572, 45731, 45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of	or anomalies 35533 43942 32177, 32180 36815 30187	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572 45729, 45731-45732, 45735, 45738, 45741, 4574	ture 46384 39013 20, 45723, 45726
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block	or anomalies 35533 43942 32177, 32180 36815	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572, 45731, 45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508	or anomalies 35533 43942 32177, 32180 36815 30187 32177, 32180	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572, 45731, 45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508 wedge excision 30165, 3016	or anomalies 35533 43942 32177, 32180 36815 30187 32177, 32180 8, 30171-30172	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572 45729, 45731-45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508 wedge excision 30165, 3016 Wedge excision for axillary hyperhidrosis	or anomalies 35533 43942 32177, 32180 36815 30187 32177, 32180 8, 30171-30172 30180	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572 45729, 45731-45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508 wedge excision Wedge excision 30165, 3016 Wedge excision for axillary hyperhidrosis wedge resection of	or anomalies 35533 43942 32177, 32180 36815 30187 32177, 32180 8, 30171-30172 30180 38440	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572 45729, 45731-45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508 wedge excision 30165, 3016 Wedge excision for axillary hyperhidrosis wedge resection of Wertheim's operation	or anomalies 35533 43942 32177, 32180 36815 30187 32177, 32180 8, 30171-30172 30180 38440 35664	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572 45729, 45731-45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508 wedge excision 30165, 3016 Wedge excision for axillary hyperhidrosis wedge resection of Wertheim's operation Whipple's operation (pancreatico-duodenectomy)	or anomalies 35533 43942 32177, 32180 36815 30187 32177, 32180 8, 30171-30172 30180 38440 35664 30584	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572 45729, 45731-45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508 wedge excision 30165, 3016 Wedge excision for axillary hyperhidrosis wedge resection of Wertheim's operation Whipple's operation (pancreatico-duodenectomy) whole body	or anomalies 35533 43942 32177, 32180 36815 30187 32177, 32180 8, 30171-30172 30180 38440 35664 30584 22060	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572 45729, 45731-45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508 wedge excision 30165, 3016 Wedge excision for axillary hyperhidrosis wedge resection of Wertheim's operation Whipple's operation (pancreatico-duodenectomy) whole body wide local excision of suspected malignancy	or anomalies 35533 43942 32177, 32180 36815 30187 32177, 32180 8, 30171-30172 30180 38440 35664 30584 22060 35536	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572 45729, 45731-45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508 wedge excision 30165, 3016 Wedge excision for axillary hyperhidrosis wedge resection of Wertheim's operation Whipple's operation (pancreatico-duodenectomy) whole body wide local excision of suspected malignancy wire or screw, buried, removal of	or anomalies 35533 43942 32177, 32180 36815 30187 32177, 32180 8, 30171-30172 30180 38440 35664 30584 22060 35536 47924, 47927	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572 45729, 45731-45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508 wedge excision 30165, 3016 Wedge excision for axillary hyperhidrosis wedge resection of Wertheim's operation Whipple's operation (pancreatico-duodenectomy) whole body wide local excision of suspected malignancy wire or screw, buried, removal of Wire, orthopaedic, insertion of	or anomalies 35533 43942 32177, 32180 36815 30187 32177, 32180 8, 30171-30172 30180 38440 35664 30584 22060 35536 47924, 47927 47921	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572 45729, 45731-45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508 wedge excision 30165, 3016 Wedge excision for axillary hyperhidrosis wedge resection of Wertheim's operation Whipple's operation (pancreatico-duodenectomy) whole body wide local excision of suspected malignancy wire or screw, buried, removal of Wire, orthopaedic, insertion of with biopsy	or anomalies 35533 43942 32177, 32180 36815 30187 32177, 32180 8, 30171-30172 30180 38440 35664 30584 22060 35536 47924, 47927 47921 30391	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572 45729, 45731-45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508 wedge excision 30165, 3016 Wedge excision for axillary hyperhidrosis wedge resection of Wertheim's operation Whipple's operation (pancreatico-duodenectomy) whole body wide local excision of suspected malignancy wire or screw, buried, removal of Wire, orthopaedic, insertion of with biopsy with biopsy or other procedure	or anomalies 35533 43942 32177, 32180 36815 30187 32177, 32180 8, 30171-30172 30180 38440 35664 30584 22060 35536 47924, 47927 47921 30391 41892	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572, 45731, 45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508 wedge excision 30165, 3016 Wedge excision for axillary hyperhidrosis wedge resection of Wertheim's operation Whipple's operation (pancreatico-duodenectomy) whole body wide local excision of suspected malignancy wire or screw, buried, removal of Wire, orthopaedic, insertion of with biopsy with biopsy or other procedure with biopsy/diathermy/foreign body/stone	or anomalies 35533 43942 32177, 32180 36815 30187 32177, 32180 8, 30171-30172 30180 38440 35664 30584 22060 35536 47924, 47927 47921 30391 41892 37318	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572, 45731, 45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508 wedge excision 30165, 3016 Wedge excision for axillary hyperhidrosis wedge resection of Wertheim's operation Whipple's operation (pancreatico-duodenectomy) whole body wide local excision of suspected malignancy wire or screw, buried, removal of Wire, orthopaedic, insertion of with biopsy with biopsy or other procedure with biopsy/diathermy/foreign body/stone with cystoscopy	or anomalies 35533 43942 32177, 32180 36815 30187 32177, 32180 8, 30171-30172 30180 38440 35664 30584 22060 35536 47924, 47927 47921 30391 41892 37318 36812	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572, 45731, 45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508 wedge excision 30165, 3016 Wedge excision for axillary hyperhidrosis wedge resection of Wertheim's operation Whipple's operation (pancreatico-duodenectomy) whole body wide local excision of suspected malignancy wire or screw, buried, removal of Wire, orthopaedic, insertion of with biopsy with biopsy or other procedure with biopsy/diathermy/foreign body/stone with cystoscopy and injection for incontinence	or anomalies 35533 43942 32177, 32180 36815 30187 32177, 32180 8, 30171-30172 30180 38440 35664 30584 22060 35536 47924, 47927 47921 30391 41892 37318 36812 37339	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572, 45731, 45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508 wedge excision 30165, 3016 Wedge excision for axillary hyperhidrosis wedge resection of Wertheim's operation Whipple's operation (pancreatico-duodenectomy) whole body wide local excision of suspected malignancy wire or screw, buried, removal of Wire, orthopaedic, insertion of with biopsy with biopsy or other procedure with biopsy/diathermy/foreign body/stone with cystoscopy and injection for incontinence with debulking operation	or anomalies 35533 43942 32177, 32180 36815 30187 32177, 32180 8, 30171-30172 30180 38440 35664 30584 22060 35536 47924, 47927 47921 30391 41892 37318 36812 37339 35720	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572, 45731, 45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508 wedge excision 30165, 3016 Wedge excision for axillary hyperhidrosis wedge resection of Wertheim's operation Whipple's operation (pancreatico-duodenectomy) whole body wide local excision of suspected malignancy wire or screw, buried, removal of Wire, orthopaedic, insertion of with biopsy with biopsy or other procedure with biopsy/diathermy/foreign body/stone with cystoscopy with cystoscopy and injection for incontinence with debulking operation with dilatation of tracheal stricture	or anomalies 35533 43942 32177, 32180 36815 30187 32177, 32180 8, 30171-30172 30180 38440 35664 30584 22060 35536 47924, 47927 47921 30391 41892 37318 36812 37339	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572, 45731, 45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508 wedge excision 30165, 3016 Wedge excision for axillary hyperhidrosis wedge resection of Wertheim's operation Whipple's operation (pancreatico-duodenectomy) whole body wide local excision of suspected malignancy wire or screw, buried, removal of Wire, orthopaedic, insertion of with biopsy with biopsy or other procedure with biopsy/diathermy/foreign body/stone with cystoscopy and injection for incontinence with debulking operation	or anomalies 35533 43942 32177, 32180 36815 30187 32177, 32180 8, 30171-30172 30180 38440 35664 30584 22060 35536 47924, 47927 47921 30391 41892 37318 36812 37339 35720	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572, 45731, 45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508 wedge excision 30165, 3016 Wedge excision for axillary hyperhidrosis wedge resection of Wertheim's operation Whipple's operation (pancreatico-duodenectomy) whole body wide local excision of suspected malignancy wire or screw, buried, removal of Wire, orthopaedic, insertion of with biopsy with biopsy or other procedure with biopsy/diathermy/foreign body/stone with cystoscopy with cystoscopy and injection for incontinence with debulking operation with dilatation of tracheal stricture	or anomalies 35533 43942 32177, 32180 36815 30187 32177, 32180 8, 30171-30172 30180 38440 35664 30584 22060 35536 47924, 47927 47921 30391 41892 37318 36812 37339 35720 41904	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572, 45731, 45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508 wedge excision 30165, 3016 Wedge excision for axillary hyperhidrosis wedge resection of Wertheim's operation Whipple's operation (pancreatico-duodenectomy) whole body wide local excision of suspected malignancy wire or screw, buried, removal of Wire, orthopaedic, insertion of with biopsy with biopsy or other procedure with biopsy/diathermy/foreign body/stone with cystoscopy with cystoscopy and injection for incontinence with debulking operation with dilatation of tracheal stricture with division of extensive adhesions with drainage of pus	or anomalies	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572, 45731, 45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747
Vulvoplasty, for repair of female genital mutilation of the uro-gyn wall vitello intestinal remnant, excision of W Warts, anal, removal under GA or nerve block warts, cystoscopy for the treatment of warts, removal of warts, removal under GA or nerve block 35507-35508 wedge excision 30165, 3016 Wedge excision for axillary hyperhidrosis wedge resection of Wertheim's operation Whipple's operation (pancreatico-duodenectomy) whole body wide local excision of suspected malignancy wire or screw, buried, removal of Wire, orthopaedic, insertion of with biopsy with biopsy or other procedure with biopsy/diathermy/foreign body/stone with cystoscopy with cystoscopy and injection for incontinence with debulking operation with dilatation of tracheal stricture with division of extensive adhesions	or anomalies 35533 43942 32177, 32180 36815 30187 32177, 32180 8, 30171-30172 30180 38440 35664 30584 22060 35536 47924, 47927 47921 30391 41892 37318 36812 37339 35720 41904 30379	Z-plasty, in association with Dupuytren's Contract Zygo-apophyseal joint, injection into Zygoma, osteotomy or osteectomy of 4572, 45731, 45732, 45735, 45738, 45741, 45745752	ture 46384 39013 20, 45723, 45726 44, 45747